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AID EFFECTIVENESS IN HEALTH

Contributed by: The World Bank and the World Health Organisation

Global Forum on Development: Pre-meeting on Aid Effectiveness in Health
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This paper describes harmonisation and alignment efforts in the health sector and discusses the inherent complexities of the sector, the associated aid effectiveness challenges, and recent efforts to address these issues. It also assesses the relevance of the Paris Declaration Principles for health and recommends using health as a tracer sector to monitor overall progress towards harmonisation and alignment. The Executive Summary of this document has been issued separately as COM/DCD/DEV(2006)5.

The Best Practice Principles for Engagement of Global Health Partnerships in Annex 2 represent a previously agreed coordination effort on global programmes and may be regarded as a companion piece to the Draft Good Practice Guidance for Integration and Effectiveness of Global Programs [COM/DCD/DEV(2006)9], which will be discussed at the "Policy Workshop on Global Programmes and the Paris Agenda" on 5 December.

Participants in the Pre-meeting on health and the Policy Workshop are asked to review the above Principles and Guidance. Both sets of documents reflect major international initiatives to better integrate global programmes into partner countries' development agendas, as called for by the Paris Declaration (Para 4.iv). They will be submitted to the Working Party on Aid Effectiveness for further review and discussion in the context of emerging issues for the 2008 Accra High Level Forum .

Contact: Ms. Rebecca Dodd, World Health Organisation (doddb@who.int); Mr. George Schieber, World Bank (gschieber@worldbank.org)

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INTRODUCTION

1. The health sector has always been an important recipient of global attention and external assistance. Humanitarian concerns about the health of the world's poor, along with fears about the spread of epidemics such as HIV/AIDS, have made health a central pillar of most development policies. Over the last 30 years attention has increased with the emergence of new health threats – such as HIV/AIDS and pandemic influenza – and with recognition that health is a key determinant of economic growth, labor force productivity and poverty reduction. At the same time, health is increasingly viewed as a human right, the fulfillment of which places obligations on both developed and developing countries.

2. Health has also been at the forefront of the debate on what aid effectiveness means from a sectoral perspective. In the mid-1990s health policymakers designed and pioneered sector-wide approaches (SWAps), which aimed to foster ownership, improve donor harmonization and aid predictability, and align policy behind a health-reform program agreed between government and donors.

3. As this paper illustrates, aid effectiveness is particularly challenging in health. As with other sectors, difficulties are the result of inefficiencies in the global aid architecture and of poor country policies; however, problems in health are exacerbated by the inherent complexities of the sector itself. The large number and diverse nature of development partners active in health, the large unmet needs, the dependency on multiple sectors to achieve health outcomes, the major roles of the private sector in both financing and delivery, and the long-term recurrent nature of most health needs have created challenges for countries, but have also stimulated innovative ideas on how to move forward. As a result, the health sector may be a good "tracer" sector for OECD/ DAC to monitor overall harmonization and alignment progress.

The organization of the paper is as follows:

4. *Section 1* sets the context in which aid for health is delivered: outlining the worryingly slow progress towards the health MDGs, despite increases in aid for health; poor commitment to health among developing country governments, with the result that health is often not prioritized within development frameworks; and, insufficient attention to equity or financial sustainability. This section also provides an overview of recent trends in development assistance for health.

5. *Section 2* describes the aid architecture in health, demonstrating that the inherent complexities of the health sector itself makes health one of the most challenging sectors for development partners to support. It provides an overview of the global aid architecture in health, including the recent emergence of global health partnerships, and it looks at the ways in which ineffective health aid impacts on developing countries, including fragile states. This section summarizes key findings from HLF research into aid effectiveness in health.

6. *Section 3* examines recent approaches to improving aid effectiveness in health. It makes the point that the Paris Declaration is a critical vehicle for aid effectiveness efforts in health, and looks at selected indicators from the Declaration to demonstrate its relevance. Experiences from health highlight some of the concrete difficulties and challenges that donors experience as they attempt to harmonize and align their aid, thus making the sector a good marker of progress and a source of 'lessons learnt' and best practice. Section 3 also reports on existing efforts to promote harmonization and alignment in health, including the *Scaling Up for Better Health Initiative,* the *Three Ones*, and innovative financing arrangements.

7. *Section 4* concludes the paper, noting that improvements in the quality of aid for health will be critically important as donors make good their promises to increase aid levels between now and 2015. It suggests that the Paris Declaration remains the basic frame of reference for aid effectiveness efforts in the health sector, and to this end recommends a strong link between the *Scaling Up for Better Health Initiative* and the work of the OECD/DAC. Finally, OECD/DAC members are asked to support country-level efforts of the *Initiative* to promote mutual accountability.

Section 1: Background and Context

8. Numerous reports[1] have highlighted the stark imbalances between rich and poor countries in terms of disease burden, the huge unmet health needs in most developing countries, and their lack of domestic resources to cope with these needs:

- 90 percent of the global disease burden is in developing countries which account for only 12 percent of global health spending;
- High-income countries spent more than 100 times per capita on health than low-income countries; and,
- Developing countries will need between US$25 – US$70 billion in additional aid per year to remove the financing constraint to scaling up to meet the Millennium Development Goals (MDGs).

9. The MDGs put health squarely at the center of the international development agenda: three of the eight MDGs relate directly to health; the poverty reduction MDG is affected when citizens are pushed into poverty by catastrophic health care costs or lost earnings resulting from ill health; and several of the other goals (e.g., education, sanitation) interact directly with health outcomes. The international community has substantially increased its aid commitments generally and Development Assistance for Health specifically to assist countries to scale up to meet the MDGs[2]:

- DAH has increased from US$2.5 billion in 1990 (0.016 percent of GNI) to almost US$12 billion in 2004 (0.038 percent of GNI), and has also increased from 4.6 percent of official development assistance (ODA) in 1990 to close to 15 percent in 2004.
- Much of this assistance, is targeted to specific diseases or interventions, which as discussed below raises issues of funding imbalances and prioritization.

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1 Refer to the following: The World Bank. 1993. *World Development Report: Investing in Health*. Washington, DC: Oxford University Press.; Gottret, Pablo and George Schieber. 2006. *Health Financing Revisited.* Washington, DC: World Bank; World Bank. 1993. *Disease Control Priorities in Developing Countries Volume 1*. Washington, DC: World Bank.; The World Bank. 2006. *Disease Control Priorities in Developing Countries Volume 2*. Dean T. Jamison, Joel G. Breman, Anthony R. Measham, George Alleyne, Mariam Claeson, David B. Evans, Prabhat Jha, Anne Mills, Philip Musgrove, eds. Washington, DC: World Bank.; WHO (World Health Organization). 2000. *The World Health Report 2000: Health Systems-Improving Performance.* WHO: Geneva.; Commission on Macroeconomics and Health. 2001. *Macroeconomics and Health: Investing in Health for Economic Development*. Presented by Jeffrey D. Sachs to Gro Harlem Bruntland, 20 December 2001. WHO: Geneva.; UNDP (United Nations Development Programme). 2005. *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*.

2 Michaud, Catherine. 2006. Harvard School of Public Health. Personal communication, November 2006.

- Partially as a result of this increased DAH, overall health spending in developing countries has also been increasing. Between 1990 and 2002, total health spending[3] in developing countries increased by over 100 percent: from US$170 billion in 1990 to US$351 billion in 2002, or from 4.1 percent to 5.6 percent of developing country GDP. However, in some countries domestic spending on health has stagnated or even reversed.

10. However, the impact of these increased resources on health has been mixed. While there have been notable successes, particularly in countries with strong and continuous government commitment to reform, overall results have been disappointing. Annex I contains the World Bank's latest estimates by region of progress towards the MDGs. It shows that the majority of countries in Africa are off-track on all the health goals. More broadly, in all regions except the Middle East and North Africa and South Asia, most countries are off-track with respect to the child mortality goal. It is in this context that questions have arisen about the effectiveness of health spending and concomitantly the integrity of the global aid architecture in health.

Section 2: Aid Architecture in Health

11. This section explores aid effectiveness issues in health. It begins with an overview of the aid architecture in health, focusing in particular on the emergence of global health partnerships (GHPs). It then describes some of the inherent complexities of the health sector itself, demonstrating why it is a challenging sector for development partners to support. Finally, it reports on the consequences of all these factors – a complex architecture, a challenging sector, and the presence of major new actors – for the delivery of health aid at country level, including in fragile states.

2.1 Global Aid Architecture in Health

12. There are more major global stakeholders in health than any other sector and literally hundreds of different flows of public and private funds to specific countries. Issues include:

- The various international organizations and stakeholders have overlapping and unclear mandates – no single organization coordinates global health policy, financing and implementation processes at country or regional levels, nor knowledge dissemination.

- Much of the increase in health aid over the past 10 years has come from new organizations such as foundations and global funds, and is targeted to specific diseases and interventions. As a result, diseases now account for an increasing proportion of donor aid. The latest Global Monitoring Report shows that while the share of health aid devoted to HIV/AIDS more than doubled between 2000 and 2004 – reflecting an effective global response to an important need – the share devoted to primary care dropped by almost half.[4]

- There are important global public goods (GPGs) *for health* (and associated market failures) that require donor support. These are not the subject of this paper. However it is important to mention that while some GPGs, such as international efforts to fight emerging disease threats, have attracted considerable attention, others such as vaccines and medicines for diseases that predominate in developing countries, have not. Section 3 reports on recent efforts to redress this imbalance.

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3 Includes external and domestic spending.

4 Share of DAH devoted to primary care dropped from 28% in 1999 to 15% in 2004. The World Bank. 2006. *Global Monitoring Report 2006: Strengthening Mutual Accountability -- Aid, Trade, and Governance.* Washington, DC: World Bank.

13. Finally, as in other sectors donor governments find it politically advantageous to raise aid 'vertically' to show their populations that their tax monies are being spent on 'good causes'. While this is an issue in all sectors, the consequences are particularly acute in health as there is a need for flexible resources that can be used to support recurrent costs, other sectors that directly impact on health, and health systems (see section 2.4). While many donors recognize the need to provide flexible funding to support country-owned health reform plans, concerns about public sector management and governance, particularly in fragile states, may make them reluctant to do so.

2.2 Global Health Partnerships: Adding to the Complexity?

14. In the last decade, the aid architecture in health has become even more complex with the emergence of large global health partnerships. It is worth remembering that part of the original rationale for establishing GHPs such as the Global Alliance for Vaccines and Immunizations (GAVI) and the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM) was to better focus health aid in areas of perceived neglect and to *simplify* the aid architecture in health, and as a consequence make health aid more effective. Many observers believe – and a range of studies suggest[5] – that this objective has not been achieved.

15. Estimates suggest that there are between 75 and 100 GHPs, depending on the definition.[6] GHPs are a heterogeneous group, ranging from advocacy to co-ordination to financing, and are diverse in nature, scale and scope. However, the vast majority relate to communicable diseases, and 60%[7] target the 'big three' diseases of HIV/AIDS, tuberculosis (TB) and malaria. HIV/AIDS attracts the most GHPs by some margin. While there are a large number of GHPs, only a handful have a major impact on health financing – notably, GAVI and the Global Fund. Between 2003 and 2005, the Global Fund committed on average US$1.16 billion annually. This is particularly remarkable given that the Fund was only established in 2002.[8] Funding from GAVI and the Global Fund now account for some 9 percent of DAH.

16. On the one hand, it is recognized that GHPs have mobilized important new resources for major health threats, and brought much needed political and technical focus to priority diseases or interventions. They have injected new energy into the aid business by supporting the private sector and community-based organisations to play a much more prominent role in the provision of health care. On the other, there has been concern that the rapid creation of new institutions in health is difficult for countries to manage, and further complicates donor harmonization efforts at the global level. In particular, GHPs may intensify the 'vertical' nature of health financing by focusing large amounts of new funding for specific, relatively narrow programs and interventions, creating separate financing and delivery silos, and leaving recipients little flexibility to reallocate funds according to their priorities or to fund health systems costs, such as salaries.

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5 Caines, Karen. 2005. "Key Evidence from Major Studies of Selected Global Health Partnerships". Background paper prepared for the High-Level Forum on the Health MDGs. April 26-27, 2005. London: DFID Health Resource Centre.; Bill and Melinda Gates Foundation. 2005. *Global Health Partnerships: Assessing Country Consequences.* McKinsey and Co. for the High Level Forum. Seattle, Washington.; Caines, Karen et al. 2004. *Assessing the Impact of Global Health Partnerships.* London: DFID Health Resource Centre.

6 Caines, Karen 2005. *Key Evidence from Major Studies of Selected Global Health Partnerships*. Background paper prepared for the High-Level Forum on the Health MDGs. April. London: DFID Health Resource Centre.

7 Ibid.

8 Michaud, Catherine. 2006. Harvard School of Public Health. Personal communication, November 2006.

17. Until recently, strongly held views on both sides were based on anecdotal, incomplete or partial information. Developing and developed countries, and GHPs themselves, agreed that better evidence was needed to assess the impact of GHPs at country level. As part of the High Level Forum on the Health MDGs (HLF) a thorough review of all existing studies was carried out and a new study was commissioned from McKinsey & Co in 20 countries.[9] Key points from the study include that GHPs pay insufficient attention to health systems, that technical assistance in support of implementation should be increased, that communication between GHPs and recipients is often poor, and that GHPs impose significant transactions costs on governments.

18. The HLF process also oversaw development of a set of *Best Practice Principles for Global Health Partnerships* (see Annex 2). Based on the Paris Declaration, the Principles were endorsed by HLF participants and have now been adopted by the boards of a number of GHPs and are informing implementation of the Paris Principles.[10]

2.3 Health: A Complex Sector[11]

19. Complexities in the aid architecture for health mirror the complexities of the sector itself. Creating and sustaining population health; providing financial protection from the consequences of ill-health; and managing, financing and governing the *health system* are all difficult and costly.

20. Improving *health outcomes* is challenging because they are:

- Dependent on a range of inputs beyond the jurisdiction of the ministry of health, in particular education, water and sanitation and nutrition, and thus require co-ordination and co-operation between health and other parts of government, something for which there is typically little incentive, finance or structure to manage.

- Reversible, if access to services is interrupted (unlike gains in education, for example).

- Dependent on individual behavior, which is typically very difficult to influence or change.

21. Providing financial protection and financing the health system is complex because:

- The bulk of the funding needed for health systems is for *long term recurrent* costs. However, in many low-income countries, a significant amount of health finance comes from external sources, most of which are unpredictable and short-term.

- Unlike education or water and sanitation, private contributions to health generally equal or exceed public contributions, making it more difficult for governments to maximize the impact of overall health investments, assure financial protection, and ensure equity.

- There are close links between health and poverty, as catastrophic medical events drive people into poverty by both reducing individuals' earning abilities and imposing large medical expenses.

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9 Bill and Melinda Gates Foundation. 2005. *Global Health Partnerships: Assessing Country Consequences.* McKinsey and Co. for the High Level Forum. Seattle, Washington.

10 These GHPs are: GAVI, Stop TB, and the Health Metrics Network

11 G. Schieber, P. Gottret, and L. Fleisher, "Getting Health Financing Right", *Finance and Development,* December 2006.

This costly 'financial protection' element is largely unique to the health sector and creates difficult tradeoffs for resource-constrained governments.

- Market failures in insurance (as in the health sector more generally) require complex regulatory frameworks.

22. Managing the *health system* is difficult because:

- Health may be governed by more than one ministry (e.g., health insurance may be overseen by the ministry of social welfare or labour rather than the ministry of health, while the ministry of education is responsible for the training of health workers). Further, oversight of health services is usually shared by central authorities and local government.

- There are well over a 100 major international organizations involved in the health sector, globally and nationally, far more than in any other sector.

- At the country level, non-state actors play a substantial and often predominant role in both the financing and delivery of healthcare services, but are often absent from the aid effectiveness and scaling-up agendas.

23. These issues are particularly difficult to manage in low- and middle-income country contexts, where capacity and governance are weak, monitoring and evaluation capacity is limited, and the quality of health plans tends to be poor. A 2004 review of 14 countries[12] found that health plans and strategies are rarely evidence-based, do not adequately prioritize, nor do they show how inputs link to outputs and outcomes.

24. Further:

- Health plans tend to be poorly linked to development frameworks such as Poverty Reduction Strategy Papers (PRSPs), Medium Term Expenditure Frameworks (MTEFs) and their associated annual budgets.

- Conversely, PRSPs rarely address the health sector adequately, or discuss the explicit complementarities and tradeoffs with other sectors.

- Few Ministries of Health can communicate effectively with Ministries of Finance on these issues.

25. This is a *catch-22*: poor public sector management, particularly in line ministries like health, has weakened government capacity and incentives to take a comprehensive approach or link health with broader development policies and plans. And the lack of such capacity makes donors reluctant to invest across the health system, perpetuating vertical approaches. Ineffective aid has exacerbated rather than created this situation – but better quality aid will be the key to progress.

2.4 Aid Effectiveness Issues at the Country Level

26. There are at least four important manifestations of ineffective health aid at the country level:

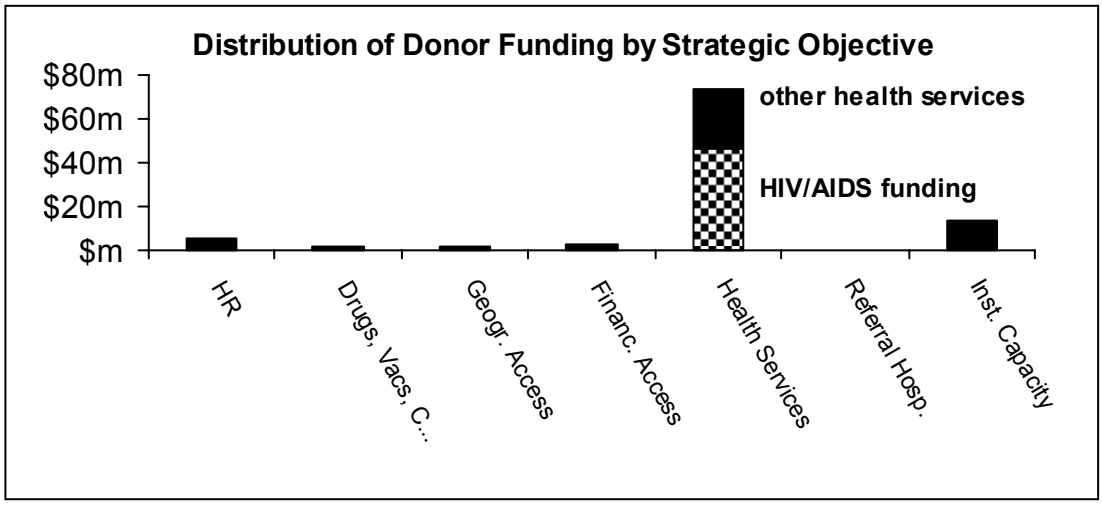
[12] Rwanda, Ministry of Finance and Economic Planning and Ministry of Heath. "Scaling Up to Reach the MDGs in Rwanda." Paper presented at the World Bank/WHO conference, "Follow-on Meeting to the Post-HLF on the Health MDGs," Tunis, June 12 and 13th, 2006. http://www.hlfhealthmdgs.org/Documents/June2006ScalingUptoAchievetheHealthMDGsinRwanda.pdf

Aid is often not aligned with government priorities and holistic health systems approaches are insufficiently funded

27. As discussed above, health aid is often earmarked for specific purposes. Only about 20 percent of all health aid goes to support the government's overall program (i.e., is given as general budget or sector support), while an estimated 50 percent of health aid is off budget.[13] As a result, many countries report difficulties in attracting sustained, flexible funding that can be used to support the health *system*: staff, infrastructure, training, management, etc.

28. In some cases separate financing and delivery silos are creating funding distortions within the sector. Rwanda is a case in point: the government has identified seven strategic objectives for health, but as Figure 1 illustrates, donor funding is heavily earmarked to just one of these, making it impossible for government to make balanced investments across the sector.

Figure 1: Distribution of donor funding for health by strategic objective in Rwanda[14]



Aid can be unpredictable, short-term and volatile

29. In addition to being heavily earmarked, health aid can be very short-term and volatile (see Figure 2). Typically, donors only commit their aid 12 months in advance, and levels of aid can vary greatly from year to year. Figure 2 illustrates this problem dramatically for four countries. When the amount of aid a country receives is likely to change at short notice, it is impossible for ministries of health and finance to make long-term plans – such as employing more doctors or nurses, widening access to AIDS treatment or scaling up health service provision – without incurring major risks of sustainability of financing for these services. Aid turned on and off may also contribute to drug resistance, as medicines are provided and then withdrawn. A related issue, which also creates difficulties for ministries of finance and planning, is that aid can be unpredictable (disbursements do not match commitments, even where the reasons are not related to performance).

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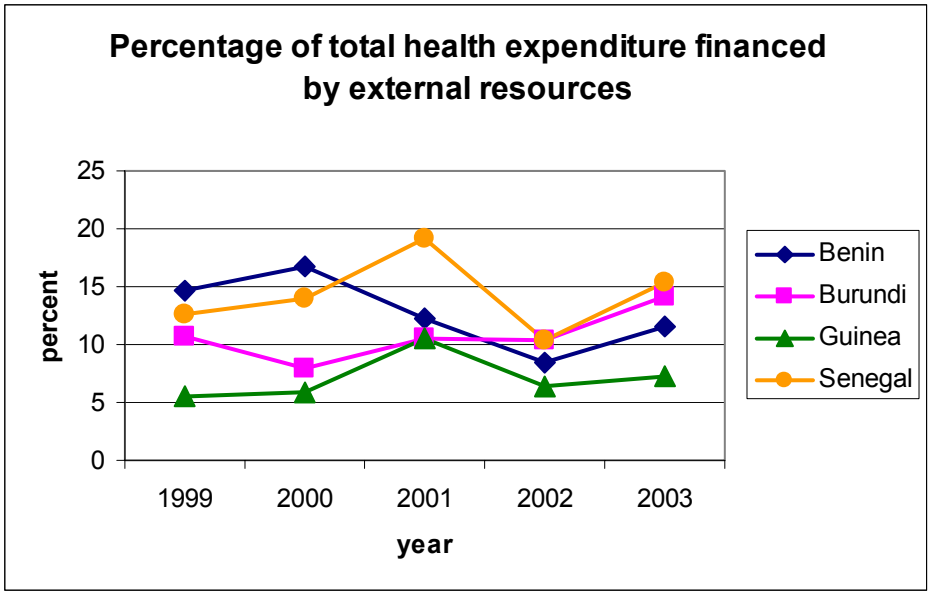
13 Foster, Mick. 2005. "Fiscal Space and Sustainability: Towards a Solution for the Health Sector." Paper presented at the World Bank/WHO conference "Third High-Level Forum on the Health MDGs," Paris, November 14-15. http://www.hlfhealthmdgs.org/Documents/FiscalSpaceTowardsSolution.pdf

14 Rwanda, Ministry of Finance and Economic Planning and Ministry of Heath. "Scaling Up to Reach the MDGs in Rwanda." Paper presented at the World Bank/WHO conference, "Follow-on Meeting to the Post-HLF on the Health MDGs," Tunis, June 12 and 13th, 2006. http://www.hlfhealthmdgs.org/Documents/June2006ScalingUptoAchievetheHealthMDGsinRwanda.pdf

30. While volatility is an issue in all aid-dependent sectors, the issue is particularly acute in health because of the high proportion of long-term recurrent costs in health budgets and the importance of external aid as a health financing source in some 30 heavily aid dependent countries

Figure 2: Volatility in aid for health, 4 countries:

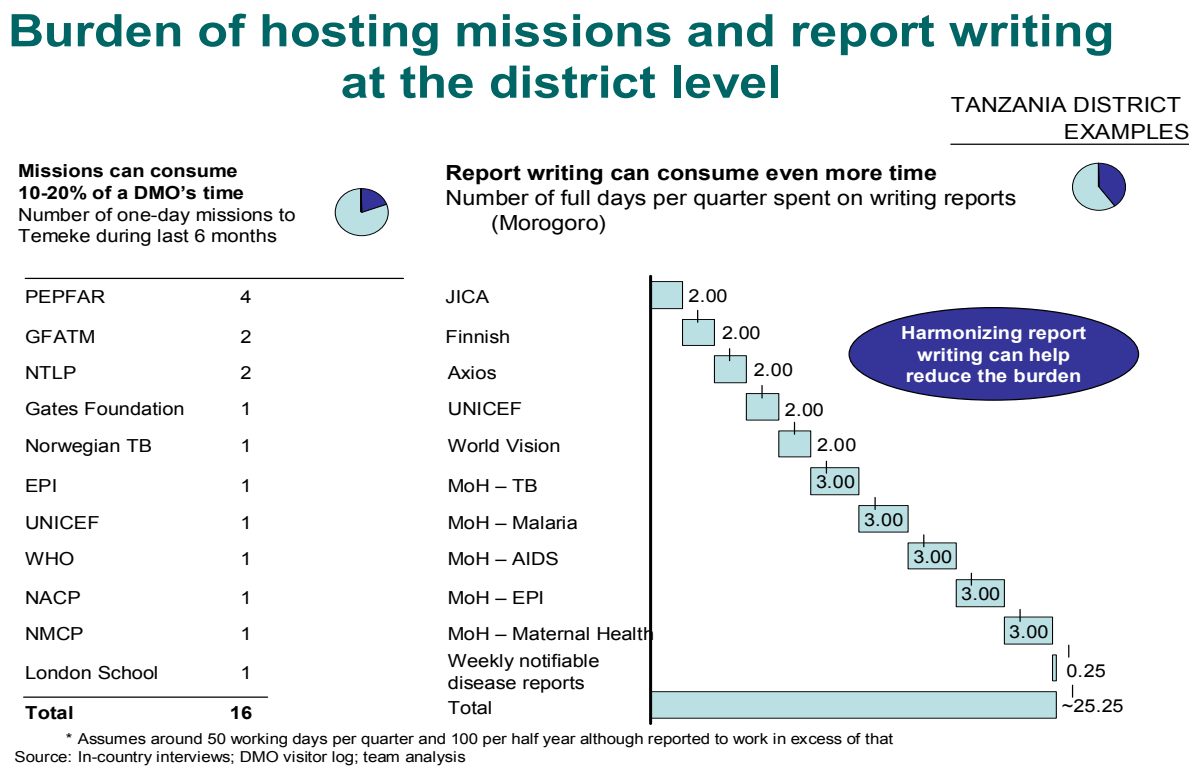


Aid may be poorly harmonized, increasing transaction costs for government

31. The high number of donors present in health, the large number of separate health programs, and large volume of resources can create high transaction costs, which many countries have only a very limited ability to manage. The issue is well illustrated by a graphic from a recent study by McKinsey and Co (Figure 3), which shows the amount of valuable time district level health staffs devote to hosting missions and report writing. While GHPs account for much of this burden, the illustration shows that this is a problem they've added to rather than created: lack of harmonization among health partners is at the root of the issue.

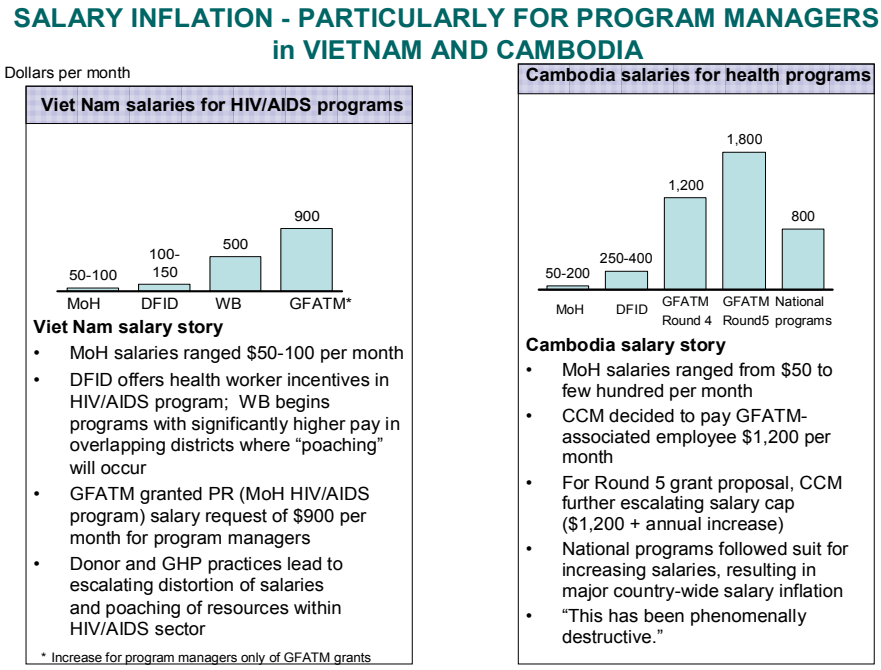
32. A related issue, also reflected in the McKinsey study, is that the presence of multiple health partners may inadvertently undermine the government's broader efforts in the health sector. This issue emerged in Cambodia and Viet Nam, where multiple donor grants fuelled wage increases among health staff (see Figure 4). This is likely to have affected the government's ability to deliver programmes in other areas. The broader point is that multiple funding streams in health may carry unpredictable risks and transaction costs unless they are well co-ordinated both with each other and with government.

Figure 3: Transaction costs of poorly harmonized aid



33. Except in a few countries - notably Uganda and Tanzania - instruments for mutual accountability of donors and recipient countries are rare. These instruments include overall compact agreements that align donor aid to countries' PRSP and MTEFs as well as sector-specific memoranda of understanding that align countries' sector strategies with their financing requirements and outline donor and country responsibilities. Although some progress has been made through Sector Wide Approaches (SWAps), these efforts rarely align the sector with the overall macroeconomic framework and cross-sectoral issues or establish clear and monitorable outputs and responsibilities.

Figure 4: Un-coordinated aid fuels salary inflation in the health sector



As donors move to general budget support, sector specific impacts need to be carefully monitored

34. Finally, aid effectiveness gains through general budget support (GBS) may have unintended spending consequences at the health sector level, if health is a low priority for governments and/or poorly reflected in poverty reduction strategies. While GBS is the most flexible and often the most desirable form of aid from governments' perspectives, there are concerns that health may not do as well as other sectors under GBS as aid is fungible (i.e., governments can reduce their domestic revenue-based support for programs they perceive to be well funded by donors, particularly when priorities do not match). In other words, if there is strong external support for the sector, governments may feel they do not need to allocate their own resources because 'health is taken care of by donors'. The combination of donor support being focused on disease-specific programs and of the low priority placed by some governments on health (as evidenced through budget allocations), could mean a double squeeze on health systems and other less favored parts of the health sector. Given the trend toward increased GBS, sector specific impacts need to be carefully monitored. Such monitoring is clearly consistent with the current trends, discussed below, for results-based aid and mutual accountability.

2.5 Fragile States

35. A separate set of concerns emerge in under-aided countries ('aid orphans'). The orthodoxy that 'aid works best in well-governed countries' is both intuitive and confirmed by experience. The difficulty is that the category of 'well governed countries' does not necessarily include those in greatest need of aid. Fragile states – those with weak governance and institutions – account for one sixth of the people living in the developing world and one third of those living on less that US$ 1 per day. These countries are least likely to achieve the MDGs: a third of maternal deaths and nearly half of under-five deaths in developing countries occur in fragile states.

36. However, it is not easy for development agencies to engage with fragile states. While not *all* fragile states are donor orphans, on average aid to such states is approximately 40% less per capita than aid to other (non-fragile) low-income countries. Aid to fragile states also tends to be more volatile. When donors do engage, they often establish parallel systems because government systems are weak. This approach can further undermine fragile states, and can make future capacity-building difficult. 'Shadow alignment' with government systems and priorities (for example, basing donors' systems on local administrative boundaries or using local planning and budget cycles) is one possible way forward.

37. Within health, fragile states present particular problems for donors. Working in health is likely to be more expensive in fragile states than in other low-income countries due to the complexities of the sector, poor infrastructure, security issues, and the need to implement small-scale operations. A particular aid effectiveness issue worth highlighting is the drop in aid which often occurs in the 'transition phase' between the end of a humanitarian crisis and the beginning of development financing. In health, this may affect service provision as humanitarian NGOs previously providing health care leave once the crisis is over, but before alternative service delivery arrangements are in place.

38. Fragile states also present opportunities for donors. A recent study[15] estimated that on average each US$1 spent on conflict prevention generates over US$4 in savings to the international community. In addition, aid can be a powerful tool in stabilizing countries which are emerging from crisis, and in accelerating their return to the development process. Investing in service delivery, including health, can be particularly effective in this regard. Donors therefore need to find and institutionalize more effective ways of working *on health* with fragile states. There is no golden recipe for success, but a paper presented at the HLF[16] suggests principles for moving forward. This work has in turn fed into the OECD DAC's work stream on fragile states, which is now looking at health in some detail.

Section 3: Towards Greater Aid Effectiveness in Health

39. To summarize the discussion so far: countries are not progressing towards the health MDGs quickly enough despite recent increases in development assistance for health. The complexities of the sector and the resulting harmonization and alignment challenges are likely to be factors. More effective aid cannot on its own deliver better health in poor countries: greater commitment to health from developing country governments, stronger health systems, better alignment of health plans with annual budgets, PRSPs and MTEFs, and improved systems for public accountability, governance and monitoring and evaluation are also needed. However ineffective aid is an obstacle to progress towards the MDGs, just as better quality aid will help secure results.

3.1: The Paris Declaration as a Key Point of Reference

40. The Paris Declaration is a key point of reference for improvements in health aid: as the framework for aid effectiveness in general, it also frames efforts to improve aid for *health*. Box 1 provides a snapshot analysis of the relevance of the Paris Declaration in this regard. It suggests that disaggregating information on health from the Paris Declaration Monitoring Survey is likely to be useful both to the health sector and to the broader monitoring exercise, particularly given the growth of development assistance for health both in absolute terms and as a share of ODA. Equally, as the OECD gathers good practice

15 DFID (Department for International Development). 2005. *Why we Need to Work More Effectively in Fragile States*. London: Department for International Development. http://www.dfid.gov.uk/pubs/files/fragilestates-paper.pdf

16 "Health Service Delivery in Post-Conflict States." Paper presented at the World Bank/WHO conference "Third High-Level Forum on the Health MDGs," Paris, November 14-15. http://www.hlfhealthmdgs.org/Documents/HealthServiceDelivery.pdf

examples from country level efforts on harmonisation and alignment in general, it may want to look in particular at the health sector. Experiences from health highlight some of the challenges that donors encounter as they attempt to harmonize and align their aid, thus making health a good marker of progress and a source of 'lessons learnt' and best practice. From the perspective of the health sector, information on progress towards the Paris Principles would be a useful complement to existing efforts to improve health aid. Any such effort would have to be done jointly within the health community – specifically the 'Scaling up for Better Health Initiative', discussed below – and the Joint Venture on Monitoring of the DAC Working Group on Aid Effectiveness.

Box 1.

THE PARIS DECLARATION AS A FRAMEWORK FOR ASSESSING AID EFFECTIVENESS IN HEALTH

This box examines five selected indicators from the Paris Declaration from a health perspective.

Indicator 3 of the Paris Declaration looks at *aligning aid flows on national priorities.* This is a particularly important issue in health for a number of reasons. First and foremost, the diverse nature of the health sector often means that countries have a range of "competing" plans, for example separate plans on population, maternal health and child health, each supported by a different donor. Thus, there may not be a single "plan" or an agreed set of priorities for donors to align behind. Secondly, the broad range of stakeholders involved in health, including NGOs and activists from the global north which seek to influence health sector spending in line with their particular priorities, underscore the need to agree upon common health sector goals. Thirdly, the independent expenditures by donors may generate large distortions and misalignments not only with respect to the burden of disease in the recipient country but also in the expenditures across regions, targeted populations and between health and other sectors which influence health outcomes. These distortions generate serious doubts as to the long-term sustainability of current expenditure efforts.

Indicator 5 is concerned with the *use of country procurement systems.* Beyond the broader issues of transparency and lack of corruption, using developing country systems to procure medicines and health equipment may raise issues unique to the health sector. First, quality is more important than it is for other kinds of products, which adds extra risk with local suppliers and systems. Counterfeit drugs are a serious global problem carrying both large financial and individual health risks. Second, international trade rules around intellectual property rights of pharmaceutical patents can post challenges for procurement efforts. Finally, as access to medicines in an inherently political issue, governments are often under pressure from donors and activist groups to invest in particular treatment regimens or drugs which may not be available locally.

Indicator 7 looks at *predictability of aid.* For the reasons discussed in section 2, this indicator is particularly important to the health sector and particularly difficult to address because of the multiple funding streams and large numbers of health donors. Also the inherently political nature of foreign aid within donor countries complicates efforts to make aid long-term and predictable.

Indicator 9 is concerned with use of *common arrangements and procedures*, including program-based approaches, while **indicator 11** encourages use of *results-oriented frameworks*. This is complicated in health as there is no formal agreement, as there is in the education sector, on what constitutes a "good sector plan" and, as discussed above, measuring results is complex in health. This means that the dialogue on whether donors should provide sector budget support must effectively start from scratch in each country, as there is no agreed framework or set of pre-requisites to compare against. Similarly, there is not yet consensus on what constitutes progress in health sector performance, nor how to monitor it, so there is no independent way of assessing the impact of sector support. The Health Metrics Network (HMN) is currently working on the issue of monitoring health sector performance, and should have an agreed set of indicators ready early in 2008. The new Health Sector Strategy being developed by the World Bank is also focusing on developing indicators to monitor results.

3.2 From consensus to action: delivering more effective aid for health

41. One of the reasons why we know so much about what is *wrong* with aid for health is that aid effectiveness is an issue of great concern to many health and HIV/AIDS donors. As a result, there is already a lot going on in the sector which is relevant to the harmonization and alignment agenda. Three processes are worthy of particular mention: the *High-Level Forum on the Health MDGs* and its follow up; the agreement of the *Three Ones* by the HIV/AIDS community and subsequent actions by the Global Task Team; and, the establishment of new*, innovative financing mechanisms* in health.

The High Level Forum on the Health MDGs (HLF)

42. The HLF was a series of three high-level meetings in 2004-5 among key donors and some 20 countries that looked at many of the aid effectiveness issues raised above. Research carried out as part of the HLF process deepened understanding on: creating 'fiscal space' for scaling up public spending, the importance of predictable aid; the impact of global health partnerships; the special circumstances of fragile states; and the need for special initiatives to improve health metrics and human resources for health. It also strengthened cooperation between the WHO, the World Bank, the IMF, bilateral donors, global health partnerships and other UN agencies, and has helped create a *consensus for action* around the scaling up agenda in health, which has some parallels to the Education for All Fast Track Initiative (EFA FTI).

43. Building on this consensus, WHO and the World Bank have begun work to establish the *Scaling Up for Better Health Initiative.* It is envisaged that this effort will operate at country, regional and global levels and focus on scaling up activities on the ground to address the range of financing, harmonization and alignment, and implementation issues constraining progress towards the health MDGs. In some countries, the focus will be on preparing more comprehensive and outcome-oriented sector strategies. In others, such strategies may already be in place and the need will be for more effective linkages with macro planning. In others the problem may be with distortions and transaction costs caused by the way aid for health is provided. More often than not a combination of actions will be required. Country level activities will of course be contingent on local circumstances, and will take account of existing processes and initiatives.

44. Country activities will be supported by actions at regional and global levels. At the regional level, the Africa divisions of the World Bank, WHO and UNICEF, together with the African Development Bank, are exploring options for regional level support for country-led actions.[17] It will work with country stakeholders to assess issues such as: the efficiency, equity, and adequacy of domestic resource mobilization efforts; volatility, predictability and durability of donor funding, including distortions created by misalignment; integration of donor funding within a sustainable fiscal framework; appropriate accountability of health financing agents; appropriate governance at the country level; and, improved and more transparent management and health information mechanisms. Based on recommendations from the assessment, country level negotiations would be facilitated to reach agreement between the Government and development

Partners on better aid alignment and effectiveness.

45. At the global level, the establishment of a dedicated secretariat is being explored. Working on the assumption that some of the key obstacles to more effective aid for health can only be 'unblocked' at headquarters (global) level, the secretariat will aim to: influence policy and practice; ensure and facilitate

[17] A proposal for a technical support facility called the Program Assistance for Facilitation in Health (PAF-H) was endorsed by the 56th Regional Committee of WHO/AFRO. Partnership Assistance Facility for Health in the African Region - A Regional Operations Mechanism WHO-AFRO August 2006 (draft).

access to high-quality technical support, as required, to regional and country operations; explore ways of working with existing, innovative financial instruments and approaches to improve the predictability of aid for health in the short term; and, in the medium- to long-term, explore potential for addressing the needs of countries with limited donor support. This will include looking at ways to improve donor accountability in health, for example through links to OECD/DAC and in particular the Joint Venture on Monitoring of the DAC Working Group on Aid Effectiveness. It will also synthesize experience and lessons learnt from country and regional operations, and facilitate access to high-quality technical support, as required. In the longer-term, the secretariat will look at the potential for new financing instruments and mechanisms to address the needs of countries with limited donor support (fragile states and donor orphans) and improve aid predictability (for example through 'buffer funds').[18] Any such financing arrangements would be designed to maximize consistency with the Paris Declaration.

The Three Ones and the Global Task Team

46. UNAIDS, together with the Global Fund, bilateral donors and other international institutions, has committed itself to harmonization and alignment in HIV/ AIDS through the concept of the Three Ones. These are: one agreed HIV/AIDS action framework which provides the basis for coordinating the work of all partners; one national HIV/AIDS coordinating authority with a broad-based multi-sectoral mandate; and one agreed country-level system for monitoring and evaluation.

47. The Three Ones are a response to criticism – predominantly from countries in Africa – that support for HIV/AIDS lacked order and coherence. The diversity of routes and sources of technical and financial assistance are overwhelming local capacity, creating enormous transaction costs and distorting human resource deployment, as staff are drawn to externally funded projects, and away from the national services. The Three Ones principles attempt to address these prevailing dysfunctions in coordinating national HIV/AIDS responses, including weak national plans.

48. Subsequent to the agreement of the Three Ones, the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (GTT) was established. In June 2005 it presented a plan to further coordinate the HIV/AIDS response, making specific recommendations to partner governments, the United Nations system, and the Global Fund to Fight AIDS, TB and Malaria (though not to bilateral donors). In particular, the GTT recommended the development of a scorecard-style accountability tool to examine the performance of national partners in creating a strong HIV/AIDS response and international partners in providing support according to the GTT recommendations. The scorecard is being piloted by UNAIDS in a number of countries. The GTT proposed that these assessments be discussed in the context of annual or bi-annual, nationally-led, multi-stakeholder HIV/AIDS programme reviews, be used to identify where real or perceived blockages lie, and to focus attention and foster change.

49. A 2006 GTT report on implementation of alignment and harmonization commitments reveals considerable scope for improvement. For example, in many countries GFATM Country Coordinating Mechanisms are not yet rationalized with the national AIDS coordination authority; many national AIDS plans are not serving as the framework for donor contributions; and, many countries report low to moderate sharing of monitoring and evaluation results by international partners. In some countries donors are involved in joint HIV/AIDS programme reviews, though these collective exercises remain the exception rather than the norm. In other countries the pattern is more encouraging and global partners are working hard to harmonize monitoring and evaluation systems. A National Monitoring and Evaluation Roadmap has brought partners together in Rwanda, Swaziland and Benin.

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[18] Foster, Mick. 2005. "Fiscal Space and Sustainability: Towards a Solution for the Health Sector." Paper presented at the World Bank/WHO conference "Third High-Level Forum on the Health MDGs," Paris, November 14-15. http://www.hlfhealthmdgs.org/Documents/FiscalSpaceTowardsSolution.pdf

Innovative Financing Mechanisms

50. Stakeholders in the health sector have responded to aid shortfalls, aid effectiveness problems, and failures in the supply of global public goods for health through the development of innovative financing methods. Three are discussed below: the International Finance Facility for Immunization (IFFim), Advanced Market Commitments (AMC), and UNITAID (previously called the International Drug Purchase Facility). The innovative finance agenda is seen as an important component of a more robust and performance-driven approach to development assistance. This is particularly true given the unintended impact that unpredictable aid has had on markets - most notably for pharmaceuticals and vaccines required by the poorest countries.

- The International Finance Facility for Immunization (IFFIm) is designed to accelerate the availability and increase the predictability of funds to be used for health and immunization programs. A pilot for the larger International Finance Facility, the IFFIm mechanism converts donor pledges of off-budget commitments of future resources into funds available for near-term disbursement through bond markets. These predictable funds will be used to ramp up activities to support new vaccines and to fund GAVI's Health Systems Window, which will provide long-term support for health systems development at country level.

- Advance Market Commitments (AMCs) for vaccines is a financial commitment from donors to subsidize the future purchase of a vaccine not yet available, *if* an appropriate vaccine is developed and *if* it is demanded by developing countries. AMCs are designed to provide vaccine companies with an incentive to invest in the research and development of vaccines, and the production capacity needed to serve developing countries, secure in the knowledge that there will be a viable market if they supply products that eligible countries want to buy. Delivery through GAVI - a partnership with established country processes - should minimize transaction costs, avoid further fragmentation and help ensure these new vaccines-specified resources are combined with GAVI's more predictable support to strengthen immunization and health delivery systems.

- The recently launched UNITAID, financed through a tax on airline tickets, is designed to provide long-term and predictable financing for drugs and diagnostic kits to fight HIV/AIDS, tuberculosis and malaria. Delivering through existing institutions such as the GFATM, it is designed to assure long-term access to high-quality drugs and commodities, and to increase/diversify their production and lower prices.

51. These new trends in development financing represent an important opportunity to increase both the quality and quantity of aid for health. The challenge is to take account of the ongoing learning process in aid effectiveness in general, in the health sector, and in integrating global programs. In this context, it is important to take account of the Paris Principles and make sure that scaling up efforts are well coordinated, complementary to existing initiatives, and don't add to the fragmentation of the global health architecture. Further, those initiatives dealing with global public good aspects of international health – the production and supply of vaccines, drugs, etc. needed predominantly by developing countries – need to be accompanied by efforts to improve the quality of health aid at county level, and to strengthen health systems. The ultimate impact on aid effectiveness at the country level will then depend on the practices of implementing agencies and partners.

Section 4: Conclusion

52. This is a critically important time to demonstrate aid effectiveness in health. As donors make good on their promises to scale up development assistance between now and 2015, many will wish to invest in health. Creating an effective aid architecture in health, which delivers results, helps make the case that 'aid works' and should leverage further resources for the sector and perhaps overall, while a dysfunctional health architecture does the opposite. One key challenge is to demonstrate the link between the aid effectiveness agenda and better health outcomes. The Paris Declaration emphasizes progress towards harmonisation and alignment, and has an in-depth monitoring and accountability process related to this objective. It does not, however, hold donors and countries accountable for development results, in health or other areas.

53. Taking forward the harmonization and alignment agenda in health is about *managing complexity* - recognizing that diversity can help bring results and that the health sector benefits from a range of partners with different ways of doing business. As part of the post-HLF agenda, there will be efforts at the country level to develop instruments for mutual accountability between donors and countries. These efforts will be initiated by the health community but will look beyond the sector and aim to ensure alignment of health strategies and goals and other development objectives. We would like to request that OECD/DAC members support their country representatives and provide them with sufficient flexibility to underwrite compacts and sector memoranda of understanding or similar instruments.

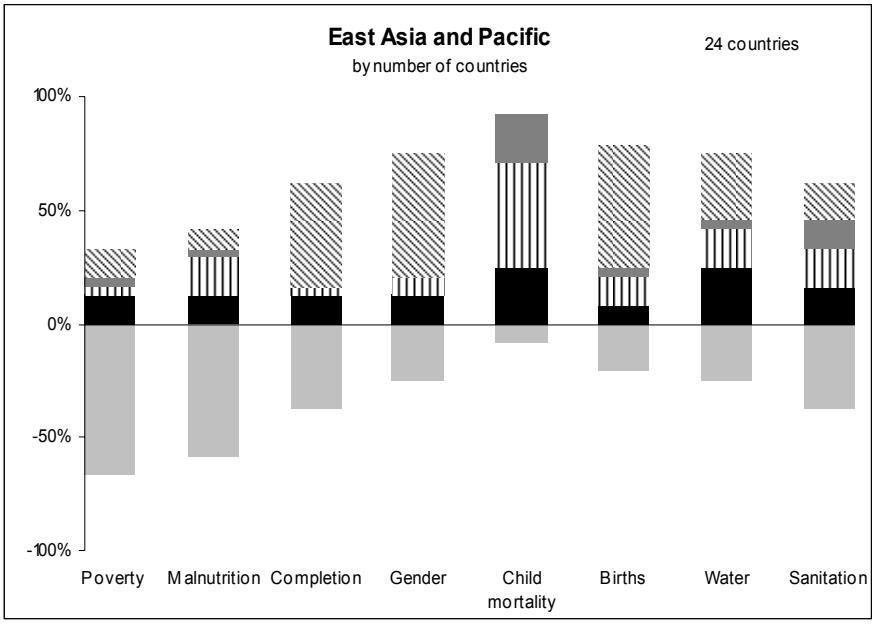
54. The Paris Declaration is the basic frame of reference for efforts to improve the quality of health aid, particularly as aid levels increase. This does not mean that all health aid will be channelled through government in the form of budget or sector support - support should and will be maintained to those working with marginalised groups (beyond the reach of government), those experimenting with innovative approaches to service delivery, the not-for-profit sector, and so forth. However, if new resources are to be used well, flexibility, predictability and alignment to country priorities must improve, and transaction costs associated with donor finance must be reduced. Developing countries recognize that providing resources in this way carries risks for donors, and are therefore looking for support to increase planning, budgeting and implementation capacity in the health sector. Mutual accountability for results is critical.

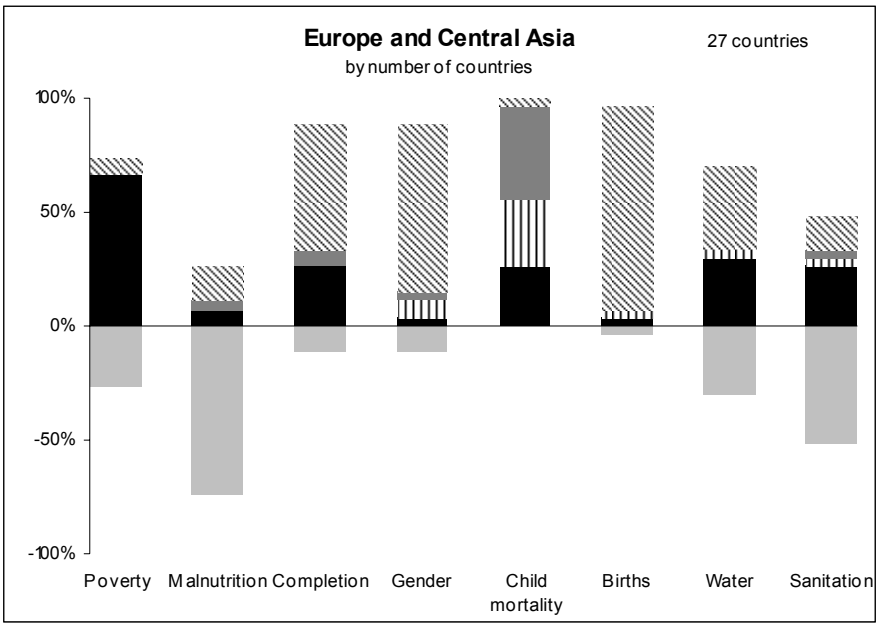
55. The *Scaling Up for Better Health Initiative*, described above, is designed to provide support for sectoral strategies to produce results, country capacity and donor effectiveness. While the initiative remains at an early stage, it has already mobilized substantial commitment at global, regional and country levels. It represents the key international vehicle for operationalizing the aid effectiveness agenda in health. One of the critical functions of the new initiative will be to find ways of tracking progress in the health sector towards the Paris Principles. This will be useful for holding health donors and country partners accountable, but should also be of interest to the development community more broadly. Thus a continuing collaboration with the OECD/DAC at all levels will be central to the success of the *Initiative.*

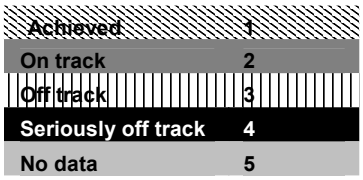
ACRONYMS AND ABBREVIATIONS

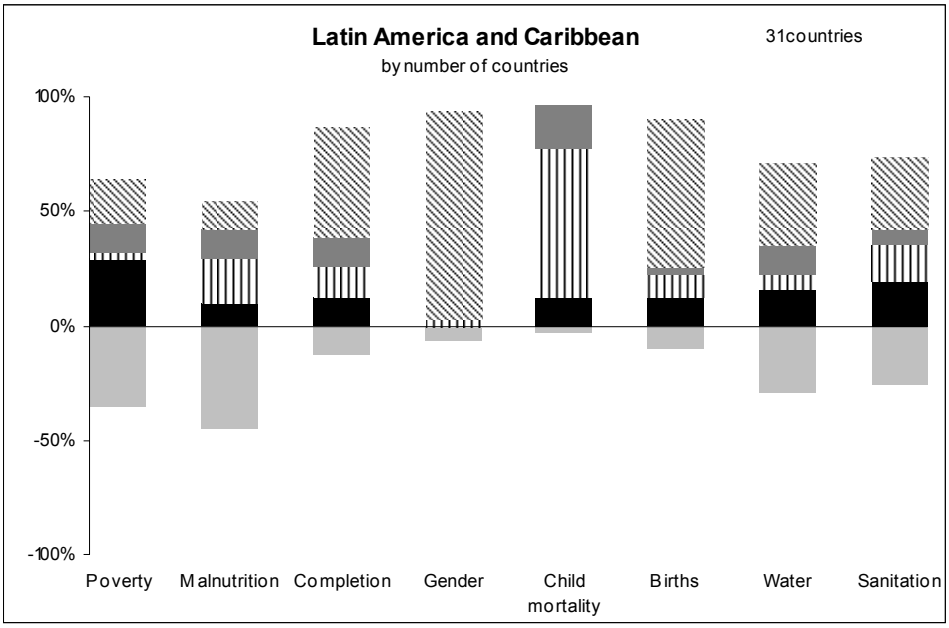
AMC	Advance Market Commitments
DAH	development assistance for health
EFA FTI	Education for All Fast Track Initiative
GAVI	Global Alliance for Vaccines and Immunizations
GBS	general budget support
GDP	gross domestic product
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
GHPs	global health partnerships
GNI	gross national income
GPG	global public goods
GTT	Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
HLF	High-Level Forum on the Health MDGs
HR	human resources
IFFim	International Finance Facility for Immunization
MDGs	Millennium Development Goals
MTEF	Medium-Term Expenditure Framework
NGO	non-governmental organization
ODA	official development assistance
PRSP	Poverty Reduction Strategy Paper
SARS	severe acute respiratory syndrome
SWAps	Sector-wide Approaches
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNITAID	formerly the International Drug Purchase Facility

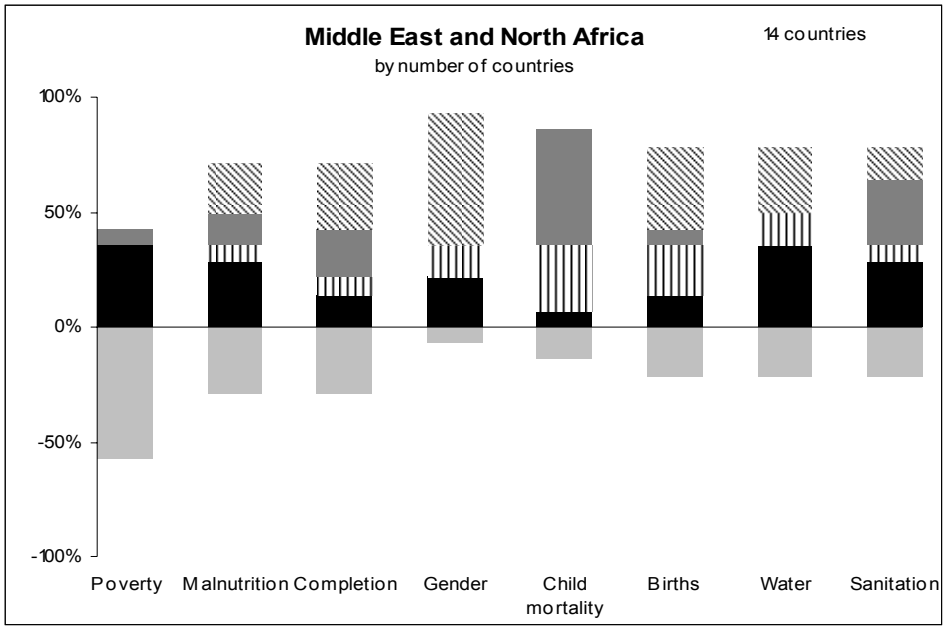
ANNEX 1
PROGRESS TOWARDS THE MDGS IN WORLD BANK REGIONS

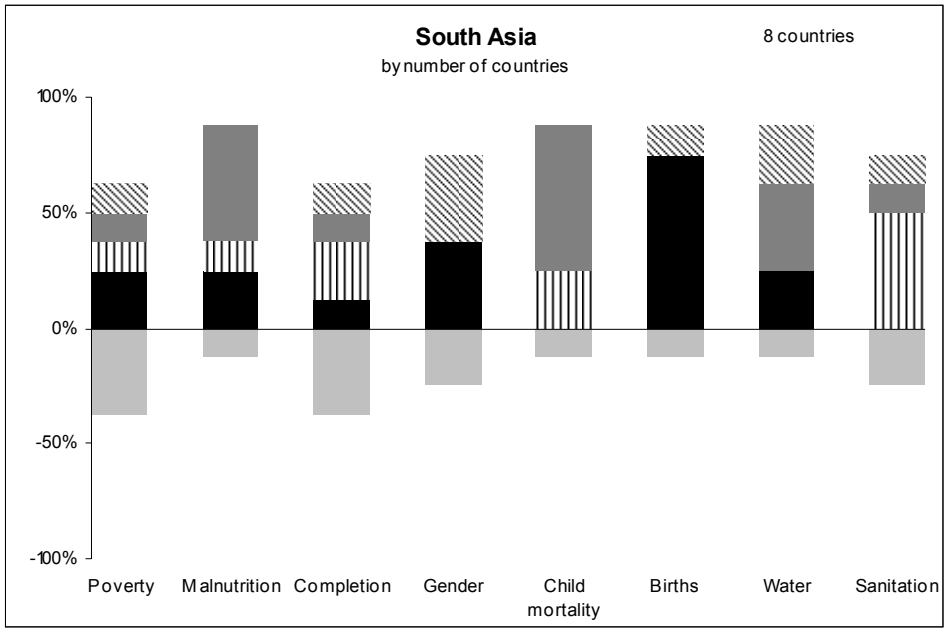


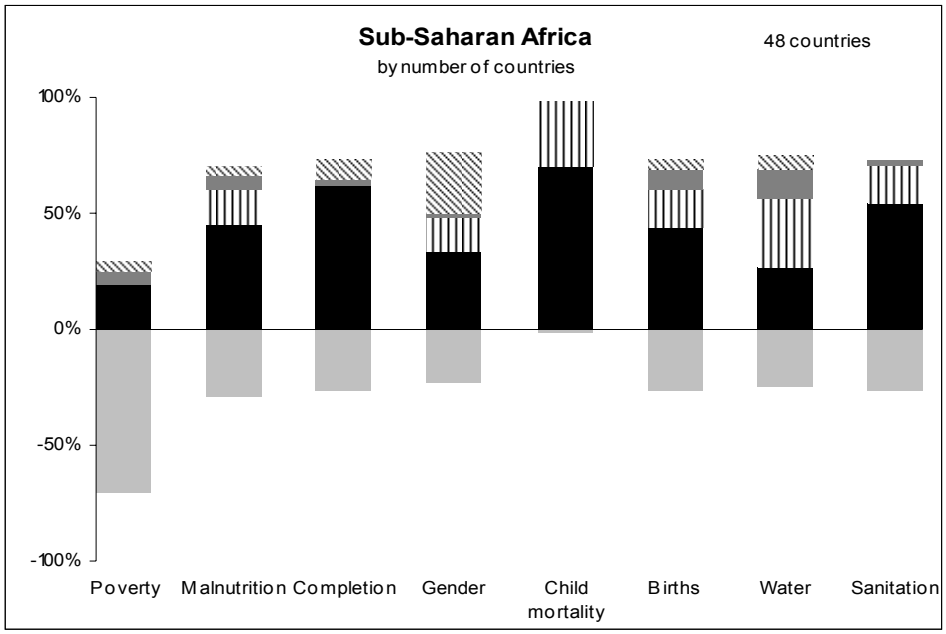





Latin America and Caribbean
31countries
by number of countries
100%
50%
0%
-50%
-100%
Poverty
Malnutrition
Completion
Gender
Child mortality
Births
Water
Sanitation


Middle East and North Africa
14 countries
by number of countries
100%
50%
0%
-50%
-100%
Poverty
Malnutrition
Completion
Gender
Child mortality
Births
Water
Sanitation





Source: World Bank Development Economics Group, staff estimates.

ANNEX 2

BEST PRACTICE PRINCIPLES FOR ENGAGEMENT OF GLOBAL HEALTH PARTNERSHIPS AT COUNTRY LEVEL	
Global Health Partnerships (GHPs) commit themselves to the following best practice principles:	
OWNERSHIP	
1	To respect partner country leadership and help strengthen their capacity to exercise it. GHPs will contribute, as relevant, with donor partners to supporting countries fulfill their commitment to develop and implement national development strategies through broad consultative processes; translate these strategies into prioritised results-oriented operational programmes as expressed in medium-term expenditure frameworks and annual budgets; and take the lead in coordinating aid at all levels in conjunction with other development resources in dialogue with donors and encouraging the participation of civil society and the private sector.
ALIGNMENT	
2	To base their support on partner countries' national development and health sector strategies and plans, institutions and procedures. Where these strategies do not adequately reflect pressing health priorities, to work with all partners to ensure their inclusion.
3	To progressively shift from project to programme financing.
4	To use country systems to the maximum extent possible. Where use of country systems is not feasible, to establish safeguards and measures in ways that strengthen rather than undermine country systems and procedures. *Country systems in this context would include mechanisms such as sector-wide approaches, and national planning, budgeting, procurement and monitoring and evaluation systems.*
5	To avoid, to the maximum extent possible, creating dedicated structures for day-to-day management and implementation of GHP projects and programmes *(eg Project Management Units)*
6	To align analytic, technical and financial support with partners' capacity development objectives and strategies; make effective use of existing capacities; and harmonise support for capacity development accordingly.
7	To provide reliable indicative commitments of funding support over a multi-year framework and disburse funding in a timely and predictable fashion according to agreed schedules.
8	To rely to the maximum extent possible on transparent partner government budget and accounting mechanisms.
9	To progressively rely on country systems for procurement when the country has implemented mutually agreed standards and processes; and to adopt harmonized approaches when national systems do not meet agreed levels of performance[19]. To ensure that donations of pharmaceutical products are fully in line with WHO Guidelines for Drug Donations[20].

[19] Countries themselves may choose to take advantage of procurement pooling mechanisms or third-party procurement, in order to obtain economies of scale.

[20] See http://www.who.int/medicines/library/par/who-edm-par-99-4.pdf

HARMONISATION	
10	To implement, where feasible, simplified and common arrangements at country level for planning, funding, disbursement, monitoring, evaluating and reporting to government on GHP activities and resource flows.
11	To work together with other GHPs and donor agencies in the health sector to reduce the number of separate, duplicative missions to the field and diagnostic reviews assessing country systems and procedures. To encourage shared analytical work, technical support and lessons learned; and to promote joint training, *(eg common induction of new Board members)*.
12	To adopt harmonized performance assessment frameworks for country systems.
13	To collaborate at global level with other GHPs, donors and country representatives to develop and implement collective approaches to cross-cutting challenges, particularly in relation to strengthening health systems including human resource management.
MANAGING FOR RESULTS	
14	To link country programming and resources to results and align them with effective country performance assessment frameworks, refraining from requesting the introduction of performance indicators that are not consistent with partners' national development strategies.
15	To work with countries to rely, as far as possible, on countries' results-oriented reporting and monitoring frameworks.
16	To work with countries in a participatory way to strengthen country capacities and demand for results-based management, including joint problem-solving and innovation, based on monitoring and evaluation.
ACCOUNTABILITY	
17	nsure timely, clear and comprehensive information on GHP assistance, processes, and decisions (especially decisions on unsuccessful applications) to partner countries requiring GHP support.
GOVERNANCE The governance principles are intended for larger partnerships with formalized governance arrangements. Partnership activities must be consistent with the regulatory framework of their host arrangements	
18	To make clear and public the allocation of roles and responsibilities within the management structure of the partnership or fund. The governing board or steering committee should have broad representation and a strong developing country voice.
19	To make clear and public the respective roles of the partnership and relevant multilateral agencies, including how the partnership relates to the host organization.
20	In the interest of public accountability, to ensure that GHP purpose, goals and objectives are clear; procedures are transparent; and timely and comprehensive information is provided publicly.
21	There should be a strong commitment to minimizing overhead costs and achieving value for money; each partnership should have an evaluation framework.
22	To be subject to regular external audit. For hosted partnerships, the auditing procedures of the host UN organization would apply. A copy of the relevant portion of the external auditors certification of accounts and audit report should be made available to the partnership board.