EVIDENCE OF THE IMPACT OF IMF FISCAL AND MONETARY POLICIES ON THE CAPACITY TO ADDRESS THE HIV/AIDS AND TB CRISES IN KENYA, TANZANIA AND ZAMBIA

A Synthesis Report of Three Country Case Studies

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Executive Summary

The macroeconomic policies advanced by the IMF are often blamed for restricting options for increasing health spending and contributing to healthworker shortages in low-income countries—a crisis now recognized as a primary impediment to achieving health-related Millennium Development Goals (MDGs), involving recurring costs often not met by donor funds. The IMF counters by arguing that governments are responsible for crafting and implementing macroeconomic policies and for setting sector budget levels; that it does not limit health care spending; that the ability of governments to spend is limited by the availability of resources; and that if government spending exceeds a country's available resources, this will have destabilizing consequences for the economy. The IMF also asserts that under-performing economies in developing countries can improve by implementing more fiscal discipline and maintaining strict macroeconomic stability. Others point out that national budget ceilings set jointly by the IMF and government authorities indirectly impacts health spending by setting limits on total national spending. Moreover, they argue that macroeconomic targets and conditions within IMF programs are set in a non-transparent and undemocratic manner, without an informed discussion of alternative policy scenarios and their trade-offs.

The governments of Kenya, Tanzania and Zambia have for decades shaped their economic policies through programs with the International Monetary Fund (IMF) and World Bank. In order to access loans from the World Bank and IMF, as well as official development assistance (ODA) from donor governments, low-income countries must implement an IMF program. Implementing an IMF program "signals" to other aid donors whether a country has the "right" macroeconomic policies and is "ready" to receive aid. This is known as the IMF's "signaling effect," and it provides the IMF influence toward shaping macroeconomic policy and determining the extent to which low-income countries can access external resources critical for development.

IMF programs include quantitative targets for inflation rates, deficit spending, accumulation of foreign currency reserves, as well as restrictions on public sector access to domestic credit. Together, these and other conditions can influence how large or how small the national budget will be in the following fiscal year. By shaping the size of the entire national budget, IMF programs have an indirect impact on the amount of resources available for sectoral budgets, including health, education and other areas where resources are necessary for people to meet their basic needs. The amount of resources available to invest in these areas impacts the speed of progress made toward meeting development targets, including the MDGs and targets set by national development and poverty reduction strategies. IMF representatives work with the Ministry of Finance, central bank authorities and related officials at the earliest stages of the budget process, setting budget guidelines that determine total public spending within the next fiscal year.

This report summarizes the findings from three in-depth country studies on the impact of IMF macroeconomic policies on options for addressing health crises and increasing health spending in Kenya, Tanzania and Zambia. It finds that the quantitative targets and other macroeconomic policies within IMF programs in these countries have been unnecessarily restrictive, making it difficult to implement a "scaling-up" agenda needed to effectively address HIV/AIDS, TB and other health needs.

The study finds that quantitative targets included within IMF programs influence the budget guidelines such that they constrain national spending to unnecessarily low levels. By targeting very low inflation (in the mid single digits) and very low budget deficits (typically around 3 percent of GDP or less), requiring the accumulation of high levels of foreign currency reserves, limiting the level of access to domestic credit and other policies, IMF programs in Kenya, Tanzania and Zambia have constrained options for increasing spending. Several underlying assumptions informing these targets have been questioned and should be reconsidered.

The study also finds that chronic under-financing and specific restrictions on wages for public workers have contributed to the critical shortage of healthworkers in the three research countries. Moreover, the process by which IMF program targets are decided leaves out the views and inputs of a range of other key stakeholders, such as parliamentarians, line ministries, academics, the media, and civil society.

Recommendations

- The IMF and other donors should work with borrowing governments, United Nations (UN) agencies, universities and research institutes to explore more expansionary fiscal and monetary policy options geared toward stimulating the productive sectors of the economy and building the future revenue base. This would enable countries to generate more of their own resources themselves over time, reduce aid dependency and enable the mobilizing of new resources for health and human development.

- Major aid donors should look not only to the IMF's assessment of countries' macroeconomic policies before providing aid to a country, but instead should consider an array of assessments by different actors.

- Aid should be fully spent and absorbed. The current practice, which can divert significant portions of foreign assistance into building foreign reserves, should be replaced by a more flexible mechanism that allows for greater aid spending domestically as intended.

- The IMF and borrowing governments should work with other donors as well as domestic and international banks to explore more flexible financing mechanisms (involving loan guarantees and subsidized credit) to accommodate higher levels of government domestic deficit financing on more favorable and sustainable terms. Such arrangements could allow for significant increases in public investment and current expenditure. More affordable and sustainable domestic borrowing arrangements could also enable countries to use countercyclical and more expansionary policies to better withstand the global economic recession.

- To improve accountability and increase transparency, governments and civil society should engage a wider spectrum of stakeholders in the formulation and review of IMF program policies, including government ministries apart from Finance, key parliamentary, labor, university and civil society representatives, and the domestic media. More transparent and participatory civic engagement should allow for wider input into the exploration of various macroeconomic policy options and should happen earlier in the budget process—before macroeconomic policies and quantitative targets are set. Governments should make public all IMF program documents.

Report Objectives

This report is intended to contribute to ongoing discussions about the impact of IMF program policies on national spending and consequently on health spending in low-income countries, and therefore how such policies impact options for fighting HIV/AIDS, TB and other major diseases, and for reversing critical healthworker shortages.

Focusing on IMF programs in Kenya, Tanzania and Zambia, the objectives of the study were to:

- Review the content, process and transparency of IMF programs
- Identify the key stakeholders in the process, their influence and relative power
- Explore how fiscal and monetary and other quantitative targets impact national budget sizes
- Examine the efficacy of the IMF policies and their underlying assumptions through desk review of the empirical research and interviews
- Identify trends in the total public (domestic) health expenditure
- Identify trends in the public (domestic) expenditure for HIV/AIDS and TB
- Identify trends in the public (domestic) expenditure for personnel for health, HIV/AIDS and TB
- Identify trends in the number of health professionals working in the health sector, HIV/AIDS and TB
- Consider trends in accessing HIV/AIDS and TB treatment services
- Identify other effects of IMF programs on country ability to respond to TB and HIV/AIDS
- Issue recommendations

The study involved both qualitative and quantitative data collection. It focused primarily on IMF polices and comprised mainly information on IMF programs obtained from documents through a comprehensive data search and interviews with key informants. In addition, the study comprised budget analysis through examination of national budget documents, medium-term expenditure frameworks (MTEFs), public expenditure reviews and expenditure records.[1]

The study focused on IMF programs including Structural Adjustment Programs (SAPs), the Enhanced Structural Adjustment Facility (ESAF), the Poverty Reduction and Growth Facility (PRGF) and the Policy Support Instrument (PSI). In each country, several relevant policy documents and reports were reviewed including strategic plans, legislation, planning guidelines and national budget documents, human resources for health data, international agreements, and technical reports from national and international databases. Data on government budget allocations for health, HIV/AIDS and TB were collected from national budget documentation and revenue and expenditure records. Other data and information were collected from relevant government ministries, IMF, the World Health Organization (WHO), World Bank and National AIDS Commissions in each country, as well as interviews with staff in government departments, civil society organizations, and donor organizations.

Through the review of secondary data and interviews, the country reports first provide an overview of IMF programs in each country, an analysis of relevant IMF policies—the content and process of policy formulation—including the transparency of the policymaking process and roles of various stakeholders. Finally, each report provides a brief analysis of the budget process, and trends of budget allocations for HIV/AIDS, TB and personnel working in TB and HIV/AIDS program (depending on the availability of data). The full-length country reports are available for download at www.cegaa.org and www.results.org.

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[1] See full details of sources of data in each full-length country report, available for download at www.cegaa.org and www.results.org.

Background on IMF Policies in Kenya, Tanzania and Zambia

In the 1980s and 1990s, IMF and World Bank loan programs for low-income countries included a number of conditions whereby governments were required to implement a series of economic stabilization policies and free market economic reforms. These Structural Adjustment Programs (SAPs) included reforms based on neoliberal economic thinking, which included reducing or weakening regulations on foreign investment, an emphasis on export production as opposed to production for local consumption, and reduced public spending on social sectors, including health and education. SAPs required that a number of restrictive fiscal and monetary policies be undertaken by the borrowing country before it was eligible for further IMF loans or bilateral aid. They were intended to prioritize debt repayments on older debts owed to commercial banks, governments and the World Bank.

In 1999, the IMF's Enhanced Structural Adjustment Facility (ESAF) loan program was replaced with the Poverty Reduction and Growth Facility (PRGF). The Poverty Reduction and Growth Facility (PRGF) is the IMF's low-interest lending facility for low-income countries. Loans under the PRGF carry an annual interest rate of 0.5 percent, with repayments made semi-annually, beginning 5.5 years and ending 10 years after the disbursement. Eligibility is based principally on the IMF's assessment of a country's per capita income, drawing on the cut-off point for eligibility to World Bank concessional lending. The PRGF replaced the Enhanced Structural Adjustment Facility (ESAF) of the IMF as a lending window for poor countries. The PRGF was designed to usher in a new era of reduced loan conditionalities to low-income countries. The IMF also claimed the new PRGF programs would be based in part on inputs from civil society, made through public consultations that were part of the drafting process of Poverty Reduction Strategy Papers (PRSPs). (PRSPs were required to be approved by the Executive Boards of the IMF and World Bank in order for poor countries to qualify for debt relief under the joint Heavily Indebted Poor Countries (HIPC) Initiative.) In 2005, the IMF introduced the Policy Support Instrument, which, unlike the PRGF, does not include a financing component. Through the PSI, the IMF works with governments to develop and endorse its macroeconomic policies, which signals to donors and markets that the government has the right mix of policies to utilize external financing. Today, IMF program policies continue to include conditions that target low inflation rates (in the mid-single digits), market-based interest rates and prices, high currency reserve levels, reduction in government expenditure and budget deficits, ceilings on the overall national resource envelope and privatization of public and state-owned enterprises.

Kenya

Kenya's first structural adjustment loan from the IMF came in 1975, precipitated by financial imbalances caused primarily by terms-of-trade shocks. Worsening economic conditions forced the government to return to the IMF in 1982 for the second structural adjustment loan. The key policy content of this SAP included the reduction of government expenditure across all sectors (including social sectors), the fiscal deficit, the government wage bill (i.e., total spending on salaries of the civil service), the number of civil service employees, as well as the privatization of state-owned enterprises. In 2000, the government of Kenya both entered into a PRGF and began preparation of the PRSP. In 2003, the government prepared an Economic Recovery Strategy (ERS) to provide the framework for economic recovery for the period 2003-2007. The ERS became the new PRSP. With the new PRSP in place, the IMF Executive Board approved a three-year PRGF arrangement for Kenya equivalent to SDR 175 million (about US$252.75 million) in November 2003.[2] As contained in IMF (2008), the Kenya government's economic strategies under this PRGF loan included reducing the domestic debt, and the restructuring of spending in favor of

[2] Special Drawing Rights. SDRs are a reserve currency issued by the IMF to member countries made up of a basket of currencies including the US dollar, the euro, the yen, and the British pound sterling. At the time of this writing one SDR was worth approximately US$1.55.

priority poverty reduction outlays and investment. The measures proposed included strengthening revenue performance through a speedy rebuilding of the integrity and capacity of the Kenya Revenue Authority and rationalization of the tax system; reducing the wage bill as a share of total expenditure by reforming the wage setting mechanism for public servants and continuing civil service reforms; and restructuring the parastatal and financial sectors to increase efficiency and reduce the government's contingent liabilities.

The Executive Board of the International Monetary Fund (IMF) completed the second review of Kenya's economic performance under the PRGF in April 2007. The completion of the review enabled the release of an amount equivalent to SDR 37.5 million (about US$56.8 million), bringing total disbursements under the arrangement to SDR 112.5 million (about US$170.4 million). The PRGF loans were approved conditional upon reforms agreed upon by the government and the IMF. Kenya's fiscal strategy was reformed to include three objectives: fiscal sustainability, in which the fiscal policy's aim was to maintain a level of expenditures that could be funded without either an increase in the present value (NPV) of overall debt relative to GDP or an increase of external debt growth; expenditure restructuring for growth and poverty reduction that proposed increasing the shares of development expenditures, especially those targeting government investments, core social expenditures (education and health) and core poverty expenditures; and improving public sector service delivery by enhancing both the efficiency and effectiveness of public expenditure through a process of internalizing the Public Expenditure Review (PER) and carrying out Public Expenditure Management (PEM) reform.

The fiscal strategy sought to maintain revenues at above 21 percent of GDP to enable the bulk of government expenditures to be met from domestic resources excluding borrowing, and to gradually reduce the level of recurrent expenditure relative to GDP as a way to increase development expenditures within what was deemed a sustainable macroeconomic framework. Public expenditure management reforms and the ministries public expenditure reviews (MPERS) were considered as a means of redirecting expenditures to national priorities and of reducing the budget deficit from 4 percent of GDP in 2003/04 to below 3 percent. The 2004 PRSP specified the measures to achieve the fiscal strategy: reducing the wage bill from 8.7 percent of GDP in FY2003/04 to 8.5 percent by FY2005/06, with any awards being matched by a proportionate downsizing of the civil service; raising of health expenditures at a growth rate at least 7.5% faster than overall expenditures; and attaining at least 12% of total expenditures by 2010, among others. The fiscal strategy assumed that these health expenditures would be focused on non-wage, non-transfer expenditures to enable a rapid increase in basic health services.

Regarding monetary policy, the government proposed to continue focusing on maintaining stability in the general price level and fostering the functioning of a market-based financial system. The Central Bank of Kenya would continue with its policy of keeping overall inflation below 5% annually, while targeting underlying inflation at 3.5%. In addition, the government would continue the policy of a market-determined exchange rate regime, with exchange rate interventions limited to smoothing short-term volatility. The policies pursued under the PRGF program sought to keep the fiscal deficit at 3% of GDP and inflation at 5%. These policies continued until the PRGF expired in November 2008. In May 2009, the government signed a new U.S.$209 million loan agreement through the IMF's Exogenous Shocks Facility (ESF) to help plug budget holes caused by declining revenues and previous increases in the cost of food, fuel, and fertilizer.

Tanzania

Tanzania's engagement with the IMF started in the late 1970s, largely precipitated by macroeconomic imbalances, economic stagnation, and a decline in per capita income. The SAP in Tanzania focused on market-oriented reforms, liberalization of the financial sector and the civil service reform, which included reduction of civil servants—mainly in the social sectors—and privatization of state enterprises. The PRGF in Tanzania was implemented in two phases. The first PRGF was aimed at sustaining

macroeconomic stability and creating enabling conditions for higher growth, with particular focus on poverty reduction. Growth was to be led by the private sector, requiring further structural reforms. Policies intended to reduce poverty included a greater reorientation of expenditures toward social spending, consistent with the objectives and priorities laid out in the PRSP. The second PRGF (2003-2006) aimed at accelerating investment-led growth and further reduction in poverty. Program objectives were to be met through a three-part strategy: increasing domestic government revenues, with a view to gradually reducing aid dependence; further liberalization of the trade regime; and enhancing the economy's supply response by removing key impediments to growth and improving the investment environment, with a view to boosting private sector development.

By 2006, the IMF was satisfied that in the course of the PRGF Tanzania had achieved strong economic performance and solidified its position as a "mature stabilizer." With market-oriented macroeconomic and structural policies backed by development partner support, Tanzania had secured high growth, low inflation, adequate reserves, and a sustainable external debt position. The authorities had met all quantitative and structural performance criteria for the final (sixth) review under the PRGF. However, an ex-post assessment of longer term program engagement highlighted several outstanding medium-term challenges, including the need to make significant inroads into alleviating poverty and to reduce gradually the dependence on aid, the need to sustain rapid growth for long periods, improve domestic revenue mobilization, and alleviate structural deficiencies. The assessment emphasized that with large aid inflows expected over the medium term, greater coordination between fiscal and monetary policies would be critical to promote the spending and absorption of such flows. At the same time, to improve external competitiveness, the assessment hinted that it would be important to enhance the supply response and absorptive capacity of the economy.

In that regard, the IMF was satisfied that Tanzania could benefit from continued IMF engagement that goes beyond a pure surveillance relationship. Against this background, the Policy Support Instrument (PSI) was deemed the appropriate form of engagement between the government and the IMF. It was envisioned that the PSI would provide a clear framework for core macroeconomic and structural policies, guided by Tanzania's second generation PRSP (MKUKUTA), and the Millennium Development Goals. It would also signal to development partners the soundness of government policies. The PSI focuses on high and sustainable broad-based growth and more rapid poverty reduction centered on three core themes: (1) Enhancing public resource mobilization and efficiency of spending to help achieve government objectives, (2) Increasing the financial sector's contribution to growth and the effectiveness of monetary policy, and (3) Improving the business environment and enhancing investment.

While the PSI does not come with financial support, the conditionalities are essentially a continuation of PRGF features. And in some cases, the targets are even tighter under the PSI. For instance, the inflation target under PSI is 5%, while under PRGF it was 6%. Likewise, the PSI demands a slightly higher level of foreign reserves (US$ 1.683bn) compared to the conditionality under PRGF (US$ 1.656bn). In May 2009, due to the impacts of the global economic crisis, the IMF called for fiscal stimulus in Tanzania amounting to a widening of the fiscal deficit by up 3% of GDP, as long as deficit spending did not jeopardize macro stability over the medium term.

Zambia

In Zambia, structural adjustment was re-introduced in the early 1990s after the country returned to the IMF in 1989. Adjustment was implemented through short-term measures such as reform of the public sector, liberalization of markets and pursuit of a tight fiscal policy aimed at bringing down the public sector deficit. The reforms were aimed at halting the growth rates of domestic credit and money supply, reducing government intervention in the market, stabilizing the macroeconomic environment and increasing international reserves. The SAPs led to massive job loss, increased dependency ratios, and a

breakdown of socio-economic networks. Carlsson and colleagues (2000) observed that in the 1990s, retrenchment and factory closings caused mass unemployment, causing peri-urban inhabitants to try to make their living from small-scale businesses. This led to overcrowding, increased diseases, poor sanitary environment and lack of clean water.

Zambia's first PRGF was introduced in 1999 and run until 2003. Under the PRGF, the IMF's goal is to maintain macroeconomic stability, with an emphasis on improved public resource management and accountability, reduced inflation, and strengthened external position. Upon expiration, the government requested another PRGF but it failed to access the facility twice in July and December 2003 because of a budget over-run, mainly due to a high public sector wage bill and weak policy implementation. The IMF placed the country on its Staff-Monitored Program (SMP), which authorized the IMF to monitor Zambia's economic performance and its spending pattern before accessing a another tranche of the PRGF loan. Zambia was initially on course to reach the HIPC completion point by the end of December 2004, but failed to fulfill an additional 15 required benchmarks. Zambia was on the SMP from 2003 to 2006, during which time it was required to satisfactorily comply with each the conditions on the SMP in order to get back "on track" with its regular PRGF programme and HIPC debt cancellation process. In 2004, after satisfactory compliance, the IMF resumed the PRGF loan programme to Zambia, offering a new 3-year line of credit amounting to SDR 220 million (about US$320 million) for the period June 2004 to September 2007 (IMF, 2008a). Most recently, in June 2008, the IMF approved another new 3-year PRGF programme amounting to SDR 48.91 million (about US$79.2 million) for the period of June 2008 to May 2011.

Key Finding 1: Fiscal and monetary policies in Kenya, Tanzania and Zambia IMF programs have been unnecessarily restrictive.

The IMF macroeconomic framework for Kenya, Tanzania, Zambia and many other low-income countries has primarily been concerned with achieving and then maintaining macroeconomic stability, rather than enabling a sufficient "scaling up" of public investment and spending needed to achieve the MDGs or fight HIV/AIDS and TB effectively.

Unnecessarily low inflation targeting

A central requirement of IMF programs in all three countries has been to keep overall inflation under 5% through restrictive monetary policies, such as rising interest rates or appreciating the exchange rate of the currency. Table 1 shows both historical and projected inflation rates in the three countries, where each country has agreed to reduce and then maintain inflation at 5%.

Table 1: Inflation-Reduction Targets (as a Percent of Annual Rate Increase)

	2005/06	**2006/07**	**2007/08** Proj.	**2008/9** Proj.	**2009/10** Proj.	**2010/11** Proj.
Tanzania	**6.8**	**5.8**	**9.3**	**6.8**	**5.0**	**5.0**

	2006	**2007**	**2008** Proj.	**2009** Proj.	**2010** Proj.	**2011** Proj.	**2012** Proj.
Zambia	**8.2**	**8.9**	**7.0**	**5.0**	**5.0**	**5.0**	**5.0**

	2005/06	2006/07	2007/08	2008/09 Proj.	2009/10 Proj.	2010/11 Proj.	2011/12 Proj.
Kenya	**11.1**	**10.4**	**18.5**	**14.5**	**5.0**	**5.0**	**5.0**

An assumption inherent in the IMF's macroeconomic policy framework is that inflation can be effectively controlled by having the central bank exclusively focus on restricting and modulating the growth rate of the money supply in the economy. However, this approach is questionable. The empirical evidence shows that in most developing countries:

- Central banks have influence over a small portion of the money supply—only the currency and reserves of the banking system.
- Monetary policy is not always effective.
- Central banks may have limited influence over all of the multiple factors that contribute to the growth of the money supply (broadly defined).
- The link between the money supply and inflation is often weak.
- Such policy targets can prevent uncontrollable growth of the money supply and hyper-inflation, but such targets often cannot "fine tune" low rates of inflation.
- Developed countries (e.g., the US & Europe, Brazil, South Africa) task their central banks with targeting interest rates, not the money supply.
- Inflationary pressures in most low-income countries tend to come from price shocks (food, energy price increases, etc) and therefore monetary policy is not effective in managing this type of inflation (non-monetary shocks).

Background research for this report found very little empirical evidence in the economics literature to justify pushing inflation down to the 5% percent level. In fact, doing so can exact costs in terms of foregone higher economic growth when spending is restricted and interest rates are increased as the main way to lower inflation. This contractionary monetary policy limits both the government's and the private sector's ability to borrow and invest toward building a larger future revenue base. This is not to say that inflation should be left unchecked, but "policies that are overly concerned with macroeconomic stability may turn out to be too austere, lowering economic growth from its optimal level and impeding progress on poverty reduction" (United States Government Accountability Office 2001). Furthermore, dangerously high levels of inflation are not a problem in most developing countries today. While there is consensus that high inflation is bad and must be brought down, more relevant questions for these three countries involve how low inflation must be brought down and at what level must it be maintained.

On this point, the IMF's position that inflation must be brought down to and maintained at 5 percent is not justified by the empirical literature or the historical record. At least nine studies have examined this question and have tried to find the "kink" in the inflation-growth relationship, or the level at which inflation begins to harm a country's long-term GDP growth rates. Fischer (1993) found the point to be between 15-30 percent, while Bruno (1995) cited a major unpublished World Bank study of the link between inflation and economic growth in 127 countries from 1960 to 1992 that found that inflation rates below 20 percent had no obvious negative impacts for long-term economic growth rates. Barro (1996) found that an increase by 10 percentage points in the annual inflation rate is associated with a decline by only 0.24 percentage points in the annual growth rate of GDP, but says nothing about the disinflation policy targets. Sarel (1996) found the danger point at 8 percent, while Bruno and Easterly (1998) found the danger point to be as high as 40 percent. Ghosh and Phillips (1998) found that the inflation-growth relationship is convex, so that the decline in growth associated with an increase from 10 percent to 20 percent inflation is much larger than that associated with moving from 40 percent to 50 percent inflation,

but this also says nothing about disinflation policy targets. Khan and Senhadji (2001) found the danger point for inflation between 11 percent and 12 percent for developing countries and 1 to 3 percent for industrialized countries. Gylfason and Herbertsson (2001) found the danger point for inflation at between 10 and 20 percent, and Pollin and Zhu (2005) found the danger point to be between 14 and 16 percent (for middle and low-income countries).

These studies show not only that estimates widely vary, highlighting the need for further research, but as Pollin and Zhu (2005) concluded, "There is no justification for inflation-targeting policies as they are currently being practiced throughout the middle- and low-income countries." The same literature was reviewed by a 2007 study from the Washington, DC-based Center for Global Development (2007), which similarly found, "Empirical evidence does not justify pushing inflation to these levels in low-income countries." Moreover, the Financial Services Committee of the U.S. House of Representatives wrote to the IMF in 2007, stating, "We are concerned by the IMF's adherence to overly-rigid macroeconomic targets" and, "It is particularly troubling to us that the IMF's policy positions do not reflect any consensus view among economists on appropriate inflation targets."

Despite these methodological problems, the IMF has followed this approach to macroeconomic policy for 25 years; it has been effective at macroeconomic stabilization, but has done poorly at generating higher economic growth rates that have translated into poverty reduction, job creation or increased public investment as a percent of GDP. While it might seem obvious that stabilization-focused central bank policy represents the only proper role for central banks, in fact, looking at history casts serious doubt on this claim. Far from being the historical norm, this focus by central banks on stabilization to the exclusion of development represents a sharp break from historical practice, not just in the developing world but also in the now-developed countries. In many of the successful currently developed countries, as well as in many developing countries in the post-Second World War period, development was seen as a crucial part of the central bank's tasks. Now, by contrast, development is no longer part of the mandate of central banks in most developing countries.

This reality underscores why the IMF is not per se a "development organization," nor do staff collectively view it as such. As an evaluation by the IMF's Independent Evaluation Office (2007) explained, there were differing views among members of the IMF Executive Board about the IMF's role and policies in poor countries. The evaluation showed that after more than seven years after the introduction of the PRSP, as well as the IMF's replacing the ESAF with the PRGF, which ostensibly was geared toward achievement of the MDGs, IMF leadership failed to instruct the staff as to how to modify the IMF's macroeconomic policies to create a scaling-up environment. As the evaluation explains, "Lacking clarity on what they should do," staff "tended to focus on macroeconomic stability, in line with the institution's core mandate and their deeply ingrained professional culture." If this approach remains intact, it will remain unnecessarily difficult for countries to reduce poverty, to achieve the MDGs, and to build up the cadre of health workers needed to effectively fight HIV/AIDS and other diseases. It is recommended that this assumption be revisited and reexamined by a much broader group of public stakeholders including CSOs, independent academics, parliamentarians, line ministries, domestic media, and donor agencies.

Unnecessarily low deficit targeting and low government spending

In all three countries, the current IMF macroeconomic framework has called for reducing and maintaining fiscal deficits at the 3% of GDP range. The recent exception is in Tanzania, where in response to the harmful impacts of the global financial crisis, a January 2009 review of the Poverty Support Instrument called for widening deficit spending up to 3 percent of GDP to provide fiscal stimulus.

Table 2 shows budget balances measured as a percent of GDP for the three research countries. The projected figures show IMF program targets for reducing the fiscal deficit to around 3% of GDP. The

IMF's conditions that deficit spending stay constrained within 3% of GDP is based on another assumption: that reducing government spending is good for the economy because deficit spending by the government "crowds out" the limited available credit in the country, thereby limiting the capacity for further private sector investment. Use of credit by the government also increases the cost of the remaining credit for use by the private sector and leads to inflation.

However, there is evidence for the reverse of this "crowding out" effect, as noted by IMF's Sanjeev Gupta and colleagues (2007). In fact, depending on the nature of the public investments, public spending can actually have a "crowding-in" effect that creates new opportunities for private investment (Gupta, et al 2007; Roy, et al 2006). However, the IMF's zero-sum approach, whereby public investment is seen to inherently crowd out private, has led to an overly restrictive stance on the government drawing from the limited supply of credit in the economy, and continues to restrain government financing for increased public spending and investment.

Table 2: Budget Balances (% of GDP; Includes External Grants)

	2005/06	**2006/07**	**2007/08** Projected	**2008/9** Projected	**2009/10** Projected	**2010/11** Projected
Tanzania	-5.5	-4.9	-1.6	-3.7	-3.2	-3.1

	2006	**2007**	**2008** Projected	**2009** Projected	**2010** Projected	**2011** Projected	**2012** Projected
Zambia	18.6	-0.2	-1.1	0.9	0.4	-3.1	-3.0

	2007/08 **IMF Estimate**	**2008/09** **Govt. Budget Projected**		**2009/10** **Projected**	**2010/11** **Projected**
Kenya	-4.8	-5.3	-4.6	-3.8	-3.8

For example, the Tanzania PSI's "cash-only" budgeting has limited the government's options to borrow resources to finance economic activity and invest in development needs. Though Tanzania has pursued such a policy for the last 10 years, much of the credit available within commercial banks is not being used by the private sector, instead sitting as idle deposits, adding additional pressures to the high cost of borrowing. As President Jakaya Kikwete recently described, "Unfortunately, most of the credit released tends to sit in the banks as excess liquidity instead of being lent out. As a result, the cost of credit made available to the private sector has to be borne by the small part that is lent." It is recommended that these IMF assumptions about deficits "crowding-out" the limited available credit for the private sector or causing inflation be revisited and reexamined, and that alternative developmental fiscal policy approaches (in which monetary policy is designed to enable and support the fiscal policy goals) be discussed and considered by a much broader group of public stakeholders, including CSOs, independent academics, parliamentarians, line ministries, domestic media, donor agencies. Moreover, donors and International Financial Institutions should work together with banks and others to develop mechanisms that would enable Tanzania, Kenya, Zambia and other low-income countries to manageably engage in higher levels of deficit spending. The offering of subsidies and loan guarantees that would make available such financing under more affordable and sustainable terms is one option to achieve this.

Squeezing fiscal space by lowering the ceiling on credit and raising the floor on international reserves

In order to help achieve its main goals of keeping inflation under 5% per year and keeping deficit spending contained, the IMF uses two important monetary targets to constrain the amount of deficit financing that the government can engage in. The first target is a ceiling on the amount of credit that will be available in the economy in the year, called Net Domestic Assets (NDA) or net domestic credit. This limited amount of available credit must be shared between the public and private sectors. The second target is a floor on the level of international hard currency reserves at the central bank or within the domestic banking system, called Net International Reserves (NIR).

Often the IMF will either lower the ceiling on available credit (NDA) or raise the floor requirement on reserves (NIR), or both, as a means of limiting the available credit that the government could access for engaging in deficit spending. In Kenya's case, the PRGF tightened both targets over the course of a couple years. This is problematic, because this policy approach limited the government's options for engaging in deficit financing, thereby blocking the possibilities for significantly scaling up investment to meet the MDGs.

By setting these two monetary targets in this way, the IMF has a substantial effect on the amount of available resources within the economy that the government has available to make the large, up-front increases in public spending and investment in the public health system needed to build the foundation for a more successful fight against HIV/AIDS and TB over the long term. The macroeconomic framework is constrained by the policy of keeping the growth rate of the money supply (inflation) low in the constant short-run, subordinating other goals. This should be revisited and reconsidered among a broader group of public stakeholders.

Table 3: IMF Program Targets for Domestic Credit Available to Government and Accumulation of International Reserves

Tanzania	**Mar 2008**	**June 2008**	**Sep 2008**	**Dec 2008**	**Mar 2009**	**June 2009**
NDA (Billions of Tanzania Schillings)	2,322	2,919	3,376	3,386	3,667	3,885
NIR (Million of US Dollars)	2,663	2,541	2,535	2,559	2,573	2,587

Zambia	**2005**	**2006**	**2007**	**2008 Proj.**	**2009 Proj.**	**2010 Proj.**	**2011 Proj.**	**2012 Proj.**
NDA (Billions of Kwacha)	3,029	348	-1,242	-2,019				
Gross International Reserves (GIR) (Millions of US Dollars)	331	595	947	1,329	1,810	2,231	2,461	2,684

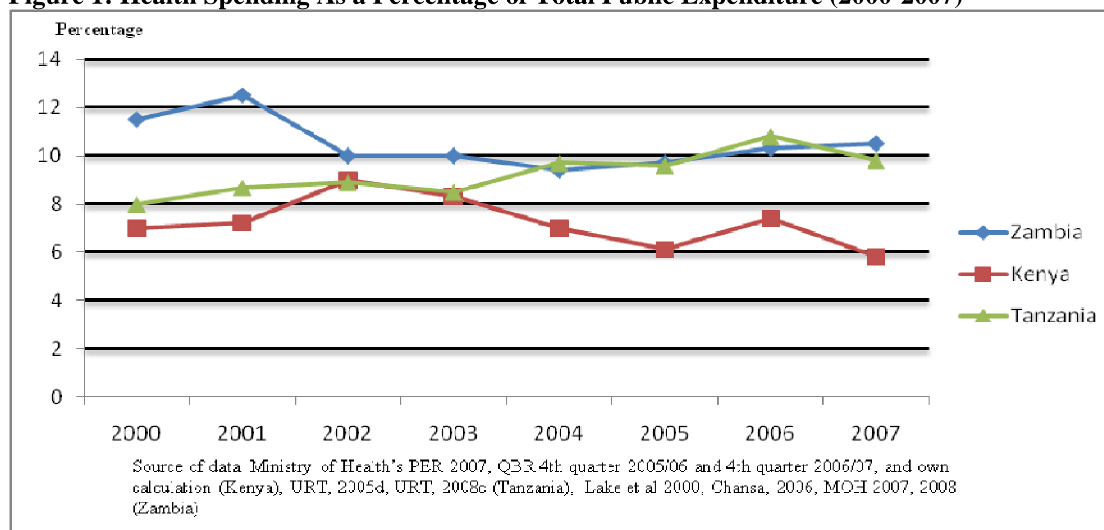
Kenya	**June 2005**	**June 2006**	**June 2007**	**June 2008**	**Sep 2008**	**Dec 2008**	**Mar 2009**	**June 2009**
NDA (Billions of Kenyan Schillings)	466.3	521.7	607.1	712.8	693.6	767.6	820.6	864.4
Credit Available to Government	112.3	117.9	157.2	132.7	158.2	185.7	172.6	171.9
Credit Available to Rest of Economy	354.0	403.8	450.0	580.1	535.4	581.9	647.9	692.5
Net Foreign Assets (Millions of US Dollars)	1,212	2,159	2,357	2,896	3,067	3,078	3,089	3,192

Key Finding #2: Governments have not met health spending commitments

All three research countries are signatories to the Abuja Declaration by the African Union (AU), which calls for African governments to allocate 15% of their national budgets to health spending, with more emphasis on HIV/AIDS programs. It is within the responsibility of governments to meet this commitment, regardless of any macro-level constraints that are part of their IMF programs. None of the three countries, however, have done so (Figure 1).

Zambia's health spending as a percent of total spending hovered around 10% from FY2002 to FY2007. In FY2004 the government spent 9.4% of its budget on health. Since FY2005, health spending slowly increased each year, to 10.5% in FY2007. Kenya's health expenditure, as a share of the total budget, has declined since FY2002, minus a temporary increase in FY2006, dropping from approximately 9% of spending in 2002 to 6% in FY2007. Tanzania's spending on health as a percent of total spending rose from 8% in FY2000/01 to 10.8% of the total expenditure in FY2006/07.

Figure 1: Health Spending As a Percentage of Total Public Expenditure (2000-2007)



Per capita health expenditure in the three countries shows relative increases from FY2000/01 to FY2006/07, with Zambia and Tanzania reaching US$14.1 in public health spending in FY2006/07. Kenya's per capita health spending increased less dramatically, from US$5.2 in FY2000/01 to US$7.6 in FY2006/07. None of the countries have come close to achieving per capita public health spending of US$40 as recommended by the World Health Organization.

Figure 2: Per capita public health allocations 2000/01-2006/07 (In Real US$)

Sources: National Health Accounts, 2002-2004; Preliminary National Health Accounts, 2005-2006 (Zambia). Ministry of Health's PER 2007, QBR 4th quarter 2005/06 and 4th quarter 2006/07, and authors' calculation. Note: An average exchange rate of Kshs 75 per US $1 used for each of the financial years (Kenya). Real figures from FY2004/05 are calculated based on the FY2004/05 prices.

Trends in HIV/AIDS and TB Expenditure

Kenya's HIV/AIDS expenditures are steadily rising, with a total of US$166 million spent on HIV/AIDS interventions in FY 2004/05. In FY2005/06, however, expenditure declined to US$153 million (equivalent to 0.8% of GDP) but more than doubled to US$312 in FY2006/07 (equivalent to 1.3% of GDP). The government's contribution is minimal, accounting for about 2% of total HIV/AIDS funding. In FY2006/07, funding from bilateral sources accounted about 93.7% of total HIV/AIDS resources, mainly because of the rapid increase in financial resources from PEPFAR, which are mostly off-budget.

TB spending in Kenya has increased substantially in recent years, from US$5 million in 2002 to US$22 million in FY2009, with the government providing only about a third of funding. Despite increases in funding from both the government and donors, a funding gap of approximately $15 million remained in the national TB program's budget in FY2009.

In Tanzania, government and donor spending on HIV/AIDS increased by 76% in FY2006/7, a real increase of 66% after adjusting for inflation. Like in Kenya and Zambia, donor funding accounts for the largest share of HIV/AIDS spending, amounting to US$182.3 million, US$333.2 million and US$496 million in FY2005/06, FY2006/07 and FY2007/8, respectively. The largest share of donor funding is off-budget, accounting for 77% of the total donor funding. As a result of the sustained increases in donor aid, total government plus donor spending on HIV/AIDS in 2007-08 was projected to be over 10% of public expenditure and over 3% of GDP.

By any measure, in Tanzania, TB expenditures decreased significantly from FY2002/03 to FY2005/06. Absolute TB expenditure decreased by 37% from FY 2002/03 to FY2005/06, from U.S.$9.1 million to U.S.$5.6 million, while Total Health Expenditure (THE) increased 129% throughout the same period. As a percent of total health expenditure, TB spending decreased from 2% to 0.55% during that time. Similarly, per capita TB expenditure decreased from TShs 64 in FY 2002/03 to TShs 185 in FY 2005/06. TB expenditure then increased substantially, to approximately U.S.$10.6 million in FY 2006/07, due to support from the Global Fund to Fight AIDS, TB, and Malaria. Tanzania's donor support for the TB program in the FY 2005/06 accounted for 57% of the total funding, while the government provided 40%.

In Zambia, overall spending on HIV/AIDS from all sources increased from US$76.9 million in FY2002 to US$161.2 million in 2006. The HIV/AIDS response is heavily dependent on donor resources, with

government investment inadequate. Donors contributed 46% of total HIV/AIDS expenditure in FY2002, 70.1% in FY2003, 74.3% in FY2005, and 74% in FY2006. Households were the second largest financiers, contributing 29% in FY2002, 19.7% in FY2003, 16% in FY2005, and 13.9% in FY2006. The government was third, contributing 17% in FY2002, 9.8% in FY2003, 7.7% in FY2005, and 9.5% in FY2006. PEPFAR was the largest contributor among donors, providing 26% of total HIV/AIDS expenditure in FY2002, 27.6% in FY2005, and 36.7% in FY2006.

A budget of $57,012,513 was required to adequately implement the National Stop TB Strategic Plan from FY2007 to FY2011. However, the NTP had available, directly or through donors (including NGOs), about $32,053,479. The NTP benefits from external financial support coming from several donors. The major donors that support operational activities of the TB program include the Global Fund (about US$13million in 2008-2009), Canadian International Development Agency (CIDA) about US$543,820, the United States Government (about U.S.$ 5million over a five year period), and PEPFAR (U.S.$7.3 million).

Key Finding 3: IMF program conditionalities have exacerbated health worker crises

Kenya, Tanzania and Zambia are experiencing critical shortages of health workers at every level of service delivery. Kenya's wage bill policy goes back to the implementation of the IMF-supported structural adjustment program. In 2005, the government could not fill the shortage of 20% due to the embargo on the recruitment of new staff under the IMF-supported policies. Although the wage bill ceiling no longer exists as an IMF program condition, the government continues to implement it, restricting the wage bill to 51.22% of recurrent expenditure. Kenya, like most African countries does not meet the WHO's standard of 1 doctor per 5,000 population. Kenya faces a variety of other health personnel problems, which include an inequitable distribution of those health personnel who are available, and an attrition of trained personnel from the health sector and from the country. Furthermore, according to the Ministry of Health, out of the total 6000 doctors trained, only 600 remain in the public health hospitals. In 2003, over 4000 nurses had left the country for United Kingdom and US. Kenya's human resource challenges are even more daunting in the light of the additional health facilities being put up under constituency development fund (CDF), with the MoH expected to staff and equip them.

While the IMF did not impose formal wage bill ceilings as binding loan conditions on Tanzania, the first wave of "public sector reforms" witnessed a significant retrenchment of public servants, and a freezing of employment in all the social sectors including the health sector. The implementation of this policy was largely responsible for the shortages of staff facing the health sector in the entire country. For example, between 1995 up to 2005, out of 23,474 graduates produced, the Government hired only 3,836 (16%). Furthermore, while 125,924 health workers are required nationwide, only 35,202 (24%) are available, leaving a deficit of 90,722 (76%) healthcare workers for both public and private sectors. Lack of adequate health personnel associated with freezing of employment has significantly limited the ability of the government to respond to the HIV & AIDS and TB crises. Recently, Tanzania failed to utilize significant amount of HIV/AIDS resources due to low absorption capacity, partly attributable to weak health system and lack of sufficient human resources. While the government of Tanzania is making efforts to hire staff to replace the lost workforce, the net effect of this move is marginal compared to existing shortages caused by freezing employment between 1993 and 2005. Out of 23,474 new graduates produced in that period, the government hired only 3,836 (16%).

The most pertinent health worker challenges identified by the Zambia Ministry of Health include: inadequate pay, allowances and incentives; poor working conditions; weak human resource management systems; and inadequate education and training systems. Severe healthworker shortages are attributed to the migration of professional staff, as well as low pay and heavy workloads. According to the MOH, IMF wage bill policy restrictions have made it difficult for the MoH to strike a balance between increasing the

numbers of health workers available, making jobs more attractive, and the need to operate within fiscal ceilings that were determined by the quantitative targets in the IMF's macroeconomic framework.

Ceilings on the government wage bill were introduced in 2000 via Zambia's IMF program. The objective was to limit the overall government wage bill for FY2000 to 5.2% of GDP in order to reduce the domestic non-interest expenditures over the medium term. In 2002, the government introduced a hiring freeze as a structural benchmark under the IMF PRGF-supported program, effectively limiting employment of core health workers (doctors, nurses, midwives, clinical officers etc) in the public service. New recruitments were mostly made against funded posts to fill the gaps left by retirees, those that had left the public service and the deceased. To comply with the reforms, the country was placed under the Staff Monitored Program (SMP) in 2003. Under the SMP, the government was expected to justify all its expenditures to avoid financial slippages, as well as meet several conditionalities, the key ones being reduction in the budget deficit to 3% of GDP and containing the public sector wage bill within 8% of GDP, which the government followed.

The restrictive wage policy initiated by the IMF program led to the loss of highly skilled staff to the private sector, international organizations and foreign nations. Restriction on employment is evident if one looks at recruitment as a percentage of the total government health budget, which declined from 8% in 2005 to 3% in 2006 and then increased slightly to 4% in 2007. In 2004, the MoH did not budget for recruitments and few new graduates were taken to replace the health workers that had died or left the sector. Between 2004 and 2007, out of a total of 5,408 graduates, only 3,897 graduate health workers were recruited through the Public Service Management Division (PSMD). By the end of 2006, only 33% of the required numbers of doctors, clinical officers, nurses, midwives, pharmacists, and paramedical staff were available, leaving a shortfall of 67%. The shortage of health personnel is compounded by the fact that the fight against HIV/AIDS and its opportunistic infections (especially TB and malaria) require additional health personnel due to increased demand for HIV/AIDS-related health care services.

The severity of the health worker problem and its impact on the provision of HIV/AIDS services is illustrated by a quote from a MoH official: "It is predictable that the National HIV/AIDS targets will be impossible to achieve without radical measures to ensure adequate staffing resources are available" (MOH 2005). During the research process for this study, a key informant in Zambia shared, "It would be desirable if much of the HIV/AIDS resources were allocated to personal emoluments (PEs). However, due to restrictions on PE/GDP ratio, the MoH is not allowed to allocate HIV/AIDS funds towards PEs. This impacts on the absorptive capacity."

Key Finding 4: A flawed policy making process neglects consideration of possible options for increased public spending.

In all the three countries, the IMF and World Bank have considerable influence within the policy-making process. In Zambia, nearly all the IMF programs and policies were designed by the IMF and negotiated with government through consultations with the Ministry of Finance and the Bank of Zambia. Key respondents indicated that other government ministries, donors, civil society, and NGOs were only consulted during the later part of the policy and budget formulation processes. For example, the initial preparation of the budget framework paper and decisions on sector ceilings involved only MOF, IMF, and the Bank of Zambia. CSOs were not part of the national policy formulation processes and were only brought on board during the formation of the Poverty Reduction Strategy Paper (PRSP) in 2001. Like the CSOs, many parliamentarians are not consulted on the budget framework paper and sector ceilings. During the development of the PRSP, the Zambian Parliament was informed of important aspects of the document only after it had been adopted by the government and accepted by the IMF and World Bank. A key informant perceived that conditionalities embedded in the PRGF are non-negotiable and come to a debtor country on a "take-it-or-leave-it" basis.

In Kenya, the formulation of the IMF policies was also not participatory or transparent. Respondents from the Ministry of Finance noted that consultations usually involved the IMF giving “suggestions” to the government on policies to be implemented. They further noted that IMF suggestions are taken into account without much alteration, implying that the IMF plays a significant role in policy formulation.

In Tanzania, the closed technocratic nature of policy formulation dominated the process of formulation of the Interim PRSP and was limited to consultations among a small group termed an “iron triangle” of donors, internationally-linked NGOs and government technocrats. Outside this sphere, consultations were virtually absent. This picture changed somewhat during the preparation of the full PRSP in the sense that representatives of civil society—most notably at the national level—were consulted in the process. However, despite the participatory nature of the PRSP at this stage, consultations were rushed and there was a deliberate move to block participation of some CSOs, thus leading to exclusion of some the local non-state actors. However, there was substantial improvement in participation during the formulation of the National Strategy for Growth and Reduction of Poverty – NSGRP (MKUKUTA). Formulation of MKUKUTA was a broadly consultative process, involving a wide range of stakeholders at all stages, including the Government, CSOs, and development partners.

However, stakeholder involvement has been limited on macro policy issues—with participation limited to the government (largely Ministry of Finance and Economic Affairs and the Planning Commission), bilateral donors, the World Bank and the IMF. While this is partly due to weak technical capacity among civil society groups, it also reflects limited success by government and the IMF in framing key macro policy issues in a manner accessible to a wider audience and in ensuring that all major macro issues were included in that debate. The evaluation by IMF’s Independent Evaluation Office noted that the ownership of the PRSP was strongest at the level of top leadership and the Ministry of Finance, followed by priority sector ministries, but was lower in non-priority central ministries. In almost all the IMF policy formulation processes, the parliament has been largely outside the process, and its ownership is low. Alternative macroeconomic policies are still not up for discussion in most PRSP consultations with CSOs.

There were varying degrees of responses regarding the transparency of the formulation of the IMF initiated programs/policies in the three countries. In Zambia, respondents from line ministries stated that they were not fully involved during the formulation but during the endorsement or induction stage when everything had been agreed. The situation in Kenya was similar. The study found that the formulation of the policies was not consultative and discussions on macroeconomic policy issues takes place within a narrow circle of officials, which potentially aggravates the lack of integration between MoH sector-level policies and the overall macroeconomic framework. Evidence from key informants indicates that key objectives and overall macroeconomic policies, targets, and ceilings decisions involve a very limited number of key government officials and IMF mission officials. Other key players such as the ministry of health, as well as stakeholders outside official circles, often have had limited input in the macroeconomic decisions made.

Those interviewed pointed out that debate surrounding the macroeconomic policy framework is a closed activity, with the role of other stakeholders, including parliamentarians, limited. Furthermore, the process of determining inflation-reduction targets, deficit-reduction targets and wage bill ceilings is still not transparent. They are based on a macroeconomic framework and quantitative targets that are only known to IMF and Macroeconomic Working Group at the Ministry of Finance.

In terms of availability of policy documents, a number of key IMF documents and memos between finance ministries and the IMF are not disclosed. Official documents detailing agreements on policies and targets are only published after the finance ministry has already signed. Policy documents such as PRSPs, which are not policy prescriptive and only make reference to macroeconomic policies and targets decided

elsewhere, are available in their final form on Treasury's website and the IMF website. But most of the crucial documentation is not, including draft policy documents that inform decisions between the IMF and government.

The situation in Tanzania in terms of transparency of the policy formulation process is not different from that of Zambia and Kenya. The study findings showed that majority of the stakeholders in the policy process had only limited information on the macroeconomic issues, and only after decisions on those policies had been made thus, making it impossible to make significant input. The World Bank, IMF, donors, and the Government (Ministry of Finance), who are well informed about the macroeconomic policies, practically were the only ones comprising the "policy formulation processes."

Conclusion

The macroeconomic policies advanced by the IMF are often blamed for restricting options for increased health spending and contributing to healthworker shortages in low-income countries—a crisis now recognized as a primary impediment to achieving health-related Millennium Development Goals (MDGs), involving recurring costs often not met by donor funds. This report is intended to contribute to ongoing discussions about the impact of macroeconomic policies on national spending and consequently on health spending in low-income countries, and therefore how such policies impact options for fighting HIV/AIDS, TB and other major diseases, and to reverse critical healthworker shortages.

This study involved a review of relevant documents and key interviews to examine the effect of IMF policies on the capacity to urgent health crises in Zambia, Kenya and Tanzania. Based on the study findings in the three countries, it can be concluded that IMF program policies have been restrictive in terms of fiscal space available to the government and have not enabled the pursuit of more expansionary policy options that could increase fiscal space. This in turn has restricted options available to governments to effectively implement and scale up health interventions, including to meet substantial challenges posed by HIV/AIDS and TB.

In all three countries the study has found that the IMF has great influence when it comes to macroeconomic policy formulation, including setting of the macroeconomic framework and annual sector budget ceilings. It was also communicated that the IMF is the key player in formulating macroeconomic policies with the finance ministries acting as a facilitator and the other stakeholders simply consenting or later authenticating what has already been decided. Other stakeholders have played minor or minimal roles in policy formulation. The process of formulation and implementation of national budgets has become slightly more transparent; however the process of determining fiscal and monetary policy targets is still not transparent.

The IMF macroeconomic programs include the same key features in all three countries examined: a reduction in the fiscal deficit and enhanced monetary policy discipline; liberalization of external and internal markets; privatization of state-owned enterprises and public divestiture from non-strategic enterprises; and improved government management through reduction of the size of the civil service and reorganizing key ministries. Most of the fiscal policy measures have centered on reduction of budget deficits through reduced domestic borrowing, maintaining low inflation and increasing foreign reserves.

The three country studies found that the IMF's restrictive fiscal and monetary policies limited government fiscal space by constraining the overall national resource envelope. This in turn affects adversely allocations to the different ministries, including the health ministry. This type of chronic under-funding over many years, particularly for long-term capital expenditures in the underlying public health infrastructure, has contributed to dilapidated health systems with overworked, understaffed, and underpaid health workforces.

While there are a number of CSOs that advocate for increasing fiscal space for various areas, there is a need by health advocates to work with economists and other stakeholders to engage much more effectively in the initial phases of macroeconomic policy making (including consideration of alternatives) as well as in the later budget-making processes.

Recommendations

There is a need for broader exploration of alternative and more expansionary macroeconomic policy options that could generate larger national budgets, from which increased investments in health, education, and other critical social sectors (including for infrastructure and human resources) could potentially be allocated. Toward this end the IMF, governments and donor agencies should consider the following recommendations:

- The IMF and other donors should work with borrowing governments, United Nations (UN) agencies, universities and research institutes to explore more expansionary fiscal and monetary policy options geared toward stimulating the productive sectors of the economy and building the future revenue base. This would enable countries to generate more of their own resources themselves over time, reduce aid dependency and enable the mobilizing of new resources for health and human development.

- Major aid donors should look not only to the IMF's assessment of countries' macroeconomic policies before providing aid to a country, but instead should consider an array of assessments by different actors.

- Aid should be fully spent and absorbed. The current practice, which can divert significant portions of foreign assistance into building foreign reserves, should be replaced by a more flexible mechanism that allows for greater aid spending domestically as intended.

- The IMF and borrowing governments should work with other donors as well as domestic and international banks to explore more flexible financing mechanisms (involving loan guarantees and subsidized credit) to accommodate higher levels of government domestic deficit financing on more favorable and sustainable terms. Such arrangements could allow for significant increases in public investment and current expenditure. More affordable and sustainable domestic borrowing arrangements could also enable countries to use countercyclical and more expansionary policies to better withstand the global economic recession.

- To improve accountability and increase transparency, governments and civil society should engage a wider spectrum of stakeholders in the formulation and review of IMF program policies, including government ministries apart from Finance, key parliamentary, labor, university and civil society representatives, and the domestic media. More transparent and participatory civic engagement should allow for wider input into the exploration of various macroeconomic policy options and should happen earlier in the budget process—before macroeconomic policies and quantitative targets are set. Governments should make public all IMF program documents.

Works Cited

Barro, J. (1996) ‘Inflation and Economic Growth’, Federal Reserve Bank of St. Louis Review, Vol. 78, pp. 153-169.

Bruno, M. (1995) “Does Inflation Really Lower Growth?” Finance & Development. Vol. 32, No. 3 September, pp. 35-38.

Bruno, M. and Easterly, W. (1998) ‘Inflation Crises and Long-Run Growth’, Journal of Monetary Economics, Vol. 41, pp. 3-26.

Carlsson J, Chibbamullilo P, Orjuela C and Saasa O (2000). Poverty and European Aid in Zambia: A study of the Poverty Orientation of European Aid to Zambia. Overseas Development Institute, London. Published in collaboration with The Nordic Africa Institute Uppsala, Sweden

Center for Global Development (2007) “Does the IMF Constrain Health Spending in Poor Countries? Evidence and an Agenda for Action Report of the Working Group on IMF Programs and Health Spending” Center for Global Development, Washington.

Financial Services Committee (2007) Letter to the Managing Director of the IMF from the House Financial Services Committee of the US Congress, November 14, 2007.

Fischer, S. (1993) ‘The Role of Macroeconomic Factors in Growth’, Journal of Monetary Economics, Vol. 32, pp. 45-66.

Ghosh, A. and Phillips, S. (1998), ‘Warning: Inflation May Be Harmful to Your Growth’, IMF Staff Papers, Vol. 45, pp. 672-710.

Gupta, S., Schwartz, G., Tareq, S., Allen, R., Adenauer, I., Fletcher, K., and Last, D. (2007) ‘Fiscal Management of Scaled-Up Aid.’ IMF Working Paper WP/07/222. International Monetary Fund.

Gylfason, T. and Herbertsson, T. (2001) ‘Does Inflation Matter for Growth?’ Japan and the World Economy, Vol. 13, pp. 405-428.

Khan, M. and Senhadji, A. (2001) ‘Threshold effects in the Relation between Inflation and Growth’, IMF Staff Papers, Vol. 48, pp. 1-21.

Independent Evaluation Office, International Monetary Fund. (2007) “The IMF and Aid to Sub-Saharan Africa”, Independent Evaluation Office, The International Monetary Fund, Washington, April.

International Monetary Fund. (2000) ‘Key Features of IMF Poverty Reduction and Growth Facility (PRGF) Supported Programs.’ August 16, 2000. Online. http://www.imf.org/external/np/prgf/2000/eng/key.htm. Accessed June 25, 2009.

Ministry of Health (2005b). *Human Resources for Health Strategic Plan 2006 – 2010*. Lusaka: Ministry of Health, Zambia

Pollin, R. & Zhu, A. (2005) Inflation and economic growth: a cross-country non-linear analysis.

Roy, R. et al. (2006) “Fiscal Space for Public Investment: Towards a Human Development Approach” by Rathin Roy, Antoine Heuty and Emmanuel Letouze. United Nations Development Program Paper Prepared for the G-24 Technical Meeting, Singapore, 13-14 September.

The Citizen, 6 November, 2008. Tanzania: Bank Loans Are Still Too Dear, Says President.

United States Government Accountability Office. (2001) ‘Few Changes Evident in Design of New Lending Program for Poor Countries.’ Washington, DC.