Emergence of a New Global Health Architecture: Trends Since the Mid-1990s.

Global health is on the international policy agenda as it never has been before. Over the last 10 years, humanitarian concerns about the health of the world’s poor, the spread of pandemics such as HIV/AIDS and fears about outbreaks of SARS and avian influenza, and the recognition that health is a key determinant of economic growth, labor force productivity, and poverty reduction have made health a central pillar of most development policies. At the same time, health is increasingly viewed as a human right, the fulfillment of which places obligations on both developed and developing countries.

During the 1990s, the global community discussed ways of renewing emphasis and strengthening action to reduce poverty and improve the health of the world’s poor. The culmination of these discussions—the Millennium Declaration and the Millennium Development Goals (MDGs)—reflects the prominence of health in the global policy arena: three of the eight MDGs relate directly to health; the poverty reduction MDG is affected when citizens are pushed into poverty by catastrophic health care costs or lost earnings resulting from ill health; and several of the other goals (e.g., education, sanitation) interact directly with health outcomes. In particular, HIV/AIDS emerged as a challenge to be addressed multilaterally as the international community became increasingly concerned about it as a development issue.

With these challenges, there was a growing sense that the traditional system of bilateral agencies and international organizations acting as the primary development partners was inadequately prepared to assist the poor countries of the world scale up to achieve the MDGs. In the past decade, there have been profound changes in the organizations that play key roles in global health. Private foundations, such as the Bill and Melinda Gates Foundation, and large global funds, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and the Global Alliance for Vaccines and Immunizations (GAVI), have entered the scene with large amounts of grant money. Other disease-specific initiatives such as the Joint United Nations Programme on HIV/AIDS (1996), Roll Back Malaria (1998), and the Stop TB Partnership (1999) were also established and have brought new financial resources for specific diseases.

Never before has so much attention—or money—been devoted to improving the health of the world’s poor. However, unless deficiencies in the global aid architecture are corrected and major reforms occur at the country level, the international community and countries themselves face a good chance of squandering this opportunity.

Taking Stock of HNP Financing in the World.

The donor level

As a direct and positive consequence of health’s becoming a high-profile issue in the global arena and attracting new partners, development assistance for health (DAH) has increased from US$2.5 billion in 1990 (0.016 percent of Gross National Income, or GNI) to almost US$14 billion in
2005 (0.041 percent of GNI) (figure I1). As a proportion of official development assistance (ODA), DAH has increased from 4.6 percent in 1990 to close to 13 percent in 2005. Much of this assistance is targeted to specific diseases or interventions, which raises issues of funding imbalances and prioritization. As a result, direct disease funding now accounts for an increasing proportion of donor aid. The latest Global Monitoring Report shows that, while the share of health aid devoted to HIV/AIDS more than doubled between 2000 and 2004—reflecting the global response to an important need, the share devoted to primary care dropped by almost half.¹

![Figure I1. Development Assistance for Health, by Source, 2000–05 (US$ billion)](image)


Fig Notes: (1) The category of ‘other multilateral’ includes the European Union, the Global Alliance for Vaccines and Immunization (GAVI), and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM). (2) World Bank total includes only IDA lending.

Most of the significant increases in development assistance for health come from bilateral donors, new global partnerships, and foundations, while contributions from the multilateral development banks and specialized UN agencies have been relatively flat.² Indeed, financing from bilateral donors accounted for more than 50 percent of DAH in 2005, and financing from new partners such as the Gates Foundation, GFATM, and GAVI accounted for almost 13 percent.³

Although health-specific aid has increased, a significant gap persists between current aid volumes and estimated needs to reach the MDGs, for example. As shown in figure I2, after a decade of decline in the 1990s in both real terms and as a share of GNI, ODA has indeed increased to some 0.33 percent of GNI in 2005. However, this level falls well short of the promised Monterrey targets of 0.7 percent of GNI and of the Millennium Project projections of 0.54 percent needed to

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achieve the MDGs.\textsuperscript{4,5} Other estimates of additional external assistance to help developing countries reach the MDGs range from US$25 billion to US$70 billion.\textsuperscript{6} These shortfalls, when coupled with the low and inefficient spending levels at the country level (discussed below), have serious implications for chances of achieving results.

Figure 12.

\textit{Source:} OECD Development Assistance Committee (DAC); projections by the OECD DAC Secretariat.


The country level

Partially as a result of this increase in DAH, overall health spending in developing countries has also been increasing. Between 1990 and 2003, total health spending in developing countries increased by more than 100 percent: from US$170 billion in 1990 to US$410 billion in 2003, or from 4.1 percent to 5.7 percent of developing-country GDP. However, despite these increases, domestic spending on health remains low and inefficient (table I1).

- Low-income countries spend less than 5 percent of their GDP on health, whereas middle- and high-income countries spend more than 6 percent and 11 percent, respectively. In exchange rate–based U.S. dollars, per capita total health spending was US$24 in low-income countries and almost US$4,000 in high-income countries, more than a hundredfold difference. Even after adjusting for differences in costs of living, the differentials are still on the order of 30 times.8,9
- Some 70 percent of total health spending is out of pocket in low-income settings, declining to 15 percent in high-income settings. In Africa, out-of-pocket spending accounts for almost 50 percent of total health spending on average, and in 31 African countries, accounts for 30 percent or more of total health spending.10 For the poor, out-of-pocket spending is the most regressive source of health sector financing and also denies all individuals the benefits of risk pooling and financial protection.

In addition, some regions’ reliance on external assistance to finance health and other sectors has serious implications for sustainability and countries’ abilities to plan for the long term. For example, external assistance plays a more significant role in health sector financing in Africa than in any other region, accounting for some 15 percent of all health spending on average, while in other regions, it accounts for less than 3 percent. Further, of the 23 countries globally in which external assistance accounts for more than 20 percent of all health spending, 15 (65 percent) of them are in Africa.11 Moreover, in Africa, external assistance accounts for 55 percent of all external flows, while in the five other developing regions, worker remittances and foreign direct investment account for the bulk of external flows with external assistance accounting for only 9 percent.12

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7 Includes external and domestic spending.
10 Ibid.
11 Ibid.
### Table I1 Composition of Health Expenditures in World Bank Regions and Income Categories, 2004

<table>
<thead>
<tr>
<th>Regions &amp; Income Levels</th>
<th>Per capita GDP ($US)</th>
<th>Per capita health expenditures ($US)</th>
<th>Per capita health expenditures ($US PPP)</th>
<th>Total health expenditures (% GDP)</th>
<th>Public (% total health expenditures)</th>
<th>Out-of-pocket (% total health expenditures)</th>
<th>External (% total health expenditures)</th>
<th>Total Revenue to GDP ratio</th>
<th>Tax Revenue to GDP ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Asia &amp; Pacific</td>
<td>1,457</td>
<td>64</td>
<td>239</td>
<td>4.4</td>
<td>39.8</td>
<td>51.0</td>
<td>0.5</td>
<td>19.1</td>
<td>15.1</td>
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<tr>
<td>Eastern Europe &amp; Central Asia</td>
<td>3,801</td>
<td>249</td>
<td>552</td>
<td>6.6</td>
<td>67.6</td>
<td>26.5</td>
<td>1.1</td>
<td>28.6</td>
<td>16.7</td>
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<tr>
<td>Latin America &amp; the Caribbean</td>
<td>3,777</td>
<td>271</td>
<td>608</td>
<td>7.3</td>
<td>51.0</td>
<td>36.3</td>
<td>0.7</td>
<td>23.0</td>
<td>15.9</td>
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<tr>
<td>Middle East &amp; North Africa</td>
<td>1,833</td>
<td>103</td>
<td>270</td>
<td>5.6</td>
<td>48.8</td>
<td>46.3</td>
<td>1.1</td>
<td>27.3</td>
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<tr>
<td>South Asia</td>
<td>611</td>
<td>27</td>
<td>131</td>
<td>4.6</td>
<td>18.8</td>
<td>76.1</td>
<td>1.6</td>
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<tr>
<td>Sub-Saharan Africa</td>
<td>732</td>
<td>45</td>
<td>119</td>
<td>6.3</td>
<td>42.1</td>
<td>46.3</td>
<td>6.8</td>
<td>22.9</td>
<td>18.2</td>
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<tr>
<td>Low-income countries</td>
<td>533</td>
<td>24</td>
<td>105</td>
<td>4.7</td>
<td>23.9</td>
<td>70.0</td>
<td>5.5</td>
<td>17.4</td>
<td>12.8</td>
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<tr>
<td>Lower middle-income countries</td>
<td>1,681</td>
<td>91</td>
<td>298</td>
<td>5.4</td>
<td>47.3</td>
<td>42.9</td>
<td>0.7</td>
<td>24.2</td>
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<tr>
<td>Upper middle-income countries</td>
<td>5,193</td>
<td>339</td>
<td>689</td>
<td>6.7</td>
<td>57.6</td>
<td>30.3</td>
<td>0.7</td>
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<tr>
<td>High-income countries</td>
<td>33,929</td>
<td>3,812</td>
<td>3,606</td>
<td>11.2</td>
<td>60.3</td>
<td>14.9</td>
<td>0.0</td>
<td>35.2</td>
<td>20.4</td>
</tr>
</tbody>
</table>

Source: World Development Indicators, IMF Government Finance Statistics

Notes: Per capita indicators weighted by population.
Out-of-pocket health spending in Sub-Saharan Africa excludes South Africa, which, if included, changes the estimate to 26 percent of total health spending.
Low and inefficient expenditure patterns in low-income countries (LICs) are matched by their domestic resource mobilization capacity. Most LICs face enormous constraints in raising additional domestic resources: on average, LICs mobilize only 17 percent of their GDP from domestic resources. Even if these countries could improve their capacity to raise resources domestically to finance health in an effort to scale up to reach the MDGs, massive increases in external assistance would be needed. Donors would still need to finance most of the gap.

Challenges in the New Global Health Architecture.

The impact of increased resources on health has been mixed, especially considering the persistence of stark imbalances between rich and poor countries in terms of disease burden, the huge unmet health needs in most developing countries, and their lack of domestic resources to cope with these needs:

- Ninety percent of the global disease burden is in developing countries that account for only 12 percent of global health spending.
- High-income countries spent more than 100 times per capita on health than low-income countries.
- Developing countries will need between US$25 billion and US$70 billion in additional aid per year to remove the financing constraint to scaling up to meet the MDGs.
- Further, most countries in Africa are off-track on all of the MDG health goals. More broadly, in all Bank Regions but the Middle East and North Africa (MENA) and South Asia (SAR), most countries are off-track with respect to the child mortality goal.

It is in this context that questions have arisen about the effectiveness of health spending and, concomitantly, the integrity of the global aid architecture in health.

Effectiveness of aid for health

There are at least four important manifestations of ineffective health aid at the country level:

- **Aid is often not aligned with government priorities, and holistic health systems approaches are insufficiently funded.** As discussed above, health aid is often earmarked for specific purposes. Only about 20 percent of all health aid goes to support the government’s overall program (i.e., is given as general budget or sector support), while an estimated 50 percent of health aid is off budget. As a result, many countries report difficulties in attracting sustained, flexible funding that can be

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used to support the health *system*: staff, infrastructure, training, management, and so on.

- **Aid can be unpredictable, short-term, and volatile.** In addition to being heavily earmarked, health aid can be very short-term and volatile (figure I3). When the amount of aid a country receives is likely to change at short notice, it is impossible for ministries of health and finance to make long-term plans—such as employing more doctors or nurses, widening access to HIV/AIDS treatment, or scaling up health service provision—without incurring major risks of sustainability of financing for these services. A related issue, which also creates difficulties for ministries of finance and planning, is that aid can be unpredictable (disbursements do not match commitments, even where the reasons are not related to performance).

![Figure I3](image)

**Volatility in Aid for Health, Selected Countries, 1999–2003**

- **Aid may be poorly harmonized, increasing transaction costs for government.** The high number of donors present in health, the large number of separate health programs, and large volume of resources may carry unpredictable risks and transaction costs unless they are well coordinated—both with each other and with government. A related issue is that the presence of multiple health partners may inadvertently undermine the government’s broader efforts in the health sector. This is likely to affect the government’s ability to deliver programs in other areas.

**Integrity of the global health architecture**

In addition to problems with the effectiveness of aid flowing into the health sector, some of the challenges of the new global health architecture stem from a lack of global governance and overlapping mandates of different aid agencies. Problems at the country level and the inherent complexities of the health sector also contribute to the quandaries concerning the effectiveness of external assistance for health.
Leadership at Global Level

There are more major global stakeholders in health than in any other sector and literally hundreds of different flows of public and private funds to specific countries. Issues include:

- The various international organizations and stakeholders have overlapping and unclear mandates—no single organization coordinates global health policy, financing, implementation processes, or knowledge dissemination at country or regional levels;
- Global Health Partnerships (GHPs) were initially promoted as tools to better focus health aid in areas of perceived neglect and to simplify the aid architecture in health, and, as a consequence, make health aid more effective. However, many observers believe—and a range of studies suggest\(^{15}\)—that this objective has not been achieved. It is recognized that GHPs have mobilized important new resources for major health threats and brought much needed political and technical focus to priority diseases or interventions. However, there is concern that the rapid creation of new institutions in health is difficult for countries to manage and further complicates donor harmonization efforts at the global level.

Finally, as in other sectors donor governments find it politically advantageous to raise aid “vertically” to show their populations that their tax monies are being spent on “good causes.” In particular, GHPs may intensify the “vertical” nature of health financing by focusing large amounts of new funding for specific, relatively narrow programs and interventions, creating separate financing and delivery silos, and leaving recipients little flexibility to reallocate funds according to their priorities or to fund health system costs, such as salaries. While this is an issue in all sectors, the consequences are particularly acute in health, because there is a need for flexible resources that can be used to support recurrent costs, other sectors that have a direct impact on health, and health systems.

Health Is a Complex Sector

Complexities in the aid architecture for health mirror the complexities of the sector itself. Creating and sustaining population health; providing financial protection from the consequences of ill-health; and managing, financing and governing the health system are all difficult and costly.

- Numerous nonhealth related factors affect health outcomes, necessitating complex cross-sector approaches.
- Health outcomes are reversible, if access to services is interrupted (unlike gains in education, for example).
- Individual behavior plays a critical role in health outcomes and is very difficult to influence or change.

Measuring health outcomes—other than sentinel events such as births or death—and attributing causality to specific factors is inherently complex.

The costly financial protection element of health financing is largely unique to the health sector (except for a few standard social protection programs such as pensions, unemployment insurance and social assistance).

The bulk of the funding needed is for long-term recurrent costs rather than the traditional donor-financed short-term investment costs, raising issues of sustainability and the need for countries to create adequate fiscal space in their budgets.

The health sector is critical in terms of both its share of the public budget and as a major source of public employment.

Well over a hundred major organizations are involved in the health sector, globally and nationally, far more than in any other sector;

The private sector plays a substantial, often predominant, role in both the financing and delivery of health care services and is often absent from the policy debate.

Market failures in insurance markets and in the health sector more generally require complex regulatory frameworks and limit governments’ abilities to simply rely on market mechanisms.

From Consensus on the Problems to Coordinated Action at Country Level

A consensus on the challenges has emerged, and new steps have been taken to improve the effectiveness of aid for health and streamline the new global health architecture through donor harmonization and alignment with country systems. The Paris Declaration is a key reference point for improvements in health aid: as the framework for aid effectiveness in general, it also frames efforts to improve aid for health.

UNAIDS, together with the Global Fund, bilateral donors, and other international institutions, has committed itself to harmonization and alignment in HIV/AIDS through the concept of the Three Ones. These are: one agreed HIV/AIDS action framework for coordinating the work of all partners; one national HIV/AIDS coordinating authority with a broad-based multisectoral mandate; and one agreed country-level system for monitoring and evaluation.

Subsequent to the agreement of the Three Ones, the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (GTT) was established. In June 2005 it presented a plan to further coordinate the HIV/AIDS response, making specific recommendations to partner governments, the United Nations system, and the Global Fund to Fight AIDS, TB, and Malaria (though not to bilateral donors). In particular, the GTT recommended the development of a scorecard-style accountability tool to examine the performance of national partners in creating a strong HIV/AIDS response and international partners in providing support according to the GTT recommendations. The scorecard is being piloted by UNAIDS in a number of countries.

Stakeholders in the health sector have responded to aid shortfalls, aid effectiveness problems, and failures in the supply of global public goods for health through the
development of innovative financing methods. These are: the International Finance Facility for Immunization (IFFim), Advanced Market Commitments (AMC), and UNITAID (previously called the International Drug Purchase Facility). The innovative finance agenda is seen as an important component of a more robust and performance-driven approach to development assistance. This is particularly true, given the unintended impact that unpredictable aid has had on markets, most notably for pharmaceuticals and vaccines needed by the poorest countries.

The HLF was a series of three high-level meetings in 2004–05 among key donors and some 20 countries that looked at many of the aid-effectiveness issues raised above. It also strengthened cooperation between the WHO, the World Bank, the IMF, bilateral donors, global health partnerships and other UN agencies and has helped create a consensus for action around the scaling up of the agenda in health.

As donors make good on their promises to scale up development assistance between now and 2015, many will wish to invest in health. Creating effective aid architecture in health—which delivers results—helps make the case that “aid works” and should leverage further resources for the sector and perhaps overall, while a dysfunctional health architecture does the opposite. One key challenge is to demonstrate the link between the aid effectiveness agenda and better health outcomes. The Paris Declaration emphasizes progress towards harmonization and alignment, and has an in-depth monitoring and accountability process related to this objective. It does not, however, hold donors and countries accountable for development results, in health or other areas.

Taking forward the harmonization and alignment agenda in health is about managing complexity—recognizing that diversity can help bring results and that the health sector benefits from a range of partners with different ways of doing business. As part of the post-HLF agenda, there will be efforts at the country level to develop instruments for mutual accountability between donors and countries. These efforts will be initiated by the health community but will look beyond the sector and aim to ensure alignment of health strategies and goals and other development objectives.