

# WHO Commission on Social Determinants of Health

## Aid and Health

**Globalization Knowledge Network**

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# Preface

The Globalization Knowledge Network (GKN) was formed in 2005 with the purpose of examining how contemporary globalization was influencing social determinants of health. It was one of nine Knowledge Networks providing evidence-informed guidance to the work of the World Health Organization's Commission on Social Determinants of Health (2005-2008): like most of the Knowledge Networks, its operations were financed by an external funder (in this case, the International Affairs Directorate of Health Canada, Canada's national ministry of health). The GKN conducted two face-to-face meetings to debate, discuss, outline and review its work, and produced thirteen background papers and a Final Report. These papers and the Final Report underwent extensive internal and external peer review to ensure that their findings and policy inferences accurately reflected available evidence and scholarship.

This GKN publication series was prepared under the general editorship of Ronald Labonté, with assistance from Vivien Runnels and copy-editing provided by Wayne Harding. All views expressed are exclusively those of the authors. A complete list of titles in the publication series appears on the inside back cover of this monograph.

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## **Aid and Health**

# **WHO Commission on Social Determinants of Health**

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1 Globalization was one of nine key themes identified for exploration and analysis by the Commission on Social Determinants of Health. Among the issues selected for the attention of the Globalization Knowledge Network is the form, role and function of Official Development Assistance (ODA), in particular international financing for health.

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# Table of Acronyms

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<b>ABC</b>	abstinence, fidelity, condom use
<b>AfDB</b>	African Development Bank
<b>CMH</b>	Commission on Macroeconomics and Health
<b>DAH</b>	Development Assistance for Health
<b>DALYs</b>	disability adjusted life years
<b>DBS</b>	direct budget support
<b>ESAF</b>	Enhanced Structural Adjustment Facility
<b>FDI</b>	Foreign Direct Investment
<b>G/DBS</b>	General or Direct Budget Support
<b>GAVI</b>	Global Alliance for Vaccines and Immunization
<b>GDP</b>	Gross Domestic Product
<b>GFATM</b>	Global Fund to fight AIDS, Tuberculosis and Malaria
<b>GHI</b>	global health initiatives
<b>GNI</b>	gross national income
<b>HIPCs</b>	Highly Indebted Poor Countries
<b>HIV/AIDS</b>	Human Immunodeficiency Virus /Acquired Immunodeficiency Syndrome
<b>HSR</b>	health systems reform
<b>IDA</b>	International Development Association
<b>IMF</b>	International Monetary Fund
<b>MDGs</b>	Millennium Development Goals
<b>MDRI</b>	Multilateral Debt Relief Initiative
<b>MTEF</b>	Medium-Term Expenditure Framework
<b>NGO</b>	non-governmental organization
<b>OBA</b>	Output-based Aid
<b>ODA</b>	Official Development Assistance
<b>OECD</b>	Organization for Economic Co-operation and Development
<b>OOF</b>	Other Official Finance
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PHC</b>	primary health care
<b>PPPs</b>	public-private partnerships
<b>PRGF</b>	Poverty Reduction Grant Facility
<b>PRS</b>	Poverty Reduction Strategy
<b>PRSP</b>	Poverty Reduction Strategy Paper
<b>RBM</b>	Results-based Management
<b>RCTs</b>	randomized controlled trials
<b>SDH</b>	social determinants of health
<b>SIPs</b>	Sector Investment Programs
<b>SWAps</b>	Sector-Wide Approaches
<b>UCI</b>	Universal Program for Childhood Immunization
<b>UNDP</b>	United Nations Development Program



## Introduction

Official Development Assistance (ODA) is defined as grants or loans (“concessional finance”) to developing countries, undertaken by the official sector, with promotion of economic development and welfare as the main objective (OECD, 2006a).<sup>2</sup> Much ODA is provided as straight grants. Where external finance is provided as a loan, it must include a minimum 25% grant element to qualify as aid.<sup>3</sup> Development Assistance for Health (DAH) is defined as “aid [as above]...to activities which have health as their main purpose”. This excludes activities in sectors that may have an indirect impact on health, such as education and water and sanitation (OECD-DAC, 2000).<sup>4</sup>

Forms of concessional financing have existed between countries for centuries; official international aid finance pre-dates the Second World War, predominantly in terms of colonial transactions and transfers.<sup>5</sup> But the modern architecture of ODA emerged at the end of World War II, with the formation of the United Nations and the Bretton Woods institutions, the success of the Marshall Plan, the establishment of the Organisation of Economic and Cultural Development (OECD), the development of independent post-colonial States, and the polarities and client relationships of the Cold War. Indeed, those colonial and Cold War origins of aid help to illu-

<sup>2</sup> ODA includes “technical cooperation”, but excludes financing for military ends. ODA is one element of overall global financial flows. Aside from general trade and currency transactions, financial transfers include Foreign Direct Investment (FDI), Other Official Finance (OOF), and private remittances. ODA flows through four primary channels: Bilateral (government-to-government); Multilateral (via United Nations and other global and regional agencies); Bilaterally or multilaterally via non-governmental organizations; via public-private partnerships (PPPs) or private philanthropic organizations.

<sup>3</sup> The problem is, this threshold appears somewhat arbitrary, including as “aid” a range of financial transfers with quite diverse concessional compositions (from 25 to 100%). The value of concessionality depends on the commercial rate of interest (that is, how costly would other sources of finance be to a borrower). At the minimum grant element, ODA can still carry a significant loan obligation. Given that the degree of concessionality influences ODA effectiveness (Kohama, Sawada & Kono, 2003) in order to understand the impact of aid more accurately, ODA needs to be analyzed using a more fine-grained measure of concessionality. Equally, it may be argued that concessional loans should be valued-as ODA- by their grant element.

<sup>4</sup> For example, in attempting to only account for DAH to HIV/AIDS, “[e]ven the most careful analysis will not permit an accurate accounting of every expenditure related to HIV/AIDS. In severely affected countries, the pandemic has an impact on practically every social and productive sector” (OECD-DAC, 2000).

<sup>5</sup> The establishment of the British Colonial Development Act in 1929 is often cited as the first example that institutionalized development aid (Fuhrer, 1996.)

minate how and why ODA – most acutely bilateral in form – reflects much more (or less) than a simple calculus of global need and resource allocation arrived at by rich and poor countries with a shared objective of development. Rather it reflects a complex geopolitical and economic interplay of interests continuing to distort aid flows today.<sup>6</sup>

Although the meaning and purpose of aid has diversified over six decades – from straight economic support, through support to ‘basic needs’ and promotion of gender, rights, and environmental sustainability, to the spread of democracy and ‘good governance’ – a persistent underlying assumption has been that aid’s real structural utility is in promoting economic growth (Fuhrer, 1996; Tomasevski, 1989). While health has for centuries been a central concern of international relations and development<sup>7</sup>, missionary emphasis on curative and palliative health, colonial hospital-based emphasis on control of diseases to which colonial actors found themselves susceptible, and post-colonial investment bias towards urbanization and industrialization, generated a highly biomedical approach to health, development and aid, concentrated on the expansion of medical/clinical capacity, and disease and reproductive control interventions (Justice, 1989; Wick & Shaw, 1998).<sup>8</sup>

The origins and evolution of ODA and DAH raise several concerns. First, aid remains closely identified with a central concern for economic growth. Without economic growth, thus, aid can be considered ineffective. But aid works in other ways more directly related to social development and improvements in human welfare. These must not be discounted in assessment of aid’s value. The tension between aid for growth and aid for poverty reduction is unhelpful (IMF, 2007). Second, donors’ motives remain closely tied in too many cases to geostrategic interests, rather than multilaterally-agreed and administered responses to developmental need. And third, aid to health remains heavily concentrated on the health

sector, and on interventions primarily conceived in terms of health services and the health care system, over potentially more coherent action on the social determinants of health.

<sup>6</sup> An historical lens illuminates the remarkable tenacity of the practice of “tied aid” - finance provided under often highly questionable terms that obligate the recipient to purchase aid-related goods and services from the donor - in spite of empirical evidence of the adverse impact of tying on aid effectiveness.

<sup>7</sup> From 15th century European practices in quarantine to the International Health Regulations emphasis on infectious disease and cross-border controls (World Health Organization, 2005), “international health” has been constituted in terms of communicable disease and the threat of pandemics to national and international security and trade (Sandler & Arce, 2002). Since 1982, G7/8 interest in health has been heavily focused on infectious disease and security. In preparing the agenda for the 2007 G8 meeting in Heiligendamm, the focus on HIV/AIDS in Africa was contextualized by an emphasis on modes of financing health systems, and broader interests in improving the region’s economic growth performance.



## Section I: Official Development Assistance (Aid)

Whether or not – and how – aid ‘works’ in improving lives and livelihoods among the global poor – and more specifically, improving the quality and equity of their collective health – depends on several key issues:

1. How much aid is being given.
2. How aid is given that is, what uses is aid restricted to, how free are recipients to apply aid finance according to contextual needs).
3. How committed are donors to the humanitarian principles of aid giving rather than to shorter-term strategic or tactical motives.

### Levels of Aid

Between 1950 and 1990, ODA increased reasonably strongly in absolute terms. As a proportion of donors’

gross national income (GNI), aid volumes have been less impressive. The 1969 Report on International Development recommended a donor target ratio of 0.7% of Gross Domestic Product (GDP) to ODA. That target remains unachieved. It is arguable that, given changes in wealth and poverty since 1969, the 0.7% target is something of an anachronism. As a mobilizing target, however, and an index of commitment and accountability, however, it may be argued still to have value.

Although the composition of ODA since 1980 has shifted from grants to loans (reflecting the impact of debt crisis on approaches to development financing), aid has diminished as a component in global financial flows, overshadowed by foreign direct investment (FDI) (Sundberg & Gelb, 2006). During the 1990s ODA fell from US\$61 billion in 1992 to \$44 billion in 1997 (Figure 1). ODA recovered towards the end of the decade, with projections of further increases (to 2010 and beyond) based

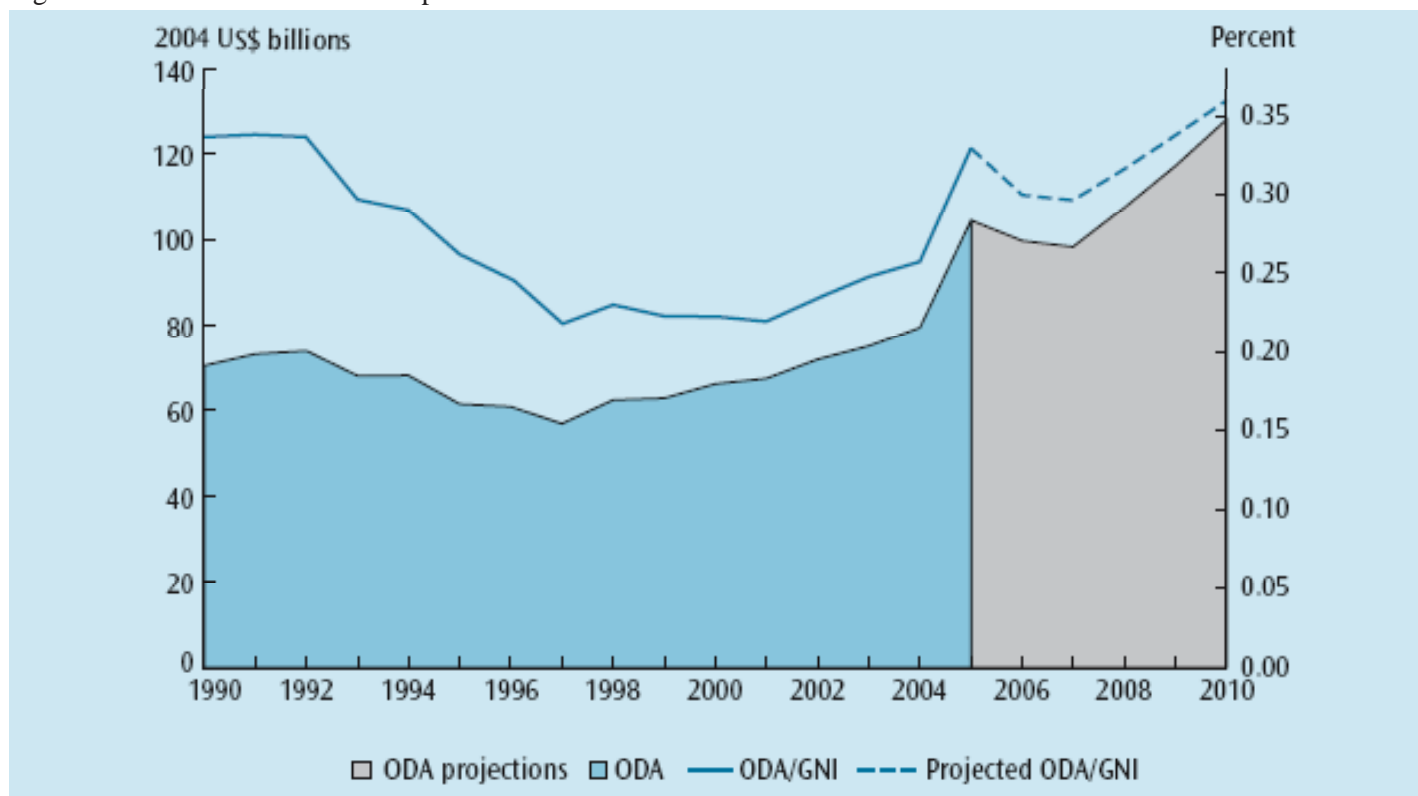
<sup>8</sup> With much less emphasis on the social determinants and/or equitable distribution of health, or actions aimed at relieving non-communicable diseases.

<sup>9</sup> Many health workers in Eastern Europe re 2005 has been hailed as a ‘watershed year’ for ODA (World Bank, 2006; ActionAid, 2005), promising an increase of around \$50 billion, including a doubling of ODA to Africa, and a reduction of total debt service of around \$1 billion per annum. Two provisos: first, the inadequacy of total ODA has been recognized for many years, with calls for a step-shift increase by international colloquia from the Copenhagen Summit (1995) and the 2nd Tokyo Conference on African Development (1998) to the Millennium Summit (2000), the Monterrey Summit on Development Financing (2002), and the Helsinki Process on Globalisation and Democracy (Addison, Mavrotas & McGillivray, 2005a/b). Second, given the proportion of recent increases dedicated to specific geo-political projects such as Iraq, there is considerable danger that the upward trend in ODA could reverse in coming years, with very serious consequences for poor countries and the sustainability of developmental gains made.

on commitments towards the MDGs.<sup>9</sup> DAC-reported aid totalled \$80 billion in 2004, rising to an estimated \$106 billion in 2005, averaging 0.33% of GNI in terms of overall commitments (World Bank, 2006).

of relative receipts for ODA and FDI points to increasing regional inequality in access to domestic and external financial resources. It also points to relatively greater and more persistent dependence among African countries on external financial

Figure 1: Levels of Official Development Assistance 1990-2010



Source: (OECD Development Assistance Committee (DAC), 2006).

Foreign direct investment *can* contribute to socio-economic development. But flows of FDI respond to other conditions than those of poverty and humanitarian need, and thus cannot be taken as an adequate substitute for aid.<sup>10</sup> The composition of ODA/FDI flows differs considerably by region. In 1997, external financing to Latin America comprised \$13 per capita in ODA, and \$62 per capita in FDI. In sub-Saharan Africa in the same period the balance was reversed, at \$27 per capita ODA compared with \$3 per capita FDI. The divergent trend between sub-Saharan Africa and other regions in terms

resources. It also points to relatively greater and more persistent dependence among African countries on external support, higher exposure to policy leverage (or lower capacity to exert policy sovereignty), and persistently unaddressed structural weaknesses in the social and productive domestic infrastructure and institutions.<sup>11</sup>

Sub-Saharan Africa remains heavily dependent on aid. Between 1991 and 2002, ODA made up over 90% of all financial flows into sub-Saharan Africa (Ahmed & Cleeve, 2004). In spite of this, Africa saw its aid receipts decline during the 1990s like other regions. Twelve of 19 bilateral donors reduced their aid to the region between 1987 and 1998. Funding for Africa from the European Union fell by 18%.

<sup>10</sup> From a development perspective, of course, different forms of FDI can have quite different impacts, e.g. portfolio (speculative) FDI (rapid inflows and outflows of which have caused devastating currency crises in recent years), FDI going into Export Processing Zones (where tax holidays and the ability for full profit repatriation often leave little in the way of increases in public revenues that can be used to improve public welfare), FDI directed principally to acquisitions or mergers (creating little or no new productive capacity), and FDI that creates new productive capacities with forward and backward linkages to the developing country's domestic economy. It is beyond this paper's remit to assess the comparative value of different forms of FDI, apart from noting that such differences matter in terms of its role in countries' capacities to improve the SDH.

<sup>11</sup> Approximately \$650 billion in aid has been channeled to sub-Saharan Africa in the post-War period (Sundberg & Gelb, 2006), fuelling the view that aid does not work. As we will argue in following sections, rather than aid being ineffective in some inherent sense, aid's effectiveness is strongly determined by the way it is designed and delivered.

Even “good economic performers” such as Ghana and Mozambique saw their aid allocations stagnate or fall (Ahmed & Cleeve, 2004; Commission for Africa, 2005). In the context of volatile, low and decreasing levels of FDI and ODA, \$1-a-day poverty in sub-Saharan Africa rose between 1990 and 1999 from 47% to 49% of the population (Addison, Mavrotas & McGillivray, 2005a). Those who argue that aid has become, or is becoming, increasingly irrelevant are simply wrong.

### **Types of Aid – Different types have different effects on development spending**

ODA comes in a variety of forms, with different kinds of impact (Sundberg & Gelb, 2006; Thiele, Nunnenkamp & Dreher 2006; Rajan & Subramanian, 2006; Mavrotas, 2003; Most & Van Den Berg, 1996). These include:

1. General budget support (direct finance to recipient budget)
2. Program aid (support to broader, often sectorally defined development policies and actions in, for example, education or health)
3. Project aid (finance and in-kind contributions targeted to a specific population group and/or tied to a specific set of, often localized, time-bound activities)
4. Food aid (associated most obviously with humanitarian interventions)
5. Technical assistance (Mavrotas, 2003).

An important distinction can be drawn between aid given as special purpose and non-special purpose grants (IMF, 2006). The lion’s share of ODA is provided in the form of special purpose grants. Such grants include debt relief, technical cooperation, food and emergency aid, and the administrative costs of aid itself (IMF, 2006). Special-purpose grants made up around 70% of aid from the DAC between 2001 and 2004 (Actionaid, 2005). Non-special purpose grants include funding for infrastructure development, health and education, and can be used to meet capital and recurrent costs (World Bank, 2006). Non-special purpose grants are more directly related than special purpose grants to spending in

the social sectors (for example, strengthening health systems) and more strongly associated with poverty reduction. However, they are in decline as a proportion of total ODA. Only 8% of current increases in aid qualify for non-special purposes. This presents a worrying picture of ODA trend, to the extent that the core aspects of a properly developmental agenda appear not only to be under-funded, but to be losing ground on volume of allocation as well.

Both emergency and food aid and debt relief to Africa show recent upward trends over declining program and project finance. If a central purpose of aid is to promote poverty-reducing public sector spending on the part of the recipient government, this is a curious outcome, since both program and project aid have been associated with increased government consumption and public sector spending, while food aid is associated with the reverse effect (Mavrotas, 2003).

There is some evidence that donors treat short-run aid (such as BOP, and investment in agriculture and industry) and long-run aid (such as investment in social sectors) as alternates in a zero-sum equation. This is problematic. In the present period – arguably strongly influenced by the focus of the Millennium Development Goals (MDGs) – the trend in ODA appears to have shifted quite far in the direction of social sector spending – apparently at the expense of investments in infrastructure and productive sector development. Although it is again acknowledged that agriculture is an essential contributor to Africa’s chances of sustainable socio-economic development, levels of aid to the agricultural sector are falling behind social spending. Between 2000 and 2004, while total USAID assistance to African agriculture rose from \$459 million to \$514 million, USAID’s Bureau for Africa health budget rose from \$295 million to \$474 million. Overall, between 2000 and 2003, agriculture’s share of total bilateral ODA declined from 13% to 9%; during the same period, health-related aid grew by 115%.

What is needed is a total quantum of aid that allows for an adequate balance of investment to both productive and social spending, if growth, poverty reduction, and health are to be coherently – and sustainably – addressed (Maxwell, 2005; Addison, Mavrotas & McGillivray, 2005a). The major contem-

porary emphasis in ODA is on its role in reducing poverty. Poverty reduction expenditures are “generally taken to mean [spending for] basic health, primary education, agriculture, infrastructure, housing, basic sanitation and HIV/AIDS programmes” (IEG, 2006). The list of pro-poor public expenditures is remarkably consistent with the social determinants of health. In the remainder of the paper we will explore how different forms of aid do or do not promote pro-poor expenditure. As well we will look at how in fact current efforts to coordinate aid under coherent recipient policy-making and action can undermine both spending on the social determinants of health in general and pro-poor spending within the health system in particular.

### The Ambivalence of Aid Donors – a variety of shortfalls and reasons:

#### Aid Commitment

Beyond the form and composition it takes, the way aid is delivered affects recipients’ capacity to plan and implement national developmental or poverty reduction strategies, including those related to health and its social determinants. Delivery does not refer simply to the means of transfer, but also to the dimensions of the donor-recipient engagement, the relationship around ideas, aims, policies and actions that aid brings about. It is difficult, for instance, for

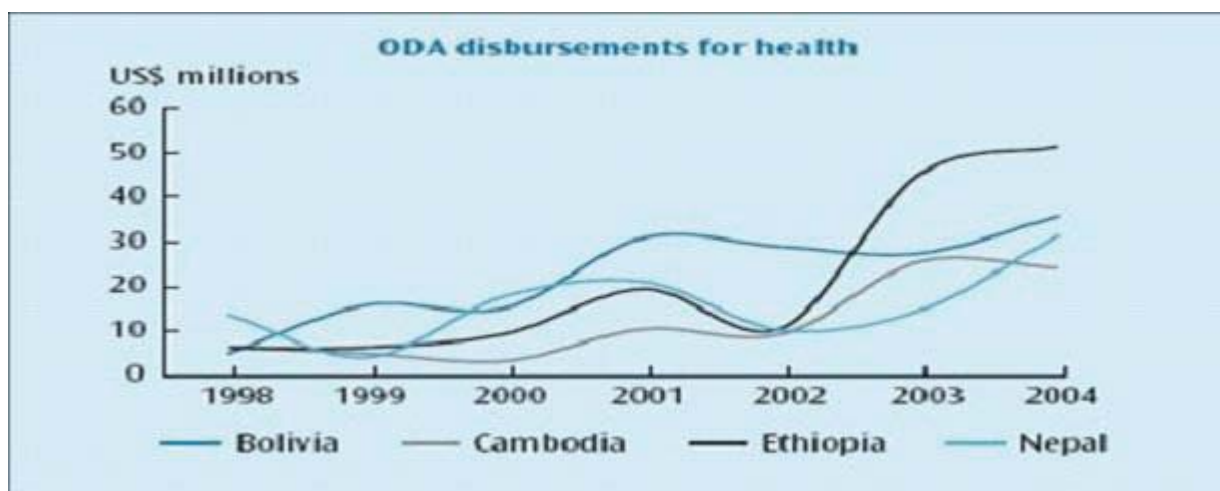
aid to promote common goals and coherent planning processes, where what is promised is not what is received, and where what is received can rise and fall according to donor decision-making which is often at best opaque.

Donor commitments rarely directly translate into what is disbursed (Michaud, 2003).<sup>12</sup> In 2005 only 70% of pledged ODA was delivered (United Nations Non-Governmental Liaison Service (UN-NGLS) , 2005). Compounding this, the level of overall aid has been highly volatile over several decades. It has tended to be pro- rather than counter-cyclical, flowing to recipient countries at times in the domestic economic cycle when it is arguably less needed (World Bank, 2006). Moreover, the scale of volatility increases the higher the dependence of the recipient on aid – making sudden reductions relatively more damaging to stability and fiscal management. Indeed, analysis suggests that the effectiveness of aid is more strongly associated with the stability of the flow, than with the amount (Quartey, 2005; Lensink & White, 2000).

#### Aid Volatility

Aid to health also shows considerable volatility in recent years (Figure 2).<sup>13</sup> And that volatility can be directly damaging to the effectiveness of health-

Figure 2: ODA for health: Bolivia, Cambodia, Ethiopia & Nepal. 1998-2004



Source: World Bank estimates from OECD-DAC database. (World Bank, Global Monitoring Report, 2006)

- 12 Major donor commitments to the Roll Back Malaria initiative between 1998 and 2003 produced disappointing disbursements, stalled at \$100 million annually across the period (Narasimhan & Attaran, 2003).
- 13 Even when the pandemic was widely acknowledged, “ODA support [for HIV/AIDS] fluctuated widely but without much upward trend” in part due to donors failing to respond to the epidemiological evidence (Attaran & Sachs, 2001).

related aid. Econometric analysis of child mortality across 75 developing countries between 1995 and 2000 found that “both low levels [of aid] and high volatility of donor funding for health explained the relatively slow progress of some countries in reducing under-five mortality” (Bokhari, Gottret & Gai, 2005).

### **Aid for debt**

In spite of consistent calls for aid to be treated quite separately from debt relief (Labonté, 2005; Arslanalp & Henry, 2006; Addison, Mavrotas & McGillivray, 2005b), the two have been and continue to be cross-related, allowing donors to save money by financing one against the other. Approximately half of the total aid for the period 2000-2004 was consumed as debt relief or technical assistance. During the period of accelerated debt relief under the Highly Indebted Poor Countries (HIPC) Initiative, aid as a proportion of recipient GDP fell among HIPC debt relief beneficiaries from an average of 13.7% to between 9.9% and 11.1% (GKN, 2007), indicating a possible trade-off between debt relief losses and reductions in aid. It is also unclear what happened to ODA to non-HIPC countries during the same period. Under the Multilateral Debt Relief Initiative (MDRI), debts written off to the African Development Bank (AfDB) and the International Development Association (IDA) were counter-weighted by reductions in grants to countries in receipt of relief.

Provided as *special purpose grants* designated as “additional to new ODA commitments” (Sundberg & Gelb, 2006), there is a view that debt relief constitutes a particularly pure form of aid in that it is entirely at the disposal of the recipient. Aside from the fact that relief and aid draw on quite different ethical relations between countries in respect to “development”, the effect of allocation in one cannot be seen as equal to the effect of allocation in the other. Moreover, where relief is offered on debt that was unlikely to be serviced anyway, the finance cannot be considered (beyond reducing debt overhang) as truly additional. For example, a reduction in debt overhang through debt relief does not effectively alleviate the problem of inward financing to the poorest countries. In these countries the real obstacles to

financing and growth are not the overhang or poor credit. Rather they are the perceived weakness of the institutional and infrastructure base, areas in which ODA can have a marked positive impact. Clearly, in such cases, debt relief and ODA are both independently required. This is especially so where evidence suggests that reduction in debt service obligations is associated with increased public sector spending in low-income countries, while ODA in some weak State contexts has been associated with increased income in the form of foreign direct investment, where ODA supports, among other things, local entrepreneurship, in the absence of government action, thereby attracting further private external investment.

### **Tied aid**

*Tied aid* is development assistance given on the contractual condition that it is spent by the recipient on goods or services provided by the donor. At high levels tied aid recoups to donors a considerable part of the aid disbursed. Tying aid reflects commercial self-interest among donors (Svensson, 2000) and it has negligible positive or actively negative impact on aid effectiveness (Mazzotta, 2005; Kohli, 2004; Kemp & Kojima, 1985). Although it has been argued elsewhere that when tied aid is well designed and effectively managed it does not necessarily compromise the quality or effectiveness of aid (Aryeetey 1995; Sowa & White 1997), it is estimated that tying reduced the value of ODA by \$5-7 billion in 2003 (OECD, 2004c), and that tied aid is in the region of 25% less effective than untied (UNDP, 2003).<sup>14</sup>

In spite of donor commitments to reverse this practice, 40% to 45% of total bilateral aid in 2005 remained tied, raising the costs of goods and services by an estimated 15% to 30% and 40% in the case of food aid (United Nations Non-Governmental Liaison Service (UN-NGLS), 2005).<sup>15</sup> Aside from evidence of reduced effectiveness of the aid itself, tied aid reduces policy space for recipient governments to make spending decisions based on in-country conditions, balancing external and domestic resources.

### **Aid Absorption**

Delivery of aid has been constrained over time by donor concerns about recipient absorption. That is the institutional and infrastructure capacity of poor countries to put aid to work. For some time it has been recognized that the effectiveness of aid appears to be non-linear, manifesting diminishing returns to growth after it reaches between 15% and 45% of the recipient's GDP (Addison, Mavrotas & McGillivray, 2005a; Clemens & Radelet, 2003; Boone, 1996). The explanation advanced is that low levels of socio-economic, infrastructure and institutional capacity in poor countries create bottlenecks in the absorption of high or rapidly rising rates of aid income.<sup>16</sup>

The question of absorption has been especially acute in the case of health aid, primarily constituted as funding to the health system. Funding "was not seen [by donors] as the most fundamental obstacle to improved health status" (Narasimhan & Attaran, 2003).<sup>17</sup> The question of absorption remains a key element in donor thinking today (De Renzio, 2005). The problem with this analysis is that it attempts to deal separately with health finance and health capacity.<sup>18</sup> Rather, the relationship between aid and poor countries' absorptive capacity for health needs to be understood in a sense as a dialectical one, in which finance to the health system increases the capacity of the health system to absorb and utilize better further finance. Health finance and health system capacity are interconnected. Evidence suggests that absorptive capacity is considerably higher in recipient country systems where assistance is targeted to structural development and adequately sequenced (Sachs, 2004; Attaran & Sachs, 2001). Moreover, the issue of absorption in the health system is considerably less relevant to the consideration of health-related finance channelled outside the health sector proper. A focus on social determinants of health can help to channel aid to health action, even where absorption problems may be a valid consideration.

## Fungibility

The effect of aid on domestic resource mobilization remains the subject of debate (Remmer, 2004; Schneider, 2005; Mavrotas, 2003). Aid finance, once in the budget system, looks very much like any other kind of national income. As a consequence, aid is very difficult to track verifiably from donor purpose to government spending. In other words, while the expectation and hope is that one dollar of aid for purpose X will result in at least one dollar additional government expenditure for X, it is by no means always so, and extremely difficult to guarantee (World Bank, 2006; Pack & Pack, 1993).

Evidence suggests that different donor-recipient contexts produce different outcomes in the relationship between aid income and public expenditure. Aid to the Dominican Republic, for example, was found to be highly fungible (mostly redirected to debt repayment and deficit financing) and to have had "no positive effect on development expenditure" (Pack & Pack, 1993). Aid to Indonesia, on the other hand, was not only "spent on the purposes for which it [was] given" but also "[had] a positive effect on own revenues" (ibid.).

Aid fungibility varies from one context to another (ibid.). The understanding and future design of aid need to take into account more closely the factors that support the role of aid in promoting pro-poor or pro-equity public expenditure (Thiele, Nunnenkamp & Dreher, 2006; McGillivray, 2003; Amprou et al., 2005).<sup>19</sup>

## Aid effectiveness

The debate about *aid effectiveness* has been going on as long as the practice of aid itself. However, a distinction should be drawn between the "aid effec-

14 It is worth bearing in mind that a call for donors to 'reverse the trend towards more tying of aid' was made as a keynote of the first DAC Chairman's report in September 1962. Again, the leaden movement of progressive aid policy among major bilateral donors points to structural inefficiencies in the bilateral system.

15 The degree to which donors can find ways to off-set aid giving is striking. 'France...(along with Germany, Austria and Canada)...include[s] in ODA the costs imputed to students from southern countries registered in French universities. These costs amounted in 2002 to \$562 million...nearly a tenth of French ODA (six times more than the aid dedicated to primary education in the countries concerned) (UN-NGLS,2005).

16 This presents a problem for the advocates of a 'big push' in aid, where the predicted increase in ODA will raise the proportion of aid to GDP above 50% in 35 recipient countries, and above 75% in 17 countries (Moss & Subramanian, 2005).

17 A review of 30 external funding agencies found that 'only 5 reported providing health assistance in more than half of the countries where they provided assistance for general development purposes' (Howard, 1983).

18 See, for example, Jamison et al., 2006 *Disease Control Priorities in Developing Countries* (2nd Ed.), Box 1.4, p.26. This thinking appears to draw on much earlier – and arguably more simplistic – notions of the relationship between factor inputs in aid and development. Rodan 1961; Adler, 1965; Guillaumont, 1971).

tiveness debate” (that is, a specific controversy over whether ODA is positively associated with economic growth), and questions about whether and how aid can be made more effective with regard to the wider aims of social development.<sup>20</sup> For all useful purposes, the aid effectiveness debate is over. As we will argue below, it works. Beyond that debate though, there is more to be done to achieve a more nuanced understanding of the relationship between the objectives attached to ODA, and how different forms of aid and means of delivery affect its capacity to impact on those objectives. We will return to this in following sections.

Post-war donors largely conceptualized underdevelopment as an economic phenomenon, caused by under-supply of financial capital and/or technical capacity in poor countries. Aid was commensurately conceptualized as a somewhat mechanistic means to prompt growth, through front-loading capital and capacity from outside (Chenery & Stout, 1966; Rostow, 1960; Lewis, 1955). The idea was that with appropriate inputs, poor countries would “take off” and undergo accelerated development.

That things quickly and persistently appeared to be working out otherwise gave considerable boost to a powerful critical movement which broadly took the view that aid was either ineffective or actually counter-productive. Aid was seen as distorting market function, creating inflationary pressure<sup>21</sup>, increasing size of government and bureaucratic inefficiency, encouraging rent-seeking and weakening governance relationships between state and population, and financing consumption rather than investment (Friedman, 1958; Griffin & Enos, 1970; Voivodas, 1973; Mosley, 1980; Bauer, 1981, 1991; performing countries should be rewarded with aid or more aid, while poor performers would not. As

Mosley et al., 1987; Boone, 1996 Svensson, 2000; Rajan & Subramanian, 2005; Quartey, 2005; Schneider, 2005; Easterly, 2003, 2006).

In the late 1990s and early 2000s, new empirical analysis – partly the result of improving data – began to evince a more positive relation between ODA and growth (Burnside & Dollar, 2000; Hansen & Tarp, 2000; Beynon, 2001; Morrissey, 2001; Hermes & Lensink, 2001; McGillivray, 2003, 2004). Indeed, meta-analyses reported consistently positive associations across dozens of individual empirical studies (McGillivray, 2004; Clemens et al., 2004). But within the new aid effectiveness school, a particular analytical emphasis arose, with powerful and far-reaching implications for the aid system. Spearheaded by analysis by Burnside and Dollar (2000), an influential policy caucus emerged affirming that aid was indeed effective in promoting growth. However, its effectiveness was significantly determined by the policy context of the recipient government. The analysis suggested that, while aid “has a positive impact on growth in developing countries with good fiscal, monetary, and trade policies...[it] has little effect in the presence of poor policies” (Burnside & Dollar, 2000). This analysis has since been extended to the field of health-related aid.

### **Effectiveness leads to recipient selectivity**

The impact of this new effectiveness analysis – remarkably quickly influential across major donors (Easterly, 2006) – was to create a drive in aid allocation policies away from earlier structural adjustment conditionality, which were patchily successful attempts to extract ex ante commitments from poor countries in search of debt relief and new aid. The new drive was towards “selectivity”. In essence, the selectivity position suggested that good policy

19 One proposal is to create the ‘Pro-poor Public Expenditure Index’ by which recipient fiscal policy can be evaluated in relation to aid income (Mosley, Hudson & Verschoor, 2004).

20 It is now widely acknowledged that development is not simply about economic growth; it is about economic growth, poverty reduction, and the host of economic and non-economic factors that mediate between the two. Understanding those factors as objects to which aid may be applied is vital to improving aid effectiveness, and has particular salience in strengthening its impact on socio-economic inequality and unequal health.

21 So-called ‘Dutch disease’; though the IMF finds no empirical evidence for this in the case of aid to sub-Saharan Africa (IMF & IEO, 2006). Moreover, evidence suggests that for certain kinds of health expenditure (e.g. purchase of pharmaceuticals), the risk of inflationary pressure is considerably reduced (Jamison et al., 2006). The potential for crowding out and induced inflationary pressure in increased aid inflows should not be dismissed. However, given structural reforms leading to increased productivity

and/or a more flexible approach to domestic absorptive capacity, Dutch disease should not be loosely deployed as a counter-argument to increasing aid per se.

22 Many of the early attacks on aid effectiveness – quite as much as early aid advocacy – derived from deeper, and inimical, emerging political traditions, and were analytically somewhat impoverished by missing, inadequate or poor quality data. ‘In truth there is no theory of development that is logically compelling and demonstrably valid. One good indicator of this deficiency is the very abundance of theories, some pointing to the importance of capital, others to the role of technical change, and still others to the significance of political institutions’ (Bates, 2006).

one might imagine, there are a number of problems with this approach.

First, the Burnside and Dollar (2000) work has been challenged on empirical grounds. Easterly, Levine and Roodman (2003) claim that, by extending the time frame of the original study, the positive association of ODA, policy environment and growth can be made to disappear. Secondly, the way “good policy” is defined in the original work is criticized for over-simplifying complex and diverse political conditions across different countries, and for favouring “policy conditions” neither wholly under government control nor uniformly associated with growth (Mosley, Hudson & Verschoor, 2004; Lensink & White, 2000; Berthelemy & Varoudakis, 1996). Thirdly, the work is challenged with respect to the quality of the data used and the reliance in the outcomes on model specification (Nakamura & McPherson, 2005).<sup>25</sup>

More recently, meta-analysis of macroeconomic effects of aid, covering 131 regression analyses and comparing them with more recent work using a “common analytical framework” that looked at associations between aid and savings, aid and investment, and aid and growth found a “coherent and positive picture” of the aid-growth relationship – even in unfavourable policy environments (Hansen & Tarp, 2000).<sup>26</sup> There is now a strong body of evidence supporting aid effectiveness. Often it acknowledges the benefits of a sound policy environment but in several cases argues aid’s effectiveness regardless of those conditions (Addison, Mavrotas & McGillivray 2005b; Snowden, 2005; Dalgaard, Hansen & Tarp, 2004; Harms & Lutz, 2003; Morrissey, 2002; Gounder, 2001; Collier & Dollar, 1998; Cassen et al., 1986).

Selectivity has also been challenged in the context of health, though arguably in a somewhat circumscribed way, where the concept of effectiveness is confined to targeted interventions in the healthcare

system. “Even in needy countries with weak policies, some kinds of carefully targeted assistance for health...can have a positive effect...[A] focus by donors on policy dialogue and technical assistance to improve the environment for DAH can set the stage for a larger infusion of financial support further down the road” (Jamison et al., 2006, p.246). “[M]any high-impact health services can be delivered to the population on a targeted basis even when national policies and institutions are weak” (ibid., p.248). There are, however, more fundamental reasons to approach selectivity with caution.

First, selectivity is overly geared to growth-related policy. Given that economic growth does not automatically translate into poverty reduction or increased equity, and that aid is explicitly tied to reducing poverty, selectivity, if it is to be applied at all, should be applied on criteria that favour governments’ demonstrating specific pro-poor policies. (Mosley, Hudson & Verschoor, 2004; McGillivray, 2003). Moreover, given that national policy conditions and pro-poor actions are themselves conditioned by factors beyond the domestic regime, vulnerability to external shocks should be included in the criteria for selection of recipients (McGillivray, 2003; Collier & Dehn, 2001; Guillaumont & Chauvet, 2001).

Second, like its antecedent conditionality, selectivity perpetuates the aspiration among donors to leverage recipient country policy. To a significant extent, matters of policy should be matters of sovereignty. And, as a complex combination of social and cultural norms evolving, often through struggle, into social, economic, executive and juridical institutions, governance is principally an endogenous process. Aside from those more general arguments, experience in any case suggests that ODA’s leverage over political process in poor countries is limited (Jamison et al., 2006; Quartey, 2005; Svensson, 2003).

Third, the logic of selectivity is that it rewards coun-

23 McGillivray identifies 35 empirical studies that affirm a positive relation between ODA and growth; Clemens et al (2004) identify another 11 studies (7 positive).

24 ‘With good policies and institutions (strong property rights, reduced corruption, an efficient bureaucracy), an extra 1% of GDP in aid is estimated to reduce infant mortality by 0.9%. By contrast, where policies are average, the decline is estimated at only 0.4%, and where policies are poor, aid is estimated to have no significant effect on infant mortality (World Bank, 2004b). A recent World Bank study found that an increase in any of six indicators of good governance is associated with at least a halving

of a country’s infant mortality rate’ (USAID, 2002, p.74).

25 The main conclusion of this discussion is that, without more evidence on the robustness of the policy index and its components, the relevance of the measure is open to debate’ (Lensink & White, 2000).

26 The authors conclude that the ‘macro-micro paradox’ of ODA (that evidence of aid effectiveness at the micro-level contradicted evidence of negligible or null effect at the macro-level) is ‘dead and buried’.

tries that perform well and implicitly punishes those performing poorly. In this there is a risk that aid will be reduced or withdrawn from countries most in need, that is, countries with the weakest institutional and infrastructure bases, including fragile and failing states. This is perverse. It runs counter to the ethical basis of aid. It risks increasing the incidence of state failure or propagating a somewhat bizarre two-tier aid structure of “orphans” (with little or nothing) and “darlings” (overloaded with assistance). In some instances it penalizes poor populations for the policy choices of minimally consultative regimes.

It is clear that aid has had considerable impact in the lives of people in developing countries. Collier and Dollar (2000, p.2) find strong evidence of effect: “We show that even with the present allocation, aid is effective in lifting around 30 million people per annum sustainably out of absolute poverty. With a poverty-efficient allocation this would increase to around 80 million people.” But the argument for effectiveness extends beyond this. A persistent emphasis on aid and growth underestimates the wide range of non-economic objectives and impacts. Most obvious is finance to projects providing direct support to people in highly vulnerable conditions. It underestimates the counterfactual – what a recipient country would have looked like in the absence of aid (McGillivray, Feeny, Hermes & Lensink, 2005) — and it does not properly account for the value of aid in reducing instability and mitigating conflict (Chauvet & Collier, 2004).

### **Problems in measuring aid effectiveness**

The literature documenting measurement of aid in relation to growth, and to a lesser extent poverty reduction, is extensive. However, deeper analysis of aid’s impact on more complex socio-structural determinants of poverty, equity and health remains a much weaker field. On one hand, there is arguably a strong disincentive for donors, recipients and intermediaries such as NGOs to invest in rigorous measurement where evidence of failure can compromise everyone’s interest in continued flows (Banerjee, 2006; Conyers & Mellors, 2005; Fielding, McGillivray & Torres, 2006; Addison, Mavrotas & McGillivray, 2005b).

The 1978 WHO/UNICEF Declaration of Alma Ata raised a global challenge to the dominance

On the other hand, clearly there are strong reasons to encourage the measurement of aid effectiveness, to demonstrate success, to learn to distinguish effective from ineffective actions, to allocate aid more efficiently, and to monitor progress towards developmental goals. The key is not to oversimplify the indicators or the methods of measurement just to achieve quantifiable results.

Following the difficulties experienced in *ex ante* conditionality and the debated value (indeed practicability) of selectivity, donors have started to look more closely at ways of applying *ex post* measurement to aid (Eyben, 2005). Results-based Management (RBM) and Output-based Aid (OBA) both lay emphasis on the sequenced release of aid finance dependent on demonstration of effects by recipients. In general this demand for ‘results’ – in a similar way to selectivity – underestimates the complex social, cultural, economic, environmental and political conditions in which aid is applied. And it underestimates the developmental processes it is explicitly or implicitly geared to promoting (Eyben, 2005). In the case of health, RBM and OBA risk driving recipient action towards interventions with immediate (and easily detectable or attributable) outcomes. An example is rates of fully immunized children stipulated by the Global Alliance for Vaccines and Immunization (GAVI) (Jamison & Radelet, 2005). These are worthwhile targets but where they overwhelmingly become the focus, they can reduce aid predictability and appropriate health system planning. The ability to achieve these targets, and hence to qualify for and so integrate into planning additional future aid resources, is often dependent on social or organizational factors well beyond the control of health system planners. Emphasis on medically-defined targets can also marginalize non-medical action for health, action aimed at improving health equity, and actions whose effectiveness takes longer to manifest itself but which may conceivably be of greater overall value (Johansson & Molund, 2006; Kemp et al., 2003; EQUINET, 2003).

A smaller school advocates the use of randomized controlled trials (RCTs) as being more rigorous than RBM and OBA to assess aid’s impact (Banerjee, 2006).

Leaving aside the ethical dimension of artificially restricting access for some forms of support designed to alleviate basic human ills, the problem here is that the kinds of aid-supported action capable of an RCT evaluation are relatively limited. They are the more conventional forms of small-scale, time-bound, stand-alone projects which characterize an earlier (and arguably more paternalistic) era of aid (Deaton, 2006a). RCT and community-based trials may be appropriate in some instances. They should not, however, lead the way backwards to a more controlling form of the relationship between aid providers and recipients, or to the reconceptualization of poverty as a matter of experimental interest and technical action.

There is a need to measure the impact of aid. But behind that, there is a need to conceptualize more clearly – across the donor-recipient relationship – what aid is aimed at. This must include not only “top-line” or aggregate outcomes, but also outcomes distributed across socio-economic groups and by other key equity stratifiers, such as gender. As well, aid outcomes need to reflect the often complex social and institutional processes involved in policy change, such as that reflected in the composition of public spending. And it must include outcomes over a longer time frame than is customarily applied (Garrett, 2007).

## Geopolitical Aid

Aid is not simply given to alleviate poverty or promote growth; nor is it allocated according simply to objectively verifiable recipient need.<sup>27</sup> Other considerations – geopolitical, geostrategic, trade- and security-related – are strongly influential in the decisions donors make about where to send their aid, an effect amplified by the Cold War (Khan, 2003; Hopkins, 2000; Stiglitz, 2002; Alesina & Dollar, 2000; Schraeder, Hook & Taylor, 1998; Hoebink, 1997; Boone, 1995). This complicates the notion of aid effectiveness, the growth-policy nexus, and hence recipient selectivity, since

ODA may be having all kinds of desired effects (from the donor’s perspective) without any sign of the ostensible benefits conventionally attached to aid. At the extreme, analysis suggests that “...developmental or humanitarian concerns, such as reduction of poverty, receive relatively little or zero weight in the [aid allocation] process” (McGillivray, 2003, p.7).

Many of the major bilateral donors tend to allocate in favour of former colonies (Isopi & Mavrotas, 2006; Mazzotta, 2005; Neumayer, 2003; Congressional Budget Office, 1999; Mosley, 1981). Japanese aid allocation is strongly influenced by geo-economic, and historical and geo-political sphere-of-influence considerations (Cooray, Gottschalk & Shahiduzzaman, 2005; Khan, 2003). US aid is positively associated with trading partnerships. It “shies away from countries with major religious parties”, and falls sharply in countries with large or growing centrist party control of national government (Mazzotta, 2005). Somewhat the exception, Nordic ODA is not associated with poor trade regimes nor with political allies, but is positively associated with evidence of democratic regimes and human rights in recipient countries (Gates & Hoeffler, 2004). Notwithstanding the universal rhetoric, the level of corruption in a potential recipient country appears to have virtually no influence over aid allocation (Isopi & Mavrotas, 2006).

Even between government departments and within the bilateral aid agencies of donor countries there is discontinuity in the way aid is conceptualized and deployed, what its primary objectives are, and consequently how its effectiveness can be measured realistically. Competition over foreign policy among trade and security interests in government often outranks humanitarian considerations. Meanwhile diverse departmental imperatives within aid agencies – and institutional resilience to “learning” – muddy the water in any attempt at linear analysis of recipient need, agreed objectives, donor allocation, and outcome measurement (McCawley, 1998; Conyers & Mellors, 2005; Mazzotta, 2005).<sup>28</sup>

<sup>27</sup> ‘The aid resources of bilateral donors, including the US, tend to follow the donors’ political and strategic priorities, not those of the countries that have the greatest need from a development perspective’ (Congressional Budget Office, 1999). Regional banks determine country assistance ‘need’ from per capita income; multilateral donors combine income with measures of physical quality of life to arrive at an assessment of need. ‘Aid continued to the Russian Federation even when the prospects for reform were bleak and there was little or no economic rationale for assistance’; IMF lending in MENA was given in spite of ‘very little evidence of economic need’ (Woodward, 2007).

In spite of 60 years of lessons learned and alleged paradigm shifts, aid is still not allocated in the most poverty-efficient manner (Collier & Dollar, 1998). Aid continues to be directed to countries for reasons other than developmental need. Recent increases in ODA have been concentrated in relatively few places. Less than a quarter of total ODA available goes to the poorest countries (United Nations Non-Governmental Liaison Service (UN-NGLS), 2005). Over 60% of the total increase in ODA between 2001 and 2004 went to Afghanistan, the Democratic Republic of Congo (DRC), and Iraq – in spite of the fact that the three countries account for less than 3% of the developing world’s poor (World Bank, 2006). Much of the ODA increase in 2005 can be accounted for against debt relief to Iraq and Nigeria.

For aid to be effective, there needs to be a transparent relationship between the developmental needs for which it is given (treating all eligible recipient countries equally) and the purposes to which it is put (United Nations Non-Governmental Liaison Service (UN-NGLS), 2005). The dominance of other political, economic and strategic interests in the way traditional bilateral aid is allocated distorts the placement of resources to “true development needs” (ibid.), and compromises the discussion of effectiveness. What is needed is a shift from bilateral interests to a more neutral system of allocation organized globally, along multilateral lines agreeing both conditions of need and forms of finance.

28 “There is serious question as to the coherence of the government of the United States as a funding agent. If it can be considered a single entity, it is certainly not a unitary actor. Authority over authorization of expenditures, appropriation of funds, programming, monitoring, and evaluation is highly compartmentalized...aid flows are appropriated to different departments in the executive by a series of committees of both houses of the US Congress. Each of these departments has its own mandate, and internal conflicts about mission and methodology to boot” (Mazzotta, 2005).



## Section II: Aid for Health

of economic and technical fixes for health in poor countries, calling for a broader approach founded in more integrated, locally managed primary care, and advocating strongly the need for attention to the wider social context by which people's health was determined. However, the second oil crisis in 1979, and subsequent debt crises of the early 1980s, brought about a major shift in economic policy discourse toward fiscal austerity (spearheaded under structural adjustment), driving a wedge into that agenda, and leading to a split in international health aid between selective primary health care (maintaining or expanding vertical infectious disease control programs) and health systems reform (HSR) (Audi-bert, Mathonnat & de Roodenbeke, 2003).

Following the second oil shock, there is little disputing that many African economies manifested calamitous macroeconomic crises. In the absence of more aid or debt relief, some downward fiscal adjustment can be argued to have been inevitable and necessary – though the scale, sequencing, and unaddressed consequences of the initial austerity programs can

be questioned. While the period following the petrodollar boom and debt crash in many poor economies certainly highlights, on the one hand, the role aid played (from the mid-80s on) in mitigating the worst aspects<sup>29</sup>, it raises, on the other, a very serious concern about the sustainability of large-scale external financing (irrespective of source). The calls for an African “Marshall Plan” and for a big push increase in global ODA (heavily focused on sub-Saharan Africa), may raise risks similar to those raised by the OPEC-fuelled boom in cheap loans. Governments of structurally poor countries would be encouraged to channel significantly larger amounts into public sector spending but without the domestic productivity or international guarantee of aid over the long term to sustain such investments after the big push is over. We will return to this later, in the discussion of the Millennium Development Goals (MDGs).

The need for economic adjustment in some form notwithstanding, health system reform tied to debt relief and continuing financial aid, drove forward fiscally

29 Reflecting calls for ‘adjustment with a human face’ documented in UNICEF’s 1987 publication of the same name.

conservative public expenditure in recipient countries and often aggressive liberalization policies. This led to a fragmentation of health care systems, downward trends in basic welfare indicators, and increasing inequity of access to health services and wider social determinants among poor and vulnerable groups most catastrophically (combined with the AIDS pandemic) in sub-Saharan Africa (Jolly, 1991; Stewart, 1991). More recently, evidence of market imperfections and failures in stagnating or deteriorating conditions in large parts of the developing world has led to a greater developmental focus on the quality of broader societal conditions. These were articulated prominently through ideas of institution-building and the role of social capital (Fine, 2002). One might have thought this a prime opportunity for the introduction of serious attention to the social determinants of health.

The Commission on Macroeconomics and Health (2001) confronted the convention of health as the product of economic growth, arguing instead that health is a vital input to growing economies<sup>30</sup>. This may present difficulties to those who view health as an intrinsic feature of good development rather than simply an instrumental input for growth. However, the CMH helped to galvanize and focus global concern for health, a concern heightened by the continuing devastation of the AIDS pandemic and the human and global security risks of SARS and avian flu. The following sections will explore how that global concern for health, and commensurate increases in aid, play through into health action in poor countries.

### **Levels of Development Assistance for Health (DAH)**

Aid dedicated to health has also seen a significant increase in the period following the Second World War, both in absolute terms and more recently as a sectoral proportion of the total aid allocation. Aid to health continued to grow even during the 1990s

as total ODA fell, and has seen significant acceleration following the millennium commitments into the early 2000s. Between 1990 and 2004, DAH rose from \$2 billion to \$11-12 billion (Schieber, Fleisher & Gottret, 2006; Michaud, 2003)<sup>31</sup>.

In spite of the money, the world's health is still in a dire state (Schieber, Fleisher & Gottret, 2006) – not only in absolute terms but also in terms of the disparity between countries and regions, and inequity within them. “The picture which emerges is of very sharp global inequalities in health, with the greatest absolute burden of ill-health being concentrated in sub-Saharan Africa and South Asia. Within other regions...some countries suffer very high rates of poverty and ill-health. And within all countries the health of the poor tends to be considerably worse than that of the rich, and disturbingly despite economic growth, in many countries, health inequality is increasing” (DFID, 2000, p.18).

The Commission on Macroeconomics and Health has estimated that aid for health will need to rise to around \$34 per capita per annum by 2007, rising again to \$38 per capita by 2015, in order to “deliver basic treatment and care for the major communicable diseases, early childhood, and maternal illnesses” (CMH, 2001<sup>32</sup>). To this end, the Commission estimated that donors would need to provide “roughly \$27bn per year (at 2001 prices and exchange rates) as of 2007 to enable the poorest countries to deliver basic life-saving health services” (CMH, 2001) – with estimates of required DAH rising to around \$38 billion per annum in 2015 (Labonté, 2005). Clearly current levels of DAH fall “far below requirement” (Michaud, 2003; OECD, 2000). Calls for a massive scaling up of aid to health look set – at least in some degree – to be realized.

But there are two provisos. First, the normative approach to aid – that is, how much is required in terms of input per capita for ideal outcomes (espoused by Jeffrey Sachs et al.) – raises potential problems for would-be recipients. Without some confidence in the

30 The instrumental view of health as a means to other, primarily growth-oriented, ends is shared by several of the major bilateral aid agencies. USAID, 2006: decent health is essential for worker productivity and individual economic welfare. It is safe to assume that investments in health contribute to growth in countries with good governance, institutions and economic policies.’ DFID, 2000: ‘Investment in good health is now known to make a vital contribution to both social and economic development. A healthy, well-educated population is a pre-requisite for nations to extract the potential benefits of globalisation.’ AusAID, 2006: ‘A healthy population is one of the building blocks of growth’.

31 Total assistance for health in 2004 is estimated at \$11.4 billion (World Bank, 2006). On average, over time, DAH has comprised around 10% of total ODA (though this varies by donor). About a third of DAH goes to Sub-Saharan Africa.

32 See also, e.g. <http://www.hlfhealthmdgs.org/Documents/FiscalSpacePerspective.pdf>.

continuity of resources in the long run, governments making spending commitments to absorb additional aid within the sectoral confines of the MDGs, for example, may find themselves further down the road over-invested (and unsustainable) in some sectors (e.g. the social sectors) and under-invested in others (e.g. the productive sectors). Promoting poverty reduction at the expense of economic growth would be a mistaken application of aid. Second, if increased aid is to be channelled to health, evidence suggests that some conceptual and structural changes may be required to make this aid more appropriate and effective.

Development assistance for health (DAH) is acknowledged to be an effective form of aid. Some would say it is unusually effective<sup>33</sup>, though clearly there are methodological problems attempting to compare it against, say, aid investments in rural infrastructure and its onward impacts on poverty. Moreover, the kinds of effects identified with DAH are often heavily concentrated in the medical/technical area, and operationalized primarily, if not exclusively, through the health sector and health care system. Evidence suggests that effectiveness of this kind, while impressive in aggregate, is often much less impressive in its impact on inequalities, and on the structural conditions that determine health and health equity (see below, DAH and Health Equity).

### **DAH and Health Equity**

The Universal Programme for Childhood Immunisation (UCI) is a good example of the effectiveness of health aid, and of the limitations in its approach. From the start of the 1980s, UCI mobilized massive resources in vaccines and program finance, raising rates of childhood immunization to a global average of almost 80%. This is, in and of itself, a tremendous achievement. Yet while the global impact suggests a triumphant success, sub-global figures betray significant and apparently entrenched regional inequalities. And, while national data show significant improvements over the period, sub-national data manifest again dramatic inequalities, such as those seen in Bangladesh (below). Given that such unevenness of effective immunization, with respect to

necessary levels for herd immunity, can compromise the overall impact of such campaign investment in the long term, these inequalities demand attention not only on grounds of equity but also of efficacy.

In Bangladesh UCI raised national rates for fully immunized children from 2% in 1986 to 62% in 1991 (though subsequently settling at around 50%). But in-country disparities in access to immunization along a range of social stratifiers (education and gender, for example) have remained notable. The case study of Bhairab illustrates well the degree to which national impacts founder on the structural inequity of local social determinants, and points to the need for analysis of aid effectiveness that takes those local conditions into account.

“In Bhairab, a traditionally low performing area, pockets of villages exist where the coverage is significantly lower (as low as 5%) than other villages. One reason for such poor coverage is the sheer size of the village and poor transportation. Villages separated from other areas by a big river and low-lying fields and remain isolated from the mainland for about eight months by floodwaters. Being very small no person from the villages gets elected to local union council and thus they are politically unimportant. The villages are far from nearest health centres and the health workers seldom visit. The villages do not have enough children to set up separate vaccination centres; for the same reason no NGO is active in these villages” (Mushtaque et al, 2003).

It may be argued that as coverage for health services increases, it is inevitable that those who are better able to avail themselves of the services (better off, less geographically remote) will experience improvements first, and that inequity may increase in the early stages of increased resource availability. This argument suggests that, for example, a rational government will allocate new resources (such as aid directed to health services) first to those whose well-being can be enhanced most cheaply. An alternative view is that aid can be used, with a view to advancing equity, in precisely the opposite manner, channelled to those parts of the population conventionally excluded from or unable to get hold of resources. As has been noted elsewhere, cost-effectiveness can

33 ...providing comparatively inexpensive improvements (including improvements directed at the poor), working better than other forms of external financing even in weak policy environments...and offering 'exceptionally high' economic benefits of such improvements (Jamison et al., 2006).

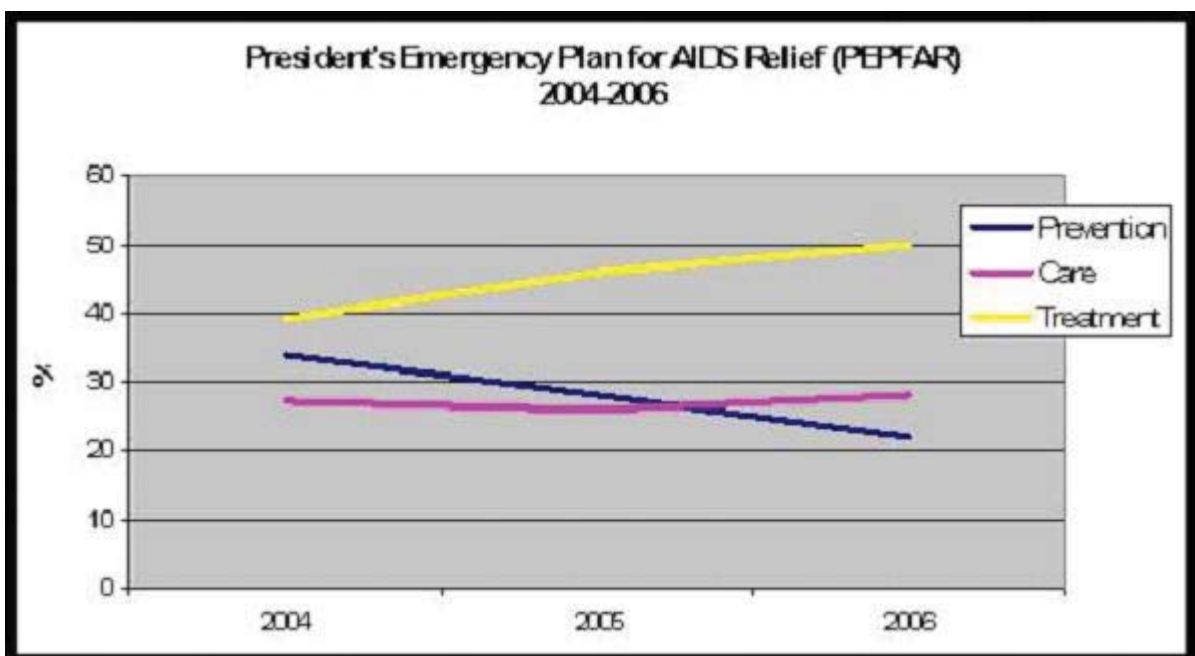
be outweighed by other national and local policy preferences, including reducing inequity.

### Investing in Action on the Causes of the Causes: SDH Framework

As it stands the major donors have recognized the cross-sectoral nature of health and the imperative to act not just on the immediate causes of poor health and health inequity but on the structural causes – the determinants of health. However, beyond the rhetoric donor practices in health aid remain heavily sector-specific, technocratic, and responsive to diseases in ways that do not match the epidemiological evidence of burden (Sachs, 2004). Within the health sector the composition of aid under-finances basic and pro-poor health. At the same time proliferating global health initiatives (GHI) such as the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) – effective in many respects – continue to channel significant health finance off-budget. This risks fragmentation of national health policy-making in recipient countries and creates competition for scarce health systems resources, in particular health human resources.

### Aid and AIDS

Figure 3: PEPFAR funding allocations



Source: author's calculations

The 2003 US President's Emergency Plan for AIDS Relief (PEPFAR) illuminates the limitations of paradigm shift in contemporary health. We can leave aside the debates about an emphasis in PEPFAR on ABC (abstinence, fidelity, condom use) and the domestic ideological underpinnings informing this. What is clear from the breakdown of allocations between 2004 and 2006 is a preference for investment in treatment over prevention. It is also a significant shift in funding away from preventive action, from over one-third in 2004, to less than a quarter two years later (Figure 3).

PEPFAR is one of the most significant single lines of international health funding in the last 20 years. It is important money, but it highlights a worrying discontinuity between donor rhetoric and the reality of donor practice that continues to privilege medical and curative intervention. This is true particularly where that intervention meets the requirements of a domestic (U.S.) policy agenda (especially in the morally loaded field of sexual, gendered and reproductive health). In 2007 the G8 identified among key health-related issues the need to broaden preventive approaches in the international field of action on HIV/AIDS, focusing on the social status and role of women. While this is enormously encouraging in principle, it is unclear from the evidence which will prevail: the money (PEPFAR) or the rhetoric (gender empowerment).

Donors are aware of problematic tensions between the cross-sectoral nature of development processes and needs, and the sector-specificity and accountability issues regarding the allocation of aid and the way it is accountably used. Interpreting trends in aid is complicated somewhat by the fact that there is a considerable time lag between changes to donor policy and impacts evident in scale and pattern of disbursement.<sup>34</sup> In particular much of the trend demonstrated here does not fully reflect changes at the level of policy among donors away from project-focused aid finance, towards financial support to whole sectors. The World Bank's Sector Investment Programs (SIPs) and the more generic Sector-Wide Approaches (SWAs) reflect the move toward the allocation of aid directly into the recipients' general

budget resource.

### **General Budget Support and the Social Determinants of Health Agenda**

There is evidence of a growing appreciation among donors of the rootedness of health in social conditions, and therefore the need to address aid to the social determinants of health. Much of the appreciation, however, remains at the level of rhetoric, while donor practices remain focused on classical health sector and health care system interventions. Moreover, the recognition of social conditions for health is not new. More than 15 years ago regional analysis in Africa showed that "weak economic and political context of the African cases was found to inhibit sustainability in these countries, suggesting that broader development issues be addressed before donors expect significant sustainability of health projects in Africa..." (Bossert, 1990). The HIV/AIDS pandemic has brought into sharp relief the socio-economic origins of many of the drivers of infection, highlighting what has been described as the need for a paradigm shift in health aid to address broader development factors (ESCAP, 2003). Yet that paradigm shift has by no stretch of the imagination been fully achieved.

Growth, poverty reduction, and health rely on complex influences and interactions internationally, nationally and sub-nationally (Aghion & Howitt, 1998). "There is nothing automatic or pre-ordained about the link between aid and development" (Riddell, 1987). The gap between increasing international attention to health and increasing release of resources, and persistently poor – and in some areas worsening – conditions of health and health inequality, points to an inadequacy in the way aid is being applied.<sup>35</sup> This is not a matter solely – or even largely – for the donors. Recipient governments obviously bear much responsibility for population health and health equity. In order to understand this process of application, we need to understand in more detail the different forms aid can take, and the dynamics of aid delivery and the relationship between parties that that engenders.

### **Aid for health: Unbalanced epidemiology**

34 DAC data do not yet reflect the emergence of new donors such as China, Korea and Turkey.

35 Central to the question of health aid application is the suggestion of 'insufficient attention to the social determinants of health' (Benatar, 2005).

That health-related aid has been increasing is welcomed. That new money for health continues to reflect other concerns than those suggested by the burden of diseases in poor countries is worrisome and points to continued over-representation of donor and special interests in the framing of aid and DAH.

During the 1990s much of the increase in health aid was concentrated in three areas – immunization, HIV/AIDS, and new product development (Jamison et al., 2006). Between 2000 and 2004 allocations to HIV/AIDS, TB and malaria took up one-fifth of total global health aid (Michaud, 2003), reflecting the health focus and financial draw of the MDGs (Jamison et al., 2006). Indeed if we exclude aid allocated to HIV/AIDS (which rose approximately tenfold), we find that in fact total DAH between 1993 and 2003 declined as a share of ODA, from 5.4% to 5% (McKellar, 2005).

Long-standing donor interests continue to distort global health financing in favour of infectious disease and reproductive health, to the disadvantage of non-communicable disease including some with massive impact on health across countries in all income brackets. Based on their proportional contribution to the burden of disease, measured in disability adjusted life years (DALYs), HIV/AIDS and reproductive and maternal health are internationally over-funded, while injury, mental health, and nutritional disorders are under-funded (McKellar, 2005)<sup>36</sup>. Between 1993 and 2003 non-communicable disease accounted for 48.9% of the total burden

of disease, but received 0.0% of “directly assignable [DAH] interventions”. When directly assignable and imputed interventions are included, non-communicable disease still received less than a quarter of the total DAH allocation, while communicable diseases received 72.9% (ibid.)<sup>37</sup>.

### **Improving the ‘Fit’ of Aid between Donors and Recipients**

Given the number of donors and recipients (not to mention the plethora of intermediary development agencies), there is considerable potential for confusion and systemic dysfunction<sup>38</sup>. For example, the Commission for Africa (2005) concluded that “the system for allocating aid to African countries remains haphazard, uncoordinated, and unfocused, to a degree that should be unacceptable.” Yet donors in many cases continue to rapidly reproduce such activities (Acharya, Fuzzo de Lima & Moore, 2004)<sup>39</sup>.

If anything, aid for health shows more pronounced capacity to exercising a fragmenting effect on recipient country health priorities, policy and action. On one hand, new global health initiatives and partnerships – while admirably raising the profile of international health – have diverted health resources off-budget. And they have paid limited attention to the need to strengthen health systems, while exercising a gravitational pull on health sector policy and planning and on the resources of often weak health systems (Brugha & Walt, 2001). On the other hand, reform processes have encouraged diversification

<sup>36</sup> In the case of infectious diseases, DAH appears to be allocated disproportionately to some over others according to a number of criteria other than burden, including: existence of cost-effective interventions; characteristics of the victims; the presence of a global advocacy community; the inability of countries to cope on their own; & the possibility of a catastrophic national and international consequences if remedial steps are not taken.

<sup>37</sup> In spite of its documented recognition of the importance of social determinants of health, and of a more strongly cross-sectoral approach to health assistance, Europeaid – the EC agency for aid established in 2001 – has adopted ‘a new focus on communicable disease’ and foresees ‘greater investment for these areas over the next few years’ (EC/AIDCO Communiqué 585, 2000).

<sup>38</sup> Transaction costs to the current international aid system are high for both donors and recipients. ‘In 2002-03, the Tanzanian government received 275 visits from donors who demanded that the government carry out in one year no less than 78 political reforms’ (Oxfam, 2005).

<sup>39</sup> It should be noted that Acharya et al., do not necessarily argue that proliferation of aid is altogether a bad thing, from the point of view of maintaining a portfolio of investments allowing donors to spread risk and experiment with approaches.

<sup>40</sup> Although it is worth considering the comparative advantages of the non-government organisation community in international health – there are an estimated 60,000 AIDS-related NGOs alone (Garrett, 2007) – the ‘proportion of aid they bring is comparatively small’ (Walt, Pavignani, Gilson & Buse, 1999).

<sup>41</sup> Full GBS funding remains relatively rare (approximately 5% of total current ODA) (Morrissey, 2002; Daniels, 2001; De Renzio, 2005); although GBS makes up a little over a quarter of ODA allocated in 2004-05 by the Strategic Partnership for Africa, specific country case studies have shown considerable difficulties in implementation (Schneider, 2005; Foltz, 1994). One reason for difficulties – and corresponding hesitancy on the part of donors – is the perception of weakness in recipient countries’ Public Expenditure Management (PEM) (OECD-DAC, 2001). Donor nervousness is reflected in the DAC advice regarding direct budget support (DBS). ‘Where commitment to social policies is not clear, donors may prefer to use NGOs or [invest in] projects’ (OECD-DAC, 2001). In other words, if the donor does not like the recipient’s policy or performance, they can throw the much vaunted processes of alignment and recipient aid ownership into reverse by reducing DBS, and reverting to project aid, or even circumventing the government altogether. This exposes the profound ambivalence underlying support for increased recipient authority in the aid relationship.

— liberalization or fragmentation — of the health care sector<sup>40</sup>.

The Paris Declaration on Aid Effectiveness (2005) raised two key issues for aid:

1. **Coordination:** the degree to which donors coordinate aid to increase coherence of approaches and reduce often high transaction costs
2. **Alignment:** the degree to which all incoming aid supports – or distorts – nationally determined policy priorities.

There have been a variety of attempts to address the deficiencies of aid coordination and alignment. These include ongoing consideration among donors, of shifting finance from individual projects and whole sectors (SWAp), to General or Direct Budget Support (G/DBS)<sup>41</sup>. GBS remains a relatively small part of overall aid. Another highly influential approach to coordination and alignment is the establishment of the Poverty Reduction Grant Facility (PRGF), following on from the Enhanced Structural Adjustment Facility (ESAF), and the adoption among recipients of the Poverty Reduction Strategy Paper (PRSP) process.

The Poverty Reduction Strategy (PRS) protocol was launched as a complement to the HIPC debt relief initiative in 1999. It was designed to organize all relevant domestic and external resources under the management of a national government – in consultation with sub-national stakeholders – to produce a coherent, multi-sectoral framework for budget and action on poverty. Although there has been critical analysis of the degree to which PRSPs have in any real sense strengthened participatory strategic planning among national and sub-national stakeholders (Woodward, 2006), it is now clear that the strategy framework in poor and indebted developing countries exercises a powerful disciplinary effect over the fiscal choices and behaviour of recipient governments. In effect, the strategy framework over-coordinates aid, including health aid, according to

ideas and approaches still heavily influenced by donor interests. It is also still heavily constrained by conventional associations between health as a set of technical problems and health action seen as a set of medical/clinical interventions effected through the health system.

As gatekeeper to most major sources of international finance (Woodward, 2007) the International Monetary Fund (IMF) and the PRSP process have – formally and informally – created a threshold of poor country access to ODA. Failure to gain approval on a new PRSP can have a dramatic downward effect on the availability of other aid. Thus, poor countries may be disinclined to put anything into the strategy that the donor would be liable to disapprove (Marcus, Wilkinson & Marshall, 2002). Moreover, as aid continues to flow into a country with an operational PRSP, the strategy itself can condition the way aid is used in favour of macroeconomic conservatism and fiscal caution (ibid.)<sup>42</sup>.

Although poverty reduction-related public spending in HICPs rose during the implementation of PRSPs from 6.4% to 8.1% of GDP, most of this was channelled to education. Finance to health and to infrastructure such as agriculture and transport, both core elements of a pro-poor, social determinants of health public spending agenda, remained steady or fell (IEG, 2006). Assessment of the impact of PRSPs suggests that the effect of reorienting public spending “towards the needs of the poor” has been the “exception rather than the rule”. Instead, health sector plans and budgets under the PRGF “often perpetuate historical patterns of spending” and “do not fully deliver on their potential to influence change” (Laterveer, Niessen & Yazbeck, 2003). This is partly perhaps because the majority of PRSP proposals lack data on the distribution and composition of the burden of disease in the applicant country.

We have seen significant increase in the total volume

42 Not least through the associated Medium-Term Expenditure Framework (MTEF), designed to convert the longer-term strategic plans into managed short and medium term public spending.

43 There are some notable exceptions to this; in the early 2000s, Tanzania spent 13% of its budget on ‘health-related goods and services’, with the Central African Republic, Namibia and Zambia at 12% each, and Mozambique, Swaziland and Uganda on 11% (Garrett, 2007). It is worth remembering that the potential for DAH to impact health (in particular among lower socio-economic groups) is limited where much or most DAH flows through public or para-state structures, while more than half of national health spending in low-income countries is private, out-of-pocket spending on private health services and pharmaceuticals. The Abuja commitment of African government to allocate 15% of public revenue to health is to be welcomed with the proviso that such increases in State support may flow through systems that either tolerate or actually exacerbate inequitable access.

of health aid over the last decade and a half. DAH is a significant element of global health spending, comprising about a third of all health spending in recipient countries in 2002. Yet, between 1990 and 2003 public expenditure to health as a proportion of GDP across recipient countries did not rise significantly. Since 2000 domestic budgeting for health in low-income countries remained flat at an average of 1.9% to 2% of GDP (World Bank, 2006)<sup>43</sup>. Moreover, the PRSP process appears not to have provoked increased public sector health expenditure. A recent analysis for the IMF found that “total health spending (from domestic and external resources) in countries implementing programs financed through the PRGF, [was] projected to rise only slightly from an average 1.8% of GDP in 2000 to a projected 2.1% of GDP in 2001-2002’ (World Bank/WHO, 2003).

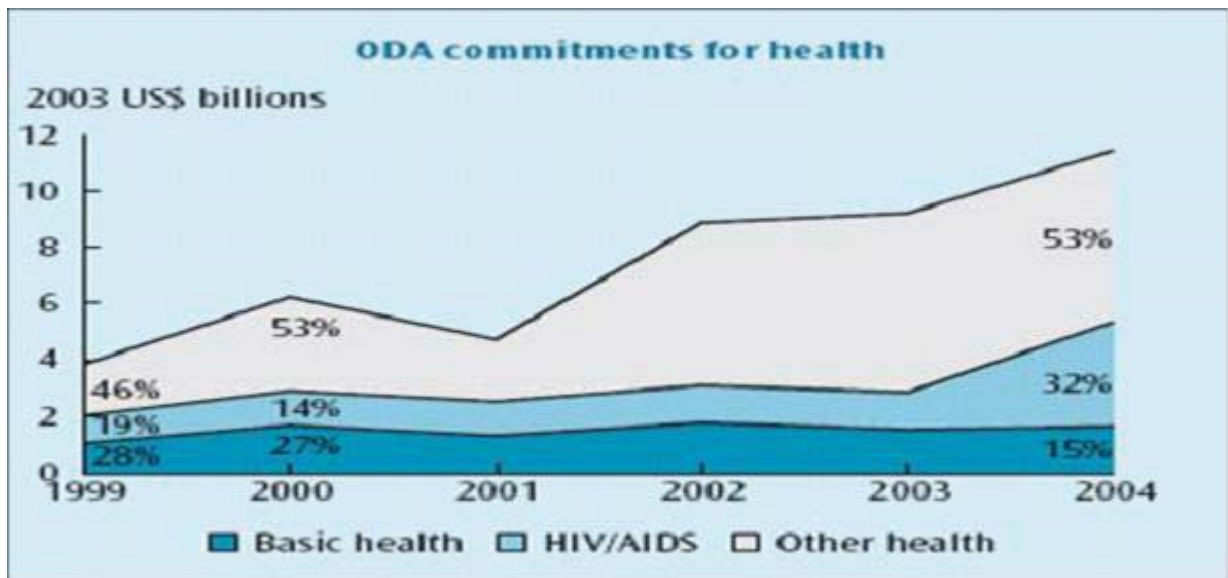
### Basic health: Aid and the health care system

As a key component of poverty reduction (IEG, 2006), basic health should be a primary target for health aid funding. While basic health can be

achieved through a variety of health sector and non-health sector entry points, the role of the health care system itself remains for the foreseeable future a central actor in the health of aid recipient countries. But, even though health-related aid has been on the increase, that increasing revenue stream has not flowed to health system strengthening and known pro-poor health system investments (in particular human capital formation at the primary health care (PHC) level).

Although DAH grew 83% between 2000 and 2006, during the same period the proportion given to primary health care (or basic health, as defined by the OECD) fell from 28% to 15% (World Bank, 2006) (Figure 4). Moreover, between 1993 and 2003, health financing associated with poverty reduction dropped from 57.2% to 42% of total DAH, and from 3.1% to 2.8% of total ODA (ibid.). ‘[B]asic health infrastructure and care’ declined from 14.1% to 12.2%; ‘health education and personnel development’ fell from 6.2% to 0.8%; and ‘basic nutrition’

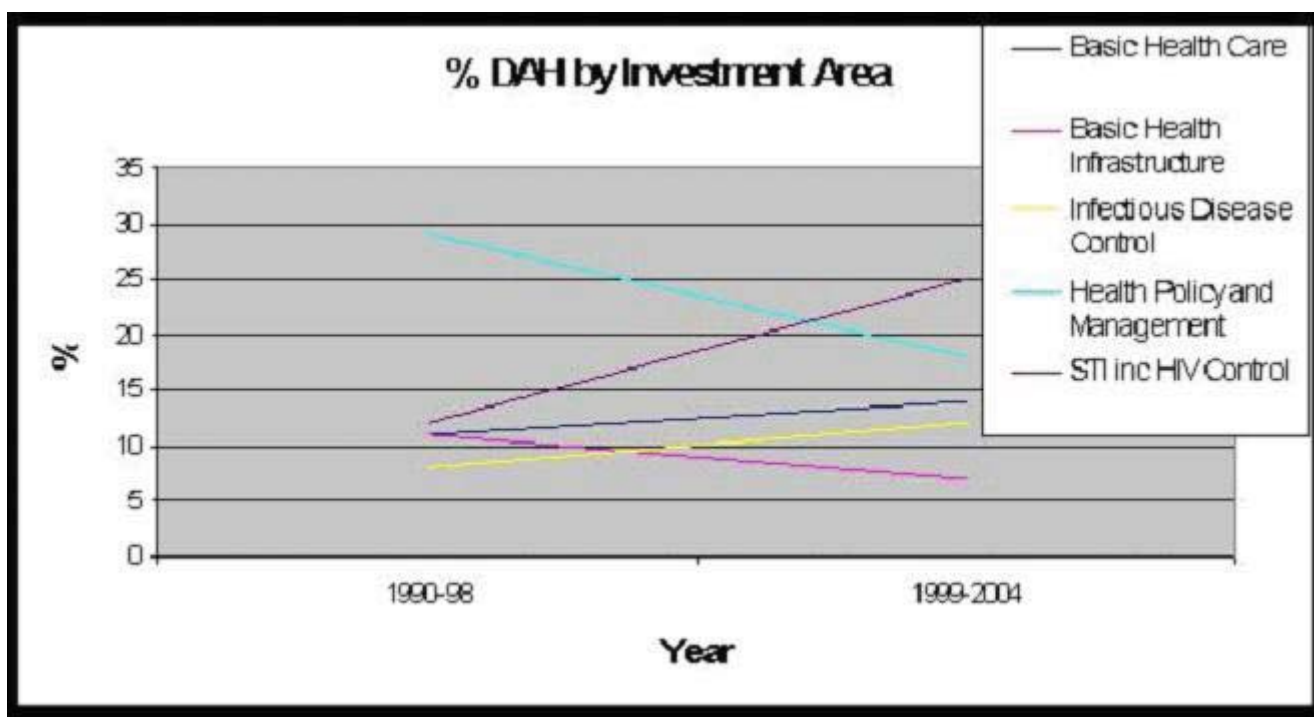
Figure 4: ODA commitments for health



Source: OECD-DAC; HIV/AIDS estimated commitments from Lewis (2005).

decreased from 10.9% to 2.8% (MacKellar, 2005). Health systems in countries around the world are in crisis. “[D]espite increasingly large amounts of funding for health initiatives being made available to poorer regions of the world, HIV infection rates and prevalence continue to increase worldwide... One major reason for the apparent ineffectiveness of global interventions is historical weaknesses in the health system of underdeveloped countries, which contribute to bottlenecks in the distribution and utilization of funds. Data from the OECD-DAC/CRS (Figure 5, below) show a similar pattern of donor allocations to health during the 1990s and early 2000s, in favour of STIs (primarily HIV/AIDS) but away from ‘basic health infrastructure’ and ‘health policy and administrative management’<sup>44</sup>.

Figure 5: Percent Donor Allocations to Health during 1990s and early 2000s



Source: OECD-DAC data base, accessed 23 October 2007; author’s calculations

44 Even where DAH explicitly support health systems (for example, GAVI, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Health Metrics Network), patterns of resource allocation do not (yet) reflect this. Of 30 proposals focusing on health system strengthening made recently to the GFATM, only three were approved. The issue of health human resources cannot be overlooked here, as avital element – and central cost – of robust health systems, yet it attracts relatively little serious attention in spite of evidence showing the correlation between density of health workers and variations in maternal, infant and child mortalities (Jamison et al., 2006).

Part of the problem is that much health aid is not eligible as “core funding,” that is funding that can go to core sector costs (primarily recurrent costs of wages, personal emoluments etc.). A recent study of 14 countries receiving poverty reduction support credits found that only 20% of donor commitments were provided as either general or sectoral budget support (Foster, 2004). “A high share of today’s ODA for health and education is transferred in forms that cannot be applied to core budgetary outlays.” (World Bank, 2006, p.60). The World Bank estimates that as much as 50% of health assistance runs outside domestic budgeting, and 30% escaped government reporting altogether (World Bank, 2006; Sundberg & Gelb, 2006).

A social determinants approach to health is sometimes perceived as opposed to investments in health systems. This is a misunderstanding. The health system is itself a key social determinant (Commission on Social Determinants of Health, 2008) – a set of social spaces and relations in which concrete experience of inequity and exclusion can be contested and changed<sup>45</sup>. “Better health care requires sustained investment in human resources, infrastructure, community-level health promotion, and essential services for primary care, as well as attention to the social determinants of ill-health” (MacKellar, 2005).

DAH needs to support a more systematic, more structurally oriented approach to health as it is promoted through the health care system. What is needed is an overall strategy for scaling up health services. This would include “detailed plans of implementation, especially a sequence of investments in physical capital (clinics, hospitals, training centres) and in health professionals” based on a financing plan, combining resources from donors and from domestic tax revenues (Sachs, 2004). “Strengthening...health systems, although a vital component in addressing the global epidemic, must however be accompanied by mitigation of other determinants as well...including social and environmental factors” (Coovadia & Hadingham, 2005).

Aid designed to promote human development (contextualized by economic growth) depends centrally

on poverty reduction through pro-poor spending, both within the health system, and more broadly on social determinants of health. Pro-poor fiscal policy centrally must be led by government (Addison, Mavrotas & McGillivray, 2005). As we have suggested, a variety of aspects of aid composition and delivery can produce public expenditure policy among poor country aid recipients. These aspects vary from off-budget global and vertical health programming to excessively conservative public expenditure management and the fragmenting effects of health sector reform. The resulting policy can under-serve both pro-poor health system function and health action that recognizes the “structural dimensions of poverty” (IMF, 2006; Sobhan, 2005; Wemos, 2005; Marcus, Wilkinson & Marshall, 2002).

### **Conclusion: Aid, social determinants and the MDGs**

The Millennium Development Goals are perhaps the best and worst example of contemporary aid. In one sense, they represent possibly the greatest moment in post-War commitment to international aid, with the arguable exception of the Marshall Plan. And they place a “central focus on public health” (Sachs, 2004). But, as far as health and development are concerned, they are an imperfect framework, representing all the problems of donor over-influence, technical over-emphasis, socio-structural inattention, and systemic and financial unsustainability.

The health-related goals perpetuate a classic donor-dominated imagination of international health – privileging infectious diseases and encouraging quick-fix investments and technical approaches. In spite of the predominance of non-communicable disease in the burden of disease in all regions save Sub-Saharan Africa, non-communicable diseases go more or less unaddressed by the goals (Jamison et al., 2005). The MDGs mimic ODA’s inattention to the issue of equity. By concentrating on aggregate health as the measure of achievement, they perpetuate the emphasis on health as an average outcome across an undifferentiated population. Action towards the health MDGs carries no necessary benefit for vulnerable groups in recipient countries, except

45 The importance of the role of health systems was reinforced recently at the WHO/EURO Forum on Social Determinants of Health, London 1-2 March, 2007.

where they are affected by progress in other goals such as those for poverty and nutrition (Spinaci, Currat, Shetty et al., 2006; Gwatkin, 2005). Conditions of extreme vulnerability, social exclusion and health inequity could remain entrenched even if the goals are met.

The goals do not address the structural level at which changes they may effect can be sustained. For example, action on the health MDGs in Sub-Saharan Africa will rely heavily on external funding<sup>46</sup>. And it is this relatively heavy reliance that “raises serious concerns about the financial sustainability of the goals in the long term” (Wibulprasert et al. 2005). The question of financial sustainability is given particular urgency by the fact that DAH is still nowhere near the estimated \$100 billion additional annual input estimated necessary (Rowson, 2007).

Where there is optimism regarding the affordability and achievability of the goals (Bryce, et al., 2005; Jones et al., 2003), it is contingent on the limitation of assessment to technical feasibility of interventions primarily organized through the health care system focusing on proximal determinants. Both Bryce et al. (2005) and Jones et al. (2003) recognize the importance of social determinants “such as poverty and characteristics of the physical environment” (Jones et al, 2003, p.65). However, both explicitly omit from their assessments of feasibility the wider field of social determinants and the more structural costs of health care system strengthening, such as human resource training and management capacity (ibid.). Other assessments state unequivocally that neonatal interventions underestimate the full costs and benefits of necessary health care system strengthening (Darmstadt et al., 2005).

The goals can be seen as interpreting health as, in essence, a technical problem, addressing it with finance, but without attention to underlying social, political and economic causes of poverty – themselves the fundamental determinants of health. There is considerable doubt regarding the structural sustain-

ability of MDG, with their somewhat simplistic focus on downstream factors and negligible action on the underlying socio-economic, cultural, political and environmental conditions that contextualize poor health and health inequity (Therkildsen, 2005; Ahmed & Cleeve, 2004; Leipziger et al., 2003).

Central to the question of aid, effectiveness and health is the question of the relationship between external financing and domestic fiscal policy for public health. The question “touch[es] on basic political questions that go far beyond mere technical solutions to medical treatment and service delivery, namely questions of equal rights and the role of government versus private sector” (Jerve, 2001, p.3). Fundamental questions of institutions of governance and the policies they underwrite extend far beyond the formal health sector. “Improved health status depends not only on programmes, policies and progress within the health sector but also – indeed perhaps more – on complementary programmes, policies and progress in other sectors” (Sundberg & Gelb, 2006; Nelson, 2001).

Post-war expectations were that economic growth would happen according to certain mechanistic adjustments to capital and that, once underway, they would translate into improved public experience in social sectors such as health. These expectations foundered in empirical disappointment. The application of conservative fiscal policy to health-related spending and market liberalization to service provision and consumption has not improved social development across the board. In some cases they have considerably worsened. A massive acceleration of international aid finance towards a set of millennial goals, the “Marshall Plan for Africa” was expected to reach everyone in each society in ways that would fundamentally change iniquitous aspects of social organization, and change them structurally and sustainably. According to the available evidence and analysis, that expectation faces disappointment.

46 Sub-Saharan Africa is the largest regional recipient of DAH, with very limited domestic resources across many of the region’s low-income countries. Most countries in Africa are heavily dependent on development assistance for health (Issaka-Tinorgah, 2001). In the case of HIV/AIDS, around 60% of total program spending across the region is externally financed, with a considerably higher share in many African countries. In Ethiopia, between 2003 and 2004, external funding for HIV was the equivalent of the total national budget for health; in Uganda and Zambia, external funding to HIV exceeded national public health spending by 185% (Lewis, 2005).



## Recommendations

Aid *is* important. It *is* effective. It *can* assist in promoting economic growth and, arguably more importantly, it can promote poverty reduction. This can be accomplished through support to pro-poor fiscal management by recipient governments, and through more targeted support. That support would range from immediate relief, through direct livelihood improvements, to *demonstration projects* testing new approaches at the local level, with potential to create an evidence base for scaling up effective forms of social action and generating political support for wider implementation.

As it is currently operationalized, the problem is that aid does not do this with anything like acceptable levels of regularity or reliability. A number of changes to aid would, on the basis of the evidence, strengthen its capacity for positive impact, both generally and on health:

1. First, the total quantities of aid and DAH are inadequate. An achievement of the Commission on Macroeconomics and Health (CMH) was to shift

global thinking about aid from millions to billions. A step-shift is required in the total quantum of aid. That said, a *big push*, doubling aid but deploying it in current compositional forms and systems of delivery, risks simply amplifying the present evidence of sub-optimal impact.

2. Second, aid allocation should not be so tightly tied to the current form of policy selectivity – focusing too heavily on macroeconomic conditions and aspects of governance. If selectivity is to have adequate meaning in relation to efforts to reduce poverty, and to allow real space for pro-equity policy choices among recipients, it should include “poverty earmarking.” That is monitoring pro-poor public expenditure, including “protected finance” for health system strengthening, equity impact indicators across key social determinants, and health equity impact indicators including health system access and key outcomes.

3. Third, program and project allocations should reflect a proper balance in the composition of aid with debt relief, tied aid, food aid and technical as-

shifting the weight of aid in favour of non-special purpose grants, allowing for increased use of aid by recipients to support core social sector spending costs. This should not be seen though as a trade off against investments in the productive sectors.

4. Fourth, the system of aid allocation requires radical reorganization to include bilateral donors, multilaterals, and the increasing off-budget influence of global health initiatives (GHIs) and large-scale philanthropy. This has been advocated before and may appear utopian in approach. However, the ongoing attempts at UN reform at least point the way towards an increase in the collective will of the multilateral body to recognize the inefficient, uncoordinated, fragmented and proliferating nature of the current arrangement. A new cornerstone of international aid is required – a global, pooled funding system, multilaterally operated (perhaps by the United Nations Development Programme - UNDP), with eligibility and allocation determined according to agreed needs and developmental objectives, and multi-year stability of donor inputs and recipient receipts.

## A Chronology of ODA

### Landmarks in Official Development Assistance

1929: British Colonial Development Act: “often cited as the first example which institutionalised development aid of the time”.

1944: International Bank of Reconstruction and Development (IBRD, later the World Bank) and International Monetary Fund (IMF) established at Bretton Woods UN Monetary and Financial Conference.

1945: UN Charter signed (50 countries). UK passes Colonial Development and Welfare Act to reorganize its national development assistance.

1946: ILO incorporated as specialized agency under the UN; UNICEF and UNESCO established. France establishes Fonds d’investissement économique et social des territoires d’outre-mer (FIDES).

1947: Marshall Plan “combines massive aid to European countries with a framework of a cooperative strategy of reconciliation and reconstruction, thus providing the impulse for a new approach to cooperation in policy-making”.

1948: European Marshall Plan recipients establish the Organisation for European Economic Cooperation (OEEC). US creates Economic Cooperation Agency (to manage the European Recovery Program). UK establishes the Colonial Development Corporation.

UN Declaration of Human Rights.\* World Health Organization (WHO) established.

1949: Truman announces Four-Point Plan.

1951: Lewis Report issued by UN (Measures for the Economic Development of Under-developed Countries, calling for UN Fund for Economic Development and International Finance Corporation.

1952: US passes Mutual Security Act as legal basis for major aid program (South Korea, Taiwan, Vietnam, the Philippines, Thailand, India, Iran, Jor-

1956: Paris Club established. International Finance Corporation established under World Bank, focusing on less developed areas.

1957: European Development Fund for Overseas Countries and Territories established;

1958: World Council of Churches circulates 1% GNI ODA target to UN delegations;

1960: Development Assistance Group (later DAC) established; OECD formed from OEEC;

1961: France establishes Ministry of Cooperation for assistance to newly independent countries (largely in Africa). US passes ‘Foreign Assistance Act’ and establishes USAID. Germany establishes comprehensive development assistance programme. Japan establishes Overseas Economic Cooperation Fund (OECF). Sweden establishes Agency for International Assistance (later SIDA).

1962: First OECD High-level Aid Review;

1965: OECD ODA Recommendations Financial Terms and Conditions;

1966: DAC emphasis on agricultural development and food production;

1967: DAC emphasis on population growth. UNFPA established;

1968: Canadian International Development Agency (CIDA) established;

1969: OECD adopts ‘Official Development Assistance’ concept. Pearson Commission recommends ODA target at 0.7% of donor GNI (target adopted by UN).

1970: DAC emphasis on untying aid.

1973: ‘Crisis in development’; DAC shift to ‘comprehensive integrated approach to development cooperation; new emphasis on basic human needs and the New International Economic Order (NIEO).

1974: First oil price shock;

1977: DAC statement on Basic Human Needs ('concern with meeting basic human needs is not a substitute for, but an essential component of, more economic growth...'; emphasis on growth and equity).

1980: DAC emphasis on Evaluation of Aid Effectiveness.

1982: Start of 'debt crisis'.

1983: DAC emphasis on 'the role of women in development'.

1985: DAC Chairman's annual report on Twenty-Five Years of Development Assistance (focuses on advances and set-backs: 'It is in the nature of official development assistance that it is concentrated on countries coping with particularly difficult problems. Official development assistance is not investment banking. It is therefore not directed to countries with the highest potential investment returns. Aid is...concentrated [on] countries with the most difficult and intractable development problems').

'If aid is to make a broad and sustained contribution to the economic and social well-being of developing countries, it must be concerned not only with the proper selection, design and implementation of individual projects but also with the support of broader sectoral and national efforts and policies'.

1986: DAC adopts Principles of Aid Coordination. IMF establishes Structural Adjustment Facility;

1989: DAC emphasis on participatory development and environment;

1992: DAC manual on Good Governance. High-level DAC meeting reviews 'basic rationales and orientations for aid in the new political and economic contexts'; 'reaffirm[s] that the basic task of official development assistance (ODA) is to support sustainable development, reduce poverty and build viable economies and societies, and generate the capacity for beneficial participation in the world economy; emphasis on 'common global problems;

1998: 2nd Tokyo International Conference on African Development calls for increased ODA;

2000: UN confirmation of MDGs;

2002: Monterrey Summit on Financing and Development calls for increased ODA;

2005: Commission for Africa calls for increased ODA (higher proportion of grant-based aid). G8 (Gleneagles) commitments to debt relief and doubling ODA (following Kananaskis and Evian).

Source: Fuhrer, 1996

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