

# 4

## External assistance for health

*Donor countries, international organizations, and development agencies will need to commit billions of dollars of additional external assistance to enable low-income countries to reach the Millennium Development Goals. Yet, recent increases in such assistance have fallen short of commitments, and even the funds that have been made available have posed problems for recipient countries. Timing is often unpredictable, exchange rates are volatile, loan and grant maturity periods are too short, and aid is not well aligned with the country's own budget processes and health priorities. For additional assistance to be effective, donors must be willing to make more flexible, long-term commitments that are integrated with the recipient's development goals, and recipient countries must work to increase their accountability and absorptive capacity.*

External assistance for health, in the form of development assistance specifically for health interventions (referred to as health aid), and overall official development assistance are important components of health financing, particularly in low-income countries. Massive increases in health aid are needed for countries to reach the Millennium Development Goals. The global estimates of what it would cost to achieve the health Millennium Development Goals range from an additional \$25 billion to \$70 billion a year, much of which must come in the form of aid. This chapter reviews the recent trends in development assistance broadly, as well as private financial flows to low- and middle-income countries. With regard to aid specifically for health interventions, it assesses the increasing diversity of donors, programs, and resources. It also examines the effectiveness and sustainability of aid from the perspective of donors and recipients—particularly the need for donors to make their commitments predictable and fungible within the recipient country's budget and for recipients to increase their capacity to absorb and be accountable for additional funds.

Official development assistance reached \$70 billion in 2003, barely higher in real terms than in 1992. Recent increases are largely due to increases in health aid, which has grown through the increasing presence of global partnerships, such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria and the Global Alliance for Vaccines and Immunization, as well as private foundations. Despite the increases, total official development assistance is only at about 0.25 percent of

gross national income in Organisation for Economic Co-operation and Development (OECD) countries, far short of the 0.7 percent those nations set as a goal at an international conference in Monterrey, Mexico, in 2002.

Although health aid increased to more than \$10 billion in 2003 from \$2.6 billion in 1990, estimates indicate that between three and seven times that much would be needed to reach the Millennium Development Goals for health. It is unclear whether the commitments will be met in terms of amount and duration required, at least in the short run. Meanwhile, recipient countries face budget constraints, and expectations of large amounts of additional official development assistance may be preventing them from making the difficult choices needed in resource-constrained environments.

Official development assistance in general, and health aid in particular, have been criticized for unpredictability of funding; proliferation of disease- and intervention-specific programs, which are often not integrated into any particular country's on-going programs; large numbers of new actors and donors; inflexibility of aid for dealing with sudden problems and crises; and lack of accountability of donors for the absence of results and progress. These problems reduce the impact of donor funding in achieving economic growth and health improvements, which is explored in detail in the next chapter.

The problems identified with aid lead to the following conclusions and recommendations:

- The flow of aid can be volatile for many reasons, including exchange rate fluctuations, political and budgetary decisions by donors, administrative delays on the donor's side, problems of absorptive capacity in the recipient country, and noncompliance with agreed conditionalities. Thus, there can be no single instrument or solution to the volatility issue; rather, the problem must be solved by tackling each source of volatility.
- Fiscal sustainability requires consideration of the fiscal contingencies generated by the volatility of donor funding. It should also motivate appropriate accountability by donors and improved capacity to use domestic resources to finance the increased expenditures initially funded by donors.
- The maturity of donor commitments must be long, in many cases more than 20 years, depending on the magnitude of the increased expenditures and the recipient country's ability to raise additional domestic revenues.
- Donor funding should increasingly be provided through budget support and aligned with increases in domestic resources over the program period.
- On the recipient side, there must be efforts to improve public expenditure management, governance, and accountability. Health plans must align with the country's broader poverty reduction strategy, medium-term expenditure framework, and monitoring and evaluation systems. Chapter 7 develops these issues further.

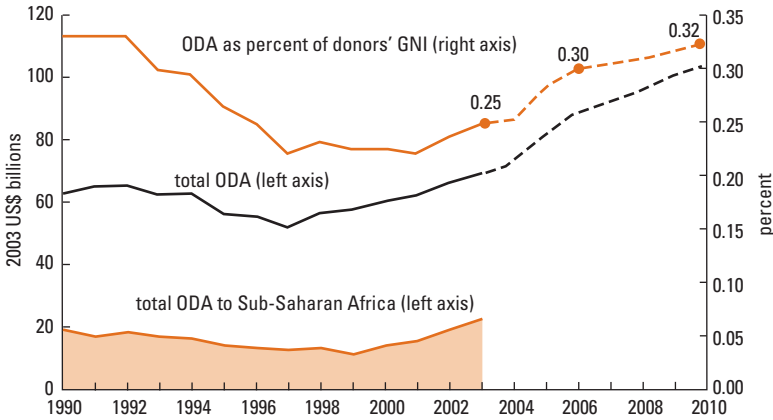
- Private capital flows from foreign direct investment and workers' remittances, which amount to some \$250 billion each year, have been largely overlooked as a source of health financing, especially in middle-income countries. If the Millennium Development Goals are to be reached, official development assistance, particularly technical assistance, should emphasize the need for appropriate policies and institutions to attract foreign direct investment to both middle- and low-income countries, as well as effective mechanisms for using workers' remittances. The emphasis on grant financing, although important, should not divert attention from these other fundamental private sources of sustainable financing for development.

### Trends in official development assistance

The current international development architecture responsible for the financing and management of official development assistance is a complicated structure including the International Monetary Fund (IMF), the World Bank, more than 20 regional development banks, some 40 bilateral development agencies, the United Nations family of organizations, thousands of large and small nongovernmental organizations, and numerous private foundations. As never before in its 50-year history, the international development system is now bringing together the state, the private sector, and civil society in complex interactions that will determine the success or failure of future development efforts. Harmonization is necessary for success in achieving the Millennium Development Goals. However, the increasing number of players in the development scene makes such harmonization increasingly difficult (Sagasti, Bezanson, and Prada 2005).

The Asian financial crisis of 1997, the Russian crisis of 1997–2000, the more recent Argentine debt default, the impact of HIV/AIDS across the world but especially in Africa, and the global public health scares of new diseases such as SARS and avian flu have led to a realization of the need to revamp international aid in a global world and to reverse the decline of official development assistance. This perception was strongly reinforced by the terrorist attacks in September 2001, which have increased global awareness of the need to deal with inequality to increase the world's security. Actions to create a new global partnership are reflected in the UN's Millennium Development Goals of 2000, the "Monterrey Consensus" on financial development and the Johannesburg Summit on Sustainable Development in 2002, and the New Partnership for Africa's Development. These renewed efforts to revamp international development have also been reflected in the recent increases in official development assistance.

After declining about 25 percent in real terms over the 1990s, official development assistance started to recuperate in 1998, reaching \$70 billion in 2003—barely higher in real terms than in 1992 (figure 4.1).<sup>1</sup> Official development assistance to developing countries increased in real terms by 7 percent in 2002 and

**FIGURE 4.1 Actual and projected official development assistance, 1990–2010**

Source: World Bank 2005b.

Note: Dashed lines indicate projections of official development assistance (ODA) based on commitments made by members of OECD's Development Assistance Committee following the 2002 UN conference in Monterrey, Mexico.

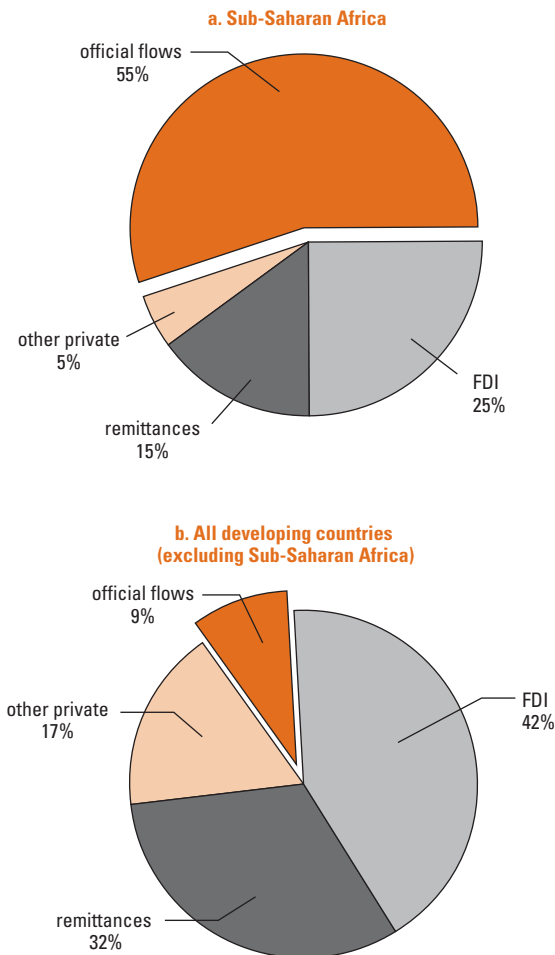
by 3.9 percent in 2003.<sup>2</sup> As a percentage of gross national income in OECD countries, assistance declined from 0.34 percent in 1992 to 0.22 percent in 2001 before increasing slightly in 2003 to 0.25 percent.

The increases in official development assistance over the past five years have not been directed toward financing efforts to reach the Millennium Development Goals, but rather have concentrated mostly on debt relief, emergency and disaster relief, technical cooperation, and administrative overhead. Of the total nominal increase between 2001 and 2003, 66 percent went to debt relief and technical cooperation (World Bank 2005b).

Sub-Saharan Africa offers a unique example of the importance of official development assistance (figure 4.2). While this region historically received approximately 20 percent of total official assistance, countries in this region received 54 percent of the total increase in such assistance between 2001 and 2003. Official development assistance is the main source of external finance in Sub-Saharan Africa, representing more than 55 percent of total external flows of about \$41 billion that these countries received in 2003. Foreign direct investment represented another 25 percent of the total long-term flows, remittances 15 percent, and other private flows 5 percent. In other regions, where foreign direct investment and remittances account for the bulk of external financial flows, official development assistance accounts for only 9 percent of such flows.

Two trends in official development assistance need special review because of their importance for the health sector: promises to provide more official development assistance and find new sources of finance and mechanisms for disbursing official development assistance.

**FIGURE 4.2** Long-term capital flows to Sub-Saharan Africa and the rest of the developing countries, 2003



Source: World Bank 2005b.

### *Promises of more aid and new financing methods*

Many countries are struggling to meet the promises they made to increase official development assistance. For example, of all OECD countries, only five (Denmark, Luxemburg, the Netherlands, Norway, and Sweden) have reached or passed the goal established at Monterrey of 0.7 percent of gross national income. Moreover,

countries in the European Community are facing difficulties living up to the much less ambitious commitment of 0.33 percent to be reached by 2006. The large fiscal deficits of several donor countries and the relatively slow growth of official development assistance in real terms create room for doubt regarding the firmness of the promises for more aid to developing countries.<sup>3</sup>

Yet, more recently at the July 2005 meeting of the Group of Eight (G-8) nations in Gleneagles, Scotland, the G-8 promised that aid for all developing countries will increase by around \$50 billion a year by 2010, of which at least \$25 billion extra a year would go to Africa (G-8 2005). France, Germany, Italy, the United Kingdom, and the European Union all reconfirmed their commitments to reach a 0.7 percent ratio by 2015. The United States proposed to double aid to Sub-Saharan Africa between 2004 and 2010 but specified no commitment to aid as a percentage of gross national income. Similarly, Japan committed to increase its official development assistance volume by \$10 billion in aggregate, including a \$5 billion Health and Development Initiative, over the next five years. Simultaneously, the G-8 agreed to a proposal to cancel 100 percent of outstanding debts of eligible heavily indebted poor countries to the International Monetary Fund, International Development Association, and African Development Bank and to provide additional resources to ensure that the financing capacities of the international financial institutes are not reduced. However, no specific mechanism or dates (other than before 2010) were provided for the increased funding.

To finance donor commitments of additional assistance, several innovative financing mechanisms have been proposed.

*Airline ticket taxation.* In June 2005, an international donors conference in Berlin proposed a “solidarity contribution levied on plane tickets . . . to combat hunger and poverty and finance global sustainable development, inter alia, health programs including the fight against HIV/AIDS and other pandemics” (World Bank 2005a, p. 5). The levy would apply to plane tickets issued to passengers departing from airports located in participating countries. Passengers in transit would be exempted. Airline companies would collect the tax, and rates would be country specific. Initial estimates were that the tax would yield €10 billion annually (about \$12 billion) on a €5 tax on all plane tickets worldwide with a €20 surcharge on business and first class tickets.

*An international finance facility.* The United Kingdom’s proposal to create an international finance facility (IFF) is based on the notions of frontloading aid (spending money now for critical development investments to reach the Millennium Development Goals) and using off-budget donor commitments (in response to fiscal constraints facing donors that have pledged to increase official development assistance).<sup>4</sup> A pilot facility of the IFF targeted to immunizations is under way. That facility would raise frontloaded, reliable funding over a number

of years to expand global immunization efforts to help achieve the Millennium Development Goal on child mortality by accelerating production of new and existing vaccines and strengthening capacity to deliver vaccines.

*The Tobin tax.* The Tobin tax dates from an idea proposed in the 1970s to curb speculative currency flows. The tax would be levied on currency transactions collected on a national or market basis. Applying the tax proceeds to development financing is a new wrinkle to the long-standing idea of a tax to reduce potentially destabilizing hot currency flows. The annualized global foreign exchange market turnover is estimated at \$300 trillion. After adjusting for various sources of leakage, it is estimated that a reasonable tax rate of one or two basis points would raise from \$15 billion to \$28 billion annually.<sup>5</sup>

*Taxes on global “bads.”* Perhaps the earliest example of a proposal to tax a global bad is the proposed global carbon tax. A more recent initiative was advocated by President Jacques Chirac of France to fund development by taxing global arms sales. The basic idea is straight from the principles of public finance: levy a tax on the production of activities associated with negative externalities (carbon emissions or arms sales). The tax revenues can be used to promote a social good (development), while the increased price as a result of the tax reduces the offending behavior, increasing societal welfare. Estimates for the amount of resources that could be raised from a tax on hydrocarbon fuels according to their carbon content vary, but revenues from high-income countries alone could raise \$60 billion.

*IMF gold sales.* A number of proposals have been advanced to fund development through gold sales by the International Monetary Fund (Sagasti, Bezanson, and Prada 2005). The rationale is that the gold held by the IMF is valued at the price prevailing at the creation of the Bretton Woods Institutions, \$30 an ounce, although the current market price is much higher. The simplest proposal calls for the IMF to slowly sell gold in the international market in amounts too small relative to total market volume to have an appreciable impact on price. Critics have argued that this would destabilize global gold and financial markets. Another approach is for the IMF to use an “off-market” sale, an approach that has been used only in exceptional circumstances.

*Creation of new special drawing rights.* The special drawing right (SDR) is an international reserve asset created by the IMF in 1969 to supplement the official reserves of member countries. SDRs are allocated to member countries in proportion to their IMF quotas. The SDR is not a claim on the IMF but is potentially a claim on the convertible currencies of IMF members. Countries holding SDRs can exchange them against currencies of other members. SDRs were introduced under the Bretton Woods fixed exchange rate system because gold and U.S. dollars were

not sufficient to support the expansion of world trade. With the shift to floating exchange rates, the need for SDRs as a reserve asset has declined. Today, the stock of SDRs outstanding is approximately SDR 21 billion (approximately \$32 billion). Of late, there have been calls for the IMF to issue new SDRs, with donor countries making voluntary donations of their SDR allocations to fund development. Estimates of the revenue-raising potential vary from \$25 billion to \$30 billion.

*How to proceed.* As proposed by the World Bank and IMF, any new mechanism to finance development or to comply with official development assistance commitments must be assessed on the basis of five criteria: revenue adequacy, efficiency, equity, ease of collection, and minimum required coalition size (World Bank and IMF 2005). Regardless of the merits of each proposal, reaching agreement among donor countries is likely to be a long and tenuous process with questionable likelihood of success.

As previously discussed, more official development assistance is certainly necessary, especially for low-income countries, and more effort to provide such funding is certainly welcome. However, overly ambitious goals and promises regarding official development assistance may create unreasonable expectations in recipient countries, which may postpone the difficult choices needed in a resource constrained environment. Donor countries should certainly provide adequate support of development efforts, and they should also recognize that recipient countries would benefit from realistic commitments, which would allow them to improve planning and make rational choices.

### *Mechanisms for disbursement*

Official development assistance can be provided in many ways. How the resources are disbursed determines whether they can be used to finance recurrent expenditures, how much the recipient country can allocate to the uses it considers most deserving, what mechanisms will be used to make the resources available to the final beneficiary, and even whether the resources will ever reach the country they are supposed to benefit.

Depending on how it is provided, donor assistance may not be recorded in the recipient country's balance of payments; may be recorded in the balance of payments but not in the government's budget ("off budget"); may be recorded on budget, but be earmarked for a particular purpose or project; or may be provided as general budget support, essentially free of restrictions regarding the expenditures it finances. Assistance not recorded in the balance of payments refers largely to technical assistance (for instance, foreign consultants) contracted and paid for by donors outside the beneficiary country. Off-budget funding (support that is reflected in the balance of payments and not in the government's budget) is for projects implemented directly by donors through nongovernmental organizations or through contracting directly with providers, by-passing the government's

public expenditure management. On-budget but earmarked funding refers to funding that is provided for a particular project or purpose, such as for building health facilities or purchasing certain drugs. General budget support is assistance that is provided through the government's budget and that governments allocate as they see fit. General budget support essentially is provided to finance gaps in financing the government's overall program.

A recent analysis of 14 countries that have developed World Bank poverty reduction strategies (Foster 2005a) shows that, although budget support is increasing as a share of donor support, on average less than 20 percent of donor disbursements are provided as general budget support. On average, for every \$1 disbursed by donors to these 14 countries, the study estimates the following distribution:

Not recorded in balance of payments	\$0.30
Recorded in balance of payments but not in government budget	\$0.20
Earmarked to specific projects recorded in budget	\$0.30
General budget support	\$0.20

Off-budget funding has been particularly prevalent in the health sector. In Uganda off-budget spending is estimated to be more than 50 percent of total health spending. In Tanzania off-budget spending was estimated to represent more than 46 percent of health spending in 2000. Although some of the off-budget spending is domestically funded, through, for example, user fees, it is largely donor funded. In part, donors encourage this behavior to be able to account for the direct impact of their resources (Wagstaff and Claeson 2004). Several countries are uncomfortable with this approach. In 2004 the Uganda Ministry of Finance was reported as having decided to cap new project aid commitments that are outside the budget (*New Vision*, Uganda, August 20, 2004). In India, an immunization program promoted by Global Alliance for Vaccines and Immunization was not implemented because the government believed it was not sustainable financially without continued, long-term, predictable grant support (Lele, Ridker, and Upadhyay forthcoming).

Donors may also decide to provide their assistance though the budget but request that the funding be earmarked. Earmarking tends to increase the rigidities of government budgets and, as with off-budget funding, may not lead to increases in overall government spending as recipient countries decide to divert their own domestic resources to other uses. This diversion is called fungibility and is analyzed in detail in a later section.

### Trends in private financial flows

Discussions about official development assistance and the Millennium Development Goals have largely concentrated on low-income countries and direct donor aid, overshadowing talk about the needs of middle-income countries and the potential of private flows. However, private flows to developing countries are

critical to achieving tangible improvements in health outcomes and to reaching the Millennium Development Goals. Private capital flows to developing countries reached an annual net average of \$169 billion between 2000 and 2003 (World Bank 2004b), close to three times the size of official development assistance over the same period. The source of this financing is mostly foreign direct investment.<sup>6</sup> Although the explosive growth in foreign direct investment that took place in the 1990s was accompanied by new policies, such as protection of property rights and clear rules regarding pricing, several issues about foreign direct investment that are more relevant now should be noted.

A large part of foreign direct investment during the 1990s came about as a result of privatizations of public enterprises, which cannot be repeated. Second, foreign direct investment has been concentrated in a few countries and in the energy, minerals, and telecommunications sectors.<sup>7</sup> Third, there is some recent disenchantment in Latin America (Argentina and Bolivia) with foreign direct investment, especially when it is associated with contentious privatizations in the water, petroleum, and electricity sectors. Finally, foreign direct investment profit remittances have increased, causing, among other things, inquiries from members of civil society and nongovernmental organizations regarding the net impact of foreign direct investment in capital flows over the medium term.<sup>8</sup> Still, foreign direct investment, which involves long-term commitment of investments, has remained resilient despite the Asian financial crisis and other problems. It is a fundamental source of financing for infrastructure and market penetration of services that are critical for growth and reaching the Millennium Development Goals (both directly through the impact of infrastructure on outcomes and indirectly through the impact of growth on outcomes).

Workers' remittances are monies sent by migrant workers to their home countries. Remittances have become the second largest capital flow behind foreign direct investment and ahead of official development assistance. Remittances, officially defined, are the sum of workers' remittances, compensation of employees, and migrant transfers. Thus defined, remittances received by developing countries rose from \$31 billion in 1990 to \$86 billion in 2001 and \$167 billion in 2005 (World Bank 2006), representing more than twice the estimated amount of official development assistance. Accounting for unrecorded and informal flows, the actual amount of remittances could be twice the officially recorded amount. There are marked differences in remittance flows by region and country. In 2005 East Asia and the Pacific region received 26 percent of total worker's remittances; Latin American and the Caribbean, 25 percent; South Asia, 20 percent; the Middle East and North Africa, 21 percent; Europe and Central Asia, 20 percent; and Sub-Saharan Africa, 8 percent. The top five receiving countries in volume were India, China, Mexico, France, the Philippines, and Spain. On a per capita basis, the top five receiving countries were Jordan, Portugal, Barbados, Jamaica, and El Salvador. Data from a number of surveys indicate

that the bulk of remittances are used for consumption, as well as human capital (health, education, and better nutrition).

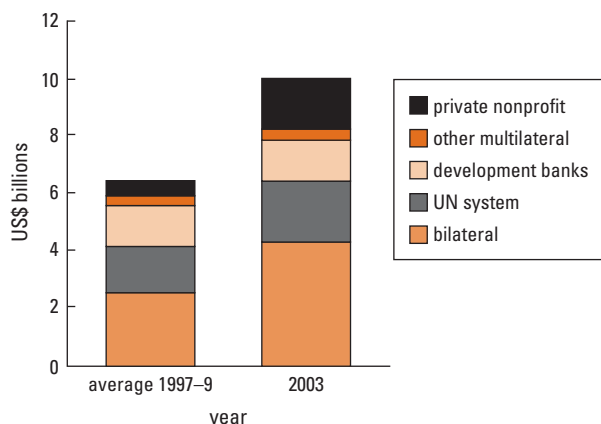
Thus, official development assistance, especially technical assistance, should emphasize the need for appropriate policies and institutions to attract foreign direct investment to both middle- and low-income countries, if the Millennium Development Goals are to be reached. Similarly, the importance of remittances cannot be taken for granted, and both donors and recipients should strive for better ways to pool these resources to increase their impact on human development outcomes and growth. The emphasis on grant financing, although important, should not divert attention from these other, much larger, private sources of sustainable financing for development. Countries and companies should eventually be able to finance their needs from domestic and international capital markets. To achieve that goal, developing countries must make strong efforts to improve their international risk ratings. This requires, among other things, political stability, sound macroeconomic policies, sound institutions, and clear rules about complying with international contracts. Technical assistance should help countries meet the requirements to ensure a sustainable flow of resources beyond official assistance for development.

### **Trends in health aid**

Development assistance for health has risen steadily since 1990 from about \$2 billion to more than \$10 billion in 2003.<sup>9</sup> Much of the post-2000 increase can be credited to an increasing number of global partnerships and a significant rise in private philanthropic funding—notably by the Bill and Melinda Gates Foundation. Partnerships and philanthropies have joined efforts to increase awareness and finance aimed at the eradication of major diseases. Global programs—such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); the Global Alliance for Vaccines and Immunization; Roll Back Malaria; the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR); and several others—represented roughly 15 percent of total health aid in 2002 and 20 percent in 2003 (Michaud 2003). Figure 4.3 reflects the increasing importance of global partnerships and private philanthropic funding in development assistance for health; such funding was considered negligible in 1990.

### *Estimates of the costs of reaching the Millennium Development Goals for health*

Despite growth, health aid still falls far short of the estimated financing required to reach the health Millennium Development Goals. A World Bank study estimated that the additional health aid required to meet the health goals is about \$25 billion a year, or almost three times the amount of development assistance for health in 2003. The Commission on Macroeconomics and Health of the World Health Organization estimated that an additional \$40 billion to \$52 billion would

**FIGURE 4.3** Development assistance for health by source, 1997–2003

Source: Michaud 2005.

Note: The category of other multilateral includes the European Union and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

be needed annually until 2015 to scale up the coverage for malaria, tuberculosis, HIV/AIDS, childhood mortality, and maternal mortality (Kumaranayake, Kurowski, and Conteh 2001). A third study estimated that between \$25 billion and \$70 billion of additional spending is needed to bring poorly performing countries up to the level of high performers (Preker and others 2003). A more recent estimate by the United Nations Millennium Project estimates that an additional \$120 billion a year would be required by 2006 to reach all the Millennium Development Goals, and this amount would increase to \$189 billion by 2015 (UN Millennium Project 2005). Of this amount, between \$30 billion and \$50 billion would be required for the health Millennium Development Goals.

Although the estimated cost of reaching the health goals ranges between \$25 billion and \$70 billion annually, all the studies acknowledge the need for additional investments, particularly for scaling up access to essential health services (Wagstaff and Claeson 2004). The increased financing available for health from donors does not match this need; that financing is mostly provided through disease- and intervention-specific programs that are off-budget, rather than as direct budget support to a country's health systems. Given the increased importance in health of these programs, they are examined here in more detail.

### *Disease- and intervention-specific health programs*

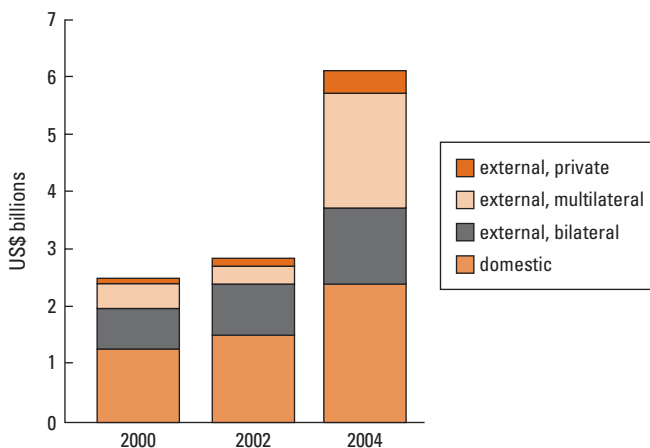
The impact of disease- and intervention-specific programs on health care systems has recently become a major topic of debate. On the positive side, such programs are effective in increasing the awareness of major global concerns such as HIV/AIDS and immunizations. They have significantly increased the resources

available in their areas of focus. They introduce new technologies to the countries in which they operate, and they seem to be more effective than general government programs in delivering services to the targeted populations. On the negative side, such disease- and intervention-specific programs potentially disrupt the country's health system. The expenditures they generate may not be sustainable within the recipient country's budget constraints. In addition, the global programs are not accountable to the recipient country. Thus, focusing solely on disease-specific initiatives can undermine the opportunity to integrate these initiatives with the country's overall health program, as well as fragment outreach, raise the demand for management skills that are already in short supply, and bleed the health system of financial and human resources in order to set up a parallel delivery operation—possibly delaying much needed institution building in the health sector (Lewis 2005).

**Increased funding for HIV/AIDS.** Resources available for HIV/AIDS have increased rapidly in recent years. Funding is heavily concentrated in a small number of countries. Donors are supporting activities in 140 countries, but approximately 72 percent of this funding is allocated to 25 countries, mostly in the highly affected countries in Africa and the Caribbean (OECD 2004). There has been steady growth in bilateral assistance for HIV/AIDS among members of the OECD's Development Assistance Committee (DAC). The upward trend in bilateral aid, however, is driven by the U.S. government's PEPFAR initiative. Excluding the United States, bilateral donor assistance for HIV/AIDS among DAC countries has been fairly stable since 2000.

Multilateral assistance for HIV/AIDS has also increased dramatically (figure 4.4). This has been due entirely to the establishment of GFATM. As of 2004 GFATM

**FIGURE 4.4** Domestic and external financing for HIV/AIDS in developing countries by source, 2000–4



Source: Lewis 2005.

contributions among DAC countries other than the United States were roughly equal to these countries' bilateral HIV/AIDS assistance. However, there is a clear reversal in the trend in multilateral assistance outside of GFATM. The establishment of GFATM has not reduced bilateral assistance for HIV/AIDS but has had a negative impact on other multilateral assistance (box 4.1).

**Impact on health systems.** The increased prominence of GFATM has led to aid coordination challenges in many recipient countries. Lele, Ridker, and Upadhyay (forthcoming) examine several countries' experiences with GFATM related to donor aid coordination. They find that GFATM has led to

- duplication in institutional arrangements (for example, between national AIDS councils and country coordinating mechanisms);
- duplication in reporting requirements, increasing transaction costs;
- delay in implementation of other donor programs, particularly in small countries;
- concern among recipient governments over the uncertainty of future external resource flows;
- a focus on treatment that may be diverting attention from prevention.

Although some early conclusions can be drawn and anecdotal evidence is available, well-documented empirical analyses of GFATM's impact on health systems are lacking. PHR*plus* has organized a collaborative research effort to examine the impact of GFATM inflows on broader health systems functioning (PHR*plus* 2005). The early findings are summarized in box 4.1.

**Mid-term sustainability.** There is widespread concern that increased donor funding through disease and intervention-specific programs may lead to a reduction in domestic spending on HIV/AIDS. While donor funding for HIV/AIDS has only recently increased significantly, domestic spending has been growing at an aggregate level (see figure 4.4). However, such substitution may be taking place at the country level (Malawi, Mozambique, and Zambia, for example), as reflected in figure 4.5.

The sustainability of additional expenditures required for scaling up HIV/AIDS treatment is a particular concern in low-income countries. HIV/AIDS treatment will require hiring additional health workers and administrators, as well as importing almost all of the drugs to treat HIV/AIDS patients. If the resources or in-kind donations dry up, the government would need to take responsibility for funding antiretroviral therapy, because patients depend on continued therapy for survival. Interruptions in antiretroviral therapy because of funding gaps reduce the benefits of treatment and, more alarmingly, can lead to resistant strains of the virus, which compromise the efficacy of future treatment (Lewis 2005). To minimize the health and financial risks caused by the unpredictability of aid, donors

### **BOX 4.1** *Impact of the Global Fund to Fight AIDS, Tuberculosis and Malaria on health systems*

#### **Policy processes**

- The majority of proposals supported by GFATM appear to be in alignment with overall national health policies and plans; issues regarding incompatibility or divergence arise during the implementation phase.
- GFATM-related planning processes appear highly centralized, even in decentralized contexts; this has led to problems as countries begin to implement GFATM-supported activities, because of a lack of ownership at subnational levels.

#### **Public-private mix**

- In many countries, there has been rapid growth of nongovernmental organizations (NGOs), which appears to be at least partially attributable to partnership opportunities created by GFATM and other funding agencies. Country stakeholders expressed concerns about “briefcase” NGOs.
- GFATM support has contributed to innovations in public-private arrangements; many different types of partnerships were observed in different contexts.

#### **Human resources**

- None of the study countries had overarching national-level strategies or plans to address human resource constraints to scaling-up HIV/AIDS services. Plans that do exist relate to specific initiatives rather than the combined needs of all initiatives, and they do not typically take into account the

potential implications of such scale-up on human resources for other programs within the health sector.

- In the face of staffing shortages and a lack of clear guidance or plans on how to motivate and retain key staff, countries and various stakeholders within countries are experimenting with alternative types of incentive packages (financial, nonfinancial, and in-kind). The effectiveness of such packages needs to be assessed.

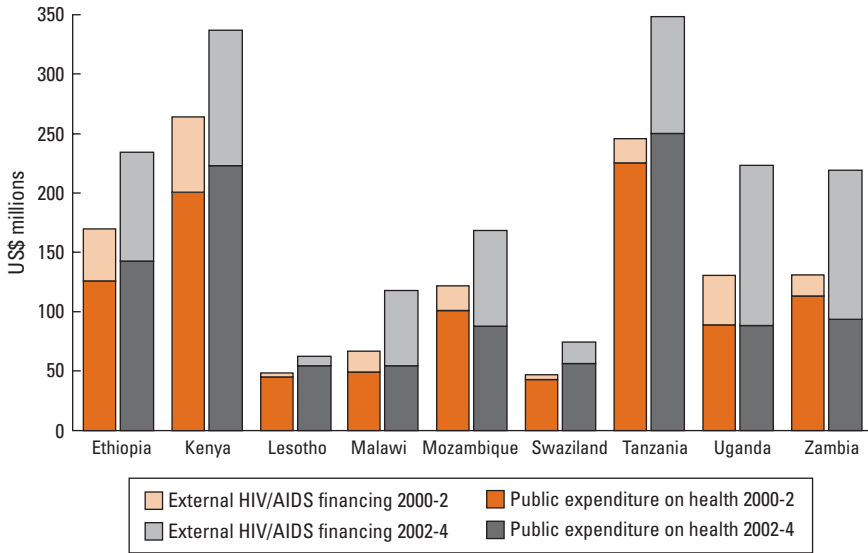
#### **Pharmaceuticals and commodities**

- All participating countries experienced delays in procuring drugs and commodities, despite using different procurement models—working through government systems, through private parallel systems, and through multilateral agencies. Procurement through government systems appears to have led to the most substantial delays.
- Lack of consistency in the pricing of different commodities, pharmaceuticals, and services supported by different funding sources was observed to be problematic in many countries. Identical resources or commodities flowing through the same distribution systems were charged for and handled differently according to whether GFATM, other donors, or the government had paid for them.

*Source:* PHRplus 2005.

could commit to fund a cohort of AIDS patients for the duration of their lives instead of annually committing to fund an HIV/AIDS program. This course of action transfers risk from recipient countries to donors and makes donors accountable for their commitments. Taking on HIV/AIDS expenditures domestically is not a minor issue in many low-income countries. HIV/AIDS monies exceed total public health budgets in some countries. In 2003–4 Ethiopia’s external flows targeted to HIV/AIDS were equal to the government’s health budget, and in both Uganda and Zambia, AIDS funds exceeded all public health spending by almost 185 percent (Lewis 2005).

**FIGURE 4.5 Domestic and external financing for HIV/AIDS in selected countries in Sub-Saharan Africa, 2000–4**



Source: Lewis 2005.

### The effectiveness of aid

The large increases in official development assistance and additional commitments have led to renewed concerns about aid effectiveness. As discussed in the next chapter, donor funding seems to have had a limited impact on child and maternal mortality. These results can be explained by several factors, including fiscal sustainability, predictability, fungibility, and absorptive capacity.

#### *Fiscal sustainability*

Fiscal sustainability is often advocated, but rarely defined, for disease- and intervention-specific programs, sectors, and whole economies. Sustainability has generally been described in terms of self-sufficiency. In its broadest context, sustainability means that over a specific time period, the responsible managing entity will generate sufficient resources to fund the full costs of a particular program, sector, or economy, including the incremental service costs associated with new investments and repayment of external debt.

The exact definition of fiscal sustainability has also been the subject of recent debate (Bird 2003; Edwards 2002; Heller 2005). Traditionally, fiscal sustainability has been associated with the concept of debt sustainability. A common approach

to assessing a country's fiscal sustainability has been its ability to meet a solvency and liquidity condition in terms of its debt. In practical terms, a country meets the solvency condition if it maintains a defined level of debt to GDP at a relatively constant rate from some defined period on (Edwards 2002).<sup>10</sup> Thus, if a country generates new debt, some time in the future it will be expected to make adjustments in taxes, spending, or both. A country meets the liquidity condition if its foreign resources allow it to meet its maturing obligations.

Defining the fiscal sustainability of a country's economy or its current fiscal situation is no easy matter. The IMF has been devoting increasing attention to these areas, particularly in light of the severe criticisms of IMF structural adjustment programs and fiscal ceilings (Tanzi and Zee 2000; Croce and Juan-Ramon 2003; Dunaway and N'Diaye 2004). Work is also under way to develop operational indicators of debt and fiscal sustainability (Dunaway and N'Diaye 2004). Although the practical definition of fiscal sustainability may change for programs supported by the IMF and IDA, it is extremely unlikely that such definitions will be divorced from a country's capacity to accommodate expenditures financed with aid within the domestic budget constraint in a reasonable period of time, while maintaining sustainable levels of debt to GDP and debt service to exports.

Certainly the discussions will hinge on what is meant by "reasonable period of time." The concept of a reasonable period of time must depend on the maturity and predictability of grants, which at this stage are short term and highly volatile. If a country receives reliable commitments of grants for a long period of time, say 20 years, these grants will be part of the revenue stream and sustainability would imply the capacity of a country to accommodate the expenditures initially financed with those grants within their own domestic envelope in the programmed 20 years.

Three features of this definition of fiscal sustainability are important:

- It strikes a compromise between the "resource constraint" definition of fiscal sustainability currently used by the IMF and the more "needs based" definition advocated by the UN Millennium Project and its director Jeffrey Sachs.
- It maintains internal (domestic) and external (debt management) prudence. Social expenditures are increased only to the extent of local capacity to overtake those expenditures within the domestic resource mobilization envelope, yet they are allowed to increase immediately based on donor grants.
- It generates the appropriate incentives for both donors and recipient countries.

To illustrate this last point, assume that donor grants are committed to a country in an unrestricted manner until 2020 and that the country does not have absorptive capacity constraints. The restraining factor to increased social expenditures would be the recipient country's commitment to expand domestic resources up to 2020 to progressively substitute for the donor funds. If it is estimated that the domestic envelope will allow such an expansion of health expenditures, the donors funds would be accepted, and the program of increased health expenditure with

grant financing, later replaced by domestic resources, would be allowed. If, however, it is unlikely that the additional margin generated in the domestic envelope will accommodate such increases in health expenditures by 2020, or there is unwillingness in the recipient country to make such a commitment to health, expenditures would not be allowed to increase as much. If, however, donors can commit resources only until 2008, the total increase in health expenditures would be constrained by the capacity to increase domestic resources for health to the level of the additional grants by 2008. In that case, the shorter-term nature of the assistance reveals the absence of donor commitment to the effort.

There is nothing strikingly new about this discussion. Some low-income countries such as Uganda already use this type of analysis in their medium-term expenditure framework. The problem is that the adoption of such a definition or policy is unilateral by the recipient country and thus does not generate the appropriate incentives on either the donor or the recipient side. Because of the current short-term nature of donor commitments and the resultant lack of predictability of donor funding, the programmed increases in expenditures are limited to the possibilities of domestic funding in the next couple of years or the next medium-term expenditure framework cycle, at best. Thus increases in health expenditures are extremely constrained. If donor resources could be committed over a longer program period (say, 10–20 years) and be well invested, increases in health expenditures could be larger, and chances of making a difference in outcomes would improve.

### *Predictability*

The core of the aid predictability problem is that low-income countries depend on vague indications of future aid commitments to fund long-term, recurring spending obligations. Though donors make substantial aid commitments, data show that commitments consistently exceed actual disbursements. Despite a poor record as predictors for disbursements, commitments continue to be used in budgetary exercises in aid-receiving countries (Foster 2005b). When coupled with the difficulty of reallocating budgets in the short term, this may have serious implications for the way governments use their domestic resources to fund their health priorities. Most notably, the unpredictability of donor aid creates fiscal sustainability problems in aid-receiving countries. Fluctuation in aid levels prevents countries from using donor aid to invest in projects that may generate recurrent costs because aid that may be available at the initiation of a project is not guaranteed to still be available over the long term.

For example, if revenues are secured for the long term, governments can pursue expenditure obligations that have future recurrent cost implications, such as taking on the cost of school fees and drug costs for the poor. If the money is available only for the next two years, however, countries will avoid making longer-term commitments, opting instead to make marginal improvements to existing services

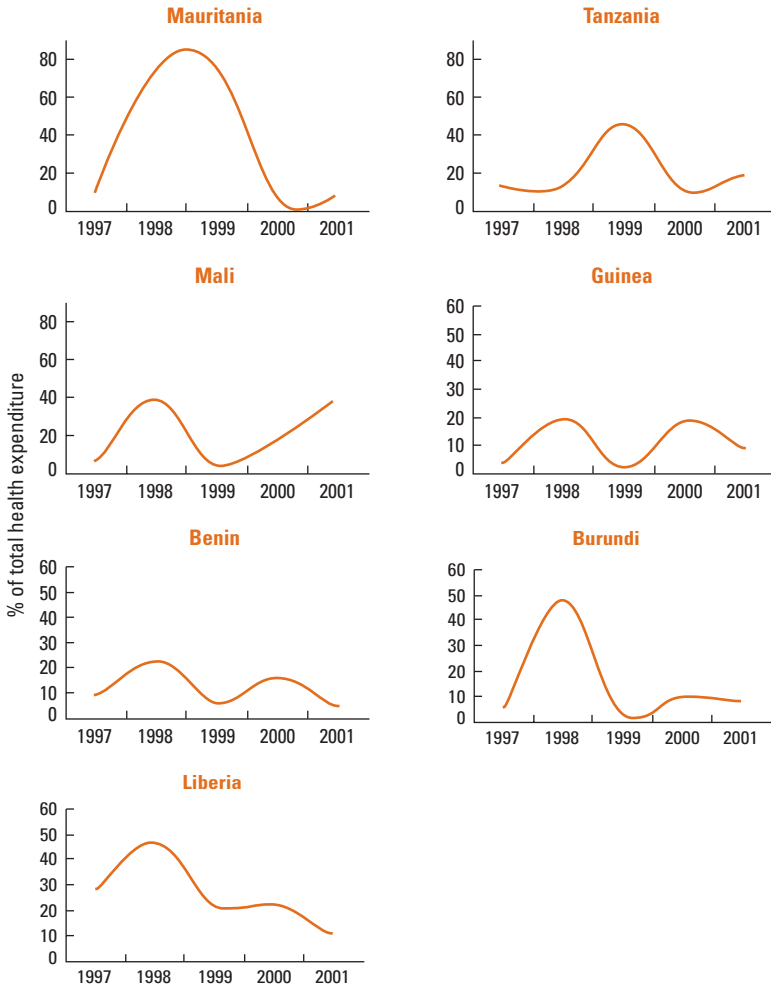
rather than aiming for bold expansions in coverage. The reason is obvious: when the money runs out, the cost of running the new facilities and paying the extra staff will stretch the available budget so far that the quality of existing as well as new services will suffer. Public expenditure plans are always subject to the risk of adjustment if resources are below expectation; the costs of making adjustments depends on the speed and predictability of changes in the availability of budget resources.

Figure 4.6 highlights the dramatic fluctuation in donor commitments that can occur over time. The variability reflects, among other things, exchange rate fluctuations, political and budgetary decisions by donors, administrative delays on the donor side, problems of absorptive capacity in recipient countries, and non-compliance with loan conditions. Commitments are reflected in U.S. dollars, and thus exchange rate fluctuations between the currency in which donors make their commitments and the U.S. dollar and between the U.S. dollar and the local currency strongly affected volatility. To illustrate, the franc in Burundi depreciated against the U.S. dollar an average of 27 percent per year between 1997 and 2000 for a cumulative depreciation of 104 percent. Moreover, the U.S. dollar depreciated against the euro, for instance, an average of 7 percent between 1997 and 2000 for a cumulative depreciation of 22 percent. Thus, in the case of Burundi, the increases in the ratio between commitments and actual health expenditures can partially reflect depreciation of the local currency in which expenditures are made against the dollar and the depreciation of the dollar against the currency in which the commitments are made, but it cannot fully explain the sharp decreases in the ratios.

Another major reason for the volatility in commitments has to do with political decisions in donor countries. Legislative constraints and the inability to compromise with successor governments inhibit donors from making long-term funding commitments. Commitments are never unconditional or irrevocable, and they require a high degree of trust by both partners. Donor preferences can change from one year to the next in response to changes in behavior in the recipient country or to political events in the donor country. The donor country's budget cycle can also be misaligned with the budget cycle of the recipient country, resulting in a serious mismatch between what is committed and what is actually disbursed.

Absorptive capacity at the country level is another reason donor commitments are often volatile and unpredictable. Absorptive capacity issues in more general terms are discussed later in this chapter; for the purpose of this discussion, absorptive capacity refers primarily to problems with spending resources made available by donors. Problems such as lack of administrative capacity or inefficiencies in public expenditure management (which inhibit already-disbursed resources from reaching projects or program executing units) may originate in the recipient country. Problems can also begin with donors, which may have burdensome procurement and reporting requirements.

**FIGURE 4.6 Donor commitments for health in seven African countries, 1997–2001**



Source: WDI and OECD/DAC donor funding database and staff estimates.

Conditionality is another major reason why donor funding is unpredictable. The worst case scenario results when disbursements are stopped in all programs for noncompliance with conditions in one program or the macroeconomic framework. However, approaches to conditionality are evolving. Donor assessments of performance are being coordinated with the budget cycle and conditions applied with a lag, to avoid disrupting the current year’s budget. Although new instruments, such as the poverty reduction support credit (see chapter 6) make

the timing of disbursement no longer dependent on completion of a long list of actions, governments still need to agree on a forward-looking policy matrix and convince donors that they have made enough progress in implementation to merit further support. Current approaches leave governments vulnerable not only to donor assessments of their performance against existing conditions, but also to difficulty in negotiating future conditions.

Any solutions to the predictability problem must address each of the causes of volatility. Table 4.1 summarizes some of the main reasons for the discrepancies between donor aid commitments and disbursements and proposes some mitigating approaches.

**TABLE 4.1 Reasons for aid volatility and possible mitigating alternatives**

Reason for volatility	Possible mitigating alternative
Donor commitments are short term, but spending obligations are long term.	<p>Longer donor commitment horizon if conditions are met</p> <p>Collective donor commitment to adjust for shortfalls by individual donors</p>
Donor commitments are conditional and hard for governments to manage.	<p>Partnership approach, joint review, and focus on implementation.</p> <p>Fewer, strategically negotiated conditions, within power and capacity of government to deliver consultation before sanction where there is "side tracking"; proportionate response to condition not being met</p> <p>Key spending programs for the poor maintained if program-specific conditions are met, even if other aspects (such as the macro economy) are temporarily off-track</p> <p>Conditions applied to future commitments not current budget, with time for government to adjust spending obligations if agreement cannot be reached</p>
Pledges and commitments are not predictably linked to actual disbursements.	<p>Transparent reporting system for significant commitments; discounting of donor figures based on past performance</p> <p>Continuous review of disbursement outlook</p> <p>Donor accountability through transparency on performance, peer review, and civil society pressure at global and country level</p> <p>Collective donor arrangements to ensure targets are met for donors as a whole; larger reserves to shield impact of shortfalls (such as the proposed aid stabilization facility of the UK Department for International Development); active use of foreign exchange reserves to manage fluctuations.</p> <p>Debt relief as predictable funding source.</p>
Disbursements may be worth less than their nominal value.	<p>Gaps in government poverty reduction strategies filled as first call on donor funds; collective government and donor group decision making on spending priorities; full disclosure of funding commitments and disbursements, transparency on funding intended to support public expenditure plans; harmonized government systems, strengthened as needed</p>

Source: Foster 2005b.

Implementing these solutions will require major donor commitment and coordination efforts. Some of the solutions could generate additional problems, such as moral hazard or large transaction costs. Box 4.2 describes a proposed facility to be financed by donors, which may be helpful in diminishing short-term volatility of funding. It also is helpful in underscoring the issues of moral hazard and difficulties that the facility itself introduces.

Faster progress toward the Millennium Development Goals depends on governments' confidence that significantly higher aid flows will be maintained in the long term. The uncertainty surrounding future aid levels makes governments reluctant to commit to ambitious public expenditure plans that depend on continued and timely donor aid disbursements for their execution. Countries face significant risks if they establish health systems that cannot be maintained if donor preferences change.

#### **BOX 4.2** *A solution to aid volatility? DFID's proposed aid stabilization facility*

At the High Level Forum 2004 in Abuja, Nigeria, the U.K. Department for International Development (DFID) proposed an aid stabilization facility to guarantee minimum overall funding levels for aid-dependent low-income countries. Additional detail was elaborated in a DFID study that recommended establishment of an aid stabilization facility (Foster 2005). This facility will guarantee countries that depend on aid to finance their public expenditure programs will not fall below certain defined limits and will not fall faster than a defined rate of decline. This recommendation provides the required assurances that aid will be broadly in line with commitments and will not be abruptly withdrawn. The aid stabilization facility is intended as a last resort, providing an insurance policy if donors fall short of their promises. The degree of security it is able to offer depends on the extent to which the donor community succeeds in taking other complementary measures to improve the medium- to long-term predictability of aid flows.

A specific mechanism for diminishing the difference between commitments and actual expenditures, although reasonable and desirable in principle, requires further analysis. Volatility in donor aid, defined as the

difference between the commitment for a given year and actual expenditures in that year, is introduced by multiple factors. Some of these factors are the donors' responsibility (such as decreased commitments because of political and budgetary reasons or slow disbursement because of bureaucracy in the donor country); some are the recipient countries' responsibility (lack of capacity to disburse, public expenditure management difficulties, or noncompliance with conditionalities under the control of the recipient country); and some are due to exogenous factors outside the full control of either partner (such as deterioration of the terms of trade and natural disasters). The design of the fund will depend on what factors it intends to insure against. Moreover, the facility must be carefully designed to avoid moral hazard on the part of both donors and recipient countries. The consequences of a poorly designed facility could be more damaging than the problems it is trying to overcome. Finally, the facility as initially proposed does not lengthen the maturity of the funding provided by donors, which, in the case of the social sectors, is a major deterrent to increasing recurrent expenditures in a sustainable manner.

## *Fungibility*

Development assistance has claimed many successes at the project level. However, at the macro level, many cross-sectional studies show little impact of donor aid on growth (Boone 1994; Burnside and Dollar 1997). Similarly, donor aid has had limited impact on child or maternal mortality (see chapter 5). What explains these apparent contradictions? The answer lies largely in the volatility of donor aid, as already discussed, and in its fungibility.

As discussed in chapter 5, the fungibility of donor aid is the diversion of funds to public expenditures other than those for which the aid is intended, including tax reduction or debt repayment. A vivid example comes from a statement in 1947 by Paul Rosentain-Rudin, then deputy director of the World Bank's Economics Department, who noted: "When the World Bank thinks it is financing an electric power station, it is really financing a brothel" (Devarajan, Rajkumar, and Swaroop 1999, p. 1). The reality is that in a resource-constrained environment, governments decrease their domestic funding of, for example, primary care, when they see that donors are funding such activities, so that donor funding may not generate additionality in spending, or at least not to the extent donors expected. Fungibility is likely to be larger when donor funding is provided off-budget and where there are a large number of donors in the country (Devarajan, Rajkumar, and Swaroop 1999). Chapter 5 discusses fungibility, including its impact on the effectiveness of donor funding and government expenditures on health outcomes, at length.

With dramatic increases in donor assistance for health, many stakeholders are wondering whether these resources actually reach the intended sectors or projects. Devarajan, Rajkumar, and Swaroop (1999) point out that this is an interesting question only if donor preferences are different from those of the recipient country. They also argue that it is not clear whether fungibility is good or bad: it all depends on what the government does with the resources that are released by the aid projects. However, the presence of fungibility, coupled with the difficulties that governments face in reallocating resources, may lead to a nonoptimal allocation of resources when donor funding is volatile.

For example, suppose that a donor gives aid to a country for primary care. Also suppose that the preferences of the donor and the recipient are not the same—the recipient does not want to increase primary care expenditures by as much as the donor does. The minister of finance is likely to argue that, because primary care is already funded from outside allocations, the government's budget will be directed only toward activities that are not receiving donor funding (secondary and tertiary care, for example). Ultimately, if donor aid is fully fungible, the final composition of expenditures (with both government and donor funding) may be exactly the same as if the government had received the resources as budget support and been allowed to make its own allocation decisions.

In this case, full fungibility may result in the optimal allocation of resources (several health subsectors are fully funded through a combination of donor aid and

government funding) from the government's perspective, but not necessarily from the donor's perspective. Problems arise, however, even when donor aid is fungible, because donor resources are also volatile. When donors stop funding a project or even decrease funding levels, recipient countries find it difficult to transfer resources on short notice away from one subsector (such as higher-level care) to another (such as primary care). Budget reallocations can be asymmetrical: that is, it may be easy to increase expenditures to secondary and tertiary care (when resources have been released through aid funding of primary care expenditures), but cutting these expenditures may be difficult. This is particularly the case because higher-level care providers in the public sector have strong medical associations, are located mostly in urban centers where it is easier to get the government's attention through protests and other means, and tend to disproportionately benefit the voting middle class. Thus, recipient countries may end up, at least in the short run, with a nonoptimal allocation of resources—in this case overspending on higher-level care and underspending on primary care when the aid diminishes.

The fungibility and volatility of donor aid, combined with the inability of recipient governments to rapidly reallocate resources, can therefore lead to a result opposite from what either donor or recipient intended. In this example, the donor's objectives were for the country to expand expenditures in primary care, and the recipient country wanted to maintain primary care at its original level. However, after the donor pulled out, neither objective was achieved: primary care spending declined, and a nonoptimal allocation of resources resulted.

There is little analysis in the literature about the impact of fungibility on health-specific aid. Empirical studies that have estimated the degree of fungibility at the country level have examined how changes in total foreign aid affect total public expenditures, how categorical aid affects the targeted categories of expenditures, whether aid is fungible among public expenditure categories, and whether aid reduces a country's own revenue effort (Pack and Pack 1990, 1993, 1996; Feyzioglu, Swaroop, and Zhu 1997; Clements and others 2004). More recently, Devarajan, Rajkumar, and Swaroop (1999) found that governments in Africa do not spend all sectoral aid in the targeted sector, nor do they treat aid as merely budgetary support. They also found that the degree of fungibility could be partially explained by the importance of a particular donor and its aid level in a country. The larger the number of donors and the smaller the importance of aid in government expenditures, the more likely aid will be fungible.

Empirical analysis prepared for this study confirms that donor aid for health is fungible. The results indicate that the domestic resources diverted from the health sector as a result of the fungibility of aid would be significant. A 10 percent increase in off-budget donor funding generates a 0.87 percent reduction in domestically funded government health expenditures.<sup>11</sup> Taking the mean values of \$19 per capita for domestically financed health expenditure and \$1 per capita for off-budget donor funding for health, the regression results imply that a \$1 dollar increase in

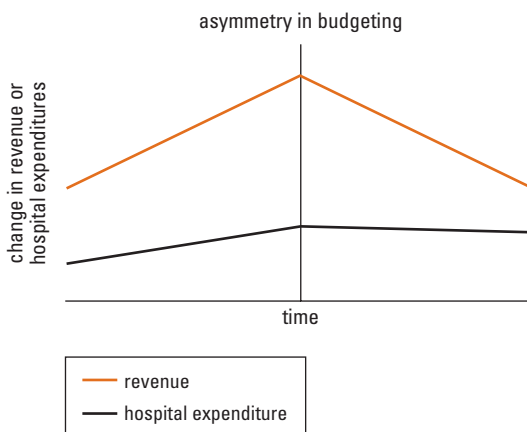
off-budget donor funding leads to \$1.65 dollar decrease in the allocation of government resources to health, holding everything else constant.<sup>12</sup>

A second important component necessary to explain the results of donor funding on child and maternal mortality is asymmetry in budgeting. To test the asymmetry hypothesis, the ratio of a change in hospital expenditures to changes in revenues was analyzed for a set of 61 countries (763 observations) over the period 1980–2001.<sup>13</sup> The hospital expenditures and revenues are all expressed in terms of percentages of GDP. These ratios are then divided into two groups, one with increasing revenue relative to the previous year (group 1) and the other with decreasing revenue relative to the previous year (group 2). A comparison of the mean values of these ratios by group shows evidence that revenue is significantly higher in group 1 (0.33) than in group 2 (0.04). Hospital expenditures respond in a more moderate way to a decreasing resource envelope than to an increasing resource envelop (figure 4.7).

Similar results are found at the country level. In Lesotho between 1984 and 1988, government health expenditures on hospitals maintained an increasing trend as a percentage of GDP, even though domestic revenues were decreasing (figure 4.8). To borrow a term from labor economics, hospital expenditure data reflects “downward stickiness”—resistance to decreasing beneath a certain level in response to declines in domestic revenues—during this time period. The same pattern was observed in Ethiopia, especially for the period from 1989 to 1992 (figure 4.9).

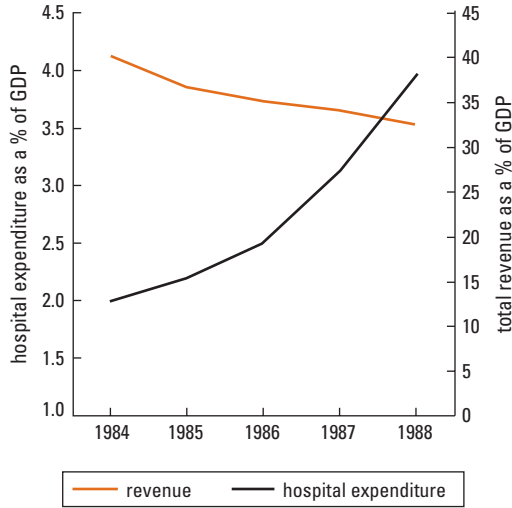
In addition to the effect of fungibility on the composition of spending, the specific form of aid (for example, grants as opposed to loans) can affect domestic revenue mobilization efforts. A recent study by Clements and others (2004) found

**FIGURE 4.7** Model of government revenue and hospital expenditures over time



Source: Staff estimates from IMF and World Bank data.

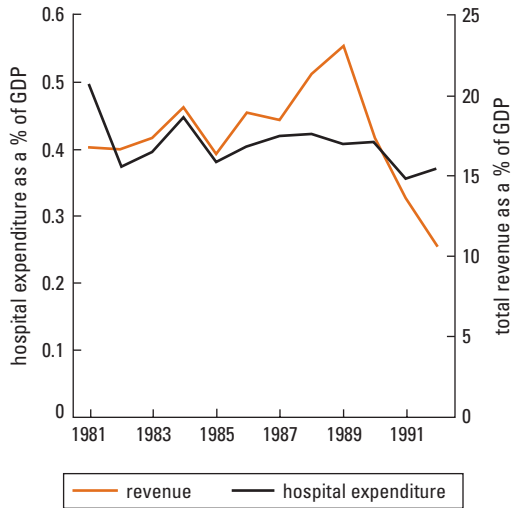
**FIGURE 4.8 Trends in domestic revenue and hospital expenditures in Lesotho, 1984–8**



Source: Staff estimates based on IMF 2001.

Note: Domestic revenues are total revenues (net of grants) as a percentage of GDP.

**FIGURE 4.9 Trends in domestic revenue and hospital expenditures in Ethiopia, 1981–92**



Source: Staff estimates based on IMF 2001.

Note: Domestic revenues are total revenues (net of grants) as a percentage of GDP.

that increases in grants to countries with weak policies and institutions resulted in a decline in total domestic revenue efforts. Thus, increases in grants to these countries do not necessarily imply net increases in resources available for expenditures. However, loans were not found to have a deleterious effect on domestic revenue mobilization. Thus, in addition to institutional arrangements, which have consistently been an important factor in aid effectiveness, and the effects of fungibility on expenditure composition, the form of aid could have important implications for domestic revenue efforts.

### *Absorptive capacity*

Large (actual and promised) increases in health aid to low-income countries have raised the question of whether countries can use these new aid flows effectively. Absorptive capacity has macroeconomic, budgetary management, and service delivery dimensions (table 4.2).

Increased aid has important implications for macroeconomic management. There are potential impacts on exchange rates, inflation, import-export balances, overall competitiveness (Dutch disease), aid dependency, domestic revenue mobilization, and future recurrent cost generation. If aid flows are off budget, they can result in corruption and substitute donor priorities for country priorities. There may not be sufficient human resources, physical infrastructure, or managerial capacity in the country to use funds effectively, and resources that are both in short supply

**TABLE 4.2 Constraints to absorbing more external resources**

	<b>Macro</b>	<b>Institutional</b>	<b>Physical and human</b>	<b>Social, cultural, and political</b>
<b>Macro/national government</b>	<ul style="list-style-type: none"> <li>• Debt sustainability</li> <li>• Competitiveness, Dutch disease</li> </ul>	<ul style="list-style-type: none"> <li>• Monetary and fiscal policy instruments</li> <li>• Exchange rate management</li> </ul>	<ul style="list-style-type: none"> <li>• Administrative, management, planning skills, trained technicians, sector specialists</li> </ul>	<ul style="list-style-type: none"> <li>• Stable national political institutions, power-sharing mechanisms, social stability</li> </ul>
<b>Fiscal instrumental/ allocative mechanisms</b>			<ul style="list-style-type: none"> <li>• Sector management skills</li> <li>• Connectivity and communications networks</li> </ul>	<ul style="list-style-type: none"> <li>• Cultural norms, weak institutions, power-sharing mechanisms</li> </ul>
<b>Service delivery/ local government</b>			<ul style="list-style-type: none"> <li>• Road accessibility, water control, geography</li> <li>• Local government skills and capacity</li> </ul>	<ul style="list-style-type: none"> <li>• Cultural norms; ethnic, caste, class relations</li> <li>• Local power structures</li> </ul>

Source: World Bank 2004a.

and critical for effective service delivery may be diverted from other important activities or simply be overwhelmed, creating implementation bottlenecks. Additional burdens are imposed on countries through donors' cumbersome reporting and administrative requirements.

Supply and demand constraints in the health sector can also be obstacles for countries to effectively employ large increases in health resources. As shown in table 4.3, these constraints can occur at all levels of service delivery and governance (Hanson and others 2001). Additional funding alone is not sufficient for overcoming structural weaknesses.

A study for the High Level Forum 2004 held in Abuja, Nigeria (Foster 2005a) showed that for the 14 countries studied, concerns about absorptive capacity frequently reflected issues of governance and accountability, disbursement problems as a consequence of procedural requirements intended to address those concerns, and public financial management issues in general. In some cases, governance and expenditure management constraints are so pervasive that major reforms need to precede or accompany increased funding (Cambodia, Tajikistan). In other cases, government procedures are overly centralized and bureaucratic and need to be reformed to permit available funding to be spent (Benin, Burkina Faso).

Addressing public expenditure management and civil service reforms requires action not only by the health ministry, but by central authorities as well. Furthermore, coordinated action by government has to be mirrored by coordination within the donor agency to support both macro and sectoral reforms. Donors' procedures for project or pooled funding are usually part of the problem, because they not only cause low disbursement, but also divert capacity away from delivering services toward satisfying the donors' demand for meetings, field trips, reports, accounts, and audits. By absorbing the capacity of financial management staff, donors' procedures also get in the way of effective government action to address the systemic weaknesses that make parallel procedures necessary.

### **Recent efforts to revamp aid**

Concerns regarding aid effectiveness have generated an intense global debate, as evidenced by the volume of literature on the subject (Burnside and Dollar 1997; Collier and Dollar 1999; Collier and Hoeffler 2002; Foster and others 2003; Clemens, Radelet, and Bhavnani 2004; Sagasti, Bezanson, and Prada 2005). These concerns have also led to some actions at the international level, such as the Paris Declaration on Aid Effectiveness, as well as efforts specific to the health sector, such as the strategy of sectorwide approaches.

#### *The Paris Declaration on Aid Effectiveness*

In March 2005, in the Paris Declaration on Aid Effectiveness, the ministers of developed and developing countries and the heads of multilateral and bilateral

**TABLE 4.3 Constraints to improving access to health interventions**

<b>Level of constraint</b>	<b>Type of constraint</b>	<b>Likelihood of additional funds to help overcome constraints</b>
<b>Community and household level</b>	Lack of demand for effective interventions	High
	Barriers to use of effective interventions (physical, financial, social)	High
<b>Health services delivery level</b>	Shortage and poor distribution of appropriately qualified staff	High
	Weak technical guidance, program management, and supervision	High
	Inadequate drugs and medical supplies	High
	Lack of equipment and infrastructure, including poor accessibility of health services	High
<b>Health sector policy and strategic management level</b>	Weak and overly centralized system for planning and management	Low
	Weak drug policies and supply system	Medium
	Inadequate regulation of pharmaceutical and private sectors and improper industry practices	Medium
	Lack of intersectoral action and partnership between government and civil society	Low
	Weak incentives to use inputs efficiently and respond to user needs and preferences	Low
	Reliance on donor funding that reduces flexibility and ownership	Low
	Donor practices that damage country policies	Low
<b>Public policies cutting across sectors</b>	Government bureaucracy (civil service rules and remuneration, centralized management system, civil service reforms)	Low
	Poor availability of communication and transport infrastructure	High
<b>Contextual and environmental characteristics</b>	Weak governance and overall policy framework	Low
	Corruption, weak government, weak rule of law and enforceability of contracts	Low
	Political instability and insecurity	Low
	Low priority attached to social sectors	Low
	Weak structures for public accountability	Low
	Lack of free press	Low
	Climatic and geographic predisposition to disease	Low
Physical environment unfavorable to service delivery	Low	

Source: Based on Hanson and others 2001.

development institutions agreed to emphasize the need for improvements in ownership, harmonization, alignment, results, and mutual accountability in aid effectiveness. Beyond the rhetoric, the most significant result of the High Level Forum on Aid Effectiveness was the establishment of specific goals and measurable targets regarding aid delivery. The indicators of progress to be measured in each country and monitored internationally are shown in table 4.4.

Establishing targets on ownership, harmonization, managing for results, and mutual accountability between donors and recipient countries is most important. The Paris Declaration on Aid Effectiveness is a good step in this direction. But more efforts are required to overcome problems of ownership and predictability of financing, which is necessary for the sustainability of health financing, fungibility of aid, and the effectiveness of aid and government expenditures in achieving the outcomes envisioned in the Millennium Development Goals. In particular, additional efforts and more ambitious targets need to be established for “aid flows [that] are aligned to national priorities” (goal 3), “more predictable aid” (goal 7), and the “use of common arrangements” (goal 9).

### *Coordinating donor funding through sectorwide approaches*

To better coordinate donor funding to support a broad government program, many countries have adopted sectorwide approaches. This strategy seeks to address the limitations of project-based forms of donor assistance, to ensure that overall health reform goals are met, to reduce large transaction costs for countries, and to establish genuine partnerships among donors and recipients wherein both have rights and responsibilities. Sectorwide approaches also explicitly recognize the need to relate health sector changes to new aid instruments, macroeconomic and public sector management, poverty reduction, and achievement of the Millennium Development Goals (Cassels 1997). A key aspect of the sectorwide approach is to improve a country’s overall policy-making processes and budget and public expenditure management by capturing all funding sources and expenditures and putting resource allocation decisions into a medium-term budget and expenditure framework based on national priorities.

The core elements of a sectorwide approach are as follows:

- The government is in the driver’s seat.
- The partnership between development partners and government results in a shared vision and priorities for the sector.
- A comprehensive sector development strategy reflects all development activities to identify gaps, overlaps, and inconsistencies. The entire sector is considered when conducting sector analysis, appraisal, monitoring, and evaluation.
- An expenditure framework is developed to clarify sector priorities and guide all sector financing and investment.
- Partnering across development assistance agencies reduces transaction costs for government (McLaughlin 2003; 2004).

**TABLE 4.4 Indicators of progress in the Paris Declaration on Aid Effectiveness**

Goal	Indicator	Target for 2010 <sup>a</sup>
	<b>Ownership</b>	
1	Partners have operational development strategies—number of countries with national development strategies (including poverty reduction strategies) that have clear strategic priorities linked to a medium-term expenditure framework and reflected in annual budgets.	<b>At least 75% of partner countries</b> have operational development strategies.
	<b>Alignment</b>	
2	Reliable country systems—number of partner countries that have procurement and public financial management systems.	<b>(a) Half of partner countries</b> move up at least one measure (i.e., 0.5 points) on the PFM/CPIA scale of performance. <b>(b) One-third of partner countries</b> move up at least one measure (i.e., from D to C, C to B, or B to A) on the four-point scale used to assess performance for this indicator.
3	Aid flows are aligned on national priorities—percentage of aid flows to the government sector that is reported on partners' national budgets.	<b>Halve the gap</b> —halve the proportion of aid flows to government sector not reported on government's budget(s) (with at least 85% reported on budget).
4	Strengthen capacity by coordinated support—percentage of donor capacity development support provided through coordinated programs consistent with partners' national development strategies.	<b>50% of technical cooperation flows</b> are implemented through coordinated programmes consistent with national development strategies.
5a	Use of country procurement systems—percentage of donors and of aid flows that use partner country procurement systems that either (a) adhere to broadly accepted good practices or (b) have a reform program in place to achieve these.	<b>Countries (a)</b> <b>All donors</b> use partner countries' procurement systems. <b>A two-thirds reduction</b> in the % of aid flows to public sector not using partner countries' procurement system. <b>Countries (b)</b> <b>90% of donors</b> use partner countries' procurement system. <b>A one-third reduction</b> in the % of aid flows to public sector not using partner countries' procurement system.

*(continues)*

**TABLE 4.4 Indicators of progress in the Paris Declaration on Aid Effectiveness (continued)**

Goal	Indicator	Target for 2010 <sup>a</sup>
5b	Use of country public financial management systems—percentage of donors and of aid flows that use partner country public financial management systems that either (a) adhere to broadly accepted good practices or (b) have a reform program in place to achieve these.	<p><b>Countries (a) (PFM/CPIA of 5 or above)</b></p> <p><b>All donors</b> use partner countries' PFM systems.</p> <p><b>A two-thirds reduction</b> in the % of aid flows to the public sector not using partner countries' PFM systems.</p> <p><b>Countries (b) (PFM/CPIA of 3.5 to 4.5)</b></p> <p><b>90% of donors</b> use partner countries' PFM systems.</p> <p><b>A one-third reduction</b> in the % of aid flows to the public sector not using partner countries' PFM systems.</p>
6	Strengthen capacity by avoiding parallel implementation structures—number of parallel project implementation units per country.	<b>Reduce by two-thirds</b> the stock of parallel project implementation units (PIUs).
7	Aid is more predictable—percentage of aid disbursements released according to agreed schedules in annual or multiyear frameworks.	<b>Halve the gap</b> —halve the proportion of aid not disbursed within the fiscal year for which it was scheduled.
8	Aid is untied—percentage of bilateral aid that is untied.	<b>Continued progress over time.</b>
	<b>Harmonization</b>	
9	Use of common arrangements or procedures—percentage of aid provided as program-based approaches.	<b>66% of aid flows</b> are provided in the context of program-based approaches.
10	Encourage shared analysis—percentage of (a) field missions and/or (b) country analytic work, including diagnostic reviews that are joint.	<p>(a) <b>40% of donor missions</b> to the field are joint.</p> <p>(b) <b>66% of country analytic work is joint.</b></p>
	<b>Managing for results</b>	
11	Results-oriented frameworks—number of countries with transparent and monitorable performance assessment frameworks to assess progress against (a) the national development strategies and (b) sector programs.	<b>Reduce the gap by one-third</b> —Reduce the proportion of countries without transparent and monitorable performance assessment frameworks by one-third.
	<b>Mutual accountability</b>	
12	Mutual accountability—number of partner countries that undertake mutual assessments of progress in implementing agreed commitments on aid effectiveness, including those in this Declaration.	<b>All partner countries</b> have mutual assessment reviews in place.

Source: Authors, based on Paris Declaration on Aid Effectiveness, September 2005, Table III (Indicators of Progress)

Note: PFM = public financial management; CPIA = country policy and institutional assessment.

a. Some of the targets require confirmation by OECD DAC member countries.

Sectorwide approaches are in various stages of development and implementation, and few fully conform to the basic specifications outlined above (Jefferys, Walford, and Pearson 2003). At this point in their evolution, sectorwide approaches are also heavily affected by new instruments, such as poverty reduction support credits, the IMF's Poverty Reduction Grant Facility, and medium-term expenditure frameworks. The following conclusions can be drawn from several recent evaluations of the effectiveness of sectorwide approaches in achieving the health Millennium Development Goals and other health system reforms (World Bank 2000; Foster and others 2000; Jefferys, Walford, and Pearson 2003; Hill 2002):

- Sectorwide approaches are more relevant in low-income countries than in middle-income countries. Middle-income countries rely less on external agencies for financing; have more mature institutions and multiple agencies involved in financing, purchasing, and providing care; and in some cases have active reform programs affecting several types of institutions.
- There is often a lack of systematic analysis of implementation capacity. More could have been done to analyze and fix implementation weaknesses. The tendency for sector programs to be overly ambitious in relation to existing capacities, a corollary of their complexity, was noted.
- Indicators used to monitor and evaluate policy changes are often poorly identified or are not broken into annual indicators for assessing the rate of progress. Other programs have tended to include too many indicators, diluting the focus on key priorities.
- Sectorwide approaches are most effective when there is high-level commitment from the government and when the health sector strategy is linked to a credible medium-term budget process and civil service reform. Links to civil service and local government reforms and budget reform are still weak.
- An annual review that is focused on the important problems and the feasible solutions is important.
- Donors as a group need to focus on delivering coherent and consistent messages, thereby giving priority to essentials.
- Pressure for immediate results must be tempered by realism to avoid disappointment and damage to programs.
- Overloaded line ministries have to achieve and maintain high levels of momentum and productivity, especially when transaction costs have increased as a result of initial sectorwide negotiations. There is danger of burn out.

Results seem even less encouraging for linking the sectorwide approach to poverty reduction strategy papers and medium-term expenditure frameworks through the budget cycle and for including the approach in donor aid from disease- and intervention-specific programs. A review of experiences with sectorwide

approaches in several low-income countries reveals key issues with which countries are grappling. The general view is that, although sectorwide approaches, poverty reduction strategy papers, and health plans may be aligned in terms of outcome indicators and overall objectives, there are large divergences in the resources required and the actual amounts reflected in medium-term expenditure frameworks, as in the cases of Cambodia and Uganda (Hill 2002). Chapter 6 discusses the links across different instruments in more detail.

In considering how to fit donor funds allocated to disease- and intervention-specific programs into sectorwide approaches in Uganda, it was reported that global initiatives have had a destabilizing impact, particularly in light of sectoral expenditure ceilings set by the Ministry of Finance. Inflows from the global initiatives are also substantial—likely to be more than \$60 million next year—three-quarters of total projected donor spending on health (\$80 million). The impact of introducing global initiatives part way through a sector program was also an issue for Bangladesh, Cambodia, Ghana, Mozambique, Senegal, and Tanzania (where only GFATM monies for malaria have been programmed into the medium-term expenditure framework) (Hill 2002).

In most of the countries examined, individual donors still undertake separate evaluations for bilateral projects and programs, even in countries that have had a sectorwide approach for more than five years. Over time this may be less of an issue, as fewer projects fall outside the sectorwide approach. In Tanzania and Zambia, evaluations are timed to coincide with the Joint Annual Reviews to reduce the burden. In Cambodia, which has yet to fully embark on the sectorwide approach, there are still multiple reporting, monitoring, accounting, and review systems for different donors.

## *Endnotes*

1. Preliminary estimates show that official development assistance reached \$78.6 billion in 2004. See World Bank 2005a.

2. The increase in official development assistance in 2003 is tightly linked to concerns of security and influenced by amounts earmarked to the start of reconstruction of Iraq and allocations to Pakistan, Colombia, and Afghanistan.

3. Spain, France, Italy, and Germany all had deficits of over 4 percent of their respective GDP in 2004 and, except for France, were all substantially below the 0.33 percent goal as of June 2004. The United State's deficit with respect to GDP was over 6 percent in 2004, and its ODA contribution was 0.12 percent of GNI that year. Japan's deficit for GDP was over 9 percent in 2004. The demographic transition in the European Union, increasing costs due to the rising costs of oil, and the accession into the European Union of new countries that have difficulties meeting increasing aid commitments also contribute to the uncertainty of ODA commitments.

4. For details on the IFF and on the proposed pilot IFF for Immunization (the IFFIm), see World Bank and IMF 2005.

5. These estimates by Nissanke (2003) assume that 80 percent of proceeds are used for development assistance and the rest are kept by rich countries. It is also assumed that volume of wholesale transactions is reduced by 5 percent to 15 percent as a result of the tax.

6. The other component is direct portfolio equity investments, which are a rather small part (about 5.4 percent of net equity flows) and unlikely to increase in the near future.

7. In 1990 East Asia accounted for 42 percent and Latin America for 32 percent of total net private capital flows (Sagasti, Bezanson, and Prada 2005). Between 1975 and 1995, 20 developing countries accounted for roughly 40 percent of total private capital flows, and this high level of concentration doubled to 80 percent in 1999, a level that has continued in recent years.

8. Protesters in Bolivia, Ecuador, and other countries claim that remittances of profit by multinationals are eventually larger than the resources invested by such companies.

9. These World Bank estimates are based on personal communication with Catherine M. Michaud at the Harvard Initiative for Global Health.

10. In technical terms a country meets the solvency condition if the present discounted value of the ratio of primary deficits to GDP is, at some defined future time, equal to the negative of the initial level of debt to GDP, that is, a government with debt outstanding must anticipate, sooner or later, to run primary budget surpluses in order for fiscal policy to be sustainable.

11. A fixed-effect generalized least squares model, similar to that of Pack and Pack (1990, 1993, 1996), was run. Model selection between random effect and fixed effects was based on the Hausmann test. Overall goodness of fit is 69.9 percent. Note that the regression does not include other control variables, such as literacy, under-five mortality rate, and maternal mortality ratio, which may lead to omitted variable bias. However, the omitted variable bias generated by the absence of these control variables is likely to bias the coefficient of donor funding off budget toward zero. This is because the coefficient on omitted under-five mortality is likely to be positive (the higher the under-five mortality rate, the more likely the government will increase spending on health), and the covariance between under-five mortality and donor off-budget health support is positive (donors will likely increase their support if the country has high under-five mortality rate).

12. Another related issue is whether there is fungibility within the health sector, independent of whether donor funding is fungible across sectors. In other words, is there a reallocation of domestic resources between primary care and higher-level care, for example, as a reaction to donor funding? The data used here do not permit analysis of this in any formal way. However, plotting time series data for some countries such as Ethiopia seems to indicate that this type of logical behavior by government is possible.

13. Revenues are domestic tax and nontax revenues net of grants as a proportion of GDP.

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