

High-Level Forum on the Health MDGs

**Fiscal Space and Sustainability from
the Perspective of the Health Sector**

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Table of Contents

Executive Summary	i
1. Introduction	1
2. Defining fiscal space and fiscal sustainability	2
2.1 Fiscal space	2
2.2 Fiscal sustainability	4
3. How much room is there to increase health expenditures?	6
3.1 Recent patterns of health spending in low income countries	6
3.2 Trends in development aid for health	10
3.3 Projections of fiscal space for health spending under alternative scenarios	11
3.4 Interpreting the results of the projections	15
3.5 Empirical evidence on the relationship between aid and public spending on health	15
4. How does donor behaviour affect fiscal space and sustainability?	17
4.1 Aid volatility and unpredictability	17
4.2 Aid coordination, harmonisation and alignment	21
5. How does recipient behaviour affect fiscal space and sustainability?	23
5.1 Ensuring productive use of expenditures	23
5.2 Absorptive capacity	25
6. Macroeconomic effects of scaling up	26
7. Conclusions	28
References	31
Annex 1 – Terms of reference	33

Fiscal Space and Sustainability from the Perspective of the Health Sector

Executive Summary

This paper has been commissioned by the Secretariat of the High Level Forum on the Health MDGs in response to a request from the 2nd HLF in Abuja to clarify the meaning of the terms fiscal space and fiscal sustainability. Its purpose is to define the concepts of fiscal space and fiscal sustainability from the perspective of the health sector, and to demonstrate their usefulness in understanding the fiscal and macroeconomic issues that will arise from an increase in aid flows. The paper addresses the following questions:

- What is the meaning of the terms fiscal space and fiscal sustainability from the perspective of the health sector?
- In the light of likely scenarios for increased donor funding how much room is there to increase public health expenditures in a sustained way?
- How does the way aid is managed affect fiscal space and fiscal sustainability from the perspective of the health sector?
- What are the challenges for aid recipients to ensure the effective use of increased aid resources in the health sector?
- What are the macroeconomic effects of increased health spending and how might this influence fiscal space and sustainability in the long term?

The paper includes projections on future levels of public expenditure on health in low income countries under alternative scenarios for changes in future aid flows, budgetary reallocation, domestic revenues and growth. Under the more optimistic scenarios many countries will achieve levels of expenditure that would potentially allow them to be in a position to achieve the MDGs. This indicates that there is significant potential to create fiscal space for health spending in low income countries, in particular where an increase in aid is accompanied by budgetary reallocation in favour of health, faster growth and a stronger revenue effort.

However, the general conclusion of the paper is that the extent to which additional fiscal space can be created and sustained depends crucially on the way both aid suppliers and its recipients manage additional aid flows. Combinations of donor and recipient behavior will determine how effectively and durably additional aid will expand fiscal space. Some of these are summarized in the table below. The best combinations suggest that fiscal space can be expanded quickly and reliably (‘Green Zone’); the worst that great caution should be exercised until reforms have shown signs of success (‘Red Zone’)

Conditions for the sustainable expansion of fiscal space

	Donor policies	Recipient policies
Green Zone <i>Far reaching changes in donor and government behaviour allow fiscal space to be expanded rapidly and sustainably</i>	Donors are able to make long term commitments to scale up aid	Governments have affordable long term investment and expenditure plans
	Donor aid flows are predictable and stable	Increase in aid is accompanied by a stronger tax effort
		Governments are able to finance any residual cash-flow variations
	Donors are able to coordinate and harmonize aid, and thereby reduce recipients' transactions costs	Governments are able to take responsibility for the management of donor aid, and bring it on budget
		Where justified, governments reallocate budgets in favour of the health sector
		Government health systems are efficient, effective and equitable
Amber Zone <i>Partial reforms in donor and government behaviour allow some increase in fiscal space, but problems of fiscal sustainability remain</i>	Some progress in increasing the long term predictability of aid and reducing short term volatility.	Governments may take on new spending commitments that cannot be sustained
	Some initiatives to improve donor coordination and harmonization, but limited use of budget support.	Governments do not improve their revenue effort
		Governments are unable to fully finance cash-flow instabilities.
		Public expenditure management systems are not yet robust enough to account for aid expenditure on budget
Red Zone <i>Great caution should be exercised in raising health expenditure until reforms in donor and government policies show success</i>	Donors are unable to make long term commitments or reduce aid flow volatility	Very weak public expenditure management
		Donor spending remains largely off-budget
		Governments do not improve their revenue effort
	Aid remains highly fragmented and projectized.	Health care providers are not well motivated or managed
		The poor do not benefit from public health expenditure

More specifically, the main priorities identified for aid donors include:

- ***Ensuring longer term predictability of aid flows***
Donors have signaled their intention to increase aid flows substantially, but recipient governments are faced with a great deal of uncertainty about the level of support that they can expect in future. On the basis of past experience, recipient governments may be reluctant to increase health expenditures, especially where new spending implies long term recurrent expenditure commitments. Unless donors can provide longer term commitments and more predictable aid flows, additional aid may not generate much additional fiscal space for health spending.
- ***Reducing short term aid volatility***
This paper highlights the extent of aid volatility and demonstrates that this is associated with significant instabilities in public expenditures on health. These, in turn, distort resource allocation and have negative consequences for service delivery and health outcomes. The risks of short term volatility may provide an additional reason for governments to be wary of budgeting on the basis of additional aid resources. Donors need to address the risk that scaling up aid will generate even greater volatility and more disruptive effects.
- ***Coordination, harmonization and alignment***
Uncoordinated, off-budget and projectised aid contributes little to durable fiscal space. Aid effectiveness would be increased if aid coordination were improved, and the alignment of donor funding with national priorities were strengthened. . Where conditions allow, the greater use of budget support would be desirable. There are encouraging signs of improved donor practice, including the recent Paris Declaration on Aid Effectiveness. However, there are contradictory tendencies in the health sector, where an increasing share of aid is provided through global health initiatives that tend to operate through parallel structures outside government budgets and management systems.

The main priorities identified for recipients include:

- ***Ensuring fiscal sustainability***
Ensuring the fiscal sustainability of health expenditures will be a major challenge for recipient governments, particularly low income countries facing 'windfall aid incomes' . There is a risk that some governments will make capital investments that they cannot fully maintain, take on too many staff to pay properly, or take on other new spending commitments that prove to be unaffordable and unsustainable in the long term. On the other hand concerns about the unpredictability and unreliability of aid flows may cause some governments to be overly cautious about using in additional aid to augment health expenditures financed from domestic resources. The key to ensuring fiscal sustainability is for recipient governments to take a long term view of expenditure commitments, growth and mobilizing domestic revenues.
- ***Using aid productively***
In the long term the main source of additional fiscal space will be economic growth. It is therefore crucial that recipient governments use aid in productive ways. Careful judgements will need to be made on the allocation of public expenditure between and within sectors taking into account the best available evidence of the impact of public expenditure on human development and economic

growth. The central challenge will be to improve the efficiency of health systems to ensure that higher spending will generate improved health outcomes. In many cases reallocating resources within the health sector towards primary health care would improve efficiency and equity.

- ***Addressing absorptive capacity constraints***

Important capacity constraints arise from organizational, managerial and governance weaknesses, which may reduce the returns to additional aid and public expenditure substantially. In these conditions it will be important to scale up aid at a measured pace, and to accompany this with institutional and governance reforms to create conditions where aid can be used effectively.

- ***Taking account of the macroeconomic effects of higher aid inflows***

There are macroeconomic risks associated with scaling up aid, in particular real exchange rate appreciation and the crowding out of private sector investment. Development aid for health is no different to other types of aid in this respect. In many cases it will still be justified to increase donor support to the health sector, in particular where this supports expenditures that provides the public goods and generates the human capital that will be required to enable private sector-led growth in future. However, the impact on private sector investment and consumption should always be considered. At a certain level of public spending the marginal costs of additional expenditure will exceed its marginal benefits. This constitutes an upper limit to fiscal space that no government should exceed irrespective of the amount of aid on offer. It is difficult to establish where this limit lies. However, most would argue that the poorest countries are some way from reaching this limit. With careful economic management to ensure that scaled-up aid supports both improved service delivery and growth, fiscal space can still be expanded.

Fiscal Space and Sustainability from the Perspective of the Health Sector

1. Introduction

It is widely recognized that current levels of public expenditure for health in low income countries are too low to achieve the MDGs. The prospect of substantial increases in aid may allow higher levels of health spending in low income countries. However, there is a great deal of discussion about the extent to which these additional resources can be used effectively to raise expenditure on health to a higher level. In other words, to what extent can fiscal space for health spending be expanded in a sustainable way?

This paper has been commissioned by the Secretariat of the High Level Forum on the Health MDGs in response to a request from the 2nd HLF in Abuja to clarify the meaning of the terms fiscal space and fiscal sustainability.¹ Its purpose is to define the concepts of fiscal space and fiscal sustainability from the perspective of the health sector, and to demonstrate their usefulness in understanding the fiscal and macroeconomic issues that will arise from an increase in aid flows. The paper will be structured around the following questions:

- What is the meaning of the terms fiscal space and fiscal sustainability from the perspective of the health sector?
- In the light of likely scenarios for increased donor funding how much room is there to increase public health expenditures in a sustained way?
- How does the way aid is managed affect fiscal space and fiscal sustainability from the perspective of the health sector?
- What are the challenges for aid recipients to ensure the effective use of increased aid resources in the health sector?
- What are the macroeconomic effects of increased health spending and how might this influence fiscal space and sustainability in the long term?

The paper will provide a broad overview of these issues, but it must be acknowledged from the outset that it is often difficult to reach firm conclusions because the evidence base is rather limited.

Although the issues it raises are relevant to all countries, the focus of the paper will be on low income countries. This is because fiscal space and sustainability are particularly serious constraints in low income countries, and are one of the main obstacles to achieving the MDGs. The arguments about scaling-up aid are also most relevant to low income countries, in particular those countries (notably in Sub-Saharan Africa) where donor aid amounts to a substantial proportion of public spending.

¹ The paper responds to an action point agreed by the HLF that requested “the World Bank and the IMF to clarify the concept of fiscal space and sustainability in the presence of long term grant funding and concessional lending at the country level and the implications for sector expenditure ceilings.”. The terms of reference are attached in annex 1.

2. Defining fiscal space and fiscal sustainability

2.1 Fiscal space

Fiscal space refers to the ability of government to make budgetary resources available for desired purposes. However, the term has been used in different ways, and its precise definition remains somewhat unclear. More restrictive interpretations of fiscal space emphasize hard budget constraints and expenditure ceilings that are designed to ensure macroeconomic stability and the availability of credit to the private sector. Advocates of a more flexible approach argue that it should be possible to support higher levels of public expenditure on meritorious goods and services that are crucial for poverty reduction, growth and achieving the MDGs.

The following definition of fiscal space taken from a recent IMF paper has been adopted here because it is sufficiently broad to encompass all of the key issues that influence judgements on the appropriate level of public expenditure.

“Fiscal space can be defined as the availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government’s financial position.” (Heller, 2005)

This paper is specifically concerned with issues surrounding public expenditure in the health sector. However, it is not possible to restrict the view of fiscal space to one particular sector. The budgetary resources made available to the health sector depend on the government’s overall fiscal policies, the demands of competing sectors, and spill-over effects from one sector to another. In any event, the size of the health budget is the result of a set of political decisions on the allocation of public resources between competing priorities.

Although fiscal space is a broad concept that applies to public expenditure as a whole, there are valid reasons for considering the problem from the perspective of the health sector. Considerations about the potential to increase public expenditure on health need to be placed with the context of the government’s fiscal position. Spending decisions in the health sector also have an important influence on the government’s fiscal position. For example, a decision to hire large numbers of additional health workers would generate upward pressure on civil service salaries and the overall public sector wage bill. Health sector policy and expenditure decisions will therefore influence fiscal space and vice versa.

In principle, there are several ways to create fiscal space for additional health spending that reflect the government’s budget arithmetic. Each offers opportunities, but also has limits. Well managed fiscal policy assesses the costs and benefits of each, as well as their political implications.

i) Increase discretionary expenditure from debt reduction

In a number of cases fiscal space available in low income countries for spending on public services, including health, is constrained by their obligations to debt servicing. In a few cases, these obligations may amount to around 50 % of total public spending. Hence the significance of recent initiatives to reduce low income country public debt.

ii) *Reallocation between sectors*

Health sector spending can be increased by reallocating expenditure from other sectors. As part of HIPC and PRSP processes some governments in low income countries have increased the share of the budget allocated to the health sector, and some are committed to further increases. However, the demands of other sectors will inevitably impose a limit on the share of expenditure that can be allocated to health. This issue is discussed further in section 5.1.

iii) *Mobilisation of domestic revenues*

Governments can raise additional revenues by increasing tax rates, creating new taxes and levies and strengthening tax collection. The low tax effort in many low income countries (usually less than 15% of GDP) indicates that there is scope to mobilise additional domestic revenues. However, experience suggests that it will be difficult to achieve a rapid improvement in revenue ratios. The Commission for Macroeconomics and Health forecasts that low income countries would probably only be able to increase their revenue ratios by 2% of GDP by 2015 (CMH, 2001). The Millennium Project suggests that a 4% increase in the revenue ratio may be feasible (Millennium Project, 2005). While increases in the tax effort may generate modest increases in fiscal space, the most important challenge will be to accelerate economic growth, which will be essential to generate the sustained increases in domestic revenues required to finance improved health services.

iv) *Increase borrowing*

Governments can also finance higher levels of public spending by borrowing from domestic and foreign creditors. However, there are costs in terms of future debt service obligations and the potential crowding out of private sector borrowing. A sound fiscal principle is that over the economic cycle governments should borrow only to invest rather than to finance recurrent expenditure. While health expenditures are generally treated as recurrent expenditure, many have argued that they should be viewed as an investment in human capital that will generate taxable returns in the long run. If this view is accepted then it would be justified to finance a higher level of public expenditure on health through borrowing so long as the expected returns exceed the costs of servicing the debt.

v) *Increase aid*

The fiscal space that is generated by aid depends on the level, duration and predictability of donor funding, as well as on the type of aid. As discussed in section 4.1 aid will generate more fiscal space where donors can long term financial commitments and can disburse aid in a predictable manner. The effect of aid on fiscal space will also depend on whether it is provided as grants or loans, whether or not it enters the government's budget, whether it is earmarked for a particular use or sector, and the extent to which it is fungible. These issues are discussed further in section 4.2.

vi) *Seignorage*

Governments can finance additional expenditure by printing money, but the opportunities to generate seignorage revenues without causing inflation are very limited.

An important aspect of health financing in low income countries is the high proportion of health expenditures that are privately financed, usually out of pocket. The relationship between public and private expenditure on health, and the implications for fiscal space are complex. An increase in public expenditure on health may substitute or complement private spending. Where substitution occurs the net provision of services may not increase. However, shifting health financing from private to public sources may improve economic efficiency where this improves the cost effectiveness of service delivery or frees up private resources to be used more productively elsewhere. In the long run such efficiency gains would have a positive effect on growth and government revenues, and thereby generate fiscal space. Public spending on health may also be preferable on equity grounds, in particular because it partially insures the poor against catastrophic medical costs. However, it must be emphasised that all of these effects are poorly understood and subject to considerable uncertainty.

2.2 Fiscal sustainability

The concept of fiscal sustainability refers to the ability of government to sustain spending on a desired purpose for its planned duration, and to meet the cost of borrowing without compromising the government's financial position. There are three conditions that need to be met in order to achieve fiscal sustainability in a strict sense:

- *For expenditures funded by loans.* The financial returns generated by the additional expenditure should cover the costs of borrowing.
- *For recurrent expenditures funded by donor grants.* If it is intended to continue these expenditures beyond the planned period of donor funding, governments must be able to raise alternative sources of revenue to replace donor funding when it is phased out.
- *For all investments.* Governments must be able to cover the recurrent costs of any new capital investment, for example the operation and maintenance costs of the construction of a new health facility, as well as the costs of capital.

Health sector spending presents particular challenges in relation to all three of these conditions. With respect to the first, it is usually impossible to assess whether or not it is justified on economic grounds to borrow in order to finance health spending because there is considerable uncertainty about the economic impact of health programmes and the level and timing of any financial return. However, it is generally considered reasonable to allow a certain level of borrowing on concessional terms to finance health programmes in low income countries so long as the government's overall financial position provides sufficient capacity to service the consequent debt.

In relation to the second, the planned duration of health programmes usually far exceeds the duration of donor commitments, which typically only cover a few years. It is therefore essential that governments consider how such programmes could be financed if donor funding were unavailable in future. This highlights the importance of strengthening the tax effort and developing non-tax sources of health financing.

On the third point, public spending in the sector is mainly in the form of salaries for staff and drug purchases: both are long-term, recurrent cost commitments that governments must be in a position to

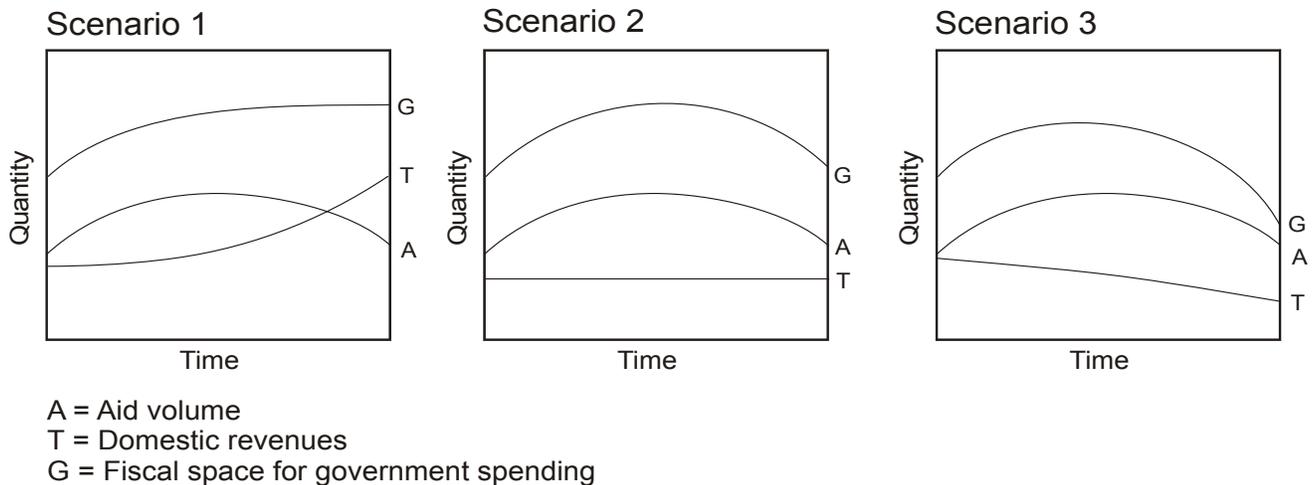
finance. Cutting these expenditures will impose high political costs, and would have damaging medical consequences. There are relatively few one-off activities that can be undertaken to improve public health.

Fiscal sustainability is a particularly important issue in the context of scaling up aid because it is not certain how long the increase in aid volumes will last. At some point in the future governments will need to mobilise additional domestic revenues in order to offset a decline in aid flows. However, it is difficult to predict how government revenues will develop under conditions of higher aid. Where aid is successful in generating growth there may be a positive effect on domestic revenues. However, there is also a risk of moral hazard: governments may relax their fiscal effort when aid is easily available. The empirical evidence of these issues is rather inconclusive. Most studies find that there is no general relationship between aid and domestic revenues, and that the fiscal response varies in different country contexts (McGillivray and Morrissey, 2001; Fagernäs and Roberts, 2004). Gupta *et al.* (2005) find that there is a difference in the fiscal response to grants and concessional loans: Aid provided as grants tends to result in reduced domestic revenues, especially in countries with weak institutions, whereas aid provided as loans results in a slight increase in domestic revenues.

In view of these uncertainties it is helpful to consider various alternative country scenarios for the future evolution of domestic revenues. Figure 1 presents three scenarios that have different implications for fiscal sustainability. The first scenario presents the most optimistic case where aid recipients' benefit from a permanent increase in fiscal space. When aid begins to decline the effect is offset by increasing domestic revenues resulting from growth or a stronger tax effort. In the second scenario, the increase in fiscal space is temporary because when aid begins to decline it is not compensated by an increase in domestic revenues. In this case additional expenditures cannot be sustained beyond the duration of higher aid flows. The third scenario represents the most pessimistic case where recipient governments reduce their tax effort in response to higher aid flows. Following the decline in aid, fiscal space will be more limited than it is at present.

While these scenarios affect government spending overall, there are particular implications for the health sector. Because health expenditures usually entail long term recurrent spending commitments there are particular risks for governments under scenarios two and three. In these two cases increased health spending will not be fiscally sustainable. Fiscally prudent governments may decide not to spend additional donor resources on health, and may instead increase spending in other sectors, which do not generate such long term obligations. An additional problem that is discussed more fully in section 4.1 is that aid is unpredictable and governments cannot accurately forecast future levels of aid. This is another reason why governments will tend to be cautious in raising health expenditures.

Figure 1: Fiscal space and sustainability under alternative scenarios for aid and domestic revenues



3. How much room is there to increase health expenditures?

A key question is how much additional fiscal space can be created under plausible scenarios for increased aid, domestic revenues and economic growth. This section addresses this question by first outlining trends in public expenditure on health and foreign aid in low income countries, and then simulating the effect of changes in key public finance variables on health spending under several alternative scenarios.

3.1 Recent patterns of public health spending in low income countries

Figure 2 compares public expenditure on health in 55 low income countries in 2002 measured in per capita terms and as a percentage of GDP.² Average expenditure was \$6.17 per capita per annum or 2.53% of GDP.³ There are significant variations between countries, but very few countries spend more than 5% of GDP.

Over the past few years there has been a gradual trend towards higher public expenditure on health in low income countries. Average public expenditure per capita on health, in low income countries, rose by 12% from \$5.49 in 1998 to \$6.17 in 2002. Expressed as a percentage of GDP, public expenditure on health rose from 2.26% to 2.53% over the same period.

In spite of recent modest increases, public expenditure on health in low income countries is still far below the minimum levels required to achieve the health MDGs. The recently published Millennium Project report provides costings for the MDGs in 5 low income countries, and suggests that in these countries present levels of expenditure on health would need to increase by \$30-48 by 2015 in order to achieve the health MDGs (Millennium Project, 2005). The Commission for Macroeconomics and

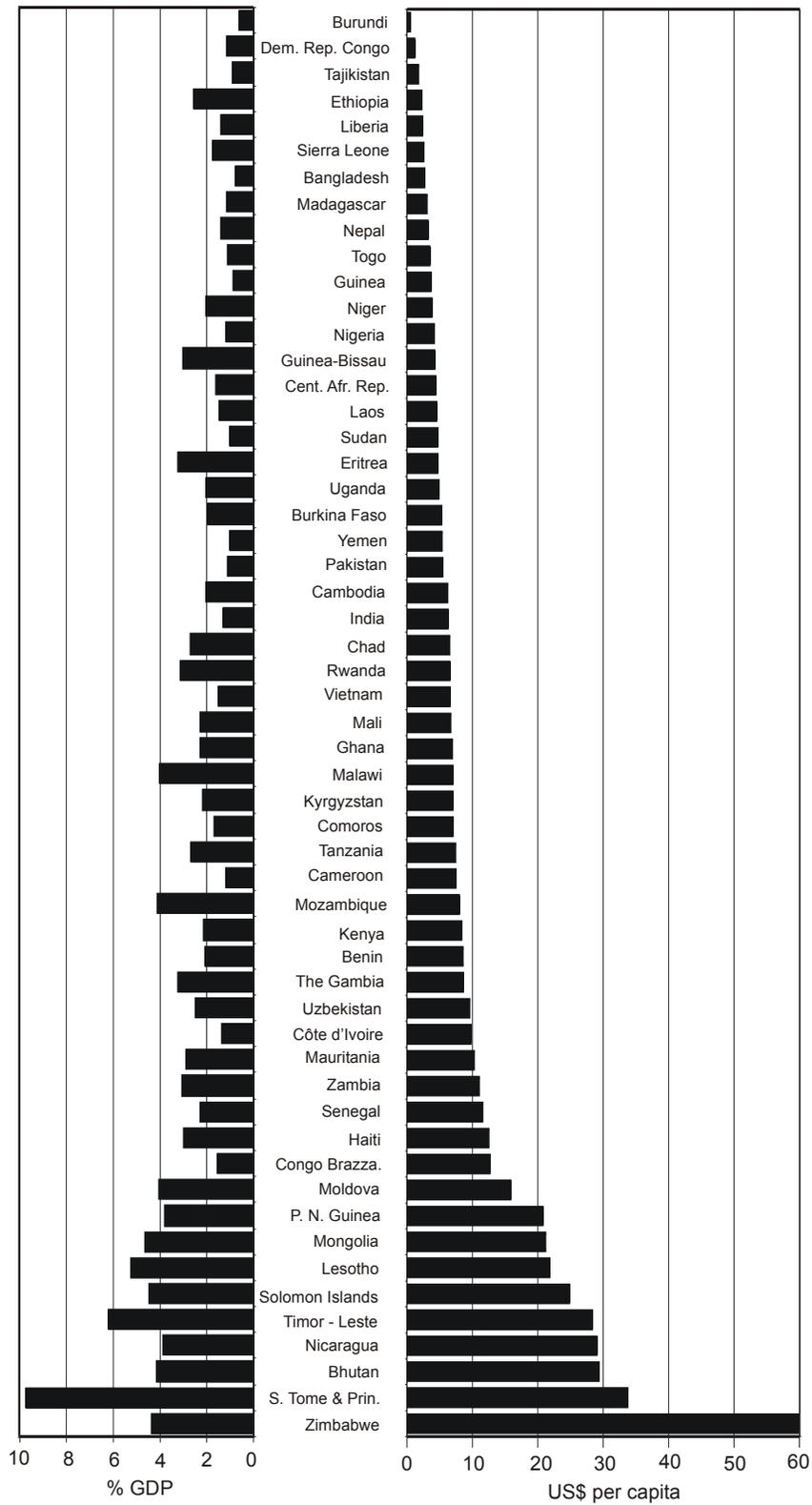
² These figures do not include private expenditure on health, which usually exceeds public expenditure on health in low income countries.

³ These averages are weighted by population size and GDP.

Health calculated that a minimum total health expenditure of \$34 per capita in 2007 (rising to \$38 in 2015) would be required to provide a basic package of essential health interventions (Commission for Macroeconomic and Health, 2001). Public health spending in the low income countries shown in figure 2 is below this level in all but two cases.⁴

⁴ If private expenditure on health is considered then six low income countries already reach a level of total health spending of \$34 per capita.

Figure 2 - Public expenditure on health in low income countries

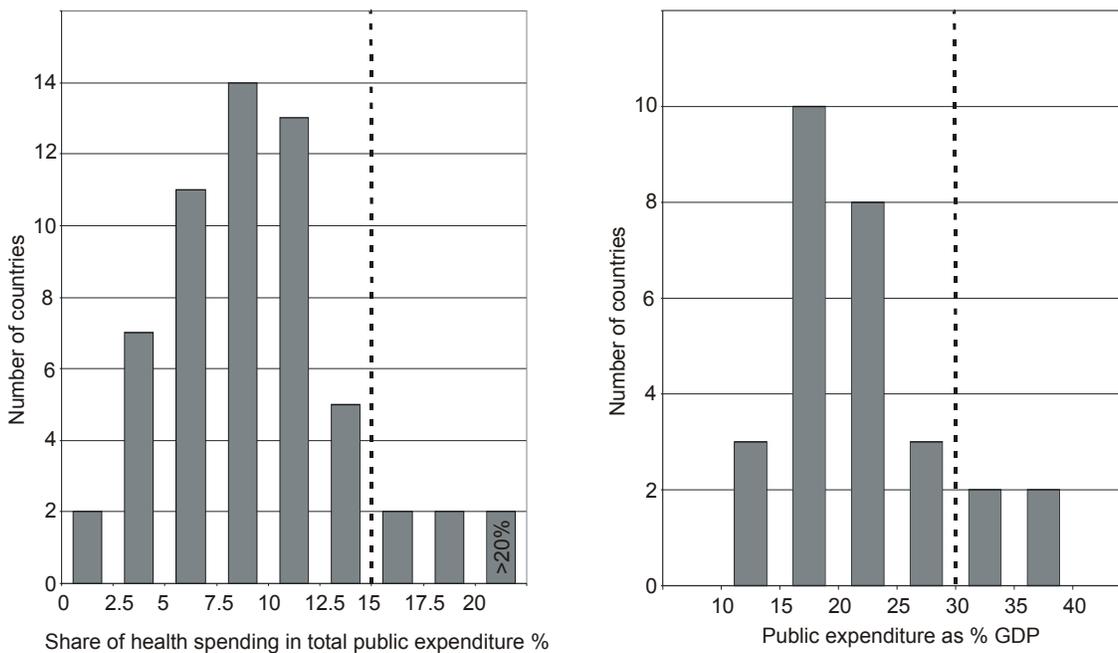


Source: World Health Report (2005)

In order to analyse the scope for increasing health expenditures it is important to examine two key ratios: (i) the share of health spending in total public spending, and (ii) government spending as a percentage of GDP.⁵ Figure 3 groups low income countries according to the first ratio. It indicates that the majority of low income countries allocate less than 10% of the government budget to health. Very few countries spend more than 15% of their budget on health, in spite of the 2001 declaration by African leaders in Abuja to increase spending to this level. There appears to be an effective ceiling on health spending at around 15% of the government budget. This reflects the competing demands of other sectors and the political constraints to reallocating resources in favour of health.

The second chart shows public expenditure as a percentage of GDP in a sample of 28 low income countries for which adequate data is available. The mean value is around 22% of GDP. There is much variation between countries, but there are few cases where government expenditure exceeds 30% of GDP.⁶

Figure 3 – Key spending ratios in low income countries



Sources: World Health Report (2005), IMF (GFS)

These figures are significant because they suggest that there is an upper limit on health spending in low income countries. Since very few allocate more than 15% of government spending to health, and public expenditure is generally less than 30% of GDP, fiscal space for health spending will usually be limited to 5% of GDP (this is confirmed in figure 2). Because public expenditure on health accounts for an average of 2.5% of GDP in low income countries, there will often be scope to increase health

⁵ The budgetary arithmetic involved is captured by the following identity: $PHE \equiv GDP \times PE/GDP \times H$; where PHE is public expenditure on health, GDP is gross domestic product or some similar measure of economic size, PE is total public expenditure and H is the share of total public expenditure allocated to health (see Hay, 2003).

⁶ The high spenders are likely to combine a strong underlying political preference for publicly financed services with substantial borrowing as low income countries generally tax less than 15% of their economies. In addition, total public expenditure includes debt servicing. In many cases, debt servicing obligations amount to a significant proportion of total government expenditure.

spending by one or both of the two fiscal adjustments.⁷ However, the resources that can be generated in these ways will be relatively modest. In a typical low income country with a GDP per capita of \$400 an increase in health expenditures from 2.5% to 5% of GDP would amount to additional spending of just \$10 per capita per annum. Although this would double the public resources available for health, which would be helpful, it falls well short of the resources estimated by the Commission for Macroeconomics and Health to be required to finance a basic package of health services. The only way to create additional fiscal space beyond this limit is to increase GDP per capita through economic growth.

3.2 Trends in development aid for health

Many low income countries, particularly in Sub-Saharan Africa, are dependent on foreign aid for a substantial proportion of their revenues and public expenditure. The creation of additional fiscal space for increased health expenditure will therefore depend greatly on future increases in foreign aid. In order to develop probable scenarios for scaling up aid it is useful to review trends in aid flows to low income countries.

Data on aid flows is provided in terms of commitments, which refer to pledges made by donors in a certain year, and disbursements, which refer to the money that is actually transferred to the recipient. From the perspective of fiscal space disbursements are the more relevant measure. However, information on the sectoral composition of aid is only available in terms of commitments. Figure 4 shows total aid commitments to low income countries for the period 1990 to 2003 and the share of aid committed for health. This indicates that development aid commitments for health in low income countries increased from around \$1.7bn in 1990 to \$5.6bn in 2003.⁸ Over this period its share of total aid commitments increased from 9% to 17%. Much of this increase has been driven by increased funding commitments for HIV/AIDS, the bulk of which has been mobilised through the Global Fund (GFATM) and the US President's Emergency Plan For AIDS Relief (PEPFAR). Global bilateral and multilateral commitments for HIV/AIDS increased from \$1.2bn in 2000 to \$3.4 bn in 2004 (Lewis, 2005).

While these figures indicate a substantial level of donor funding for the health sector, it is important to put them in perspective. The \$5.6 bn committed in 2003 amounts to only \$2.56 per capita in all low income countries. Although this amounts to 42% of public expenditure on health, it is a modest contribution in relation to needs.

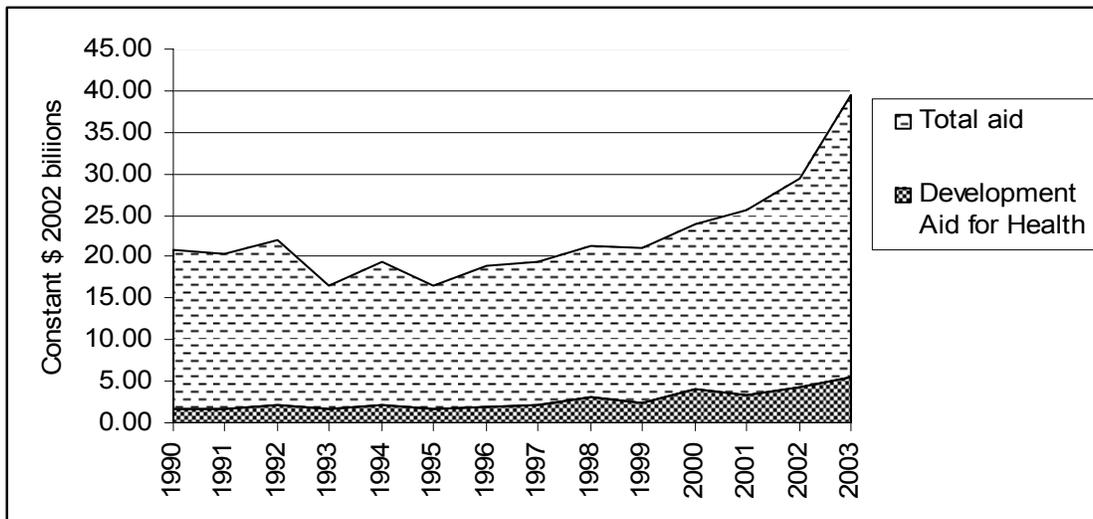
Development aid for health appears more significant if the analysis is restricted to low income countries in Sub-Saharan Africa. In 2003 development aid for health totalled \$3.8 bn in these

⁷ The first is through budgetary reallocation towards the health sector. In principle this can be achieved 'at the stroke of a pen' by a high level political decision, although in practice matters are typically complicated by political issues. The second is by raising the ratio of public spending to GDP, either by increasing the tax base or tax rates or by borrowing. The former requires sustained effort. Fiscal performance is generally considered to be good if the tax-GDP ratio rises by 0.5 % per annum.

⁸ All aid figures are reported in 2002 constant dollars. The figures were derived from the OECD DAC Creditor Reporting System (CRS). They include aid recorded under purpose codes 120 Health and 130 Population. A substantial proportion of aid recorded under the CRS is not recorded by sector (for example, general budget support). It was assumed these commitments would be spent in the health sector in the same proportion as aid that is recorded by purpose code. The figures presented here are comparable to those quoted by Michaud (2003) and World Bank (2005), who report totals for all developing countries. Using the above method total development aid for health in all developing countries was estimated to be \$9.6bn in 2003 – the same as the figure reported by the World Bank (2005).

countries, or \$6.08 per head. This figure is equivalent to average public spending per capita on health in Sub-Saharan Africa, and indicates the extreme aid dependence of these countries.

Figure 4: Aid commitments to low income countries since 1990



Sources OECD DAC Creditor Reporting System

Data on aid disbursements indicate a similar upward trend. However, they are not available on a sectoral level. Public statements made by donors following the Monterrey conference and the G8 summit in Gleneagles indicate that net aid disbursements to all developing countries are likely to increase from around \$80 billion now to \$130 billion in 2010. Net disbursements to Africa are projected to double between now and 2010 (OECD DAC estimates).

3.3 Projections of fiscal space for health spending under alternative scenarios

It should be clear from the above discussion that the maximum expansion of fiscal space for health spending depends on a combination of measures: increases in the share of public expenditure allocated to health; increases domestic revenues and, in the right conditions, increases in aid. None of these measures is likely to be sufficient on its own, and the mix of measures adopted by an individual country will depend on what the potential yield from each measure is likely to be, taking into account costs, risks, institutional strengths and economic prospects. This section presents some simple projections on the future level of public expenditure per capita on health in individual low income countries under alternative scenarios when the measures above are combined in different ways:

- Aid. The projections are based on the assumption that the aid/GDP ratio doubles between now and 2015. In order to take account of the effect of volatility the present level of aid is taken to be the average level of net disbursements over the three most recent years for which data is available.
- Proportion of the government budget spent on health. It is assumed under most scenarios that governments continue to spend the same share of their budget on health in 2015 as they do

presently. Under some scenarios it is assumed that governments increase the share of the government budget spent on health to 15% in line with the 2001 Abuja Declaration.⁹

- **Growth.** Under most scenarios it is assumed that economic growth continues at the average rate for the past ten years. Certain scenarios simulate the effect of increasing the growth rate to 2% above the long term average.
- **Domestic revenues.** Under most scenarios it is assumed that the ratio of domestic revenues to GDP remains constant. The final scenario simulates the effect of increasing this ratio by 4% of GDP by 2015 (in line with the projections of the Millennium Project).

The five alternative scenarios are described in table 1 below:

Table 1 – Alternative scenarios for aid, public finance and macroeconomic variables

Scenario description	Scenario 1 Base case	Scenario 2 Higher aid	Scenario 3 Budgetary reallocation	Scenario 4 Faster growth	Scenario 5 Higher revenue ratio
Aid/GDP ratio	Aid/GDP ratio remains at current level	Aid/GDP ratio doubles by 2015			
Proportion of the government budget spent on health	Health share of budget held constant	Health share of budget held constant	Health share of budget increases to 15%	Health share of budget increases to 15%	Health share of budget increases to 15%
Growth rate 2005 - 2015	Growth continues at its long term average rate	Growth continues at its long term average rate	Growth continues at its long term average rate	Growth increases to 2% above its long term average rate	Growth increases to 2% above its long term average rate
Domestic revenues/GDP	Present ratio of domestic revenues to GDP is maintained	Present ratio of domestic revenues to GDP is maintained	Present ratio of domestic revenues to GDP is maintained	Present ratio of domestic revenues to GDP is maintained	Ratio of domestic revenues to GDP increases by 4% by 2015

Simulations of public expenditure on health under the five scenarios were conducted for 30 low income countries for which adequate data were available. Table 2 shows how many of these countries will reach different levels of public expenditure on health in 2015 under the five scenarios.

The simulations make a number of important assumptions. First, the projections are based on the assumption that government spending is equivalent to the sum of domestic revenues and net aid disbursements, and that there is no fiscal deficit. Second, aid is assumed to be on-budget and fungible between sectors. Third, it is assumed that population continues to increase at present growth rates.

Countries spending more than \$30 per capita are shown within the grey zone on the table. Following the analysis of the Commission on Macroeconomics and Health this is considered to be the minimum level of public expenditure required to provide a minimum package of essential health services.¹⁰

⁹ In the few cases where government's already spend more than 15% of their budgets on health it is assumed that there is no increase in the share of the budget allocated to health.

¹⁰ The Commission for Macroeconomics and Health calculates that total health expenditure per capita will need to exceed \$38 by 2008 in order to provide a package of essential health services. This figure includes private expenditure on health. It is very difficult to predict the

The table indicates that the doubling of aid alone (scenario 2) makes a relatively modest contribution to fiscal space. The average increase in public expenditure above the base case is around \$4 per capita, and only 3 countries out of thirty achieve public expenditure on health greater than \$30 per capita (compared to 2 countries in the base case), and these were already spending most.

Combining increased aid with a reallocation of public expenditure in favour of health would allow a more substantial increase in health spending. This is modelled under scenario 3, which assumes that 15% of the budget is spent on health. The projections indicate that under this scenario average public expenditure on health would increase to nearly \$25 per capita by 2015, and spending in 8 countries would exceed \$30 per capita.

The effect on fiscal space is even more pronounced where increased aid and budgetary reallocation is accompanied by faster growth. Scenario 4 describes cases where growth accelerates to 2% above the long term average. In this case average public expenditure per capita on health exceeds \$30 by 2015, although spending in slightly more than half of the countries remains below this level.

Scenario 5 describes the best of all cases where additional fiscal space is created by a stronger revenue effort, in addition to faster growth, budgetary reallocation and increased aid.

effect of increasing public expenditures on private health expenditure. For the purposes of this analysis it is assumed that allowing for private contributions, public expenditure per capita on health would need to be in excess of \$30 in order to provide essential health services.

Table 2 - Projections of per capita public expenditure on health in 2015

Projected public expenditure per capita on health in 2015	Numbers of countries falling into each expenditure class for each scenario				
	Scenario 1 Base case	Scenario 2 Higher aid	Scenario 3 Budgetary reallocation	Scenario 4 Faster growth	Scenario 5 Higher revenue ratio
\$ 0 - 5	6	5	0	0	0
\$ 5 - 10	12	5	4	1	1
\$ 10 - 15	6	11	5	4	3
\$ 15 - 20	3	3	6	6	3
\$ 20 - 25	0	2	3	4	6
\$ 25 - 30	1	1	4	2	2
\$ 30 - 40	1	1	3	6	5
\$ 40 - 50	1	0	3	1	3
\$ 50 - 60	0	1	0	4	4
\$ 60 - 80	0	1	2	0	1
\$ 80 - 100	0	0	0	2	1
\$ 100 +	0	0	0	0	1
Average per capita public expenditure on health for all 30 countries	\$11.63	\$15.52	\$24.94	\$31.97	\$35.73

Data sources: Revenue data (IMF GFS), health spending (WHO World Health Report), aid (OECD DAC database), other variables (World Bank, World Development Indicators).

The Millennium Project has provided detailed costings of the additional resources required to meet the MDGs in five low income countries. For three of these countries adequate data was available to simulate whether health spending would reach these targets under the five scenarios. The results are presented in table 3. It is notable that none of the three countries would achieve the required additional health spending under scenarios one to four. Only Cambodia would reach the target under scenario five.¹¹

¹¹ The expenditure targets calculated by the Millennium Project are somewhat higher than costings provided by the Commission on Macroeconomics and Health. In addition, the projections do not include private expenditure on health, which would help to somewhat narrow the gap.

Table 3 - Projections of fiscal space compared with MDG spending targets

	Additional per capita spending in 2015 required to meet health MDGs/ 2003 US\$	Additional per capita public expenditure on health in 2015 projected under alternative scenarios / US\$				
		Scenario 1 Base case	Scenario 2	Scenario 3	Scenario 4	Scenario 5
Cambodia	32.00	5.01	10.59	20.70	28.06	32.25
Tanzania	48.00	2.75	8.05	12.62	18.22	21.14
Uganda	44.00	3.15	7.39	16.90	22.85	25.84

3.4 Interpreting the results of the projections

The above simulations indicate that there is significant scope to create fiscal space for health spending in low income countries, in particular where an increase in aid is accompanied by budgetary reallocation in favour of health, faster growth and a stronger revenue effort. Under the more optimistic scenarios many countries will achieve levels of expenditure that would potentially allow them to be in a position to achieve the MDGs, but probably not by 2015 as any effects of increased spending would be lagged. Although many countries do not reach this level of spending under any scenario, there would still be a substantial increase in health expenditures that could make a significant difference to service delivery and health outcomes.

The above projections provide a useful indication of the additional fiscal space that may potentially become available under alternative scenarios. However, the scenarios are generally rather optimistic, and the projected expenditures should be regarded as being at the top end of what may be feasible. There are several reasons for caution:

- It is probably too optimistic to assume that governments will allocate 15% of public expenditure to the health sector. Very few low income countries have achieved this (see figure 3).
- Aid recipients may be inclined to allocate a relatively small share of additional aid to the health sector because of the unpredictability of aid and the long term recurrent spending commitments that are generated by health expenditures.
- The assumption that additional aid will be provided on-budget is not realistic given present patterns of aid delivery (see 4.2).
- An average increase in the revenue/GDP ratio of 4% by 2015 would represent a very strong tax effort that would only be achieved by the best performing countries.

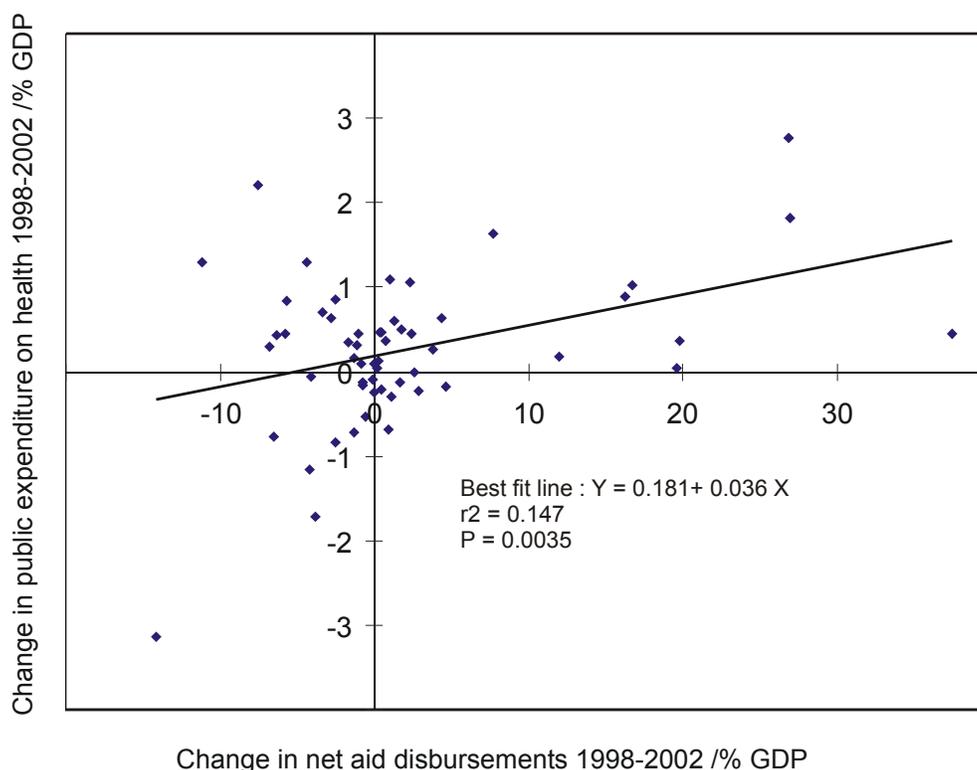
3.5 Empirical evidence on the relationship between aid and public spending on health

In order to assess how public expenditure on health would respond to increases in aid it is instructive to examine aid recipients' past behaviour in utilising additional aid flows. Theory suggests that governments will shift their own resources away from sectors that benefit from international aid

(fungibility). The empirical evidence on this point suggests that the fiscal response to aid varies greatly between countries.

Figure 5 plots changes in net aid disbursements over the period 1998 to 2002 against changes in public expenditure on health over the same period in 56 low income countries. Although there is a wide variation in the fiscal behaviour of different countries, there is a statistically significant correlation between changes in aid volumes and changes in public expenditure on health. The slope of the best fit line shows that the effect of additional aid on health expenditures has been quite small: an increase in aid of 10% of GDP has been associated with an increase in public expenditure on health of 0.36% of GDP. This would imply that only 3.6% of aid is used to finance health expenditures.

Figure 5 – Response of public expenditure on health to changes in aid



Sources: OECD DAC database on aid disbursements, WHO World Health Report 2005

NB: Values for net aid disbursements and public expenditure over the period 1998-2002 were adjusted using a Hodrick-Prescott filter.

The effect of the filter is to indicate the trend in values over the five year period and to strip out the effect of volatility from one year to the next.

Given that low income countries typically spend around 2.5% of GDP on public health expenditure, this implies that aid stimulates health spending to a slightly greater degree than domestic revenues. However, there is significant fungibility in the use of aid. Although donors earmark 17% of their commitments (see section 3.2), the increase in health spending generated by an increase in aid is far

less than this. The explanation is that governments have responded to increases in aid for the health sector by shifting their own resources out of the health sector.

This finding indicates that if governments maintain their present fiscal behaviour future increases in aid will only generate relatively modest increases in public expenditure on health. Much will depend on whether governments' fiscal behaviour will change in future, most importantly by reallocating donor and domestic resources in favour of health.

4. How does donor behaviour affect fiscal space and sustainability?

This paper has so far considered the potential effects of changes in the aggregate level of aid volumes on the recipient's fiscal space. However, there are other aspects of donor behaviour that have an important effect on fiscal space and sustainability. This section considers two important problems: (i) the volatility and unpredictability of aid, and (ii) its lack of coordination, harmonisation and alignment. It will be argued that the maximum additional fiscal space will not be created unless these problems are addressed.

4.1 Aid volatility and unpredictability

Aid commitments and disbursements fluctuate considerably over time. There are various types of instability caused by different aspects of donor behaviour

- Short term volatility from one year to the next. This is often the result of project management and disbursement delays, exchange rate fluctuations, non-compliance with agreed conditionality, and political problems in recipient countries.
- Commitment – disbursement gaps. Donors often cancel their commitments or delay disbursements by several years.
- Longer term unpredictability of aid. Donors are usually unable to make long-term aid commitments because the length of donor programming cycles is typically only a few years. In addition, bilateral aid commitments are typically dependent on the donor country's political cycle: a change in government can make a great difference to a donor country's aid policies.

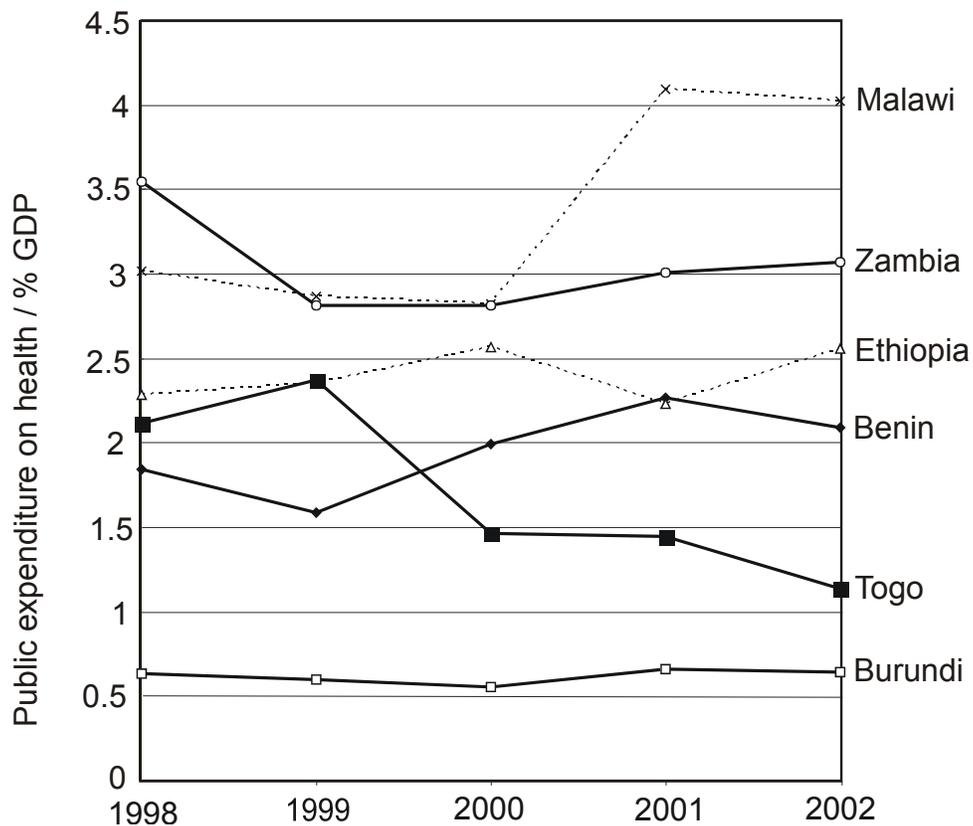
The instability of aid can be measured both in terms of aid commitments and disbursements. Aid commitments are by nature very unstable because they reflect periodic announcements by donors of new projects and programmes covering several years. They also provide an uncertain basis for governments to plan expenditures over the medium term. On average donors disburse only around two thirds of the aid they have committed, and in low income countries this ratio is only about 50% (Bulir and Hamann, 2005). There is evidence that the gap between commitments and disbursements is widening. The ratio of disbursements to commitments for all recipient countries fell from 82% to 66% between 1990 and 2001 (Bulir and Hamann, 2005).

Volatility in disbursements creates particularly difficult problems for recipient countries because when expected aid resources do not arrive governments are unable to execute budgets as planned. Recent empirical studies indicate that there is substantial volatility in aid disbursements. Bulir and Hamann (2005) demonstrate that aid volatility is around 40 times greater than the volatility in domestic revenues

when expressed as a percentage of GDP. Furthermore, in spite of donor initiatives to ensure more stable levels of aid, volatility appears to have become more severe over the 1990s. Moreover, aid flows have tended to be procyclical, and have thereby exacerbated the effects of volatility in domestic revenues. Aid flows have generally increased when domestic revenues are strong and fallen back when domestic revenues are weak.

Given the magnitude of aid volatility and unpredictability it would be expected that there would be an impact on public expenditure. The evidence on the instability of public spending on health suggests that this is probably the case. Figure 6 shows public expenditure on health over the period 1998-2002 for six African countries. These examples are broadly representative of the patterns observed in low income countries. The chart shows that there are significant differences between countries. For example, Burundi and Ethiopia have managed to maintain fairly stable health budgets. However, volatility has been substantial in Benin, Malawi, Togo and Zambia, where variations in health expenditure from one year to the next have often exceeded 0.5% of GDP.

Figure 6 – Volatility in public spending on health in selected African countries



Source: World Health Report (2005). Public expenditure includes aid financed expenditures

An association between volatility in aid and volatility in public expenditure on health can be demonstrated, although this does not prove causality. The results of a bivariate regression analysis are

shown in figure 7, which plots volatility in net aid disbursements against volatility in public expenditure on health for 56 low income countries for the period 1998-2002.¹²

The results demonstrate a positive and statistically significant relationship between aid volatility and volatility in public expenditure in health. The R-square value indicates that 20% of the volatility in public expenditure is explained by volatility in aid. In addition, figure 8 shows that the volatility of public expenditures on health tends to be greater in more aid dependent countries.

Figure 7 – Volatility in public health spending is correlated with volatility in aid

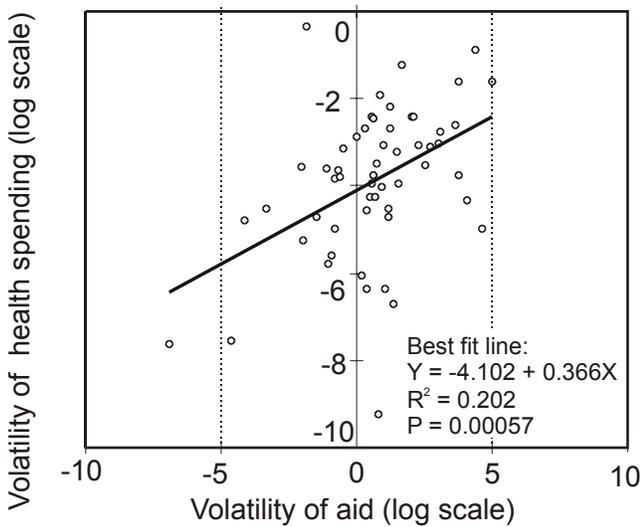
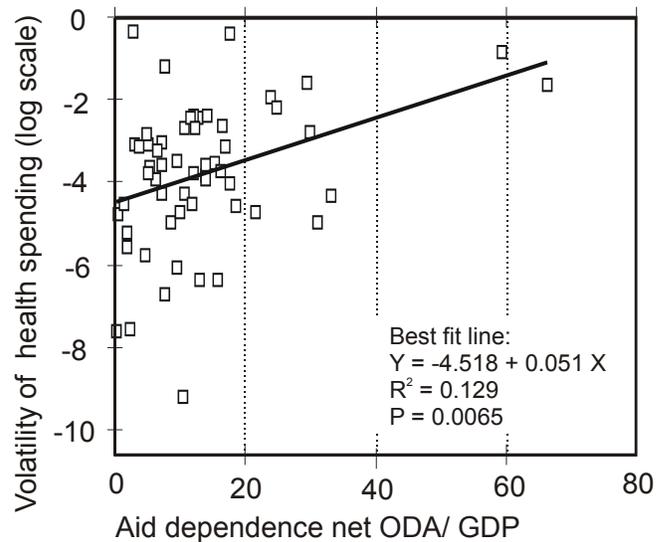


Figure 8 – and is greater in more aid dependent countries



Sources: World Health Report (2005), OECD DAC database, World Development Indicators (2005)

These findings provide some interesting insights into the effects of aid volatility and unpredictability on fiscal behaviour and fiscal space. In principle, governments can cushion the effects of short term volatility by temporarily drawing on reserves or by borrowing. However, the above observations suggest that governments have not been able or willing to cushion fully the effects of aid volatility. The most likely explanation is that many low income countries are bound by conservative budgetary rules that force them to cut back expenditures if aid does not arrive. Many countries operate cash budgets that restrict borrowing and make it impossible to spend resources that have not yet been received. A common practice is to issue a hastily prepared supplementary budget after aid monies have arrived. Volatility will therefore have an immediate effect on fiscal space, and the level of public expenditure is likely to respond rapidly to fluctuations in aid receipts.

¹² Time series data was collected for net aid disbursements and public expenditure on health (both expressed as % GDP) for the period 1998-2002. The measures of volatility were constructed following the method of Bulir and Hamann (2005). A Hodrick-Prescott filter was applied to the time series data in order to distinguish between the effects of short term volatility and longer term trends and to calculate deviations from trend ($\lambda=100$). The volatility measure is the natural logarithm of the variance of these detrended values.

Volatility in health expenditures is likely to have a negative effect on service delivery. When governments experience sudden budgetary shortfalls difficult decisions must be taken on which expenditures to cut. The burden of adjustment tends to fall on more discretionary types of expenditure, such as drug purchases and new investment, rather than non-discretionary expenditures, such as salaries. This has been a common problem across the developing world where health workers are often unable to deliver services because of the lack of operating and maintenance spending.¹³

Another effect of aid volatility may be to influence the allocation of resources between levels of health care. There is some evidence that there is greater volatility in expenditures on primary health care than at secondary and tertiary levels because primary health care tends to be more dependent on donor funding (World Bank, 2005). In addition, aid volatility is likely to result in the funding shortfalls for primary health care. If donors fund primary health care then governments are likely to reallocate their own resources to other uses, including higher level health care. When there is a shortfall or delay in donor funding governments find it difficult shift their own resources back into primary health care.¹⁴

Aid volatility and unpredictability may also have longer term effects on fiscal space and public expenditure. If governments cannot be confident that committed donor funds will arrive or that existing donor funded programmes will continue for more than a few years, they may be understandably reluctant to increase expenditures on areas that generate long term recurrent spending obligations. Where aid is volatile and unpredictable an increase in aid may not generate a proportional increase in sustained health expenditures.

These arguments assume special importance in the context of a substantial scaling up of aid. There is a risk that the problems of volatility and unpredictability may become even more severe when aid is scaled up. In addition, it may be difficult to persuade recipient governments to make ambitious plans for the expansion of health services unless donors can instil greater confidence that increased aid will materialise and that higher aid volumes will be sustained over the medium to long term. In the light of past experience fiscally prudent governments would have good reason to discount donor promises to scale up aid. They may be particularly reluctant to use risky aid funds to finance long term recurrent health expenditures. The case of anti-retroviral therapy is a well known example of the dilemma facing aid recipients. While many governments are under great pressure to expand these programmes, current forms of aid may be too unpredictable and unstable to finance the required lifelong treatment programmes. The consequences of budgetary cuts in these programmes would be catastrophic because interruptions in anti-retroviral therapy reduce the benefits of treatment to individuals, and may lead to the emergence of more resistant strains of the virus that would reduce the effectiveness of treatment for everyone.

It is difficult to generalise about how recipient government will respond to these problems. Some governments may react to increases in aid in a fiscally prudent manner, and increases in health

¹³ The effects also tend to be worse in countries that have decentralised their health budget management systems as funding stability is maintained by the centre at the expense of the periphery. Regional and district budget managers are typically unsure when or whether funds to finance non-staff recurrent expenditure will arrive. This makes them unreliable customers for local supplies of medical materials.

¹⁴ A forthcoming World Bank volume on health financing includes a model of resource allocation between levels of health care where aid is volatile and fungible. The model assumes that governments will be able to increase spending on higher levels of health care more easily than they can reduce spending. Hence an increase in donor funding for primary health care will tend to result in a rapid shift of government resources towards higher level health care. These funds cannot easily be returned in case of a shortfall in donor support (World Bank, 2005). The model predicts that following shortfall in donor funding the level of spending on primary health care would be lower than in the absence of aid.

expenditure will be relatively restrained. Other governments, taking a short term view, may be inclined to spend unpredictable, lumpy aid receipts on projects that have unaffordable recurrent cost implications. Either way the outcomes will be sub-optimal.

4.2 Aid coordination, harmonisation and alignment

Aid should not be viewed as a single category, but rather as a diverse and fragmented set of resource flows. In most low income countries there is a proliferation of donors using many different types of instrument to manage their funds. Proliferation is perhaps most extreme in the health sector. Foster states that: “The health sector has more active donors involved in more individual activities than any other sector, and the problems are getting worse, with the recent addition of significant new sources of funding.” (Foster, 2004, p 68).

The fragmentation of aid should be viewed as a constraint on fiscal space for two main reasons. The first is that donor aid is only partly integrated into recipient government budgets. Around half of donor aid is provided off-budget, and is used to provide technical assistance or to fund NGO projects. These resources will only create fiscal space where there is scope for fungibility. However, the extent to which off-budget donor spending will free up government resources to be used elsewhere is quite limited. Even where aid is accounted for in government budgets, the majority is provided for donor managed projects. Again, there may be scope for fungibility, but the increase in fiscal space will be less than if the government could exercise full discretion over the use of donor funds. The only category of aid that is on-budget and under the full control of recipient governments is general budget support. However, only a small part of aid is provided in this form. A recent analysis of aid relationships in 14 developing countries revealed that only 20% of donor aid was provided as general budget support (Foster, 2004).

The second reason why the fragmentation of aid constrains fiscal space is that the proliferation of projects imposes major efficiency costs. There is a substantial waste of resources resulting from management duplication, weak coordination and the establishment of parallel planning and management structures. Projects are often not well integrated into national health systems, and in the worst cases may undermine these systems by depriving them of staff and resources. Project aid tends to result in unbalanced patterns of spending, and makes it very difficult for governments to prioritise spending in pursuit of a coherent strategy. Recipient countries also face a significant administrative burden managing multiple relationships with donors. All of these inefficiencies waste public resources and thereby deprive governments of fiscal space.

The above arguments suggest that providing a greater share of donor resources in the form of budget support would have a positive effect on fiscal space, and would improve aid effectiveness more generally. In the context of scaling up aid, this may be the only viable option to increase funding without overstraining domestic administrative capacity. However, the shift towards budget support may not necessarily result in increased public expenditure on health. Although the evidence on this point is limited, one recent study of Tanzania indicates that following the start of budget support in 2001 there has been an increase in public expenditure on health in per capita terms, but the share of health spending in the budget has remained unchanged (Lawson *et al.*, 2005). This example indicates that there is no reason to expect that budget support will result in changes in public expenditure allocation.

In general budget support will only generate higher public expenditures on health where governments and donors share a common preference for higher health spending. There is no guarantee that this will be the case. Donors typically earmark budget support for use in certain sectors, but such conditions may not be respected where governments have different spending priorities. In some countries budget support will not be an appropriate aid instrument; in particular where donor and government are very different, and where there are poor standards of public financial management and accountability. Under these conditions there may be a case for providing off-budget project aid or channelling support to non-state actors. However, this approach will not prevent fungibility, and may not result in higher health spending than if aid had been provided on budget.

There is a risk that the inefficiencies caused by the fragmentation of aid delivery will get worse as aid flows increase. However, recent trends indicate a gradual shift away from project aid towards budget support (DFID, 2002). This has been associated with the provision of debt relief and Poverty Reduction Support Credits in the context of PRSPs. In the health sector the Sector Wide Approach (SWAP) has become an important form of aid delivery that has provided a basis for improved donor coordination and the alignment of donor funding in support of a government-owned policy and expenditure framework.¹⁵ However, this approach has so far been limited to a relatively small number of countries.

The Paris Declaration on aid effectiveness is an important signal of donor commitment to address problems of aid coordination, harmonisation and alignment. Discussions are currently underway to set targets for improvements in several aspects of aid management and delivery, including reporting aid on budget, increasing the proportion of aid provided as budget support, improving aid predictability, untying aid procurement rules, avoiding the use of parallel systems and deploying joint country missions. All of these objectives, if implemented, should help to maximise the fiscal space created by additional aid flows.

The major exception to the general trend towards improved aid coordination, harmonization and alignment has been the growth of global health initiatives, for example GFATM, PEPFAR, GAVI and philanthropic foundations funding health programmes. There has been a particularly dramatic increase in funding for HIV/AIDS, most of which has been provided through global initiatives, rather than from the traditional sources of bilateral and multilateral aid. In several countries external funding for HIV/AIDS is already equivalent to or greater than the public health budget.¹⁶ The majority of funds distributed by the global initiatives has been provided off-budget, and have been channelled through parallel structures, often to projects implemented by NGOs or private contractors. This strategy reflects the urgency of responding to global health emergencies, and the weaknesses in the capacity and governance of national health systems. However, there are concerns that standalone HIV/AIDS programmes may undermine the ability of government to develop well functioning, integrated and sustainable health systems. The large scale funding available for HIV/AIDS will inevitably draw human and financial resources out of national health systems weakening their capacity to respond to other health priorities (Lewis, 2005). There are also more general concerns that insufficient attention has been given to the long term financial sustainability of HIV/AIDS programmes as discussed above.

¹⁵ Within the SWAP framework donors usually continue to provide funding in the form of projects, but there are also examples of pooled funding.

¹⁶ In Ethiopia and Mozambique external funding for HIV/AIDS in 2002-2004 was almost equal to the public health budget; in Uganda and Zambia it was significantly greater (Lewis, 2005).

5. How does recipient behaviour affect fiscal space and sustainability?

While donor behaviour has an important influence on fiscal space, recipient government policies determine the key variables that establish fiscal space: growth, revenue effort and the allocation of public expenditures. This section discusses two important challenges that need to be addressed by aid recipients in order to create fiscal space for health spending, and to utilise it effectively. These are concerned with: (i) allocating resources to their most productive uses, (ii) strengthening absorptive capacity.

5.1 Ensuring productive use of expenditures

In the long term the main source of additional fiscal space will be economic growth. There is no other way to achieve the sustained increase in domestic revenues that will be required to fully finance MDG goals in low income countries. It is therefore very important that public expenditure is spent in productive ways that, first, improve health status, and, as a result, generate accelerated economic growth. From the perspective of this paper there are two crucial issues: (i) the allocation of spending between the health sector and other sectors, and (ii) the pattern of spending within the health sector.

In principle, decisions on the sectoral composition of public spending should be guided by evidence on social returns. Unfortunately, there is great uncertainty about the rate of return on spending in different sectors, in particular in the health sector. There is considerable debate about whether higher public expenditure on health results in improved health outcomes in low income countries. While some econometric studies find a positive relationship between public expenditure and health, others find no statistically significant relationship (see Roberts, 2003 for a review of these studies). More recent studies have found stronger evidence of a link between public expenditure and health indicators, in particular in relation to the benefits of immunisation which seems to be particularly sensitive to differences in government health expenditure. For example, Rakjumar and Swaroop (2002) find that higher public expenditure on health lowers infant mortality rates in countries with good governance. Bokhari *et al.* (2005) find a statistically significant relationship between public expenditure on health and the under five and maternal mortality rates. However, all of these studies show that the effect on health of higher public health spending is relatively small.

Despite important exceptions,¹⁷ most studies find that health outcomes are more strongly determined by variations in income levels than variations in public spending on health. Roberts (2003) reports that around 75-80% of the variations in health outcomes between countries are explained by differences in GDP per capita (Roberts, 2003). Higher levels of income provide many types of social benefit that result in improved health, for example improving living standards, better education and delayed age of first pregnancy. Moreover, growth is essential to generate the domestic resources that will be required to finance future improvements in health services. However, this should not imply that governments should invest all of their resources in fostering growth rather than improving health services. Important health problems can and do persist even in rapidly growing economies, for example high maternal mortality. In addition, the relationship is two way: improvements in health indicators will also stimulate growth. While the evidence base is incomplete, there are a number of studies that purport to establish a

¹⁷ Where better than expected health outcomes for income have been found, for example, Cuba, China, the Soviet Union Kerala State and Sri Lanka in the 1980s, these seem to have been associated with extraordinarily strong political commitments to public investments in health, unusually high budget allocations and a highly motivated workforce. See also Keefer & Khemani, 2005.

causal link between better health, greater productivity and economic growth. All of these arguments suggest that neither growth nor public spending alone will be sufficient to improve health outcomes. Improving health in low income countries will depend on both of these factors.

It is not the purpose of this paper to enter into the complexity of the debate about the health impacts of public expenditure. However, from the perspective of fiscal space a number of observations can be made that may help to guide decision making on the share of public expenditure allocated to the health sector.

- There will always be a great deal of uncertainty about economic returns to health spending, in particular the financial and taxable returns. Furthermore, there is likely to be a significant time lag between public investments in health and the timing of economic benefits. In view of these uncertainties, which are not unique to the health sector, the usefulness of evidence on rates of economic or social return in guiding spending decisions is questionable. However, further research may help to strengthen the evidence base.
- Rates of return to health spending will vary between countries. Much depends on the quality of governance and the effectiveness of health systems in delivering basic services. In countries with better functioning health systems higher public expenditures will result in greater improvements in health indicators. In countries with poorly functioning health systems, the returns to higher spending may be close to zero. In these countries the immediate focus should be on reforms to improve service delivery efficiencies and equity. Improving providers' incentives, particularly to care for poor people, and removing incentive distortions are at the heart of improving the returns to additional public expenditure on health. This will include improving governance, building capacity and strengthening management, as well as exploiting the comparative advantage of different types of provider. Radical rethinking may be required on the public role in health and the structure of the government health workforce.
- At the level of individual countries it is possible to make informed judgements about the cost of expanding access to essential health services. Such information provides a more practical basis for health budgeting than cross country evidence on rates of return to health spending.
- It is important to ensure that resources are available for complementary investments in other sectors that contribute to improved health outcomes. For example, investments in transport infrastructure may be required to improve access to health services.
- The opportunity costs of increased public expenditure on health need to be considered. It would not be desirable to crowd out expenditures in other sectors that may have a stronger and more immediate impact on growth than health spending.
- It must also be recognised that the benefits of public spending on health should not be viewed solely in terms of economic returns. As highlighted by the Millennium Development Goals improvements in health indicators are a benefit in their own right. Furthermore, public spending on health can provide an important safety net for the poor partially protecting them from the risk of incurring catastrophic medical costs.

The common wisdom is that in many low income countries public expenditure is misallocated within the health sector. The bulk of health budgets in low income countries has tended to be directed at secondary and tertiary health facilities offering curative services that mainly provide private benefits to small numbers of people. Primary healthcare has tended to receive lower priority, and there has been a particular tendency to under-fund promotional, preventative (such as the control of communicable diseases) and environmental services that generate public goods, such as a safer health environment, that benefit everyone, but individuals are unwilling to pay for. A reallocation of public expenditure towards primary health care may be justified both on equity and on efficiency grounds provided there is also a way of funding the catastrophic costs of secondary and tertiary care for poor people. The empirical evidence for the appropriate balance is limited. In many low income countries, for reasons discussed above, neither primary nor higher level care is properly financed.

Although improvements in the allocation of public expenditure may be desirable, political pressures often prevent reform. Political elites and non-poor urban groups, who have a stronger political voice, tend to focus their demands on subsidies for secondary and tertiary health care. Medical staff often form an influential lobby group, who tend to call for the expansion in the provision of higher level health care because of the greater incentives that this provides in terms of salaries, career advancement and the official and unofficial fees paid by patients. There are few organised interest groups advocating greater provision of preventive and primary health care because the benefits tend to be more dispersed. This makes a just and efficient allocation of the government health budget between levels of service all the more difficult to achieve.

In the context of scaling up aid there is a particular risk that the additional resources will be misallocated or used wastefully. When resources are more abundant, it is harder for governments to withstand pressures from unions and special interest groups. More generally, it may become more difficult to maintain discipline in spending decisions and to deny funds for bad projects. This underlines the importance of strengthening systems of public expenditure planning and management, budget monitoring and public accountability as an essential condition for scaling up aid.

5.2 Absorptive capacity

The debate about scaling up aid has also highlighted the question of whether recipient countries have the capacity to absorb large increases in aid flows. The term absorptive capacity is not precisely defined, but is commonly used to refer to the policy and institutional constraints that prevent additional funds from being used effectively. These include the weakness of budgeting systems, failures in public administration, shortages and mismanagement of human resources and skills, and broader governance failures, including corruption.

There is some debate about whether absorptive capacity is a constraint on fiscal space (Heller, 2004). In a strict sense fiscal space is determined by resource availability rather than by absorptive capacity. However, absorptive capacity constraints may mean that governments cannot effectively utilise additional fiscal space. In the context of scaling up aid, absorption constraints may generate increasing inefficiencies and waste. Where aid resources are not invested productively opportunities to generate fiscal space through economic growth will be missed.

It is difficult to generalise about absorptive capacity constraints because the problems vary among countries and between different types of expenditure. Some types of expenditure are amenable to rapid scaling up, for example the purchasing of drugs and the extension of free service provision. Funding can also be used to address certain capacity constraints. For example, low public sector wage rates and low government sector productivity characterise many health systems in low income countries. Additional funding for staff recruitment and salary increases might address these human resource constraints and low levels of motivation amongst health workers that undermine the performance of public health services. However, there is a risk that this would lead to demands for wage increases across the public sector, generating broader pressures on fiscal space. Moreover, increased pay alone is unlikely to generate productivity gains. Fundamental employment, pay and management reforms are almost certainly required to ensure that enhanced fiscal space is translated into better quality health services.

The most difficult absorption problems usually relate to concerns about governance, public accountability and the risk of corruption. There are often very serious weaknesses in planning and management capacities that prevent resources being delivered ‘on the ground’, where they are needed. Public institutions often fail to provide incentives to use resources efficiently and to respond to user demands. Where oversight and financial controls are lacking there is a serious risk of corruption.¹⁸ To a certain extent technical assistance funded by donors can help to improve systems of public sector management. However, in most cases there is a need for broad ranging public sector reform, which will depend more on high level political commitment than on donor aid.

A recent study of health financing in 14 countries found that many types of absorption constraint could be addressed through well targeted funding and technical assistance. However, the weakness of governance and public sector management was found to be a serious absorption constraint in several countries. In two countries (Tajikistan and Cambodia) governance and expenditure management constraints were judged to be so pervasive that major reforms would be needed to precede or accompany increased funding. In another two cases (Benin, Burkina Faso) government procedures were found to be over-centralised and bureaucratic, and in need of reform in order to permit available funding to be spent (Foster, 2004).

6. Macroeconomic effects of scaling up

It is increasingly recognised that aid inflows have significant macroeconomic effects, particularly in low income, aid dependent countries. There is a concern that large increases in aid could result in appreciation of the real exchange rate (Dutch disease) and tighter monetary conditions that would hurt the private sector, and producers of tradable goods in particular. These risks may impose limits on fiscal space and the extent to which higher aid flows can be spent without undermining growth. This section discusses the macroeconomic effects of aid in general, as well as specific arguments that apply to the health sector.

There are essentially two macroeconomic risks associated with scaling up: (i) real exchange rate appreciation, and (ii) crowding out of the private sector. The first risk arises because higher

¹⁸ The recent suspension of the GFATM programme in Uganda illustrates the risk of corruption in the context of large increases in donor funding.

expenditures financed by aid may increase demand for non-tradable and tradable goods. Where the demand for non-tradable goods cannot be met from spare capacity the price of non-tradables relative to tradable goods will increase, and the real exchange rate will therefore appreciate. The second risk occurs where governments try to avoid these inflationary effects by restraining demand, usually by tightening monetary policy. Higher interest rates reduce private sector borrowing and thereby constrain private sector demand. In this case aid creates fiscal space for government spending, but only by taking space away from the private sector. The extent of crowding out depends a great deal on whether or not there is spare capacity in the economy.

Both of these effects have been observed in low income, aid dependent countries. Real Exchange Rate appreciation has been observed in Uganda (Adam and Bevan, 2003) and Tanzania (Kweka et al., 2005) during the late 1990s at a time of increasing aid inflows. No such effect has yet been observed in Ethiopia, but macroeconomic modelling of the effects of scaling up suggest that Dutch disease could occur in future under conditions of higher aid flows (Andrews *et al.*, 2005). In Tanzania there is evidence of a sharp reduction in private sector credit since the mid 1990s coinciding with a period of higher aid inflows (Kweka et al., 2005).

There are two main ways that aid can be used in order to avoid these macroeconomic risks. First, aid can be used to improve economic productivity and thereby relieve capacity constraints. Second, aid can be used to finance imports, in which case there is no effect on domestic demand. There are reasons to believe that both of these effects might be observed in the use of development aid for health, in which case the macroeconomic risks would be limited.

The productivity effects of health spending have been discussed in section 4.1. Although the evidence on the economic returns to health spending is unclear, there is potential for aid financed public expenditures on health to raise labour productivity and thereby create additional capacity in the economy. However, these benefits would not be immediate. In the short term higher public expenditures may create demand pressures before the additional capacity can be created.

It has been suggested that a large proportion of development aid for health would be spent on imports. The Commission for Macroeconomics and Health estimate that the import content of required additional expenditures could be as high as 50% (Commission for Macroeconomics and Health, 2001). However, the Millennium Project has estimated that the local cost content of additional expenditures required to achieve the health MDGs would be around 70-75% (Millennium Project, 2005). Much depends on which additional goods and services will be provided. For example, the large scale expansion of ARV treatment programmes would require low income countries to import substantial quantities of drugs.¹⁹ However, there are good reasons to expect that the majority of additional health expenditure would be spent domestically. Health workers' salaries are likely to absorb a substantial share of additional spending. Furthermore, the type of interventions that would be required to reduce child and maternal mortality would appear to be local cost intensive because they mainly require simple technologies combined with significant human resource inputs.

These arguments suggest that there is nothing special about public expenditure on health that will reduce the macroeconomic risks of higher aid flows. Substantial increases in public expenditure, for health, inasmuch as it is spent on government-provided, rather than privately-provided services, will

¹⁹ If, however, public procurement simply replaced private drugs purchases then there would be a net increase in domestic demand

shift demand from the private to the public sector. In many cases such increases in spending may be justified, especially where this produces public goods and generates the human capital that will be required to enable stronger private sector-led growth in future, albeit after some time. However, the impact on private sector investment and consumption should always be considered. At a certain level of public spending the marginal costs of additional expenditure will exceed its marginal benefits. This constitutes an upper limit to fiscal space that no government should exceed irrespective of the amount of aid on offer. It is difficult to establish where this limit lies. However, most would argue that the poorest countries are some way from reaching this limit. With careful economic management to ensure that scaled-up aid supports both improved service delivery and growth, fiscal space can still be expanded.

7. Conclusions

The general conclusion of this paper is that the potential to use aid to generate sustainable fiscal space for substantial increases in health expenditures in low income countries depends crucially on the way aid suppliers and its recipients manage additional aid flows. Combinations of donor and recipient behavior will determine how effectively and durably additional aid will expand fiscal space. Some of these are summarized in the table 3 below. The best combinations suggest that fiscal space can be expanded quickly and reliably ('Green Zone'); the worst that great caution should be exercised until reforms have shown signs of success ('Red Zone')

Table 3 – Conditions for the sustainable expansion of fiscal space

	Donor policies	Recipient policies
Green Zone <i>Far reaching changes in donor and government behaviour allow fiscal space to be expanded rapidly and sustainably</i>	Donors are able to make long term commitments to scale up aid	Governments have affordable long term investment and expenditure plans
	Donor aid flows are predictable and stable	Increase in aid is accompanied by a stronger tax effort
	Donors are able to coordinate and harmonise aid, and thereby reduce recipients' transactions costs	Governments are able to finance any residual cash-flow variations
		Governments are able to take responsibility for the management of donor aid, and bring it on budget
	Where justified, governments reallocate budgets in favour of the health sector	
		Government health systems are efficient, effective and equitable
Amber Zone <i>Partial reforms in donor</i>	Some progress in increasing the long term predictability of aid and reducing short term volatility.	Governments may take on new spending commitments that cannot be sustained
		Governments do not improve their revenue effort

<i>and government behaviour allow some increase in fiscal space, but problems of sustainability remain</i>	Some initiatives to improve donor coordination and harmonisation, but limited use of budget support.	Governments are unable to fully finance cash-flow instabilities.
		Public expenditure management systems are not yet robust enough to account for aid expenditure on budget
Red Zone <i>Great caution should be exercised in raising health expenditure until reforms in donor and government policies show success</i>	Donors are unable to make long term commitments or reduce aid flow volatility	Very weak public expenditure management
		Donor spending remains largely off-budget
	Aid remains highly fragmented and projectised.	Governments do not improve their revenue effort
		Health care providers are not well motivated or managed
		The poor do not benefit from public health expenditure

Main priorities for aid donors

- ***Ensuring longer term predictability of aid flows***

Donors have signaled their intention to increase aid flows substantially, but recipient governments are faced with a great deal of uncertainty about the level of support that they can expect in future. On the basis of past experience, recipient governments may be reluctant to increase health expenditures, especially where new spending implies long term recurrent expenditure commitments. Unless donors can provide longer term commitments and more predictable aid flows, additional aid may not generate much additional fiscal space for health spending.

- ***Reducing short term aid volatility***

This paper has highlighted the extent of aid volatility and has demonstrated that this is associated with significant instabilities in public expenditures on health. These, in turn, distort resource allocation and have negative consequences for service delivery and health outcomes. The risks of short term volatility may provide an additional reason for governments to be wary of budgeting on the basis of additional aid resources. Donors need to address the risk that scaling up aid will generate even greater volatility and more disruptive effects.

- ***Coordination, harmonization and alignment***

Uncoordinated, off-budget and projectised aid contributes little to durable fiscal space. Aid effectiveness would be increased if aid coordination were improved, and the alignment of donor funding with national priorities were strengthened. Where conditions allow, the greater use of budget support would be desirable. There are encouraging signs of improved donor practice, including the recent Paris Declaration. However, there are contradictory tendencies in the health sector, where an increasing share of aid is provided through global health initiatives that tend to operate through parallel structures outside government budgets and management systems.

Main priorities for aid recipients

- ***Ensuring fiscal sustainability***

Ensuring the fiscal sustainability of health expenditures will be a major challenge for recipient governments, particularly low income countries facing 'windfall aid incomes'. There is a risk that some governments will make capital investments that they cannot fully maintain, take on too many staff to pay properly, or take on other new spending commitments that prove to be unaffordable and unsustainable in the long term. On the other hand concerns about the unpredictability and unreliability of aid flows may cause some governments to be overly cautious about using in additional aid to augment health expenditures financed from domestic resources. The key to ensuring fiscal sustainability is for recipient governments to take a long term view of expenditure commitments, growth and mobilizing domestic revenues.

- ***Using aid productively***

In the long term the main source of additional fiscal space will be economic growth. It is therefore crucial that recipient governments use aid in productive ways. Careful judgements will need to be made on the allocation of public expenditure between and within sectors taking into account the best available evidence of the impact of public expenditure on human development and economic growth. The central challenge will be to improve the efficiency of health systems to ensure that higher spending will generate improved health outcomes. In many cases reallocating resources within the health sector towards primary health care would improve efficiency and equity.

- ***Addressing absorptive capacity constraints***

Important capacity constraints arise from organizational, managerial and governance weaknesses, which may reduce the returns to additional aid and public expenditure substantially. In these conditions it will be important to scale up aid at a measured pace, and to accompany this with institutional and governance reforms to create conditions where aid can be used effectively.

- ***Taking account of the macroeconomic effects of higher aid inflows***

There are macroeconomic risks associated with scaling up aid, in particular real exchange rate appreciation and the crowding out of private sector investment. Development aid for health is no different to other types of aid in this respect. In many cases it will still be justified to increase donor support to the health sector, in particular where this supports expenditures that provides the public goods and generates the human capital that will be required to enable private sector-led growth in future. However, the impact on private sector investment and consumption should always be considered. At a certain level of public spending the marginal costs of additional expenditure will exceed its marginal benefits. This constitutes an upper limit to fiscal space that no government should exceed irrespective of the amount of aid on offer. It is difficult to establish where this limit lies. However, most would argue that the poorest countries are some way from reaching this limit. With careful economic management to ensure that scaled-up aid supports both improved service delivery and growth, fiscal space can still be expanded.

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Annex 1: Terms of Reference

Background Paper for the High-Level Forum on the Health MDGs on “Fiscal Space and Sustainability from the perspective of the health sector”

Background

The Second High-Level Forum on the Health MDGs, meeting in Abuja in December 2004, tasked the World Bank and the IMF to:

1. clarify the concept of fiscal space and sustainability in the presence of long term grant funding and concessional lending at the country level and the implications for sector expenditure ceilings;
2. work with other development partners on possible mechanisms to increase the volume and predictability of funding taking into consideration the DFID proposal²⁰ (and potentially others); and
3. report back to the Third High Level Forum (HLF3), scheduled for December 2005.

These terms of reference relate to the first point. Work which explores the political and technical feasibility of mechanisms to increase aid predictability (in particular on Buffer Funds) will be undertaken separately.

Purpose

In the context of requests made in Abuja, the High Level Forum Secretariat is commissioning two papers which outline key issues in fiscal space and aid sustainability *from a health sector perspective*. The papers will (i) **make the case for more predictable aid for health** by providing an overview of literature on aid sustainability, volatility and related topics, and (ii) **map out the parameters of the solutions**, without making recommendations.

At HLF3 in Paris, presentation of the paper will be followed by a series of responses which look at solutions in more detail - (for example, but not yet finalised): EC on long-term commitments; DFID on the Aid Guarantee Fund; IMF on Dutch Disease and increasing reserves; as well as presentations from Ministers of Finance on how they are managing these issues on a day -to-day basis.

Contents: Paper 1 - Overview of Fiscal Space, Aid Sustainability and related issues

The paper should include a summary of recent trends in aid levels (overall and for health) as well as a definition of Fiscal Space and Fiscal Sustainability

²⁰DFID tabled a proposal to move at a faster pace to provide longer term predictable financing. The note suggests that progress is being made within the DAC framework on improving the predictability of bilateral financing, but that multilateral mechanisms are needed to make faster progress. The proposal is to consider IDA financing for 50% of the required incremental recurrent cost for more ambitious health sector plans (designed to reach the MDGs) over a 6 to 7 year time period, with bilaterals providing the other 50%. To overcome the uncertainties of fluctuations in donor funding over the medium term, the establishment of a separate pooled fund to operate along-side the IDA program is envisaged.

In considering constraints generated by donor behavior, the consultants may wish to mention the following issues (where possible, this should be done from a health perspective; illustrations from country work could also be used);

- evidence on volatility of donor aid
- short term commitments
- absence of harmonization
- the burden of donor reporting requirements (e.g., worries about fungibility, need to prove “additionality”)
- Harmonizing disbursements with the budget cycle

Recipient country constraints might include:

- macroeconomic Constraints: Dutch Disease, debt sustainability, levels of aid dependency, limited capacity to increase domestic resources
- absorptive capacity, including low managerial capacity
- “political constraints” and the need to balance the compositions of expenditures for growth and outcomes

In describing the issues outlined above, the consultants might look at the potential *contribution and limitations* of existing processes such as the OECD/DAC work on Harmonization and Alignment for Aid Effectiveness, as well as the move to PRSPs, budget support and multi-sector investments.

Sources of information

In addition to publicly-available literature on these topics, the paper should draw on recent work by DFID, the IMF, and the World Bank and IMF including two papers by Peter Heller, a major draft Bank study on health financing and work in Ethiopia, Rwanda and Madagascar which model the fiscal implications of dramatically scaling-up aid between now and 2015. *Country illustrations should be woven into the text rather than presented separately.*

Length

15-20 pages single-spaced A4, with a 2-3 page executive summary