Debt relief and public health spending in heavily indebted poor countries*

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Abstract The Heavily Indebted Poor Countries (HIPC) Initiative, which was launched in 1996, is the first comprehensive effort by the international community to reduce the external debt of the world's poorest countries. The Initiative will generate substantial savings relative to current and past public spending on health and education in these countries. Although there is ample scope for raising public health spending in heavily indebted poor countries, it may not be advisable to spend all the savings resulting from HIPC resources for this purpose. Any comprehensive strategy for tackling poverty should also focus on improving the efficiency of public health outlays and on reallocating funds to programmes that are most beneficial to the poor. In order to ensure that debt relief increases poverty-reducing spending and benefits the poor, all such spending, not just that financed by HIPC resources, should be tracked. This requires that countries improve all aspects of their public expenditure management. In the short run, heavily indebted poor countries can take some pragmatic tracking measures based on existing public expenditure management systems, but in the longer run they should adopt a more comprehensive approach so as to strengthen their budget formulation, execution, and reporting systems.

Keywords Financing, Organized/organization and administration; Financial management; Health expenditures; Financing, Government; Policy making; Health services accessibility; Quality of health care; Poverty; Least developed countries (*source: MeSH, NLM*).

Mots clés Organisation financement/organisation et administration; Gestion financière; Dépenses de santé; Financement par gouvernement; Choix d'une politique; Accessibilité service santé; Qualité soins; Pauvreté; Pays les moins avancés (*source: MeSH, INSERM*).

Palabras clave Organización del financiamiento/organización y administración; Administración financiera; Gastos en salud; Financiamiento gubernamental; Formulación de políticas; Accesibilidad a los servicios de salud; Calidad de la atención de salud; Pobreza; Países menos adelantados (*fuente: DeCS, BIREME*).

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Introduction

The Heavily Indebted Poor Countries (HIPC) Initiative, launched in 1996, was the first comprehensive effort by the international community to reduce the external debt of the world's poorest countries. It went beyond earlier debt relief initiatives in that it covered also debt from multilateral creditors, e.g. the International Monetary Fund (IMF) and the World Bank, and placed debt relief within an overall framework of poverty reduction.

In 1999, the HIPC Initiative was enhanced to further strengthen the links between debt relief, poverty reduction, and social policies. The aim of the enhanced HIPC is to channel government resources, available as a consequence of debt relief, into poverty-reduction activities. Under the programmes being negotiated between countries eligible for debt relief and the World Bank and the IMF, government spending on public services that directly affect the poor, such as preventive health care and primary education, should increase.

By the end of June 2001, a commitment had been made to debt relief for 23 of 41 eligible countries: Benin, Bolivia, Burkina Faso, Cameroon, Chad, the Gambia, Guinea, Guinea-Bissau, Guyana, Honduras, Madagascar, Malawi, Mali, Mauritania, Mozambique, Nicaragua, Niger, Rwanda, São Tomé and Príncipe, Senegal, Uganda, United Republic of Tanzania, and Zambia. At this stage, referred to as the decision point, interim debt relief becomes available to these 23 heavily indebted poor countries if they meet certain conditions. The interim relief is provided by the IMF, the World Bank and other creditors at their discretion. At the completion point, reached when the countries have fulfilled the requirements of policy implementation laid down at the decision point, all the creditors provide the remainder of the debt relief to which they have agreed (Box 1).

In the present paper we analyse selected fiscal policy issues related to debt relief, focusing on the 23 countries that had reached their decision point under the enhanced HIPC Initiative framework by June 2001. Presented are estimates of the reduction in the stock of debt and debt service after HIPC assistance. Possible uses of HIPC assistance are discussed in the context of poverty-reduction strategies, and issues related to monitoring the use and effectiveness of debt relief are considered.

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Box 1. **Enhanced HIPC Initiative**

How does the HIPC Initiative work?

In order to be considered for HIPCI assistance, a country must face an unsustainable debt burden, beyond the scope of available debt relief mechanisms, and must establish a track record of reform and sound policies through programmes supported by the IMF and the World Bank. Furthermore, the country must (i) produce a full or interim Poverty-Reduction Strategy Paper by the **decision point** and (ii) make progress in implementing this strategy by the **completion point** (see below). Eligible countries qualify for debt relief in two stages.[a]

- In the first stage the debtor country has to demonstrate a capacity to use prudently the assistance granted by establishing a satisfactory track record (demonstrating a strong commitment to reducing macroeconomic imbalances and sustaining growth-oriented policies), normally for a three-year period, under programmes supported by the IMF and the World Bank. At the end of this period, the country reaches the **decision point**, when the IMF and the World Bank decide on its eligibility on the basis of a debt sustainability analysis. If the external debt situation of the country is found to be unsustainable, it qualifies for assistance under the HIPC Initiative, and the international community makes a commitment to provide sufficient assistance for the country to achieve debt sustainability.
- In the second stage, when eligibility for support under the HIPC Initiative has been demonstrated, the country must establish a further track record of good performance under programmes supported by the IMF and the World Bank. No limit is specified for the duration of this stage, which depends on the satisfactory implementation of key structural policy reforms agreed at the decision point, the maintenance of macroeconomic stability, and the adoption and implementation of a poverty-reduction strategy developed through a broad-based participatory process. During this stage, bilateral and commercial creditors are generally expected to reschedule obligations falling due, with a 90% reduction in net present value. Both the World Bank and the IMF may grant interim relief if the country stays on track with its programmes supported by these institutions. At the end of this stage the country reaches its floating **completion point** and the remaining amount of debt relief is irrevocably committed.

Estimated debt relief under the HIPC Initiative

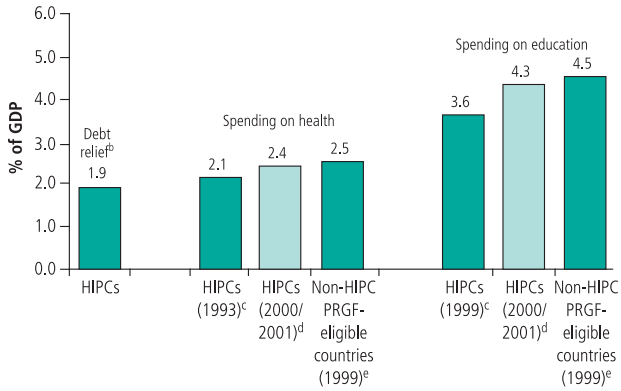
On the basis of a costing exercise conducted in March 2000, the total cost of the assistance to be provided under the HIPC Initiative is estimated to be US$ 29.3 billion in 1999 net present value terms. As of the end of June 2001, more than 70% of that amount had already been committed to the 23 countries that had reached the decision point. The great majority of the 41 countries eligible to benefit from the HIPC Initiative are in sub-Saharan Africa. In net present value terms, US$ 20.5 billion of debt relief is in place for 23 of these countries: US$ 14.8 billion for 19 countries in Africa, and US$ 5.7 billion for four countries in Latin America and the Caribbean (Table 1).

[a] For more details, see URL: http://www.imf.org/external/np/exr/facts/hipc.htm

Decrease in debt service

Countries receiving debt relief under the HIPC Initiative should see their debt servicing payments drop by 1.9% of gross domestic product (GDP) per year over the period 2001–03, relative to what they paid in 1998–99 (Fig. 1). Based on an average weighted by each country's GDP, debt service payments can be expected to decline by 1.6% of GDP. Savings on debt service could be quite significant for some countries. For example, Guyana's savings from debt relief can be expected to average 9% of GDP per year over the next few years. However, some HIPC debt relief may not be immediately reflected in the beneficiary countries' budgets. For example, relief on debt owed to the IMF may not initially

Fig. 1. **HIPC debt relief and public spending on health and education[a]**



Sources: Country authorities and IMF staff estimates.

[a] Public spending on health and education typically refers to that of the central government, including transfers to subnational governments for education and health care.
[b] Average reduction in annual debt service by country in 2001–03. Excludes Sao Tomé and Principe.
[c] 19 of the 23 HIPCs that had reached the decision point by June 2001.
[d] 14 countries in the case of health spending, and 13 countries in the case of education.
[e] 19 countries eligible for assistance from the IMF's Poverty Reduction and Growth Facility.

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appear in a country's fiscal accounts because it accrues to the central bank rather than to the budget (except for CFA franc zone countries). Hence, a country may need to set up a special account in the central bank in order to identify savings stemming from HIPC relief so that they can be transferred to the budget as grants. Similarly, some public enterprises may benefit from debt relief in the form of write-downs of government-guaranteed debt. However, such write-downs would not be reflected in the government budget unless the savings they entailed were transferred to it.

Poverty-reduction measures

The use of funds saved because of debt relief is guided by each country's poverty-reduction strategy, delineated in a poverty-reduction strategy paper (PRSP) that determines the basis for access to concessionary loans from the IMF and the World Bank. Countries formulate their poverty-reduction strategies in collaboration with these institutions and with civil society and development partners. Updated annually, a PRSP describes a country's plan for macroeconomic, structural, and social policies for three-year adjustment programmes that are designed to foster growth and reduce poverty. Strategies are results-oriented in order to encourage countries to adopt policies that will lead to tangible and measurable improvements in the well-being of the poor. As of November 2001, eight heavily indebted poor countries had finalized PRSPs, and the others had articulated their strategies in interim PRSPs.

All the PRSPs of the 23 heavily indebted poor countries that have reached the decision point include measures aimed at increasing the access of poor people to primary and preventive health care and to primary education. Some PRSPs also call for increased spending on water and sanitation (nine countries), roads and road maintenance (seven countries), and rural development (eight countries), and some include programmes that provide housing for the poor and measures to strengthen social safety nets.

The funds that become available as a result of debt relief under the enhanced HIPC Initiative are substantial relative to current and past spending on health and education. The 1.9% of GDP released every year is equivalent, on average, to

Table 1. **Debt relief (in 10^6 US$) committed under the Heavily Indebted Poor Countries Initiative (HIPCI): status as of June 2001 and public spending on health and education (in 10^6 US$)**

Country	Debt relief						Approval date	Health spending[c]		Education spending[c]	
	NPV[a] reduction			Nominal debt service relief							
	Original framework[b]	Enhanced framework	Total	Original framework[b]	Enhanced framework	Total		1999	2000–01	1999	2000–01
TOTAL	**3117**	**17 371**	**20 489**	**6170**	**27 720**	**33 890**		2.1	2.4	3.6	4.3
Africa	**2413**	**12 365**	**14 779**	**4970**	**20 430**	**25 400**		1.7	1.8	3.2	3.7
Benin	...	265	265	...	460	460	Jul 00	1.7	2.0	3.1	3.9
Burkina Faso	229	169	398	400	300	700	Jun 00	2.5	...	3.9	...
Cameroon	...	1260	1260	...	2000	2000	Oct 00	0.6	0.8	1.8	2.2
Chad	...	170	170	...	260	260	May 01	1.9	2.1	2.2	2.3
The Gambia	...	67	67	...	90	90	Dec 00	3.6	...	5.5	...
Guinea	...	545	545	...	800	800	Dec 00	0.2	0.5	1.8	2.0
Guinea-Bissau	...	416	416	...	790	790	Dec 00	1.2	2.6	1.6	4.0
Madagascar	...	814	814	...	1500	1500	Dec 00	1.2	1.7	3.0	3.0
Malawi	...	643	643	...	1000	1000	Dec 00	...	...	...	...
Mali	121	401	523	220	650	870	Sep 00	1.1	1.7	3.7	3.9
Mauritania	...	622	622	...	1100	1100	Jan 00	1.7	2.0	5.3	5.6
Mozambique	1716	254	1970	3700	600	4300	Apr 00	3.0	3.3	3.4	5.5
Niger	...	521	521	...	900	900	Dec 00	2.2	...	2.7	...
Rwanda	...	452	452	...	810	810	Dec 00	...	...	...	...
São Tomé and Príncipe	...	97	97	...	200	200	Dec 00	...	...	...	...
Senegal	...	488	488	...	850	850	Jun 00	1.3	1.4	4.1	4.2
Uganda	347	656	1003	650	1300	1950	Jan 00	2.2	2.1	3.8	4.2
United Republic of Tanzania	...	2026	2026	...	3000	3000	Apr 00	...	...	...	...
Zambia	...	2499	2499	...	3820	3820	Dec 00	1.5	...	1.8	...
Latin America	**704**	**5006**	**5710**	**1200**	**7290**	**8490**		3.6	4.6	5.2	7.4
Bolivia	448	854	1302	760	1300	2060	Jan 00	3.3	3.7	6.2	6.3
Guyana	256	329	585	440	590	1030	Nov 00	4.1	4.6	6.1	8.6
Honduras	...	556	556	...	900	900	Jul 00	1.8	...	3.4	...
Nicaragua	...	3267	3267	...	4500	4500	Dec 00	5.3	5.5	4.9	...

Sources: HIPC Initiative country documents and IMF staff estimates.

[a] Net present value.

[b] In addition, debt relief of US$ 345 million was approved for Côte d'Ivoire under the original framework.

[c] Public spending on health and education typically refers to that of the central government, including transfers to subnational governments for education and health care.

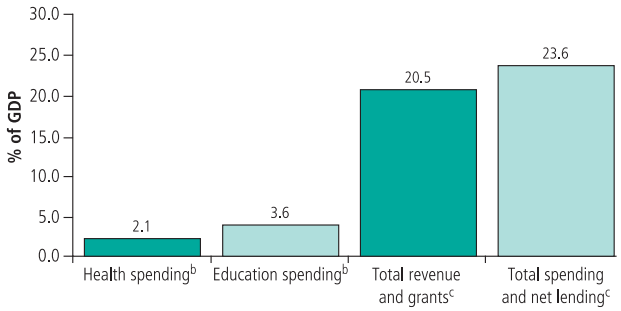
roughly 50% and 90% of public spending on education and health care, respectively, during 1999 in heavily indebted poor countries that have reached the decision point.[a] Spending on poverty-reduction programmes, including health care, could increase by even more than the resources freed by the enhanced HIPC Initiative. For the 23 countries that have reached the decision point, total public spending and total revenues, including grants, are estimated at 24% and 21% of GDP, respectively, while public health spending is estimated at 2.1% of GDP in 1999 (Fig. 2). By tilting the composition of public spending in favour of poverty-reduction programmes, the poverty-reduction strategy paper could increase the budgetary allocations for them.

There is ample scope for raising expenditure on health care in HIPCs. Although HIPCs that have reached the decision point have increased their public health care outlays sharply in real per capita terms since the mid-1980s (Fig. 3), they still spend less on health care than other low-income countries. In 1999, for example, non-HIPCs eligible for debt relief from the IMF's Poverty-Reduction Growth Facility spent about 1% of GDP more on health care than HIPCs that had reached the decision point. In terms of total government outlays, only about 9% of spending was devoted to health care in 1999 in the heavily indebted poor countries, ranging from US$ 3 a person in Madagascar to US$ 35 a person in Bolivia and Guyana.

Because of the urgent health needs of many heavily indebted poor countries and the challenges posed by HIV/AIDS, it is tempting to argue that all HIPC relief should be channelled to higher public spending on health. Indeed, it has been suggested by some — including Jubilee 2000, in a joint statement issued in May 2000 by Jeffrey Sachs and Ann Pettifor — that the external debt servicing payments being made by HIPCs should be sequestered in a special fund designed to meet these needs (*1*). However, even if improvements in health indicators are the most important objective of government policy, it may not be advisable to spend all the savings from HIPC debt relief on public health. Other government spending programmes, such as those for water and sanitation, nutrition,

[a] Public spending on health and education typically refers to that of the central government, including transfers to subnational governments for education and health care.

Fig. 2. **Total revenue, total spending, and public spending on health and education in HIPCs that have reached the decision point**[a]



Sources: Country authorities and IMF staff estimates.

[a] 1999 or the most recent data available. Public spending on health and education typically refers to that of the central government, including transfers to subnational governments for education and health care.
[b] Refers to 19 of the 23 decision point HIPCs. Excludes Sao Tomé and Principe where high levels of debt relief and government expenditures distort the unweighted average.
[c] Refers to all decision point HIPCs except Sao Tomé and Principe.

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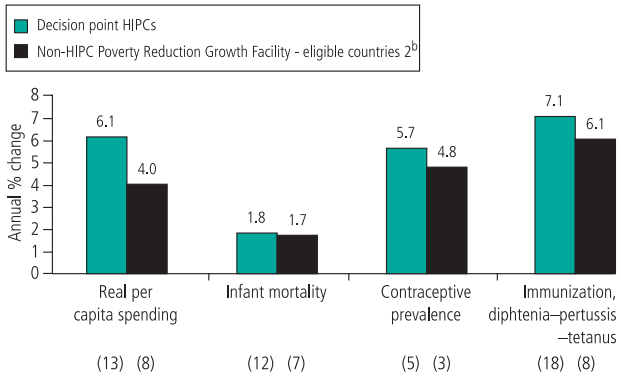
Fig. 3. **Annual percentage change in public health spending and social indicators, 1985–99**[a]



Sources: World Bank, World Development Indicators 2000 database; country authorities; and IMF staff estimates.

[a] Average improvement between the first year since 1985 in which the country embarked on an IMF-supported programme and the most recent year for which data are available. Numbers of countries are shown in parentheses. Health spending data typically refer to that of the central government, including transfers to subnational governments for health care.
[b] Excludes transition economies.

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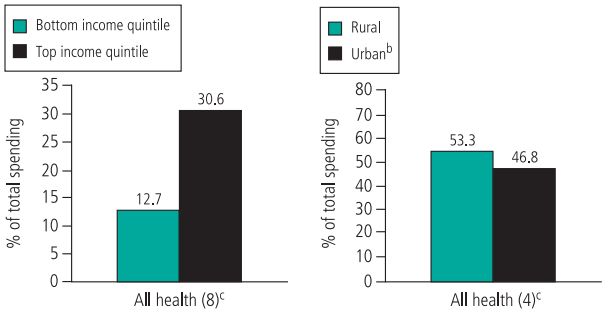
Fig. 4. **Benefit incidence of public spending on health care in heavily indebted poor countries**[a]



Source: See ref. *(6)*

Note: Data are from the latest year for which they are available in the early 1990s.

[a] Public spending on health typically refers to that of the central government, including transfers to subnational governments for health care.
[b] In countries in the sample, on average a quarter of the population lives in urban areas.
[c] Figures in parentheses are number of countries.

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and education for women of childbearing age, might be more effective in improving the health status of the poor.

Furthermore, an exclusive focus on raising public health outlays in heavily indebted poor countries as a means of improving health indicators is not justified. While health indicators have, on average, improved from low levels in such countries since the mid-1980s (Fig. 3), higher public outlays on health have not always been associated with better performance on social indicators (*2–4*). This has partly reflected inefficiencies in spending and in the allocation of health outlays to activities that have relatively little effect on social indicators and the well-being of the poor. Benefit incidence studies confirm that the poor receive a disproportionately small share of the benefits from public health outlays in heavily indebted poor countries (Fig. 4) (*5*).[b] A comprehensive strategy to improve health outcomes should therefore focus not only on securing additional resources for public health but also on eliminating the inefficiencies in spending and on reallocating funds to programmes that are most beneficial to the poor, e.g. those that provide women with antenatal care and vaccinate children against preventable diseases.

Mindful of these considerations, many PRSPs focus on steps to improve the efficiency of social spending, including health, and reallocate expenditures to pro-poor activities within each sector. Poverty-reduction strategies have generally aimed to improve the quality and extend the coverage of public health services, placing emphasis on disease prevention (Box 2). In order to achieve these objectives, the heavily indebted poor countries are committed to increasing public outlays on health programmes. In line with the above considerations, however, resources freed by debt relief have to be allocated to a wide spectrum of poverty-reducing programmes, and health sector outlays are expected to increase by an average of 0.4% of GDP between 1999 and 2000–01, which is less than the total amount of HIPC debt relief.

As well as improving the allocation and efficiency of social spending, HIPCs have to overcome a number of additional obstacles if they are to achieve their goals for poverty reduction. Economic growth is a key factor in poverty alleviation and has to be raised well above its historic average in many countries. Furthermore, capacity constraints in the social sectors have to be confronted if large increases in the provision of social services are to be realized over the next few years.

Monitoring the use of debt relief for heavily indebted poor countries

It is critical that debt relief results in an increase in public spending related to poverty-reducing programmes and that the funds are used for their intended purposes and reach the poor. In this respect it is vital that all poverty-reducing expenditure be tracked, and not just that associated with the HIPC Initiative.

[b] The benefit incidence of government spending is defined here in terms of who receives the benefits from government services. This expenditure is considered to be well or poorly targeted if the poorest quintile's share of benefits from the spending is larger or smaller, respectively, than that of the richest quintile. Government expenditure is considered to be progressive or regressive if the benefits to the poorest quintile are larger or smaller, respectively, than the benefits to the richest quintile relative to the respective quintile's income or expenditure. Health spending is found to be well targeted, on average, in 38 studies, except for sub-Saharan Africa (which accounts for most HIPCs at the decision point) and transition economies.

Box 2. **Health care measures included in poverty-reduction strategies**

In their poverty-reduction strategy papers, the 23 heavily indebted poor countries that have reached the decision point have outlined their main goals on health care and the measures for achieving them.

Expanding coverage of or access to health facilities, particularly for the poor, by:

- increasing the supply of basic medicines by making generic drugs more affordable and improving the distribution of drugs and vaccines (Cameroon, Malawi, Mauritania, Niger, and São Tomé and Principe);
- establishing a minimum health services package that covers primary care, antenatal care, and vaccinations (Burkina Faso, Chad, Senegal, and United Republic of Tanzania);
- providing basic health insurance (Bolivia);
- expanding the health infrastructure (Benin, Bolivia, Chad, Mauritania, and Senegal);
- increasing the number of health workers (Burkina Faso).

Improving the health of the population by:

- raising awareness about health issues and intensifying efforts to disseminate public health information (Mozambique);
- promoting immunization and increasing the vaccination rate (Guinea-Bissau, Mali, Niger, and Uganda);
- strengthening programmes to combat infectious diseases (Malawi, Mauritania);
- educating mothers about nutrition and family planning methods (Benin, Bolivia, São Tomé and Principe, and United Republic of Tanzania);
- curbing the spread of sexually transmitted diseases through educational programmes and public awareness campaigns that disseminate information on their transmission and prevention (Bolivia, Burkina Faso, Cameroon, Guinea-Bissau, Madagascar, Malawi, Mozambique, and Rwanda).

Improving the quality of health services by:

- providing training programmes for health staff (Guyana, Niger, Rwanda, and United Republic of Tanzania);
- adopting a system for annual performance evaluation in the health sector (Benin);
- modernization through increasing the participation of the private sector (Nicaragua);
- improving the management of hospitals (SãoTomé and Principe);
- decentralization (Malawi, Nicaragua, and São Tomé and Principe).

The objectives are increases in spending on poverty-reduction programmes, and in the share of total public spending devoted to these programmes.

Such tracking requires the identification of spending on poverty reduction in the context of each country's poverty-reduction strategy. What is tracked as poverty-reducing is therefore bound to be country specific. In the short run, the analysis of the shift in spending towards more pro-poor programmes should focus on broad estimates of central government spending by function, e.g. education and health care. However, within a given category, e.g. health care, such estimates cannot distinguish between expenditure intended to help the poor and other spending (e.g. hospital care in urban areas). Countries are therefore being encouraged to provide more detailed data. As these become available through improvements in budget classification, it should be easier for countries to track spending on basic social services for the poor, such as primary education and preventive health care.

The tracking of expenditure on poverty-reduction programmes requires improvements in public expenditure management systems and an increase in technical assistance from international institutions and donors. In the short run, the improvements will involve pragmatic steps, i.e. bridging mechanisms, to bolster the identification and reporting of spending on poverty-reducing programmes, on the basis of existing public expenditure management systems. These bridging mechanisms are meant to establish meaningful links between poverty-reducing spending identified in PRSPs and existing or new expenditure classification systems. In the medium term, more comprehensive improvements in budget formulation, execution and reporting are necessary.

Weaknesses in budget classification are likely to hamper the tracking of poverty-reducing spending in heavily indebted poor countries. For example, difficulties can be expected in connection with appropriately classifying the programmes listed in Box 2 within established or new expenditure classification systems. Furthermore, additional work is needed in order to fully capture foreign-financed capital expenditure in budget reporting systems. The tracking of poverty-reducing spending at the subnational level is also likely to pose additional challenges for public expenditure management systems.

The ultimate aim of tracking expenditure on poverty-reduction programmes is to evaluate whether they benefit the poor. In itself the allocation of additional spending to these programmes will not suffice to bring about the desired reduction in poverty. Countries should therefore monitor the delivery and impact of poverty-reduction programmes. In this connection, it would be of value to monitor the benefit incidence of health programmes and to conduct periodic surveys in order to assess whether budgetary funds are used for their intended purposes.

Assessing the effectiveness of these programmes would be made easier if countries improved the quality of data on social indicators. Because such data are produced infrequently, it is difficult to assess the impact of spending. Fewer than half of the PRSPs for countries that have reached the decision point provide data on four or more of the six health indicators (infant, child, and maternal mortality rates; percentage of births attended by skilled personnel; prevalence of contraceptive use; and prevalence of human immunodeficiency virus (HIV) infection among pregnant women aged 15–24 years) used by international institutions to monitor the developmental progress of poor countries (*7*). In their PRSPs, more than half the 23 heavily indebted poor countries acknowledge constraints that prevent them from monitoring social indicators with any degree of accuracy and note that more work is needed in this area. More timely and fuller data can be expected to contribute towards strengthening poverty-reduction strategies as countries obtain more rapid feedback on trends in social indicators and on the impact of programmes on these indicators.

In addition to obtaining reliable, detailed data, the HIPCs will need to mobilize domestic resources to augment those made available to them under the enhanced HIPC Initiative, so as to ensure adequate funding over the long term for poverty-reduction programmes. They will thus have to strengthen governance and tax administration, while developing institutions that are better able to monitor government spending, in order to achieve sustained improvements in living standards for their poorest citizens. They will also have to devise poverty-reduction strategies that are conducive to high economic growth. This is a requirement for ensuring that the burden of external debt remains sustainable in relation to the size of the economy.

Summary and conclusions

The HIPC Initiative represents an important step forward towards placing debt relief in an overall framework of poverty reduction. Debt relief under the HIPC Initiative can be expected to reduce significantly the total stock of debt and generate substantial savings on debt servicing relative to current and past public spending levels on health and education.

There is scope for raising public health spending in HIPCs. However, other government spending programmes, such as those concerned with water and sanitation, nutrition, and education for women of childbearing age, might be even more effective in improving the health status of the poor or reducing poverty more generally. Furthermore, a comprehensive strategy for tackling poverty should focus not only on securing additional resources for health spending but also on improving the efficiency of these outlays and reallocating funds to programmes that are most beneficial to the poor. Mindful of these considerations, heavily indebted poor countries are increasingly investing in a wide spectrum of poverty-reducing programmes and are taking steps to enhance the efficiency of these outlays.

It is critical to ensure that debt relief results in an increase in poverty-reducing expenditure and that it reaches the poor. All poverty-reducing spending, not just that financed by HIPC debt relief, should therefore be tracked. This requires improvements not only in budget classification and reporting but in all aspects of public expenditure management. In the short run, the improvements should involve pragmatic measures to strengthen the identification and reporting of spending on poverty-reducing programmes, on the basis of existing public expenditure management systems. In the medium term, a comprehensive strengthening of budget formulation, execution and reporting is required. A vigorous programme of technical assistance from international institutions and donors is needed if these improvements are to be realized. It is also necessary that heavily indebted poor countries mobilize domestic resources to augment those made available under the enhanced HIPC Initiative. ■

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Conflicts of interest: none declared.

Résumé

Allégement de la dette et dépenses de santé publique dans les pays pauvres très endettés

L'initiative en faveur des pays pauvres très endettés (initiative PPTE, ou HIPCI en anglais), lancée en 1996, est le premier effort global de la communauté internationale en vue de réduire la dette extérieure des pays les plus pauvres du monde. Elle a pour objectif de générer des économies substantielles afin de couvrir les dépenses publiques actuelles et passées de ces pays dans le domaine de la santé et de l'éducation. Néanmoins, bien qu'il y ait largement matière à augmenter les dépenses de santé publique dans les PPTE, il ne serait peut-être pas judicieux d'y affecter toutes les économies réalisées dans le cadre de l'initiative. Toute stratégie globale visant à combattre la pauvreté doit également viser à améliorer l'efficacité des services de santé publique et à réattribuer des fonds aux programmes les plus utiles aux pauvres. Pour assurer que l'allégement de la dette permettra d'augmenter les dépenses visant à réduire la pauvreté et à aider les pauvres, toutes les dépenses de ce type, et non seulement celles qui sont financées par les ressources de l'initiative, devront être suivies. Il faut pour cela que les pays améliorent tous les aspects de leur gestion des dépenses publiques. A court terme, les pays pauvres très endettés peuvent prendre quelques mesures pragmatiques fondées sur les systèmes actuels de gestion des dépenses publiques, mais à plus long terme ils devront adopter une approche plus globale de façon à renforcer leurs systèmes de formulation, d'exécution et de rapport budgétaires.

Resumen

Alivio de la deuda y gasto en salud pública en los países pobres muy endeudados

La Iniciativa en favor de los países pobres muy endeudados (HIPCI), lanzada en 1996, es el primer esfuerzo amplio emprendido por la comunidad internacional para reducir la deuda externa de los países más pobres del mundo. Su objetivo consiste en propiciar economías sustanciales en relación con el gasto público, presente y pasado, en salud y educación en esos países. Sin embargo, aunque existe un amplio margen para aumentar el gasto en salud pública en los países pobres muy endeudados, tal vez no convenga dedicar a ese fin la totalidad de lo ahorrado gracias a los recursos de la HIPCI. Toda estrategia amplia orientada a combatir la pobreza debería centrarse también en mejorar la eficiencia de los desembolsos en salud pública y reasignar los fondos a los programas más ventajosos para los pobres. A fin de asegurar que el alivio de la deuda se traduzca en un aumento de las inversiones en mitigación de la pobreza y beneficie a los pobres, es necesario seguir de cerca todo ese tipo de gastos, no sólo de los costeados con recursos de la HIPCI. Para ello los países deben mejorar todas las facetas de su gestión del gasto público. A corto plazo, los países pobres fuertemente endeudados pueden adoptar algunas medidas pragmáticas de seguimiento basadas en los sistemas vigentes de gestión del gasto público, pero a más largo plazo deberían adoptar un enfoque más amplio para reforzar sus sistemas de formulación y ejecución del presupuesto y de preparación de informes al respecto.

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