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# Global Health Initiatives and Aid Effectiveness in the Health Sector

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## *I. Introduction*

Development assistance to health has increased dramatically in the last decade. The overall increase in official development assistance (ODA) facilitated by the Millennium Development Goals, an increased prioritization of the social sectors in ODA and the urgency of the rapidly spreading HIV/AIDS pandemic all contributed to this increase. The health sector also is the only sector that has seen innovative development finance implemented on a significant scale, most importantly in the form of aid disbursed through global health initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and UNITAID.

Aid to health has played an important role in the provision of health services in developing countries. Yet, the provision of such services remains a quintessential task of national governments, and donors cannot substitute for strong national health systems in the long run. Global health initiatives are characterized by high selectivity of funding and a strong emphasis on results, and by a prioritization of global public goods. Both of these characteristics raise questions on their impact on national health systems. Funding that is selective and tightly linked to results may raise the administrative burden on health systems, may not be predictable and thus may undermine national budgeting processes, for example. A prioritization based on global public goods on the other hand will not reflect national health priorities and therefore has to be careful to support rather than undermine the broader health system. This working paper will assess the impact of global health initiatives on national health systems in light of these potential pitfalls.

The paper proceeds as follows. Section II discusses the state of global health, financing needs and current aid to health. Section III introduces innovative financing mechanisms in the health sector and the global health initiatives that are mostly responsible for disbursing them. Section IV assesses their impact on national health systems in light of the aid effectiveness agenda. Section V concludes.

## *II. The State of Global Health*

Despite significant progress over the 20th century, there are large unmet health needs in developing countries. To fill this gap, substantial financing will be needed to improve national health systems and access to health services. While this is primarily a responsibility of national governments – donors are not well placed to finance the large recurring costs of health interventions – development assistance for health does play an important role, in particular in the fight against communicable diseases.

[1] I would like to thank David Woodward and Diana Alarcon for extensive comments on earlier versions of this text. All errors remain mine.

*Global Health Needs*

Health for all is considered both a basic human right and essential for social and economic development. Health is central to human happiness, and it contributes to growth and development as healthy populations are more productive, live longer and save more. Member states of the World Health Organization have long recognized the importance of health for all and have committed to providing universal access to health services without causing hardship for individuals when paying for these services (WHO 2010a).

The twentieth century has seen dramatic improvements in health. Mortality rates fell and life expectancy rose steadily and across all regions. Remarkably, the gap in life expectancy between developed and developing economies decreased at the same time. Rising health equality in the second half of the twentieth century thus stands in marked contrast with increasing global inequalities in incomes (Jamison 2006). Nonetheless, and despite these improvements and the political commitment to health for all at the global level, most low income countries and some middle income countries still face severe constraints in providing universal access to health services. They suffer from a mismatch between the massive health needs of their growing and often poor populations and insufficient resources to fund their health systems. This mismatch has been exacerbated in recent years by a small number of communicable diseases, most notably HIV/Aids, as well as the increasing prevalence of non-communicable diseases in developing countries. The HIV/Aids crisis in particular overburdened health systems in severely affected countries that had already been weakened by insufficient investments during the period of structural adjustment and the increased emigration of health workers (WHO 2009a).

As a result, and despite significant progress since the year 2000, the world is unlikely even to reach the health-related Millennium Development Goals (MDGs), let alone fulfil broader health needs, unless efforts are accelerated significantly. The eight goals are interdependent of course, and all of them have repercussions on health. But Goals Four to Six target health outcomes explicitly. In Goal Four, the global community committed to reducing child mortality. While regions such as Northern Africa and Eastern Asia are on track to achieve the target indicator and reduce under-five mortality rate by two thirds by 2015, Sub-Saharan Africa and South Asia are much less likely to do so. With one in eight children dying in Sub-Saharan Africa before the age of five, the disparity with other developing regions has actually widened. The biggest gaps remain in Goal Five on maternal health. Maternal mortality dropped by 34 per cent between 1990 and 2008, but the targeted reduction by three quarters by 2015 will in all likelihood not be achieved. Maternal deaths are concentrated in Sub-Saharan Africa and Southern Asia, which account for 87 percent of the global total (United Nations 2011b). Most progress has been made in tackling major diseases, and HIV/Aids, malaria and tuberculosis in particular. This reflects major efforts and investments by the international community and national governments, which have succeeded in reducing deaths from malaria, tuberculosis and HIV/Aids, in slowing new infections and in expanding treatment for HIV/Aids.

*Financing Needs for Global Health and the Funding Gap*

Improvements in health outcomes depend on the interplay between economic growth, technological and scientific progress, and institutional changes that translate these advances in public health knowledge into reduced mortality (Jamison 2006). Poverty accounts for many of the underlying factors of ill health in developing countries – undernutrition, lack of access to safe water and sanitation, poor living and working conditions, and low education levels. These social determinants of health are the most powerful explanation for remaining inequalities in health and will improve in tandem with equitable economic growth only (Labonté and Schrecker 2009).

Poverty reduction is not a sufficient condition for improving health however. Technical progress and the discovery of affordable treatments of disease and preventive interventions such as vaccinations, as well as their delivery through functioning health systems play an equally important role. Development assistance for health has typically – and justifiably from a sector-perspective – focussed on these latter aspects, with varying degrees of emphasis on technological fixes and health system support. And while there are disagreements over the relative merits of horizontal sector-wide support or more targeted and technology-driven interventions (disagreements that are of particular relevance in the discussion over innovative finance in health), the importance of functioning health systems for sustainably improving health and achieving the Millennium Development Goals is undisputed.

The World Health Organization defines health systems as "all organizations, people and actions whose primary intent is to promote, restore or maintain health" (WHO 2007). They thus include not only public, but also private providers of health care, such as faith-based institutions. The common purpose of a health system is to improve overall health and equity in health, while being responsive to health needs, financially fair, and efficient in its resource use.

Six key building blocks of national health systems can be identified – health system financing, a health workforce of sufficient size and quality, access to drugs and other essential supplies, reliable health information systems, service delivery and governance (WHO 2007). Low income countries and their development partners have to direct their efforts at all these levels, ensuring for example that their policies do not undermine the retention of public health workers or access to affordable drugs at the international level, or render the governance structure of the health system more complicated.

Shortfalls in financing are therefore an important, but not the only bottleneck to be addressed in order to improve health outcomes. Nonetheless, the financing gap is wide, and is reflected in extreme global inequalities in current spending on health. Low and middle income countries, which have 84 percent of the global population and 92 percent of the global disease burden, account for only 12 percent of global health spending (Schieber et al. 2006). The mobilization of additional resources will thus be crucial to address these imbalances. While this is primarily a responsibility of national governments, aid to health will undoubtedly play a part in this mobilization.

According to recent estimates, low income countries spend on average $25 per capita on health annually, and government health expenditure amounts to $12 or just below

half of total spending. Private expenditure represents an additional $13 per capita, and most of this is out-of-pocket spending at the point of service delivery. External assistance, which funds both private and public expenditure, amounts to $6 on average for low income countries, and represents less than a quarter of total spending.

Despite the prominence and high profile of development assistance for health, the vast majority of resources are thus raised domestically (Taskforce 2009a). Since expenditures for health are overwhelmingly of a recurrent nature, financing out of domestic budgets, which is a much more predictable and less volatile source of funding, is the preferable mode. Human resources alone account for half of the total spending on health in any given year (WHO 2010a), and given that donors are often unwilling to fund such expenses, the majority of resources must come from domestic sources.

A precise quantification of the financial needs to address the remaining gaps in global health is difficult, but they are generally considered to be big. In a study carried out for the Taskforce on Innovative International Financing for Health Systems, the WHO finds that merely achieving the health-related MDGs - a much more limited objective than fulfilling health needs – would require an additional $29 per person per year of health sector spending in low income countries by 2015. In total, an additional $251 billion would have to be raised between 2009 and 2015 (Taskforce 2009a). 40 percent of the additional funds would finance capital investments, while 60 percent represent the higher recurrent costs of paying for an expanded health work force and increased medical supplies and drugs.

The funding gap is biggest in Sub-Saharan Africa, which faces additional costs of $150 billion, or 60 percent of the total. In terms of specific programmes, the spending requirements are biggest in supporting health systems (75 percent of the total additional costs), and infrastructure, transport and equipment, as well as human resources in particular, which account for 22 percent of total additional spending needs. Additional spending needs on specific diseases on the other hand are comparatively low, which reflects the current emphasis and priorities of donors on vertical interventions – that is on specific diseases or on selected interventions across countries.

*Current Sources of Finance for Development Assistance for Health*

Health has become a key priority of international development cooperation in the last decade. In 2009, development assistance for health (including population and reproductive help) by members of the OECD Development Assistance Committee amounted to $12.47 billion, which represents 11.4 percent of total bilateral development assistance. Multilateral donors prioritize health even more and spend 15.3 percent of their aid on health. In total, commitments to development assistance for health amount to $19.9 billion (OECD 2011a). OECD statistics do not however paint a complete picture of external funds available for global health. They exclude bilateral donors that do not report their aid flows to the Development Assistance Committee, as well as most private funds – e.g. foundations and corporate donations. The Institute for Health Metrics and Evaluation attempts to track all global health resource flows and has estimated that total development assistance for health has

reached $25.2 billion in 2009. Private sources of funding account for 19 percent of the total (IHME 2010).

Bilateral, multilateral and private flows of aid for health have risen sharply in the last decade, driven to a large extent by the rise of disease-specific funds, and the global focus on combating the spread of HIV/AIDS. Bilateral and multilateral donors as reported by OECD have increased their spending from $3.9 billion in 2000 to $19.9 billion in 2009 (see Figure 1)[2]. In terms of the geographical distribution, Africa is the biggest recipient of development assistance for health. Approximately 40 percent of total aid for health went to the continent in 2009. This growth was driven predominantly by HIV/AIDS, which accounted for almost half of the total increase in aid for health between 2002 and 2009. Spending increases for malaria, the health workforce, basic health and medical care, and reproductive health each account for roughly 10 percent of the increase. Overall, 39.5 percent of aid for health went to HIV/AIDS in 2009 (Kates et al. 2011).

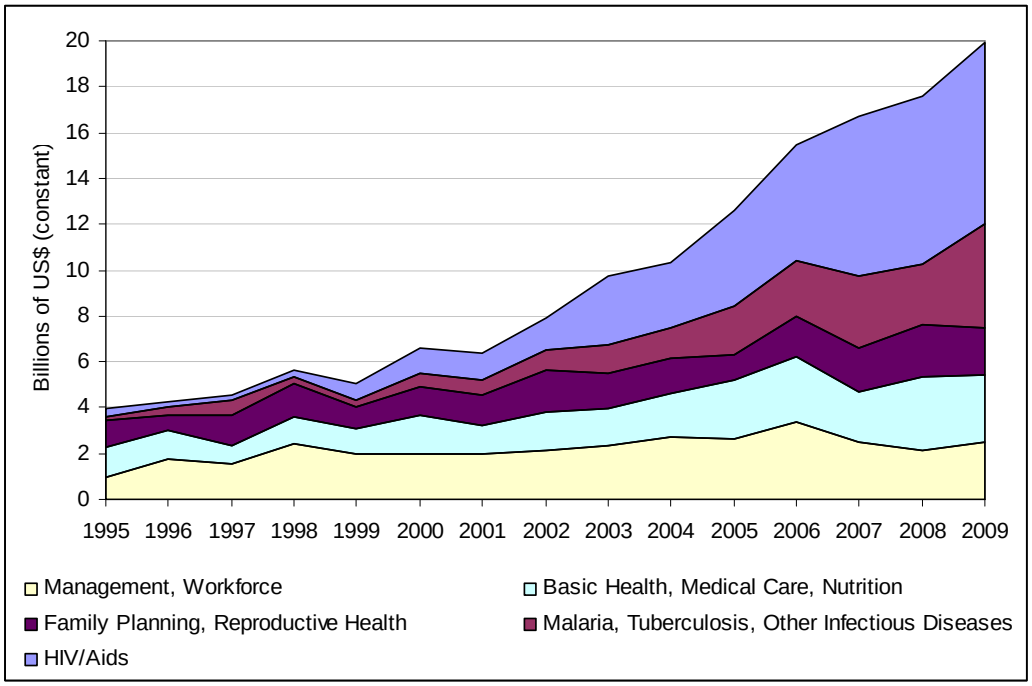
Additional resources raised in the fight against HIV/Aids and other high profile communicable diseases have largely been disbursed through institutions set up specifically for this purpose. These global health initiatives, most prominently the Global Fund to Fight Aids, Tuberculosis and Malaria, the Global Alliance for Vaccines and Immunization (GAVI Alliance), and UNITAID, are public-private partnerships that have raised and disbursed substantial amounts of aid for health, stemming from traditional bilateral aid, private sector and philanthropic sources and innovative financing mechanisms. Because they conceptually divide the health system into 'vertical slices' rather than horizontally by level of care, and because they focus their interventions predominantly on a few specific diseases, they are also often referred to as vertical funds.

The heavy focus of development assistance for health on HIV/AIDS and on communicable diseases more broadly does not match the actual disease burden in developing countries. While they are more prevalent than in high income countries, they still represent only a small percentage of the overall burden of disease. Measured in DALYs[3], HIV/Aids, tuberculosis and malaria account for 5.2 percent, 2.7 percent, and 4 percent of the total disease burden in low income countries respectively (WHO 2008). In comparison, diarrhoea alone represents 7.2 percent of DALYs, and perinatal and maternal conditions account for 14.8 percent. Non-communicable diseases, which are largely ignored by donors and draw less than three percent of overall aid to health (Nugent and Feigl 2010), represent almost a third of the disease burden.

[2] Extracted from OECD DAC Qwids Database, 13 December 2011; total health includes Health, Population Programmes and Reproductive Health

[3] DALY stands for disability-adjusted life years, and takes into account both premature death and disability caused by disease

Figure 1: Total ODA to Health, all Donors reporting to OECD




Source: OECD DAC ODA Statistics

Infectious diseases and pandemics have always been a priority in international development, and this prioritization is justifiable to some extent because their control is a regional or even global public good that would be underfinanced by national governments. HIV/AIDS in particular has been given special consideration because of its potentially unparalleled impact. The prioritization by donors becomes problematic however when it distorts national priorities rather than providing additional resources for financing the fight against HIV/AIDS. There is evidence that donor funds do not match national health priorities as expressed in poverty reduction strategies for example (MacKellar 2005). This problem is exacerbated when aid for health bypasses national budgeting and cannot be used to finance recurrent spending such as wages of health sector workers. On both accounts, the global health initiatives with their vertical operating model have been the subject of intense scrutiny.

### *III. Innovative Finance in Health*

Innovative development finance played an important role in the overall surge of development assistance for health. While it is overshadowed by traditional development assistance and philanthropic contributions in quantitative terms, there were large innovations in governance, administration, allocation and distribution of aid to health, most prominently through the global health initiatives. A critical characteristic of these initiatives is their vertical approach to health programmes – a focus on specific diseases and interventions, which has a long and partly successful tradition in addressing such specific causes, but which raises questions over their impact on health systems and broader health outcomes.

*Innovative finance mechanisms in health*

In purely quantitative terms, and in comparison to the overall surge in funds available for health aid, revenues raised by innovative finance play an important, yet still minor role. In the period between 2002 and 2011, they have raised a total of $ 5.5 billion[4] for health initiatives (United Nations 2011a). Using a classification the OECD has adopted in a recent mapping exercise (OECD 2011c), mechanisms are included that mobilize additional funding, have public sector involvement, and involve cross-border resource transactions.

The most important mechanisms in the health sector are the International Finance Facility for Innovation (IFFIm) and the Solidarity Levy on airline tickets, which have raised $ 3.4 billion and $ 1 billion respectively in this period. IFFIm is the largest initiative in financial terms. Set up in 2006, IFFIm securitizes long-term pledges from donor governments, issuing vaccine bonds in the capital markets to make large volumes of funds available immediately for GAVI programmes. Front-loading provides predictable funding for governments and vaccine producers. In contrast to IFFIm, the Solidarity Levy on Airline Tickets raises additional funds from a new source. It is currently implemented in nine countries, paid by individuals buying an airline ticket, and collected nationally through the air carriers. Its rate varies and is set by participating countries. France has pioneered the levy, introducing it in July 2006, and has raised € 544 million (up until December 2009, see OECD 2011c). 90 per cent of these funds are disbursed to UNITAID. Together with revenues from the remaining countries, the Solidarity Levy represents 70 percent of overall contributions to UNITAID (WHO 2010b).

On a smaller scale, advance market commitments for pneumococcal vaccines, the Affordable Medicines Facility for Malaria and Product(RED) account for between $ 200 million and 400 million each. Lastly, the OECD also counts Debt2Health swaps, IDA and IBRD loan and credit buy-downs as innovative finance. Together, they raised another $ 322 million (United Nations 2011a, OECD 2011c).

With the exception of debt buy-downs, all these funds are channelled into the three major and recent global health initiatives – the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and UNITAID. These global health initiatives have been a key driver of the surge in development assistance for health. They have been extremely successful in raising resources for targeted interventions on specific diseases, most notably HIV/Aids. The Global Fund to Fight Aids, Tuberculosis and Malaria alone has approved funding of $22.4 billion since its inception in 2002, and has, together with the GAVI Alliance, UNITAID and other public-private partnerships, drastically changed the aid architecture and governance in global health. In this sense, they constitute the most important innovation in global health and development assistance for health. Since innovative sources of finance in health are currently almost exclusively disbursed through them, the impact of innovative finance on aid and development effectiveness in health is thus closely tied to the vertical funds.

[4] Most of these resources are counted as part of Official Development Assistance for Health

*Vertical vs. Horizontal Approaches in Aid to Health*

Approaches to improving public health have long been characterized by a tension between vertical approaches, i.e. the targeting of specific diseases and limited interventions to achieve results in a priority area, and horizontal approaches that strengthen health systems. This tension goes back at least to the 1950s, when campaigns were conducted to eradicate smallpox (Mills 2005). It is reflected also in changing approaches to development assistance for health, where the pendulum between vertical and horizontal approaches has swung back and forth (Sridhar and Tamashiro 2009). This debate is important because poorly executed disease control programmes or vertical interventions can potentially harm health systems, and therefore not only undermine their own long term impact, but weaken broader health outcomes. Among the risks are a duplication of efforts, leading to inefficient facility utilization, gaps in care that leave unmet recipients' demand for basic health care services, and reduced capacity of state health systems to improve its own services when vertical interventions are externally funded. On the other hand, vertical programmes may well be justified when a disease is too rare for general health professionals to maintain the necessary specialist skills, when specific risk groups are targeted, or in the case of epidemic control (Unger et al. 2003).

The Alma Ata Declaration, adopted in 1978, declared health to be a fundamental human right, and this universal approach to promote and protect health for all led to a horizontal model of aid to health. Affordable and equitable access to health systems was seen as critical and therefore country health systems had to be supported and strengthened. The broader turn away from state provision of services in the period of structural adjustment soon weakened this consensus however. The imposition of user fees, increased use of private sector providers and competition, a focus on selective provision of cost-effective interventions and technical solutions rather than comprehensive care all became part of the policy package typically prescribed by donors (Lister 2008).

In this context, and in response to the impending crisis caused by the spread of HIV/AIDS in particular, large global health initiatives were launched to lead the fight against HIV/AIDS, tuberculosis and malaria, and to deliver vaccines to those in need. The sense of urgency and scepticism towards traditional aid modalities led to the embrace of a different, vertical model. It was to be evidence-based and guided by independent scientific review, and focus on quantifiable results, while the delivering institutions themselves would remain lean, transparent and include the private sector and civil society in their governing structure (Isenman and Shakow 2010). The importance of strong health systems to sustainable improvements in health remained undisputed, but took a back seat as a vertical and targeted approach became the dominant form of development assistance for health.

*The global health initiatives and innovations in aid to health*

The adoption of this vertical approach was a key precondition for tapping new sources of finance, and for attracting philanthropic donors in particular, which are very results-driven (Hardon and Blume, 2005). Indeed, the Global Fund, GAVI and similar programmes have managed to raise significant resources, largely from traditional donors, but also from philanthropy and from innovative sources.

*The Global Fund*

By far the biggest of the vertical funds is The Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM). Created in 2001 as an initiative of the United Nations and the G-8, the Global Fund has received more than $19 billion in contributions from donors between 2002 and 2010. Its funding stems overwhelmingly from traditional bilateral donors, accounting for 94 per cent of its total funding. The Gates Foundation contributed 3.5 per cent, while UNITAID, Product(RED) and Debt2Health account for 1.9 per cent of the Global Fund's budget (Global Fund 2010).

Table 1: Major Global Health Initiatives

| Major Global Health Initiatives | Focus of Operations and Modalities | Sources of Funding | Disbursement |
|---|---|---|---|
| Global Fund to Fight Aids, Tuberculosis and Malaria | **Funding proposals submitted by Country Coordinating Mechanism; selection by expert panel; implementation at the country level. Financing for HIV/Aids, tuberculosis, malaria programmes, and health system strengthening** | **$19 billion in contributions between 2002 and 2010; 94% from traditional bilateral funds, 3.5% from the Gates Foundation, 1.9% from innovative sources (UNITAID, Product(RED), Debt2Health)** | **The Global Fund disbursed US$ 15.6 billion for grants in 153 countries between 2002 and 2011[5]** |
| Global Alliance for Vaccines and Immunization (GAVI Alliance) | **Countries with GNI below $1.500 receive grants to improve immunization and access to vaccines; implementation by national authorities in cooperation with UN agencies** | **$3.3 billion (63%) from direct contributions (bilateral and others), $1.9 billion (37%) from innovative sources (IFFIm and AMC)** | **Total disbursements amounted to US$2.8 billion by the end of 2010** |
| UNITAID | **Global drug purchasing facility that uses its market power to lower prices of effective HIV/Aids, malaria and tuberculosis treatments** | **$1.3 billion total contributions, of which approximately 70 percent from Solidarity Airline Levy** | **Between 2006 and 2010, UNITAID disbursed $955 million to its partners** |

Sources: Global Fund (2010), GAVI Alliance (2010, 2011), WHO (2010b)

While its funding structure thus is relatively traditional, its governance and disbursement mechanisms certainly qualify it as an innovative aid model. The Global Fund is an independent organization governed by a board consisting of representatives from donor and recipient governments, civil society, the private sector and affected communities. It has a lean structure and small secretariat, and does not implement any programmes itself. Countries submit proposals for funding to the Global Fund through the Country Coordinating Mechanism (CCM), a country-level partnership on which key stakeholders are represented. Proposals are assessed and selected for funding by a technical expert panel. Once approved, the funds are paid out to the principal recipients, usually ministries of finance or health, or international

[5] Data obtained from the Global Fund website, see: http://portfolio.theglobalfund.org/en/DataDownloads/Index (12 January 2012)

agencies, which are nominated and overseen by the CCM, and which are responsible for implementation at the country level. An evaluation after two years determines whether targets have been met and funding should be continued for a second phase.

The Global Fund thus operates as a challenge fund, rewarding the best project proposals in a process of competitive tendering for a fixed amount of resources on a global level (Isenman et al., 2010). This allocation model is in line with two core principles of the Global Fund: ownership of programmes and a focus on performance. Disbursements are always based on country-based funding proposals to ensure national ownership, and the selection of proposals occurs at the global rather than the national level on the basis of their quality.

By the end of 2011, the Global Fund has approved grants and disbursed funds of a total value of $15.6 billion. 55 per cent of disbursements were made in Sub-Saharan Africa, followed by the East Asia and Pacific and the South Asia regions with 14 and 9 per cent respectively. In terms of diseases, the focus has been HIV/AIDS, which accounts for 55 per cent of total grants, 28 per cent were dedicated to malaria and 17 per cent to tuberculosis[6].

In November 2011, the Fund had to cancel its 11th funding window however, announcing that it will only fund projects already approved but will not issue new and additional grants until the end of 2013. This is due to sharply deteriorating funding outlook for the Global Fund itself, reflecting budgetary pressures in main donor countries.

*GAVI Alliance*

The GAVI Alliance was launched at the World Economic Forum in 2000, in response to deteriorating immunisation coverage rates in many developing countries, and aims to increase access to immunization in developing countries. It acts as a funding mechanism, providing predictable and sustainable resources for countries to adopt new vaccines, and also manages to lower global vaccine prices by aggregating demand and procurement and encouraging competition. As a private public partnership, GAVI's board is composed of representatives of donor and developing countries, multilateral institutions and the Gates Foundation, the vaccine industry and civil society. Similar to the Global Fund, the Alliance has a lean secretariat and no country or implementation structures. It provides funding for new and underused vaccines, immunisation services and health system strengthening based on eligible countries' proposals, and relies on partner agencies such as WHO, UNICEF and the World Bank for implementation support at the country-level.

In the period between 2000 and 2010, the GAVI Alliance has received $5.2 billion in cash from its donors. $2 billion come from bilateral donors, $1.2 billion from the Gates Foundation, and $1.9 billion from innovative sources of finance, overwhelmingly from the International Finance Facility for Immunization (IFFIm). Both IFFIm and Advanced Market Commitments (AMC) are also projected to raise

[6] Data obtained from the Global Fund website, see: http://portfolio.theglobalfund.org/en/DataDownloads/Index (12 January 2012); Health-system support is always attached to grants for one or more specific diseases

significant resources for the GAVI Alliance in the coming decade. Total AMC commitments up to 2020 amount to $1.5 billion and overall IFFIm commitments are $6.2 billion (GAVI Alliance 2010).

GAVI-eligible countries – those with a Gross National Income (GNI) per capita below $1,500 – submit funding proposals through an Interagency Coordination Committee (ICC), which has to be set up prior to receiving funding and consists of representatives from government and civil society as well as WHO and UNICEF. GAVI announces funding windows in new and underused vaccine support, immunisation services support and health system strengthening support. Countries can access these funds if they fulfil eligibility criteria which range from multi-year immunization plans and costing and financing analysis to coverage rates of specific existing vaccines in the case of funding proposals for the introduction of new vaccines. In contrast to the Global Fund, GAVI is therefore not a challenge fund, since its funding windows provide a de facto indicative allocation of funds based on the number of children in age cohorts in eligible countries (Isenman et al. 2010).

In its early years GAVI focused on new and underused vaccine support, and provided funding for three underused vaccines in particular: Hib (influenza type B), hepatitis B and yellow fever. This emphasis on introducing new vaccines in developing countries was critical in winning industry as a partner for GAVI (Hardon and Blume 2005). In addition, countries received immunisation services support (ISS). ISS funding has a 'reward' component, with $20 paid per additional child receiving diphtheria, tetanus and pertussis injections above the country's original target. From 2005, GAVI adjusted its priorities and, responding to criticism, put more emphasis on health system strengthening, through its health system strengthening support programme.

*UNITAID*

UNITAID is an international drug purchasing facility that was launched in 2006 to supply affordable medicines for HIV/Aids, malaria and tuberculosis for patients in low income countries. Founded by Brazil, Chile, France, Norway and the United Kingdom, it is now supported by 28 countries and the Gates Foundation. To achieve its goals, UNITAID relies on an innovative, global market-based approach in delivering affordable medicines. It uses its purchasing power to lower market prices of drugs of proven quality and to create sufficient demand for niche products with high public health benefits. The distribution of drugs is then handled by its implementing partner organizations such as the Global Fund and UN agencies. This contributes to its lean structure.

The majority of funding for UNITAID's interventions comes from a levy on airline tickets, which is a sustainable and predictable source of finance and in this sense integral to its operating model. Between 2006 and 2010, UNITAID received total contributions of $1.3 billion, of which approximately 70 per cent stem from the Solidarity Levy on Airline Tickets (WHO 2010b). Norway collects its contribution to UNITAID through a tax on $CO_2$ emissions. The remainder of the budget comes from bilateral contributions and from the Gates Foundation.

## *IV. Global Health Initiatives and Aid Effectiveness*

The global health initiatives have generally been successful in achieving their stated goals. Yet, because of the narrow nature of these goals, this leaves unanswered the question of their impact on health systems more broadly. The aid effectiveness agenda, with its emphasis on national ownership and alignment of aid with national priorities, is a useful yardstick in assessing the impact of the Global Fund and GAVI on national health systems and broader health goals.[7]

### *Focus on Results and Meeting Stated Goals*

The major strength of vertical funds is generally seen as their ability to achieve rapid and visible results. Both the Global Fund and GAVI report strong progress in their priority areas of intervention, quantified in millions of lives. GAVI claims that its vaccination programmes have prevented more than 5 million future deaths since its inception in 2000. The Global Fund reports that more than 3 million people receive antiretroviral treatment financed by its grants. The simplicity and tangibility of such indicators have played an important role in the ability of the Global Fund and GAVI to secure additional funding.

Independent evaluations largely confirm their positive impact in their respective areas of intervention. An external evaluation carried out in 18 countries found the Global Fund to have contributed to rapidly increasing funding for HIV/AIDS, a major expansion in access to services, large increases in treatment coverage, and similar progress in the distribution of bed nets and other preventive measures against malaria (TERG, 2009). GAVI's flagship programme, support for new and underused vaccines, has allowed countries to scale up their vaccination programmes, and has also contributed to increasing the supply stability of under-used vaccines and to creating viable markets in low income countries (CEPA, 2010).

### *The Aid Effectiveness Agenda and Global Health Initiatives*

Despite the impressive results of vertical interventions, and the successful raising of new funds, the disadvantages of the vertical model were pointed out from early on, and increasingly so with the advent of the aid effectiveness agenda agreed upon in Paris in 2005. The failure of aid to significantly reduce poverty and increase growth rates in developing countries in the 1980s and 1990s had led to calls not only to scale up ODA and refocus it on poverty reduction, but also to increase its effectiveness. High transaction costs, fragmentation and lack of coordination associated with project-based aid, and the lack of policy change induced by conditionality were commonly blamed for ODA's limited impact (Dijkstra 2010).

In response to the failure of conditionality, increased country ownership of programmes and policies came to be seen as an effective remedy. The Paris Declaration on Aid Effectiveness, endorsed by over 100 donors and developing countries in 2005 and reaffirmed in the 2008 Accra Agenda for Action and the 2011

[7] The section will focus on the Global Fund and GAVI mostly, and UNTAID is only considered in selected areas, as it disburses its funds to multilateral implementing partners. Direct assessment of effectiveness at the country level would thus be difficult.

Busan Declaration, committed both donors and aid recipients to adhere to the principles of national ownership of development strategies, alignment of aid with national priorities, harmonization of donor activities, a focus on results, mutual accountability, and predictability and transparency.

Ownership of the development policies by partner countries is the core principle of the aid effectiveness agenda. Donors commit to align their support with the national development strategy. Real and meaningful ownership of recipient governments would imply that they have the policy space to decide on national policies independent of donor preferences, and that they are accountable in these choices to their citizens first and foremost (Whitfield and Fraser 2009). The aid modality that best embodies these principles is budget support. Yet in 2008, budget support represented only three percent of gross DAC donor disbursements (United Nations 2010b). Worryingly, country case studies also indicate that where it happened, the shift towards budget support has been used by donors to be involved intimately in the budgeting process and thus in the early phase of priority setting and policy planning, further undermining country ownership (see for example Bergamaschi 2009 for the case of Mali and de Renzo and Hanlon 2009 for Mozambique).

The difficulty in *creating* ownership is mirrored by an overall lack of progress in implementing the aid effectiveness agenda. Out of 13 targets established for 2010, only one has been met, and recipient countries have been much more successful in implementing the Paris Declaration than donors (OECD 2011d). This is not entirely surprising. Donors do have their own sets of preferences, based on ideological, commercial and political interests. Aid agencies exist precisely to mediate between donors and recipients in case these preferences diverge from recipients' preferences (Martens 2008). In such cases, ownership of aid projects by the recipient will always be limited. Donors and aid agencies use conditionality to correct any misalignment in preferences. Yet, Paris and Accra have not led to a shedding of conditionality. Rather ownership was added on top of conditionality, and attempts were made to reconcile these concepts. Donors pledged that conditions would be drawn from the partner's national development strategy, limited in number and mutually assessed. Of course this assumes that donors fully endorse such a development strategy. Yet, there is no discernible decrease in the overall number of conditions (United Nations 2010b).

A related tension exists in the focus on achieving results. To achieve sustainable progress, successes should be measured by improved development outcomes over the medium term. Yet, increased pressure to demonstrate visible results in the short term often leads to a focus on outputs, and to the by-passing of country systems. It can also undermine the predictability of aid flows. The rise of vertical funds is an expression of this trend, and budgetary pressures in donor countries are only likely to increase this tension.

Lastly, harmonization of donor activity is much less a priority for recipient countries than for donors (UN 2010b). If a country had a strong national development strategy, then it should be capable to coordinate donors, as countries such as Botswana and India show (UN 2010b, Maipose 2009). In fact, if recipients have ownership over the development strategy, then donors can be seen as competitors in a market to deliver capacity support and technical assistance. By this measure, there is actually too much concentration of donors already (Rogerson 2005).

The global health initiatives face an inherent tension between their vertical approach and the aid effectiveness agenda as laid out above – which promotes a horizontal approach through ownership, harmonization, sustainability, and alignment with country priorities. Both the Global Fund and the GAVI Alliance emphasize their commitment to the aid effectiveness agenda, and the Global Fund is a signatory to the Paris Declaration. And while they are considered exemplary in some areas, most notably in their transparency and focus on results, their structure and focus nonetheless makes adherence to all its principles difficult, raising concerns about donor harmonization and alignment, the increased burdens placed on health systems and the weakening the delivery of non-focus diseases (Spicer and Walsh 2011).

*Ownership and Alignment with Country Priorities*

The core notion of development effectiveness is country ownership of a national development strategy and donor alignment with the priorities lined out in this strategy. General budget support and sector-wide approaches are the aid modalities that most closely reflect these principles. In development assistance for health, sector-wide approaches have played a relatively minor role however – amounting to less than 8 percent between 2002 and 2006 (Piva and Dodd 2009). The vertical funds in particular face an obvious challenge in aligning their aid with national priorities. On the other hand, both the Global Fund and the GAVI Alliance disburse funds based upon the submission of proposals by countries and implementation is carried out by nationally nominated principal recipients. While this demand-driven process is intended to create ownership of the programmes, it is inherently limited within the priorities set by funders (Radelet and Levine 2008, Sridhar and Tamashiro 2009).

In practice, three factors have impeded strong country ownership – a narrow focus on high priority diseases which distorts country priorities, a high administrative burden that stretches in-country capacity, and the proliferation of new actors which increases aid fragmentation. Alignment with country priorities poses the biggest challenge for the vertical funds. Their very success in raising resources for health is often attributed to the strong focus on a few high profile diseases. As a result, and as discussed above, the overall increase in development assistance for health is largely driven by an increase in funds earmarked for HIV/Aids in particular, but also tuberculosis, malaria and childhood immunization, and does not match the actual disease burden in low income countries. At the country level, this can lead to extreme discrepancies in funding for different diseases, most notably a very heavy emphasis on HIV/Aids in African countries (Jones 2010). Non-communicable diseases for example are neglected by the vertical funds, as are other tropical diseases, acute respiratory infections, diarrhoea and others. There is also some indication that countries would prioritize primary health care more (WHO 2009a).

Country health systems could be weakened by the use of parallel systems and the duplication of planning structures and delivery channels. In a review of aid effectiveness in the health sector, the OECD found that they did indeed contribute to the duplication of existing coordination structures, requiring extensive time and resources to create and participate in these structures, which undermines country ownership (OECD 2011b). In the case of the Global Fund, the setting up of the Country Coordination Mechanism and the complex application procedures represent

an additional burden for under-staffed and under-resourced countries and lead them to rely on external expertise in the end. National systems have also reportedly suffered from a drain of resources, in particular human resources, which have moved from the public sector to follow donor money in the private sector and NGOs (Biesma et al. 2009). In addition, the proliferation of health funds contributes to increasing fragmentation. A study in seven recipient countries has found that global HIV/Aids initiatives have rendered the aid coordination and governance structure more complex, creating multiple coordination bodies at the national level with overlapping membership and mandates (Spicer et al. 2010).

In response to these criticisms, both the Global Fund and the GAVI Alliance have scaled up their health system support and have increased efforts to better coordinate their efforts at the country level. The Global Fund reported that by 2009, expenditures that contribute to system strengthening, most importantly on human resources, training, and infrastructure, account for 39 percent of its total expenditure. The GAVI Alliance on the other hand has introduced a health system strengthening funding window. They also partake in efforts to improve harmonization and coordinate support for health systems through the International Health Partnership (IHP)+ and the Health Systems Funding Platform.

IHP+ was established in 2007 to translate the Paris Principles into practice in the health sector, and supports a single country-led health strategy. Both the Global Fund and the GAVI Alliance are signatories to IHP+. Together with the WHO and the World Bank, they have created the Health Systems Funding Platform, which puts IHP+ principles into action by raising and coordinating funds for health system strengthening, mostly those of the Global Fund and the GAVI Alliance, and disbursing them based on a single national health plan, fiduciary arrangement and monitoring and evaluation framework. It has provided assistance in the form of budget support and technical assistance in a limited number of pilot countries, but there is still a lack of stringent evaluations to assess its impact at the country level (OECD 2011b). Glassman and Savedoff (2011) note however that its approach does not differ from previous and unsuccessful coordination attempts and might be hampered by the same flaws: too narrow a focus that excludes health sector governance, payment mechanisms and factors outside the sector itself such as infrastructure, unclear measures of progress and, as a result, unpredictable funding flows.

*Focus on Results, Accountability, Transparency and Predictability*

In addition to ownership, alignment and harmonization, the Paris Declaration calls for a focus on development results, mutual accountability, and more transparency and predictability of development cooperation. Overall, the vertical funds have had a generally positive impact on these aspects of the development effectiveness agenda.

The achievement of rapid and significant development results is generally seen as the major strength of the vertical funds. Both the Global Fund and the GAVI Alliance have had a dramatic impact in their respective fields and have used these visible successes to raise large amounts of money for development assistance for health. At the same time, the focus on visible results could potentially defer attention from underlying determinants of long term performance such as country capacities and

institutional quality (Isenman et al. 2010). The more recent emphasis on health system strengthening can be interpreted as an attempt of the Global Fund and the GAVI Alliance to counteract this shortcoming. Nonetheless, the tension between visible results and health system strengthening is indicative of a potential inconsistency in the aid effectiveness agenda itself – as pointed out earlier, it is not always easy to reconcile a results-driven agenda with an emphasis on strengthening country systems and ownership of development strategy.

The Global Fund and the GAVI Alliance are also generally praised for their transparency. To the extent that they rely on innovative mechanisms of finance, they are also able to raise resources more predictably, most prominently through IFFIm in the case of GAVI, and through the Solidarity Levy in the case of UNITAID. This is very notably not the case for the Global Fund however, which depends to an overwhelming extent on bilateral contributions and which had to dramatically scale back its operations recently due to budgetary constraints of its main donors.

Predictability in fund raising at the global level – where it exits – does not however translate automatically in predictable disbursements at the country level. There is an inherent tension in the Global Fund's model in particular, which has elements of strong selectivity and performance-based funding. The provision of relatively short-term financing for three to five years stands opposed to the long-term obligations that partner countries take on and which include the financing of medical staff, medicines and vaccines over much longer periods of time (Isenman and Shakow 2010).

*The Global Fund in Mozambique*

The strengths of the Global Fund as well as the tensions described above – a high administrative burden, a prioritization of interventions based on a global rather than a national rationale, and a lack of predictability in disbursements – all play out in the Global Fund's involvement in Mozambique. It plays a prominent role in the country's health sector, disbursing $243 million since its inception, and ranking second in size only to the United States as a major donor of health aid in recent years. It has had a strong impact in all three of its priority areas, making a key contribution to the country's large scale antiretroviral therapy programme that reaches 250 000 people living with AIDS, detecting and treating 60 000 tuberculosis cases, and distributing almost 4 million bed nets (Global Fund, 2012).

This contribution has to be seen in a context of severe underinvestment in the health sector and of heavy dependency on foreign aid. Mozambique's health infrastructure is still hampered by destruction from war, particularly in rural areas. It suffers from one of the lowest densities of health workers world wide, with only 0.03 doctors and 0.21 nurses per 1000 inhabitants (WHO, 2009b). The country also relies heavily on foreign assistance to finance its health expenditures. In 2010, almost half of its national health budget was externally financed. Such levels of aid dependency raise important challenges for the national health system, for priority setting by national authorities and for the sustainability of health interventions.

In order to strengthen the national health system, donors contribute sector-specific budget support through a common fund for health, PROSAUDE, since 2003. The Global Fund initially supported the sector-wide approach, and Mozambique became

the first country that integrated Global Fund grants into a common on-budget funding arrangement (Koenig and Goodwin, 2011). Only a few years later however, they were taken off-budget again, at the request of the national ministry of health. It proved too difficult to harmonize procedures for Global Fund grants with the pooled funding arrangement. Application procedures and reporting requirements tied up significant resources, and the ministry was constrained in policy implementation by delays in disbursement. In 2007 for example, the Global Fund had disbursed only 54 per cent of promised funds, all in the last four weeks of the year (Informal Governance Group and Alliance 2015, 2010). Eventually, a separate and external unit in the ministry of health had to be set up to deal with the administrative requirements of Global Fund grants (KPMG, 2010).

The Global Fund is not alone in its struggle to harmonize procedures and to reduce the transaction costs of aid. Pooled funding continues to represent only a small share of total aid to health. In 2009, the common fund received $80 million, while vertical funding, including project aid, amounted to $376 million (KPMG, 2010). Despite the commitment by donors to follow a sector-wide approach, aid to health thus remains fragmented and largely off-budget. The Global Fund does participate in the International Health Partnership Country Compact, which allows donors that operate outside the common fund – such as the Fund, GAVI and USAID – to align their actions. The Country Compact is seen by many stakeholders as a useful process, and has for example validated and facilitated funding for a joint human resource strategy (Koenig and Goodwin, 2011).

The outsized role of donor funding in Mozambique's health budget also implies that their spending priorities will be strongly reflected in overall health expenditure. The national government's biggest priority is to increase equity in access to health services and their quality, in particular primary health care. Donors support this process, but they put a much greater emphasis on HIV/AIDS. Between 2006 and 2008, more than half of total health aid was directed to the fight against HIV/AIDS, but only seven per cent on basic health infrastructure and only four per cent on basic healthcare (Koenig and Goodwin, 2011). The Global Fund dedicated almost 70 per cent of its total funding to HIV/AIDS. On the other hand, there is evidence that HIV/AIDS programmes are increasingly integrated with other health services, which has both increased access to treatment in rural areas and strengthened general health infrastructure (Pfeiffer et al., 2011). The Global Fund has also financed new health worker training in Mozambique, albeit at a relatively small scale (Oomman, Bernstein and Rosenzweig, 2008).

Lastly, Mozambique is extremely vulnerable to reductions in aid inflows. Cutbacks in international funding for the fight against HIV/AIDS – as seen in the cancellation of the Global Fund's 11$^{th}$ funding round, but also in planned reductions to the United States' initiative on AIDS relief – can have a devastating impact on the country's treatment programme. In fact, Mozambique is expected to face shortages of antiretroviral medication by the end of 2012. Its funding for tuberculosis – provided almost entirely by the Global Fund – runs out in mid-2013, without a prospect for alternative funding (Médicins sans Frontières, 2011, 2012).

The case study of Mozambique reiterates themes and challenges that emerge from the literature review of the global health initiatives' effectiveness in the provision of aid as defined in the Paris Declaration and subsequent agreements. These are often not specific to the vertical funds – bilateral donors often face similar challenges – but they do raise important questions that need to be addressed going forward.

The provision of health care is a core task of national governments. Therefore the strengthening of national health systems has to be a critical component of all aid to health. Both the Global Fund and GAVI recognize this imperative and provide funding for health system strengthening programmes. However, in both cases they comprise only a relatively small proportion of the overall project portfolio (13.5 per cent of disbursements in the case of GAVI), and the health system support provided remains closely linked to their specific mandates and interventions. Training of health professionals for example is largely limited to in-service training for disease-specific or immunization-related tasks, while their contribution to the training of new health workers is relatively low (Vujicic et al. 2012).

Separate structures, accounting, monitoring and evaluation mechanisms also put a heavy administrative burden on recipient countries and make it difficult to integrate donor funds into national health budgets, potentially weakening national health systems. This is a problem for other bilateral and multilateral donors as well, and a concentration of resources in multilateral vehicles such as the Global Fund could actually contribute to greater harmonization of donor activities and thereby ease the administrative burden. The Health System Funding Platform is a clear attempt to achieve this and a step in the right direction, but so far the global health partnerships have struggled to make progress on this account. In Mozambique, Global Fund projects had to be taken off-budget again because of different procedures and delays in disbursements, and Biesma et al. (2009) find evidence for difficulties in integrating funds into coordinated national plans in other countries as well.

Lastly, the different prioritization – globally determined by the global health partnerships, but often different from national priorities – can skew health systems away from domestic priorities. However, this would only be problematic in the case that vertical programmes draw resources from other interventions such as basic health care, rather than simply adding to national health care efforts. There is no unequivocal evidence for this, but in some countries health workers did move from the public sector to better compensated positions in projects funded by donors (see for example Drew and Purvis 2006).

## *V. Conclusion*

Innovative aid mechanisms have changed the landscape of global health dramatically over the last decade. Their most obvious success is the raising of significant amounts of new resources, which were successfully used to combat HIV/Aids and other infectious diseases. With their narrow focus, they have succeeded in capturing global attention and were able to tap both traditional sources of development finance and new and innovative sources – through philanthropy and innovative mechanisms such as the airline levy.

In purely quantitative terms, these innovative sources have however played a relatively minor role so far. For this reason, the big global health initiatives are not immune to unpredictable funding flows that characterize traditional development assistance. The Global Fund in particular, which relies to a very large extent on contributions from traditional donors, has been dramatically affected by budgetary constraints in its main donor countries and had to cancel its latest funding window. The innovative sources of finance, and levies and taxes in particular, are much less likely to be affected by sudden reversals in donor country priorities. They thus have great potential to improve the predictability and sustainability of global aid for health and contribute to meeting the large unmet needs in the future, but cannot play this role yet.

In terms of the quality of aid delivery, successes in narrowly targeted interventions stand side by side with the more ambivalent impact of vertical funds on national health systems. This ambivalence reflects a broader tension between attempts to increase country ownership and alignment of aid with national priorities with an increasingly results-driven agenda that emphasizes efficiency. Both the Global Fund and the GAVI Alliance have responded to these criticisms by scaling up their spending on health system strengthening in recent years. It is too early to definitely assess the impact of this shift in priorities, but it does represent a step towards a much advocated diagonal model, where funds are raised vertically but disbursed horizontally – through national health systems and thus aligned with country priorities (see for example Ooms et al. 2008).

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