



# **Flow of Donor Funds in Cambodia, Indonesia and Sri Lanka:**

## *Synthesis of Key Findings*

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## FLOW OF DONOR FUNDS IN CAMBODIA, INDONESIA AND SRI LANKA

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This report comprises the synthesis of three country studies that were conducted in Cambodia, Indonesia, and Sri Lanka at the request of the Coordination of Macroeconomics and Health Support Unit at the World Health Organization (WHO) between May and October 2004. They represent a first attempt to document the flow of external funds to the health sector in each country. Findings reported are based on the available information from multiple data sources. They are nevertheless preliminary, and should be followed by more detailed studies to refine estimates provided here. Detailed accounts of each country study are provided as **Appendices A (Cambodia), B (Indonesia) and C (Sri Lanka)**.

### OVERVIEW

#### ***Goals and Objectives***

The main goal was to collect and analyze the data available to answer questions that lie at the core of the recommendations of the Commission on Macroeconomics and Health (CMH) – namely the extent to which external funds meet national priorities in the health sector, fill financial gaps to meet health Millennium Development Goals and target populations that suffer a disproportionate share of the disease burden, particularly the poor.

The specific objectives were:

- Document the flow of donor funds within the country from external financing sources to providers;
- Review recent trends in both levels and allocations of these funds; and
- Provide the empirical evidence needed to compare donor investment strategies in different country contexts.

#### ***Global and country contexts***

Health has become a major focus of the political debate regarding the volume and allocation of development assistance to reduce poverty. Indeed three of the eight Millennium Development Goals (MDGs) that were endorsed by all countries are health related<sup>2</sup>. MDGs and the Report of the Commission on Macroeconomics and Health provide a common platform for action at the global and national levels, and set forth a very dynamic interactive process between donors and recipient countries, as well as among donors themselves. Well defined indicators and interim reports to measure progress towards reaching MDG goals provide clear targets for resource allocations in the health sector, and call for a major increase of external and national funds to scale-up available cost-effective interventions. One of the most difficult challenge for donors and countries is to maximize the effectiveness of limited resources to reach sometimes conflicting goals, particularly overcoming the limitations of

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<sup>2</sup> Health related MDGs: Reduce Child Mortality, Improve Maternal Health, Combat HIV/AIDS, malaria and other diseases

weak health systems and limited health manpower to reach health MDG targets by 2015, while at the same time strengthening national health systems and the quality of care particularly among poor and marginalized populations, which suffer a disproportionate share of the preventable disease burden.

The country contexts of Cambodia, Indonesia and Sri Lanka are very diverse and vary in population size, socio-economic indicators, and overall health outcomes (See **Table 1** at the end of this report)

This paper provides an overview of methods applied to each country study,

## METHODS

The standardized approach recommended for National Health Account (NHA) provided the analytical framework to track the flow of external funds in countries. The NHA framework provides “a systematic compilation and display of health expenditures from financing sources to providers. It traces how much is being spent; where it is being spent, what it is being spent on and by whom; how that has changed over time, and how that compares to spending in countries that face similar conditions”<sup>3</sup>.

Financial flows are tabulated by financing sources, financing agents and recipient (See **Box 1**)

### **Box 1. Tracking Financial Flows: Main Categories Included in NHA**

**Financing sources:** Institutions or entities that proved the funds used in the system by financing agents

**Financing agents:** Institutions or entities that provide the funds used in the system by financing agents

**Providers:** Entities that receive money in exchange for or in anticipation of producing the activities inside the health accounts boundary

**Source:** World Health Organization, World Bank, and United States Agency for International Development. *Guide to producing national health accounts with special applications for low-income and middle-income countries*. WHO, 2003.

The allocation of funds within the health sector can be reported in different ways, including:

1. inputs into the health system at different levels (e.g. wages, drugs, food, buildings);

<sup>3</sup> World Health Organization, World Bank, and United States Agency for International Development. *Guide to producing national health accounts with special applications for low-income and middle-income countries*. WHO, 2003.

2. expenditure type (recurrent and capital); function (e.g. prevention of communicable diseases; family planning, research and development in health; education or training of health personal);
3. geographic area; or
4. main beneficiaries.

Each of these categories can be further disaggregated into components of interest. For example communicable diseases can be sub-divided as HIV/AIDS, tuberculosis, malaria, dengue hemorrhagic fever. Levels of detail provided by financing sources and financing agents regarding the allocation of donor funds vary, and are not readily available for many of these aggregates.

Several developing countries, including Indonesia and Sri Lanka, have conducted NHA studies. However, NHA accounts have two major limitations for the tracking external resource flows. First, NHA include only funds provided by external financing sources that are channeled through the Treasury but fail to capture funds that are channeled outside of government. The second limitation of NHA is that they do not track expenditures of funds from external financing sources within the country separately from those provided by national financing sources. We selected the NHA framework to track resource flows flow from external financing sources to the main implementing agents within the country to ensure that:

- Study findings complement existing NHAs; and
- Flows are standardized and comparable across broad range of countries.

## KEY FINDINGS

This section provides a comparative analysis of the main findings from the three country studies and discusses common patterns as well as important differences in the way external donors allocate their funds and interact with partners within each country.

### ***External financing sources***

External funds are one of three major financing sources for health - the two other sources being public revenues (through taxation or user fees) and private contributions to insurance schemes and/or out-of-pocket payments. The relative importance of these different sources of revenues varies greatly among countries.

In Cambodia, private (mostly out-of-pocket) revenues contributed 83 percent of total health expenditures, and the government contributed 18.6 percent in 2002. In Indonesia private expenditures contributed approximately one-third and private expenditures two-thirds of total health expenditures. In Sri Lanka, public and private financing sources contributed approximately half of total health expenditures each.

The percent of government expenditures for health and the share of total health expenditures from external sources provide good indicators of government and donor support to the health sector. Government expenditures on health (as percent of GDP) were 12 percent in Cambodia, 3.2 percent in Indonesia, and 3.7 percent in Sri Lanka. External resources as percent of total expenditures for health in Cambodia (4.9 percent) were more than double the share of health expenditures in Indonesia (1.8 percent), and Sri Lanka (1.9 percent) (See **Table 2**). Disbursements from donor funds exceeded government disbursements in 2003 in Cambodia.

The relative importance of the different financing sources - bilateral development agencies, UN agencies, development banks, public private partnerships, foundations and non-governmental organizations - varied significantly between countries as well as within countries over time. Half of all development assistance for health (DAH)<sup>4</sup> was provided as bilateral ODA in Cambodia, and as concessional loans from development banks in Indonesia. Major public-private partnerships (GAVI and the GFATM) contributed 25 percent of total DAH in Sri Lanka and less than 10 percent in the two other countries. (See **Table 3**)

In all three countries, a few financing sources contributed the bulk of external funds. These were the United States Agency for International Development (USAID) in Cambodia; the Asian Development Bank (ADB), USAID and the World Bank in Indonesia; and the Government of Japan, the GFATM, and WHO in Sri Lanka (See **Table 4**).

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<sup>4</sup> Development Assistance for Health (DAH) includes official development assistance (ODA) to the health sector as well as non-concessional loans provided by the World Bank and regional development banks to developing countries (e.g.) WB IBRD loans); private foundations, and NGOs (own funds).

### ***Financing agents***

Financing agents are the institutions or entities that channel the funds provided by financing sources and use those funds to pay for, or purchase, activities. The selection of financing agents plays a key role in defining the interaction between external financing sources and the Government in each country. Shares of external funds channeled through the Treasury (“on-budget”) and those that by-pass the government (“off-budget”) are good indicators of government control over the allocation of donor funds. The major trade-off from a donor’s perspective is between contributing to the strengthening of weak financial institutions, which often lack transparency and accountability, particularly in the context of incomplete decentralization of the health sector, and the need to ensure that monies reach their intended targets and are used efficiently. Funds executed by the Treasury do not include donor administrative costs or technical assistance provided by donors to support external consultants.

Estimated share of funds disbursed through Treasury were 20.5 percent in Cambodia; 80 percent in Indonesia; and 50 percent in Sri Lanka. Development bank loans were always channeled “on-budget”, and funds made available by UN agencies always executed “off budget” though the country offices of each agency.

The choice of financing agents differed among bilateral agencies and public private partnerships as well as between countries. For instance, bilateral ODA provided by Japan was channeled “on-budget”, whereas those from USAID were always channeled “off-budget”. GAVI and the GFTAM have developed innovative approaches whereby funds are disbursed through the Treasury under direct oversight of country coordinating mechanisms. Therefore it is not entirely clear whether those funds are channeled through the Treasury or not.

### ***Providers***

Providers are the entities that receive the money in exchange for, or in anticipation of, executing the activities. Typically the money is provided by a single financing agent to a large number of providers. This was particularly the case for funds designated to finance the provision of health services. As a result, tracking the allocation and disbursements of funds to providers is particularly difficult, and was generally not readily available.

## **DISCUSSION**

The studies conducted in Cambodia, Indonesia, and Sri Lanka are a first attempt to provide an account of interactions between external and national financing sources and from financing sources to providers at different levels of the health system, which is not well captured in NHA studies. Evidence-based policy making relies heavily on the availability of reliable and timely empirical data on both inputs and outputs of the health system. Tracking the allocation of donor funds within recipient countries is an integral part of this effort. The initial assumption was that the data on external resource flows was available at the country level and that data from different sources had simply not been systematically collected and integrated. This assumption was far from being true. The data available to track external funds at the country level was quite limited and

inappropriate to fully document the flow of funds within recipient countries. The major information gap pertains to the flow of funds to the numerous providers of activities, particularly the provision of health services by local and international NGOs at different levels of the health system and varying collaboration with - and support to - the provision of care in the public sector. Hence the time and effort required to complete each country study was much greater than had been envisioned. The three country studies represent only a first step to track the allocation of external funds within recipient countries.

In spite of major limitations of the available data, the three country studies yielded interesting findings. The review of flows of donor funds in Cambodia, Indonesia and Sri Lanka underscore their complexity and cautions against oversimplifying the issues that either strengthen or limit the effectiveness of development assistance for health (DAH). Findings might be best viewed as the outcome of compromises reached between donors and recipient countries to reconcile competing priorities: i) the allocation of funds between health and other sectors; ii) national and externally driven priorities in the health sector; iii) national autonomy and donor financial reporting requirements; iv) short-term and long term allocation of funds to maximize the effectiveness of aid to strengthen the performance of health systems; and v) harmonizing donor practices and administrative requirements of different donors. The main issues that emerged in Cambodia, Indonesia and Sri Lanka are not meant to be comprehensive. Donor and national stakeholders may well face other difficult choices in balancing competing priorities in other countries.

The report of the Commission on Macroeconomics and Health provides a powerful argument that better health is indeed a major driving force of economic development and thus the health sector should be a much higher funding priority on the part of national governments and external financing sources. The report did not stop with advocacy and recommendations. It also sparked actions that have immediate relevance for Cambodia, Indonesia and Sri Lanka, as well as numerous other developing countries – particularly the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria and the establishment of National CMH commissions to implement the recommendations of the CMH report in countries.

The prominence of health in the broader development agenda varied among the three countries. It was low in Indonesia, high in Sri Lanka and Cambodia. The major challenge for the CMH follow up in Indonesia is to raise awareness of the direct links between health and development among donors and the government. The effort of major donors to the health sector to change perception and increase the prominence of health has been difficult and met several setbacks. The experience in Indonesia points to the fact that engaging major stakeholders in the public and private sectors while necessary may not be sufficient. The Consultative Group on Indonesia (CGI) did not provide the expected platform for the implementation of the CMH recommendations, and much remains to be done to increase the profile of health and external and national funding for the health sector. The set-backs that were encountered has prompted a new strategic approach to strengthen interactions between donors to the health sector (Partners in Health).

The WHO country office is playing a major role in strengthening interactions among Partners in Health and moving away from simple sharing of information to developing a common agenda that could strengthen the position of health relative to other sectors in the CGI.

In Sri Lanka the CMH was very effective in identifying major gaps in the performance of health systems and developing a research agenda, but has yet to establish much stronger interactions with the Ministry of Health.

In Cambodia no formal mechanism has been added to promote the recommendations of the CMH within the county. The government and donors have demonstrated their strong commitment for health and are already working closely to strengthen the performance of the health system and improve health.

The allocation of external funds was similar in Cambodia, Indonesia and Sri Lanka, even though the country contexts are quite different. They aim at improving health and the performance of health systems. The allocation of donor funds was in large part driven by the MDG targets for health – reducing the burden of major infectious diseases (HIV/AIDS, malaria, tuberculosis) and reducing child and maternal mortality. Overall, these priorities are consistent with national priorities, since they target common goals. The relative allocation of donor funds to each major component nevertheless varied between countries, and was driven by the particular mix of donors active in each country. This is particularly evident regarding new funding provided by the GFATM and GAVI in each country. These new institutional arrangements pool funds from a numerous public and private sources, and demand a much stronger involvement of national stakeholders at all stages of project development and implementation than had previously been the case. The disbursement of funds, committed for five years, is contingent on performance.

Thus, the key issue regarding the allocation of external funds is not so much the choice of priorities as it is the balance between commonly agreed priorities, which directly impact the overall performance of national health systems, particularly in countries that have weak health systems, a shortage of manpower, and in which donor funds represent a large share of revenues (e.g., in Cambodia and Indonesia).

Other promising strategies to increase the effectiveness of aid and elicit stronger participation of country stakeholders include the SWIM – a mechanism in Cambodia ensuring the pooling of funds provided by the Asian Development Bank, the World Bank, and DFID to meet common goals, while still allowing donor agencies to define specific objectives and maintain direct oversight of the financial managements; pilot projects to develop Equity Funds (USAID, UNICEF, ADB) in Cambodia as a strategy to subsidize health services expenses for the poor to increase access to secondary referral health facilities, supplement salaries of health personnel, and improve the quality of care; and MEDICAM, the Membership Organization for NGOs Active in the Health Sector in Cambodia, dedicated to strengthening interactions among the very large number of national and international NGOs as well as between NGOs, other donors and the Ministry of Health.

## **KEY RECOMMENDATIONS**

- Findings from the studies conducted in Cambodia, Indonesia and Sri Lanka, although preliminary, demonstrate the added value of tracking external flows within countries. Sub-accounts that focus on the allocation of donor funds in greater detail than is found in the aggregate national figures should be further developed and regularly conducted in many more countries to complement NHA studies.
- National and regional CMH commissions should play an important role in promoting better and more timely data on the allocation of donor funds within countries as this information is essential to monitor changes in the volume and allocation of donor funds.
- Trends and patterns in the allocation of external financial flows should be linked to the performance of health systems to inform decisions regarding the future allocation of donor funds, and improve the effectiveness of DAH.

<b>Table 1. Summary country statistics - 2001</b>				
<b>Data Sources</b>		<b>Cambodia</b>	<b>Indonesia</b>	<b>Sri-Lanka</b>
WHO 2003	Population 2002 (millions)	13.8	217	19
WDR 2003	GDP per capita \$ 2002	280	710	840
	Population below the National Poverty Line		17.1	
WHR 2004	Total expenditure on health as % of GDP	11.6	2.4	3.6
WHR 2004	Total expenditure on health p. capita (US\$)	30	16	30
WHR 2004	General government expenditures on health (as % of total government expenditures)	16	3	6.1
WHR 2004	Government expenditure on health p.capita (US\$)	2.7	4	15
WHR 2004	General government expenditures on health (as % of total expenditures on health)	14.1	25.1	48.9
WHR 2004	Private expenditures on health (as % of total expenditures on health)	85.9	74.9	50.5
WHR 2004	External resources (as % of total expenditures on health)	19.7	6.5	3.1
WHR 2004	Life expectancy at birth (both sexes)	54.6	66.4	70.3
	<b>MDG Indicators</b>			
BAPPENAS	Population below the National Poverty Line	36	17.1	
	Infant mortality rate	95	35.0	12.2
	Mortality rate of children <5 yr old	124	46.0	
WHO	TB prevalence p. 100,000	311	272	
WHO	TB mortality p.1000	107	59	
MDG progress report	Malaria prevalence p.100,000	988	850	421.6
MDG progress report	HIV/AIDS prevalence (pregnant women 15-24)		2.7	
	HIV/AIDS prevalence (pop. 15-49)	3.7		
MDG progress report	Proportion of underweight children >5 yr	45	31	
MDG progress report	Medium (%)		21.5	
MDG progress report	Severe (%)		9.4	
	Proportion of children 12-23 months immunized against measles	55	71	75-99
	Maternal mortality rate	437	307	46.9

<b>Table 2. Selected National Health Accounts Indicators: measured levels of expenditures on health, 1999-2002</b>						
		<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>
<b>Cambodia</b>	Total expenditures on health as % of gross domestic product	10.5	10.8	11.8	11.8	12
	General government expenditures on health as % of total government expenditures	11.8	11.3	15.7	16	18.6
	Per capita government expenditure on health at average exchange rate (US\$)	3	3	4	4	5
	General government expenditures on health as % of total expenditures on health	10.1	10.1	14.2	14.9	17.1
	Private expenditures as % of total expenditures on health	89.9	89.9	85.8	85.1	82.9
	External resources on health as % of total expenditures on health	12.4	13.4	18.8	19.7	4.9
<b>Indonesia</b>	Total expenditures on health as % of gross domestic product	2.5	2.6	2.8	3	3.2
	General government expenditures on health as % of total government expenditures	3.3	3.8	3.5	4.7	5.4
	Per capita government expenditure on health at average exchange rate (US\$)	12	18	20	21	26
	General government expenditures on health as % of total expenditures on health	27.8	29.6	25.4	35.8	36
	Private expenditures as % of total expenditures on health	72.2	70.4	74.6	64.2	64
	External resources on health as % of total expenditures on health	8.8	8.3	6.6	2.9	1.8
<b>Sri Lanka</b>	Total expenditures on health as % of gross domestic product	3.4	3.5	3.6	3.6	3.7
	General government expenditures on health as % of total government expenditures	5.8	5.1	6.1	6.1	6
	Per capita government expenditure on health at average exchange rate (US\$)	15	15	16	15	16
	General government expenditures on health as % of total expenditures on health	51.3	49	49.2	48.9	48.7
	Private expenditures as % of total expenditures on health	48.7	51	50.8	51.1	51.3
	External resources on health as % of total expenditures on health	2.8	2.7	2.7	3.1	1.9

Source: WHO World Health Report 2004

<b>Table 3. Disbursements by Major External Financing Sources (as percent of total external)</b>			
	<b>Cambodia</b>	<b>Indonesia</b>	<b>Sri Lanka</b>
	<i>2003</i>	<i>2002</i>	<i>2003</i>
<b>Bilateral ODA</b>	<b>53</b>	<b>34.5</b>	<b>42</b>
<b>Multilateral ODA</b>	<b>31</b>	<b>63.1</b>	<b>32</b>
<i>Of which:</i>			
UN agencies	20	13.7	24
Development Banks	6	49.4	8
<b>Private non profit/PPPs</b>	<b>16</b>	<b>2.4</b>	<b>26</b>
<b>Total (US\$, millions)</b>	<b>83.5</b>	<b>188.2</b>	<b>14.3</b>

<b>Table 4. Major external financing sources</b>			
	Source	US\$ (million)	% total
<b>Cambodia</b>	<b>Donor total</b>	<b>131.5</b>	
	<i>Of which:</i>		
	USAID	26.9	20.5
	Japan	7.6	5.8
	UNFPA	6.8	5.2
	GFATM	6.5	5
	DFID	6	4.5
	sub-total	53.8	41
<b>Indonesia</b>	<b>Donor total</b>	<b>188.2</b>	
	<i>Of which:</i>		
	Asian Development Bank	72.4	38.5
	USAID	35.6	18.9
	World Bank	20.6	10.9
	sub-total	128.6	68.3
<b>Sri Lanka</b>	<b>Donor total</b>	<b>14.3</b>	
	<i>Of which:</i>		
	Japan	3.8	26.6
	GFATM	3.1	21.7
	WHO	2.4	16.8
	sub-total	9.3	65.1