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Notes on International Development Assistance in Health and its Effectiveness: The Interests of Recipient Countries

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NOTES ON INTERNATIONAL DEVELOPMENT ASSISTANCE IN HEALTH AND ITS EFFECTIVENESS: The Interests of Recipient Countries

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Working Group 6 of the Commission on Macroeconomics and Health

By

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I. INTRODUCTION

The Commission on Macroeconomics and Health (CMH) was established by key stakeholders interested in improving global health. The objectives of the work of The Commission include establishing health as a major object of development and recommending decisions and actions that will improve the impact of Development Assistance in Health (DAH), particularly on the well-being of the poor. The Commission will review amounts of resources available in relation to the potential pool of resources; examine how what is available is used and what results have been achieved; and explore in what ways the world could do better. The Commission assumes that not enough is being done at the moment and that more ought to be done and done in better and more effective ways than is currently the case.

It is to be expected that there will be many interests at play and indeed there are. Each interest will be pursued in a genuine quest for progress and yet the interests will and do conflict. International (health) economists are interested in costs and efficiency being particular about how to buy more healthy life years for each dollar available, thus focusing on interventions, effectiveness and efficiency. Scientists and programme experts are concerned about health technologies especially in developing new and better health technologies (like vaccines for malaria and HIV/AIDS). They would like to shift resources to this area. They are also concerned about getting the technologies delivered to those who need them as directly as possible, often in conflict with recent health reform activities which discourage the vertical focus in delivering such technologies. Social development experts are particularly interested in examining how the poor are affected by development action and tend to cover a much wider area than the traditional health focus. The pharmaceutical industry, which in recent times has been under intense social pressure over availability to HIV/AIDS medication is looking for ways to invest in research and development for the development of drugs and vaccines for the diseases of poor without significantly jeopardising profits. They have expectations that DAH could be used resolve this problem. They are reluctant to over-commit their own resources when they cannot be sure of adequate returns on their investment. Interests such as those described above and others all aim to direct resources towards their perceived priorities. Even before the establishment of the CMH, these interests were heightened by the emergence of new and substantial funds such as the Global Alliance on Vaccine Initiative (GAVI), and Roll Back Malaria (RBM). The manoeuvres for what priority to invest in and through whom to disburse funds had already started.

In all the events and scenarios described above, International Development Agencies, research, development and academic institutions and international experts have an effective voice in articulating priorities. The same cannot be said for the main target of the efforts – the recipient (poor) countries and within them the poorer echelons of society. It is accepted development philosophy that development is carried out <u>with</u> the people and not <u>for</u> the people. The perceptions, the carrying capacity and the expectations of the beneficiaries are therefore important element of development effort. Whilst it is rational and scientific to base decisions on hard facts and evidence, it is also important to realise that the best laid plans, are implemented in an environment and a context. It is not always

possible to define such environment and context in clear and tangible terms. There are intangibles, hidden factors or silent perspectives. Yet failure to take these on board may result in severe constraints in implementing well laid out plans. *The point being made here might be compared to transplant surgery. The donor organ may be scientifically sound but the sick recipient is a complex environment. The more that environment is understood, the better the likelihood of successful transplantation. A major focus of research in transplant surgery is to deepen the understanding of the recipient environment so as to minimize rejection. A most important contributory factor to 'rejection' in both transplant surgery and health development is not technical competence of surgeons or experts, but inadequate understanding of factors associated with the recipient environment.*

Working Group 6 (WG6) of The Commission has a mandate to study levels and trends as well as the effectiveness of DAH. In doing so, it has explored ways in which what is available can be better used and how an increased DAH (should that result from the work of the Commission) could be better channeled and absorbed. It was decided that inputs from recipient country level officials of both government and civil society organisations working in policy and the management of development assistance was critical to this work. Regional consultations were therefore organized in Accra, Ghana and another (taking advantage of the People's Forum of government and NGOs) in Dhaka, India. The messages from these consultations whilst not new had an impressive and forceful quality. This led WG6 to commission papers including this one, to convey important perspectives of recipient countries. WG6 considers that the perceptions and the expectations of the beneficiaries are critical elements of development effort.

The purpose of this paper

Unlike other papers commissioned therefore, this paper is not a research report. It is more an essay, aiming to present experiences and honest expectations of developing countries in relation to development assistance. This is being done through the eyes of the author and based on extensive country level (Ghana) and some general African experience. It discusses new trends of thought in International DAH and how we expect these to impact on developing countries. This paper will draw a lot from the Accra consultation during which very specific messages particularly expectations and concerns were articulated. It will go beyond cataloguing expectations and concerns and discuss practical issues for positively impacting on the health of the recipient countries.

II. GENERAL PERSPECTIVES ON DEVELOPMENT ASSISTANCE AND THE WORK OF THE COMMISSION

Over the past decade, there has been a wave of health sector reforms in Africa. Most countries in Africa are heavily DAH dependent. Therefore, a major component of health sector reforms has involved making more effective use of DAH at the country level. A recent review by Mick Foster and others confirmed relatively high proportions of donor (including NGO) contributions to public health expenditure in developing countries especially Sub-Saharan Africa; being 53% in Tanzania, 58% percent in Uganda and 70% in Mozambique.

Whilst political and economic objectives are common and real in the development business, health gains remain the major focus. Donors as a group are beginning to work with governments using a common framework for implementation and performance monitoring. This section will focus on the main principles and framework for DAH assistance at the country level. The issues of regional and global initiatives will be discussed in the next section.

Important Principles of DAH

There is a growing consensus among the key stakeholders that to be effective, health development should be based on sound institutional, organizational and management systems, that the relationship amongst the stakeholders should be one of partnership and that government ownership/leadership of the country programme is critical to success. Whilst most will agree, the practical interpretations given to these concepts by different stakeholders differ. However, the interests of recipient countries who are directly affected, gives practical interpretations to these principles. They wish to be treated with respect and trust; they wish to be allowed to evolve their own strategies and to learn by doing; they wish DAH to be invested in areas which over time will make them more equal partners in technical and policy dialogue and not in areas that will bypass their systems and leave them perpetually weak.

Partnership

A recurring message to donors and intermediaries from the Accra consultation was '*do not give us fish but teach us to catch fish*'. The point was made that much as the concept of partnership was critical, what prevails on the ground was a partnership 'among unequals'. When resource constraints are very severe and when governments can generally invest only $3 - $8 per capita on health, it is extremely difficult and probably unwise for countries to refuse or turn down offers of resources because of principles. For partnership to be truly effective there needs to be a process of 'equalisation'. Such a process will require donors and intermediaries to make substantial shifts in the way they define pre-requisites for engagement. Indeed, they will need to change from demanding these pre-requisites from government to supporting governments to create the pre-requisites. It is not rational on the one hand to set out to help a country because it has weak systems which are under-funded, under-staffed and under-motivated and on the

other hand to demand as a pre-requisite that they demonstrate adequate capacity. The concept of 'equalisation' in this context calls for understanding and concessions on the part of donors and intermediaries. There is a critical need for partners to support and enhance institutions that deal with issues of implementation and accountability.

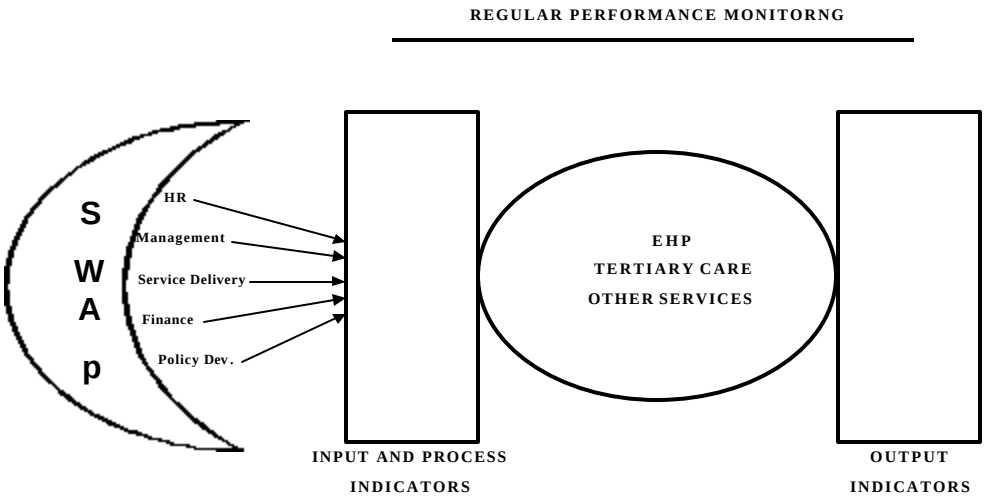
Government ownership and leadership

There is little disagreement on the fact that governments should own and lead health development in their countries. However, owning and leading is not a passive process. It has to be exercised and requires adequate and appropriate capacity to articulate and defend what is required, to negotiate and deliver on agreed outputs and to be transparent and accountable. To begin with, this capacity to exercise ownership and leadership is not adequately developed in the recipient countries. If it is considered important that recipient countries are able to exercise ownership and leadership effectively, then developing that capacity ought to be a central theme of DAH.

Framework for DAH to Countries

The principles discussed above make an argument for initial and effective support for institutional, organizational and management support to recipient countries. *This can be compared to preparing to go on a journey. Apart from planning the journey and mapping out the route, one needs a sound vehicle. The effort in getting the vehicle road worthy should be at the initial stages and be comprehensive enough to ensure minimal breakdowns.* This paper will not attempt to justify the Sector-wide Approach (SWAp). However, it assumes that that SWAp is generally accepted as a credible and effective framework for undertaking health sector reforms. That it ensures adequate attention to capacity building. Figure 1 below illustrates the relationship between the capacity building inputs and the desired health outputs in SWAp.

FIG 1: A CONCEPTUAL FRAMEWORK FOR SWAp



Source: *Dr A Issaka-Tinorgah 'Implementing a Health Sector-wide Approach (Health SWAp) in Malawi. (pp20) June 2001.*

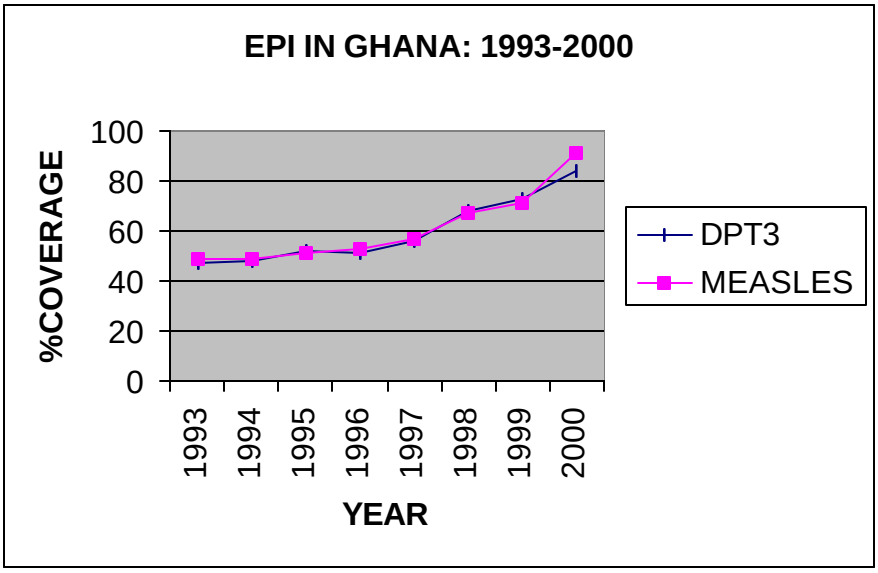
The inputs and processes of SWAp energise the whole system and enable the system to improve delivery at all levels of care. Differences in outputs will depend on the differential emphasis given to different services. SWAp places great emphasis on the development of management systems, decentralization, integration of services and strengthening overall local delivery capacity all based on the country's systems. This framework may not be valid for countries with serious problems such as conflict situations, severe macroeconomic problems or very severe human resource constraints. In such circumstances, local institutions may be non-existent, very disorganised or extremely weak. More direct involvement of development partners may be justified as a stopgap or emergency measure.

Whilst SWAp is considered an effective approach to health reforms, implementation experiences have shown that in discouraging vertical programmes, SWAps have unfortunately often led to declines in the coverage of such programmes. It is not acceptable to have populations continue to suffer from diseases for which interventions are available and effective. It is even more unacceptable as a consequence of reform to roll back progress. Experience to date in the implementation of SWAp has tended to emphasise the processes and the inputs to a relative neglect of the 'content' or improved and comprehensive service delivery. This observed problem is however a shortcoming of implementation rather than of principle and concept. Experience in Ghana with the

Expanded Programme on Immunisation (EPI) demonstrates that concentrating on management and organization need not be at the expense of actual delivery of technical interventions. On the contrary, it could ensure rapid and sustainable improvements given the right orientation.

Under the current health sector reforms in Ghana, the first period of implementation covered the period 1997 to 2001. The reforms supported specific district strengthening, decentralization and improved decision making at district level. As well, the proportion of total annual recurrent budget allocated directly to districts (and under district control) was increasing, rising from less than 10% in 1994 to 40 % by 2000. The precaution by some that districts lacked the capacity to manage such increases in direct budget allocation was not borne out by the experience.

The figure below shows levels of immunization coverage using measles and DPT3 in children under 12 months.



Before 1997, Ghana had stopped centrally managed immunization campaigns. EPI was managed and organized by districts which determined when and how to supplement routine immunization at static sites with outreach immunization and with mini-mass campaigns. What the above demonstrates is how districts converted the increased management capacity into service outputs.

On the other hand, before 1997, the control of guineaworm and tuberculosis were vertical programmes. These had Programme Managers, controlling and distributing earmarked resources and determining to a large extent the timing of activities. These services did not immediately benefit from the increased management capacity at the district level and services stagnated and even declined in some instances. The districts seemed to be waiting for directives and resources from Programme Managers even though they were receiving and managing more funds than they had ever had. There ought to have been an

active process to transfer responsibility for those programmes to districts. Once this was realized and action taken, the declines were reversed.

Several conclusions may be drawn from this section and include the following:

- Capacity building is central to 'equalising' the partnership and for governments to exercise ownership and leadership. Such capacity implies creating a critical mass of expertise; it implies developing the capacity to articulate, document and defend vision and policy; and it implies sound organizational and management systems.
- Developing such capacity should be considered an early rather than later activity.
- It is important to take a medium to long-term perspective in health development. It is only in such a context that a framework involving an initial focus on institutional development that may seem to be at variance with core business, can be understood.
- That a focus on building organization and management processes need not result in loss of progress with technical service delivery.

The Commission could be a very potent force for health development at the country level if it championed the issues raised here and made them central to DAH objectives and operations. The Commission has the status to influence donors and intermediaries to make the changes in attitude, regulations and modalities that are necessary to enhance country level capacity. By the same token, The Commission could, by championing different interests cause a massive diversion of DAH resources from country level sustainable development in favour of other interests. *From the country perspective, CMH has a key role as an intermediary and a champion for country level capacity building and sustainable health development.*

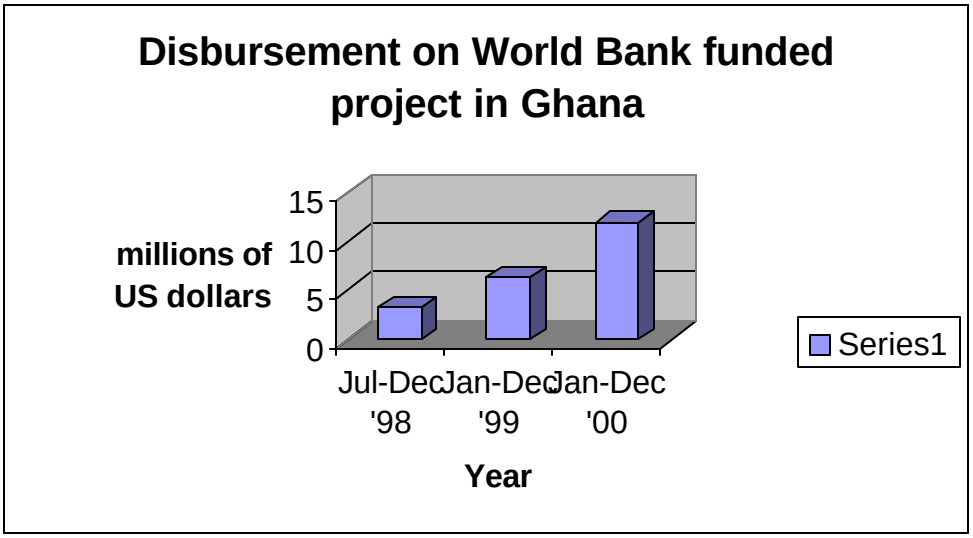
III. SOME SPECIFIC ISSUES

This section discusses two current and relevant issues from the country perspective – global public goods and universal access to a basic package of services. This paper attempts to make a strong case for country level support based on institutional capacity development. It is however true that other arguments are being made, for example, for redirecting investment to global initiatives and public goods. It has been argued that redirecting resources from the country level to other activities might end up providing greater benefits to countries. For example, in reducing HIV/AIDS drugs by more than 80%, the pharmaceutical industry may then make a bid for available or new DAH funds, arguing that such funds be directly allocated to the pharmaceutical industry who will then supply these drugs free to countries that currently cannot afford them. The purpose of this paper is not to make the case that all DAH should be allocated to country level operations. It however aims to sound the warning that in this debate, the country level interests have been thinly represented but are fundamental to success. Whilst it is not an 'either or' situation, the balance between country level support and global initiatives ought to be critically considered.

Global Public Goods and Country Level Support

In finding ways to make DAH more effective, the argument is being made by some that the emphasis on country level support is inefficient and ought to be reviewed critically. It is argued that absorptive capacity is very low in poor countries and trying to push more funds into such systems is not a helpful venture. Also, that inspite of large expenditures in DAH at country level in the past, not much has been achieved. The alternative suggested is to redirect effort and funds to interventions expected to have far reaching effects across countries, especially in poor countries. These interventions refer particularly to relevant biotechnology were new vaccines or drugs could be developed and in recent times through global initiatives such as those for malaria and HIV/AIDS.

Whilst it is true that absorptive capacity is low, it is dangerous to use that as reason for changing tracks. Low absorptive capacity is not caused by country-factors alone. Cumbersome regulations and administrative requirements of donor agencies often contribute significantly to low disbursement. Indeed, any donor that develops a programme, which turns round to record very low disbursement/expenditure rates, sometimes less than 10% of target, must accept a significant part of the blame. It is more than likely that they are making unreasonable demands of a country they know has weak systems. Ghana and Zambia as part of their reforms worked with their development partners to develop more supportive modalities for disbursement of DAH. In Ghana, disbursement of DFID and World Bank funds are ahead of schedule as a result. A rare feat and certainly never before experienced in Ghana. Figure 2 demonstrates rates of disbursement on the 5-year World Bank funded 'Health Sector Programme Support Project for $35 million which became effective July 1998.



The experience of the effectiveness of DAH is mixed. Whilst it is true that in some cases, large expenditures have not resulted in significant improvements in health, it is equally true that in other cases, modest expenditures have resulted in significant health gains. It is also true that in many instances, the expectations of donors based on their investment are

unrealistic and unreasonable. Significant and sustainable gains take time especially in systems that are weak to start with. To declare a programme ineffective after three to five years is probably not a fair assessment. To also limit time horizon to three to five years does not allow the programming of adequate and necessary institutional development. Sustainable development is rarely achieved in such circumstances.

As indicated earlier, the issues raised in this section are not to make a case against global initiatives and regional and global public goods. Such initiatives, if properly directed, can lead to greater efficiencies, much greater benefits to countries and to closing the inequalities gap within and among countries. Providing vaccines, making drugs for diseases such as tuberculosis, filariasis and AIDS more accessible to the poor by regional and global initiatives can only help the poor. However, it must be realized that these benefits could be illusive and such initiatives could worsen inequalities. Whilst public goods are described as 'inexcludable', barriers to access do exist. These barriers go beyond the provision of logistics (vaccines, drugs, vehicles etc) to deliver interventions. The basic requirement for countries to effectively access regional and global public goods in health is a health system able to respond to institutional and organisational challenges as they evolve. The Roll Back Malaria (RBM) programme for example aims to strengthen weak systems to enable them to effectively deliver a service, which involves multiple interventions. The major challenges for RBM include avoiding the tendency to develop into a vertical malaria programme whilst building national and sub-national capacities to respond to emerging challenges including malaria. These same challenges should guide the development of global initiatives and the provision of public goods.

DAH in support of the concept of universal access to a basic package of services

'Universal access to a basic package of services' has become a major objective of almost all health sector reform initiatives, at least in the African region. The basic package for each country is designed to deal with the diseases causing the bulk of illnesses. Most of these affect the poor and have relatively cheap, simple and effective interventions. As these diseases affect the poor predominantly, dealing with them will also close the inequalities gap. Equity and poverty reduction are major objectives of governments and donors. The emergence of global initiatives and global funds as well as the work of The Commission provide an opportunity to redirect DAH. The question then is whether it is desirable and feasible to channel DAH resources to the provision of universal access to a basic health package in recipient countries?

The answer to above question is yes both to desirability and feasibility. It is however, important to do this within a sector-wide context. The basic health package should not be seen as an island in the health sector. It must be linked with and rationalised with other services and other levels of care. In the eighties and early nineties, a very narrow definition of Primary Health Care (PHC) led to a focus on interventions and not systems and to a neglect of hospitals as these were somehow perceived as the 'enemy'. The middle to late nineties saw most developing countries with a stock of highly deteriorated

hospitals. Recent reforms are reversing these trends and PHC is now perceived in the context of district health systems including the first level (district) hospital and a referral system. Another example is the focus of reforms in Zambia, which initially involved only district health services. Before long, it was realized that a neglect of the other levels negatively affected district level performance and overall gains. This confirms the message in figure 1, which is that to get the desired outputs, the inputs and processes must be applied across board in a rational manner.

In making decisions about basic health packages, developing countries do not usually stop other services so as to fund the defined package. Rather they accept that the basic package will be implemented alongside other services and that universal access will be achieved over time. To this end, coverage is expected to increase gradually and resource allocation is designed to shift in favour of the basic package over time. Such shifts involve amounts of available budget as well as determining which sources of funds (private, government, DAH) would finance which service. It will be strategic to make universal access to a basic package of services a major focus of DAH. However, this should not result in unbalanced health development. The basic package should be seen as a priority within comprehensive health development. Allocation of DAH resources should thus not exclude support and development of other services and should be integrated with overall national resource allocation.

IV. CONCLUSIONS AND RECOMMENDATIONS

From the foregoing, there is a call for changes in the rules of engagement between recipients and donors. There is a call for partnership, which requires donor and development agencies to accept to work with weak government systems and committing to work genuinely to strengthen these systems over time as the basis for sustained health development. There is a call to help recipient countries develop their institutional capacities so as to be able to exercise effective leadership, to respond to emerging challenges and to make effective use of global initiatives. These are not issues that would generate much controversy. There is wide acceptance that these are important. The main challenge is how to realize these principles.

This paper cannot fully deal with the ‘how’ of this issue because it is complex involving such issues as redefining the role of government in health, decentralisation, health financing, public private mix, the heavy flight of professionals from recipient countries to donor countries, etc. Some general recommendations for the way forward will nonetheless be made.

1. Country level capacity building is fundamental to health development. Without it most initiatives will either not reach intended beneficiaries or not be sustainable.

2. The Commission should accept to be the champion of country level capacity development. This implies;

- strongly promoting the changes required of development agencies so as to be more supportive of countries – committing to allocate technical and financial resources to build up weak government systems, maximizing use of local human resource capacity, concentrating more on performance and outputs rather than inputs and strict adherence to administrative requirements etc.

- promoting a set of inputs and processes as the basis for successful country level health system development – see figure 1

3. Global initiatives and public goods have a great potential to benefit recipient countries. This needs to be developed alongside credible efforts to ensure country level capacity development. The Commission and the International Health Community should balance the bids for more DAH into global initiatives with the needs for country level capacity development.

The International Health Community has to make its platform the health of the poor. To try to help the poor without effective country level delivery systems will be extremely difficult if not impossible. The future of health development will have to be anchored on improved country level health system performance. In a decade from now, we are going to be recounting the results of the work of The Commission. If it fails to influence the International Health Community to anchor health development on sound country level systems, on systems that are much better than we have now, it will be unlikely that it would have improved the health of the poor.

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