International Development Assistance and Health

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The Report of Working Group 6 of the Commission on Macroeconomics and Health

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Presented to
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and
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…we know enough about development policies to make a fair assessment of the quality of policies across countries and over time. We emphasize, however, that learning about development policy is an ongoing process. In fact, one of the main roles of effective aid is to support countries' learning about good policy, both drawing on existing knowledge and creating new knowledge.

—*Devarajan, Dollar, and Holmgren,*

Aid and reform in Africa, 2001

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Foreword

The Commission on Macroeconomics and Health (CMH) was launched in January 2000 by Dr Gro Harlem Brundtland, Director-General of the World Health Organization. Its mission was to analyse the impact of health on development and to examine ways in which health-related investments could spur economic development. The Commission worked to develop specific recommendations that would save lives, reduce poverty, and spur economic growth through a scaling up of investments in the health sector of developing countries. The final report of the Commission, *Macroeconomics and Health: Investing in Health for Economic Development*, was released in December 2001.

The Commission focused its work on the world's poorest people, in the world's poorest countries. Millions of impoverished people die every year of conditions that are readily prevented or treated. Technologies exist to avert millions of deaths due to malaria, TB, HIV/AIDS, diarrhoeal disease, respiratory infection, and other killers. These tragic deaths—and the enormous economic and social costs associated with them—reflect the basic fact that essential life-saving health services are out of reach of hundreds of millions of the world's poor. And yet, without extending these life-saving interventions, poverty is likely to be exacerbated and to be passed to the next generation. The economic costs of ill health, the Commission documented, are enormous and pervasive.

The findings of the Commission are both stark and also encouraging. It will take a lot of money and much more political and organizational effort than has been seen in the past generation to accomplish the tasks at hand. Curbing the HIV/AIDS pandemic, or the resurgence of tuberculosis and malaria, or major killers of children such as diarrhoeal disease and vaccine-preventable diseases, will not happen by itself. Yet the task is feasible, with breathtaking achievements possible. The Commission calculates that if the donor countries contribute around 0.1% of their GNP—one penny for every $10 of income—and if that effort is matched by a suitable increase in effort within the low-income countries themselves, it should prove possible to avert 8 million deaths per year by the end of this decade. As of 2007, the donor contribution would be around US$ 27 billion per year, or roughly four times the current US$ 6 billion in official development assistance for health. The reduction in human suffer-

ing would be enormous. The economic gains would also be striking, around the order of US$ 360 billion per year during the period 2015–2020, several times the costs of scaling up the health interventions themselves, counting both the donor and recipient country efforts.

To arrive at its conclusions, the Commission organized its research and intensive analysis mainly within six working groups, which in turn engaged the energies of a worldwide network of experts in public health, finance, and economics. Each working group held several meetings around the world, commissioned papers, debated alternative approaches, circulated drafts to the policy and scholarly community, and made detailed recommendations to the full Commission in the form of a Working Group Report. Working group members included CMH members, staff of various international agencies, and experts from governments, academic institutions, NGOs, and the private sector. The Working Group Reports, prepared by the working group co-chairs in consultation with the entire working group membership, are a synthesis of the commissioned background papers and the culmination of each working group's detailed review of the literature and intensive deliberations.

The Commission's findings are therefore based heavily on the crucial work of the six working groups, each of which was responsible for taking stock of the existing knowledge base on a particular topic in order to identify implications for policy and for extending that knowledge base as appropriate. The working groups, with their titles, topics, and chairs, are:

- Working Group 1, Health, Economic Growth, and Poverty Reduction, addressed the impact of health investments on poverty reduction and economic growth. Co-Chairs are Sir George Alleyne (Pan American Health Organization, USA) and Professor Daniel Cohen (Ecole normale supérieure, Paris, France).
- Working Group 2, Global Public Goods for Health, studied multi-country policies, programmes, and initiatives having a positive impact on health that extends beyond the borders of any specific country. Co-Chairs are Professor Richard G. A. Feachem (Global Fund to Fight AIDS, Tuburculosis, and Malaria, Geneva, Switerland) and Jeffrey D. Sachs (The Earth Institute at Columbia University, New York, USA).
- Working Group 3, Mobilization of Domestic Resources for Health, assessed the economic consequences of alternative approaches to resource mobilizations for health systems and interventions from domestic resources. Co-Chairs are Dr Alan Tait (former senior IMF

official) and Professor Kwesi Botchwey (The Earth Institute at Columbia University, New York, USA).

- Working Group 4, Health and the International Economy, examined trade in health services, health commodities, and health insurance; patents for medicines and trade-related intellectual property rights; international movements of risk factors; international migration of health workers; health conditions and health finance policies as rationales for protection; and other ways that trade may be affecting the health sector. The Chair of this working group is Dr Isher Judge Ahluwalia (School of Public Affairs, University of Maryland, College Park, USA).
- Working Group 5, Improving Health Outcomes of the Poor, examined the technical options, constraints, and costs for mounting a major global effort to improve the health of the poor dramatically by 2015. Co-Chairs for this working group are Dr Prabhat Jha (University of Toronto, Canada) and Professor Anne Mills (London School of Hygiene and Tropical Medicine, UK).
- Working Group 6, International Development Assistance and Health, reviewed health implications of development assistance policies including modalities relating to economic crisis and debt relief. It focused on the policies and approaches of international developmental agencies. One emphasis was on the appropriate balance between country-specific work and support for activities that address international externalities or provision of international public goods. The Co-Chairs are Mr Zephirin Diabre (United Nations Development Programme, USA), Mr Christopher Lovelace (World Bank, USA), and Ms Carin Norberg (Transparency International, Germany).

It is my great pleasure and honour to introduce *International Development Assistance and Health: The Report of Working Group 6*. This Report is critical to the overall findings of the Commission, since it established three important points. First, substantial increases in donor funding are necessary to achieve the aims of improved health outcomes in the poorest countries. As already noted, adequate scaling up of essential health interventions in low-income countries will require around US$ 27 billion by 2007, or approximately four times the current levels, and some US$ 38 billion by 2015. Second, more money must be complemented by improved donor-recipient mechanisms, especially mechanisms that pool resources, harmonize goals, enhance poor-country ownership of national plans, increase predictability and sustainability of needed funding, and

encourage long-term thinking. Third, there must be much more feedback from donor-supported projects to future programs, based on careful monitoring and evaluation that offers an opportunity for continuing learning and upgrading of programs. These important principles are considered in the context of ongoing donor-recipient processes, such as the Poverty Reduction Strategy Paper (PRSP) framework of the Bretton Woods institutions, the sectorwide approaches for pooling donor finance, and global funds such as the new Global Fund to Fight AIDS, Tuberculosis, and Malaria.

The Commission, together with the working groups' co-chairs and members, gratefully acknowledges the financial and technical support provided by the donor community. A particular thank you is due to the Bill and Melinda Gates Foundation, the Government of Ireland, the Government of Norway, the Government of Sweden, the Grand Duchy of Luxembourg, the Rockefeller Foundation, the United Kingdom Department for International Development, and the United Nations Foundation.

Jeffrey D. Sachs
Chair of the Commission on Macroeconomics and Health
August 2002

Preface

Working Group 6 embarked on the preparation of this Report with great enthusiasm, welcoming the opportunity to contribute to the now energetic debates about how best to structure and ensure increases in the flow of development assistance for the health sector. We would like to express our appreciation to the Commissioners and to those financing the activities of the Working Groups for this opportunity. Preparation of the Report brought together a range of questions on the overall levels of development assistance in the health sector, and especially its effectiveness, that we believe were long overdue. Although we believe our efforts have yielded an important initial consideration of these issues, we believe that we have just begun to scratch the surface. Several issues deserve further deliberation on the part of both donor and recipients of assistance in this sector as we move forward. We would like to point to three questions that emerged from the work reported here as issues for future analysts of development assistance and effectiveness to consider:

Is the volume of development assistance for health the central issue? As documented in Chapter 2 of the Report, it is clear that although overall levels of assistance are slowly growing, the amounts available are pitifully small relative to estimated costs of improving health outcomes. But although the Working Group concludes that there is an urgent need for additional resources and welcomes news of the establishment and initial operations of the Global Fund to Fight AIDS, Tuberculosis, and Malaria as a step in this direction, we are also struck by the need for a great deal more focus on the mechanics of assistance. As discussed in the concluding sections of this Report, we are especially concerned that future analysis of development assistance focus more sharply on the reasons for, and especially specific interventions for easing, so-called absorptive capacity. This line of inquiry is likely to lead future analysts towards a more explicit and detailed analysis of the transactions costs that constrain absorption of assistance, and to the identification of organizational and institutional development interventions that expand absorptive capacity at the country level.

How should donors evaluate their performance in knowledge transfer and technical assistance? The Working Group recognized early in its deliberations that there is an urgent need to understand better the factors

that influence effectiveness in the transfer of "intangibles"—knowledge and ideas through development assistance. It is increasingly evident that familiar approaches to the provision of "technical assistance" are a source of considerable frustration to donors and recipients alike. On the one hand, recipients appreciate exposure to experience and global knowledge; on the other, it is increasingly clear that basing the provision of this support on an expert/trainee paradigm undercuts ownership and adoption. As the global information revolution unfolds, we believe the development assistance community should find ways to structure and support more effective cross-country exchanges of experience, particularly of results of interventions, and to ensure that recipients are recognized as peers in the process of knowledge transfer. A more open and transparent approach to the review, and especially evaluation of development assistance projects and programmes, is an important step in this direction.

Are donor agencies willing to strengthen the analysis of the efficiency of development assistance? As detailed in Chapter 2 of this Report, the Working Group was frankly dismayed to learn how constrained information is on levels, forms, and objectives of development assistance. It is evident to us that all members of the donor community must work to enhance the clarity and transparency of their work, starting with harmonization of classification schemes and improved reporting on disbursements. Beyond this, the Working Group was frustrated in its efforts to learn more about the factors that influence the efficiency of development assistance. Detailed comparative data on donor agency staffing, location, business processes, and decision making is simply not available, which inevitably inhibits the depth of any discussion of "reforming the architecture" or improving the efficiency of development assistance. The recent shift towards programmatic and budget support and the need to promote country ownership signal a need for strategic consideration of the allocation of always-constrained administrative budgets within donor agencies.

Zephirin Diabre, Christopher Lovelace, and Carin Norberg
New York; Washington, DC; and Berlin
August 2002

Acknowledgements

This Report synthesizes the findings and recommendations of Working Group 6 (WG6) of the Commission on Macroeconomics and Health (CMH), which addresses as its critical issue the questions "*How much, and what forms of development support are needed to improve health outcomes for the poor?*"

Complementing the work of several of the other CMH Working Groups, WG6 sought to clarify the issues that non-health specialists, particularly macroeconomists and staff of Ministries of Finance and Planning, consider in managing development assistance to achieve health sector goals. It focused on describing current patterns in the level of development assistance in health and on the effectiveness of various forms of developmental assistance and their interactions with country policies, players and priorities. Its work aimed to clarify the factors, at country as well as donor levels, that inhibit or facilitate the translation of policy objectives and resources into actions designed to improve health sector performance and/or health outcomes on the ground—assessing the degree to which DAH is doing the right thing and doing things right.

The Working Group met several times and shared its findings and emerging recommendations with other Working Groups and members of the Commission in meetings in Addis Ababa (March 2001), Mexico City (June 2001), and Geneva (August 2001). This Report synthesizes the findings and recommendations that emerged from this collaborative effort. The Report was prepared by Susan Stout (World Bank) and Bjørn Ekman (SIDA, Swedish International Development Cooperation Agency) under the leadership of Working Group 6 Co-Chairs James Christopher Lovelace (World Bank), Carin Norberg (Transparency International), and Zephrin Diabre (United Nations Development Programme). The draft report was reviewed by an anonymous reviewer identified by the World Health Organization and by all members of Working Group 6 in November 2001. The Working Group would like to thank Meta de Coquereaumont of Communication Development Incorporated for editing the Report.

1. Introduction

As part of an overarching review of the relationship between health, economic development, and poverty the Commission on Macroeconomics and Health asked Working Group 6 to examine development assistance policies in the health sector. Its review focused on answering two questions: How much development assistance is needed, and what form should it take, to improve health outcomes for the poor? The Working Group tried to determine whether current levels of development assistance for health are adequate to the task of improving health outcomes for the poor and to derive lessons for increasing the effectiveness of the resources available for development in the health sector.

These two questions were explored through a series of commissioned background papers (see Annex 2) and consultations with key players in the design and implementation of development assistance for health, from donor agencies to civil society, health professionals, and stakeholders from partner countries (see the terms of reference for Working Group 6 in Annex 3). The review also drew extensively on the findings and recommendations of the other Working Groups and on an extensive review of the literature on the effectiveness of development assistance for health and the impact of structural adjustment on health outcomes, among others.

1.1 Three messages for the development community

Three primary messages for the international development community emerged from this collaborative process: more financial resources, improved effectiveness of resources, and greater learning from experience are all necessary to accelerate progress towards improved health.

1.1.1 More financial resources

Significant additional resources are needed to respond to today's major public health challenges and the diseases of the poor. Based on results of Working Group 5's estimates of the costs of scaling up proven heath interventions and considering current and projected levels of development assistance for health, Working Group 6 concludes that the donor community should work to increase the amount of assistance from about US$ 6.7 billion annually today to about US$ 27 billion annually by 2007 and US$ 38 billion annually by 2015.[1]

These amounts, although large compared with today's level of commitment, are inadequate for current and projected levels of demand. Increased allocations for health are an investment in global health that carries an economic return. Working Group 1 has shown that reducing disease burdens increases the potential for economic growth, benefiting the entire international community through increased markets for products and consumption. Increased resources for health and subsequent reductions in the disease burden will also contribute to sociopolitical stability and democratic development in the affected countries, since disease and poor health are threats to human development in all its dimensions.

1.1.2 Improving the effectiveness of resources at donor and country level

Although necessary, simply mobilizing additional development resources for health will be far from sufficient to support achievement of the health-related Millenium Development Goals. Providing additional resources without an explicit focus on the factors that constrain the disbursement and effectiveness of funds already available or that lead to the diversion or leakage of funds will ultimately result in frustration and backlash.

The number of agencies active in the provision of assistance has grown substantially, resulting in a proliferation of transaction costs that countries must bear to access and absorb available assistance. Large increases in health assistance over a short period of time without fundamental reforms to current management structures at the donor and country level will risk continued inefficiencies, delivery failures, and ultimately, unnecessary delay in the reduction of avoidable death and disease among the poor.

Finding ways to channel significant new financial resources to health problems while simultaneously building capacity is the core challenge for developing country governments and their donor partners. Money can help overcome a range of problems, including the infusion of new and more effective leadership and management, but money is no substitute for the hard and time-consuming work of building organizational and institutional capacity. Donors and partner governments also need to look at actions from both a short-run and a long-run perspective and commit themselves accordingly. Achieving better health outcomes involves risk taking and greater trust in the willingness and capacity of developing country partners.

1.1.3 Learning more from experience

Although there is little question that development assistance for health often plays a catalytic role in changing health status or reforming health systems, it is also evident that neither donor agencies nor countries are doing enough to learn from their experience. Knowledge of what works in the sector is crucially important. Addressing public health challenges requires significant investments not just in physical infrastructure, but also in research and in monitoring and evaluation that encourage rapid generation and dissemination of knowledge about how to achieve results.

Donor agencies and countries must find ways to accelerate the development of intellectual capital in sectoral management. The mobilization of global and national institutional capacity to gather and use evidence of the results of development assistance to improve technical and allocative efficiency would be an important step in easing absorptive capacity constraints and improving accountability in the health sector.

1.2 An information vacuum

The analysis for this Report was guided by a conceptual framework that provides a useful heuristic for thinking about the many possible pathways through which external assistance might strengthen health systems or influence health outcomes in other ways (see Annex 4).

In seeking to organize information on levels and trends in the amount and form of development assistance for health, Working Group 6 found little definitive analytic or empirical work on either the quantity or the efficiency and effectiveness of development assistance in the health sector.

Although there are solid order of magnitude estimates of the amount of foreign assistance flowing into the health sector, there is no simple agreed system for classifying official development assistance across possible subsectors within the health sector or across agencies. And although the Organisation for Economic Co-operation and Development (OECD), especially through its Creditor Reporting System, has worked hard to improve the accuracy and regularity of reporting at the global level, both remain weak at national and subnational levels. Donor agencies themselves are often in the dark about much of what their assistance is doing in the sector. Information problems are compounded at the country level, since governments need to interact with multiple agencies of various sizes, each with different reporting and procedural requirements, fiscal years, personalities, and other characteristics.

Beyond the resulting complexity and information vacuum, Working Group 6 found a remarkable absence of empirical information on the efficiency and effectiveness of development assistance for health.[2] There are, of course, many cases where development assistance for health has contributed to improvements in national and local health policies and programmes and to better health outcomes. A study of the long relationship between Sweden and Viet Nam, commissioned by WG6, provides a case in point (Jerve et al., 2001). Nevertheless, solid empirical evidence enabling the drawing of a clear causal line from donor input to outcome is rare. Self-critical analyses of the effectiveness of ways of doing business in the sector are also rare and tend to concentrate on prospective analyses of what might happen through the injection of new resources rather than on retrospective analyses of what went well, or not so well, when resources were made available under particular circumstances.

1.3 The consultation process

Working Group 6 sought two kinds of consultations to buttress its analytic work. It met with officials and staff of selected agencies to identify factors that influence donor decision making on the allocation of resources to health (relative to other sectors) and, within the health sector, allocations to specific purposes and modalities of assistance. The Working Group also sought to document how different agencies evaluate the effectiveness of external assistance and the cost factors influencing the effectiveness of their work.

These consultations were implemented through a series of interviews with staff (largely non–health specialists) of a sample of multilateral and bilateral agencies (see WG6 background paper 2 by Nelson and WG6 background paper 4 by Ojermark). Members of the Working Group also attended the World Health Assembly 2001 and joined in the many discussions of the Global Fund for HIV/AIDS, Tuberculosis, and Malaria (GFATM) initiated in the fall of 2000 in advance of the Okinawa meetings of the G8.[3] Findings from these discussions are incorporated in the exploration of the levels of and effectiveness of development assistance for health (Chapter 2).

The Working Group also organized consultations with stakeholders (government, civil society, and other groups) in selected countries on the relevance, effectiveness, and efficiency of various forms of external assistance. Two events were key to this process.

First, Working Group 6 was represented at the People's Health Assembly (http://www.pha2000.org), a global meeting organized by a

group of progressive civil society and nongovernmental activists. More than 1500 activists from over 94 countries met to renew calls for international commitment to the Health for All goals articulated in Alma Alta in 1978 and to launch a major critique of current international development policies, in particular those of the World Bank and the World Health Organization (WHO), and the health impacts of the policies of the World Trade Organization (WTO) and the Trade-Related Aspects of Intellectual Property Rights (TRIPs) agreement. Working Group 6 organized a discussion on the challenges of development assistance for health, which led to a review of the literature on the impact of structural adjustment on health outcomes (see WG6 background paper 6 by Breman and Shelton) and to important insights on participation in decision making on development assistance for health.

A second country-level consultation was hosted by Ghana's Ministry of Health in Accra in April 2001. In addition to officials of the Ministry of Health, the meeting included representatives of Ghana's large and active network of nongovernmental health service delivery organizations, civil society, the private sector, and representatives from the health sectors of Kenya, Uganda, and Zambia. The conclusions and recommendations from this meeting are incorporated in Chapters 3 and 4.

This Report synthesizes the findings from these sources, focusing first on what was learned about the levels and sources of development assistance for health, how that assistance is allocated within the sector, and what forms it takes. It then looks at what was learned about aid effectiveness and the issues that donors and countries alike must face as they plan on the future of development assistance for health. Building on work by Working Group 5, the Report presents a rough estimate of how much development assistance for health will need to grow to address current and emerging public health priorities. It also presents some thoughts on how these flows might best be structured and organized to address the constraints to greater effectiveness.

2. Amounts, Allocations, and Actors in Development Assistance for Health

Working Group 6 reviewed evidence on trends in the amount and form of development assistance for health from two sources. First, in a paper presented to the Commission and Working Group in November 2000 (WG6 background paper 10), the OECD provided an overview of broad trends in official development assistance (ODA). These data do not include resources from the multilateral development banks and several major UN agencies, nor can the data be disaggregated by recipient country or form of assistance.

Working Group 6 therefore commissioned an analysis of current patterns of assistance, constructed from analysis of formal reporting to the OECD and its Creditor Reporting System, supplemented by questionnaires sent to all major donors in the health sector, including multilateral development banks (WG6 background paper 1). This provided a slightly more refined picture of how development assistance is allocated within the health sector. The present Report refers to these more complete data on development assistance for health as *DAH*. In addition to ODA, it includes lending and credits from multilateral development banks, and, as feasible, transfers from major foundations (see Box 2.1 for definitions of ODA, DAH, and related terms).

This chapter looks first at broad trends in the flow of ODA (exclusive of support from multilateral banks and several UN agencies) to the health sector, building on OECD data, and subsequently presents a more disaggregated picture of current levels and forms of DAH, building on analysis commissioned by Working Group 6.

2.1 Amounts of Development Assistance for Health: ODA and DAH

Although overall ODA has decreased since the end of the Cold War in the early 1990s, DAH has been increasing in recent years. Total DAH, less private foundation sources, reached some US$ 6.7 billion a year in the late 1990s (Table 2.1), with the annual growth rate averaging 3.3% over the period and continuing to grow after 1998.

Box 2.1 Definitions and data sources

ODA and DAH. *Official development assistance* (ODA) is defined by the Development Assistance Committee (DAC) of the OECD as grants and loans to countries and territories on Part I of the DAC list of aid recipients (developing countries), which are undertaken by the official sector, with promotion of economic development and welfare as the main objective, on concessional financial terms (if a loan, with a grant element of at least 25%).

ODA to the health sector is the largest component of development assistance for health (DAH). DAH is broader than ODA. It includes nonconcessional loans provided by the World Bank and regional development banks to developing countries and funds from private foundations and NGOs (own funds) that contribute directly to the promotion of development and welfare in the heath sector in developing countries.

Governments provide ODA through two major channels: as direct bilateral aid, through transactions directly with partners in developing countries (mostly developing country governments, but also local or international NGOs); and through multilateral organizations—the UN family: the World Health Organization (WHO), Pan-American Health Organization (PAHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), and the United Nations Development Programme (UNDP) are the most important players in the health sector; the development banks: the African Development Bank (AfDB), the Asian Development Bank (ADB), the Inter-American Development Bank (IADB), and the World Bank; and the European Community (EC).

Commitments and disbursements. *Commitments* are funds that are set aside to cover costs for a project, which most often spans several years. *Disbursements* are funds actually expended. Total amounts initially committed for a given project may differ from amounts actually spent, because funds that were committed may be canceled, reduced, or increased during the project lifetime.

Most agencies routinely report commitments made each year, but only a few report disbursements. This is why the analysis here is based on commitments rather than disbursements. Commitments tend to fluctuate from year to year. To minimize the impact of yearly fluctuations, estimates reported in this study are yearly averages over a period of three years (1997–1999).

Table 2.1 DAH by agency (millions of US dollars, 1997–1999 average)

Source of funds	Amount
Multilateral agencies	4 121
United Nations System	1 493
WHO[a]	864.2
Regular budget	406.1
Extrabudgetary funds	458.1
PAHO[b] (own funds)	136.0
UNICEF[b]	275.8
UNFPA[b]	197.5
UNDP[b]	132.9
IARC[b]	22.1
Development Banks	2 031.0

World Bank	1 345.80
IDA	722.0
IBRD	535.4
Inter-American Development Bank (IADB)[c]	245.7
Asian Development Bank (ADB)[d]	287.7
African Development Bank (AfDB)[d]	151.4
European Commission[d]	597

Bilateral agencies (country)	**Health**	**Population**	**Total**
	1 982.4	***577.5***	***2 559.0***
United States	535.8	385	920.8
Japan	338.6	21.2	359.9
United Kingdom	267	19.3	286.3
Germany	118.6	65.7	184.3
France	128.4		128.4
Netherlands	80	21.5	101.4
Australia	64.8	14.9	79.6
Sweden	58.7	20.4	79.1
Spain	72.9	1.9	74.8
Belgium	58.8	1.7	60.5
Norway	41.3	15.1	56.4
Denmark	48.1	0.9	49
Austria	48.9	0.1	49
Canada	22.6	6.1	28.7
Italy	20.6	1	21.6
Switzerland	17.2	0.7	17.9
Finland	16	1.2	17.2
Luxembourg	16.2	0.5	16.7
Ireland	10.4		10.4
Portugal	8.6	0.1	8.7
Greece	5.8		5.8
New Zealand	3.1	0.2	3.3
Total			6 680

a. Details of international health programme costs for 1998–1999 (actual disbursements).
b. Estimates provided by agency for 1997; more recent years were not available.
c. Average of commitments for 1998 and 1999.
d. Average commitments 1997–1999. Includes ADB, JSF, ADF, and OCR.

Sources: World Bank, IADB, ADB, and AfDB databases; all other bilaterals: from DAC online database; EC, Overview of EC's Health, AIDS and Population Portfolio in Developing countries (1990–1999); United States, USAID database; United Kingdom, Department for International Development (DFID) database; all other bilaterals, DAC on-line database.

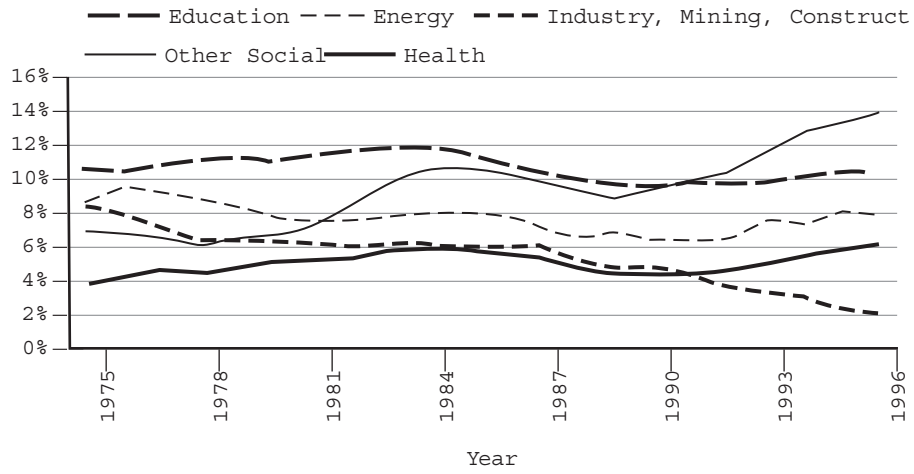
Although the precise figures should be viewed with caution, the orders of magnitude and relative shares of the distribution of ODA and the current direction of DAH can be seen clearly.

- ODA for health has increased steadily since 1975 (Figure 2.1), at an average annual growth of 3% in real terms. Despite a marked decline in total ODA since 1992, aid to health has continued to grow, averaging close to US$ 3.5 billion a year during 1996–1998.
- Approximately 7% of total bilateral and multilateral official development assistance (ODA) has been directed to health during the most recent years.

A more disaggregated consideration of the allocation of DAH (ODA plus UN and multilateral bank contributions) is useful in interpreting the implications of trends. Tables 2.2 and 2.3 show that DAH has increased from the low levels of the 1980s, averaging some US$ 6.7 billion a year between 1997 and 1999. (Data were averaged across 3-year periods to allow for the lumpiness of year-on-year changes in allocations.)

Overall DAH continues to come primarily from public sources (93% from bilateral agencies, multilateral banks, and UN agencies in 1990 and 89% today) and to go primarily to public agencies in recipient countries (Figure 2.2) But smaller private agencies, including international NGOs and foundations, continue to provide a significant proportion of assistance, often working at a much smaller scale with a long-run view towards opportunities for replication and scaling up.

Figure 2.1 Aid to health as a share of total ODA 1973–1998: 5-year moving average



Source: Development Assistance Committee data.

Table 2.2 DAH: Allocations by country income group and source, average 1997–1999[1] (in US dollars)

	Development Banks (all)	WHO	Bilaterals	UNICEF	Total DAH
Low-income	1 080 237	152 670	1 717 700	155 227	3 105 834
Lower middle	367 827	60 005	873 151	33 188	1 334 171
Upper-middle	487 554	17 509	100 237	4 314	609 614
Total	1 935 618	230 184	2 691 088	192 729	5 049 619

1 WG6 country database. The country database includes all funds that were allocated to individual countries for the following agencies: WHO, UNICEF, WB, IADB, ADB, AfDB, all bilateral agencies as reported to CRS. For those agencies total exclude funds allocated to regions, or funds for which the destination was not specified. The country database does not include agencies for which overall estimates but no allocations by country were available. These are: PAHO own funds, UNFPA, UNDP, IARC, and the EC.

Table 2.3 DAH by level of socioeconomic development: annual average commitments 1997–1999 of bilateral agencies, development banks, WHO, UNICEF

Level of economic development[1]	Population (millions)	DAH (millions)	DAH/capita
Least Developed	643	1 473	2.29
Other Low Income	1 777	1 666	0.94
Lower Middle Income	2 126	1 300	0.61
Upper Middle Income	564	610	1.08
High income	858	2	0.00
Total	5 969	5 052	0.85

1 Classifications are those used by the World Bank to classify countries by income.

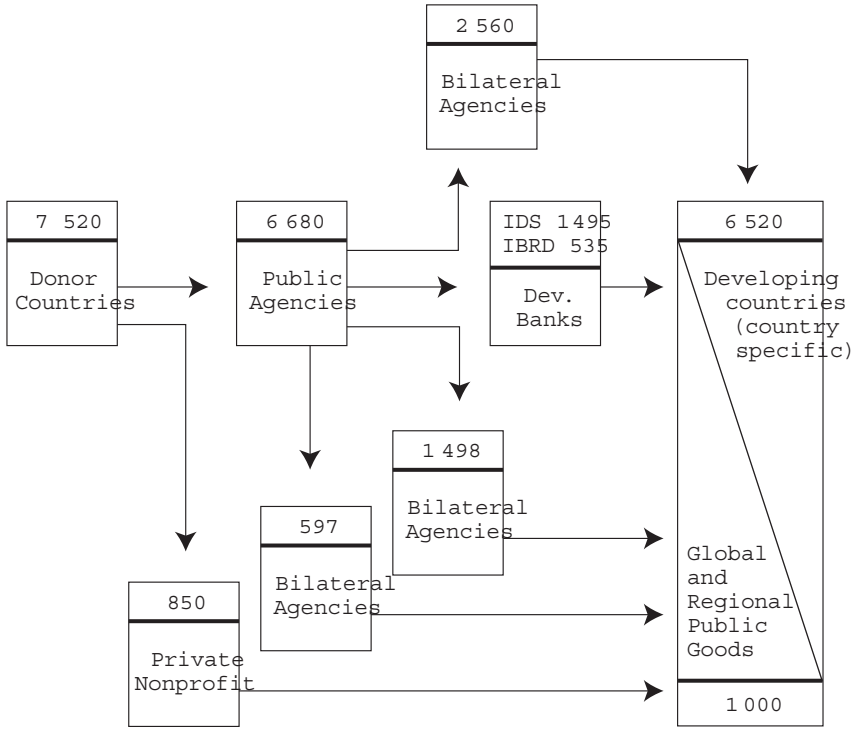
Source: Michaud, C. WG6, Background Paper 1. Data provided by AfDB, ADB, IADB, WB, WHO, UNICEF, DFID, USAID OECD CRS database for all other bilateral agencies

Sixty-two per cent of DAH from public sources only, or 54% of DAH and private foundation resources, comes from multilateral agency contributions, including lending from the IBRD and regional development banks. The remainder is allocated by a large number of bilateral agencies, with the United States providing the largest share.

2.2 How is development assistance for health allocated?

Working Group 6 also examined the allocation of development assistance for health by region, income level, and health objectives, within the limitations of the data.

Figure 2.2 Development assistance for health (DAH) average yearly commitments, 1997–1999 (millions of dollars)

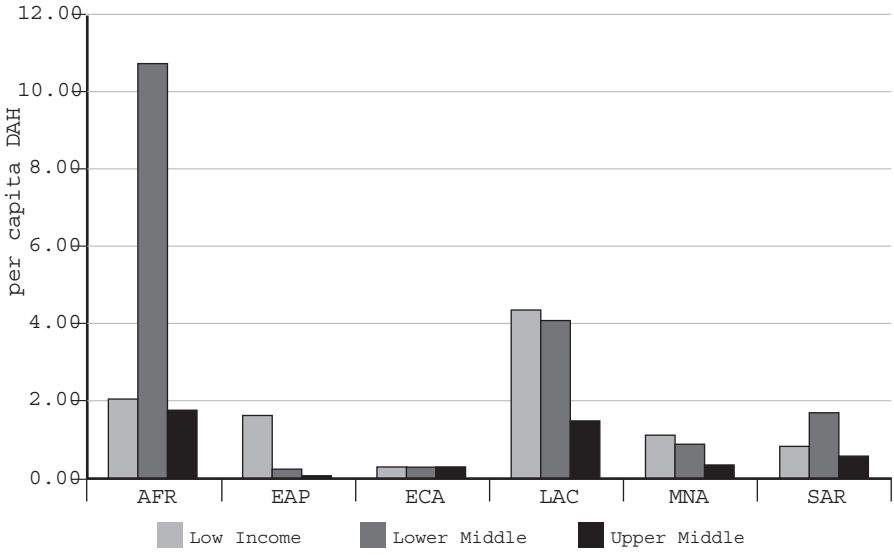


2.2.1 Allocation by region and national income level

The allocation of DAH is broadly higher in Africa and among lower-income countries, suggesting that allocations in the health sector are oriented to the poor (see Figure 2.3). This is confirmed by the allocation of DAH across country income groups (see Table 2.2). DAH allocations are largest for the least-developed (as defined by the UNDP) low-income countries, at approximately US$ 2.29 per capita, followed by US$ 0.94 per capita among other low-income countries and US$ 0.61 among lower middle income countries (the share rises slightly, to and US$ 1.08 per capita, among upper-middle-income countries).

The same pattern of concentration on countries with the least resources is evident in the allocation of DAH among countries classified by current public and private health expenditures (see Table 2.4). About 47% of DAH is allocated to countries that spend less than US$ 20 per capita on health and about 28% to those spending less than US$ 40 per

Figure 2.3 DAH: Distribution by region and level



capita. The overall amounts of DAH are nevertheless very small, amounting to less than US$ 1 per capita even in countries with low total expenditures.

The work of the Commission on Macroeconomics and Health focuses primarily on lower-income countries. But it is important to look at the amounts of DAH going to middle-income countries as well, in order to examine whether DAH should be withdrawn from middle-income countries to concentrate more heavily on the problems of the poor in low-income countries. Even if that were politically and administratively feasible, reallocating all forms of DAH from middle-income to low-income countries by 2005 would reduce the resource gap only slightly. Such a reallocation would be controversial both politically and from a technical and health policy perspective, since several middle-income countries face public health risks with potential externalities beyond their borders and should continue to qualify for health assistance.

A major implication of the distribution of DAH by country income level is that policy-makers need to concentrate on overall levels and trends on the resource mobilization side of the argument, rather than on a trade-off between middle- and low-income countries. The central concern will

Table 2.4 DAH to countries by current per capita health spending, average annual commitments, 1997–1999

Current per capita health spending	Average health spending per capita (unweighted average)	DAH per capita (US dollars)	Total DAH	
			Amount (billions of US dollars)	Share of total (%)
$0–$20	12.6	0.91	2.12	47
$21–$40	30.3	0.95	1.28	28
$41–$60	51.5	2.22	0.45	10
$61–$100	80.4	1.08	0.14	3
$101 and above	776.9	0.28	0.55	12
Total			4.54	100

Note: Includes bilateral agencies, development banks, WHO, UNICEF.

Source: Data provided by AfDB, ADB, IADB, WB, WHO, UNICEF, DFID, USAID; OECD Creditor Reporting System database for all other bilateral agencies.

be to persuade key stakeholders in donor countries to allocate increased resources generally and to DAH specifically.

2.2.2 Allocation by health objective

Estimating the allocation of DAH across all diseases and health problems proved impossible for several reasons. First, the OECD Development Assistance Committee and Creditor Reporting System databases do not include disease-specific categories, and several bilateral agencies report that projects have multiple components that cannot be attributed to specific diseases. Similarly, the European Commission does not provide sufficient detail for such a disaggregation. Moreover, donor agencies do not have an agreed framework for classifying allocations across functional dimensions, making it impossible to describe systematically the content of assistance directed at, say, "health system strengthening" or "systems development". Also, definitions for particular public health issues change over time. For example, the definition of *population policy* has expanded broadly since the 1994 United Nations International Conference on Population and Development in Cairo to include not only family planning but also reproductive health and sexually transmitted diseases, including HIV/AIDS.

Thus the analysis by health problem or objective is limited to agencies that completed a questionnaire developed for this study or that otherwise provided sufficient information. These agencies are WHO,

UNICEF, multilateral development banks, Department for International Development (DFID), and USAID.

Country-specific activities were divided into four categories: disease-specific projects and programmes, systemic support to the health system, family planning and reproductive health, and a residual (other country-specific) category:

- *Disease-specific activities.* Of an estimated US$ 1.7 billion to support disease-specific activities, US$ 337 million (20%) was for HIV/AIDS, including sexually transmitted diseases; US$ 250 million (15%) for vaccine-preventable childhood diseases; US$ 180 million (10%) for maternal and perinatal conditions; US$ 87 million (5%) for malaria; US$ 81 million (4.5%) for tuberculosis; and US$ 47 million (3%) for noncommunicable diseases. The balance of approximately US$ 660 million (40%) was reported as "other" disease-specific activities.
- *Family planning and reproductive health.* An estimated US$ 660 million of total DAH was allocated to family planning and reproductive health programmes.
- *Systemic support.* An estimated US$ 875 million went to the systemic support of health systems, US$ 254 million (29%) of it to primary health care and US$ 148 million to secondary and tertiary care.
- *Technical assistance and administrative costs.* Approximately half the funds for technical assistance for which data were available (approximately US$ 1 billion) went to support the transfer of ideas and knowledge, and the other half the transfer of equipment (drugs, vaccines, contraceptives, other supplies, and local institutional capacity building).

2.3 Where does development assistance for health come from?

Resources for development assistance for health come from many different sources and through many different channels.

2.3.1 Traditional and new actors

Governments, with tax payer money, in the European Union, Japan, North America, and the Nordic countries are the primary source of funding for development assistance for health. Substantial funds are also raised through voluntary contributions in those countries. Recently, private foundations have been contributing an increasing and significant amount of resources for international health concerns. All these sources are likely to remain (and new ones may emerge) over the coming 5 to 10 years, and

this will have an important impact on the future financial architecture in global health. It also means that more partners are learning to cooperate at both global level and country levels.

The entry of significant new sources of funds from private philanthropy is an important new development. Although Working Group 6 does not have detailed data on the levels or forms of foundation contributions, data from a review of international grantmaking (Renz and Samson-Atienza, 2000) estimate that philanthropic contributions to international activities totaled about US$ 508 million in 1994, with about US$ 67 million or 13% going to health activities of all types. Overall international giving grew to US$ 679 million in 2000, with about US$ 109 million or 16% allocated for health purposes of all types.

Although small relative to ODA and DAH, foundation giving can serve as the sharp edge of the wedge in support of innovation in health policies and programmes, thus playing a strategic role far beyond that suggested by the volume of giving. In the 1960s and 1970s for instance, grants from the Ford and Rockefeller Foundations led the way in supporting the establishment of research and academic training centres that turned out many of today's public health leaders. Their support of the establishment of key technical agencies, such as the Population Council or schools of public health and medicine, in a number of countries was a major contribution to the intellectual capital of the health field. The Packard Foundation today is focusing resources on a set of countries that larger donors are unable or unwilling to support for geopolitical reasons and is also supporting the development of a new generation of leaders in public and reproductive health.

The entry of the Bill and Melinda Gates Foundation, now endowed at more that US$ 20 billion, represents a major ramping up of philanthropic capacity in the sector. The Gates Foundation has given more than US$ 2.2 billion to a wide range of initiatives since 1995 (see Table 2.5) and currently has the capacity to provide some US$ 500 million a year. Several other new entrants, including the United Nations Foundation, are a further significant new DAH resource. Links between sources of official development assistance and private philanthropy are also growing, either through direct contributions (as in the Gates Foundation's role in the establishment of Global Alliance for Vaccines and Immunization (GAVI) or indirectly through cooperative work on shared programmes at national and global levels.

Table 2.5 Bill and Melinda Gates Foundation annual giving, 1995–2001

Year	Amount (US$)	Number of grants	Average size of grants
1995	$1 750 000	2	$ 875 000
1997	$2 957 200	3	$ 985 733
1998	$152 239 193	34	$ 4 477 623
1999	$1 219 957 173	71	$17 182 495
2000	$ 685 570 588	72	$ 9 521 814
2001	$ 233 679 271	13	$17 975 329
Total	$ 2 296 153 425	$195	$51 017 994

Source: Author's correspondence with Bill and Melinda Gates Foundation

2.3.2 Channels of development assistance for health

Donor government allocations to DAH are channelled in a variety of ways: directly to partner governments; through the UN system; through NGOs working at country, regional, and global levels; and through various global initiatives involving several stakeholders. Most of the agencies and organizations involved have their own policies and regulations. This proliferation of actors and channels for DAH implies a strong need for careful coordination of actors at all levels—global, regional, and national—made all the more important because the objectives and interests of these actors are not always the same. That proliferation also calls for careful analysis when assessing the functions and effectiveness of the current system for financing DAH.

The last few years have seen an increase in the number of global initiatives for health. This has led to a gradual unification of the guiding principles for managing health funds in a number of health areas, such as vaccine development and immunization, malaria control, and tuberculosis-related interventions. It has also led to a proliferation of disease-specific initiatives that have vastly increased the size of the global health management and funds channelling system.

This proliferation of channels of funds may have increased the accompanying administrative costs for managing DAH. For example, the cost of channelling funds from donor governments through national agencies to the multilateral system is estimated to reduce the funds available for direct health interventions by some 17%, excluding any additional overhead arising from the use of funds by the multilateral organizations. Likewise, the average donor-funded health project leaves less than 50% of available funds for what are normally termed *project costs*—capital costs

of infrastructure and equipment and recurrent costs for drugs and materials, but excluding technical assistance (authors' estimate).

2.4 Forms of development assistance for health

There has been a clear change in the forms of development assistance for health over time. The objectives have shifted from single-purpose efforts to control particular diseases or to improve, for example, family planning programmes to efforts to expand health system capacity and strengthen national health policy frameworks through systemic reform and global initiatives for improving disease control.

There are also important variations in the mode of development assistance for health, with more donors allocating more resources to programmatic and adjustment-style lending and moving away from highly specific project-based approaches.

It is difficult to describe variations in development assistance for health beyond the most superficial categorization of objectives. However, an estimated 65% or more of resources in the sector (across all categories of objectives) are allocated for physical goods (civil works, pharmaceuticals, medical equipment and supplies), 10 to 15% for technical assistance and training, and the remainder for a range of (ideally incremental) recurrent expenses.

A small proportion of assistance is allocated for policy research and evaluation at the country level and for other economic and sectoral analysis, most of it done by donor agency staff or consultants. Working Group 6 was unable to derive an adequate picture of similarities and differences among donor agencies in the distribution of resources across overhead and programmatic uses, including the proportion allocated to policy advice and in-country management.

2.4.1 Global initiatives

Throughout the history of development assistance in health, much of the interventions have been channelled through disease-specific health interventions targeted at eradicating or reducing the prevalence of a single disease. The most successful of these initiatives is probably the complete eradication of smallpox, which began in the 1960s.

Targeted disease-control programmes often have short- to medium-term perspective and have often been relatively successful in achieving their stated targets. Some observers worry, however, that these targeted programmes sometimes ignore the need for systematic and coherent approaches to health sector development. Notwithstanding this concern,

there are strong indications that these programmes have generated positive systemic effects in developing skills in management and programme planning, and in establishing rational case management principles.

In recent years, a new generation of disease-control programmes, in which malaria and tuberculosis are among the targeted diseases, has been launched. The Global Alliance for Vaccines and Immunization (GAVI) is strengthening the already-existing Expanded Program on Immunization, which has shown signs of weakness as donors have tried to withdraw from its support. HIV/AIDS is also getting increased attention as the pandemic is getting worse.

The collaboration between sectorwide approach models of aid implementation and specific disease-control programmes must be based on dialogue and partnership. Ways need to be explored in which each approach reinforces the other for optimal results. At the same time, disease-control programmes and global health initiatives should reduce their emphasis on global or regional targets to allow more flexibility in choice and priority setting at country level. The model for Integrated Management of Childhood Illness (IMCI) may be an example of how disease-control activities can be designed to facilitate integration with wider health sector development programmes.

2.4.2 Global public goods

One consequence of globalization in the health sector is the realization that major health threats such as the HIV/AIDS pandemic, the rapid increase in microbial resistance, the emergence or reemergence of infectious diseases, the harmful health effects of environmental changes, and biological terrorism are no longer confined within national borders. Working Groups 2 and 4 of the Commission on Macroeconomics and Health have contemplated how to define and create incentives for the provision of global public goods.

The largest share of ODA has traditionally supported country-specific activities. As world integration increases, so does the importance of providing more funding for regional and global public goods, defined as commodities, services, and resources that benefit regions or even the world. Using data averaged over 1997 through 1999, only about 13.3% of estimated DAH (US$ 1 billion) was committed to the development and provision of global public goods in the health sector. Multilateral agencies (WHO and the World Bank) committed an average of US$ 460 million a year, the Gates Foundation US$ 461 million, and other bilateral and UN agencies provided the rest.

This contrasts sharply with other estimates of financing for health-related public goods that Working Group 6 was able to identify. The World Bank's annual report *Global development finance*, for instance, includes all ODA allocated to the health sector overall (based on the OECD database), or about US$ 3 billion, in its estimate of total assistance for global public goods. But much of this is allocated to goods and services in the health sector that that are more properly considered private goods than public goods. Estimating more precisely how much DAH is or should be allocated to global public goods in the health sector requires a more precise definition of health-related global public goods. This definition will need to include efforts to prevent or treat communicable diseases with cross-border spillovers as well as more intangible goods and services, including knowledge and technical know-how.

2.5 Use of development assistance for health

Even less is known about how much and what forms of assistance are actually disbursed than is known about how much money is allocated to development assistance in the health sector. Each agency tracks its own accounts, but there is no common database that allows comparison of disbursements by all donors at the international or national level. Despite this, however, it is clear from reports by individual agencies, anecdotes, and feedback at the national level that disbursement of committed funds is typically much delayed.

Disbursement delays cans be caused by anything from simple administrative obstacles and communication problems to more profound differences in views about how best to implement shared programme objectives. Estimating programme costs is more of an art than a science, which can result in overestimation of needed funds. The rules that donor and government agencies must follow to ensure appropriate fiduciary control over resources can themselves present hurdles to undertrained programme staff and understaffed programme offices; political change, planned or unplanned, can also disrupt even the most careful implementation plans. Problems of these kinds are commonly referred to as problems of *absorptive capacity*.

Interviews with non-health experts in a range of multilateral and bilateral agencies revealed broad consensus on the relationships between health and economic growth and on the desirability of putting more resources into the health sector. They also revealed a concern that increases be calibrated to avoid overwhelming absorptive capacity and be managed in ways that limit opportunities for leakage and corruption. Working

Group 6 probed this issue further in conversations with staff at the donor and country levels. As discussed in the next chapter, it became clear that donors and countries need to focus on several shared issues to ensure that additional resources for the sector will be put to effective use.

3. How Donors and Governments Can Make Development Assistance for Health More Effective

It is easy to forget, when flooded by daily press briefings on the horrors of the HIV/AIDs pandemic and the ravages of continued and sustained poverty throughout the world, how much health has improved in the last 50 years. At about 66 years, global average life expectancy today is nearly 40% higher than it was 50 years ago. Infant mortality and total fertility rates have also both improved by about 40% in the 30 or so years since concerted national and international attention was focused on the design and implementation of health and population policies.

Development assistance for health plays a crucial role in the rapid dissemination of large-scale immunization, family planning, and reproductive health programmes and in a number of critical child health innovations. The successful eradication of smallpox is an example of what can be accomplished through deliberate national and international cooperation. Support of nutrition programmes in South Asia and elsewhere have shown how much health can be improved through better nutrition. Development assistance for health contributes directly to the expansion of the knowledge base on public health issues and policies in developing countries, and it stimulates significant progress in health financing and related policy analyses.

There is little question that development assistance has yielded some major improvements in public health. But determining how much and what forms of development assistance for health should be the focus of donor efforts in the twenty-first century requires a more in-depth understanding of development effectiveness.

3.1 Lessons on aid effectiveness

Several recent studies (Burnside and Dollar, 1998; and more recently Devarajan, Dollar, and Holmgren, 2001) suggest that the relationship between foreign assistance and economic growth—or, in one study, infant mortality—is strongly mediated by the quality of a country's overall macroeconomic policy framework.[4] Both econometric analyses and case studies provide compelling evidence that, in the presence of high levels of corruption, ambiguous property rights, and macroeconomic instability,

foreign assistance leads to little or no change in economic or poverty indictors. As summarized by Burnside and Dollar (1998, p. 14):

> In developing countries with weak economic management—evidenced by poor property rights, high corruption, closed trade regimes, and macroeconomic instability—there is no relationship between aid and the change in infant mortality. In these distorted environments, development projects promoted by donors tend to fail. Furthermore, aid resources are typically fungible, so that these projects are not in fact what is financed by aid. Aid is financing the whole public sector at the margin, which is why the overall quality of management is key to effective assistance. A government that cannot put effective development policies into place is not likely to oversee effective use of foreign aid.

These observations apply as well to debates on the form and levels of development assistance for health. Several recent evaluations confirm that the overall performance of the civil service is a major influence on health sector performance (see for example, Johnston and Stout, 1999; Stout et al., 1997). Civil service reform and institutional transformations—through upgrading of state agencies' ability to perform as supervisors and monitors of government and private sector activities—are also pertinent to the functioning of the health sector. Several recent projects and sectorwide evaluations show that the effectiveness of development assistance for health is highly dependent on ownership, capacity, and transparency of the primary actors in the health sector—the Ministry of Health, other government agencies, and public and private providers of health care services.

These policy issues are especially hard to manage in the health sector because of the strong moral content of health-related concerns, perhaps best illustrated by the many conceptual and ethical challenges in estimating the value of a saved life. Health policy is a rich ground for political and ideological debate—and distributional issues are at the very heart of questions about the appropriateness and effectiveness of health policy choices.

The risk of substituting a desire to "do good" for rigor and pragmatism is especially high in this sector because of its strong association with poverty reduction and the empathic response to the tragedy of preventable disease and early death. But a desire to do good can even produce harm when, for instance, untested or only partially considered policy

alternatives produce unintended consequences or when pressures to speed the introduction of new treatments inappropriately truncate clinical trials and safety research. Decision-makers involved in setting and implementing policies governing the amounts, forms, and flows of development assistance for health need to be sensitive to these "feel good"[5] risks, given the many technical and practical problems of policy evaluation in the sector.

Strategies for development assistance for health must balance the need for significant resources with the need to adapt the levels and forms of assistance to variations in the capacity (and will) to put assistance to effective use, the need to enhance ownership and build capacity while transferring resources, and the need to ensure accountability to both donor agency stakeholders and consumers. As discussed in greater detail in the concluding section of this Report, balancing these requirements is best accomplished through a collaborative learning-by-doing strategy, in which donors and recipient countries cooperate to accelerate the generation and sharing of knowledge of what works.

3.2 Capacity constraints and effectiveness

The literature on development effectiveness emphasizes problems of limited absorptive capacity at the country level. However, in reviewing lessons of experience and drawing on the consultations conducted for this study, it is increasingly evident that donor behaviour and procedures can also influence effectiveness.

3.2.1 Constraints at the donor level

The great number of agencies and donor-funded projects risk overtasking weak and limited institutional and human capacities in some countries. The arithmetic of the situation is revealing. Some 22 bilateral agencies are members of the DAC and 10 major multilateral agencies are active in the health sector—each with its own policy mandate, operational procedures, and financial and technical reporting requirements. Although not all agencies are active in all countries, many are active in several countries. The sheer number of people and agencies working in the sector creates administrative problems that severely reduce the effectiveness of development assistance for health relative to what it might be were funds managed in a coherent and coordinated manner under government leadership.

The aid coordination challenge is, of course, well known, and it has been the subject of major evaluations by the World Bank and others

(World Bank, 1998). The health sector pioneered the concept of a sectorwide approach as a possible response. Although progress has been encouraging towards the development of a common policy framework to guide country and donor decision making in the sector, sectorwide approaches have been less successful in overcoming specific implementation difficulties. Experience highlights the need for donors to work systematically to harmonize procedures for policy and programme review, procurement of health sector goods and services, supply chain management, and financial management.

Most donors seek to report on the accomplishments of their own projects, to answer to key stakeholders and owners—many of whom continue to seek reports that attribute outcome changes to particular donors. This approach to describing the results of projects is often in addition to, and sometimes rather than, particular interventions, and it reinforces attention to particular vertical disease programmes rather than to broad, systems-level impact. It is also increasingly clear that failure to identify the institutional and systems-level changes that are the object of sectorwide approaches, or failure to build national capacity to assess changes in the quality and quantity of services delivered through the sector, risk loss of support for reforms that are often politically challenging.

The administrative costs borne by donors also act as a constraint on effectiveness. Donor agencies naturally and appropriately seek to minimize administrative costs in order to maximize the transfer of resources. However, this can lead to cuts in staff and travel time, for instance, which reduce the donor's capacity to develop the local knowledge necessary to provide credible and responsive advice to countries struggling with complex reform or delivery challenges. Many resources allocated to specific countries are spent on administration and overhead costs and excessive use of technical assistance. Of the money that reaches the country most is spent on equipment, material (including drugs), and capital investments. Little funds are used (officially) for salaries and other personnel costs, one of the major expenditure items in the health sector. This approach risks undermining the financial sustainability of programmes once donor funds are withdrawn.

3.2.2 Constraints at the country level

Working Group 6 noted broad frustration with the inadequacies of the administrative mechanisms for the design and implementation of health policies and programmes, along with continuing problems of weak ownership and accountability.

3.2.2.1 Inadequate organizational and administrative capacity

Too often, countries as well as donors treat the institutional and organizational requirements of implementation as a constraint rather than a target of policy reform. Staff in donor agencies feel pressure to contribute to policy dialogue, delegating nuts and bolts issues to more specialized staff who may be unaware of possible linkages between administrative requirements and opportunities for dialogue with the country on institutional and organizational reform. And yet lack of procedural clarity, conflicts in rules of the game for different agencies, and serious underestimates of the time and financial costs of administrative change within Ministries of Health (and across levels of the health system) have greatly hampered the achievement of visible results.

More generally, there is widespread concern among health and non-health specialists alike that organizational and administrative capacity in developing countries constrains the potential contribution of current levels of development assistance for health—much less vastly increased levels. Health sector specialists and generalists in multilateral and bilateral agencies interviewed for this study repeatedly suggested that funding was not the fundamental obstacle to improved health status. Additional funds can improve health status quickly only to the extent that workable delivery systems are in place or can be rapidly created.

It is clear that it is these "software" elements of health systems that make investments in physical hardware effective. But donors, particularly those operating on a large scale, have had less success in achieving changes in software than in the provision of inputs. Development assistance for health has been more successful in expanding the physical infrastructure for health service delivery, particularly in the public sector, than in improving service quality and efficiency or building institutional capacity.

The feasibility of delivering services thus varies immensely by country and even within countries for a wide range of reasons, including differences in the availability of skilled personnel, physical infrastructure, transport and communication facilities, legal and regulatory framework, and many other factors. Effectiveness is determined by institutional as well as technical variables. Bringing about sustained behavioural change requires that delivery systems, whether supported by national or external resources, be adapted to country and local contexts.

Low pay and poor work conditions among senior and mid-level civil servants can make it difficult to attract skilled, entrepreneurial managers for implementing assistance. The basic inputs for improving health outcomes—medical equipment, civil works contracts, pharmaceuticals—are

all in high demand in environments of crushing poverty and large, typically highly informal markets, increasing the risks of leakage and corruption. This can discourage donors from using flexible approaches that rely on local expertise and slow their efforts to delegate responsibility to local agencies and staff.

Both bilateral and multilateral agencies have traditionally managed their investment and assistance programmes through a combination of in-country staff and technical reviews. Frustrations with the quality and effectiveness of technical assistance are legion on both sides. There is widespread recognition that technical assistance and weaknesses in ownership are strongly though paradoxically connected. To be most effective, technical assistance requirements must be "owned" by the receiving agency, as evidenced through their active participation in the definition of terms of reference, identification of possible sources, and selection of technical assistance providers. Unfortunately, however, recipient and donor agencies can have very different views on the need and possible value of technical assistance, and these differences can lead to major delay or disagreements during project implementation.

At the same time, widening the range of institutions and expertise involved in finding solutions to public health problems is likely to add considerable value to development assistance for health. Work is under way in the education sector in Latin America to capture synergies and economies of scale by promoting comparative analysis and joint resolution of implementation problems by using a continuous learning framework. Country teams from implementing agencies in different countries, accompanied—but not led—by donor staff, join in collaborative Project Implementation Reviews to work on common solutions. Rapid changes in information technology are also creating opportunities to promote more exchange at the country level on the objectives and outcomes of development assistance projects.

3.2.2.2 Weak mechanisms for strengthening ownership and reducing transaction costs

Studies have identified a growing gap between the development assistance priorities of donors and those that partner countries emphasize in achieving sustainable development. National, and even provincial and local, ownership of the goals and objectives of externally financed projects is often low, inevitably undermining project success.

Sectorwide investment programmes in health are a response by donors to the perceived failures of earlier approaches, which were increas-

ingly viewed as fragmented, unsupportive, and largely ineffective. Recipients, for their part, often view changes in donor behaviour as erratic swings from one extreme to another in response to changes in "development fashion". One striking finding of the consultation processes for the WG6 Report is the high degree of mistrust and even cynicism on the part of recipient governments and stakeholders towards donor governments and agencies, especially towards what they characterized as indecisiveness, frequent shifts in behaviour, and an obsession with the new, often viewed as old ideas in new trappings.

Those engaged in development assistance for health need to seek common ground on which to work together to increase the effectiveness and impact of development assistance for health, regardless of its source of finance. Donors need to look for signs of ownership and national leadership of health sector development. Important indicators include a broad-based consultation process on health policy development under Ministry of Health leadership; Ministry of Health chairmanship of major sectoral and subsectoral meetings with national and external development partners; Ministry of Health control of drafting and finalization of major policy documents; Ministry of Health leadership of donor coordination processes; and national government budgetary appropriation or allocations of domestic financial and other resources for health development.

3.2.2.3 Inadequate mechanisms of accountability

Weak or absent measurement systems and accountability systems that are transparent, responsive to programmatic goals, and adapted to national and local decision making are another constraint to the successful design and implementation of health policies and programmes. Working Group 6 discussed these issues with country representatives at a workshop in Accra in April 2001. Highlights of this discussion are summarized in Box 3.1.

At an aggregate level, development assistance for health, like development assistance generally, is most effective in supportive policy environments, including stable and open macroeconomic and political regimes, and where there is evidence of strong political commitment to health policy goals. However, the burden of disease is highest in countries without supportive environments, which creates a dilemma. Should donors withdraw from countries where political and institutional environments are not supportive? Knowing that policy matters does not answer the question of what donor resources should do, and how they should do it, in settings where the policy and institutional environment are

not propitious. What is the appropriate role of external assistance in settings with limited commitment to health objectives or to ensuring better opportunities for the poor?

Box 3.1 Making development assistance for health more effective: Summary notes of findings of Accra Workshop, April 2001

- Need to understand DAH effectiveness issues at national as well as international levels better
- Sectorwide approaches (SWAPs) provide a framework for health system reform and strengthening; characteristics of SWAPs include:
  - — Enables comprehensive approach to easing constraints to sectoral performance
  - — Key to SWAPs is that all partners (donor and implementing agencies) support a unified policy framework—aiming to reduce transaction costs as a consequence, unified financing, accounting, and monitoring systems
- Strategies for more effective development assistance for health
  - — Development partners should support a sectorwide framework
  - — Development partners should avoid confusing "basket funds" with larger purpose of SWAPs
  - — Donors should put more trust in governments as implementers, be prepared to take risks, avoid conditionalities
- Base development practice and policies on evidence!
  - — Make better use of information already available (LSMS, DHS, etc.)
  - — Build better information systems
  - — Improve systems for incorporating research into policy more effectively
- Primary responsibility for setting priorities is with government
  - — Partners need to be willing to negotiate on all issues, be flexible
  - — Keep balance between disease control and capacity/institution development
  - — Capacity building needs to focus on priority setting
  - — Civil society in general and consumers should have voice in policy making
- Countries need to know/understand/have better information on views, philosophies, resources, and comparative advantages of different development partners
  - — Feedback sessions such as the Accra Workshop are useful and should be repeated
- Recognize that development is a process and changes take time: partners need to recognize that the pace of change is 10 to 15 years, not an annual planning cycle!
- Global initiatives risk rushing countries away from systems and capacity development—which are being accomplished through SWAPs; all partners need to manage/minimize these risks
  - — Need to ensure that implementation of global programmes are integrated into existing sectoral programmes
  - — Put global initiatives in context—recognize their weaknesses and risks, but avoid "throwing baby out with the bathwater".
  - — Need to recognize that "partnerships" are among unequals, may need to consider role for intermediaries

- What makes it difficult for governments to "just say no" to availability of assistance for donor-defined objectives?
  - — Information gaps
  - — Limited capacity and opportunity for countries to articulate what is needed, bargaining skills
  - — Countries have long lists of priorities—they may find it better to say "yes" to a donor interested in a lower priority and then use the resources for their highest priority than to "just say no" to working with the donor altogether.
  - — Difficulties with power/responsibility arrangements among key national level agencies (Ministries of Finance, Ministries of Health, Cabinet, Parliament, other ministries)
  - — Underestimation of administrative costs
- What capacity is needed to equalize the partnership?
  - — Need critical mass of expertise, leadership, cohesion among leadership team
  - — Capacity to articulate vision for the directions of the health sector
- How should donors and government partners address capacity issues?
  - — Develop capacity within organizational frameworks
  - — Consider development of a "basket" for Human Resources
  - — Should recognize that capacity and institution building takes a long time (e.g. consider the Thailand case, investments beginning in early twentieth century)
  - — Build skills for policy analysis and evaluation
- Need to review levels/amounts and forms of technical assistance
  - — Identify/build approaches that promote ownership and capacity building
- Capacity need not be approached completely in-house. Also employ
  - — Research and academic units
  - — National or regional consultancies
  - — Civil society/NGOs
- Make creation/maintenance of intellectual capacity central to DAH
  - — Find ways to make transfer of skills between countries, and between experts from developed world and national experts mutually beneficial
  - — Sabbatical arrangements for management levels
  - — Recognize that public sector reform process is slow, and civil service conditions constraining service delivery in most settings
  - — Accept necessity of salary "top ups"
  - — Increase production of HR for delivery staff, deliberate "remittance" policies
- Commission is useful in bring partners together to discuss these issues, but these benefits will be put at risk if conclusions and recommendations are at variance with needs and views of developing countries "up the creek".

4. Priorities for Development Assistance for Health

With the preceding analysis as a base, the Report turns again to the two questions that the review set out to answer: How much development assistance is needed, and what form should it take, to improve health outcomes for the poor?

4.1 How much money will be needed?

Other Working Groups of the Commission on Macroeconomics and Health have shown that improving health contributes to economic growth and poverty reduction. Working Group 3 found that both low- and middle-income countries have considerable scope for increasing domestic expenditures in health but that these resources are far from adequate to meet the costs estimated by Working Group 5 for scaling up proven interventions.

4.1.1 Estimate of needed funding

Working Group 5 of the Commission prepared estimates of the costs of scaling up a basic package of interventions, based on what is known about current levels and sources of funds and on reasonable though crude estimates of the level of domestic health resources. Working Group 6 used these estimates in its consideration of the requirements for future funding.

Working Group 5 estimates included US$ 7 to 10 billion a year for the HIV/AIDS pandemic in low- and middle-income countries and US$ 2 billion a year for tuberculosis and malaria. Adding the costs for maternal health care and childhood diseases (such as pneumonia, meningitis, and diarrhoea) and improvements in the health care infrastructure and overall health system to the estimates for HIV/AIDS and tuberculosis and malaria would bring the amount needed to four times current levels of international resources for health, or US$ 27 billion by 2007 and US$ 38 billion by 2015.

The financing picture that emerges is challenging. The projected cost of scaling up programmes to address the major communicable diseases and basic maternal and child health services (Cahuana et al., WG5 background paper) is several times higher than current levels of domestic spending on health and all sources of development assistance for health.

The gap between domestic resources available for health expenditure (projected to grow at par with national population growth rates) and the resources required to provide core interventions in the health sector is estimated at more than US$ 10 billion at the starting year of the projections. This estimate is clearly sensitive to assumptions about the proportion of current expenditure allocated to these interventions.

Although the point estimates are highly uncertain, these projections provide a good indication of the enormous dimension of the public health challenge ahead. Meeting these requirements will place enormous demands on the political will and commitment of leaders in the developed and developing world.

4.1.2 Sources of funds

The international public and private communities are allocating increased resources to global health, particularly for disease-specific initiatives. For example, the European Union proposes to focus its health interventions on HIV/AIDS, malaria, and tuberculosis, potentially amounting to some €1.7 billion (about US$ 1.5 billion) over the next 5 to 10 years. Work in progress suggests that UNICEF, with its unique branding equity, has considerable potential for tapping NGO resources, much of which would be spent on child health and other health-related programmes in countries.

Although the largest contributions will have to be public resources from the OECD countries, substantial funds will also need to be raised through other mechanisms. Preliminary calculations indicate that debt reductions and cancellations for the least developed countries through the Heavily Indebted Poor Countries (HIPC) debt initiative and similar mechanisms will make about 2% of GNP available for some 30 heavily indebted poor countries, and perhaps around one-fourth of that will be allocated directly to the health sector. Proposed reductions in drug prices for HIV/AIDS patients in developing countries will help to make such interventions more affordable. All this would still not be enough to achieve global development goals for health, however.

Private foundations, including the Bill and Melinda Gates Foundation, the UN Foundation, and the Rockefeller Foundation (all in the United States) have substantially increased their allocations of DAH in recent years. These funds have been directed primarily to HIV/AIDS interventions, vaccination programmes, and research and development for new drugs and vaccines against the major diseases of the poor. This funding

will likely continue, with private sources forming a significant part of the global health budget in the coming years.

The single largest contribution to DAH, however, would come from DAC countries living up to the ODA target set by the United Nations of 0.7% of GNP. This would make an additional US$ 100 billion available for international development and poverty reduction. Today, only a few small countries achieve this target, but several promising changes are under way. The Irish Government expects to reach the 0.7% target by 2007, the British Government plans to increase the aid budget (DAH allocations should rise as well, judging from the increased attention in the country to global health in the past year or so), and the Swedish Government will increase its aid budget from the current 0.71% of GNP to 0.86% by 2004. Reforming policies and practices for managing DAH would also be important, including reducing reliance on external technical assistance and tied aid.

4.2 How can these resources be made more effective?

At the global level, many bilateral and multilateral agencies, NGOs, and private sector entities are engaged in international development cooperation in health. Even at the country level, as many as 50 to 60 partner entities may be involved, generating enormous demand for coordination and creating difficult resource utilization problems. Indeed, the current financial architecture, which allocates funds for health in an uncoordinated and largely unpredictable fashion, may reduce the effectiveness of resources at the aggregate level.

Some change is already under way. The international architecture for health will look different in the near future, as donors and countries apply more comprehensive and results-oriented approaches to development assistance, with a sharper focus on poverty reduction. This focus is beginning to take shape in the development of Poverty Reduction Strategy Papers (PRSPs), a vehicle for wide local and national participation in plans for poverty reduction. Donors and borrowers continue to seek ways to reduce the transaction costs of assistance and to build ownership through more sectorwide approaches. Recently, proposals have also been made for a Global Fund to Fight AIDS, Tuberculosis, and Malaria that would raise new financial resources for global health initiatives. These are all opportunities to strengthen the effectiveness of limited development assistance resources for health.

4.2.1 Use the Poverty Reduction Strategy Paper framework

Several recent reviews of experience with projects and programmes to support sectorwide reform note continuing gaps between the content of health policy (a relatively strong suit in the design of most sectorwide approaches) and the larger planning and budgeting framework for resource mobilization at the country level. Policies to decentralize core health system management may, for example, conflict with the rules for fiscal management, thus delaying implementation of agreed health sector reforms. Donors and country health authorities are therefore increasingly attuned to the need to coordinate health policy dialogue with work on reform of public sector management, particularly of planning and budgeting systems.

New approaches to the organization of development assistance, especially the PRSP process, provide an opportunity for health sector planners to deepen this dialogue. At the country level, preparation of PRSPs enables health advocates to engage private, public, and civil society representatives in discussions of a country's health policy framework and to increase understanding of how resources are mobilized and allocated, including an assessment of what information and indicators of progress are used (if any) in the allocation process. Reforms in resource allocation systems should include creating incentives for the use of evidence in health sector decision making.

With a better picture of how decisions are actually made, it should be possible to propose, test, and implement ways to incorporate performance measures into reformed resource allocation and mobilization procedures. Building performance measures into health activities from the beginning would create stronger incentives for the use of information in decision making.

4.2.2 Build on experience with sectorwide approaches

The health sector was a pioneer in efforts to strengthen country ownership and improve donor coordination through sectorwide approaches to the delivery of development assistance for health. The literature suggests that sectorwide approaches are facilitating the development of a single unifying health policy framework at the country level and, though less successfully, encouraging harmonization of reporting and budgeting requirements by donors. Both these outcomes should reduce the costs of aid administration in the long run.

There is still considerable scope for making sectorwide approaches even more effective. At the country level, the development of a health pol-

icy framework for a sectorwide approach enables country leaders to articulate and implement health sector objectives. As evidenced in Mexico, building national consensus around a statement of national health policy can become an important vehicle for promoting social cohesion. Experience elsewhere shows that involving consumer groups, representatives of civil society, and the public more generally in defining health policy and outcomes improves the success of interventions. Strengthening systems for holding national leadership accountable for the achievement of health policy goals will contribute directly to popular ownership of the goals.

One way to do that is through sectorwide approaches. Sectorwide approaches have generated support for general health policy principles and, in some cases, have transferred more resources more quickly than project-style investment strategies would have been expected to do. Donor staff must be responsive to the expectations of their primary authorities and stakeholders, most of whom seek quantifiable indicators of the results of foreign assistance—and relatively rapidly. This can lead donors and country-level planners to promise more than can be delivered or to seek immediate gains in place of more complex and fundamental institutional change. The same phenomenon underlies the tendency for individual donors to define their objectives relative to specific project boundaries.

To counteract this tendency, countries should insist that all donors (especially bilateral donors with strong parliamentarian oversight) support an explicit and comprehensive plan for regular monitoring of country-level sectoral performance, based on local routine health information system reporting. Donors should build political support among core owner stakeholders for strategies to strengthen the administrative backbone for the delivery of health sector goods and services. They should complement this advocacy with explicit measurement of progress towards easing absorptive capacity constraints.

These changes will mean less emphasis on the achievement of project objectives and flag waving for particular disease outcomes or campaigns as a gauge of success, and more reliance on evidence of sectoral-level accomplishments. More important, this approach requires a commitment by countries and donors to invest in the research and information infrastructure necessary to enable regular reporting on sectoral performance. Such systems for measuring results must be designed not, as in the past, primarily to extract information to serve the accountability requirements of donor constituencies, but to ensure locally responsive decision making.

4.2.3 Match instruments and modalities to specific contexts

Development assistance for health, like development assistance generally, is most effective in supportive policy environments, with stable and open macroeconomic and political regimes and strong political commitment to health policy goals. But the burden of disease is highest in countries without supportive environments. Knowing that policy matters does not answer the question of what donor resources should do in unfavourable policy and institutional settings. What is the appropriate role of external assistance in settings with limited commitment to health objectives or to ensuring better opportunities for the poor?

The amount, focus, and scope of development assistance for health to any one country should be guided by a comprehensive development strategy. Donors should not look too intently at any specific aspect of the strategy, but should instead assess the country and its health sector by its potential for development, especially country ownership and sectoral leadership of the national development processes. Table 4.1 shows the basic principles for deciding on the type of health intervention, depending on the country context.

Table 4.1 Allocation of development assistance for health according to country context

Country context	Mode of development assistance for health
Sound policy and basic institutional capacity Policy documents prepared, civil service reformed, sustained track-record on performance, and sustained budget allocations to health	*Sector budget support* Untied funding to health budget, limited technical assistance component, agreed monitoring and evaluation systems
Policy and institutional capacity strengthening in process Undertaking policy development work, reforming civil service, decentralizing health sector, initiating sectorwide approaches, and budget allocations between 5 and 8% of GNP	*Support for policy and institutional development* Mix of disease-specific interventions and systems development programmes, large technical assistance components
Weak structures due to crisis or complex emergencies Nationwide civil war, absence of leadership, and government budget allocations below 5% of GNP	*Targeted support for service delivery* Humanitarian assistance, disease-specific interventions, special child immunization programmes, special nutrition programmes

Source: Swedish International Development Cooperation Agency (SIDA), unpublished memo, 2001.

4.2.4 Take a comprehensive approach

In discussions of development assistance for health, Working Group 6 was struck by the continuing tensions between disease-specific approaches and health-systems or sector reform–focused approaches in the design of policies and programmes for development assistance for health. Proponents of each approach are found at all levels, typically with strong views on the advantages of the favoured approach and the disadvantages of the other.

Proponents of the disease-specific approach argue that it is more cost effective and emphasize the benefits of focusing political and administrative resources on specific measurable objectives. Fund raising and development of a campaign mentality capable of handling implementation obstacles are relatively straightforward for efforts to eradicate a specific disease, but far more complex for something vaguely called "system strengthening". Some donor agencies are obliged to report on specific diseases. One bilateral agency, for instance, receives the bulk of its funds according to a set of earmarked categories and is under legislative obligation to report results for specific diseases. Proponents of sectorwide or system-strengthening approaches, on the other hand, argue that development assistance for health should strengthen the performance of health systems overall by focusing on institutional and organizational capacity and long-term sustainability.

Comprehensive health sector development is a way to reconcile these two approaches. It acknowledges the need for both disease-specific interventions and systemic improvements, while seeking to identify synergies that support and reinforce both kinds of efforts, as discussed above in Chapter 2.

4.2.5 Reconsider conditionality

Donor conditionality in development assistance for health has been widely debated since its introduction in the early 1980s in structural adjustment programmes. Over the years, special conditions for financial disbursements were also introduced in sector and project support programmes, including health. Aid conditionality was usually intended to persuade (or force) the recipient to undertake certain policy actions. Today, special conditions on financial disbursements are used much less frequently, as donors have found such conditionality to be of limited effectiveness—even counterproductive in some circumstances. Since aid works best in favourable policy environments—something that cannot be bought by more aid—there seems little justification for conditionality.

Aid conditionality is hard to reconcile with fair and equal relationships between aid recipients and donors. To be effective, development assistance for health needs to be based on a genuine partnership. Instead of conditions, mutual agreements on certain issues need to be formulated, and instead of prerequisites for the use of funds, a shared agenda for development should be elaborated and agreed on.

4.2.6 Make donor country policies for development cooperation, trade, and domestic labour markets more coherent

Health sector development requires a wide range of human capacities—medical professionals for health service delivery; managers, epidemiologists, logisticians, and accountants for health care system performance; and economists and public health specialists for health policy development and monitoring. Extreme shortages in all these areas continue to impede health sector development and effective service delivery in many of the poorest countries. External technical assistance can rarely substitute effectively for national human resources. To some extent, the capacity problem is due to the migration of qualified personnel from developing countries to the European Union and North America, in particular.[6]

Both pull and push mechanisms are at play. Low rates of remuneration are a strong push mechanism, but even more important are domestic policies in the European Union and North America that encourage the immigration of highly qualified professionals to sustain their own faltering supplies in a period of demographic transformation. These policies risk further damaging the fragile human capacities of the poorest developing countries. To avoid undermining the very outcomes donors seek for the health sectors in developing countries, the countries of the European Union and North America should better coordinate their policies for development cooperation, trade, and domestic labour markets.

Scientific and medical research is similarly in need of greater policy coherence, to foster research and development (R&D) in areas of importance to developing countries. More R&D partnerships are needed between developed and developing countries, with the long-term goal of building sustainable research capacities in developing countries. In particular, more resources are needed to change the 90/10 distribution bias—where only 10% of available health research funds are allocated to conditions that effect 90% of the world population.

4.2.7 Consider a global fund

Other proposals for improving the effectiveness of development assistance for health call for establishing a global fund for health. The immediate objective would be to raise substantial additional funds for global health initiatives, particularly HIV/AIDS, tuberculosis, and malaria. The underlying objective would be to increase the effectiveness of development assistance for health through improved recipient-donor coordination and greater speed in the delivery of funds. The fund would not replace existing funding or allocation mechanisms.

Some observers are critical of the proposal for a global fund for health. They are concerned that it will divert attention from the critical issues in development assistance for health, increase administrative costs, and lead to underfunding and crowding out of existing programmes.

The basic principles, scope, and coverage of a global fund are still under discussion, but such concerns and other risks in pursuing this option should not be overlooked. All else being equal, a global fund for health may add an additional layer to the current system, generating more opportunity costs for international policy-makers in many parts of the world and more transaction costs and opportunity costs to already overstretched ministries of health in poor countries. Any global fund for health should be able to deliver services on the ground in a timely and efficient manner and sustain them over a long period of time. These concerns need to be addressed in the continued process of developing the operating structure of a global fund for health.

5. Towards a Strategy to Improve Effectiveness and Specific Recommendations

The recommendations in this chapter for improving the effectiveness of development assistance for health are based on the analytical work summarized in this Report, stakeholder consultations, literature reviews, and extensive discussions with with staff from donor as well as country-level implementing agencies. The recommendations are guided by a set of strategic principles for identifying policies and options that take into account different approaches to absorptive capacity, development effectiveness, and a mix of instruments. These principles are presented as a series of risks and requirements that policy-makers will need to balance as they consider options for mobilizing, allocating, and organizing development assistance for health.

Above all, Working Group 6 recommends that the Commission for Macroeconomics and Health focus on the opportunities to complement new resources and mechanisms for development assistance for health, including the global fund for health, with a much more deliberate and adequately financed effort to encourage country-to-country learning from results. Local ownership of health policies can best be encouraged by the evolution of a learn-by-doing approach to health policy that enables each country to adapt global experience to its own priorities and conditions.

5.1 Balance urgency and sustainability

The starkest policy dilemma in development assistance for health is the tension between the need to move rapidly on the HIV/AIDs pandemic and other major health problems while simultaneously strengthening health system performance. The tension between the need for action and the constraints of absorptive capacity is all the stronger because communicable disease challenges are often gravest where institutions are weakest. The high human, social, and economic costs of infectious diseases magnify the risks inherent in "feel good" actions within the health sector. A key strategic principle going forward will be to balance a sense of urgency with a commitment to the establishment of systems that provide for considered decision-making and sustainable results.

5.2 Let countries drive coordination

Some 30 to 40 years of development cooperation have taught the international development community that successful and sustainable development processes are founded on nationally based forces of change and willingness to progress. Non-national actors cannot force or buy such processes no matter how much money they spend. Consequently, development partners need to express significantly more trust in the willingness and ability of countries to perform well.

Calls for donor coordination are routine in reports on development assistance for health, and there is a clear consensus by donors and national actors that better coordination should be a key objective. That calls for coordination are so often repeated reinforces the Working Group's conviction that genuine coordination requires a strong will at the national level to overcome internal incentives within the donor community for supply-driven approaches. As our colleagues attending the Accra discussions of development assistance for health repeated, the shift towards country-driven approaches is welcome, but achieving it will require greater assertiveness (a willingness to "just say no") at the country level, as well as a greater sense of trust in country priority setting among donors.

5.3 Strengthen incentives for effectiveness

A major theme throughout the Working Group's discussions and findings is the need for a sharper focus on assessing the effectiveness of donor assistance in the health sector, particularly by national agencies and consumers. Recipients of assistance have the most to gain from ensuring that it is put to effective use and the most to lose from inefficient or poorly administered assistance. But accountability is still approached primarily as a concern of donors, whose complex financial management, procurement, and monitoring requirements are designed to enhance accountability and transparency. Studies of development assistance have shown that these very procedures and processes are a source of much of the high transaction cost that troubles development assistance.

Few donor agencies are likely to relax their rules in the absence of credible and reliable performance measurement and accountability systems at the country and local levels. Simple exhortations about the need for such systems, like the routine calls for better monitoring and evaluation within donor agencies, will not ensure their development and use. Building local accountability systems will require changing managerial and institutional incentives and creating opportunities to build skills and interest in measuring and tracking results.

5.4 Match modes of assistance to the strengths and weaknesses of the policy and institutional environment

Perhaps the thorniest decisions in development assistance for health in today's environment concern the allocation of limited resources. On the one hand, a growing body of literature suggests that aid is most efficient in countries with large numbers of poor people and strong policy and institutional frameworks. On the other hand, poverty and public health challenges are typically greatest where policy and institutional environments are weakest. The development effectiveness literature underlines the need to be more explicit and selective concerning the allocation of resources relative to poverty and the policy and institutional framework. But it is clearly neither feasible nor sensible for health sector donors to cease operations in countries with weak policy and institutional frameworks while waiting for macroeconomic and institutional conditions to become more favourable.

What is needed is a better match between particular modes of assistance (such as policy dialogue, financial transfers, and technical assistance) and the strengths and weaknesses of particular policy and institutional environments in a health-specific context. Donors and countries need an explicit framework for assessing the effectiveness of development assistance for health relative to country-owned health sector policies and priorities. This framework should help donors develop a clearer understanding of their comparative advantage within the health field and ultimately help reduce transaction costs through more deliberate donor specialization in particular contexts.

5.5 Balance new global fund and existing mechanisms

A global fund for health would be instrumental in capturing additional resources, but it should be complementary to bilateral and multilateral sources of development assistance for health and other targeted global and regional funds. It should avoid increasing transaction costs by piggybacking to the extent possible on existing mechanisms for development assistance for health (thus avoiding the establishment of a new bureaucracy).

A global fund could become a pathfinder for more efficient delivery of development assistance for health. It could be an impetus to further reform (for example, it could encourage the mainstreaming of sectorwide approaches) and broaden the reach of bilateral agencies beyond the countries that receive their direct assistance for health programmes.

If effective, such a fund could expand its purpose over time. At first it could do so through alliances with existing funds (such as the Global Alliance for Vaccines and Immunization). It could blend its efforts with those of international financial institutions, using multisectoral approaches and other grant, concessional, and nonconcessional lending tools to strengthen health systems and to reach countries that are not eligible for the global fund. It also would allow more "virtuous" conditionality in the larger development flows (such as Poverty Reduction Support Credits and other adjustment modalities).

5.6 Place a high priority on accountability and learning

Pressures for greater accountability and sustainable results in a field as complex and uncertain as public health can lead to misplaced precision and counterproductive inflexibility. As in any endeavour with outcomes that are difficult to measure, there is a risk that concerns with process compliance and procedure will displace measures of outcome and consumer responsiveness, so that procedure becomes a weak substitute for impact assessment. A learning approach that recognizes and rewards the use of evidence in decision-making at all levels needs to replace the notion that expertise resides in one part of the world and must be flown into and dispensed in another. Shifting a greater share of the burden for assessing and reporting on results from donor agency staff to national institutions could help to build commitment as well as analytic and managerial capacity.

Promoting accountability without recognizing the need for the resources—human and financial—for generating and sharing lessons on what works in what contexts and with what effect would be an inappropriate response to the many uncertainties of the health sector. Donors and countries alike should find ways to reward the institutions and individuals responsible for producing solid, credible evidence of solutions to public health problems. This will require systematic assessment of evidence and its credibility—the heart of the accountability problems of development assistance for health.

5.7 Specific recommendations

From these strategic principles, the Working Group drew several specific recommendations on increasing resource levels and improving the effectiveness of development assistance for health:

5.7.1 On the level of development assistance for health

- *Working Group 6 recommends that reforms to the way donors and countries do business in development assistance for health be undertaken, with an emphasis on accountability that learns what actually works and what doesn't from the experiences of the consumers.* Increased resources without accompanying reforms may be detrimental in the long run, since the willingness to sustain high levels of development assistance for health is likely to be reduced if results cannot be accounted for.

5.7.2 On the effectiveness of development assistance for health

Improving the effectiveness of development assistance for health requires that donors and partner governments change the way they conduct their business. Several principles can guide these efforts:

- *Ownership is central and cannot be bought by external agents.* Country governments need to assume ownership and leadership in comprehensive health sector development. It is the responsibility of the partner governments, through the Ministry of Health, to engage all partners in the health sector in setting sectorwide priorities and programmes. It is the obligation of external partners to abide by the terms stipulated by the Ministry of Health. In principle, all donors active in the health sector should be part of an ongoing sectorwide approach. Similarly, all available funds should be reflected in the process, so that a comprehensive financial framework for health sector development and disease control can be elaborated at the country level.
- *Donor countries and their agencies must respect the national priorities and development agenda of partner countries and express trust and confidence in the partner government's ability to lead.*
- *The abandonment of all conditions and ex ante requirements on the use of funds would be a clear expression of the trust that should underlie all development assistance.* After careful assessment of the national policies and strategies for health sector development, resources need to be made available in as transparent and flexible a manner as possible. Flexibility gives improved value for money, since it means that the best available price can be sought on the world market.
- *Both donors and partner countries need to learn systematically from experience.* Development assistance for health needs to be assessed

continuously through independent scientific reviews in order to lead to incremental improvements.

- *Donors and governments need to be more focused on poverty reduction, which implies an increased focus on results and outcomes.* Donors need to focus more on achieving intended outcomes rather than on tracking their own funds and the current status of various processes, which leads to an overburdening of local institutional capacity and reduce the efficiency of development assistance for health.
- *Donors and governments need a results orientation,* which requires more coherent and refined monitoring and information systems that collect, assess, and disseminate relevant data.
- *Countries need better coordination and country-level management of resources.*
- *Donors need to take a comprehensive health sector development approach* that balances the need for specific disease control interventions with systems-strengthening measures to reinforce and sustain health sector gains.
- *Any new initiative for development assistance for health needs to ensure that funds are channelled more effectively from donor agencies to the district level in partner countries for improved service delivery* (whether the funds are additional or not is irrelevant as long as the new initiative does not add a layer to the already-malfunctioning structure for development assistance for health).
- *All partners should strive for a financial architecture that ensures less variability and more predictability of funds.* Successful health sector development and cooperation require long-term commitments and reliable sources of financing. Large financial variability makes planning and investment decisions more difficult in already-difficult environments.
- *All development assistance for health should be untied.* Tied aid has been shown to be a particularly inefficient way of managing development assistance.
- *Country-donor partnerships for any new or renewed engagement should take a long-term perspective.* Improvements in public health and health outcomes take time—sometimes a very long time—to achieve.
- *Health sector interventions should be based on the overall health situation and analyses of the most cost-effective interventions (prevention as well as service delivery) to target the burden of disease.* Aid modal-

ities need to be agreed on accordingly and should depend on the current status of the health system and institutional capacity.

- *The availability of external resources should not drive national-level priority-setting processes.* Global funds for health outcomes should facilitate rather than replace local priority setting and decision-making.
- *Donor agencies need to improve their specific country knowledge.* Agencies need to strengthen their analytical capacities in health sector issues.

5.8 Conclusion

The challenges in planning future levels and forms of development assistance for health are enormous. Pressures for tangible responses to global health challenges are increasing by the day. But there are also clear opportunities to build on and shape growing popular and political awareness of the causes and possible remedies to global public health problems and scope for a major rethinking of the goals, objectives, and structure of development assistance for health.

The work of this and other Working Groups reinforces longstanding observations that the health sector in many developing countries is grossly underfunded. There simply are not enough resources in developing countries to meet the ever-growing demand for medical care and simultaneously to launch and sustain the basic preventative and care programmes that are necessary to meet intensifying public health challenges. Although the political will to "do something" about the problems may be growing, the mechanisms for providing additional and more effective assistance are in need of repair if they are to handle the stresses of a large increase in the volume of health sector assistance.

But the opportunities are also profound. Development assistance for health has worked in the past, and donors and countries are already collaborating to make it work more effectively. Donor agencies are learning more about how to work in genuine partnership with each other and with their country counterparts. Important innovations in approach and structure are being identified and tested daily. Many show great promise. The consensus on the International Development Goals and debt relief initiatives promises to create even more opportunities for innovation and improved performance. The entry of major philanthropic interests into the sector signals the potential for tapping new sources of enthusiasm and expertise for development goals.

The environment is thus ready for significant shifts in the approach to development assistance for health. It is our hope that, as the Commission for Macroeconomics and Health ponders these opportunities, it focuses first and foremost on the power of ideas and the capacity of organizations and individuals everywhere to learn from their own experience. Learning by doing is the key to success, and Working Group 6 strongly urges that the Commission propose structures and global arrangements that will promote shared learning and accountability for results in the sector.

A global network of learning organizations in the health sector, made up of established centres of expertise and country-level implementers and service providers of all types, if properly connected through a common agenda, could generate and share global knowledge of what works and why and find solutions to ease absorptive capacity constraints. The Commission should stimulate the establishment of such a network as a critical complement to the establishment of a global fund for health. In doing so, the Commission would be taking a major step towards ensuring that global efforts to generate more resources for health are complemented by global efforts to ensure accountability for results.

Notes

1. The term *billion* is used in this Report to mean one thousand million, as in US English usage, not one million million, as in British English usage.
2. This is not to gainsay the fact that there are multiple project-level evaluations and studies, but rather to emphasize that few of these are designed to assess the effects of donor assistance programmes that may address multiple interventions in a single sectorwide package, or address system-strengthening objectives more generally. We hasten to acknowledge that careful programme and policy evaluation is relatively rare in the developed world as well (see Pritchett, 2000, for a discussion of the political economy of evaluation, and why "it pays to be ignorant").
3. The Group of Eight (G8) are the leaders of eight major industrialized democracies and the President of the European Commission. They have met together for annually since 1975 to address the major economic and political issues facing their nations and the international community. A history of the G7/G8 process is available at http://usinfo.state.gov/topical/econ/group8/summit00/history.htm.
4. Working Group 6 originally planned to commission an econometric analysis of the relationship between levels of DAH and data on health outcomes and health expenditures to examine the relationship analogous to the more general work on aid effectiveness by Dollar and others. Two factors made that unwise, however. First, despite our best efforts, we lacked sufficient time-series data on lev-

els of DAH and national health expenditure data to build a sufficiently robust dataset for the analysis. Second, the state of the art of the measurement of health policy environment is not sufficiently well developed at this stage to justify such an approach.

5. *Feel good risks* are risks that are taken to provide goods or services whose utility is to make the purchaser feel less guilty about pain and suffering that they perceive others as experiencing and are themselves unable to control.
6. Executive Summary of the CMH meeting in Bellagio, 2001.

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Annex 1 List of Acronyms

ADB	Asian Development Bank
AfDB	African Development Bank
DAC	Development Assistance Committee
DAH	Development assistance for health
DFID	Department for International Development
DHS	Demographic and Health Surveys
EC	European Community
GAVI	Global Alliance for Vaccines and Immunization
HIPC	Heavily Indebted Poor Countries
HNP	Health, Nutrition and Population Sector
IADB	Inter-American Development Bank
IBRD	International Bank for Reconstruction and Development
IDA	International Development Agency
IMCI	Integrated Management of Childhood Illness
LSMS	Living Standards Measurement Survey
MOF	Ministry of Finance
ODA	Official development assistance
OED	Operations Evaluation Department (World Bank)
OECD	Organisation for Economic Co-operation and Development
PAHO	Pan-American Health Organization
R&D	Research and development
SWAPs	Sectorwide approaches
TRIPs	Trade-Related Aspects of Intellectual Property Rights
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organization
WTO	World Trade Organization

Annex 2 Background Papers Prepared for Working Group 6

Paper 1: Development Assistance for Health (DAH): Average Commitments 1997–1999 (**Michaud C**)

Paper 2: Perspectives on Improving Health in Poor Countries: Qualitative Assessment of Multilateral Agency Views and Behaviour (**Nelson J**)

Paper 3: Ideas Work Better than Money in Generating Reform—But How? Assessing Efficiency of Swedish Development Assistance in Health to Vietnam (**Jerve AM**)

Paper 4: Qualitative Assessment of Bilateral Agency Views and Behaviour: Interviews With Non-Health Specialists (**Ojermark M**)

Paper 5: Global Health Initiatives and National Level Health Programs: Assuring Compatibility and Mutual Re-Enforcement (**Forsberg BC**)

Paper 6: Structural Adjustment and Health: A Literature Review of the Debate, its Role-Players and Presented Empirical Evidence (**Breman A, Shelton C**)

Paper 7: A Case Study on the European Commission's Contribution to Development Assistance and Health (DAH) (**Daniels D**)

Paper 8: Review of Externally Aided Projects in the Context of their Integration into the Health Service Delivery in Karnataka (**Narayan R**)

Paper 9: Notes on DAH and Its Effectiveness: The Interests of Recipient Countries (**Issaka-Tinorgah A**)

Paper 10: Recent Trends in Development Assistance in Health (**OECD**)

Annex 3 Terms of Reference

The following terms of reference are adapted from the revised guidelines provided by the Commission on Macroeconomics and Health in July 2001 for the work of WG6.

Terms of Reference

Introduction

1. The Commission's Sixth Working Group (WG6) addressed as its critical issue the question "**How much, and what forms of development support are needed to improve health outcomes for the poor?**" The work was conducted within the framework of the overall mandate of the Commission on Macroeconomics and Health (CMH), bearing in mind the terms of reference of the CMH's Working Groups 1 through 5.
2. Complementing the work of Working Group 1 (Health, Economic Growth, and Poverty Reduction), WG6 clarified the issues that non-health specialists, particularly macroeconomists and staff of Ministries of Finance and Planning, consider in managing development assistance to achieve health sector goals. It focused on the effectiveness of various forms of international developmental assistance in health (DAH) and their interactions with country policies, players, and priorities.
3. Its work aimed to clarify the factors, at country as well as donor levels, that inhibit or facilitate the translation of policy objectives and resources into actions designed to improve health sector performance and/or health outcomes on the ground—and assessed the degree to which DAH is doing the right thing and doing things right. It examined activities of various types, including those directed at specific country issues (whether diseases-specific or systemic), and, as feasible, including alternative forms of cooperation, such as activities that aim at the provision of international public goods, linking with the recommendations of Working Group 2 (Global Public Goods for Health). The objective of the work was to help both donor agencies and countries to achieve their stated main objective—poverty reduction—through improving health systems and health outcomes by

adjusting the level, format, and management of development assistance for health (DAH).

Context and Issues

4. Several contextual issues are relevant to the scope and content of the Working Group's activities.
   - Poverty is seen increasingly as multifaceted, with health, for example, accounting for about half of the International Development Goals that all DAC and major multilateral donors and governments support. Economic growth is increasingly seen as a means rather than an end of development.
   - Frustration with the slow pace of change in poverty, recognition of the interrelationships among many development challenges, pressures for debt relief, and a renewed appreciation of the role of partnership and ownership in securing development effectiveness are fueling rapid change in the forms and types of development assistance.
   - The appalling toll of the HIV/AIDs pandemic, renewed visibility of malaria, and the re-emergence of infectious diseases highlight the need to identify forms of cooperation that will promote global public goods while preserving and making more effective the provision of development assistance for strengthening health system performance at the national level.
   - Health outcomes are influenced by changes beyond the health system as well as by improvements in the quality, accessibility, effectiveness, and efficiency of medical care services. Comprehensive health policies must consider policy levers and programmes in other sectors (e.g. water and sanitation, food pricing, quality and distribution, regulation of tobacco, etc.) while also addressing the complex and politically sensitive issues underlying medical care delivery. Health policy choices are uniquely complex, and more so in highly resource- and capacity-constrained environments.
   - Addressing this complexity therefore requires the evolution of mechanisms that bring together a wide range of stakeholders, including key players in the supply of goods and services (public and private) as well as consumers and financiers. Recent analyses of aid effectiveness suggest that the transfer of ideas, tapping national capacity building, and local ownership of policy objectives are as important as financial transfers in ensuring the effec-

tiveness of aid. And our understanding of how to transfer knowledge is less well developed than our understanding of how to transfer financial resources. Building the institutional means to ensure sustained results has been a major stumbling block in the sector.

- Yet responsibility for health is primarily a national responsibility and donor policies and bureaucratic procedures are typically highly "sectoralized". These factors constrain the evolution of comprehensive health policies at the national level while missing opportunities to address global public goods at the transnational level. There is uncertainty about "what counts" as external assistance (i.e. how much of ODA is effective, and what other forms of external influence should be considered as determinants of health policies and outcomes).
- This uncertainty exists in an environment of shrinking political and financial support for development assistance among both developed and developing country constituencies, heated debate on the effectiveness of development assistance overall, and intensifying pressures
  for greater accountability for results from every "foreign assistance" dollar.
- At the same time, while always difficult, recent trends towards a higher proportion of programmatic and sectorwide approaches to official development assistance in health make it increasingly unrealistic to attribute changes in health system performance or health outcomes to particular elements of external assistance. A more holistic analysis of the impact of national as well as external resources may be appropriate in the future.
- There is evidence that the effectiveness of ODA is strongly conditioned by the policy and institutional context (of both donor and recipient/borrower), "ownership" of policy and programmatic initiatives, and participation in the development and implementation of these initiatives. The relevance and implications, if any, of these observations for the health sector need to be articulated. It is important to complement the now conventional wisdom that "policy and institutional context matters" with a systematic consideration of the implications for assistance in the health sector.

Focus and scope

5. WG 6 conducted its work through four major clusters of analysis and consultation:
   - Documentation of current *levels and recent trends in DAH*, using both aggregate data and, more selectively, through analysis of the allocation of DAH across health objectives and by modalities in a number of countries. The purpose of this was to yield a descriptive account of how many and what type of resources are currently being allocated to the health sector through conventional development assistance channels. It also sought to document, building on the activities of WG2, current levels of allocations to "global public goods" in the health sector, as a basis for consideration of future scenarios on the levels and directions of DAH.
   - Consultations with officials and staff of a selected number of agencies identified *factors that influence donor decision making on the allocation of resources to health (relative to other sectors),* and among various purposes and modalities of assistance within the health sector. The WG also documented how different agencies approach the evaluation of the effectiveness of external assistance and the cost factors influencing the effectiveness of their work.
   - *Consultations with national level stakeholders* (official, from civil society and other groups) in a selected number of countries on the relevance, effectiveness, and efficiency of various forms and types of external assistance.
   - To articulate the findings and implications of these analyses, WG6 also prepared a series of **prospective scenarios** to facilitate the CMH's consideration of future trends in DAH and their implications. Review and discussion of these scenarios, again, through a consultative process, formed the basis of the WG's recommendations.

Phasing the WG's Activities

6. The WG organized its work in three phases to optimize the use of the members' time and to ensure that their consultations with country and agency level focus on prospective as well as retrospective issues.
   - *Phase I: Background Studies*: During the first phase, the WG commissioned three background studies that: 1) documented recent trends in DAH, 2) synthesized lessons on the effectiveness of DAH from the research literature (including previously conducted case studies), and 3) constructed a framework to guide the WG's con-

sideration of possible scenarios for the direction of DAH. These three papers were prepared between July and November 2000, and their results were reviewed in a 2-day workshop of the WG membership (its second meeting) held just prior to the November meeting of the CMH. The objective of this meeting was to prepare detailed guidance for the conduct of the consultative phase of the WG's work, including interview guidelines for agency and country level consultations.

- *Phase 2: Donor Agency and National Level Consultations*: During the second phase, the WG commissioned two forms of consultation. First, the WG commissioned a series of case studies/consultations with five to six donor agencies currently active in DAH. The objective of these consultations was to build a better understanding of how a selected set of bilateral and multilateral donor agencies allocate their financial and human resources, and focused in particular on the role and views of decision makers outside of the health sector. The review also described the factors that guide the allocation of overall levels of assistance to the health sector. (By scheduling these discussions to follow the work to document trends in DAH, we were also able to solicit agency views and explanations on the rationale for the patterns revealed through those data.) The reviews also collected agency views on the effectiveness of different modalities and instruments for delivery of foreign assistance, and agency approaches to assessing aid effectiveness in this sector.

  In addition, WG6 sought opportunities to consult with interested stakeholders through participation in the Peoples Health Assembly 2000 in Dhaka, Bangladesh; a workshop on development assistance co-hosted by the Ministry of Health in Ghana and the UK Department of International Development; and consultative meetings during the World Health Assembly in May 2001 and the United Nations conference on least developed countries in May 2001.

  These two arms of consultation culminated in a third meeting of the entire WG in mid-late March 2001. During this meeting, the WG reviewed and commented on the findings generated through the consultative process, focusing in particular on assessing the consultative process relative to the prospective scenarios developed during Phase 1. The outcome of this meeting was agree-

ment on the primary messages and recommendations to be developed in the WG's Report and recommendations.

- *Phase 3: Consolidation and Preparation of Report*. The third phase synthesized the findings of Phase 1 and 2 into this summary Report. As results of Phases 1 and 2 were completed, the Working Group identified linkages with the activities and conclusions of the other five Working Groups and incorporated these linkages in the final Report.

Annex 4 Conceptual Framework for Assessing Effectiveness of DAH

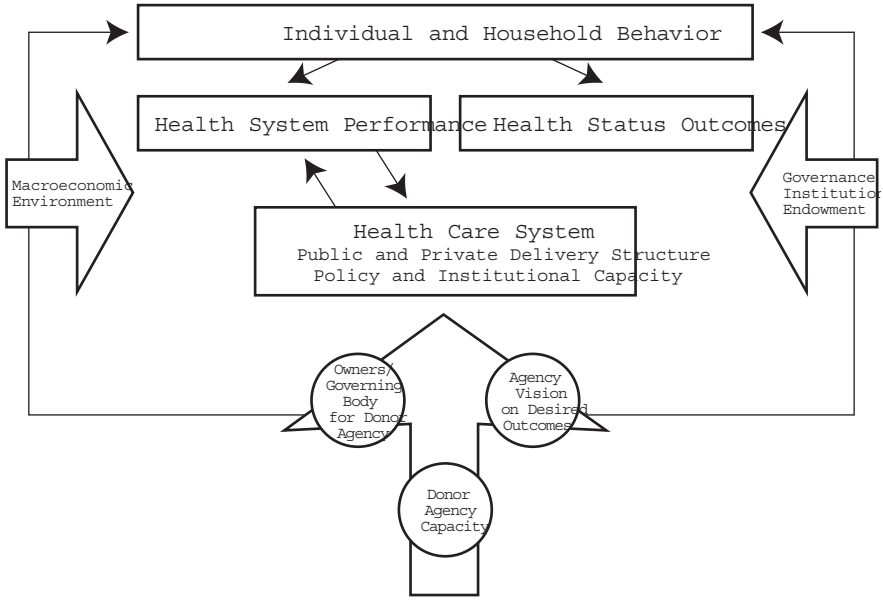
What factors influence change in health outcomes? What factors influence the performance and effectiveness of health systems? And last, what are the possible interactions between these factors and the influences and characteristics of donor behaviour?

Morbidity, mortality, and fertility, themselves interrelated, are determined by an array of factors in addition to health services. The most important are income, nutritional status, education, and the quality of the environment—including access to and use of safe water and sanitation. The next most important are individual and community practices related to nutrition, sanitation, reproduction, alcohol and tobacco use, and other health-seeking behaviours, which are in turn related to social and economic status and culture, and play major roles in mortality and morbidity.

Accordingly, health-related interventions can reduce the burden of disease either through preventive services and encouraging healthy behaviour, or by providing curative care. Increased understanding of the causes of disease and improved interventions for both preventive and curative services has improved health outcomes throughout the world. Prevention is often (although not always) more cost-effective than treatment, but strong demand for curative services can result in a disproportionate emphasis on the medical care. Both preventive and curative interventions must manage the link or interface (including the absence of such a link) between individuals' and households' behaviour and the supply system to be effective.

Understanding factors that influence the reach and utilization of services and information requires an understanding of the characteristics of the health system. The attributes of the particular goods and services that are delivered as part of particular interventions and, more fundamentally, institutional capacities to improve health system performance and outcomes need to be better understood. Although we are far from being able to specify the paths through which they exert their influence, it is clear that a country's macroeconomic and institutional endowment can influence qualitative and quantitative dimensions of health system perform-

Figure A4.1 Framework for reviewing development assistance in health



Source: Johnston and Stout (1999).

ance. In fact, there is considerable evidence to suggest that understanding these variables better is fundamental to unpacking the less-than-robust relationship between health expenditures and changes in health outcomes.

Not all health activities have the characteristics of public goods—differentiating among specific goods and services within the sector is key to influencing the efficiency and effectiveness of service delivery in this sector, and builds on recent analyses of the incentives and disincentives surrounding the provision of public and private goods. A set of questions takes on particular urgency in view of the increasing linkages between rapid and extensive changes in the global economy and the emergence of health issues that could be characterized as *global public goods*.

And last, as illustrated in the bottom element of Figure A4.1, it is also important to understand the institutional and political factors that influence donor behaviours. The form and effectiveness of DAH is influenced by each agency's objectives, the views of its owners and stakeholders, operational capacity, and ideas on what "adds value" in the sector. Recent discussions of so-called sectorwide approaches and the evolution of programmatic instruments in the health sector have contributed much to our

appreciation of the need to review donor as well country-level capacity and governance. We thus sought information on what factors influence the way donor agencies approach the issue of development assistance and health, and what issues are relevant to their decisions about who much and what forms of the DAH they support.

Annex 5 List of Tables, Figures, and Boxes

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