

**HIGH-LEVEL FORUM ON  
THE HEALTH MILLENNIUM DEVELOPMENT GOALS**

**RESOURCES, AID EFFECTIVENESS AND HARMONIZATION**

**ISSUES FOR DISCUSSION: SESSION 2**

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## SUMMARY

Achieving the health MDGs represents one of the greatest challenges in international development. Not least because they include the goal of reversing the global epidemic of HIV/AIDS. To this we have to add the steep declines required in child and maternal mortality, where progress lags far behind aspirations in many parts of the world. Improving health outcomes will not be possible without major improvements in health delivery systems, which in turn depend on changes in public sector management, new forms of engagement with the private sector, as well as interventions well beyond the health sector itself. Moreover, improvements in health are essential if progress is to be made with the other MDGs, including the reduction of absolute poverty.

This paper briefly outlines some issues for discussion in relation to development assistance for the achievement of the health MDGs: how can it be made more effective, how much more is needed, and what has been the effect of trying to harmonize the efforts of different actors?

Increases in the quantum of aid are necessary but not sufficient: progress will equally depend on policy and institutional change on the part of both donors and governments. Furthermore, the role of development assistance has to be set in the context of changes in national fiscal policies; the domestic policies of donor governments; the management of international debt; and trade policy reforms which increase access to developed country markets.

Beyond the areas of broad consensus, however, lies a critical debate. In essence: should health, and particularly the HIV/AIDS epidemic in some countries – given their potential impact on social and economic development, the magnitude of their financial needs, and the *urgency* needed to prevent a catastrophic situation getting worse – be treated differently from other sectors? The growing support for global initiatives that aim to provide funding additional to national budgetary allocations suggests a positive answer. But others argue strongly that keeping health and AIDS separate from the disciplines imposed by national budgetary systems is not in the long-term interests of the sector.

There is no doubt that global health initiatives will continue to coexist with nationally-led multisectoral processes such as PRSPs. Similarly, donor-financed projects will continue to coexist with budget and sector-wide support. Dealing with the complexity that this implies is a reality. The challenge in articulating a vision of how the health MDGs are to be achieved is not to further polarize the debate. Rather, it is to define a strategy that recognizes the need for immediate and urgent action, features progressive institutional capacity development, identifies good examples of harmonization in practice, and looks toward long-term financial sustainability.

## 1: Issues, challenges and prospects

Achieving the health-related MDGs presents special challenges in relation to increasing the effectiveness of development assistance and harmonization. These are presented here in summary form to give a sense of the range of issues that have to be addressed. Selected points are then explored in more detail in the subsequent sections of the note.

- Even allowing for greater efficiency in resource use, there remains a significant gap in **resource availability** if the health MDGs are to be achieved. How resource needs should be quantified remains a matter of some debate.
- In the absence of concomitant **policy and institutional change**, both within and beyond the health sector, increases in ODA alone are unlikely to be fully effective. Developing a consensus on what constitutes effective policy and institutional change across the full range of health MDGs will be a key component of a vision of how they can be achieved.
- Countries that implement reforms – the good performers – are likely to attract additional resources. At the same time, a vision for achieving the health MDGs has to make provision for the many millions of people that live in countries with **poor policy environments**, or where **states in crisis** – for whatever reason – are unable to fulfil basic functions.
- Health spending – even spending on primary care – does not automatically **benefit poor people**, and the measures used to assess progress against the MDG targets are based on national aggregates. A further element of the vision is therefore to ensure that health policies, health systems and the aid instruments that support them are designed both to maximize the impact of better health on poverty, and to address the needs of poor people.
- There is growing support for aligning external assistance around national **poverty reduction strategies**. The preparation of PRSPs may draw on sectoral strategies when they exist. The greater challenge is to ensure that the poverty analysis which informs the PRSP also influences the orientation and focus of work in the health sector. In addition, there is a need to be more clear about how **national AIDS strategies** – which are themselves multisectoral – can most productively relate to the PRSP process.
- The focus of much of the drive toward harmonization is primarily on how donors can better support *public* policies. In many low income countries, however, a large share of both health financing and provision occurs in the **private sector**. This creates a challenge as to what harmonization can achieve, and highlights the need to broaden the agenda so that it includes ways in which governments can build networks with civil society, NGO groups and private business.

- The search for new resources, and the need to attract new donors, has led to the creation of, and proposals for, **new aid instruments**, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the International Finance Facility and the Millennium Challenge Account. The key challenge is to attract funds that are genuinely additional, and to ensure accountability that will satisfy new financiers, without creating greater demands on thinly stretched administrative systems.
- The availability of additional, earmarked grant funds for health – from mechanisms such as the Global Fund – can and has led to tensions between **financial ceilings** set by ministries of finance aiming to maintain macroeconomic stability on one hand, and the need to expand the resource envelope in the health sector, on the other.
- It is widely accepted that there is a role for different types of aid delivery instruments. Whilst many donors are moving toward providing assistance as **budget and sector-wide support**, significant amounts of external assistance in health still come in the form of projects. If projects have a clear purpose and are aligned with national strategies, they can fulfil an important role in terms of innovation, capacity-building and policy experimentation. When the proportion of off-budget finance increases, however, the risks increase. In part, this is due to transaction costs – particularly due to separate reporting requirements – but more fundamentally by exempting a large part of in-country spending from democratic scrutiny.
- Only by **working to scale** will the health MDGs be achieved. The challenge facing national authorities is to deliver on priority outcomes, whilst building effective systems capable of addressing multiple health conditions. This is particularly difficult when agencies compete for scarce human resources to work on specific programmes.
- Both development agencies and governments are concerned to **increase the predictability of aid**, but at the same time there is a growing trend to link disbursements to **measures of performance**. Such measures must be able to demonstrate change in the period between tranches of assistance. Intermediate indicators must necessarily be clearly linked to health impact and outcome, and there must be consensus on the benchmarks which will be used to demonstrate progress or lack thereof.

From this list of issues it is evident that improving effectiveness and increasing harmonization has many dimensions – affecting all stages of the programme cycle, from analysis, through implementation to monitoring and evaluation. However, whilst the list of challenges is long, there are a growing number of examples, cited in the text which follows<sup>1</sup>, where development assistance has been made more effective and there has been positive benefits from harmonization. Even if existing instruments are imperfect, improvements are clearly possible.

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<sup>1</sup> Examples are described in more detail in : *The Millennium Development Goals for Health: Rising to the Challenges*. World Bank 2003, which is available as a background document for the High-Level Forum.

Whilst the focus of the note is primarily on what happens in relation to harmonization at country level, this can be enhanced by enabling actions at a global level. Examples include agreements affecting access to life-saving drugs through the interpretation of TRIPS in the Doha Declaration on Public Health and innovative mechanisms for pooling drug procurement (e.g. for HIV/AIDS in Latin America and the Caribbean).

2: **Analysis and strategy development:  
estimating costs and mobilizing resources**

The achievement of the MDGs depends on economic growth. But economic growth alone in many countries will be insufficient. Similarly, spending in areas such as rural infrastructure or education will have a synergistic effect on decreasing levels of child mortality. The MDGs are interdependent with each other and, there is a potentially positive feedback loop with economic growth. Moreover, as noted above, increases in funding alone – without due attention to the policies and institutions that influence how it is spent – are unlikely to produce the desired results.

Nevertheless, **current levels of health spending in most low-income countries are insufficient for the achievement of the health MDGs**, raising the question of how much is needed. This section suggests that it makes sense to focus estimates of resource needs at country level, but even then there are differences in opinion as to how they should be calculated. The subsequent section looks at the instruments for setting out policy and institutional changes.

The Commission on Macroeconomics and Health (CMH) suggested that countries could increase the allocation of **domestic budget resources** for health by an *additional* 1% of GNP by 2007. To date, there is little evidence of this happening. A recent analysis from the IMF, for example, suggests that *total* health spending (from domestic and external sources) in countries implementing programmes financed through the Poverty Reduction Growth Facility (PRGF), is projected to rise only slightly from an average 1.8% of GDP in 2000 to a projected 2.1% of GDP in 2001-2002. Other work from the IMF is more encouraging, in 14 PRSP countries “poverty-reducing spending” is projected to rise from 25% in 1999 to 32.5% of government expenditures in 2002.<sup>2</sup>

The key point that these and other figures point to, is that even if countries were able to act on the CMH recommendations there would still be a substantial shortfall to be met primarily from **increases in development assistance**. To achieve the MDGs as a whole, it has been suggested (for example in the Monterrey Consensus) that an additional US\$ 50 billion of

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<sup>2</sup> What is defined as poverty-reducing spend varies across countries but includes education, basic health care plus or minus HIV/AIDS and water and sanitation.

development assistance is needed each year. Looking at health specifically, the CMH report recommends an increase from the current *total* of around US\$6 billion to US\$ 27 billion a year of aid for health by 2007 and to US\$ 38 billion a year by 2015. The other global estimate is for total resource requirements to address HIV/AIDS. The most widely quoted figure by WHO and UNAIDS, which includes resources to strengthen delivery systems, is US\$ 10 billion per year, of which a little under half would be for care and treatment. The current estimate for achieving the target of getting three million people in developing countries on antiretroviral treatment by 2005 is a minimum of US\$ 5.5 billion annually by the end of 2005.

At Monterrey, pledges were made which could provide an additional US\$ 12 billion annually in donor funding by 2006. In health, which has increased as a percentage of total aid over the last decade, there has been some modest progress – from US\$ 6.4 billion on average between 1997-1999 to US\$ 8.1 billion in 2002 – with much of the increase attributable to commitments to the Global Fund, and to HIV/AIDS more generally. Furthermore, most would agree that the issue is not just one of increasing total spend in the absence of doing something about the **effectiveness of resource use**, and the capacity of donors to disburse, and countries to absorb resources more effectively. Nevertheless, it is equally evident that if the CMH or other spending targets are to be met, something very significant is going to have to change.

Given the mismatch between aspiration and reality, is it likely that resource availability will be increased by making available more accurate estimates of need? Whilst there may be a case for costing what will be needed to achieve very specific targets (such as “three by five”), it is questionable whether there is much political mileage to be gained by estimating, and publicizing, another **global headline figure for the health MDGs**.

Efforts might be better directed toward looking at **resource needs in individual countries**. Here, however, differences in approach have emerged with important policy implications. Oversimplifying for the sake of brevity:

- One view is based on the costs of scaling-up interventions, and the systems needed to deliver them, to meet the various MDG targets. This approach, which results in higher estimates, is based on two important assumptions. First, that the additional funds can be readily absorbed and efficiently utilized (and therefore that the poorest countries need, and can use, the most resources), and secondly, that the various interventions act *relatively* independently from each other, and from the feedback effect of economic growth. This approach does not preclude addressing some systemic constraints such as salary increases.
- An alternative approach starts from current resource availability, and is predicated on the interplay between improved policies, systems, governance and increments in aid. Where the first approach looks at the 2015 targets and works back to the money that is needed now, the latter starts with an analysis of current constraints and looks at how to

progressively relax them, thereby increasing the quantum and effectiveness of spending.<sup>3</sup> This approach attempts to avoid the problem of two competing scenarios by allowing governments to manage current realities whilst aspiring to better performance and increased income.

### 3: **Analysis and strategy development: health and PRSPs**

The debate about how to estimate resource needs raises questions about **the purpose of PRSPs**. In effect, those that would encourage countries not to shy away from ambition and base their strategies on “real” costs would use the PRSP as an advocacy tool. The alternative approach based on a different interpretation of “realism” encourages countries to focus on more immediate projections of resource availability. The middle way is to encourage countries – as part of the PRSP process – to prepare a set of alternative medium-term scenarios with different patterns of aid, systems development and policy reform. The PRSP in Rwanda, for example, takes this form.

Whilst it is tempting to focus exclusively on the financial impact of PRSPs, it is equally important to examine their influence in other ways. To what extent do PRSPs fulfil their potential as a way of improving health policies, governance and institutions? This in turn will affect how health is treated in **Medium Term Expenditure Frameworks** (MTEFs) and national budgets – and thus resource allocation and the effectiveness of spending in the sector.

Potentially, PRSPs are important instruments for the health sector:

- As responsibility for the overall PRSP is based in either the ministry of planning or finance, the PRSP process can help illustrate the importance of health to poverty reduction, and thus strengthen the case for increased investment.
- By bringing a poverty reduction lens to the health sector, PRSPs can catalyse a more pro-poor analysis of health challenges, and prompt an examination of why existing policies fail to reach vulnerable groups.
- The process thus offers an opportunity to reorientate national health plans and strategies to those health actions most likely to impact on poverty and the needs of the poor.

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<sup>3</sup> A key question in estimating resource needs is: how much will it cost to overcome key constraints that limit achievements in each country. Budgeting for overcoming constraints (marginal budgeting for bottlenecks) in relation to the achievement of specific health MDGs has been piloted in several countries – including Ethiopia, India and Mali.

Some countries are beginning to show **the real potential of PRSPs**. In Uganda, the process helped ensure a reorientation of the health policy towards the needs of the poor. In Mauritania, the PRSP profoundly changed the approach to delivering services for poor people – and was in addition successful in dramatically raising health spending. In other countries too, the PRSP process has sparked a process of more analytic thinking about how to reach the poor with health interventions – even if that thinking is not yet translating into new policies and strategies.

The problem is that several of the analyses that have been carried out suggest that these are the exceptions rather than the rule. Whilst the PRSP cannot be a document that sets out sectoral strategy in any detail, too often **PRSPs do not fully deliver on their potential** to influence change. For the most part, PRSPs appear to draw on existing national health strategies, without examining their effectiveness or their ability to reach the poor. In addition, whilst paying lip service to links with the MDGs, few PRSPs capitalize on the opportunity presented by a cross-sectoral planning process to promote the achievement of health and human development outcomes through non-human development inputs such as transport, fiscal policy (e.g. tobacco taxes) and household energy. For the most part, PRSPs rely on health sector delivery of traditional health services, providing few pointers to the most **essential areas of policy and institutional reform** needed to achieve the MDGs.

In conclusion, PRSPs are an important entry point for tackling poverty/health challenges in low-income countries. However, PRSPs alone are not sufficient as a means of creating capacity or commitment to poverty issues in ministries of health. Greater support from health development partners, links with other processes, defining key policy and institutional changes to increase effectiveness, and continuing advocacy with higher levels of government, remain essential to achieve this end.

#### 4: **Implementation challenges: new actors, new instruments**

A wide range of strategies have been proposed for raising additional resources for the achievement of the MDGs. Most current strategies have two targets in common: non-traditional donors, particularly from the private sector; and those OECD countries that are furthest from providing 0.7% of GNP as development assistance.

Whilst there is no question that new resources are needed, the means by which they are managed and disbursed are important. Inevitably, there is a need to manage tensions that emerge between the desire to reduce transaction costs and support national policies on one hand, and some of the demands of new actors and new systems on the other.

- **Private foundations** – such as the Bill and Melinda Gates Foundation – have become becoming major financiers of health and development on a par with both the larger

bilaterals and development banks in terms of volume of aid, whilst seeking a more distinct identity in terms of approach.

- The **corporate sector**, whilst increasingly active, has yet to find a fully settled role outside of its own sphere of operations. Part of the thinking behind mechanisms like the Global Fund was to provide a business-like environment for tackling priority health problems and, at the same time, offering a common and secure channel for investors lacking a country presence. However, two years on from the launch, corporate involvement in the fund, as a significant donor, has been limited. Inevitably, this raises questions about whether common funding channels such as the Global Fund provide sufficient visibility for potentially sceptical shareholders, or whether the corporate sector's role lies more in support through the provision of goods and services in kind .
- The proposed **International Finance Facility** involves the private sector in a completely different way. Long-term commitments come from traditional governmental donors, but these are used to leverage immediate and additional resources for aid by issuing bonds in the international capital markets, thereby enabling the front-loading aid of when it is most needed. Disbursement from the IFF would be through established bilateral and multilateral channels and thus does not require its own channels and systems. It is therefore compatible with basket funding and the provision of budget support. Whilst the IFF sets its sights clearly on increasing aid before 2015, one can anticipate that needs will continue after this during the pay-back period.
- Whilst the US Government has been a strong supporter of common mechanisms such as the Global Fund, a larger proportion of its development assistance is managed through **new and existing bilateral mechanisms** (such as the proposed Millennium Challenge Account and the President's Emergency Plan for AIDS Relief). Three features stand out: a highly selective focus on countries with specified policy environments; satisfying accountability requirements through working through off-shore institutions; and a refusal to support organizations that pursue activities contrary to domestic political positions (such as support for abortion). Whilst these requirements make it difficult for the US to join in common financing arrangements at national or sector level, the level of resources and political support that has been brought to bear against diseases such as HIV/AIDS is of major significance.
- In the space of three years, the **Global Fund to Fight AIDS, Tuberculosis and Malaria** has grown from an idea to an organization that has received pledges of totalling over US\$ 4.8 billion. During this time, the Board and Secretariat have had to negotiate many of the tensions inherent in providing aid for health. They include, among many others: support for national strategies versus targeted projects; eligibility for all countries or only the poorest; working through governments versus giving more prominence to the non-state sector; building national capacity to monitor versus setting up parallel systems; supporting

locally-owned PRSPs whilst trying to shift national priorities towards the three diseases; earmarking funds for priority purposes or regions versus allowing a demand-led system; and so forth. To handle these debates and succeed in disbursing over US\$ 172 million to 94 programmes in 66 countries is no mean achievement.

- The new **IDA Credit Buy-down** mechanism focuses on increasing resources flows for key programmes, whilst increasing the concessionality of funding and focusing attention on impact.

Four conclusions: (a) the experience of the Global Fund and GAVI shows that raising new resources from non-traditional donors is possible (but that despite the importance of the engaging the private sector, governments still provide the bulk of resources raised); (b) that other new approaches such as the IFF merit being explored; (c) that plurality in terms of channels and systems would seem to be an inevitable consequence of trying to increase aid for achieving the health MDGs in the near term; (d) there is a tendency for the new philanthropic donors to focus on specific diseases and health conditions and to shy away from systems strengthening *per se*.

#### 5: **Implementation challenges: increasing resources and economic health**

One of the many effects that the establishment of the Global Fund has had is to increase the overall quantum of grant resources available to health. In several countries, this has given a new edge to the long-standing debate about **the impact – real or potential – of increases in aid on macroeconomic stability**.

It is useful to separate out the economic from the sovereignty argument. The economic argument centres on what constitutes financial sustainability. In addition, some have made the case that increases in aid, depending on what it is used for, can influence exchange rates, export competitiveness and thereby, economic growth. Individual economists disagree on the seriousness of these issues in different contexts, and the extent to which they should act as a brake on external assistance.

However, in countries faced with a serious disease burden, there would seem to be no contest. Failing to address adequately epidemics such as HIV/AIDS and other major causes of ill-health will hit economies considerably harder and potentially for a longer period of time. It is therefore necessary to consider, or redefine, fiscal policy in a context in which the death of teachers, police and health workers is currently occurring at a rate faster than the state can replace them.

The sovereignty issue is perhaps more difficult. Ministries of finance have to balance competing demands and to make judgements about the relative contribution of many sectors to

poverty reduction. They are accountable for achieving economic growth targets and, in a resource scarce environment, have to set spending limits. The issue therefore is: whose decision is it, and who calls the shots when a donor – such as the Global Fund – insists that their earmarked funds be additional to previously agreed spending limits? This issue will be illustrated in the case study from Tanzania and Uganda.

The issue of fiscal discipline, manifest in the form of resource ceilings, raises its head in other ways – particularly in relation to **public sector employment**. A significant increase in development assistance for, say, AIDS treatment or child health, will have limited impact if there are insufficient health workers available to staff health centres and clinics. At the same time, there is no doubt that many countries have wrestled for years with the inefficiencies that occur when staff salaries squeeze out all other forms of operating expenditure. Staff take time to train, and there is thus a lead time before national authorities can respond to new financial circumstances. Most will want to be reassured that levels of assistance will be sustained so that they are not forced to return to the situation before the increases arrived, or to retrench newly hired employees. This issue will be explored further in the session on human resources.

6: **Implementation challenges:  
defining a role for project spending**

A growing number of donors provide an increasing proportion of their assistance as budget support. If the PRSP and MTEF are agreed by all concerned, then financing directly through the national treasury is an obvious next step.

At the same time, it is evident that in the health sector, one can expect **that a significant proportion of aid will still come in the form of projects**. It is also the case that relatively few countries are running SWAps that genuinely cover all forms of sectoral spending. Many of the reasons for this are related to the requirements of different donors and have been touched on in previous sections. In addition, several governments regard some aspects of health spending as not being up for negotiation or scrutiny by outside agencies. The question to ask then is does this matter, and are there any reasons which would actually argue *for* the use of projects?

- Many argue strongly that to achieve health goals means working through **civil society and grass-roots organizations**. Groups at risk of HIV or TB that live on the margins of society are often best reached by other groups that also operate outside society's mainstream. Channelling funds to such groups *through* governments is often challenging, particularly whilst trying to work to scale and maintain consistent quality standards – even if these groups have the capacity to absorb more resources.
- Health sector plans and budgets often perpetuate historical patterns of spending. They rarely contain adequate provision for **systems building or innovation**. How many

national budgets in Africa or Asia, for instance, made provision for spending on AIDS, let alone AIDS treatment? While the Global Fund is keen to be seen as a supporter of PRSPs and SWAps, it also has a major role as a source of innovation and capacity-building.

Clearly there is a role for project spending – particularly in policy experimentation. Problems arise when off-budget spending increases in volume, when it is used to divert genuine national priorities, when it generates disproportionate costs in terms of management time, and – most critically – when it is used in the absence of some **overall sectoral strategy** that has been subject to some form of democratic process. The form that such a strategy should take – as noted in the section on PRSPs – requires further exploration. Some argue that if development assistance operates increasingly at an overall budget level, through instruments like the PRGF, sectoral support will not be necessary. An alternative approach is to seek a closer match between the needs of particular countries and the balance of aid instruments used.

## 7: **Implementation challenges: managing multiple partners**

At the heart of the harmonization agenda is the way that development partners interact with national authorities. Several aspects of this relationship – particularly alignment around national priorities as reflected in the PRSP and MTEF – have been touched on. There are, however, several other **practical aspects of harmonization**: the nuts and bolts issues that make all the difference in reducing transaction costs.

They include: shared analytic and sector work; joint review missions; seeking agreement on common financial management standards; using pooled procurement arrangements; negotiating common policies between development partners in relation to project management, contracting and payment of technical assistance; and training and staff development. Whilst the focus at country level is often on pooling of resources – or basket funding – progress can be made on some of these other issues between a wider group of donors.<sup>4</sup>

Whilst the **Rome Declaration** focused on mainstream harmonization efforts operating on a broad front, coordination of national and donor responses is equally important when it comes to issues such as **HIV/AIDS**. Recent work identifies three principles: *one* agreed action framework; *one* national AIDS authority; *one* country-level monitoring and evaluation system (“three ones” in the jargon). Whilst a move in this direction is a logical response to competing structures, coordination mechanisms and systems, the challenge is to link AIDS-specific coordination to mainstream harmonization in a way which is mutually reinforcing.

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<sup>4</sup> Whilst several examples are included in the background document from the World Bank, there is more work to be done in systematically identifying good practice in practical harmonization.

8: **Monitoring and evaluation:  
performance and predictability**

Both governments and development agencies are concerned to **increase the predictability of aid**. In the absence of greater certainty about aid flows, governments find it hard to plan, budget and recruit adequate numbers of staff. If AIDS treatment, where lifetime continuation is essential, becomes dependent on major increases in development funding, the issue will become even more acute. At the same time, there is a growing concern to link disbursement to performance and it is impossible to sustain political support for aid in an environment where it cannot be shown that results are being achieved. The experience of GAVI, which relates funding to measures of performance, but also engages in financial sustainability planning, is particularly important in this respect.

It is in this context that one session of the Forum will examine current thinking in relation to **assessing progress** toward the health MDGs. Challenges include reaching agreement on precisely what is going to be monitored, what constitutes satisfactory achievement, and how roles and responsibilities of governments and agencies are to be coordinated. This is in itself a key part of the health agenda.

Lastly, like the MDGs themselves, **performance is part of a compact between donors and countries**. In this context, it will be interesting to learn about progress being made by the OECD/DAC working party on aid effectiveness that is tracking progress towards the implementation of the Rome Declaration and the OECD/ECA peer review mechanism.