Aid instruments and health systems development: an analysis of current practice

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There has been a clear shift in the policy of many donors in the health sector – away from discrete project assistance towards more broad-based sectoral support. This paper, based on interviews with officials in a number of bilateral and multilateral agencies, explores whether this shift in policy has been matched by similar changes in the form or range of aid instruments. The paper develops a framework for examining current practice in relation to the different objectives that donors seek to promote through technical and financial assistance. In particular, it looks in some detail at the advantages and disadvantages of budgetary support compared to more traditional forms of project assistance. It concludes that the debate should not be about whether one form of aid is better than another. Ideally, they should be complementary and the forms, channels and systems used for managing aid need to be assessed in relation to how they help to achieve the mix of development objectives that are most appropriate to the country concerned. The review demonstrates that this is a complex task and that to achieve an effective balance is not easy. The final section summarizes the main themes emerging from the discussion and suggests some preliminary conclusions and proposals for future action.

1 Background

There has been a clear shift in the policy of many donors in the health sector – away from discrete projects towards more broad-based sectoral support. At a recent meeting of the WHO Health Sector Reform Forum in Geneva the question was raised as to whether this shift in policy has been matched by similar changes in the form or range of aid instruments employed by donors. Following the April 1994 meeting of the Forum, the Sectoral Policy Unit (DGVIII/A/1) of the EC commissioned a review of health policies and the range of aid instruments employed by donors working in the health sector.

This paper is based on a review of documents and interviews with individuals from selected donor agencies. The aim has been to identify current trends in health sector policy and to reflect key aspects of the debate about how these policies are being promoted through the use of different types of aid instruments. The review has, of necessity, had to be somewhat selective. Rather than trying to provide a comprehensive picture of the policies and programmes of each and every agency, the purpose of the paper is to develop a framework for analyzing and provoking discussion about the effectiveness of aid in the health sector. The policies, programmes and activities of the donors consulted and the experience of particular countries are used throughout the document to illustrate the debate around specific issues.

Section two of the paper is used to develop a framework for the review. This has three main components: the changing agenda for health systems development and health sector reform; the objectives of donor assistance in the health sector; and a typology of aid instruments. Section three discusses a range of current issues in relation to the effectiveness of donor assistance in the health sector. The final section summarizes the main themes emerging from the discussion and suggests some preliminary conclusions and proposals for future action.

2 Framework for the review

Health systems development and health sector reform: the changing agenda

Two clear trends are evident in donor agency thinking in relation to the provision of aid to developing countries. On one hand, as governments start to liberalize internal and external markets, the focus of policy dialogue at a macro-level is starting to focus
increasingly on public expenditure management generally and, more specifically, on the role of
government in relation to the provision of core public services such as health. At the same time, it is in-
creasingly recognized that the effectiveness of individual health sector projects is constrained by the
policy and institutional environment in which they operate. There is thus a convergence, from these dif-
f erent points of view, on the importance of a more comprehensive analysis of specific sectors such as
health and the macro-economic, institutional and political context in which they function.

Within the health sector, there is increasing emphasis on health sector reform. However, while this is a
useful shorthand term, there is no consistently-applied, universal package of measures which con-
stitute health sector reform. It is also clear that whereas the term reform implies a relatively short-
term process of change, there is a recognition among most donor agencies that the need in many recipient
countries is for a sustained process of policy, institutional and systems development, and thus extended
and flexible forms of partnership.

Several of the donors consulted have either recently revised their health sector policies or are in the pro-
cess of so doing. In line with a more sector-based approach, a number of common concerns in the area
of policy and institutional reform emerge. These include:

- linking reform in the health sector with reform of the public sector and civil service, especially with
  regard to personnel and financial management;
- promoting the decentralization of planning and management either within sectoral agencies, to
  local government bodies or to autonomous district or hospital boards;
- reorganization of health ministries to reflect their changing role in policy development, priority
  setting, resource allocation and monitoring of performance;
- introducing measures to promote cost containment and prioritize resource allocation;
- broadening health financing options through the introduction of user fees, community financing or
  health insurance;
- strengthening and reforming management, support and monitoring systems in line with new organiza-
tional relationships;
- liberalizing policies in relation to the private sector and developing structures and systems for work-
ing more closely with private providers;
- developing systems through which the public can exert greater influence over health service
  provision.

Despite the increasing interest in these policy and institutional issues, it is also clear that there remain
substantial differences of opinion, both within and between agencies, in relation to health sector policy.

- A more detailed analysis of sectoral spending would reveal considerable differences in the relative
  emphasis given to health systems development as compared to specific aspects of health service
delivery (such as reproductive health, HIV/AIDS, child survival and so forth).
- There remains a debate about the extent to which specialized health agencies, like WHO, or the
  health budget of bilaterals should be used to promote health development more broadly through the
  provision of support to other sectors (education, housing, employment etc.).
- Within the policy and institutional agenda, some agencies favour the promotion of specific strategies
  (such as community financing or user charges). Others prefer to take a more pragmatic or country-
specific view toward helping governments analyzing health financing options. Opinions differ about the
desirability of introducing changes based on the experience of industrialized countries – particularly
in relation to managed-market reforms.
- Whilst most donors support the general notion of decentralization, particularly in relation to the
district, there remain differences in preferred strategy – some focusing their assistance on specific districts, others supporting district or regional development from a national perspective.
- These differences in relative priority within the sector, and in the emphasis given to particular
  strategies, affect the way that assistance is provided.

Objectives of donor assistance

It is well recognized that aid effectiveness is influenced by the commercial, political, diplomatic and
ideological interests of donors (Cassen & Assoc. 1986). However, irrespective of the precise nature of
institutional and policy reforms, the financial and technical assistance provided by donors will aim to
fulfil a number of related objectives. Donor support will aim to:

- ensure that there are sufficient funds available in the health sector to ensure access to basic levels
  of care;
promote the equitable and efficient use of public funds;
• promote the formulation, adoption and implementation of policy and institutional reforms;
• discourage the abandonment of the reform process;
• avoid increasing aid dependency.

These generic objectives, which, despite differences in technical strategy, are common to most major donor agencies, provide a framework for examining the appropriateness of the means by which aid is provided. They are used in this review as a framework for analyzing current practice in Section 3.

Aid instruments: a typology

There is a need for common vocabulary for discussing aid instruments. This is a complex field, and one in which it is easy to get bogged down in definitional issues. What follows is necessarily something of a simplification.

Forms, channels and systems

In thinking about the way aid is provided it is useful to distinguish between:
• the form of aid: whether it is provided as project, programme or sector aid, as a loan or a grant, balance of payments support, budgetary support, counterpart funds, timeslice operations, technical assistance and so forth;
• the channels through which aid funds are provided: through bilateral or multilateral agencies, multi-donor consortia, contractors, NGOs;
• the systems in place for formulating and implementing aid policy and managing and accounting for aid funds.

The form of aid used, the channels through which it is provided and the systems by which it is managed will all influence the effectiveness of donor assistance. Of concern to many donors at the moment, and the main thrust of this paper, is the form that aid takes – particularly the balance between project and programme aid. It is therefore useful to look in more detail at what is meant by these terms.

Project aid

Traditionally, a large proportion of donor assistance to the health sector has been provided in the form of projects. These have a number of common characteristics:
• projects provide resources directly to the health sector – in many but not all cases, these resources do not pass through and are therefore wholly additional to the government budget;
• they are appraised as a discrete set of activities; planned inputs, activities and objectives for each project are negotiated between donor and recipient; the identification, design, appraisal and approval processes take place over an extended period of time;
• projects usually combine different types of input and can include support for capital and recurrent expenditure, local and offshore purchases of goods and services, and technical assistance; traditionally, capital investments and offshore costs have been favoured by donors over recurrent and local expenditure.

Some donors may require that a recipient government ensures that specified amounts of local currency are allocated in the government recurrent budget to support project activities. These are referred to as counterpart funds, but it is important to note that this is a different use of the term from the counterpart funds generated from programme aid.

Programme aid

Programme aid is a generic term used to describe a variety of forms of donor assistance, which can include the provision of foreign exchange, import credits, goods or food. Some of this programme aid is sold to the private sector and thus generates local currency (counterpart funds), which then become available to support either general government expenditure or expenditures within one or more specific sectors. The donor providing the programme aid usually retains some control over how counterpart funds are used by the recipient. Increasingly, counterpart funds from programme aid are being made available to the health sector.

Rather than use the term counterpart funds (which has more than one meaning) or programme aid (which can also be confusing when talking about health or sectoral programmes), I have used the term budget support, except when referring to the aid instruments used by specific agencies. For the remainder of this document, budget support refers to funds generated from different forms of programme aid.
aid which is available for spending in the health sector.

Budget support has a number of characteristics which contrast with project aid:

- the only resource transfer that takes place is the provision of the programme aid; the local currency that is generated is used to support government expenditure usually through the budget; it will result in additional funds to the health sector only to the extent that this is part of a planned increase in an overall public expenditure programme; budget support can be used to secure or protect resources, enabling governments to meet budgeted obligations which might otherwise not be available.
- budget support is usually described as ‘fast disbursing’ and not subject to the same appraisal procedures as project aid; agreements between donor and recipient are generally based on an analysis of overall sectoral spending.
- budget support is usually concerned with relatively large amounts of money (compared with most projects), it may complement or be linked with project assistance, but does not usually include technical assistance per se.

In most cases the provision of budget support is linked to conditionalities which may be concerned with macro-economic policy or to policy/institutional reform within the health sector. In addition, funds from budget support may be earmarked for expenditures in one particular sector such as health, or for specified expenditures within the sector.

Once we start to look at the practices of individual donors, the distinctions between projects and budget support can become less clear-cut. For example, where a donor is concerned that earmarking of budget support may not be effective, they may insist that the funds be channelled to an organization outside the government responsible for providing funds, say, to NGOs running community health projects. Local currency generated from budget support has also been used, by USAID for example, to provide local costs for donor-funded projects. Clearly, the further one progresses down this road, the more budget support becomes hard to distinguish from project aid. Table 1 provides a simplified summary of the situation.

**Sector aid**

The term sector aid is used by an increasing number of donors. Unlike budget support or project assistance, sector aid does not describe one particular form of donor assistance. Rather it reflects the consensus, at a policy level, that a more holistic approach to health sector development is required.

Experience with sector aid for health is limited, and an attempt to describe its characteristics necessarily shifts from description of current practice toward an outline of intention. A key concern of sector aid is that it is based on a comprehensive analysis of sectoral needs – conducted jointly with the recipient government and, in an ideal world, by major donors acting in partnership. The analysis will also take into account the economic and political context in which the health sector is operating.

In terms of aid instruments, sector aid is likely to consist of a package comprising of a number of project components with or without provision of budget support. The relative importance of budget support compared to project assistance, and the way in which the components of project assistance are designed, managed and implemented, will influence the effectiveness of donor assistance in meeting its objectives.

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<th>Table 1. Programme aid</th>
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3 Analysis of current practice

To structure the discussion about the appropriateness of different forms of aid, we return to the five generic objectives defined for donor assistance. In addition, there is a need to review two cross-cutting issues – donor co-ordination and financial accountability.

Providing adequate financial support to ensure access to basic levels of health care

*Most developing countries require financial assistance from donors because they have insufficient domestic resources to provide basic levels of health care for their populations.*

In many countries, the rationale for financial assistance from donors is that there are insufficient local funds to ensure that the population has access to basic services. This results from an *absolute* shortage of resources and may be made worse by a combination of distorted government spending priorities (where health loses out to other sectors or military expenditures), inappropriate investment decisions within the health sector, and pressure to reduce public spending in the process of macro-economic adjustment. The net result in many countries – where recurrent cost funding tends to be the hardest hit – has been a serious deterioration in physical capital and an under-resourced and demoralized workforce.

Despite the obvious need for an increase in funding, there are many disadvantages in addressing this objective through project assistance. In many of the poorest countries there are arguably too many projects already, swamping limited administrative and managerial capacity with the needs of detailed project design and monitoring. The focus of many projects has, until recently, been on capital development, where the need is to support operating and maintenance costs. In addition, the coverage of projects is frequently quite limited and the volume of the resource transfer relatively modest compared to the level of need. There is thus a strong case for budget support.

One of the main ways in which donors have addressed this problem is through social sector conditionality attached to structural adjustment lending. In order to be eligible for general budget support from the World Bank or other associated donors, a government will agree to increase the proportion of the budget allocated to health. A recent review of health sector reform in Africa (Donaldson 1993) states that social policy reforms have been included as conditions in 11% and as critical actions in 24% of World Bank Structural Adjustment Loans (SALs) and Sectoral Adjustment Loans (SECALs) and it is suggested that this trend is likely to continue. Increasing the proportion of government revenue allocated to health has also been included as a condition for the receipt of World Bank Health and Population Project Loans. Other donors, such as the EU, have specified that budget support funds be earmarked for use in the health and education sector.

Although this mechanism can in theory increase the volume of resources available for health development a number of difficulties may arise in practice.

- Structural adjustment lending is normally linked to macro-economic conditionality. Whilst this is often perceived as an advantage, if a country’s macro-economic reform programme goes off track, leading to a suspension of loan disbursement, health sector funding will suffer.
- An absolute increase in funds does not guarantee that the poor or other vulnerable groups will be any better off. If systems for allocating resources within the sector are inequitable or inefficient, the increase can still be hijacked for use on inefficient services or by well-served populations.
- As funds from budget support are disbursed through regular government channels, they are likely to be subject to delays in disbursement and arbitrary drawing limits, which affect spending across all sectors.

In situations where donors do not have the confidence that governments will actually increase health sector spending despite conditionality, or where intrasectoral resource allocation mechanisms are very weak, the tendency is to use extra-budgetary channels, or to earmark budget support for health or for particular expenditures in the sector. Both of these strategies, however, have their own inherent problems, not least because they are likely to occur in those countries with the weakest administrative systems. In both cases the workload involved in monitoring disbursements and expenditures increases for both donors and recipients.

Several agencies have argued that the need for absolute increases in health spending supported by donors is in danger of being overlooked in the face of the current enthusiasm for health sector reform. Clearly, it is essential for governments to maintain or improve basic services. At the same time, it is important that large injections of funding from budget...
support do not enable governments to postpone needed reforms. Sectoral analyses need to establish whether the key problem is an absolute scarcity of resources or whether the problem lies more in how funds are allocated and used within the sector. In most countries, donor support for the provision of basic levels of health care cannot be disassociated from the need for policy, institutional and budgetary reform. These objectives are considered in the next two sections.

Promoting the equitable and efficient use of public funds

There is a chronic imbalance in the way that public funds are allocated in the health sector; aid should not make the situation worse.

In many countries there is a chronic imbalance in the way that public funds are allocated in the health sector: between capital and recurrent costs; salary and operating expenditures; tertiary and primary care; urban and rural spending, and so forth. The form that donor assistance takes should at least aim to not make these imbalances worse. Ideally, it should have the objective of improving equity and increasing the efficiency with which public funds are allocated.

Conventional forms of project aid can introduce or maintain distortions in the way government funds are allocated in a number of ways.

- Projects can, and increasingly do, support recurrent costs but frequently these small-scale or single intervention projects are not affordable on a large scale. There is little to be gained by ‘donor-supported islands of excellence in a sea of under-financing’.11

- In many countries, donor-funded projects are used to support donor-driven priorities – in some cases because there is genuine concern for a neglected aspect of health care (such as reproductive health) and in others because this represents a way of demonstrating a clear-cut impact on a specific aspect of health status. The availability of project funds for the popular interventions frees up government resources for other ‘priorities’ – those which have to be maintained because they are essential for a credible health care system (such as referral hospitals) or those for which there is a vocal political lobby. In either case, the availability of project funding does not help the development of a government budget which reflects overall priorities.

- Project funds are often very attractive to health care managers: they are often disbursed more quickly and can be used more flexibly. This can be a great help in getting things moving in a rigid administrative environment. Equally, however, it can result in underspending on key items (such as travel, supervision and supplies), sending all the wrong signals to the finance ministry.

In summary, unless project resources are taken into account when reviewing overall public spending in health, or drawing up what is referred to as le tableau des operations financières de l’état (TOFE) in francophone countries, they can exacerbate inappropriate investment planning.

Budget support has the advantage that funds are normally disbursed through the government budget. This mechanism has been used successfully to ensure additional health sector funding, either by increasing the proportion of government expenditure allocated to health or by ensuring that funds are available to meet budgeted recurrent costs.12 The problem is that budget support can equally well maintain inequitable or inefficient patterns of spending, unless it is also used as a means for initiating a dialogue on intra-sectoral allocations and disbursement procedures. The issue being debated in those agencies providing significant amounts of budget support to the health sector (particularly the EC and USAID) is the extent to which budget support should be earmarked. There are clearly some advantages to earmarking, not just on the donor side. Earmarking of funds can be an advantage to a Ministry of Health concerned to protect expenditures from predators in well-connected parts of the sector or other spending ministries. There are, however, a number of potential problems:

- If government revenues suddenly decrease, cuts in expenditure have to be made. If budget support is earmarked for the health sector as a whole, its funding will be protected. However, if funds are earmarked for particular expenditures within the health sector, government can no longer distribute cuts as it thinks fit. If say, maternal and child health (MCH) or district level services have to be protected, other budget lines are cut disproportionately. In an under-resourced system, this may lead to serious problems, for example in hospital care.

- Care needs to be taken as to what part of the budget is earmarked. Picking out specific services has more or less the same effect as funding vertical programmes – removing decision-making power from those concerned with implementation
and increasing the centralization of decision-making. This is not to say that budget support cannot be used to promote decentralization. Rather, it is important to ensure that earmarking is used to support and not to inadvertently undermine institutional and policy reform.

• Effective earmarking of budget support requires an understanding of the structure of the government budget and the way funds are spent in practice. It is of little use to specify that budgetary support should be used only for ‘primary health care’ if this constitutes an artificially circumscribed set of activities at district level, or for ‘preventive services’ if no such budget line exists.

There is considerable variation in the way donors control the disbursement and spending of budget support. In some cases it can be released in tranches against the completion of specified reforms with no further accounting. At the other end of the spectrum, government departments are reimbursed for specified expenditures on a bill-by-bill basis. This variation usually depends on the donor’s analysis of the country’s budgetary and administrative system. We therefore return to the conundrum that the countries with the weakest systems have to deal with the most complex and labour-intensive administrative requirements. It also emphasizes a point made by several donors, that budgetary support does not, in itself, lead to a decrease in the cost of aid administration.13

Returning to the objective of improving the efficiency and effectiveness of government resource allocation, the analysis of current practice suggests that the debate is not between project aid and budget support. Instead, the key issue is the extent to which aid promotes or undermines the development of more rational budgetary systems. Although there are many disadvantages to conventional projects, this is by no means inevitable. A good example of project aid which supports the reform of the budgetary system is provided by DANIDA’s support to the health sector in Zambia. Although funds are provided from project assistance, they support recurrent costs throughout the country, are reflected in the government budget, and are programmed by district management teams.

Promoting the formulation, adoption and implementation of policy and institutional reforms

Health sector reform is a complex and politically risky undertaking for any government. How can different forms of donor assistance be used to promote the process most effectively?

To address many of the health sector problems in developing countries requires reform of policies and institutions combined with appropriate organizational and systems development. This is a complex and politically difficult process for any government. Both budget support and project aid have been used to promote reforms with differing degrees of success.

Lessons from experience

Well-documented analyses of past experience are relatively scarce and the messages from existing evaluations are far from clear cut. One World Bank study (cited by Donaldson 1993) found that with respect to the total fulfilment of social sector conditionality, country performance lags behind all other policy reform areas except wage policy. In this study, only 59% of social policy conditions and 55% of critical actions were fully implemented, compared to other areas where implementation was as high as 79%.

Studies on the effectiveness of USAID Non-Project Assistance (NPA) (Donaldson 1993; Foltz 1994) – judged primarily on the basis of the extent to which conditions were met and funds disbursed – identify some of the factors affecting success. Not surprisingly, the conclusion is that success depends on the type of reform being promoted; the political and institutional environment in which reform has to take place; the degree of political backing and ownership of the reforms; and the way the programme is designed, managed and supported by technical assistance. Foltz’s paper is particularly helpful in illustrating these points by contrasting the experience of using NPA in Niger and Nigeria.

In Niger, starting in 1986, US$10.5million was to be released in a series of five tranches dependent on policy and institutional reforms in six areas. In addition to population and family planning reforms, these included the introduction of cost-recovery, the implementation of cost-containment measures in hospitals, changing resource allocations in the national budget, establishing new planning and monitoring systems, and reallocating personnel. The programme required the creation of three completely new institutions: a semi-autonomous secretariat to disburse the funds; a department of planning, which in practice was run largely by the expatriate technical assistance team; and an inter-ministerial committee to oversee
the reforms, which was never actually created. The population policy reforms were implemented, but progress in all other areas was much slower than expected and in many areas, beyond carrying out studies, nothing changed. After a series of delays in disbursement it was agreed that many of the reform objectives were not feasible. The requirements for further disbursement were simplified, but by late 1993 only one of the conditions for the final three tranches had been met.

By contrast, in Nigeria an NPA grant of US$36 million was disbursed against conditionalities relating to the transfer of personnel to Local Government Administrations (LGAs), the liberalization of private practice and contracting out hospital laundry. In this case, the design of the programme was far simpler. The key reform of decentralization to LGAs was agreed to before the grant began and, although there is no evidence that the other reforms were ever implemented, the main policy conditions were met. No new institutions had to be created, administration of the grant was far simpler and, in a sense, Nigeria was rewarded for what it planned to do already.

The experience of USAID provides several clear pointers, particularly the need to develop a clear understanding of the institutional and political environment in which reform is planned. It also demonstrates that although fast-disbursing budget support may be the appropriate instrument to stimulate certain types of policy and budgetary reform, it is not necessarily the best instrument for the longer-term objective of institution building. More liberal policies may either make little difference or actually be counter-productive, unless institutions in the public sector become more effective.¹⁴

It is useful to consider some general issues which emerge from the experience of other donors

Ownership and political support
That reforms need clear political backing and commitment is almost a statement of the obvious. The notion of local ownership has, similarly, become an accepted part of the jargon. When a government is clearly committed to a publicly-accepted programme of reform, the issue of ownership and political backing is relatively straightforward. What happens though in a more plural system? In many countries, those that wish to support reforms have to contend with more conservative political and bureaucratic colleagues. How should they be supported? What happens when the impetus for reform comes from opposition parties that because of their political status cannot be overtly supported by donor agencies?

Understanding the levers
Both in the design of projects or conditionalities linked to budgetary support, there is a need to understand what is actually going to lead to change. There is much evidence that conditions relating to the preparation of policy documents or the conduct of policy-related studies hold no guarantee that findings or recommendations will ever be implemented. Similarly, inter-ministerial committees have a poor track record. Model districts rarely provide a stimulus for system-wide change. Reorganization of ministries of health, without complementary changes in financial management, are often undertaken in response to conditions set by donors without leading to significant changes in the way they are actually run.

Can donor support undermine reform?
We have already touched upon the issue of the need for a balance between providing sufficient funds to ensure access to basic services, whilst not shielding recipient governments from the economic factors that make reform necessary. It is easy for donors to give conflicting messages in this respect. In Bangladesh, for example, the donor-funded Manpower Planning Unit is charged with developing policy in relation to an affordable level of personnel. At the same time the donor consortium continues to provide the salary costs of an unsustainable number of field staff.

Rethinking the role of technical assistance
Many donors are starting to look more carefully at the role of and need for technical assistance. The problems that arise when resident technical assistance personnel take over responsibility for analytic or implementation work are well recognized. Most donors acknowledge that with a more broad-based sectoral approach to health development there is a need for experienced personnel that can assist governments in analyzing the implications of different reform options and assisting in the design of new structures and systems. They face difficulty, however, in locating a sufficient number of individuals with the right combination of skills and experience. The need of many reform-minded ministries is for individuals who can respond pragmatically to local issues. Difficulties arise if technical assistance personnel are committed instead to the objectives of an international or global project (notably in the USAID system) or the imperatives of working in an academic institution.
Clearly, there is no straightforward relationship between donor assistance and the promotion of policy and institutional reform. Lessons learned to date do, however, suggest a need for an approach which is more contingent on the circumstances of the country concerned and a more precise understanding of the objectives of reform.

**Radical reformers**

Some countries are in a position to implement a radical process of reform. This may be the result of unavoidable economic circumstances – crisis generated reforms (e.g. the former Soviet Republics) – or of political courage and foresight (e.g. Zambia or Mexico).

In these circumstances, where there is a clear agenda for change, substantial external assistance may be required to back the reform process. Funds may be necessary in order to secure improvements in primary services prior to closing hospitals; to pay for the costs of retrenchment and pension payments; to cope with temporary increases in running costs when ministry jobs are put up for competition, and so forth. Aid may be provided in the form of budget support, sectoral project loans, multi-component projects or time-slice operations. In addition to the large transfers of resources, countries may wish to have access to advice and technical assistance through mechanisms like the ODA Know-How Fund.

**Tentative reformers**

Few countries are in the position of implementing radical and wholesale change. In many, the process is more piecemeal and incremental. Often there is a perceived need for reform but little agreement about the form it should take. There is a danger that a large injection of funds, rather than driving the process of reform, may instead undermine it.

In this group, there is a need for careful analysis by donors, and supporters of reform within government, about options for change and an assessment of how donor support can be used to the best effect, taking into account the issues discussed above. It will mean looking at different components of the reform process and deciding where there is a need to strengthen bureaucratic systems in the short term, even if there is an intention to implement more radical institutional changes in the long term. Donors will need to recognize the need of reformers to build (often painfully slowly) political and bureaucratic alliances with their more conservative colleagues.

Some more refractory problems, such as developing affordable levels of staffing, may not be effectively addressed by the Ministry of Health alone. Reform in the first instance may be better driven by Civil Service Ministries or Ministries of Planning and Finance.

There may be a need for more targeting of resources in the short term, through earmarking of budget support or specific projects, but this will need to be in concert with work on improving budgetary and accounting systems, to allow less tied forms of support to operate in future. There may also be a case, either through project assistance or budgetary support, for substantial inputs designed to strengthen specific support systems (drug procurement and distribution, medical equipment supply and maintenance) at critical phases in the reform process.

When the pace of reform is uncertain, donors need the flexibility to respond to changing circumstances. If project assistance succeeds in helping to build a consensus around an agenda for reform, budget support may be needed quite rapidly in order to maintain the momentum of the reform process.

**Reluctant reformers**

Although they may face equally serious problems, governments in several countries are reluctant or see no need to introduce reforms. Such countries may be extremely poor and are often, as a result, the focus of donor assistance. In these circumstances, it is much less likely that donor assistance can be used effectively to promote institutional change. There is also a danger that business as usual on the part of donors will allow governments to ignore or postpone the need to change.

There is a need therefore to carefully identify specific aspects of policy change that may improve the operating environment for projects (such as decreasing government control over the work of NGOs). If budget support is needed, it will almost certainly need to be carefully earmarked or be channelled through extra-budgetary mechanisms, to ensure that it reaches areas or populations in need. Donors may also use project funds to support groups that are active in working with community organizations trying to develop innovative systems outside government and stimulate public demand for better quality services.

If there is no clear commitment to reform there is often little to be gained by demonstration projects.
Instead, it may make more sense to encourage governments to contract out services to NGOs working in under-served areas.

Discouraging the abandonment of reforms

Donors wish to maintain some control over funds if reforms go off track or are reversed. How can this be achieved?

Whilst donors are keen to promote the implementation of reform and systems development in the health sector, the opposite side of the coin is that they are also anxious to maintain some control if the process of reform goes off track or is reversed. Conventional wisdom is that it is difficult to stop project aid once implementation has begun and that therefore budget support provides more leverage. Whilst this is demonstrably true in the case of general budget support for structural adjustment, it is important to question whether the same factors operate at sectoral level.

The review of USAID experience in Niger provides an example of where the release of tranches of budget support was delayed as a result of conditionalities not being met. However, it was realized at a mid-term review that some of the conditions were not realistic. In Ghana the threat of suspending disbursement of World Bank project funds played a role in speeding up the reorganization of the Ministry of Health but, given the other factors involved, including the desire of Ministry staff to introduce change, it is probably wrong to suggest a direct causal relationship.

It is also important to acknowledge the potential for tension between technical advisers keen to see the release of aid funds being linked to the implementation of change, and aid administrators equally keen to meet spending targets. Pressure to spend can clearly be a disincentive to use budget support as a tool for promoting reform. In this regard it would be useful to look more closely at reward systems in donor agencies. To what extent are staff rewarded on the basis of the quality of projects as opposed to the amount of grant or loan funds disbursed?

The detrimental effects of parallel systems are usually discussed in the context of accounting. There are, however, plenty of other cases where parallel systems developed at the behest of donors help to undermine the very capacity that project objectives aim to build. Several donors, frustrated by inefficient foreign exchange allocation systems and cumbersome port controls, by-pass rather than help to reform government mechanisms for procuring drugs and supplies. DANIDA, in collaboration with other donors in Tanzania, has recently helped to rebuild the drug procurement and supply system that had been by-passed by what, in its time, was considered a model essential drug programme. The default mode for many World Bank Projects in the health sector is to establish a Project Implementation Unit, responsible not only for monitoring expenditures but for inspecting capital development projects and procuring equipment and

Reducing aid dependency

Many countries will require external financial assistance for many years to come; donor support should not increase aid dependency.

A sectoral approach to health systems development on the part of donors does not, in itself, guarantee that sectoral spending plans will be affordable or realistic. There are many examples of countries that have developed national health policies and programmes as a tool for bidding for donor resources, but which do not define clear priorities for government spending or take realistic account of the likely levels of government revenues, donor funds and fee income. In trying to work out what constitutes a reasonable level of sectoral spending, donors, as well as recipients, need to avoid suspending disbelief about what is actually possible.

Most health service staff are accustomed to operating expenditures being squeezed when resources are short, and thus the suspension of budget support may have limited impact. This is particularly true where the proliferation of projects give managers ready access to operating funds from project budgets, or budget support from other donors continues without interruption.

The question of whether the potential threat of suspension of aid provides donors with leverage over the reform process begs another more important question. In the case of structural adjustment, for better or for worse, there is a recognized set of policy reforms that governments are required to follow. Health sector reform is much less straightforward. There is no policy or institutional blueprint; the menu is strictly à la carte. It is therefore much less clear cut as to what is meant by reforms going off track. Before getting too involved in questions of leverage, there is a need to gain a clear idea in different country situations of what exactly is meant by reform and what kinds of systems and methods are needed in order to track progress.
supplies. There is a strong case to be made for ensuring that these functions are undertaken, not by a parallel unit, but by the relevant parts of the MOH's own organization.

In identifying areas for donor support, it is useful to look for areas which require higher expenditure now to permit lower levels of expenditure later. This is particularly important in relation to the more radical reform programmes where payments toward pension funds or redundancy packages are needed in order to reduce salary costs in the future. A further example is the rehabilitation of hospitals. The running costs of many hospitals could be significantly reduced by the rehabilitation or replacement of out-of-date infrastructure such as boilers, heating plants and so forth. This is not an argument for supporting excess hospital capacity or the provision of high-tech medical equipment. Rather, it recognizes that hospital running costs will remain a drain on the budget and that in some cases a modest level of investment could reduce unnecessary expenditure in the future.

If donor funds for essential expenditures are provided through projects and donor administered procedures, there is little incentive for governments to make the necessary provision within the budget. If, on the other hand, expenditures are included in the budget they are more likely to continue to be funded, if only through the usual process of budgetary inertia.

Finally, there is increasing recognition among the donors consulted that in many countries long-term support for recurrent costs in the health sector will be needed. This is particularly the case given the decline in general budgetary support. Thus donors need to plan within a realistic time frame. It is also important to recognize that much recurrent spending (on research or training) has investment characteristics.

**Donor co-ordination**

_The need for better donor co-ordination underlies all the preceding issues; in practice it is hard to achieve._

In a paper entitled 'Programme Aid Beyond Structural Adjustment', Stephen Denning of the World Bank outlined the integrated sector investment approach, which was endorsed by the Special Programme of Assistance (SPA) meeting in October 1993 (Denning 1994). More recent documents set out the characteristics of Sector Investment Programmes in more detail (World Bank 1995). The approach has six characteristics: it should be sector-wide in scope; be based on a clear sector policy framework and strategy; local stakeholders, usually governments, should be fully in charge; all donors active in the sector should be involved; implementation arrangements should, to the extent possible, be common to all financiers; local capacity building should take precedence over the use of long-term technical assistance. The approach should be applicable to any sector requiring donor support, including health, and should cover both investment and recurrent expenditure.

Whilst this approach is set out as an ideal, it is equally clear that there are few countries where this situation is easily achievable in the health sector. The paper makes somewhat sweeping assumptions about the willingness of donors to accept common implementation arrangements and the 'low unintrusive role' that will be needed for the approach to succeed. It also assumes away the differences of opinion that exist among 'local stakeholders', and only contrasts programmes developed by foreign consultants that are not owned, compared to those prepared by government which are.

In practice, the requirements and objectives of co-ordination may differ according to the circumstances of the country concerned. At one extreme are those countries which have a clearly articulated policy where the priority is for donors to support nationally-owned health development strategies. Zambia provides a good example of a country which is now in a position to manage donor inputs and, in many respects, comes close to fulfilling the criteria of the integrated sectoral investment approach described by the World Bank. At the other end of the spectrum are those countries with weak systems of governance and no clear health development policies. In these circumstances, there is a need for a co-ordination mechanism within the donor community, to reduce the flow of contradictory signals to government and to ensure better value for money from aid spending.

Where the onus is on donors to develop mechanisms for co-ordination, further problems arise. Which donor should take the lead in co-ordinating the others? What recourse do other donors have if they perceive that the lead donor is usurping the role of articulating health development policy on behalf of government, in a way with which they do not agree?

The effectiveness of co-ordination is also influenced by donor systems for formulating and implementing
aid policy and the *channels* through which aid funds are provided. If a donor agency has to operate within its own centrally-determined spending targets, it is harder for the agency concerned to respond to country needs and to co-ordinate its efforts with other agencies on the ground. For this reason, most agencies have moved toward spending programmes which are driven more by locally determined country strategy.

In relation to channels of assistance, for many smaller bilateral donors it is attractive to co-finance projects implemented by a development bank or multilateral agency. This may be done by co-financing in a single multi-bi arrangement or as part of a multi-donor consortium. Such mechanisms offer a number of advantages: for the recipient they reduce the workload entailed in dealing with several donors consecutively; and for donors, buying in to a co-financed project can reduce the workload for thinly-stretched technical and administrative staff. This view however is far from universal. Several donors are concerned either because they lose control over funds, or because the need to maintain the support of all members of the consortium can result in a lack of focus in the policy dialogue with the recipient government.

In summary, the situation in most countries is a long way from the ideal. Whilst common implementation arrangements for multi-donor sectoral investment programmes remain a desirable aim, reality will be different for some time to come. Donors will continue to work in a variety of partnerships forged for a variety of reasons and influenced by working relationships in the country concerned. The need for the immediate future is perhaps less for the Holy Grail of seamless co-ordination. In an imperfect world, it may make more sense to put more effort into forming *pragmatic alliances and developing common analytic frameworks*, which are based on a holistic approach to reform and which try to define best practice in key areas of health sector development.

**Accounting for aid funds**

> Accounting requirements should follow from [donors'] policy goals, not constrain them.

Most donors find that their room to manoeuvre in using aid to pursue the objectives set out above is limited by accounting requirements. In theory, there is a strong case for suggesting that if aid is provided in order to promote policy or institutional reforms, then it should be accounted for in terms of whether those reforms have actually been implemented. The difficulty, however, is that many donors are required by their national parliaments, member states or governing bodies to be able to account for how money was actually spent.

Projects, especially those implemented by technical assistance personnel that retain control of the funds, provide the easy way out. The donor staff member disburses all funds directly or the contractor provides audited accounts to the donor and the administrators are satisfied. The alternative is to account for funds through the government budget. Whilst this is clearly more desirable, few government health systems which are major aid recipients have accounting and auditing systems which satisfy donor requirements. The result is a series of special accounts or development budgets for the channelling of donor funds. All of which inhibit the policy goal of developing an integrated budgetary system which reflects overall sectoral priorities.

Whilst the current situation is clearly unsatisfactory both to donors and recipients, there are several signs of progress. In developing their new sectoral policy, DANIDA have, for example, involved the national audit authorities in reviewing accounting requirements to try and ensure that administrative mechanisms keep pace with changing policy goals. In ODA a recent review of the aid programme by the National Audit Office has stimulated discussion about the need to bring accounting requirements more into line with sector-based policies. In the field, the DANIDA-supported health sector programme in Zambia has required that each district in the country send a staff member for training in accountancy so that districts can account directly for the funds they receive from the Ministry of Health. The success of this approach is likely to be monitored closely by other donors wishing to implement similar sector aid packages elsewhere.

**4 Summary, conclusions and proposals for action**

The analysis of current practice reveals a number of difficulties in improving the degree of fit between health reform and development objectives and the forms, channels and systems for providing aid. It also suggests some preliminary conclusions which may be helpful in focusing agency thinking in the future.

The first and main conclusion of this review is that the debate should not be about whether one form of
<table>
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<th>Objectives of donor support</th>
<th>Project aid</th>
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<tr>
<td>Providing adequate financial support to ensure access to basic levels of health care</td>
<td>Disadvantages of conventional project aid can include: limited administrative capacity in poorest countries, focus on capital development, modest resource transfers.</td>
<td>Budget support can provide the volume of resources needed but difficulties may arise through links with macro-economic conditionality, inequitable and/or inefficient budget allocations, ineffective disbursement systems.</td>
<td>In most countries, donor support for the provision of basic levels of health care cannot be disassociated from the need for policy, institutional and budgetary reform.</td>
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<tr>
<td>Promoting the equitable and efficient use of public funds in the health sector</td>
<td>Disadvantages of conventional project aid can include: creation of islands of excellence, distortion of government spending priorities, underspending on key budget lines, sending misleading signals to ministries of finance.</td>
<td>Support through the budget is a powerful tool for ensuring the government budget reflects overall spending priorities. The key issue is the degree to which budget support should be earmarked for specific expenditures. Problems may arise with earmarking due to fluctuating revenues, if centralised decision making is encouraged, if spending priorities cannot be matched with existing budget structures.</td>
<td>Project support need not distort spending priorities if: funds are reflected in the government budget, it is based on an analysis of overall sectoral needs. Programme design needs to assess the extent to which either form of aid promotes or undermines the development of more rational budgetary systems.</td>
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<tr>
<td>Promoting policy and institutional reform</td>
<td>Project aid has an important role in the promotion of institutional and policy reform, particularly in helping recipient countries analyse sectoral problems, identify options for change design new structures and systems, formulate reform strategies and manage budget support. Area-based projects, which demonstrate innovative approaches, have had limited success in promoting system-wide change.</td>
<td>Support through the budget has been successfully linked to conditionalities on the level and structure of health spending. Conditionalities have been successfully used to promote some types of policy reform, but have been less effective in relation to institutional reform and capacity building.</td>
<td>In most countries there will be a need for a careful mix of project aid and budget support. The design of programmes will be contingent on country circumstances and the specific agenda for reform. Considerations will include: ownership and political backing, understanding of the levers of change, the need for different types of technical assistance.</td>
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<tr>
<td>Discouraging the abandonment of reforms</td>
<td>The proliferation of projects which provide managers with easy access to funds for recurrent expenditure can reduce the leverage that can be exerted through budget support. It is difficult to suspend the disbursement of project aid once implementation has begun.</td>
<td>Budget aid can be interrupted more easily if conditionalities are not met. This can be difficult in the face of pressures to spend aid budgets, poorly designed conditionalities, lack of co-ordination between donors providing budget support.</td>
<td>Health sector reform differs from macro-economic adjustment in that there is little agreement what constitutes effective reform. There is therefore a need to carefully define the policy and institutional objectives of reform and develop tools for tracking its progress.</td>
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<tr>
<td>Reducing aid dependency</td>
<td>Projects have encouraged the development of parallel systems for accounting for funds, procuring drugs and monitoring capital development.</td>
<td>Budget support can help to ensure that key expenditures are maintained, if only through budgetary inertia.</td>
<td>A sectoral approach does not guarantee realism. There is still a need to define priorities and take realistic account of levels of government revenues, donor funds, fee income and institutional capacity. Support for recurrent expenditure can have investment characteristics, especially when donor supported expenditure is designed to decrease long-term running costs.</td>
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aid is better than another. Ideally, they should be complementary and the forms, channels and systems used for donor assistance need to be assessed in relation to how they help to achieve the mix of development objectives that are most appropriate to the country concerned. The review has suggested that this is a complex task and that to achieve an effective balance is by no means easy. The arguments developed in Section 3 of the paper are summarized for reference in Table 2.

**Promoting health systems development and health sector reform**

**Sectoral development**

A consensus is developing among donor agencies about the need for a sectoral approach to health systems development. Sector aid packages will usually need to include different forms of aid and will need to be set in the context of overall government public expenditure programmes.

**Focus on the budget**

Ensuring that a greater proportion of donor assistance passes through the government budget can promote improved public expenditure management. Strengthening government financial management and accounting systems is also the key to dealing with the problems of financial accountability, and will reduce the need for parallel systems.

**Promoting health sector reform**

The use of aid to promote sectoral development cannot assume a direct parallel with macro-economic adjustment in the way that aid instruments are used. Health sector reform consists of a complex agenda of policy, institutional and systems change. The design of aid programmes needs to be contingent on the degree of political backing for reform and to carefully match aid instruments to the specific objectives they are designed to achieve.

**Methods, tools and processes**

**Frameworks for sectoral analysis**

There is a need to develop more effective frameworks for health sector reviews which include political, macro-economic institutional and budgetary analysis. The focus of reviews should not just be limited to defining problems, but should attempt to identify the potential for change in the health sector.

**Frameworks for tracking the progress of health reform**

There is limited experience available to guide the monitoring of health sector reform programmes. Methods for tracking reform will need to take into account the often conflicting mix of objectives that reform and development programmes are designed to achieve.

**Skill development and capacity building**

There is a need for more health sector specialists in developing and developed countries with skills in political, institutional and budgetary analysis. There is a concern among many donors that schools of public health often fail to provide relevant training.

**Better communication between health specialists, aid administrators and economists**

To ensure a better match between the objectives of health sector development and the aid instruments designed to promote their achievement, there is a need for health professionals and advisers to increase their understanding of the range and effects of the aid instruments available.

**Documenting experience**

The review points to a need for more systematic evaluation of experience: in relation to the effects of policy and institutional change in the health sector; and, equally important, the way in which the forms, channels and systems for managing donor assistance are used in order to promote change.

**Endnotes**

1 The objectives for donor support used in this review have been adapted from a paper by Mick Foster: ‘The Future of ODA Financial Support to Economic Reform in Africa’. ODA, 1994. I have drawn extensively on this paper in organizing much of the material in the latter part of the document.

2 This framework has been taken from an ODA paper ‘Bilateral Aid to Developing Countries: Channels, Forms and Systems for Achieving Objectives’ prepared in July 1993 by Greg Toulmin and Neil Gregory.

3 This mechanism has been developed by the Inter-American Development Bank as a means of providing more flexible support to sectoral reform programmes. In essence, a time-slice operation provides funding for the sector as a whole over a fixed period of time, recognizing that programmes within the sector will be at various stages of development when funding begins and ends.

4 A mechanism by which the UK government makes available technical assistance to the countries of Eastern Europe and the Former Soviet Union. More recently, the Know How Fund concept, which allows recipients to access a broad range of UK expertise, has been extended to countries in Latin America.
5 The terminology applied to programme aid depends on the donor concerned. USAID, for example, refers to programme aid as Non-Project Assistance (NPA), which has three basic programmatic forms: Commodity Import Programmes, the sale of agricultural commodities (Public Law 480–Title 1), and cash transfers. The European Commission (EC), similarly, has three programmatic forms: the Structural Adjustment Facility, Sectoral Import Programmes and Food Aid.

6 Even this term is not wholly satisfactory as in certain circumstances local currency generated from programme aid may pass through extra-budgetary channels.

7 Once again terminology varies, for example in DANIDA the term used is ‘sector programme aid’.

8 ODA distinguished between Type A Sector Aid, which consists of fast-disbursing funds with conditionalities linked to the overall public expenditure programme, and Type B, which is sector specific and may combine fast-disbursing budget support as part of a package which includes project aid for capital development and technical assistance.

9 Extra-budgetary channels may also be used when structural adjustment lending has been suspended as was the case in Peru where budget support from CIDA was channelled through the independent Development Foundation and used for funding small-scale health and welfare projects.

10 The Intensified Co-operation Office (ICO) in WHO, for example, argue that the poorest countries cannot hope to provide even the most basic levels of health care without a significant increase in donor funding.

11 Foster. 1994. op cit (Note 4).

12 The latter effect has been particularly important in countries in receipt of EC Structural Adjustment Funds, such as Ghana. Budgeted allocations for non-salary recurrent costs are rarely available in practice due to revenue shortages. Budget support is helping to overcome this problem and thereby increase the efficiency of resource utilization. However, recent assessments suggest that the EC is supporting a growing proportion of a declining health budget.

13 For example, USAID plans to provide US$35m of Non-Project Assistance (NPA) to the Education Sector in Ghana between 1991-5. Monitoring involves one full-time expatriate and a local accountancy company and is estimated to cost US$3m or 12% of total expenditure (Singleton 1993).

14 Many donors have focused on the need to liberalize private practice and to promote private financing of care through user charges and insurance. In the absence of effective systems for regulating quality, targeting subsidies and managing the health labour market, policy reforms alone can exacerbate the problems of inequity and inefficiency that the reform process was designed to address.

15 A number of people from both bilaterals and multilaterals made the point that decisions about working in partnership with the World Bank depended less on their agency’s policy and more on the working relationship and trust established with individual task managers.

16 This approach to co-ordination was adopted at a recent meeting of EU health experts at which a decision was taken to look at both developing country needs and donor policy and practice in relation to drugs and medical equipment; human resource policy, planning and management; health financing and financial management; decentralization; and capacity building.

17 Foster M. 1994. op cit (Note 2).

References


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Biography

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