

# Does Debt Relief increase Public Health Expenditure? Evidence from Sub-Saharan African HIPCs

By

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## Abstract

The high debt burden of African countries is regularly cited as a major impediment to their ability to invest in health, education, water, sanitation and other essential human development infrastructure. In recognition of that, the IMF and other multilateral creditors launched the Heavily Indebted Poor Country Initiative in 1996 that was thereafter supplemented by the Multi-Relief Debt Initiative. This paper examines the impact of the HIPC in increasing public expenditure on health in Africa, using an econometric model. It investigates the relationship between public expenditure on health and a number of its determinants based on a sample of African countries. Two dummies are included for countries that have reached the decision point and countries that have reached the completion point among the other determinants, as well as the amount of debt relief committed and disbursed under the HIPC initiative. The results of the econometric analysis show that the HIPC initiative indeed has a positive impact on the level of public expenditure on health. Moreover, this impact occurs as soon as countries reach decision point, thus confirming the significance of the reforms implemented as a prerequisite for receiving debt relief under the initiative. Moreover, the funds disbursed under the HIPC initiative do not appear to be fungible, as the impact of debt relief on public health expenditure is substantial and robust. Further analysis comparing efficiency of use of HIPC funds between Africa and other developing regions suggests that these funds seem to be used less efficiently in African HIPCs than in their Asian and Latin American counterparts, as evidenced by the negative coefficient of the Africa regional dummy. This suggests that an important area of policy in Africa is to increase the efficiency of use of HIPC debt relief resources.

**Key words:** Debt relief, HIPC initiative, Public health expenditure, Millennium Development Goals, Health outcomes.

**JEL Keywords:** H63, H51, H11, H68.

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## 1) Introduction

Most African countries have poor health outcomes, which are both a cause and a consequence of their low level of economic development. While the importance of social expenditure for economic growth has been widely acknowledged (Fan 2008, Amoako 1996), this recognition is only slowly translated into concrete actions in terms of budget allocation; as an illustration, the average share of government expenditure allocated to health in Africa was 8.8% in 2005 (WHO, 2008), and only five African countries have met the commitment made in the Abuja declaration to allocate at least 15 % of their national budget to the health sector.

It has been argued and demonstrated that the structural adjustment programme (SAP) adopted by most African countries during the 1980s at the instance of the Bretton Woods institutions imposed budgetary cuts on many African countries. These cuts, which were required in order to stabilize public finances, also translated into less public expenditure in the social sectors, including health. The result was a health sector crisis that was pervasive across the continent in the 1990s (Lurie et al, 1995; Samba, 2004). These countries were also overwhelmed by unsustainable debt burdens that left few resources to invest in social sectors. For example, over the 1992-1997 period, debt service in Kenya, Tanzania and Zambia represented at least 40 per cent of their governments' budgetary resources; meanwhile, the share of budgetary resources allocated to basic social services were only 12.6%, 15% and 6.7% respectively (UNDP, 2000). As a consequence, the high debt burden of African countries became an additional impediment to the ability of African countries to invest in health, education, and other essential human development infrastructure. Indeed, Lora and Olivera (2006) provide evidence that public debt crowded out the provision of social services between 1985 and 2003 in a sample of 50 countries, most of which are from Africa. In this framework, debt relief initiatives appeared as glimmers of hope to increase the level of social expenditure in Africa.

The history of debt relief efforts goes back at least two decades prior to the Heavily Indebted Poor Country Initiative (Hepp, 2005a). Official creditors had been providing debt service relief to low-income countries ever since repayment problems first developed on a systematic basis in the late 1970s and early 1980s. The Cologne Initiative marked a further step with official attempts to help low-income countries with payment difficulties to grow out of their liquidity problems (Daseking and Powell, 1999). Following that initiative, other initiatives<sup>1</sup> were launched to deal with official commercial claims and gradually shifted the paradigm of Paris Club rescheduling techniques from simple cash flow support to more complex mechanisms which would slowly reduce the stock of outstanding debt. However, these debt relief initiatives did not lead to debt sustainability for debtor countries, mainly because their economies had not grown as fast as expected. Debtor countries did also engage in a vicious circle of debt rescheduling and new loans to reimburse debt.

The Heavily Indebted Poor Country (henceforth HIPC) Initiative launched in 1996 by the International Monetary Fund and the World Bank precisely aimed at ensuring that no poor country faces a debt burden it could not manage. The initiative consisted of providing debt relief to poor countries faced with unsustainable debt burdens and that demonstrated a record of reforms and good macroeconomic policies. This was a radical departure from previous initiatives because it included cancellation of debt owed to multilateral institutions. The objective of the HIPC initiative was threefold: (1) lower countries' debt-service payments significantly, (2) free up resources that will be spent on poverty reduction, and (3) provide a lasting exit from debt

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<sup>1</sup> Concessional reschedulings agreed on in Toronto (1988), in Trinidad (1990), in London (1991) and in Naples (1994) are some examples of these initiatives.

problems<sup>2</sup>. A clearly stated goal of the HIPC debt relief initiative is thus to provide additional resources for social sector (including basic health care) to the populations of eligible developing countries.

Many highly indebted countries were not qualified because the eligibility criteria for the initiative were too restrictive<sup>3</sup>. Besides, eligible countries were granted debt relief only after reaching completion point. Due to these limitations, the initial HIPC was criticized as or not delivering enough relief and for not delivering it in time, thus failing to solve the debt question. The enhanced HIPC initiative was then introduced in 1999 to correct these shortcomings and to bring many countries back to sustainable debt levels. By reducing the debt ratios that qualified a country's debt as unsustainable (from 200-250% to 150 %) and by adopting procedures for faster and easier debt relief, the enhanced HIPC (eHIPC) initiative more than doubled the amount of debt relief provided under the original HIPC with the provision that much of this relief must be allocated to the social sector, including health.

Among the eight Millennium Development Goals (MDGs) defined by the Millennium Declaration, three directly address health outcomes, while two other goals are related to health in a lesser extent. With this emphasis of health issues as the development challenges faced by the international community, public spending has even gained more momentum and the HIPC initiative was supplemented in 2005 by the Multi-Relief Debt Initiative (henceforth MDRI), following the G8 Gleneagles's meeting in order to help countries accelerate progress toward the MDGs. The MDRI provides 100% debt cancellation of the debt owed to the IMF, the International Development Association (the concessional branch of the World Bank), and the African Development Fund by all countries that reached or will reach the completion point of the HIPC initiative.

However, very little is known or understood about the contribution of the debt relief initiative to public health expenditure. In particular, not much known is known on whether it resulted in additional resources for health in the beneficiary countries. Drawing on earlier work (Audibert et al 2005, Hepp 2005b), this paper contributes to the emerging literature on the application of debt relief resources to the social sector in Africa. It does so by exploring whether or not debt relief contributed significantly to scaling up public expenditure on health in HIPC-debt relief African countries. Specifically, I analyze the impact of debt relief under the HIPC initiative on public health expenditure (henceforth PHE) on a sample of African countries, by including two dummies for decision and completion point of the initiative, as well as the amount of debt relief among other determinants of public health expenditure used in the literature.

Following this introduction, the next section presents a literature review of the impact of debt relief on public health expenditure, as well as on the impact of public health expenditure on health outcomes. The empirical model and its results are presented in section three and four respectively while the last section provides the conclusion and policy implications.

## **2) Literature review**

This literature review consists of two parts. The first part summarizes the results of previous studies on the impact of debt relief on social expenditure, while the second part sums up the conclusions of existing literature on the effect of public health expenditure on health outcomes,

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<sup>2</sup> Source: "Debt relief under the heavily Indebted poor Countries Initiative", IMF Factsheet.

<sup>3</sup> In order to be eligible to the initial HIPC initiative, a country must have a ratio of debt stock to a country's export between 200% from 250%, despite full application of traditional, bilateral debt relief.

since the ultimate goal of the HIPC initiative and the MDRI is to help achieve better development outcomes, among which are health outcomes, in eligible countries.

### **a. Debt relief and public health expenditure**

Most HIPCs were already familiar with debt relief. Before the initiative, debt relief was meant primarily to address debt sustainability, with the ultimate goals of achieving growth and poverty reduction. Nonetheless these latter goals were not expressed as explicitly as in the HIPC initiative. What was new however about HIPC initiative is that it explicitly required that budgetary resources freed up by the initiative be used for poverty reduction purposes (Dessy and Vencatachellum, 2007). The expectations placed on the HIPC initiative for increasing PHE are thus great, but the question remains as to what it is realistically possible to achieve.

Arslanalp and Henry (2006) find unlikely that debt relief will help poor countries escaping from poverty for two main reasons. First, the amount of debt relief released under the initiative is trivial<sup>4</sup> and second, the main economic difficulty facing most HIPC is not debt overhang<sup>5</sup>, rather it is the lack of functioning economic institutions. The two authors go as far as predicting that HIPC initiative and MDRI may amount to a “Pyrrhic victory”: a symbolic win for advocates of debt relief that clears the conscience of the rich countries but leaving the real problems of the poor countries unaddressed.

On the other hand, Dessy and Vencatachellum (2007) warn that debt relief can be inefficient and inequitable, mainly for four reasons: (i) it penalizes countries which managed well their economies and have sustainable debt burdens, so it intrinsically contains an element of adverse selection, (ii) there is no guaranty that countries will not embark on a new borrowing binge and find themselves in the same situation some years later, (iii) freed-up resources may be overestimated if the country was only paying a fraction of debt service before debt relief and (iv) public expenditure is fungible and there is no evidence that expenditure will increase for the targeted services.

Kaddar and Furrer (2008) emphasize that the relevance of debt relief initiatives in terms of boosting health expenditure depends essentially, at the global level, on the compliance of donors with their aid commitments and, at the domestic level, on the success of health officials in advocating for an adequate share of the additional fiscal space. They thus recommend careful monitoring of fungibility and additionality (the extent to which new inputs add to existing inputs at national and international level). Given the important role of health in the achievement of the Millennium Development Goals, and the fact that all eligible countries identify this sector as a priority in their Poverty Reduction Strategy papers, health is expected to benefit from significant additional resources and the volumes of released resources are important enough in certain countries to make a difference for priority programmes that have been underfunded so far.

As pointed out by Heller (1999), realizing higher social spending is only an intermediate objective. While there has been an increase in poverty-reducing expenditure in HIPCs (as evidenced by Table 1 below), higher social expenditures are not a goal in themselves; there is a large gap between more social expenditures and the realization of better social outcomes and

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<sup>4</sup> We can argue that the purpose of debt relief under the HIPC initiative is not to generate immediate growth, but long-term and delayed growth through government's (not external creditors') investment in social sectors. Investing in human capital will in turn lead to poverty reduction, even though it is not one stated goal of the initiative. A second claim against this conclusion is that the amount of debt relief provided to poor countries can appear trivial for rich countries; nevertheless it constitutes a substantial amount for most HIPCs.

<sup>5</sup> Debt overhang means that a country owes more money to its creditors than it is able to pay (Krugman, 1988).

reduced poverty rates. If successful, higher social expenditure may lead to an improvement in social indicators, and contribute to enhanced social outcomes. But it needs to be recognized that numerous factors *other* than government outlays will have an impact on social indicators. These include the level of private spending in related sectors such as water, sanitation, per capita income, demographic trends, and the effectiveness of the outlays themselves.

**Table 1:** Summary of Poverty-Reducing Expenditures by the African HIPC's that Have Reached Decision Point

	1999	2000-2001	2002	2003	2004	2005
		Actual	Estimate		Projections	
Poverty-Reducing expenditure	4,140	4,466	5,491	7,077	8,333	10,776
Ratio of poverty-reducing expenditure to government revenue	38.6	40.4	41.9	43.1	43.0	45.7
Ratio of poverty-reducing expenditure to GDP*	5.5	5.6	6.1	6.8	7.0	8

Sources: HIPC country documents; and IMF staff estimates.

\*: Weighted averages.

Despite these cautious predictions, the experience of Uganda, the first country qualified for the HIPC initiative provides a glimmer of hope concerning the impact of debt relief on poverty reduction strategies and debt sustainability. Uganda's experience with the HIPC Initiative has been broadly positive (Kuteesa and Nabbumba, 2004). As a result of both initiatives, Uganda was granted debt relief amounting to \$1 billion in Net Present Value terms to be delivered over a period of twenty years. The resources saved from HIPC debt relief allowed Uganda to increase the budget for the most critical areas such as primary education, primary health care, rural roads, safe water and sanitation, and agriculture. From 2000 to 2004, annual expenditures on education increased by 9 percent. Yearly growth for health expenditures was 20 percent. There have also been substantial increases in spending on water, rural roads, gender, HIV/AIDS, justice, law and order, and on environmental spending. Uganda's Universal Primary Education policy, initiated in 1997, has led to an upsurge in gross primary enrolment from 2.6 million to 7.3 million pupils in 2002; HIV/AIDS prevalence rates have fallen considerably from 14 percent in the mid-1990s to 6.5 percent during 2001-2002; the share of the rural road network being maintained regularly has increased from 20 percent in 1997-98 to 60 percent in 2000; access to water has improved nationally from 40 percent in 1997 to 52 percent in 2001; poverty incidence fell dramatically from 56 percent in 1992 to 35 percent in 2000. While there remains many challenges for development in Uganda (access to sanitation, pupils' retention and the quality of education, slow progress in the progress in reducing infant, child and maternal mortality rates), the efforts are noticeable and attributable to a large extent to the availability of funds freed under the HIPC initiative (Kuteesa and Nabbumba, 2004).

### **b. Impact of public health expenditure on health outcomes**

Many studies in the 90s and early 2000s found no or very little impact of public health spending on health outcomes. Musgrove (1996) summarized the results of studies on the link between public health spending and health outcomes and found no evidence that total spending on health has any impact on child mortality. Filmer and Pritchett (1999) concluded that government health expenditures account for a negligible portion (less than one-seventh of one percent) of the variation in under-five mortality across countries, moreover this result was not even statistically

significant; the results of their analysis suggest that 95% of cross-national variation in mortality can be explained by socio-economic factors, namely country's income per capita, inequality of income distribution, extent of female education, level of ethnic fragmentation, and predominant religion. Peters et al (2000) found a weak statistical association between the two variables on a sample of developing countries. In 2004, Wagstaff and Claeson showed that good policies and institutions (as measured by the World Bank's Country Policy and Institutional Assessment or CPIA Index) are important determinants of the impact of government health expenditures on outcomes. Specifically, as the quality of policies and institutions improves, the impact of government health expenditures on maternal mortality, underweight children under age five, and tuberculosis mortality also increases and is statistically significant. Again however, the impact of government expenditures alone on under-five mortality remains not significantly different from zero. More recently, Day and Tousignant (2005) replicated Peter et al's results on a sample of developed countries.

On the other hand, other studies have shown the very opposite result, concluding that health spending has a strong impact on health outcomes. As early as in 1975, Anderson provide some evidence of a positive impact of public financing of medical care on overall mortality and morbidity rates. These results were confirmed by the works of Hadley (1982), Forbes and McGregor (1984), Elola et al (1995), Leu (1986), Hitiris and Posnet (1992) or Babazano and Hillman (1994).

Using data for 50 developing and transition countries observed in 1994, Gupta, Verhoeven and Tiongson (1999) found that health expenditure reduces childhood mortality rates. More recently, numerous studies found a positive and robust association between public health spending and health outcomes. Using a panel data on 160 developed and developing countries, Issa and Ouattara (2005) showed a strong negative relation between health expenditure and infant mortality rates. Bokhari et al (2006) provide evidence linking a country's per capita government health expenditures to two health outcomes: under-five mortality and maternal mortality. The results of their study show that the elasticity of under-five mortality with respect to government expenditures ranges from -0.25 to -0.42 with a mean value of -0.33. For maternal mortality the elasticity ranges from -0.42 to -0.52 with a mean value of -0.50.

In a comprehensive study on health financing and using data from 113 developing countries, Gottret and Schieber (2006), found that that an increase in government health expenditures has a larger net impact in reducing under-five mortality and maternal mortality than an percent increase in education, roads, or sanitation of the same magnitude. Moreover, they found this impact was greater on under-five mortality than on maternal mortality. Their results also show that donor funding has a direct impact on under-five mortality, but not on maternal mortality. Nonetheless, donor funding indirectly affects maternal mortality by increasing the impact of governmental health expenditures on this outcome.

Nixon and Ulmann (2006) examined the effect of health expenditure on infant mortality and life expectancy on a sample of developed countries (European Union). Their results show a marginal but positive effect for health expenditure on the examined health outcomes. The authors conclude that these results are consistent with evidence confirming diminishing returns in the area of health care in developed countries. In line of this, small amounts of health expenditure in developing countries (as most of the HIPC's) would almost certainly have a bigger impact on health outcomes.

The most recent evidence of a positive link between health spending and health outcomes is provided by Anyanwu and Erhijakpor (2008). These authors found that government spending on

health is an important factor for achieving good health outcomes. Using data from 47 African countries between 1999 and 2004, they show that health expenditures have a statistically significant effect on infant mortality and under-five mortality.

### 3) Empirical model

To investigate the impact of the HIPC initiative on public health expenditure, I first present some methodological issues, and then I move to the specification of the model before describing the data used in the empirical analysis..

#### a. Debt relief and social expenditure: some methodological issues

In analyzing the impact of debt relief on social expenditure, there are some concerns that should be kept in mind, as they result in potential methodological problems. These are mainly related to the difficulty of locating the funds freed up under the debt relief in national budgets, to fungibility and to the additionality of resources.

*Difficulty to locate debt relief funds into national budgets :* In their study, Audibert et al (2005) found that being a HIPC (only countries that have reached decision point) was associated with a higher public health expenditure, even though there was no significant effect of the budgetary constraint overall on the level of PHE. This effect can be explained by the fact that resources freed up in the recipient country thanks of debt relief are rechanneled into health expenditure. Hepp (2005b) found different results from those of Audibert et al. (2005). For this author, debt relief does not have a positive effect on health expenditures. This controversy could be explained by the fact that it is difficult to measure debt relief. As pointed out by Gupta (2001), some HIPC debt relief may not be reflected immediately or never in the beneficiary countries 'budgets. For example, relief on debt owed to the IMF may not appear in a country's fiscal accounts because it accrues to the central bank instead of the budget. Some countries may open special accounts in the central bank to identify savings from HIPC then they transfer these savings in their budgets as grants. Debt relief for public enterprises may not be reflected in the national budget unless the write-downs of their government-guaranteed debt are transferred to it. Another reason why debt relief savings do not automatically lead to a net transfer of resources is that in the case where a country is in default, the relief is simply reflected in a clearing of arrears, as this is the case in Guinea-Bissau and Zambia. Kaddar and Furrer (2008) pointed out that debt relief resources differ from other financing sources, as they do not constitute fresh money arriving from external sources. In addition, funds freed under the initiative are not register in national budgets following the same rules in all countries. Indeed, they identified three different debt relief management systems according to which countries track their expenditure. The first of these systems, the institutional fund mechanism, introduces a framework that allows clear distinction between the allocation and use of debt service savings and ordinary public resources; the second management system for debt relief fund is the virtual fund mechanism, under which the country's existing budget classification is adapted to tag the savings from debt relief; and under the last mechanism, the same allocation, reporting and accountability standards are used for debt relief funds and traditional budget resources.

*Fungibility:* The contradictory results between Hepp (2005b) and Audibert et al. (2005) could also be explained by fungibility. The resources freed up by debt relief may have been used in other

sectors instead of leading to additional expenditure in health or social expenditure<sup>6</sup> (Hepp, 2005b). In Uganda, there has been evidence of fungibility of the funds released under the HIPC initiative; though social spending has steadily increased under Fund-supported programs, and has continued to increase since Uganda qualified for the HIPC Initiative completion point, military spending has also significantly increased, in connection with the hostilities in the Congo (Heller, 1999).

*Additionality of resources:* A key concept underlying the HIPC Initiative is additionality; which means that “debt relief should supplement, not replace, the flow of assistance in the form of grants and concessional loans to the poorest countries.”<sup>7</sup> Indeed, debt relief reduces debt servicing, but creditor countries, most of whom are also the main providers of Official development Assistance (ODA) can be tempted to reduce their grants or new loans, resulting potentially in a decrease of the net resource transfer. There is evidence that in the past, debt relief has been given instead of, not in addition to, foreign aid. Prior to 1996, aid flows amounted to roughly 13.7 percent of GDP in the heavily indebted poor countries. Since 1996 that figure has dropped to between 9.9 and 11.1 percent (Arslanalp and Henry, 2006). If the impact on the net resource transfer is minimal, debt relief cannot propel the HIPCs toward sustained growth and poverty reduction.

## b. Model specification

In analyzing the impact of the HIPC initiative on PHE, the basic specification of the model will be as follows:

$$Y_{i,t} = \alpha_{i,t} + \beta_x X_{i,t} + \gamma_z Z_{i,t} + \varepsilon_{i,t} \quad (1)$$

Where  $Y_{i,t}$  is a public health expenditure,

$X_{i,t}$  is a matrix of interest variables,

$Z_{i,t}$  is a matrix of control variables

and  $\varepsilon_{i,t}$  that can be decomposed as:

$$\varepsilon_{i,t} = \theta_i + \delta_t + \phi_{i,t}, \text{ where } \phi_{i,t} \text{ is an i.i.d term.}$$

OLS is not used because it does not properly address potential problems of error, omitted variables and endogeneity. Moreover, in the presence of correlation between explicative variables and error terms, the generalized least squares (GLS) estimator is not only convergent (like the OLS), but also efficient. So the model is first estimated using GLS to account for the potential correlation aforementioned. Among our variables, the proportion of births attended by skilled health staff is likely to be an endogenous variable due to reverse causation with the dependent variable. This endogeneity will be accounted for using the instrumental approach proposed by Hausman and Taylor (1981), which uses both the between and within variation of the strictly exogenous variables as instruments.

For the Hausman Taylor (HT) estimation, variables are classified into three groups:

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<sup>6</sup> Mahelet and Bizuayehu, (2008) warn that besides the allocation of debt relief to other sectors than the health and social ones, HIPCI may have more perverse effects than expected. Specifically, it could lead to moral hazard incentives to borrow with the hope that part of the debt will be written-down.

<sup>7</sup> Quote from: *HIPC initiative: Status of Implementation*, page 9, IMF, April 2002.

- Time-invariant variables: debt relief;
- Endogenous variables: percentage of births attended by skilled health staff;
- Exogenous variables: all other variables.

For robustness sake lastly, I also estimate the model using the Generalized Moments Methods (GMM). The GMM estimator has the double advantage to correct for potential endogeneity by yielding instruments and to assess the impact of the lagged value of the dependant variable.

There exist two variants of the GMM estimator in dynamic panel: the first difference estimator and the system estimator. The first difference estimator developed by Arellano and Bond (1991) consists of taking for each period the first difference in order to eliminate specific country effects, and then instrumenting explicative variables of the first difference equation by their lagged values. As for the estimator GMM-system estimator, developed by Blundell and Bond (1998a), it combines first difference equations with level equations where variables are instrumented with their first differences. Using Monte-Carlo simulations, Blundell and Bond (1998b) showed that the estimator of GMM system performs better than the estimator in difference developed by Arellano and Bond (1991), the latter yielding biased results on finite samples when instruments are weak.

I use the GMM-system estimator for the dynamic estimation, where current values are used as instruments for exogenous variables; lagged values for one period are used as instruments for weakly exogenous variables<sup>8</sup> and lagged values for at least two periods are used as instruments for endogenous variables.

For the GMM estimation, the model estimated is:

$$Y_{i,t} = \alpha_{i,t} + \beta_{i,t} X_{i,t} + \gamma_{i,t} Z_{i,t} + \mu_{i,t} Y_{i,t-1} + \varepsilon_{i,t} \quad (2)$$

Where  $Y_{i,t}$ ,  $X_{i,t}$  and  $Z_{i,t}$  represent the same groups of variables as in equation (1), and  $t-1$  denotes the previous period.

### Dependent variable

$Y_{i,t}$  is represented by three indicators successively. Hepp (2005b) used total health expenditure per capita as his dependent variable. My concern in this paper is *public* health expenditure. Furthermore, I consider that analyzing the impact of the HIPC on PHE would lead to different policy recommendations according to the impact the initiative has on the three different indicators.

I first use PHE as a percentage of total health expenditure. This variable is an indication of the financing of health system. The effects of catastrophic health expenditure on households in developing countries have been studied in the literature (Su et al 2006, Xu et al 2006, Xu et al 2003). Xu et al (2003) recommend that out-of-pocket expenditure be reduced to levels lower than 15% of total health spending in order to significantly decrease the incidence of catastrophic payments on households in developing countries. This could be done if health financing from other sources, especially PHE increase.

Then I use PHE as a percentage of total government expenditure. African Heads States pledged in the Abuja Summit (2001) to allocate at least 15% of their national budget to health. To date, only five of them have met the criteria<sup>9</sup>. Using this indicator for the dependent variable

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<sup>8</sup> Weakly exogenous variables are defined here as variables that are predetermined or that can be influenced by past values of dependant variables, but which are not correlated with future realizations of error term.

<sup>9</sup> According to the last data provided by WHO (national health accounts 2006), the countries that have met the Abuja commitment are Botswana, Burkina-Faso, Liberia, Malawi and Rwanda.

would allow assessing if debt relief under the HIPC is likely to help African countries keep the promise the made in Abuja.

Finally, I use per capita PHC (international \$ PPP) as our dependent variable. While the other two measures of PHE relate ultimately to the MDGs, this indicator seems to be the one that best matches the efforts the government is doing to finance the health MDGs. Lack of adequate funding is among the reasons identified for the slow progress towards the health MDGs in Africa (ECA, forthcoming). The health MDGS report emphasises that the level of public spending in health in most African countries is abnormally low by both African and international standards<sup>10</sup>. While the link between health spending and health outcomes is not always clear, adequate funding is nevertheless a prerequisite for achieving good health.

### Interest variables

$X_{i,t}$  is a matrix of three variables, including two dummies for decision point and completion point of HIPC and MDRI, as well as the amount of debt relief committed for countries that have reached decision point.

From the onset of the initiative, a number of countries have been judged eligible (based on the criteria of GDP per capita and unsustainable debt burden), among which 33 African countries. However, in order to reach the decision point, countries should exhibit a track record of sound policy changes, expressed in the poverty reduction strategy paper (PRSP). At the decision point, countries may begin receiving interim relief on its debt service. In order to receive the full and irrevocable reduction in debt available under the HIPC Initiative (which is the completion point), the country must in addition establish a further track record of good performance under IMF- and IDA-supported programs, implement satisfactorily key reforms agreed at the decision point, and adopt and implement the PRSP for at least one year (refer to the annex for a description of how the HIPC initiative works).

The codification of our dummies for HIPC is as follows:

- Dummy Decision takes value 1 from decision point to completion point and 0 otherwise.
- Dummy Completion takes value 1 from completion point onward and 0 otherwise.

Thus, the value of decision point dummy will be 1 for all eligible countries from the date they reach decision point to the date they reach completion point, and then it will be 0. It is also 0 for countries that have not reached decision point yet.

Similarly, the value of completion point dummy is 0 for countries that have not reach completion point yet and 1 from the date countries reach completion point onward<sup>11</sup>.

For every year (2001, 2002, 2003, 2004, 2005 and 2006), the values for Decision and Completion dummies will not overlap, they cannot be 1 for the same period or 0 for the same period.

Because decision and completion points are associated with actual debt relief, the coefficients associated with the corresponding dummies are expected to be positive.

While it might look complex at first sight, this codification allows for a clear interpretation of the coefficients of the dummies in the regression because they will indicate only the impact of the

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<sup>10</sup> The minimum value of per capita PHCE in our sample is less than 1USD for Congo, Democratic Republic.

<sup>11</sup> We consider the decision point of the original initiative and completion point of the enhanced initiative. For amount committed, we consider the sum of the amount committed under the original and the enhanced frameworks as well as under the MDRI. Data on countries' financial status are all from IMF's financial position in the Fund, as of November, 30 2008, available from IMF's data and statistics website.

stage considered (decision point or completion point) without accounting for the impact of the previous stage.

### **Control variables**

$Z_{i,t}$  is composed of variables representing the traditional determinants of PHE: PHE is influenced by many factors that could be classified as socio-economic conditions, demand-side related factors and socio-political factors. Socio-economic factors are GNI per capita and budgetary resources (aid and debt service). Demand-side related factors are population density, population structure, population's health status and socio-political factors are corruption and the effectiveness of government.

The impact of all these variables on PHE has been widely acknowledged in the literature. Most on the studies on the determinants of public health expenditure found that GDP per capita is the most important factor. Numerous authors found a strong positive association between GDP (or GNI per capita) and PHE in developing countries (Audibert et al, 2006; Gbesemete and Gerdtham, 1992) as well as in the developed world (Hansen and King, 1996; Parkin et al, 1987; Newhouse, 1977). Budgetary resources also influence PHE; the relationship is supposed to be positive with aid and negative with debt service. Nonetheless, Hicks (1991) and Gallagher (1993) consider that health is among protected sectors and that the crowding-out effect of interests' payment on public expenditure does not affect health sector<sup>12</sup>. On the other hand, some authors emphasized that aid do not necessarily increased lead to an increase in PHC (Cassen, 1994).

The objective of health expenditure is to improve health outcomes. So, if health outcomes are believed to be poor by government and by population, the government will engage more spending in this sector in order to achieve health outcomes that will be judged satisfactory. So the relationship between PHE and health outcomes is supposed to be positive. However, concerns have been raised about the direction of the relationship and the interdependence between these two variables, as the level of expenditure in health sector also influences health outcomes (Correa and Namkoong, 1992), making it an endogenous variable.

The concentration of population in urban areas or over the whole national territory is not without effect on health, and therefore on HCE. Indeed, rapid urbanization and population concentration usually go hand in hand with a deterioration of health status, translating into an increase in the prevalence of infectious diseases and therefore of demand for health care. Despite the evident link between population concentration and health care demand, the direction of the relationship is less obvious when it comes to health care supply. Two effects of opposite signs can be expected from population concentration; on the one hand unit costs are lower due to economies of scale, so there is a negative relationship between population concentration and PHE. On the other hand however, people adopt new habits of consumption of public services offered and health care supply needs to increase to adjust to the new health care demand, so that the relationship between population concentration and health care supply (PCE) is a positive one. This positive relationship has been well documented in the literature (Lavy and Germain 1994, Lavy et al 1995, Audibert et al 1998).

Correa and Namkoong (1992) have showed that political circumstances can affect governments' health policy. Political circumstances include on one side the articulation and aggregation between health needs and health demand are led and on the other side the manner government

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<sup>12</sup> There is also evidence that structural adjustment programmes did bring about a health sector crisis in most African countries, obviously through the reduction of PHE (Lurie, 1995; Samba, 2004).

decisions respond to these needs<sup>13</sup>. Audibert and Mathonnat (2000) consider that corruption has a sizeable influence on PHE.

Aid per capita and debt service serve as indicators for resources availability. I did not use population structure because of lack of time-series data for this indicator. The number of physicians/nurses for 1000 people, which would have served as a proxy for supplier-induced health expenditure (Hepp, 2005b) is not included in our regression neither because of lack of time-series data.

A dummy for African countries is included among the variables in order to allow comparison between African and non-African HIPC.

### **c. Data**

The sample is made of the 41 HIPC eligible countries, including all African countries as well as all non-African HIPCs (Afghanistan, Bolivia, Guyana, Haiti, Honduras and Nicaragua). The sample composition is provided in the Annex. A dummy for African countries is included among the variables in order to allow comparison between African and non-African HIPCs.

The time period for this study is 2001-2006. Because the initiative was launched in 1996, countries that might be eligible were known from 1997, but the first country to be eligible reached decision point in 2000 and no impact on health expenditures could be expected before 2001.

The data come from various sources that are presented in Table 2.

## **4) Results**

This section presents the results of the econometric analysis. There is one table for each measure of the dependent variable, with the first column reporting the results of equation (1) using GLS and the second column reporting the results of equation (1) using random HT. The last column reports the results of equation (2).

As we can see from the three tables summarizing the results (Tables 4 through 6), the impact of the HIPC initiative (and MDRI) on PHE is positive and substantial. With all the measures of PHE, decision point and the amount of debt relief committed greatly increase PHE. This positive impact persists when endogeneity is corrected for (using the Hausman-Taylor estimator and when GMM is used as an alternative estimation technique. GNI per capita appears and aid per capita also appear as the main determinants of PHE, in accordance with earlier studies. Surprisingly enough, debt service does not appear to have an impact on PHE. This could be explained by the likely correlation between debt service and debt relief. Actually, the correlation table does not reveal a high correlation between the two variables, but this is because the amount of debt relief used in the regressions is the amount committed; the correlation is much higher with the amount of debt relief disbursed<sup>14</sup>. Because only part of debt relief is disbursed at decision point, one would expect an increase of PHE at completion point, when the full debt relief is granted, however, there is not such an impact of completion point on PHE in my results. A comparison of between African and non-African HIPCs shows that on average African countries perform worse than their Asian and Latin American and Caribbean counterparts, suggesting a lower efficacy in the use of HIPC funds, despite the positive value of the coefficient

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<sup>13</sup> In the database World Governance Indicators, Government Effectiveness is the indicator that accounts for the adequation between population's needs and government's response. It measures perceptions of the quality of public services, the quality of the civil service and the degree of its independence from political pressures, the quality of policy formulation and implementation, and the credibility of the government's commitment to such policies.

<sup>14</sup> The value of the coefficient of correlation between the two variables is -0.41.

of government effectiveness. This positive coefficient confirms what is intuitive: HIPC countries which implement good policies spend more on health.

Besides these general features, the impact of the HIPC on each measure of the dependent variable is more specific.

For the first measure of PHE (percent of total health expenditure), debt relief under the HIPC seems to modify the structure of health care financing by significantly increasing the percent of public spending in total health spending. This result is encouraging; while the primary purpose of the HIPC initiative is not to affect the structure of financing of health care, this could serve as a tool to shift health financing towards more public financing thus decreasing catastrophic health expenditure, especially since health insurance is not well developed in Africa (Mwabu, 2008).

As for the second indicator for the dependent variable (PHE as percent of total government expenditure), one might question the real impact of HIPC, since debt relief frees funds that would have otherwise been used for debt repayments. Indeed, contrary to what could be believed, it is not straightforward that debt relief translates into higher PHE; mentioned earlier, these funds are fungible and can be used on non social sectors or on other social sectors. Specifically, the results presented in Table 5 show that debt relief has a positive and substantial impact on the share of public expenditure allocated to health; the coefficient is quite high and robust, suggesting that there is not much fungibility of the funds freed under the initiative and that HIPC countries consider health as a priority sector.

When the dependent variable is per capita government expenditure on health, the impact of debt relief and of the dummy decision point is the most consistent and the explicative power of the model is also the highest (R-squared =0.724) with this measure of the dependent variable. This result could be a good omen for the achievement of the health MDGs in Africa, provided that the trend persists, but also that higher financing translates into effective health interventions.

The impact of the remaining determinants of PHE is inconclusive or contrary to what has been found previously in the literature. For example, population growth rate appears to have no impact on the level of PHE when the dependent variable is PHE as percent of total health expenditure, and for the three indicators under the GMM specification. My results also suggest that urbanization and births attended by skilled health staff do not affect PHE in HIPC countries.

## **5) Conclusion**

The purpose of this paper was to explore whether or not debt relief contributed significantly to scaling up public expenditure on health in HIPC-debt relief African countries. My results show that debt relief under HIPC is effective in increasing public health expenditures. Moreover, the impact of HIPC initiative on public health expenditure occurs as soon as countries reach decision thus confirming the effectiveness of the reforms implemented in order to receive debt relief under the initiative. The funds released under HIPC do not appear to be fungible, as the impact of debt relief on public health expenditure is substantial (high value of the coefficient) and robust. However, HIPC funds seem to be used less efficiently in African HIPC countries than in their Asian and Latin American counterparts, as evidenced by the negative coefficient of regional dummy for Africa.

HIPC initiative contributes to the increase of PHE at decision point, when debt relief is actually disbursed. While this result may seem obvious, it raises the question of the effectiveness of reforms implemented before eligibility and decision point. The process of debt relief under the

initiative implies that countries implement a set of sound macroeconomic reforms before being granted debt relief (see Annex).

The substantial impact of debt relief under the HIPC initiative on PHE suggests that HIPC funds are not fungible. That would suggest that African HIPCs comply with their PRSP and actually a great share of their debt relief funds on health sector. However, efficiency in the use of HIPCs funds is likely to be an issue for African HIPCs, as on average they perform worse than their Asian and Latin American and Caribbean counterparts.

These results also bring up further questions. Since the empirical model in this paper already include debt service and aid per capita among the covariates, it would be interesting to investigate the other channels through which the HIPC initiative could possibly affect PHE. Specifically, further research in this area is needed to better understand why there is no additional impact of the completion point on the level of PHE, while the additional funds will be released to countries only when they reach completion point.

Finally, it should be borne in mind that numerous factors *other* than public expenditure on social sectors will have an impact on social indicators. The HIPC initiative does certainly provide additional funds that will be used on the health sector and that can help achieve the health MDGs in Africa; however these additional funds alone are not sufficient without addressing means to improve the efficiency of public health expenditure on health outcomes in Africa.

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**Table 2:** Data and source

Variables	Indicator	Measurement unit	Source
Public Health Expenditure	PHE, General government expenditure on health as percentage of total expenditure on health	%	WHO, National Health Accounts
	General government expenditure on health as percentage of total government expenditure	%	
	Per capita government expenditure on health	PPP, int USD	
HIPC	Dummy Decision point (1 if country has reached the decision point)		Author, using IMF data
	Dummy Completion point (1 if country has reached completion point)		
Debt relief committed	Deb relief under the HIPC and the MRDI, in NPV terms, committed and disbursed	Million USD	IMF
GNI per capita	GNI per capita PPP	PPP, intl. USD	WB, World Development Indicators
Debt service	Debt service, ratio to exports	%	WB, World Development Indicators
Immunization	Immunization rates against measles (0-23 months)		
Aid per capita	ODA per capita	Million USD	OECD
Urbanization	Urbanization rate (% population living in urban areas)	%	UNDP, Human Development Reports
Births attended by skilled staff	Percentage of births attended by skilled health personnel	%	World Bank
Population growth	Population growth rate	%	UNDP, Human Development Reports
Government effectiveness	Government effectiveness index		United Nations Statistics division
			Worldwide Governance Indicators (WGI)
Africa	Dummy variable for African countries	1 if country is located in Africa, 0 otherwise	Author's construction

**Table 3:** Descriptive statistics

<b>Variable</b>	<b>Obs</b>	<b>Mean</b>	<b>Std-Dev</b>	<b>Min</b>	<b>Max</b>
General government expenditure on health as percentage of total government expenditure	238	51.30	19.01	2.2	90.73
PHE, General government expenditure on health as percentage of total expenditure on health	235	9.81	4.918	1.1	38.84
Per capita government expenditure on health (PPP int. \$)	235	84.75	109.00	1	609.9
Debt relief committed	246	530.25	953.36	0	6311
GNI per capita (PPP)	224	2713.53	3232.54	200	16620
Debt service (as % of exports)	188	11.15	13.42	0.89	135.30
Aid per capita	220	353.69	775.21	-55.22	10819.59
Immunization rate	246	71.52	18.39	23	99
Births attended by health staff	202	52.96	21.39	5.7	99.2
Government effectiveness	246	-0.685	0.653	-2.25	1.21
Corruption control index	246	-0.620	0.607	-1.91	1.22
Urbanization rate	238	40.66	17.33	6.28	86.9
Population growth rate	238	2.31	0.89	-0.1	6.5
Infant mortality rate	239	115.71	63.10	10.9	262.1

**Table 4:** Debt relief and PHE (% of total expenditure on health)

Dependant Variable	PHE as % of total health expenditure		
	GLS	HT	GMM1/
Decision point	8.06** (2.79)	4.36** (2.50)	2.48** (2.12)
Completion point	6.40* (1.88)	1.03 (0.06)	0.46 (0.48)
Debt relief, committed	0.011** (2.38)	0.10* (1.65)	0.23** (1.97)
Log of GNI per capita	8.67*** (3.38)	5.22* (1.87)	6.44* (1.80)
Urbanization	0.04 (0.61)	0.51 (0.40)	-0.54 (1.27)
Aid per capita	1.78** (2.19)	0.72 (1.16)	1.01*** (4.32)
Births attended by skilled staff	0.01 (0.17)	0.03 (0.11)	0.00 (0.12)
Government Effectiveness	5.44** (2.14)	2.36* (1.90)	3.22** (1.99)
Population growth rate	1.61 (1.07)	2.08 (1.31)	11.06 (1.08)
Debt service	-0.31* (1.95)	-0.26 (1.24)	1-.72 (1.19)
Africa	-6.01* (1.80)	1.35** (2.89)	2.49** (2.01)
Lagged value PHE			0.58*** (4.32)
Constant	28.08 (1.51)	13.27 (0.72)	2.09 (0.66)
R-squared (between)	0.374		
AR(1)			0.010
AR(2)			0.554
Sargan-Hansen test			0.165
Observations	175 (34)	175 (34)	175 (34)

Notes: \* Significant at 10%

\*\* Significant at 5%

\*\*\* Significant at 1%

1/ For the GMM estimation, lags of two periods are used for births attended by skilled staff and the lagged value of dependent variable, lags of one period are used for aid per capita and debt service. The other variables are considered as instruments in this model.

**Table 5:** Debt relief and PHE (as % of total government expenditure)

Dependant Variable	PHE as % of total government expenditure		
	GLS	HT	GMM1/
Decision point	1.38* (1.74)	0.59* (1.80)	2.14** (2.61)
Completion point	0.96 (0.89)	0.90 (1.64)	2.40 (1.07)
Debt relief, committed	0.01* (1.69)	0.01** (2.63)	0.01* (1.71)
Log of GNI per capita	0.09* (1.68)	0.03*** (3.88)	1.28** (2.49)
Urbanization	0.03 (0.16)	0.02 (0.69)	-0.13 (0.41)
Aid per capita	0.05** (2.18)	0.06*** (2.91)	0.01** (2.88)
Births attended by skilled staff	0.02 (0.78)	0.00 (1.00)	0.58 (0.51)
Government Effectiveness	1.49** (1.96)	1.80** (2.42)	3.22** (1.99)
Population growth rate	2.03*** (4.70)	1.11** (2.41)	1.86 (1.08)
Debt service	-0.39 (0.81)	-0.24 (1.46)	-0.08 (0.99)
Africa	-3.90 *** (4.08)	2.14* (1.94)	4.85** (2.56)
Lagged value PHE			2.48** (2.12)
Constant	17.54*** (3..27)	15.33* (02.48)	2.59 (1.34)
R-squared	0.242	0.238	
AR(1)			0.024
AR(2)			0.616
Sargan-Hansen test		0.298	0.149
Observations	175 (34)	175 (34)	175 (34)

Notes: \* Significant at 10%

\*\* Significant at 5%

\*\*\* Significant at 1%

1/ For the GMM estimation, lags of two periods are used for births attended by skilled staff and the lagged value of dependent variable, lags of one period are used for aid per capita and debt service. The other variables are considered as instruments in this model.

**Table 6:** Debt relief and Per capita government expenditure on health

Dependant Variable	Per capita government expenditure on health		
	GLS	HT	GMM1/
Decision point	4.63 (0.65)	2.19** (2.06)	3.18* (1.70)
Completion point	3.59 (0.44)	0.82 (0.39)	0.06 (0.61)
Debt relief, committed	0.17* (1.81)	0.15** (1.98)	0.09** (2.30)
Log of GNI per capita	5.14*** (7.85)	3.21* (1.70)	9.56*** (5.57)
Urbanization	0.24 (1.58)	1.03 (1.64)	-0.53 (1.59)
Aid per capita	4.21** (2.06)	0.25*** (3.75)	3.05 (0.31)
Births attended by skilled staff	0.96*** (3.87)	1.09 (1.23)	2.31 (1.63)
Government Effectiveness	-0.52*** (3.00)	0.70** (2.63)	2.84* (1.67)
Population growth rate	6.87* (1.79)	4.62** (1.98)	11.06 (1.08)
Debt service	-0.21 (0.52)	-1.74 (1.27)	-3.83 (1.21)
Africa	-5.63*** (6.43)	-1.98*** (3.39)	-0.57** (3.57)
Lagged value PHE			0.89*** (3.93)
Constant	26.17 (1.38)	9.07 (1.07)	10.66 (0.37)
R-squared	0.724		
AR(1)			0.009
AR(2)			0.581
Sargan-Hansen test			0.468
Observations	175 (34)	175 (34)	175 (34)

Notes: \* Significant at 10%

\*\* Significant at 5%

\*\*\* Significant at 1%

1/ For the GMM estimation, lags of two periods are used for births attended by skilled staff and the lagged value of dependent variable, lags of one period are used for aid per capita and debt service. The other variables are considered as instruments in this model.

**Table 7:** Correlations among the variables

	PHE pc	PHE TGE	PHE THE	HIPC	DP	CP	Debt r (comt)	GNI pc	Debt serv	Aid pc	Pop grow	Im- mun	Birth Att'd	Govt Eff	Contr Corrup	IMR	Urb Pop
PhE	1																
Per cap PhE	0.19	1.															
(% TGE)																	
PhE (% THE)	0.49	0.43	1														
HIPC	-0.19	-0.08	-0.28	1													
DP	-0.28	0.02	-0.1	-0.15	1												
CP	-0.11	0.13	0.15	-0.14	-0.08	1											
Debt relief (co'td)	-0.21	0.11	-0.03	-0.15	0.34	0.31	1										
GNI per cap	0.87	0.03	0.43	-0.15	-0.32	-0.17	-0.27	1									
Debt serv per cap	0.33	0.09	0.11	-0.07	-0.08	-0.09	-0.08	0.30	1								
Aid per cap	-0.03	-0.06	-0.03	0.16	-0.13	0.04	-0.05	-0.02	-0.02	1							
Pop growth	0.13	-0.28	0.05	-0.06	0.04	0.00	-0.01	0.11	-0.0	-0.09	1						
immu	0.38	0.14	0.27	-0.29	-0.17	0.12	0.12	0.27	0.14	-0.04	-0.00	1					
Births Att'd	0.70	0.06	-0.22	-0.22	-0.12	0.00	-0.12	0.72	-0.08	-0.09	0.15	0.47	1				
Govt Effect	0.31	0.15	0.10	-0.19	-0.01	0.15	0.03	0.28	0.03	-0.03	0.05	0.33	0.26	1			
Contr of Corru	0.43	0.15	0.19	-0.29	0.02	0.14	0.03	0.42	0.15	-0.10	0.07	0.26	0.24	0.84	1		
IMR	-0.53	-0.08	-0.35	0.24	0.31	0.06	0.15	-0.46	-0.14	0.09	-0.05	-0.54	-0.62	-0.25	-0.22	1	
Urb pop	-0.14	0.03	-0.00	-0.05	0.08	-0.01	-0.03	-0.13	-0.12	-0.00	0.27	-0.14	0.10	0.06	0.06	0.01	1

## Annex: What is the Heavily Indebted Poor Countries (HIPC) Initiative?<sup>15</sup>

The HIPC Initiative is a comprehensive approach to debt reduction for heavily indebted poor countries pursuing IMF- and World Bank-supported adjustment and reform programs. It was first launched in 1996 by the IMF and World Bank, with the aim of ensuring that no poor country faces a debt burden it cannot manage. In 2005, to help accelerate progress toward the United Nations Millennium Development Goals (MDGs), the HIPC Initiative was supplemented by the Multilateral Debt Relief Initiative, which allows for 100 percent relief on eligible debts by three multilateral institutions—the IMF, the International Development Association (IDA) of the World Bank, and the African Development Fund.

To be considered for HIPC Initiative assistance, a country must: (1) be IDA-only and PRGF-eligible; (2) face an unsustainable debt burden; (3) establish a track record of reform and sound policies through IMF and IDA-supported programs; and (4) have developed a Poverty Reduction Strategy Paper (PRSP). Once a country has made sufficient progress in meeting these criteria, the Executive Boards of the IMF and IDA formally decide on its eligibility for debt relief, and the international community commits to reducing debt to the agreed sustainability threshold. This is called the **decision point**. Once a country reaches its decision point, it may immediately begin receiving **interim relief** on its debt service falling due. In order to receive the full and irrevocable reduction in debt available under the HIPC Initiative, the country must in addition: (i) establish a further track record of good performance under IMF- and IDA-supported programs; (ii) implement satisfactorily key reforms agreed at the decision point, and (iii) adopt and implement the PRSP for at least one year. Once a country has met these criteria, it can reach its **completion point**, at which time lenders are expected to provide the full debt relief committed at decision point.

Forty-one countries have been found to be eligible or potentially eligible for HIPC Initiative assistance. Twenty-three countries have already reached their completion points and have received or are receiving irrevocable debt relief from the IMF and other creditors. Ten countries have reached their decision points and some of them are receiving interim HIPC Initiative debt relief. Eight countries, have not yet reached their decision points (see Table 8).

For the 33 countries for which packages have already been approved, debt service paid, on average, has declined by about 2½ percent of GDP between 1999 and 2007. Their debt burden is expected to be reduced by about 90 percent after the full delivery of debt relief.

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<sup>15</sup> This information contained in this annex is based on the IMF factsheet: Debt Relief Under the Heavily Indebted Poor Countries (HIPC) Initiative, October 2008.

**Table 8:** List of Countries That Have Qualified for, are Eligible or Potentially Eligible and May Wish to Receive HIPC Initiative Assistance (January 2009)

Post-Completion-Point Countries (24)		
<b>Benin</b>	Guyana	<b>Rwanda</b>
Bolivia	Honduras	<b>São Tomé &amp; Príncipe</b>
<b>Burkina Faso</b>	<b>Madagascar</b>	<b>Senegal</b>
<b>Burundi</b>	<b>Malawi</b>	
<b>Cameroon</b>	<b>Sierra Leone</b>	
<b>Mali</b>	<b>Mauritania</b>	<b>Tanzania</b>
<b>Ethiopia</b>	<b>Mozambique</b>	<b>Uganda</b>
<b>The Gambia</b>	Nicaragua	<b>Zambia</b>
<b>Ghana</b>	<b>Niger</b>	
Interim Countries (Between Decision and Completion Point) (10)		
Ahghanistan	<b>Democratic Republic of Congo</b>	Haiti
<b>Central African Republic</b>	<b>Guinea</b>	<b>Liberia</b>
<b>Chad</b>	<b>Guinea Bissau</b>	<b>Togo</b>
<b>Congo</b>		
Pre-Decision-Point Countries (7)		
<b>Comoros</b>	Kyrgyz Republic	<b>Sudan</b>
<b>Côte d'Ivoire</b>	Nepal	
<b>Eritrea</b>	<b>Somalia</b>	