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AND

PUBLIC HEALTH SPENDING IN

HEAVILY INDEBTED POOR COUNTRIES (HIPCS) [1/]

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THE DEBT RELIEF INITIATIVE AND PUBLIC HEALTH SPENDING IN HEAVILY INDEBTED POOR COUNTRIES (HIPCS)

I. INTRODUCTION

The Heavily Indebted Poor Countries (HIPC) Debt Initiative is the first international effort to reduce the external debt of the world's poorest, most heavily indebted countries, and represents an important step forward in placing debt relief within an overall framework of poverty reduction.[1] The initiative was initially designed to provide exceptional assistance to eligible countries following sound economic policies in order to help them reduce their external debt burden to sustainable levels. Following a comprehensive review of the original 1996 HIPC Initiative, a number of modifications were approved in October 1999 to provide enhanced (e.g., faster, deeper, and broader) debt relief and strengthen the links between debt relief, poverty reduction and social policies.[2] Resources freed under the Enhanced Initiative must thus be used for poverty-reducing programs. By end-2000, HIPC debt relief was committed to 22 countries under the Enhanced Framework.[3]

The purpose of this paper is to present estimates of debt relief to these countries, and discuss its possible use for various poverty-reducing programs, including for health programs. This paper is structured as follows: Section II presents estimates of the stock of debt and debt service after HIPC assistance and other forms of debt relief; Section III discusses possible uses of HIPC assistance, including for health programs; Section IV addresses issues related to monitoring the use and effectiveness of HIPC assistance; and Section V summarizes the paper.

II. ESTIMATED DEBT RELIEF UNDER THE HIPC INITIATIVE

The total costs of the assistance to be provided under the HIPC Initiative is estimated at US$28.6 billion in 1999 net present value (NPV) terms, spread across bilateral, commercial, and multilateral creditors. This estimate covers 32 countries out of 41 countries eligible under the Initiative.[4] The Paris Club bears the bulk of the total bilateral

[1] The original HIPC debt initiative was proposed by the World Bank (WB) and International Monetary Fund (IMF) and agreed by the governments around the world in the fall of 1996.

[2] The major modifications to the targets and thresholds between the original and enhanced HIPC initiative were to reduce: (i) the ratio of the net present value of debt to exports (from 200–250 percent to 150 percent), and the ratio of the net present value of debt to revenue (from 280 to 250 percent); and (ii) the thresholds regarding both the ratio of exports to GDP (from 40 percent to 30 percent), and the ratio of revenue to GDP (from 20 percent to 15 percent).

[3] These 22 countries are Benin, Bolivia, Burkina Faso, Cameroon, The Gambia, Guinea, Guinea-Bissau, Guyana, Honduras, Madagascar, Malawi, Mali, Mauritania, Mozambique, Nicaragua, Niger, Rwanda, São Tomé and Príncipe, Senegal, Tanzania, Uganda, and Zambia. Out of this group, only Uganda has reached the completion point under the enhanced HIPC framework. HIPC debt relief committed through end-2000 amounts to about 70 percent of the total envisaged HIPC debt relief.

[4] Nine HIPC-eligible countries were excluded from the costing exercise due to the following reasons: (i) two countries (Ghana and Lao P.D.R.) have indicated that they will not seek assistance under the HIPC Initiative; (ii) four countries are not expected to require assistance under the HIPC Initiative: Yemen has a sustainable debt

(continued…)

costs (75 percent), followed by non-Paris Club official creditors (17 percent) and commercial creditors (8 percent). Among multilateral creditors, the World Bank accounts for almost half (44.3 percent) of the total multilateral costs, followed by the African Development Bank and African Development Fund (16.5 percent), the IMF (15.8 percent) and others (23.4 percent) (Table 1).

HIPC debt relief committed as of end-December 2000 amounts to US$20.3 billion in NPV terms or US$ 33.6 billion in nominal terms to 22 countries that have reached the "decision point" under the enhanced HIPC framework.[5] US$14.6 billion is allocated to 18 countries in Africa and the remaining US$5.7 billion to four countries in Latin America and the Caribbean (Table 2).[6] These countries have reached their "decision points" as they have demonstrated a strong commitment to reduce macroeconomic imbalances and sustain growth-oriented policies, normally over a three-year period. An assessment of the needed assistance has been made and appropriate relief committed, including reductions in the stock of debt. The full stock of debt reduction is to be implemented following a further period of sound economic policies, at what is then called the "completion point" (for more details about decision and completion points, see Box 1).

On average, HIPC debt relief is projected to reduce the total stock of debt of the 22 countries by almost 50 percent. Nominal debt service relief will be quite significant for some countries. For instance, at US$4.5 billion (US$3.3 billion in NPV terms), Nicaragua will be receiving the largest debt relief under the HIPC Initiative. Other countries receiving large HIPC debt relief (exceeding US$2 billion per country, in nominal terms) include Bolivia, Mozambique, Tanzania, and Zambia; while countries receiving relatively small levels of debt relief in absolute terms include São Tomé and Príncipe and The Gambia (with less than US$200 million each). In percentage terms, debt reductions range from over 80 percent (Guinea-Bissau and São Tomé and Príncipe) to less than 20 percent (Honduras and Senegal) (Table 2 and Figure 1).

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burden (as indicated by its latest debt sustainability analysis) and the debt levels of three other countries (Angola, Kenya, and Vietnam) are currently expected to be sustainable with debt relief under traditional mechanisms; and (iii) three countries (Liberia, Somalia, and Sudan) have weak databases and a protracted period of time will be required to resolve their large arrears, including to multilateral institutions.

[5] Only Uganda has reached both the decision and the completion points under the enhanced framework.

[6] This amount can also be divided between the debt relief committed to the seven countries that reached their completion points under the original framework (US$3.5 billion in NPV terms), plus that committed to the 22 countries that have reached either the decision or completion points under the enhanced framework (US$16.8 billion in NPV terms).

Table 1. HIPC Initiative—Estimates of Potential Costs by Creditor
(In billions of U.S. dollars, in end-1999 NPV terms, potentially qualifying HIPCs)

	Updated Costing Exercise (32 countries)	In Percent of Total Costs
Total costs 1/	**28.6**	**100.0**
Bilateral and commercial creditors	**14.6**	**51.0**
Paris Club	11.0	38.5
Other official bilateral	2.5	8.7
Commercial	1.1	3.8
Multilateral creditors	**14.0**	**49.0**
World Bank	6.2	21.7
Of which: IDA	5.6	19.6
IBRD	0.6	2.1
IMF	2.2	7.7
AfDB/AfDF	2.3	8.0
IDB	1.1	3.8
Others	2.2	7.7
Memorandum items:		
Total costs including Liberia, Somalia, and Sudan	37.3	

Source: *Enhanced Initiative for Heavily Indebted Poor Countries—Review of Implementation* (EBS/00/166, 08/14/00).

1/ Excluding Liberia, Somalia, and Sudan, as well as Ghana and Lao P.D.R.

Table 2. Debt Relief Committed Under the Enhanced HIPC Initiative
(In billions of U.S. dollars)

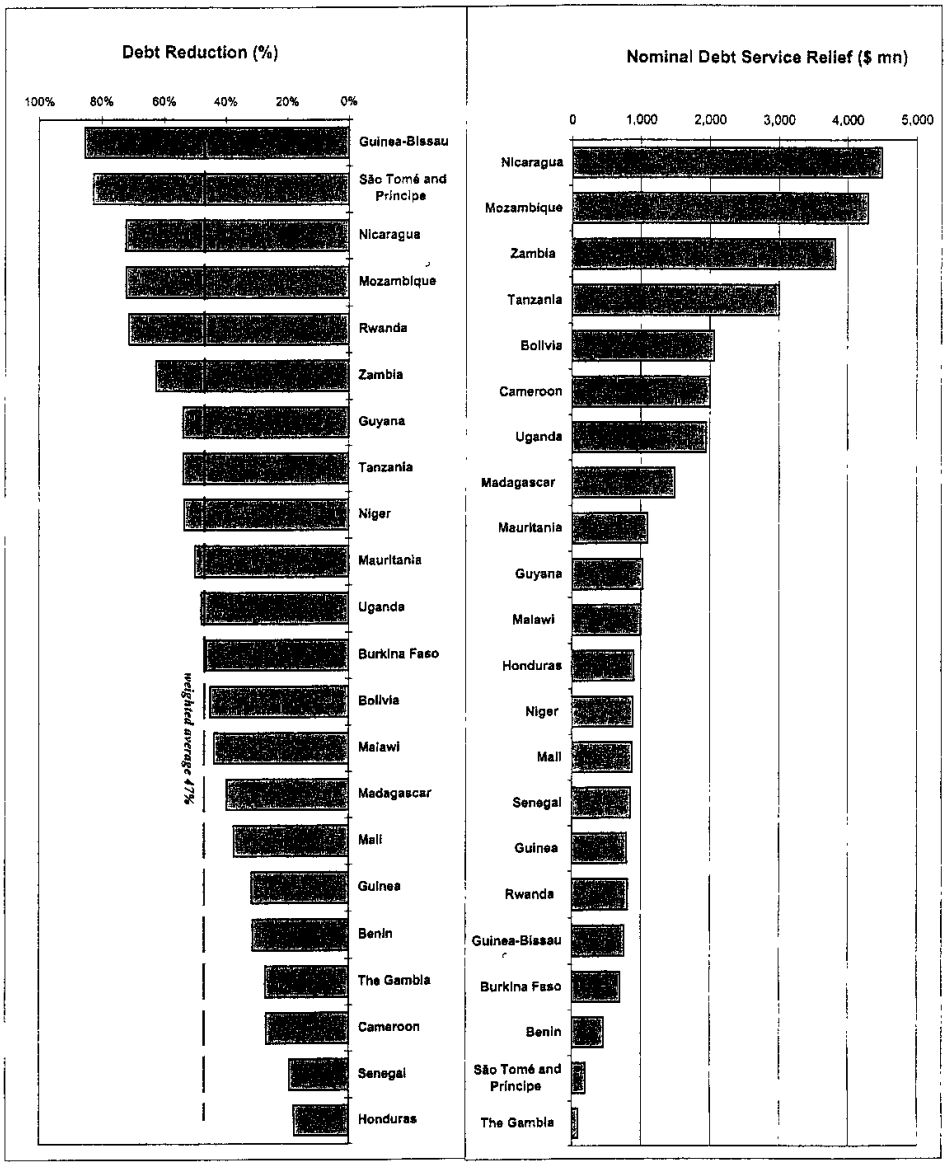
Country	NPV Debt Reduction		Nominal Debt Service Relief 3/
	Committed Debt Relief	Percentage Reduction 1/ 2/	
TOTAL	20.3	47 4/	33.6
African Countries	14.6	46 4/	25.1
Benin	0.3	31	0.5
Burkina Faso	0.4	46	0.7
Cameroon	1.3	27	2.0
The Gambia	0.1	27	0.1
Guinea	0.5	32	0.8
Guinea-Bissau	0.4	85	0.8
Madagascar	0.8	40	1.5
Malawi	0.6	44	1.0
Mali	0.5	37	0.9
Mauritania	0.6	50	1.1
Mozambique	2.0	72	4.3
Niger	0.5	54	0.9
Rwanda	0.5	71	0.8
Sao Tome and Principe	0.1	83	0.2
Senegal	0.5	19	0.9
Tanzania	2.0	53	3.0
Uganda	1.0	48	2.0
Zambia	2.5	63	3.8
Latin American Countries	5.7	49 4/	8.5
Bolivia	1.3	45	2.1
Guyana	0.6	54	1.0
Honduras	0.6	18	0.9
Nicaragua	3.3	72	4.5

Sources: World Bank and IMF staff estimates.

1/ Calculated on basis of net present values of debt and assistance committed (see Figure 1).
2/ Cumulative reduction, including traditional debt relief, is estimated at about two-thirds (see Figure 2).
3/ Estimates based on HIPC Initiative assistance in net present value terms (NPV) as approved by the Executive Boards of the IMF and the World Bank.
4/ Weighted average based on debt stocks in NPV terms.

Figure 1: Enhanced HIPC Initiative Comparative Debt Reduction and Debt Relief for 22 Decision Point Countries

Status as of End-December 2000



Source: "Debt Relief for the Poorest Countries: Milestone Achieved" (December 22, 2000), http://www.imf.org/external/np/hipc/2000/state/state.htm

Note: Debt reduction is measured by the common reduction factor. This refers to the percentage by which each creditor needs to reduce its debt stock at the decision point so as to enable the country to reach its debt sustainability target. The calculation is based in net present (NPV) information. For Bolivia, Burkina Faso, Guyana, Mali, Mozambique and Uganda, assistance under the original and enhanced framework is combined.

Box 1. Decision and Completion Points

Eligible countries qualify for debt relief in two stages.[1] In the first stage, the debtor country will need to demonstrate the capacity to use prudently the assistance granted by establishing a satisfactory track record, normally of three years, under IDA- and IMF-supported programs. In the second stage, after reaching the **decision point** under the Initiative, the country will implement a full-fledged poverty reduction strategy that has been prepared with the broad participation of civil society, and an agreed set of measures aimed at enhancing economic growth. During this stage, IDA and IMF may grant interim relief, provided that the country stays on track with its IDA- and IMF-supported programs. In addition, Paris Club creditors, and possibly others, are expected to grant debt relief on highly concessional terms. At the end of the second stage, when the floating **completion point** has been reached, IDA and the IMF will provide the remainder of the committed debt relief, whereas Paris Club creditors will enter into a highly concessional stock-of-debt operation with the country involved. Other multilateral and bilateral creditors will need to contribute to the debt relief on comparable terms.

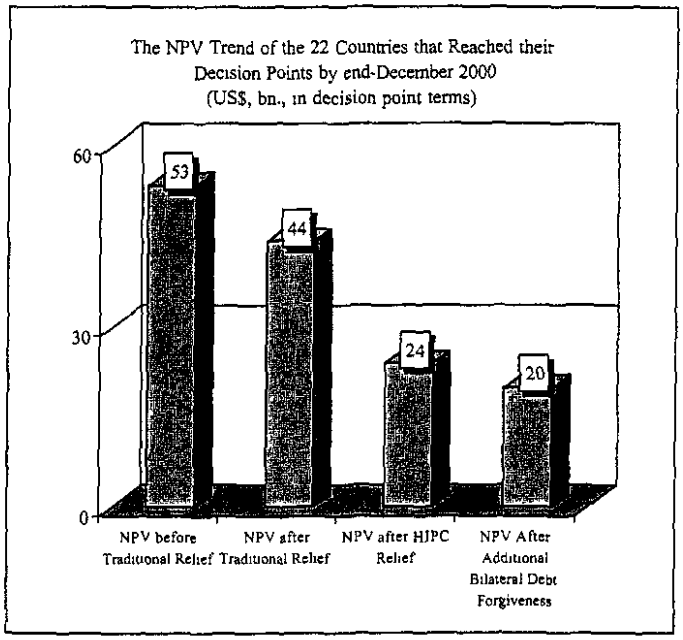
[1] For more details, see http://www.imf.org/external/np/hipc/hipc.htm.

Combined with other debt relief programs (such as traditional debt relief[7] and additional bilateral debt forgiveness), the HIPC Initiative will reduce the stock of external debt of these 22 countries by almost two thirds, from US$53 billion in NPV terms to roughly US$20 billion. The stock of debt (in NPV terms) is estimated to decrease 17 percent after the application of traditional debt relief, 55 percent after the application of both the traditional and HIPC debt relief, and 63 percent after the combined application of traditional and HIPC debt relief and bilateral debt forgiveness (Figure 2).

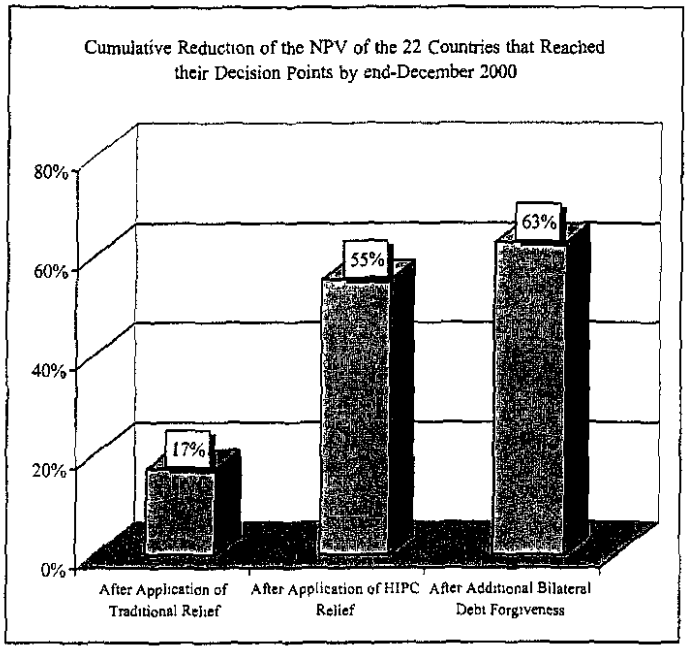
[7] Such as the Paris Club's Naples Terms.

Figure 2: Enhanced HIPC Initiative Debt Service Reduction for 22 Decision Point Countries

Status as of End-December 2000



Note. The debt stock before any relief is estimated at US$53 billion in NPV terms or US$73 billion in nominal terms



Source: "Debt Relief for the Poorest Countries: Milestone Achieved" (December 22, 2000), http://www.imf.org/external/np/hipc/2000/state/state.htm

In nominal terms, this combined debt relief will contribute to a decline in the debt service of these 22 countries by one third on average, **from around US$3 billion in 1998 and US$2.5 billion in 1999 to US$1.8 billion in 2001 and US$1.9 billion in 2002**. The ratio of debt service to exports will be cut from 20 percent in 1998 and 15 percent in 1999 to less than 10 percent in 2001 and beyond. Debt service as a percent of GDP is projected to decline from an annual average of around 5 percent in 1997 to 2¾ percent in 2001. Over time, debt service is estimated to steadily decrease to less than 2 percent of GDP by 2005 (Table 3). This will result in a reduction in average annual debt service per year in Bolivia, for example, from US$319 billion in 1998-99 to US$240 billion in 2000–05, and in Mozambique from US$95 billion to US$53 billion over the same time period.

The annual cash flow to the budget resulting from HIPC assistance alone to the 22 countries is estimated at around 2 percentage points of GDP (and the median by 1.5 percent of GDP) during 2001–05 (Tables 4 and 5). For some countries the cash flow to the budget could be quite significant (as in Guyana and São Tomé and Príncipe, whose HIPC debt relief exceeds 7 percentage points of GDP per annum over the next few years).[8] [9] This provides the maximum amount by which health spending could increase in HIPCs on account of debt relief, provided existing donor flows are maintained.

In sum, the HIPC Initiative has significantly lowered the stock of debt and debt service payments in the 22 countries that have reached their decision points. The challenge now is to harness these and other resources to combat poverty in the context of a comprehensive framework—an issue we turn to next.

III. The Use of HIPC Assistance in the Context of a Country's Poverty Reduction Strategy

A. Debt Relief and Health Spending in HIPCs

Under the Enhanced HIPC Initiative, debt relief is to be utilized for poverty-reducing programs in the context of a country-owned poverty reduction strategy (PRS). Each country's strategy—delineated in a poverty reduction strategy paper (PRSP)—will determine the basis for access to Bank and Fund concessional lending. The PRS is to be formulated by

[8] When actual debt service paid was small or negligible due to the accumulation of external arrears, HIPC assistance may be associated with increased debt service payments owing to the regularization of relations with creditors. This regularization of relations, however, could trigger *additional* donor flows.

[9] HIPC assistance from the IMF may not immediately show up in the fiscal accounts, as it accrues to the central bank (with the exception of CFA franc zone countries). Hence, countries may need to set up special accounts in the central bank to identify such HIPC assistance and provide transfers to the budget as grants. In a similar fashion, some HIPC assistance may accrue to public enterprises in the form of write-downs of public enterprise debt guaranteed by the government. In these cases, such debt write-downs will only be included in the government budget if arrangements are put in place to transfer this assistance to the budget.

Table 3. HIPCs: Debt Service Due After Enhanced HIPC Initiative 1/
(As a percent of GDP)

	1998	1999	2000	2001	2002	2003	2004	2005
Benin	2.6	2.9	2.6	1.7	1.5	1.3	1.1	1.0
Bolivia	4.8	3.3	3.2	2.1	2.2	2.3	2.3	2.3
Burkina Faso	…	2.1	1.3	1.0	1.1	1.1	1.0	1.0
Cameroon 2/	…	…	…	3.4	2.2	2.2	2.4	2.5
Gambia, The	…	…	4.6	3.5	3.1	1.5	1.6	1.7
Guinea	…	…	2.6	1.3	1.4	1.4	…	…
Guinea-Bissau	…	…		1.9	2.0	2.2	0.9	…
Guyana	…	…	10.4	6.5	4.5	4.8	5.0	…
Honduras	…	…	2.8	2.1	3.0	3.7	3.0	2.9
Madagascar	…	…	2.7	1.5	1.2	1.3	1.4	1.3
Malawi	…	…		3.4	3.4	2.5	2.3	2.3
Mali	…	…	3.4	2.3	2.1	2.0	1.9	1.7
Mauritania	…	…	8.4	7.4	6.6	4.0	3.2	3.0
Mozambique	…	…	1.2	1.0	1.0	0.9	0.9	0.9
Nicaragua	…	…	5.2	4.4	6.7	5.0	3.8	3.6
Niger	…	…	…	…	2.2	1.1	1.1	1.0
Rwanda	…	…	…	0.9	0.6	0.4	0.5	0.4
Sao Tome and Principe	…	…	…	4.4	2.5	2.4	1.6	1.5
Senegal	…	…	3.6	3.1	2.6	2.3	3.4	1.8
Tanzania 2/	…	…	2.7	1.7	1.4	1.3	1.3	1.2
Uganda 2/	…	…	0.6	0.5	0.5	0.6	…	…
Zambia	…	…	5.0	5.3	4.8	4.4	3.6	3.0
Simple average	…	…	3.8	2.8	2.6	2.2	2.1	1.8

Memorandum items:

Debt service due in 1997, as a percent of GDP 3/	
HIPCs (30)	5.1
non-HIPCs PRGF-eligible countries (20)	2.9

Sources: Country authorities; and IMF and World Bank staff estimates.

1/ Debt service due after the full use of traditional debt relief mechanism and assistance under the Enhanced HIPC Initiative.
2/ On fiscal year basis (i.e., 2000 column shows FY2000/01).
3/ Number of countries in parenthesis.

Table 4. Impact of HIPC Debt Relief on the Budget
(In cash terms and as a percent of GDP)

	2001	2002	2003	2004	2005	2001-05 (average)
Benin						
Enhanced	0.8	0.9	0.9	0.7	0.6	0.8
Bolivia	2.1	1.8	1.6	1.3	1.1	1.6
Original	0.8	0.6	0.4	0.3	0.3	0.5
Enhanced	1.3	1.3	1.2	1.0	0.8	1.1
Burkina Faso	1.3	1.3	1.2	1.0	0.9	1.1
Original	0.7	0.6	0.6	0.5	0.4	0.6
Enhanced	0.6	0.7	0.6	0.5	0.4	0.6
Cameroon 2/						
Enhanced	0.7	1.3	1.1	0.7	0.6	0.9
Gambia, The						
Enhanced	1.0	1.0	2.4	...	...	1.5
Guinea						
Enhanced	1.2	0.9	0.9	...	...	1.0
Guinea-Bissau						
Enhanced	-1.9	...	...	...	...	-1.9
Guyana	7.1	8.0	7.2	7.3	6.8	7.3
Original	4.1	4.2	3.6	3.2	3.1	3.6
Enhanced	3.0	3.8	3.6	4.0	3.7	3.6
Honduras						
Enhanced	1.2	1.3	...	...	...	1.2
Madagascar						
Enhanced	1.0	1.0	...	...	...	1.0
Malawi 2/						
Enhanced	1.0	2.0	2.5	...	...	1.9
Mali	1.5	1.6	1.5	1.4	1.3	1.5
Original	0.4	0.3	0.3	0.3	0.3	0.3
Enhanced	1.1	1.3	1.2	1.1	1.0	1.1
Mauritania						
Enhanced	2.2	...	...	...	...	2.2
Mozambique	2.5	2.1	2.0	1.8	1.7	2.0
Original	2.1	1.8	1.7	1.6	1.5	1.7
Enhanced	0.4	0.3	0.3	0.3	0.3	0.3
Nicaragua 2/						
Enhanced	2.7	5.0	5.6	...	...	4.4
Niger						
Enhanced	0.9	1.0	2.1	2.3	2.1	1.7
Rwanda						
Enhanced	1.5	1.5	1.4	1.4	...	1.5
Sao Tome and Principe						
Enhanced	7.8	9.5	8.2	9.1	8.8	8.7
Senegal						
Enhanced	0.6	0.9	0.8	0.9	0.8	0.8
Tanzania 2/						
Enhanced	1.0	1.0	0.9	0.7	0.8	0.9
Uganda 2/	1.4	1.3	1.2	...	...	1.3
Original	0.7	0.6	0.5	...	...	0.6
Enhanced	0.8	0.7	0.7	...	...	0.7
Zambia 3/						
Enhanced 2/	6.9	...	...	...	...	6.9
Simple averages						
Total	2.0	2.3	2.4	2.6	2.5	...
Original	1.5	1.3	1.2	0.7	1.1	...
Enhanced	1.6	1.8	2.0	2.0	1.9	...

Sources: IMF documents, and Fund staff estimates.
1/ Includes countries that have reached their completion points under the original HIPC framework, plus those tha reached either their decision or completion points under the enhanced HIPC framework.
2/ On fiscal year basis.
3/ In 2001, the budget only gets 3.3 percent of GDP because the remaining 3.6 percent of GDP corresponding to t relief of the IMF remains with the Bank of Zambia.

countries in collaboration with the staffs of the World Bank and IMF, as well as civil society and development partners. Updated annually, PRSPs describe a country's plan for macroeconomic, structural, and social policies for three-year adjustment programs to foster growth and reduce poverty. The PRS is to be results-oriented, so as to encourage the design of policies that will lead to tangible and measurable improvements in the well being of the poor. In this context, the HIPC Initiative helps free up resources to support poverty-reducing spending within the context of the PRS.[10]

Given the focus in PRSPs to shift public outlays to poverty-reducing activities, poverty-reducing spending—including for health—could increase by even *more* than the resources freed by the HIPC Initiative. In the 22 countries that had reached the decision point by end-2000, total public spending and total revenue (including grants) are estimated at 26 percent of GDP and 22 percent of GDP, respectively (Table 5). The PRSP process should tilt the composition of existing public spending in favor of poverty-reducing programs. The resources for additional health spending could also come from other categories of spending that are less productive. Thus, the increase in budgetary allocations for poverty-reducing programs—including health care—could exceed HIPC assistance, depending on the weight assigned to health programs in the PRSP.

Existing allocations for health care in HIPCs are relatively low. Based on the latest available data (mostly 1999), only 8½ percent of total government outlays in HIPCs were devoted to health care. This spending ranged from a low of US$3 per person in Madagascar to US$35 per person in Bolivia and Guyana (Table 6). Furthermore, HIPCs are spending less on health care than other low-income countries: These outlays absorbed 1.8 percent of GDP in HIPCs in 1998, compared with 2.6 percent of GDP in other low-income countries that were classified as eligible for the Poverty Reduction and Growth Facility (PRGF). These figures suggest that there is ample scope to raise public health outlays in HIPCs.

An exclusive focus on raising health outlays in HIPCs is not justified, however, given the need to improve the intrasectoral allocation and efficiency of this spending. Real health expenditures have increased since the mid-1980s in HIPCs, and health indicators have, on average, improved (Figure 3). More rapid progress can be made, however, by more tightly focusing this spending on activities that affect the well being of the poor. Higher health spending has not always been associated with better performance on social indicators, in part reflecting inefficiencies and the allocation of these public outlays to activities that have

[10] For more details on PRSPs, see "Poverty Reduction Strategy Papers—Operational Issues," SM 99/290, December 1999, available in the Internet at http://www.imf.org/external/np/pdr/prsp/poverty1.htm.

Table 5. HIPC Assistance, Revenue, and Expenditure
(In percent of GDP)

	Total HIPC Assistance 2001-05 2/	Current Levels 1/				2001 (Projected)
		Health Spending		Total expenditure and net lending	Total revenue and grants	Health Spending (in percent of GDP) 3/
		in percent of GDP 3/	in percent of total expenditure			
Benin	0.8	1.7	10.2	17.1	19.5	2.2
Bolivia	1.6	3.1	10.7	29.1	23.6	…
Burkina Faso	1.1	…	…	27.3	23.9	2.9
Cameroon	0.9	0.6	3.5	17.2	15.7	…
Gambia, The	1.5	1.8	7.9	22.7	20.0	2.1
Guinea	1.0	…	…	16.0	12.5	…
Guinea Bissau	-1.9	…	…	32.2	21.4	…
Guyana	7.3	4.1	11.2	36.6	36.3	3.8
Honduras	1.2	2.1	9.9	21.2	19.7	3.0
Madagascar	1.0	1.2	7.4	16.2	15.0	1.9
Malawi	1.9	2.2	7.5	29.5	23.6	…
Mali	1.5	…	…	24.5	20.6	…
Mauritania	2.2	1.9	7.6	25.7	31.6	2.2
Mozambique	2.0	3.0	11.7	25.6	23.6	…
Nicaragua	4.4	…	…	31.3	32.5	…
Niger	1.7	…	…	18.2	14.2	2.4
Rwanda	1.5	…	…	18.6	15.7	…
Sao Tome and Principe	8.7	…	…	69.8	43.9	9.5
Senegal	0.8	1.3	6.1	20.7	19.2	1.4
Tanzania	0.9	…	…	14.7	14.6	…
Uganda	1.3	2.2	8.5	26.0	16.7	…
Zambia	6.9	…	…	29.2	25.5	…
Unweighted average	2.2	2.1	8.5	25.9	22.2	3.1
(Median)	(1.5)	(2.0)	(8.2)	(25.1)	(20.3)	(2.3)
Memorandum items:						
Chad	…	1.4	7.3	18.7	12.9	…
Cote d'Ivoire	…	1.0	4.4	21.9	19.0	…
Ethiopia	…	1.1	3.3	32.7	21.5	1.9
Health spending in 1998 (in percent of GDP) 4/						
HIPCs (28)		1.8				
non-HIPCs PRGF-eligible countries (18)		2.6				

Sources: Decision Point documents; FAD expenditure database;WEO database; national authorities; and IMF staff estimates.
1/ Mostly 1999.
2/ See Table 4 for details.
3/ Data drawn in most cases from Decision Point documents (See Table 6).
4/ Data drawn from FAD expenditure database. Transition economies are excluded.

Table 6. Health Spending in HIPCs
(In units as indicated)

	US$ per capita	In percent of GDP				
	1999	1999	2000	2001	2002	2003
Benin	6.8	1.7	2.0	2.2	…	…
Bolivia	35.3	3.1	3.2	…	…	…
Burkina Faso	...	…	2.8	2.9	2.9	2.9
Cameroon 2/	3.7	0.6	…	…	…	…
The Gambia	6.2	1.8	1.9	2.1	2.2	2.2
Guyana	35.6	4.1	3.7	3.8	4.0	4.2
Honduras	16.9	2.1	2.6	3.0	3.0	…
Madagascar	3.0	1.2	1.8	1.9	2.1	2.4
Malawi	4.1	2.2	…	…	…	…
Mauritania	6.9	1.9	2.0	2.2	2.3	…
Mozambique 2/	6.9	3.0	…	…	…	…
Niger	...	…	…	2.4	2.6	3.1
Sao Tome and Principe	...	…	…	9.5	10.3	10.4
Senegal	6.1	1.3	1.4	1.4	…	…
Uganda 2/	6.7	2.2	…	…	…	…
Unweighted average 3/	11.5	2.1	2.4	3.1	3.7	4.2
Memorandum item:						
Average increase, 1999 to 2001, percentage point of GDP 4/				0.4		

Sources: Decision Point Documents; FAD expenditure database; WEO; and staff estimates.

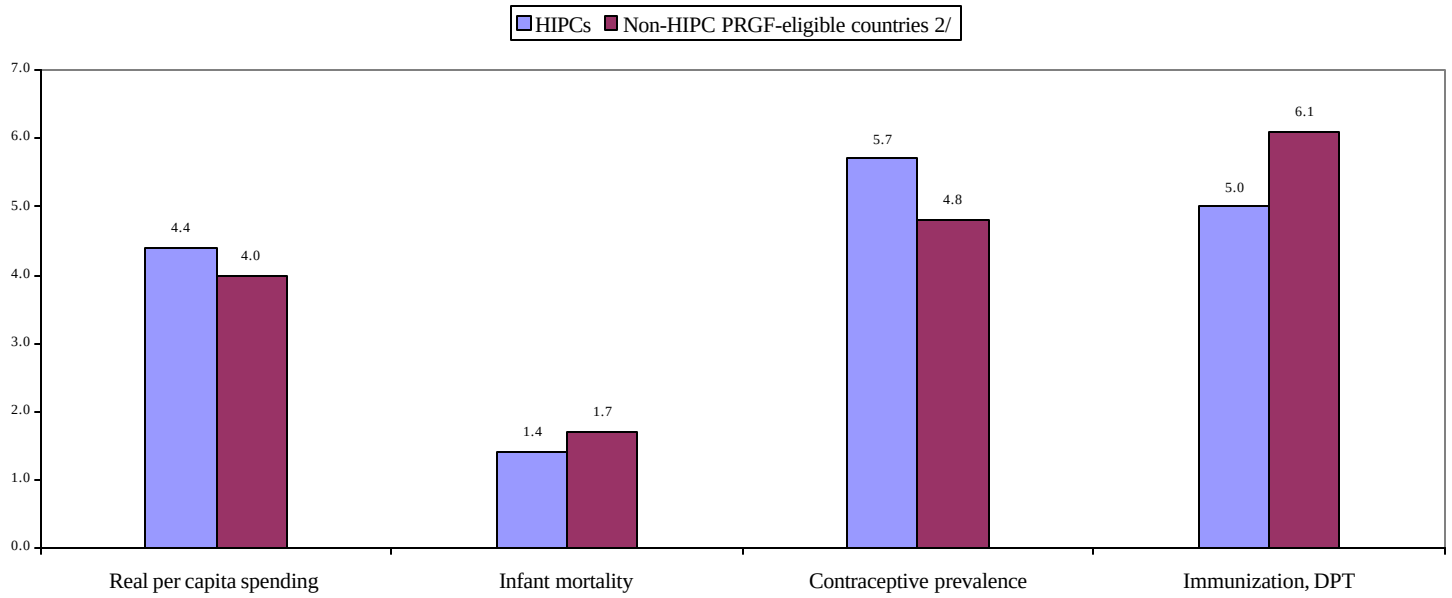
1/ No disaggregated information are available for Guinea, Guinea Bissau, Mali, Nicaragua, Tanzania, Rwanda and Zambia.

2/ Data from FAD expenditure database.

3/ Sample size varies over time, as shown.

4/ Based on average increase in spending between 1999 and 2001 for countries with data for both years.

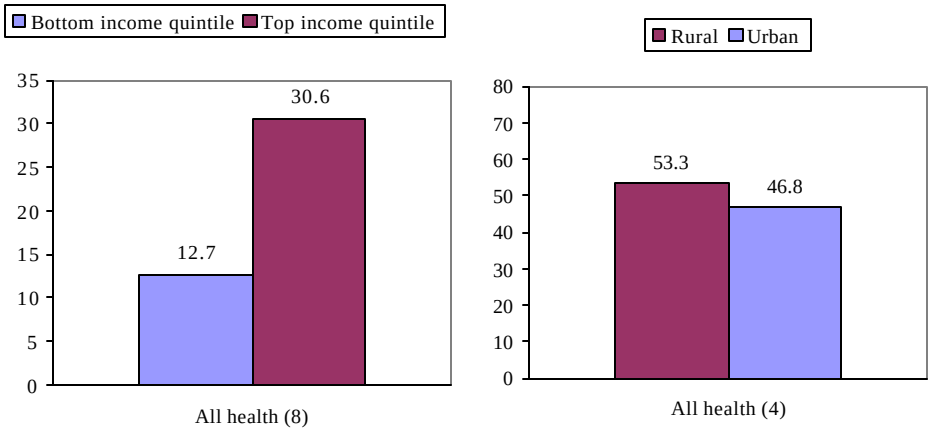
Figure 3. Annual Percentage Change in Health Spending and Social Indicators, 1985-99 1/



Source: World Bank, World Development Indicators 2000 database; country authorities; and IMF staff estimates.
1/ Average annual improvement (in percent) between the first year since 1985 (for which the country had an IMF-supported program) and the most recent year which data are available.
2/ Excludes transition economies.

relatively little effect on social indicators, such as curative services.[11] Benefit incidence studies indicate that that the poor reap a disproportionately small share of the benefits from public health outlays in HIPCs (Figure 4), further underscoring the need to more sharply target these outlays. As such, improving the efficiency of government expenditure in poverty-reducing activities and reallocating social spending (including health) to pro-poor activities is an important focus of PRSPs.

Figure 4. Benefit Incidence of Public Spending on Health Care in HIPCs, Early 1990s
(In percent of total spending; number of program countries in parentheses;
latest year for which data are available)



Source: H. Davoodi and S. Sachjapinan, "How Useful Are Benefit Incidence Studies?" IMF Working Paper (Washington: International Monetary Fund, forthcoming).

[11] For an examination of the tenuous link between public health spending and health indicators, see S. Gupta, M. Verhoeven, and E. Tiongson, "Does Higher Government Spending Buy Better Results in Education and Health Care?," IMF Working Paper 99/21 (Washington: International Monetary Fund, 1999)—available via the Internet: http://www.imf.org/external/pubs/cat/shortres.cfm); and D. Filmer, J. Hammer, and L. Pritchett, "Weak Links in the Chain: A Diagnosis of Health Policy in Poor Countries," *The World Bank Research Observer*, Vol. 15, No. 2, August 2000.

B. Should All HIPC Relief Be Used For Health Spending?

The main challenge for HIPCs is to select an "optimal" combination of poverty-reducing programs. Given the multidimensional nature of poverty and the differing starting point of countries, this optimal combination of programs will necessarily be country specific and depend on the perceived flow of social benefits from such outlays. This implies that resources provided by HIPC assistance may be used not only for public health interventions, but for other poverty-reducing activities, such as primary education. Even if improvements in health indicators are seen as the most important objective of government policy, complementary programs in other areas (such as water and sanitation, nutrition, and education programs for child-bearing age women) may be necessary. In light of the comprehensive nature of the PRS, it is critical that the chosen public programs are compatible with sustainable economic growth and greater income-earning opportunities for the poor.

C. PRSPs and Health Sector Interventions

In spite of these potential differences, PRSPs prepared thus far for HIPCs have identified several common programs.[12] They include programs aimed at enhancing access to primary and preventive health care services, as well as increasing the access of the poor to primary education. They have emphasized infrastructure programs in the areas of water, roads, electricity and telecommunications, and some have also proposed programs to provide housing to the poor and to strengthen social safety nets.

With respect to the health sector, PRSPs have generally aimed at improving the quality and extending the coverage of public health services (with emphasis on preventive services). Interventions in this area include (i) increasing the supply and distribution of basic medicines; (ii) establishing minimum health services packages; (iii) increasing the number of health workers and expanding health infrastructure; (iv) initiating health education programs, including for family planning and prevention methods regarding sexually transmitted diseases; (v) establishing training programs for health staff; and (vi) steps to improve service delivery (Box 2).

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[12] To date, most HIPCs have produce interim rather than the full PRSPs. I-PRSPs summarize the current understanding and present analysis of a country's poverty situation, describe the poverty reduction strategy, and lay out the process for producing a fully developed PRSP (or f-PRSP). As of end-December 2000, 21 HIPCs had presented their PRSPs for consideration of the IMF and WB's Executive Boards: 18 were Interim PRSPs and the remaining were full-PRSPs. As many as 18 HIPCs are planning to produce full PRSPs in 2001.

Box 2. Health Interventions in PRSPs

Main goals:

- Expand the coverage or access to health facilities, particularly for the poor;
- Improve the health status of the population by reducing rates of mortality, morbidity, and malnutrition; reducing the incidence of transmissible diseases, the spread of malaria and STDs, and the progression of HIV/AIDS; and increasing immunization rates;
- Improve the quality of health services.

Main programs to achieve these goals:

- Expand the coverage and access to health services and facilities by: (i) increasing the supply of basic medicine by making generic medicine more easily affordable and improving drug distribution, including for vaccines (Cameroon, Malawi, Mauritania, Niger, and São Tomé and Príncipe); (ii) setting a minimum health services package to cover primary care, prenatal care, and vaccinations (Burkina Faso, Senegal, and Tanzania); (iii) providing basic health insurance (Bolivia); and (iv) expanding health infrastructure (Benin, Bolivia, Mauritania, and Senegal); and increasing the number of health workers (Burkina Faso).
- Improve the health status of the population by: (i) raising awareness about health issues and intensifying efforts to disseminate public health information (Mozambique); (ii) promoting immunization and increasing the vaccination rate (Guinea-Bissau, Mali, Niger, and Uganda); (iii) strengthening programs to combat infectious diseases (Malawi, Mauritania); (iv) providing health education programs to mothers regarding nutrition and family planning methods (Benin, Bolivia, São Tomé and Príncipe, and Tanzania); and (v) implementing programs against sexually transmitted diseases, including awareness campaigns to educate the population regarding transmission and prevention methods (Bolivia, Burkina Faso, Cameroon, Guinea-Bissau, Madagascar, Malawi, Mozambique, and Rwanda).
- Improve the quality of health services by: (i) providing training programs for health staff (Guyana, Niger, Rwanda, and Tanzania); (ii) upgrading health workers' career streams (São Tomé and Príncipe); (iii) setting up a system of annual performance evaluation in the health sector (Benin); (iv) modernizing the health sector by increasing the participation of the private sector (Nicaragua); (v) improving the management of hospitals (São Tomé and Príncipe); and (vi) decentralizing services (Malawi, Nicaragua, and São Tomé and Príncipe).

To achieve these health sector objectives, HIPCs are committed to increasing public outlays on health programs. Accordingly, most decision point documents include some quantitative targets for raising public expenditure on health (Table 6). If all resources released from HIPC assistance (equivalent to around 2 percent of GDP per year for the next few years, as indicated earlier) were fully allocated to the health sector, public spending on health as a share of GDP would, on average, double from its 1999 level. However, in line with the considerations described above, HIPCs plan to allocate these resources to a wide spectrum of poverty-reducing programs, and health sector outlays are expected to increase by an average of 0.4 percentage point of GDP between 1999 and 2001.

IV. Monitoring the Use and Effectiveness of HIPC Assistance

It is critical that the resources allocated to poverty-reducing programs, including for health, are used for their intended purposes and reach the poor. Simply allocating additional spending to these programs will not suffice to bring about the desired reduction in poverty. This implies that HIPCs will need to track the use of all public resources directed to poverty-reducing programs and monitor their effectiveness over time.

A. Tracking the Use of Poverty-Reducing Spending

All poverty-reducing spending needs to be tracked, not just that associated with the Enhanced HIPC Initiative, to ensure that the overall composition of expenditure becomes more pro-poor. This will require the identification of poverty-reducing spending in the context of each country's PRS, as well as an appropriate budget classification system that can disaggregate spending by program. Tracking will also require effective accounting and audit systems. At the present juncture, however, program classifications of expenditure are rare in HIPCs, and this and other weaknesses in public expenditure management (PEM) necessitate a pragmatic approach in the short run. This pragmatic approach will involve the tagging or coding of poverty-reducing spending identified in PRSPs in the context of budget preparation and execution. Tagging will be facilitated by the provision of more disaggregated expenditure outturn data in education and health that helps distinguishing spending in these sectors which is genuinely pro-poor (e.g., preventive health care) from that which is not (e.g., free education for all at public universities). While HIPCs adopt these short-term measures to strengthen tracking, it is critical that they move ahead with reforms of their PEM systems over the medium term. Implementing the required improvements in PEM in both the short- and medium-term is an ambitious task, and will require concerted effort by HIPCs and a scaled-up program of technical assistance.

B. Monitoring outcomes

The ultimate aim of tracking poverty-reducing expenditures is to evaluate whether they actually reach the poor and provide them with meaningful benefits, including improving their health status. Therefore, in addition to tracking spending, countries should also monitor the actual delivery and impact of all poverty-reducing spending. In this regard, monitoring the benefit incidence of health programs and conducting periodic public

expenditure tracking surveys (to assess whether funds in the budget actually reach their intended uses) could be helpful. Assessments of the impact of public spending on health outcomes should be conducted with due caution, given the complexity of this relationship. Health indicators are determined not only by the level and efficiency of public health spending, but by a host of other factors, including private health spending, demographic trends, and public expenditures in other areas such as sanitation and water. Moreover, there could be a significant lag between spending and improvements in social indicators such as life expectancy and infant mortality rates, among others.

Assessing the effectiveness of poverty-reducing spending would also be facilitated by improved data on social indicators. Data on social indicators, including in health, are produced infrequently (typically in five year intervals), making it difficult to assess the impact of spending. More timely data would also be needed to strengthen the PRSP process by providing more rapid feedback on trends in social indicators and the impact of health programs on these indicators.

V. SUMMARY

- **A primary objective of the Enhanced HIPC Initiative is to tilt the composition of budgetary spending towards poverty-reducing programs**. Therefore, resources freed under the enhanced HIPC debt relief initiative should be directed to poverty-reducing spending, including that in the health sector.

- **Debt relief provided by the HIPC Initiative will release a substantial amount of fiscal resources that can be utilized for poverty-reducing spending.** HIPC debt relief for the 22 countries that have qualified for the enhanced HIPC framework by end- December 2000 is estimated to free up budget resources (in cash terms) of around 2 percent of GDP annually during 2001–05.

- **Debt relief under the Enhanced HIPC Initiative is to be utilized in the context of a country-owned poverty-reduction strategy (PRS)**. Each country's strategy is delineated in a poverty reduction strategy paper (PRSP), which determines the basis for access to Bank and Fund concessional lending. The PRS is to be formulated by countries in collaboration with civil society to ensure country ownership.

- **Given the focus in PRSPs to shift public outlays to poverty-reducing activities, poverty-reducing spending—including for health—could increase by even *more* than the resources freed by the HIPC Initiative**. The amount by which health spending will increase relative to other poverty-reducing outlays will be determined in the context of each country's PRSP. The modest amount of spending in health relative to total government outlays suggests there is ample scope for reallocation. Nevertheless, it will be crucial to improve the intrasectoral allocation of spending in health to ensure that this spending is destined for activities that benefit the poor. Strengthening the efficiency of this spending will also be necessary to achieve the desired improvement in social indicators.

- **All poverty-reducing spending needs to be tracked, not just that associated with the Enhanced HIPC Initiative, to ensure that the overall composition of expenditure is becoming more pro-poor.** This will require the identification of poverty-reducing spending in the context of each country's PRS, as well as an appropriate budget classification system that can disaggregate spending by program. A concerted effort by HIPCs, supported by technical assistance, will be required to improve public expenditure management (PEM) to achieve these goals.

- **More rigorous monitoring of the actual delivery of poverty-reducing spending, and its impact on social indicators, would provide policymakers with a better roadmap for policy design.** Along with periodic public expenditure tracking surveys (now in place in about one-fifth of HIPCs), more timely data on social indicators would facilitate the design of effective programs to combat poverty.