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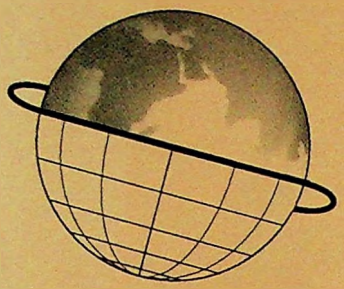

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Debt for Health Swaps: A source of additional finance for the health system?

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Debt for Health Swaps: A source of additional finance for the health system?

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ABSTRACT

At a time when restrictions on government spending put pressure on health sector financing it is important to search for new potential sources of finance to maintain and improve the provision of health care in developing countries. Debt-for-health swaps may be one possibility.

Debt conversions, of which debt-for-health swaps is a particular example, are increasingly used as part of debt management strategies of heavily indebted countries. One potential advantage from the point of view of the debtor country of such conversions is that they imply a transformation of the external debt of the government into domestic debt, thereby resulting in less pressure to generate foreign exchange for debt service.

A debt-for-health swap represents an opportunity for a foreign donor to increase (relative to a straight gift) the local currency equivalent of a donation. This can be achieved by first using foreign exchange to buy a country's external debt at a discount in the secondary market, and then donating this debt to the target country in exchange for domestic funds. In the best of scenarios, the local currency proceeds can be multiplied by a factor of two or three compared to a regular donation of foreign exchange to the government.

Although debt swaps do have certain advantages, it must be recognized that there are certain constraints associated with them. One is that they do not generate any foreign exchange for the recipient country, a fact that must be taken into account in the design of the health project financed by the swap. Another constraint is that the domestic macroeconomic situation of the recipient country may suffer as a consequence of the increased *domestic* debt implied by the swap. It is important to keep this in mind when countries are approached with proposals for debt swaps.

Debt-for-health swaps may present an opportunity to increase funding for the health sector on a temporary basis. The WHO can play an important role in this respect by providing technical services relating to the identification of suitable health projects, by mobilizing additional funds from traditional or new donors, and by serving as an intermediary in the debt conversion process. In fact, some of these functions are already being accomplished. It should be emphasized, however, that the window of opportunity to carry out debt-for-health swaps is limited in time.

DEBT FOR HEALTH SWAPS
A SOURCE OF ADDITIONAL FINANCE FOR THE HEALTH SECTOR?

1. The need for increased financing for health

Limits on government spending, the related debt service burden, and for some countries, the recent need to devote larger amounts of foreign exchange for energy imports put the health sector at potential risk of having to cut back due to lack of funding. This threat makes it important to search for new sources of finance in order to maintain and improve the provision of health care.

The external debt of many developing countries may, paradoxically as it may seem, constitute a conduit through which additional temporary funding for health projects may be channeled. Recently considerable interest has been focused on the possibility of exchanging some of a country's external debt for increased health expenditures in that country by means of so-called debt-for-health conversions (or swaps). This report explains what exactly these swaps are, how they are expected to work, what role they might play in financing health projects, and which steps would have to be taken to implement them.

2. What are debt conversions.

As a part of a strategy for dealing with the financing burden of their external debt, a number of debtor countries have negotiated *restructuring* agreements with their creditors. These agreements include such elements as changing the maturity of the debt and the interest rate charged, allowing for a grace period for debt service payments, and outright canceling of some portion of the debt. Debt *conversion* is another example of debt restructuring.

The term debt conversions, or debt swaps, may refer to any of a number of different methods for transforming the external debt of a country into new type of liability, normally denominated in domestic currency rather than in foreign exchange. Debt-for-equity, debt-for-development, debt-for-nature, and debt-for-charity swaps are all examples of such conversions that have actually been carried out. To give a general understanding of what is involved consider two examples.

A *debt-for-equity* swap means that the foreign owner of the debt instrument trades it in for a share of ownership in a domestic firm. This would typically come about in two steps. The creditor would first convert the debt instrument into domestic currency at the central bank. With that money, and with the approval of the government, he would then buy shares in the domestic company. Three points are important to keep in mind regarding these transactions. First, no foreign exchange would be involved even though the original debt was denominated in, say, dollars. Secondly, the foreign creditor now has a claim on the domestic private sector rather than on the government.[1] Third, the government has transformed its foreign debt either into domestic debt or into an increase in the domestic money supply depending on how the purchase of the original debt was financed.

[1] Furthermore, the income generated by this claim is now dependent on the performance of the domestic company and not directly on a stipulated interest rate as was the case with the original debt

A *debt-for-nature* swap involves an exchange of foreign debt for a promise by the government to finance a domestic environmental protection project. One way for the government to do this is to issue domestic debt in exchange for the foreign debt. The domestic debt is held by a special fund which is set up to administer the environmental project.[2] Note that the debt-for-nature swap has some similarities, but also some important differences, with the debt-for-equity swap. The similarities consist of the fact that no foreign exchange is involved in the transaction, and that the government has exchanged foreign debt for domestic debt. The main difference is that the foreign owner of the debt gets nothing in return except the guarantee that the environmental project will be financed. In essence, the owner of the foreign debt has made a donation to the country. This means that there is little chance that commercial bank creditors themselves will want to enter into a swap of this kind whereas they may for profitability reasons be interested in a debt-for-equity conversion. Instead, debt-for-nature and related swaps are carried out by other entities who have an interest in the particular project being financed and who for this reason procure the commercial debt in the secondary market.

Debt-for-development, debt-for-charity, and as we shall see, debt-for-health swaps share the essential properties of the debt-for-nature swap. They rely on donations from abroad, they generate domestic funds but no foreign exchange for domestic projects, and they lead to an expansion of domestic debt by the government. These features should be kept in mind when we evaluate the advantages and disadvantages of debt-for-health swaps for channeling funds into the health sector, and when we design a procedure for implementing such swaps.

In order to understand the motivations behind debt swaps, we must ask why a commercial bank would be interested in exchanging debt it holds on a country for equity in firms located there rather than investing in the country directly? Similarly, why would a donor first use dollars to buy debt and then exchange this debt for an environmental project rather than donate the dollars directly to the country in exchange for local funds for the same project? The answer to these questions is that a debt swap may generate more domestic currency and hence more resources than a straightforward foreign investment or donation. Thus a given amount of foreign exchange may allow the investor or donor to undertake a larger project if it is done through a debt swap than if it is done directly.

The reason why a debt swap may be advantageous has do with the so called secondary market for debt. (See the box on page 9) In this market, the value of the debt for most highly-indebted developing countries is less than its face value. This means that it is possible to buy $10 million, say, of debt for only $5 million if the discount is 50%. If the central bank of the debtor country is willing to exchange the full value of the debt for domestic currency in a swap operation, the foreign investor or donor effectively gets $10 millions worth of domestic currency for only $5 millions. For a donor interested in financing a health sector project, this represents an opportunity to increase the local-currency resources with no extra commitment of foreign exchange.

[2] Depending on the nature of the debt, the fund may be able to sell it to local investors for cash or it may have to hold it to maturity.

3. A stylized example of a debt-for-health conversion

In order to illustrate how a potential debt-for-health swap might provide funds for a health project consider the following illustrative example. Suppose a donor wants to give $1 million for a rural clinic program in a developing country.[3] Suppose that the exchange rate between the currency of that country (the Peso) and the dollar is 10 Ps/$. A direct gift to the country's health authorities would make 10 million pesos available for the rural clinic program. Consider now the alternative possibility of channeling the funds to the health project via a debt swap, and suppose for the sake of this example that the secondary market price of claims on this country is 25%, i.e 25 cents to the dollar. In this case, the donation of $1 million will buy debt with a face value of $4 millions. If the central bank of the developing country is still willing to exchange that debt at the official exchange rate of 10 Pesos per dollar, the domestic currency value of the donation will be 40 million pesos. The debt swap has thus generated a greater amount of domestic currency for our rural clinic program than the straight donation.

The conclusion that the debt-for-health swap is necessarily a preferred way to support health projects needs to be tempered somewhat by the following considerations. First, the above illustrative calculations assumed that the central bank of the recipient country was willing to exchange the face value of the donated debt at the official exchange rate of 10 Ps/$. This need not be so. In fact, since the authorities are not servicing the external debt fully, it would be surprising if they were willing to exchange it at face value for domestic currency. This is equivalent to giving 40 pesos per dollar for a donation of external debt but only 10 pesos per dollar for a donation of foreign exchange. This may not be the intention of the central bank, nor in its interest.[4]

A second cautionary remark is the domestic financing of the debt swap may have inflationary consequences. Depending on the rate of inflation already present in the economy any additional pressures may be difficult to accept by the authorities. In addition, measures that may have to be adopted to counteract the inflationary impact of the debt conversion may have adverse effects on that segment of the population that was supposed to benefit from the swap in the first place.

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[3] Notice that the foreign exchange would have to be provided on a donor basis rather than on a commercial basis as in the case of debt-for-equity swaps. A commercial bank holding claims on a country may be willing to exchange these for equity participation in a debtor-country firm because it expects to earn higher returns on the equity. The same bank would not be interested in a debt-for-health swap since it does not generate any profits for the bank. Possible exceptions to this rule would occur if there were tax advantages to the bank of agreeing to a debt-for-health donation or if it there were certain public relations reasons to enter into such swaps. In these cases the bank effectively becomes a donor itself.

[4] Note that countries have had damaging experiences with certain types of debt swaps for this reason. In terms of our numerical example, domestic residents have at times had the possibility to exchange 10 million pesos for $1 million at the central bank, use the dollars to buy debt in the secondary market for a face value of $4 million, and in a debt-for-equity deal been able to exchange this debt for 40 millions pesos worth of domestic equity. This so-called round-tripping has generated a healthy profit at the expense of the central bank, which has therefore become hesitant in agreeing to other types of swaps as well.

Thirdly, it should be recalled that a debt swap does not generate any foreign exchange for the health project, only local funds. To the extent that the project requires imported goods (vaccines, for example), the necessary foreign exchange must come from other sources. The financial authorities in the country may not be willing or able to provide that foreign exchange. In this case the projects identified for debt-for-health swaps should have a predominantly domestic-currency content.

Finally it might be pointed out that the domestic-currency proceeds of the swap would probably not be paid out directly to the authority or agency responsible for overseeing the health project. Some other way of disbursing the funds would be agreed on such as issuing government bonds to the agency or establishing a special "social fund" from which the necessary funds for the health project could be withdrawn as needed.

4. Will debt-for-health conversions increase financing for health?

In order to evaluate the desirability of debt-for-health swaps it is necessary to make a judgement as to whether they are likely to increase funding for the health sector. There are two aspects of this question relating to donor behavior and host government behavior respectively.

How likely is it that debt-for-health swaps will generate *additional* funds from donors? This is a question that is very difficult to answer. On the one hand it must be realized that different types of aid to developing countries are substitutes. If additional amounts are donated to health projects, it is likely that other sectors will obtain less. Political forces which have ties with these sectors would then organize to maintain the status quo. The outcome could then be a situation where no additional aid in terms of foreign exchange will be allocated to the health area; aid that was previously given in other forms will now simply be channelled through debt-for-health swaps. However, even if this scenario comes about, the fact that debt swaps generate larger amounts of domestic funds than other forms of aid means that greater financial resources will nevertheless accrue to the health sector.[5]

Even if traditional donors were not to increase their donations to a significant extent, it is still possible that additional resources could be generated if *new* donors could be brought in. They may be convinced to provide aid for health by the opportunity offered by the swap facilities to see a substantial increase in

[5] There is a scenario that is even less favorable for the health sector. This corresponds to the case where foreign donors have a target for the amount of recipient-country funds they are willing to give. In this case the debt swap possibility will obviously not provide any extra resources.

The secondary market for developing country debt

This is a market where it is possible to buy and sell commercial bank claims on developing countries. A bank which wants to reduce its exposure in a particular country can sell part or all of its claims to another investor. In order to do so, the selling bank has to agree to a price lower than the face value of the debt. This price is typically quoted as a percentage of the face value. For example, the table below indicates that the price of Nigerian debt was 33% in July 1990 implying that commercial bank debt of this country with a face value of $10 millions could have been bought for $3.3 millions.

Secondary market prices
(cents for $1)

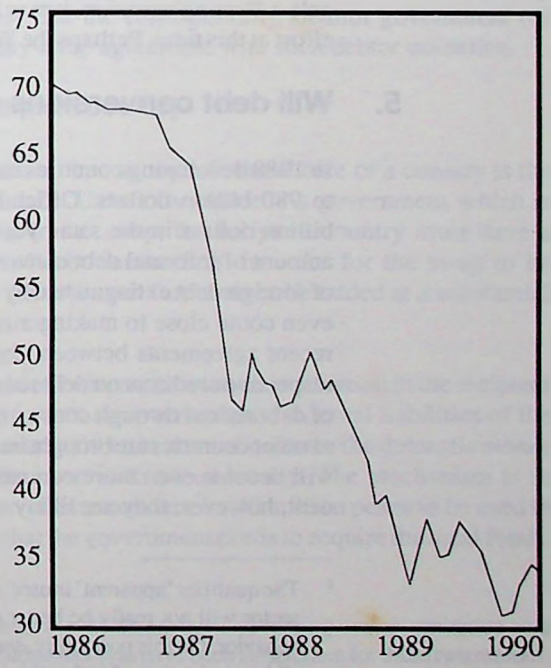
	March 1989	July 1990
Ecuador	11	16
Poland	36	14
Morocco	42	45
Nigeria	21	33

What determines the prices shown in this table? In very general terms they depend on the expectations the creditors have concerning the debt service capabilities and intentions of the debtor. For instance, the fact that Polish debt was traded at 14% in July reflected the judgement that only 14% of the contractual debt service payments will ever be settled. The fall in the price from 36% to 14% from March 1989 to July 1990 indicates that market participants have revised downwards the chances of recuperating their outstanding claims on Poland.

Judgements about the debt service intentions of a country obviously depend on its total amount of debt outstanding as well as its economic prospects. The accompanying chart indicates that as the indebtedness of developing countries has increased, the average secondary market price has fallen quite steadily. This dependence of the price on the total amount of debt can sometimes lead to a reluctance of private creditors to write off their loans to certain countries who also have a substantial amount of official debt outstanding. For if official creditors should forgive a significant portion of their claims, the value of the remaining debt would increase. For this reason, commercial creditors would like to see official debt write-offs since it would increase the likelihood that the remaining debt could be serviced more fully.

It should be noted that the secondary market for developing country debt only concerns the claims held by commercial banks. So called Paris Club debt (debt held by governments and official institutions) is not traded on this market. The reason is a reluctance on the part of these creditors to admit that their claims are worth less than their face value. This reluctance is more politically based than grounded on economic sense.

Secondary Market prices for Developing Country debt
(15 heavily indebted countries. In % of face value)



Source: *IMF, World Capital Markets*, April 1990

recipient-currency resources for each dollar's worth of aid. Additional donors may also be brought in by the apparent possibility to contribute to the solution of two problems simultaneously, namely both the debt and the health problem of the recipient country.[6]

Suppose additional funds from foreign sources are indeed made available from debt-for-health swaps. Does this automatically mean that the health sector will dispose of a larger total amount of resources? Not necessarily. The local government may simply reduce domestic resources devoted to this sector. The justification would be that the additional foreign funds have liberated scarce budget resources for other urgent uses. Without wanting to take a view on whether such actions would be likely or in the government's interest, it must be recognized that there exist forces that would push in this direction. Action should accordingly be taken to reduce their chances of success to a minimum by putting conditions on the debt swaps that attempt to bind the government to allocate a greater amount of productive resources to the health sector.

It is extremely important to realize that debt-for-health swaps are likely to provide additional funds only *temporarily*. One reason for this is that the amount of total swappable debt is only finite. In addition, many other types of debt swaps are being considered by governments and donors. It follows that recipient governments should not come to rely on these additional funds on an ongoing basis and as a consequence reduce budget allocations. If they were to do this, the health sector may be left worse off in the long run by accepting funds generated by debt swaps.

If governments can be induced to maintain their contributions to the health sector, the temporary nature of the debt-for-health opportunity may be taken advantage of to generate increased international support. By arguing that the debt swap is only a fleeting occasion, it may be possible to convince donors to make a special effort at this time. Perhaps the WHO could play a role of salesman in this context.

5. Will debt conversions solve the debt problem?

In 1988 developing countries had an outstanding volume of long-term debt equal to 980 billion dollars. Officially recorded debt conversions amounted to 7.9 billion dollars in the same year. Even if this figure does not include a certain amount of informal debt conversions and therefore understates the total volume of foreign debt extinguished by this method, it is clear that debt swaps do not yet even come close to making a substantial dent in the overall debt problem. The recent agreements between Costa Rica, Mexico, and the Philippines and their respective creditors on debt reduction and restructuring suggests that the volume of debt retired through conversions will increase in the near future. Furthermore, as other countries are brought into negotiations one should expect that conversions will become even more common. Compared to the total amount of outstanding debt, however, they are likely to remain modest for the foreseeable future.

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[6] The qualifier 'apparent' is used in this sentence to indicate the possibility that the health sector will not really be better off from the donation as a result of local government behavior. On this possibility, see the discussion below. When a donor gives $1 million, all he can be sure of is that this is the additional amount of resources made available to the recipient country. Since funds are fungible, he can not be sure what additional project these funds have made possible.

If *total* debt conversions are small relative to the outstanding debt, it is obvious that debt-for-health swaps should not be looked upon as a solution to the debt problem of developing countries. The potential scale of such swaps is simply too small. So while they have a potential for contributing significantly to the financing of the health sector, debt-for-health swaps should not be judged on their potential for resolving the larger problem of developing country indebtedness.

6. Implementation

The implementation of a debt-for-health swap requires dealing with a number of issues relating to the identification of a donor and a recipient country, the elaboration of a suitable health project, the procurement of the debt, and the establishment of a local procedure for disbursing the funds and monitoring the project. Each of these issues will now be discussed in turn with the objective of identifying the main constraints that need to be considered in each case.

a. Identification of a donor

It has already been pointed out that debt-for-health swaps can not be considered as a profit-generating undertaking. For this reason, the list of potential donors includes primarily entities that have a basically charitable or political motivation for their actions. Development agencies and charitable organizations are the leading candidates. Businesses might be a possible source of donations if they thought this would provide public relations benefits or if donations could be used to reduce tax liabilities.[7]

Some countries' debt is owned almost exclusively by governments and official multilateral institutions.[8] Since this type of debt is not traded on the secondary market, it would be necessary that the corresponding creditor government (or institution) be the donor in any swap agreement with such debtor countries.

b. Identification of a recipient country

The first factor that must be taken into account in the choice of a country is the size and type of its external debt. Unless the donor is a government which is willing to participate directly in the swap, the recipient country must have a certain amount of *commercial* debt outstanding. In order for the swap to be advantageous for the donor, the debt must furthermore be traded at a substantial discount in the secondary market.

A second important consideration is the macroeconomic situation in the recipient country. As explained above, a debt swap reduces the external liabilities of the debtor government, but it increases either its *domestic debt* or the domestic *money supply* depending on how the swap is financed locally. The mechanism is as follows. A swap of $ 1 million of external debt for 40 million pesos to be used in a local health project implies that the government needs to acquire the local funds.

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[7] An early debt swap financed the Midland bank involving water sanitation and reforestation projects in the Sudan seems to have been undertaken for these two reasons.

[8] Madagascar and Viet Nam are examples of such countries.

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It can borrow them from the public in which case the domestic government debt grows. A higher domestic debt implies greater debt service payments in the future putting pressure on the government's budget.

The alternative to acquiring the 40 million pesos by local borrowing is to resort to the printing press, in other words to create more domestic money. The consequences of such a policy would be increased demand, inflation, and balance of payments difficulties.

From this discussion it follows that countries that already have precarious budgetary situations, a potential or actual inflation problem, or a sizable external deficit are not likely to be suitable candidates for a debt swap since their macroeconomic problems could be aggravated by such an undertaking. Even if the authorities themselves were tempted to reduce its foreign debt by means of a swap, it is quite possible that the International Monetary Fund or the World Bank would oppose it in order to limit the negative macroeconomic consequences.

One consideration may make the macroeconomic constraints just mentioned less binding for debt-for-health swaps taken in isolation than for broader-based debt conversions. This is the fact that the feasible size on health projects financed in this way will be small relative to the economy as a whole. The budgetary or inflationary consequences of such swaps may therefore be minor.[9]

Related to the potentially inflationary consequences of a debt swap is the absorptive capacity of the country. If domestic resources required for the expansion of the health sector are in short supply, then this sector cannot absorb additional funds without putting pressure on costs. Little improvement in services may under such circumstances be obtained.

A final consideration is that the recipient government must be favorably disposed to the swap. The authorities may be reluctant for many reasons. They may feel that they have other more urgent spending priorities than the health sector. They may also have a different view on the debt service payments they will make than is implicit in the secondary market discount on their debt. They may for instance have little intention of paying anything even though a positive market price suggests the contrary. They may also be hoping to obtain large debt reductions through negotiations with their creditors and would therefore be unwilling to enter into smaller swap deals which would indicate a willingness on their part to make concessions in exchange for debt reductions. Furthermore, they may fear that the debt-for-health swap will drive up the price of their debt in the secondary market thereby making other conversions less attractive. Whatever the reasons for reluctance on the part of the government in a potential recipient country, there is little chance of discovering them without actually approaching the authorities with a specific proposal.

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[9] This should not be taken to mean that these consequences can be ignored in the identification of a country suitable for a swap operation mainly because a debt swap can not be treated in isolation but must be incorporated into the country's overall macroeconomic strategy.

c. Selection of a suitable health project

Several considerations must be kept in mind when a health project is chosen to be financed by a debt swap. First it should be remembered that a swap will generate no foreign exchange. Priority should thus be given to projects that require mainly domestic resources. If some foreign exchange is needed, the donor should be encouraged to provide part of his donation in the form of a debt swap, and part in the form of foreign exchange. Otherwise it is likely that the whole operation will fail because of the inability of the central bank to come up with the foreign exchange resources.

A second consideration stems from the fact that the debt-for-health swaps generate funds only on a temporary basis. This implies that only projects needing temporary funds should be financed this way or that plans must be established concerning their continued support after the funds obtained through the debt swap are exhausted.

A final constraint on a project financed by a debt swap is the fact that 5 million dollars is the minimum amount of debt that can be purchased on the secondary market while keeping brokerage fees moderate.

d. Procurement of the debt

Acquiring the debt of a country on the secondary market is best done through a broker such a commercial bank or an accounting firm with experience in the matter. The fees for such brokerage services are in the neighborhood of 0.5% of the face value of the debt. It would be prudent also to involve the broker in other aspects of the process, especially those dealing with negotiations with the recipient government and with the establishment of a disbursement and monitoring strategy for the health project. The total fee for a particular swap deal would then include also the time involvement of the broker which will obviously vary with the duties he is asked to undertake.

e. Creation of a local disbursement and monitoring structure

The donor who provides the foreign exchange for a debt-for-health swap will certainly want to have some guarantees that the local-currency proceeds from the swap will actually be used for the project agreed on, and that other government expenditures on the health sector will not be cut correspondingly. To some extent, these guarantees will have to be based on trust in the government's intentions as determined in negotiations leading up to the swap agreement. They will also be determined in part by the choice of project to be financed. But some additional safeguards should be established. One would be to take the funds generated by the swap out of the regular budget of the health ministry (which would presumably be the intermediary in the recipient country). This would imply appointing some other organization to receive the funds and to disburse them according to the requirement of the project. This organization would either receive the funds in the form of an account with a domestic financial institution or in the form of government bonds with maturities that correspond to the needs of the project.

7. The role of the WHO

The WHO could assist in the realization of debt-for-health swaps in a number of ways from providing technical assistance in identifying appropriate health projects to taking an active role in resource mobilization, negotiation with the recipient country, and monitoring the progress of the financed project. *Technical assistance* in the identification of important health projects as well as in their execution is of course already provided on a regular basis by WHO staff. The additional criteria imposed by the particular nature of debt swaps can readily be incorporated in established selection procedures.

The WHO could seek to *mobilize resources* for debt-for-health swaps in several ways. The simplest would be to encourage traditional donors to take advantage of the special opportunities offered by the swap possibilities to increase their pledges. Going outside traditional donors would require making it known that the WHO will be able to act as a conduit of funds for health projects and actively soliciting these funds. Finally one could imagine using WHO resources for the purpose of financing swap operations.

The WHO could also act as an *intermediary* to facilitate debt-for-health swaps. It could advise countries that are approached by donors and it could advise donors which would like to finance swaps. The advisory role could also be extended to the provision of disbursing and monitoring functions for the financed projects. The intermediary role could furthermore include brokerage-type services related the financial aspects of the swap operations although it should be noted that this would require expertise currently not available in the organization.[10] In addition, it would be possible to conceive of WHO as a manager of a future Debt-For-Health Fund established by member countries to channel additional resources into the health sector.

Recognizing the potential role it can play in facilitating debt-for-health swaps, the WHO has already started some work in this area. Current activities are principally those related to the promotion and advocacy of the swap mechanism among creditors, debtors, and potential donors. In collaboration with the World Bank and in consultation with the IMF the WHO is playing a limited intermediary role by giving advice both to creditors and debtors, and by providing technical assistance in the identification and formulation of projects suitable for debt for health swaps.

To assist in policy and strategy development and to review WHO activities in this area a working group on debt-for-health swaps has been established at WHO with participation from the World Bank, WHO staff, and consultant macroeconomists and financial analysts. This group has identified a number of debtor countries which could benefit from this mechanism to finance existing health projects.

[10] For this reason it is undoubtedly more cost effective to leave brokerage functions to entities which already carry them out on a regular basis. Commercial banks and accounting firms have already been identified as possibilities. The World Bank also has recently set up a Financial Advisory Unit which is able to provide technical assistance on the design of swap programs.

Preliminary exploratory contacts with these countries are underway. These countries were selected on the basis of the criteria discussed above including country requests, the amount and type of outstanding debt, feasible and available health projects, absorption capacity of the health sector, general economic situation, and the potential availability of alternative financing schemes.

For a supplementary discussion of the issue of debt-for-health swaps, see the document "Debt For Health Conversion, Analysis and Strategic Planning Coordination", Pan American Health Organization, March 1990.

World Debt Tables 1989-90, External Debt of Developing Countries, Volume 1, Analysis and Summary Tables, The World Bank and *International Capital Markets, Developments and Prospects,* International Monetary Fund, April 1990 contain data on the debt situation of developing countries and discussions of the evolution of debt management strategies.
