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CENTRE ON GLOBAL HEALTH SECURITY WORKING GROUP PAPERS

Development Assistance for Health: Critiques and Proposals for Change

Suerie Moon and Oluwatosin Omole

April 2013

WORKING GROUP ON FINANCING | PAPER 1



HARVARD

Global Health Institute





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EXECUTIVE SUMMARY

Introduction and landscape

As of 2009, developing countries accounted for 84% of the global population and 92% of the burden of disease, but only 29% of GDP and 16% of health spending. The past decade has witnessed unprecedented political attention to health challenges in developing countries, as demonstrated by extraordinary growth in the level of international financing and a diverse array of new actors engaged in global health generally, and development assistance for health (DAH) in particular (Murray et al., 2011). This rapid expansion has contributed to impressive achievements such as a dramatically scaled-up response to the HIV pandemic (WHO, UNAIDS, UNICEF, 2011), improved control of malaria in many endemic countries (WHO, 2011), reinvigoration of research and development of medicines for diseases that primarily affect the world's poor (Moran et al., 2011) and exceptional declines in childhood mortality (UN Interagency Group for Childhood Mortality Estimation, 2012), among others. The decade also saw a departure from the traditional modes of DAH that characterized the second half of the 20th century – that is, a near-complete reliance on public-sector funding, the UN system and bilateral aid agencies – and witnessed instead the emergence of new actors and significant experimentation with new institutional forms such as public–private partnerships (PPPs) (Szlezak et al., 2010).

However, these developments have also raised key questions about the existing DAH system: Are the resources sufficient and sustainable? Are they being spent in the right way and on the right thing? Who should pay and who should receive, and how much? Who should decide, and how? These questions have been sharpened by the economic crisis and the subsequent stagnation in DAH from the traditional donor countries (IHME, 2012; Leach-Kemon et al., 2012).

At the same time, the system is being challenged by at least two major transitions: First is the 'health transition', in which many developing countries are wrestling with both communicable and non-communicable diseases as well as new health threats linked to processes of globalization (Frenk et al., 2011). Second is an economic transition with the rise of some middle-income countries – notably the BRICS (Brazil, Russia, India, China, South Africa) and MIST (Mexico, Indonesia, South Korea, Turkey) – leading to increasing multipolarity in the global system. This phenomenon has at least two components: some formerly low-income countries are developing quickly and are increasingly able to finance their own health needs; and some middle-income countries are both continuing to grow and exerting increased political influence in the global system, including as new donors. These transitions are taking place in the context of ongoing economic, social and political globalization, characterized by the intensified movement of people, goods, resources, ideas and microbes across borders. Finally, as the 2015 deadline for the Millennium Development Goals (MDGs) draws near, debate has intensified regarding what international financing for health should look like in the post-MDG era. The moment seems ripe to take a hard look at the DAH system, and to take stock of the many proposals that have been advanced to improve on the status quo.

DAH has increased dramatically over the past two decades, almost doubling from \$5.7 billion in 1990 to \$10.8 billion in 2001, and nearly tripling to \$28.1 billion (2010 dollars) by 2012 (IHME, 2012). DAH comprised about 5% of total spending on health in developing countries, with total (domestically sourced) government health spending estimated at \$521 billion in 2010 (IHME, 2012). However, disaggregating developing countries reveals large differences in the relative importance of DAH by income group, with external financing accounting for a hefty 25.9% of total health expenditure in low-income countries, but only 2.7% in lower-middle-income countries and 0.2% in upper-middle-income countries (see Table 1). It is therefore likely that many of the shortcomings of the existing DAH system hit low-income countries the hardest.

Table 1: Health expenditure (2009, current \$)*

	Population (%)	GDP (%)	Per capita GDP (\$)	Health expenditure (US\$ billion/ % of GDP)	Health expenditure per capita (\$)	External resources for health (% health expenditure)	Proportion of health expenditure public/private/out of pocket (%)**
World	100	100	8,491	6,132/10.6	901	0.19	61/39/18
High-income countries	16	71	36,761	5,172/12.6	4,690	0.02	63/37/14
Upper-middle-income countries	36	22	5,224	796/6.2	326	0.22	54/46/33
Lower-middle-income countries	36	6	1,412	154/4.4	62	2.73	39/61/53
Low-income countries	11	1	500	21/5.3	25	25.85	39/61/38

*All data from the World Bank World Development Indicators database.

**Out-of-pocket expenditure is a subset of private expenditure; it is shown here as a proportion of total health expenditure.

Governments remain by far the largest source of DAH, accounting for about 70% of the total. However, private sources of funding (including foundations, NGOs and corporations) have grown in importance, increasing from 8% of total DAH in 1990 to 16% in 2000 and 15% in 2010, with the largest single contributor being the Bill & Melinda Gates Foundation (IHME, 2012). International financing was directed towards a range of health issues, with HIV/AIDS receiving the largest total amount, followed by maternal, newborn and child health. Malaria, health-sector support and tuberculosis ranked lower in terms of total funding received, but each of these areas saw rapid increases in recent years. Non-communicable diseases received the least funding of the disease categories tracked by IHME, and the rate of contribution has been increasing at a slow pace (IHME, 2012).

Critiques of the DAH system

Many of the critiques regarding the existing system of DAH mirror those of the development aid system more broadly, while others are specific to the health sector. We categorize the critiques into seven broad groups, with brief summaries of each:

1. *Total amount of financing:* Existing financial resources dedicated to health fall short of needs, and significant international resources will be required particularly to support the poorest countries (Chatham House, 2011; Committee of Experts to the Taskforce on International Financial Transactions and Development, 2010; McCoy and Brikci, 2010).
2. *Volatility and uncertainty of financing:* Aid disbursement is irregular and information on future financial flows is uncertain, which is particularly detrimental when DAH funds recurring costs in the health sector such as salaries, drugs and transport; volatility can also undermine longer-term efforts to build health systems (Lane and Glassman, 2009).
3. *Additionality of financing:* External financing may displace rather than augment domestic financing for health (Farag et al., 2009; Lu et al., 2010). Critiques have been raised regarding fungibility between health and non-health spending (such

as between health and road-building) and between various priorities within health spending (such as between HIV and malaria). There is considerable disagreement in the literature regarding the degree to which DAH is in fact additional (or fungible), the reasons behind it, and whether it is necessarily negative (Batniji and Bendavid, 2012; Garg et al., 2012; Ooms et al., 2010; Sridhar and Woods, 2010; Stuckler et al., 2011).

4. *Priority-setting*: Critiques on priority-setting in DAH centre around three distinct but interrelated questions: *how* priorities actually get set, with disagreement on whether donor interests, recipient needs or other factors determine final priorities (Shiffman, 2006); *who should* set priorities, with concern that donors continue to drive decision-making at the cost of meeting recipients' greatest needs or highest priorities, which also undermines country ownership (Kapuriri, 2012; Kickbusch, 2002; Ollila, 2005); and *how* priorities *should* be set, with concern that spending is not rationally allocated on the basis of objective indicators such as recipient income or disease burden (Sridhar and Woods, 2010).
5. *Coordination*: The proliferation of actors involved in DAH, particularly over the last decade, has exacerbated the problem of coordination among them, with the predictable consequences of system fragmentation, inefficiencies, confusion, gaps and transaction costs. The total number of major global health actors (donors, foundations, initiatives, etc.) was estimated to be at least 175 in 2008, not accounting separately for the thousands of active NGOs (McColl, 2008).
6. *Accountability*: The existing DAH system has weak mechanisms of accountability, particularly for strengthening the accountability of stronger actors towards weaker ones. Critiques encompass a diverse set of issues regarding *who* should be accountable to *whom*, and for *what*. While discussions of accountability have tended to focus on relationships between donor and recipient governments, also significant are accountability relationships between governments and their own constituents (Hudson and GOVNET Secretariat, 2009; Sridhar and Woods, 2010) and those between donors and recipients across societies as increasing amounts of DAH are channelled outside governments (Jordan and van Tuijl, 2006).
7. *Rationale*: Debates have arisen regarding what *is* and what *should* be the rationale or justification for DAH. The foundations of the existing system of DAH and ODA were built after the Second World War and decolonization, and were initially framed as 'foreign aid', with recipients in a hierarchical relationship of dependence on donors. Alternative framings have since emerged, including 'cooperation', which implies a more equal relationship based on the principle of mutual benefit; 'restitution', which emphasizes obligations to remedy past and/or ongoing wrongs; or 'global solidarity', based on the notion of the emergence of a global society bound together by relationships of interdependence (Mackintosh et al., 2006; Frenk and Moon, 2012). Each of these framings implies different institutional arrangements for DAH and is reflected in various reform proposals for the DAH system.

Proposals for reforming the DAH system

We roughly divided proposals for reform of the DAH system into three categories: those that primarily seek to address financing issues (e.g. volumes, predictability); those that seek primarily to address governance issues within the existing DAH system (e.g. additionality, coordination, priority-setting and accountability); and those that reach beyond the DAH system. (Some proposals may fit within more than one category.)

1. *Financing-oriented proposals* (e.g. volumes and predictability): In response to critiques regarding insufficient levels and high volatility of DAH, a number of proposals for innovative financing mechanisms have been advanced – both specifically for health and more broadly for development. These include international taxes such

as a levy on financial transactions (such as trade in equities or currencies), 'sin taxes' on products that are (potentially) harmful to health (such as tobacco, alcohol or some foods), a tax on every individual earning more than \$1 billion per year, or expanding the tax on air tickets currently used to fund the global health initiative UNITAID. Estimates of total amounts that could be raised range from \$5 billion to \$400 billion per year, depending on the tax rate, the taxed item, and those countries that implement it.

Other proposals involve novel mechanisms for managing financial flows (rather than generating new financial flows), including: leveraging the IMF's Special Drawing Rights to back bonds for development purposes; building on the GAVI Alliance's International Finance Facility for Immunization, which front-loads investments by using long-term pledges from donor governments to sell 'vaccine bonds' in capital markets; designating a 'swing donor' or donor of last resort that would counterbalance unpredictable disbursements by individual donors to smooth out resource transfers; and building on the Global Fund to Fight AIDS, Tuberculosis and Malaria's (GFATM, or Global Fund) Debt2Health initiative, which redirects funds for debt repayment by recipient countries to domestic health investments. Finally, earmarked contributions from the sale of products by the private sector have been proposed to generate additional funds for health, such as (Product) Red.

2. *Governance-oriented proposals within DAH system* (e.g. additionality, priority-setting, coordination, and accountability): At national level, proposals to improve coordination (many of these at least partially implemented) have included: Sector-Wide Approaches (SWAs), General Budget Support or donor specialization in one sector, referring broadly to the principle that donors coordinate within a given country and with its government to harmonize aid with country priorities, and with each other; the Three Ones approach for HIV/AIDS, referring to one action framework, one national coordinating authority, and one monitoring & evaluation system for all actors involved in a country's response to HIV/AIDS; and the One UN/Delivering as One initiative to improve coordination among UN organizations within a country based on six principles – One Leader, One Budget, One Programme, One Office, One Voice for advocacy, and One Fund.

At international level, recent initiatives and proposals include: the 2005 Paris Declaration on Aid Effectiveness, signed by more than 100 countries and international organizations and based on the five principles of ownership, alignment, harmonization, results and mutual accountability, with the follow-up 2008 Accra Agenda for Action putting additional emphasis on ownership, 'inclusive partnerships' and results; the International Health Partnership (IHP+), started in 2007 to apply the Paris Declaration principles to the health sector, and provide better coordination for donor countries and agencies; the H8, an informal group of eight health-related organizations (WHO, UNICEF, UNFPA, UNAIDS, GFATM, GAVI, the Bill & Melinda Gates Foundation and the World Bank) formed in 2007 to improve coordination, especially on the health-related MDGs; and the H4+ for maternal and child health, created in 2010 (WHO, UNFPA UNICEF, UNAIDS, UN Women and the World Bank) to coordinate support for countries with the highest infant and maternal mortality rates. In addition to these organizational approaches, conceptual approaches to coordination, such as priority-setting methodologies, can also be seen as efforts to improve governance. For example, the development of the Disability- (or Quality-) Adjusted Life Year (DALY/QALY) and the Disease Control Priorities Project (DCPP) both aimed to make priority-setting more rational, objective and evidence-based. Other initiatives, such as the UN Commission on Information and Accountability for Women's and Children's Health, seek to improve accountability of DAH actors through transparency and the use of information and evaluation. Last, some proposals urge restructuring of existing institutions, rather than new coordination efforts, such as the call for a consolidated global 'Principal Financier(s)' to channel funding to national health strategies (Dybul et al., 2012).

3. *Proposals reaching beyond the existing DAH system:* Some proposals reach at least one step beyond the existing set of actors and institutions in DAH. These include the proposal for a Global Social Protection Fund for long-term resource transfers (or redistribution) to poorer countries or populations to meet basic health needs, based on an expansion of the notion of social protection beyond the nation-state (Ooms et al., 2010). Many have also argued for the increased use of formal international law to improve global health, building on the precedent established by the 2005 WHO Framework Convention on Tobacco Control (FCTC). Proposals include those for a treaty on research and development of new medicines (WHO Consultative Expert Working Group on Research and Development (CEWG): Financing and Coordination, 2012), an alcohol convention (Sridhar, 2012), a chronic disease 'global compact' (Magnusson, 2009), a 'fake drugs' treaty (*The Lancet*, 2011a), an obesity convention (*The Lancet*, 2011b) and a Framework Convention on Global Health (Gostin, 2007).

Criteria for assessing proposals

Inherent in many of the critiques and proposals is a set of criteria regarding how an ideal DAH system would function – or, to frame the issue more broadly, how global health could be financed. With respect to financing, there would in an ideal system be sufficient and predictable financial flows to provide at least a basic minimum standard of health care for all. With respect to governance, decisions regarding both the ends and means of DAH would be made through processes widely deemed to be legitimate. In practice, this may mean that those most affected by such decisions are substantively involved in making them (e.g. decisions on priority-setting), and that decisions are made with a maximum degree of transparency and with due consideration of objective evidence. An ideal system would also make efficient use of resources, for example by minimizing overlap or duplication of effort, and be effective in achieving its aims (e.g. of improving health or health equity, strengthening human security, protecting human rights). Furthermore, an ideal system would be characterized by agreed and clearly delineated roles and responsibilities of national and international actors. Finally, in an ideal system, actors would comply with agreed norms and commitments, such as those regarding financing, monitoring and transparency. Applying these criteria across the various proposals may help to assess both how desirable and how politically and/or technically feasible implementation may be.

Conclusions

The past decade has witnessed significant and rapid change in the system for DAH, and we are now entering an era of major transition. This background paper offers an overview of the system and its major areas of weakness, followed by a review of a broad range of proposals to address them and criteria by which such proposals could be weighed. Many proposals are aimed at addressing one or two major concerns, rather than all. This is not necessarily problematic, as long as they are clearly recognized as such, rather than as panaceas. Nevertheless, it raises two questions: how ambitious should efforts at systemic reform be; and how interconnected are existing problems? More specifically, if financing and governance arrangements are fundamentally inseparable, can or should they be addressed in an integrated way? Furthermore, many of the proposals are characterized by a 'big idea' but remain nascent and would benefit from more detailed implementation plans. In particular, many proposals do not outline basic governance arrangements, such as who would have decision-making power, how decisions would be made, or how new initiatives would mesh with the existing architecture. Finally, greater consideration is warranted of the political and technical processes required to implement change, such as the minimum number of countries or other actors required to effect significant systemic change.

While it is beyond the scope of this paper to make recommendations on any specific proposal, we hope that the analysis presented here will facilitate critical and candid review of the system, with the aim of building stronger and more equitable institutions for financing global health.

1. INTRODUCTION

Purpose

This background paper was developed to facilitate the deliberations of the Chatham House Working Group (WG) focusing on domestic and international financing for health. It sought to do so by responding to the following four questions:

1. *What does the system for Development Assistance for Health (DAH) look like today?* A brief description of the landscape.
2. *Should the system be changed, and, if so, why?* A summary of the major critiques of the existing DAH system, based on a literature review and input from WG members.
3. *What might be done?* A summary of proposals that have been advanced to address these critiques.
4. *What should be done?* A list of key issues and related questions for discussion, including a proposed set of criteria for assessing these proposals.

While recognizing that the issue of international financing is closely linked to that of domestic financing, the scope of this paper is limited to focusing primarily on debates around the former.¹

Context

As of 2009, developing countries² accounted for 84% of the global population and 92% of the burden of disease, but only 29% of GDP and 16% of health spending.³ The past decade has seen unprecedented political attention paid to health challenges in developing countries, as demonstrated by extraordinary growth in the level of international financing and a diverse array of new actors engaged in global health generally, and DAH in particular (Murray et al., 2011).⁴ DAH has been defined as ‘financial and in-kind contributions made by channels of development assistance – that is, by institutions whose primary purpose is providing development assistance to improve health in developing countries’ (Institute for Health Metrics and Evaluation (IHME), 2011). This rapid expansion has contributed to impressive achievements such as a dramatically scaled-up response to the HIV pandemic (World Health Organization et al., 2011), improved control of malaria in many endemic countries (World Health Organization, 2011), reinvigoration of research and development of medicines for diseases that primarily affect the world’s poor (Moran et al., 2011) and exceptional declines in childhood mortality (UN Interagency Group for Childhood Mortality Estimation, 2012), among others. The decade also saw a departure

1 While recognizing their importance, we exclude consideration of other financial flows that may affect resources available for health, such as remittances, foreign direct investment, or outflows from low- and middle-income countries to high-income countries.

2 We use the term developing country to refer to all low- and middle-income countries, as classified by the World Bank. The most recent year for which data were relatively complete and available was 2009.

3 This sentence updates the calculation by Gottret and Shieber (2006) that ‘Developing countries account for 84 percent of global population, 90 percent of the global disease burden, and 20 percent of global GDP, but only 12 percent of global health spending.’ Updated population, GDP and health expenditure data are from the World Bank, and burden of disease estimates from the Global Burden of Disease 2004 Summary Tables (World Health Organization, 2008).

4 The Institute for Health Metrics and Evaluation (IHME) has defined DAH as ‘financial and in-kind contributions made by ... institutions whose primary purpose is providing development assistance to improve health in developing countries (2011)’. We adopt the term DAH, as it is currently widely used in the literature, but note that other terms may also be used, such as global health financing, health aid or foreign aid. Alternative terms include external financing or international financing for health, but these could imply a broader field of enquiry that would encompass all health financing that crosses borders, such as remittances. The term global health financing could, arguably, include both national and international financing. These terms are not used in this paper for the sake of clarity.

from the traditional modes of DAH that characterized the second half of the 20th century – that is, a near-complete reliance on public-sector funding, the UN system and bilateral aid agencies – and witnessed instead the emergence of new actors and significant experimentation with new institutional forms (Szlezak et al., 2010). Examples of new actors and approaches include the Bill & Melinda Gates Foundation and other private not-for-profit organizations, public–private partnerships (PPPs) such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM, or Global Fund) and GAVI (formerly the Global Alliance for Vaccines and Immunization), product development partnerships such as the Drugs for Neglected Diseases initiative and Global Alliance for TB Drug Development, and the airline tax-funded initiative UNITAID.

However, these developments have also raised key questions about the existing DAH system: Are the resources sufficient and sustainable? Are they being spent in the right way, and on the right thing? Who should pay and who should receive, and how much? Who should decide, and how? These questions have been brought into sharper focus by the economic crisis, and the subsequent stagnation or decline in DAH from the traditional donor countries (Leach-Kemon et al., 2012).

At the same time, the system is being challenged by at least two major transitions. The first is the ‘health transition’ (sometimes more narrowly called the ‘epidemiological transition’), in which many developing countries are wrestling with both communicable and non-communicable diseases as well as new health threats linked to processes of globalization (Frenk et al., 2011). The second is an economic transition with the rise of some middle-income countries – notably the BRICS (Brazil, Russia, India, China, South Africa) and MIST (Mexico, Indonesia, South Korea, Turkey) – leading to increasing multipolarity in the global system. This phenomenon has at least two components: some formerly low-income countries are developing quickly and are increasingly able to finance their own health needs, and some middle-income countries are both continuing to grow and exerting increased political influence in the global system, including as new donors. These transitions are taking place in the context of ongoing economic, social and political globalization, characterized by the intensified movement of people, goods, resources, ideas and microbes across borders. Finally, as the 2015 deadline for the Millennium Development Goals (MDGs) draws near, debate has intensified regarding what international financing for health should look like in the post-MDG era. The moment seems ripe to take a hard look at the DAH system, and to take stock of the many proposals that have been advanced to improve on the status quo.

2. LANDSCAPE⁵

Trends

DAH has increased dramatically over the past two decades, almost doubling from \$5.7 billion in 1990 to \$10.8 billion in 2001, and nearly tripling to \$28.1 billion (2010 dollars) by 2012, according to estimates by the Institute for Health Metrics and Evaluation (IHME) (2012).⁶ However, after a period of sustained rapid growth, the rate of increase fell in 2011 and it seems that overall levels of DAH may have reached a plateau (Leach-Kemon et al., 2012).

Total domestically sourced government health spending in developing countries was estimated at \$521 billion in 2010 (IHME, 2012). Thus DAH comprised about 5% of total spending on health in developing countries. However, disaggregating developing countries reveals large differences in the relative importance of DAH by income group, with external financing accounting for a hefty 25.9% of total health expenditure in low-income countries but only 2.7% in lower-middle-income countries and 0.2% in upper-middle-income countries (see Table 1).⁷ Thus it is likely that many of the shortcomings of the existing DAH system (summarized in the next section) hit low-income countries the hardest.

Table 1: Health expenditure (2009, current \$)*

	Population (%)	GDP (%)	Per capita GDP (\$)	Health expenditure (US\$ billion/ % of GDP)	Health expenditure per capita (\$)	External resources for health (% health expenditure)	Proportion of health expenditure public/private/out of pocket (%)**
World	100	100	8,491	6,132/10.6	901	0.19	61/39/18
High-income countries	16	71	36,761	5,172/12.6	4,690	0.02	63/37/14
Upper-middle-income countries	36	22	5,224	796/6.2	326	0.22	54/46/33
Lower-middle-income countries	36	6	1,412	154/4.4	62	2.73	39/61/53
Low-income countries	11	1	500	21/5.3	25	25.85	39/61/38

*All data from the World Bank World Development Indicators database.

**Out-of-pocket expenditure is a subset of private expenditure; it is shown here as a proportion of total health expenditure.

Sources

Governments remain by far the largest source of DAH, accounting for about 70% of the total. In 2010 the United States was the largest governmental donor by size of disbursements, with the other major donors (in decreasing order) being the governments of the United Kingdom, France, Germany, Canada, Japan, Norway, Spain, the Netherlands and Australia. If ranked by DAH as a proportion of GDP, the top 10 donors, in decreasing order, would be Norway, Luxembourg,

5 For a comprehensive, detailed picture of financial flows for DAH, see IHME (2011) and IHME (2012).

6 Note that all IHME figures are expressed in 2010 dollars.

7 Authors' analysis of 2009 data from the World Development Indicators database of the World Bank. Note that these data differ from the IHME database, and provide a slightly different picture of the role of external financing.

Sweden, the United Kingdom, the United States, Belgium, Ireland, the Netherlands, Denmark and Finland. In addition to the continued central role of governments, private sources of funding (including foundations, NGOs, and corporations) have also grown in importance, increasing from 8% of total DAH in 1990 to 16% in 2000, and 15% in 2010, with the largest single contributor being the Bill & Melinda Gates Foundation (IHME, 2012).

Governments remain the largest source of development assistance for health, accounting for over two-thirds of the total, but private sources have grown from 8% in 1990 to 15% in 2010

Channels

As noted above, there have been significant changes in the channels by which DAH is disbursed, with a pronounced shift away from the traditional multilateral institutions and towards PPPs. The share of DAH channelled through UN agencies decreased from 35% in 1990 to 26% in 2000 and to 17% in 2010, while the share of the World Bank and regional banks fell from 23% in 2000 to 8% by 2010. The shares via GFATM and GAVI grew from less than 1% of DAH each in 2002 (the first year for which data on both were available) to 12% and 4%, respectively, in 2010. Finally, the share of DAH going through bilateral agencies fluctuated but remained significant: 49% in 1990, 32% in 2000 and 43% in 2010 (IHME, 2012).

Recipients

As of 2010, the principal regions receiving DAH by total amount were sub-Saharan Africa (\$8.07 billion, or 29%) and South Asia (\$1.78 billion, or 6%). The top 10 countries ranked by total amount received (from 2008 to 2010) were, in decreasing order, India, Nigeria, Tanzania, Ethiopia, South Africa, Kenya, Uganda, Mozambique, Zambia and the Democratic Republic of the Congo (IHME, 2012).

Spending

International financing was directed towards a range of health issues. HIV/AIDS received the largest total amount, increasing rapidly from \$0.735 billion in 2000 to \$6.757 billion in 2010, by which point it accounted for 24% of total DAH. The second largest category was maternal, newborn and child health, which received \$5.167 billion in 2010 (18% of DAH) – a significant increase from \$2.899 billion in 2000, but a category in which growth has been slower and more sporadic than that seen in other issue areas. Malaria has in recent years received a rapid increase in funding, from \$0.230 billion in 2000 to \$1.857 billion in 2010, driven largely by the Bill & Melinda Gates Foundation and US government funding (via the President's Malaria Initiative). Health-sector support has also increased significantly, especially from 2005, growing from \$0.145 billion in 2000 to \$1.181 billion in 2010. Tuberculosis funding increased significantly as well, from \$0.153 billion in 2000 to \$1.095 billion in 2010. At \$0.185 billion in 2010, non-communicable diseases (NCDs) received the least funding of the categories tracked by IHME; and financing for NCDs has been increasing at a slow pace, up from \$0.112 billion in 2000. Finally, there has also been a significant increase in spending in areas that provide global benefits – including potential global public goods such as health research or the development of new technologies – from \$0.044 billion in 1990 to \$0.654 billion in 2000 and to \$3.5 billion (equivalent to 12% of total DAH) in 2010 (IHME, 2012; IHME, 2011).⁸

⁸ 'Health research or the creation of public goods for multiple regions or projects that donors categorized as benefiting the entire world' (IHME, 2011).

Broader ODA trends

To put these trends in perspective, it may be useful to consider what has been taking place more broadly in development assistance. The OECD defines official development assistance (ODA) as

*grants or loans to countries and territories on the [Development Assistance Committee's] DAC List of ODA Recipients (developing countries) and to multilateral agencies which are: (a) undertaken by the official sector; (b) with promotion of economic development and welfare as the main objective; (c) at concessional financial terms (if a loan, having a grant element of at least 25%).*⁹

Total ODA increased markedly over the past decade: levels did not change significantly from 1990 to 2000, declining from \$80.3 billion to \$76.4 billion over this period (in 2009 dollars), but then grew to \$123.5 billion in 2010. Overall ODA has increased substantially, but has grown more slowly than has DAH. DAH was about 6% of ODA in 1990, 12% in 2001 and 19% by 2010 (IHME, 2012).¹⁰ However, ODA fell by 2.7% in real terms from 2010 to 2011, to \$133.5 billion (in 2011 dollars), the first drop since 1997 (OECD, 2012). The 2011 ODA level represented 0.31% of the combined gross national income (GNI) of DAC countries, far from the internationally endorsed ODA target of 0.7% of GNI. The largest donors by total amount in 2011 were (in decreasing order): the United States, Germany, the United Kingdom, France, the EU institutions and Japan, with the United States contributing 23% of the total and the 15 EU members of the DAC contributing 54%. The largest donors by proportion of GNI were, in decreasing order, Norway, Luxembourg, Sweden, Denmark and the Netherlands, with aid in 2010 ranging from 1.01% to 0.81% of GNI. The principal recipients by total amount in 2010 were, in decreasing order, Afghanistan, Indonesia, India, China and Iraq. Top recipients of ODA as a percentage of GNI in 2010 were, in decreasing order, Liberia, the Solomon Islands, the Marshall Islands, Haiti and Micronesia, with ODA ranging from 177% to 41% of GNI.¹¹

In 2011, countries belonging to the OECD Development Assistance Committee devoted 0.31% of their combined gross national income to official development aid, well below the internationally endorsed target of 0.7%

⁹ <http://www.oecd.org/dac/dacglossaryofkeytermsandconcepts.htm#ODA>.

¹⁰ Note that DAH and ODA are not exactly comparable since DAH includes both public and private transfers, while ODA includes only public transfers. Nevertheless, even when looking only at health ODA as a proportion of ODA, it is clear that the proportion of spending on health also grew over the same period, from less than 2% in 1990 to 8% in 2000 and to 12% in 2010 (IHME, 2012).

¹¹ All data from OECD.

3. CRITIQUES

Many of the critiques regarding the existing system of DAH mirror those about the development aid system more broadly, while others are specific to the health sector. We summarize each of the major critiques below.

Total amount of financing

A major line of critique is that existing levels of DAH are insufficient. Unlike the overall ODA target of 0.7% of GNI, there is no clearly established global norm regarding the level or proportion of international financing that should be dedicated to health. Nevertheless, many estimates have been carried out on financing needs, with a range of estimates based on a specific country, disease, the MDGs or the health sector more broadly.¹² Perhaps the most frequently cited estimates of the total amount of international financing needed have come from the WHO Commission on Macroeconomics and Health (CMH) (2001) and the Taskforce on Innovative International Financing for Health Systems (Taskforce) (2009).

The CMH estimated that donor spending, both for a package of essential interventions at country level and on the supply of global public goods, would need to reach \$27 billion by 2007 and \$38 billion by 2015. These calculations were based on projections that in low-income countries total annual spending would need to reach \$57 billion by 2007 and \$94 billion by 2015. Given the extremely scarce financial resources in these countries, the CMH forecast that domestic resource mobilization would fall short of need, and that donor funds would be required to fill the estimated gap of \$22 billion per year by 2007 and \$31 billion per year by 2015 (compared with an estimated \$6 billion contributed in 2001). The remaining \$5–\$7 billion would be dedicated to research into diseases primarily affecting the poor, and other global public goods. According to a calculation by Chatham House (2011), DAH had reached about half the CMH target for 2007 (\$40 billion in 2008 dollars).

The 2009 Taskforce report concluded that an additional \$10 billion per year was needed for health expenditure in poor countries. Annual spending on health in low-income countries was an estimated \$31 billion, equivalent to \$25 per capita. Of that \$25, \$10 came from out-of-pocket payments and \$6 from DAH. The additional cost to achieve the health MDGs by 2015 was estimated at \$36–\$45 billion (\$24–\$29 per capita), with sub-Saharan Africa accounting for between 60% and 80% of the total required.

These figures may be an underestimate. McCoy and Brikci (2010) pointed out that the Taskforce drew on two different costing models with implicit programmatic choices within them.¹³ The estimates also assumed a significant degree of private expenditure, which may be infeasible or inequitable for poor households. They also argued that the accuracy of the estimates may have been affected by important limitations in the cost data, such as estimates on disease burden, improving health systems management, health worker remuneration and infrastructure of existing health facilities. They concluded that the estimate of required future funding from governments and donors was too low. Their critique is a reminder that estimates of financing needs often reflect not only technical differences linked to data and methodology, but also significant political differences regarding approach and possibilities for change.

Other estimates have focused on more specific organizations, diseases or objectives. For example, for its 2011–13 replenishment, GFATM estimated that it required \$13–\$20 billion for the two-year period, but received pledges of only \$11.7 billion (Hood, 2011) and subsequently cancelled a funding round for the first time in its history (Boseley, 2011). The 2008 Global Malaria Action Plan estimated that total spending would need to reach \$5.1 billion per year from 2011 to 2020 to cover prevention, treatment and programme-strengthening, with an additional

¹² For a concise discussion of the range of estimates and methodologies, see Hecht and Shah (2006).

¹³ The two models were a higher-cost WHO model that emphasized scaling up of both facility- and community-based services, and a lower-cost World Bank/UNICEF model that advocated scaling up low-cost, community-based services before strengthening facility-based services.

\$750–\$900 million needed for research and development for new tools; however, spending only amounted to \$1.6 billion in 2008 (Roll Back Malaria (RBM) Partnership, 2008). The Stop TB Partnership estimated that \$47 billion was needed to combat tuberculosis from 2011 to 2015, including \$37 billion for programme implementation and \$10 billion for research and development, with a gap averaging \$2.8 billion per year that would need to be filled by donors (Stop TB Partnership, 2011); DAH for tuberculosis reached \$1 billion for the first time only in 2009 (IHME, 2011).

There seems to be widespread agreement that existing financing resources dedicated to health fall short, and that significant international resources will be required, particularly to support the poorest countries

Despite the variation in methodological approaches and political perspectives, there seems to be widespread agreement that existing financing resources dedicated to health fall short, and that significant international resources will be required, particularly to support the poorest countries.

Volatility and uncertainty of financing

In addition to insufficient total levels of financing, critiques have been raised regarding volatile and uncertain aid flows, which Lane and Glassman (2009) define as ‘a pattern of aid disbursement that is irregular’ (volatility) and when ‘information on future aid commitments over the medium term is [un]known and [un]available to aid recipients’ (uncertainty). Volatility in overall aid flows has been linked to significant income shocks, inflation, harmful effects on exchange rates, disrupted fiscal planning, reductions in domestic investment and reductions in total public spending (Celasun and Walliser, 2005; Gelb and Eifert, 2005; Kharas, 2008; Lane and Glassman, 2009). Kharas (2008) estimates that volatility reduces the value of aid to recipients by 15–20%, and notes that volatility varies considerably by donor and therefore could be significantly improved by changes in donor policies on, for example, modalities of disbursement and the time horizons of commitments.

When it comes to health aid in particular, volatility can be particularly detrimental when aid dollars are used to fund recurring costs such as salaries, drugs and transport, and can also undermine longer-term efforts to build health systems. In short, ‘aid flows are volatile when they need to be stable and uncertain when they need to be predictable’ (Lane and Glassman, 2009). Lane and Glassman (2009) show that health aid is more volatile than public health spending in recipient countries, and point out that since aid tends to be pro-cyclical, it exacerbates rather than counteracts fluctuations in domestic health spending. They also argue that health aid volatility can be caused by donors, recipients and the ‘aid incentive structure that governs how principal and agent interact and how funds are requested and disbursed’. Examples of factors creating volatility include short-term donor commitments, variable gaps between disbursements and commitments, back-loading of disbursements and making aid conditional on the mobilization of additional financing (Lane and Glassman, 2009).

Additionality of financing

Critiques regarding the additionality of DAH concern the extent to which external financing is added to pre-existing domestic health spending, as against the extent to which it seems to displace such spending. Critiques have been raised regarding fungibility between health

and non-health spending (such as between health and road-building) and between various priorities within health spending (such as between HIV and malaria). (We do not focus here on corruption or other illegal diversion of government funds, but rather on the shifting of funds from one purpose to another within the government budget.) According to Garg et al. (2012), donors generally want recipient countries to show their commitment to the donor-funded priority by demonstrating that funds are 'additional' to government funds and do not replace government spending or cause governments to shift their resources to other activities.

There is considerable disagreement in the literature regarding the degree to which DAH is in fact additional (or fungible), the reasons behind it, and whether it is necessarily negative. Several scholars have argued that general development assistance to governments displaces government spending and thereby undermines the effectiveness of aid (Feyzioglu et al., 1998; Pack and Pack, 1993; Pettersson, 2007). A number of recent studies on health financing have found that recipient governments, on average, spend less of their own money on health if they receive health assistance (Frag et al., 2009; Lu et al., 2010). Frag et al. (2009) found evidence that DAH often substitutes for domestic health spending and found the largest (proportional) effect in low-income countries, with each 1% growth in DAH associated with a 0.14% decrease in government health spending from 1995 to 2006 (or a \$1 increase in DAH to low-income countries was associated with a \$0.27 decrease in government health spending). In middle-income countries, 1% growth in DAH was associated with a 0.04% reduction in government health spending (or each \$1 in DAH was associated with a \$0.63 reduction in government health spending). Lu et al. (2010) found that for every \$1 of DAH to governments, these reduced health spending by \$0.43–\$1.14. However, they found that in countries where DAH is largely channelled through NGOs, governments maintain or increase their levels of health spending. Lu et al. also observed that at the country level, while shares of government expenditures allocated to health increased in many regions, they decreased in many sub-Saharan African countries. If DAH is not additional to existing government health expenditure, donors may in future be less willing to contribute or earmark funds for health.

In contrast to these average results, country-level studies in Honduras, Rwanda and Thailand found increases in domestic spending in response to increases in donor funding (Garg et al., 2012). Sridhar and Woods (2010) also caution that misinterpretations of Lu and colleagues' findings may lead to an 'unsubstantiated' conclusion: that funding for health should not be routed through governments, but rather through private channels such as NGOs. They argue that the strength of the findings of Lu et al. is undermined by questions regarding the data set on government spending on health, as well as that on development assistance for health, and concerns regarding the channelling of aid through NGOs, which does little to strengthen country capacity. We note recent correspondence in the *The Lancet* that continues to debate the findings of Lu et al. (see Murray, 2012; Roodman, 2012).

Why might recipient countries sometimes decide to repurpose DAH – or shift their own resources in response to DAH? Stuckler et al. (2011) hypothesize that countries may redirect health financing into reserves in response to World Bank and IMF advice on how to cope with aid volatility, as well as recommendations to keep government spending low. In evaluating IMF-borrowing countries versus non-IMF-borrowing countries, they found that \$1 in DAH was associated with only an additional \$0.45 for health spending in non-borrowers, but with even less, \$0.01 ('complete displacement'), in borrowers. On average, health system spending grew at about half the speed in borrowers as against non-borrowers (Stuckler et al., 2011). Ooms et al. (2010) suggest that 'crowding out' may be a more appropriate term than 'fungibility', and argue that averages obscure the variation in explicit policy choices that lead governments to shift resources from one sector to another. They note that governments may shy away from increasing recurrent health expenditure because of uncertainty regarding the long-term predictability of international aid, linking fungibility to the problem of volatility (discussed above). In the light of the findings on fungibility, Hecht and Shah (2006) point out that it may not be fruitful for donors to expend energy in earmarking their funds for specific programmes, but rather they may want to consider broader sector-wide support (or even general budget support), thereby linking the debate on additionality to those on vertical versus horizontal programmes (see below for further discussion).

Adding further complexity to the debate are arguments that fungibility is not necessarily negative. In general, fungibility seems to reflect differences in the priorities of donors and recipients. If the priorities reflected in DAH allocations are not necessarily the 'right' priorities for countries (see further discussion of priority-setting below), the argument goes, then government budgets should not necessarily be determined by what donors have decided. Batiniji and Bendavid (2012)¹⁴ argue that aid displacement is not necessarily negative, as long as it still delivers socially desirable outcomes such as other pro-poor spending, economic growth or improved health. Finally, Ooms et al. (2010) conclude that donors should either leave allocation decisions fully in the hands of national governments or craft a political bargain where long-term predictable external support to the health sector is guaranteed in exchange for clear domestic commitments on health spending.

Priority-setting

There are three related but distinct debates about priority-setting: *how do* priorities actually get set, *who should* set priorities (donors versus recipients versus others), and *how should* priorities be set? We summarize each of these in turn.

The issue of donor-driven priorities is a long-running debate in development aid generally, as well as in health aid specifically. There has been concern that aid is an instrument of foreign policy intended primarily to advance a donor's own interests,¹⁵ rather than those of the recipient, leading to donor-driven priorities that are not necessarily in the best interests of the population on the receiving end (Ollila, 2005). Kickbusch (2002) has argued that global health priorities are a reflection of the economic and political interests of the donor countries, and that since the mid-1990s the arguments for greater US engagement in global health have been expressed increasingly in terms of national interests or enlightened self-interest. Others have gone further, arguing that aid has done much harm through poorly conceived policies, the creation of dependence and/or the undermining of good governance, and that countries would be better off without it (Easterly, 2006; Moyo, 2009). While it is beyond the scope of this paper to evaluate the evidence and analysis behind broad debates on development aid, highlighting them may help shed light on some of the health-specific discussions that follow.

There has been concern that aid is an instrument of foreign policy intended primarily to advance a donor's own interests, rather than those of the recipient, leading to donor-driven priorities that are not necessarily in the best interests of the population on the receiving end

Shiffman (2006) describes three alternative hypotheses for what drives global health priorities: the 'provider interest', 'recipient need' and 'global policy' frameworks. 'Provider interest' in the area of health could emerge because a disease is a threat to the citizens of the donor nation – perhaps because a disease is new and therefore poorly understood (e.g. Ebola, H5N1), deadly (e.g. Ebola, drug-resistant TB or HIV/AIDS) and/or spreading particularly rapidly (e.g. H1N1 pandemic flu). 'Recipient need', on the other hand, whether defined by the recipient, donor or third party, would imply that priorities are set based on criteria such as burden of disease, high

14 Initially, Batiniji and Bendavid (2012) raised concerns about the reliability and heterogeneity of the data used to draw some of the conclusions made by Lu et al. (2010) arguing that nearly half of the observations are missing for low-income countries, and for use of a different model. However, the authors have since retracted this critique and seem to agree with the findings of Lu et al. (see: <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001214>).

15 Indeed it is not uncommon for governments to make this argument explicitly to their constituents to justify ongoing spending of scarce government resources on non-citizens.

costs or local capacity constraints. Finally, the ‘global policy’ hypothesis suggests that global priorities are set not only on the basis of provider interest or recipient need, but also through processes of socialization whereby decision-makers do not always begin with clear preferences but come to be socialized – for example by attending international meetings – to support certain priorities such as polio eradication or HIV treatment. The repeated interaction of donors and recipient governments may lead to a process of policy (and priority) diffusion (Shiffman, 2006).

However, Kipiriri (2012) argues that it is in fact donors that largely set priorities at both global and national levels, citing the MDGs as a key example. She points to the lack of inclusive, explicit decision-making processes as being problematic for the legitimacy of such approaches to priority-setting, arguing that ‘(i) most of these organizations are not elected or appointed by the host countries, (ii) they are not representative of the general population they seek to serve, (iii) in most cases, they lack any legal frameworks for their activities and (iv) sometimes they may not conform to or respect the local values and norms.’

These scholars seek to explain how priorities are actually set. There has also been significant debate in the literature regarding *who should* set priorities and *how it should* take place. Arguably, consensus has been reached that it is recipient countries, rather than donors, who should set their own development and health priorities, as reflected in the 2005 Paris Declaration on Aid Effectiveness (and follow-up processes in Accra 2008 and Busan 2011) and in the broadly espoused principle of ‘country ownership’. In making the case for country-driven priority-setting, the OECD argued that ‘every “donor-driven” project not only promotes dependency, but actually undermines the necessary processes of development ... the host country and the intended beneficiaries must have a direct stake and sense of ownership at all stages, otherwise projects will not be maintained or will become heavy, unwanted burdens’ (OECD, 2011b).

However, the principle of country ownership raises three separate but overlapping difficulties. First, if a donor disagrees that a country’s priorities are indeed the right ones, what obligates or motivates that donor to continue to provide resources? Second, if the government’s priorities are not set in a credible or legitimate way – for example, if domestic political processes are not democratic, are inequitable and/or not evidence-based – should the donor support them? Third, what happens if, despite the rhetoric, donors in fact continue to set priorities? In response to questions such as these, the notion of ‘mutual accountability’ has gained prominence in the aid effectiveness debate, pointing to the interlinked responsibilities of both donor and recipient countries. (We further discuss accountability in the following section.)

There is consensus that recipient countries, rather than donors, should set their own development and health priorities, but this principle of country ownership raises several difficulties

There is also considerable critique of the way in which priorities are set, focusing on the apparent disconnect between objective indicators, such as recipient income or disease burden, and the level of DAH allocated. Indeed, the development of the now widely used Disability-Adjusted Life Year (DALY) as a unit of measurement was motivated, in part, to help donors and governments make difficult resource allocation decisions (Michaud et al., 2001, as quoted in Shiffman, 2006). IHME ranked countries according to their burden of disease, on the one hand, and the amount of DAH received, on the other, to illustrate the mismatch between the two (see Annex 1). IHME notes that NCDs account for 45% of the disease burden in developing countries, but only 1% of DAH in 2009 (IHME, 2011). Overall, the largest amount of DAH does not go to the poorest countries or to those with the highest disease burden, nor is it dedicated to the diseases that account for the greatest burden of disease. Indeed, Sridhar and Woods (2010) have concluded that ‘donors neither set nor fund priorities in a rational way’.

Much of this debate has centred around the mobilization of funding for HIV/AIDS, which critics argue is disproportionate to need, is relatively costly (or less cost-effective than other interventions) and can exhibit many of the negative effects associated with vertical programming (since much HIV spending takes that form), such as distorting health systems (Easterly, 2006; England, 2007). However, others have argued that the coat-tails effect of political mobilization around HIV was necessary to attract new funding to global health in general, that HIV treatment is cost-effective, that the spreading epidemic had to be stopped and that HIV spending could strengthen health systems if targeted to do so (‘t Hoen et al., 2011; Yu et al., 2008). In one of the first studies to examine DAH allocations by disease, Shiffman (2006) argued that HIV attracted a disproportionate share of global health financing (46% of financing, while comprising 31% of total burden of disease, compared with acute respiratory infections, which drew 2% of funding but accounted for 26% of disease burden); however, he also pointed out that the DALYs linked to HIV increased more rapidly than those for any other disease from 1990 to 2000, and that donor investment could be seen as a response to growing need. His analysis also showed that certain diseases targeted for elimination or eradication would generate higher costs per DALY as disease incidence dropped, citing polio and onchocerciasis as examples. Shiffman’s analysis underscores the counter-argument that DALYs are too simple a metric to drive priority-setting, and that legitimate reasons may underlie the different levels of spending allocated to specific priorities. Thus, a mismatch between DALYs and dollars may not necessarily mean that a disease is ‘under-’ or ‘overfunded’.

The debate on priority-setting is also closely linked to long-standing debates on ‘vertical’ versus ‘horizontal’ programmes, or, in other words, between donor financing of disease-specific programmes versus health systems strengthening. Vertical programmes refer to instances where ‘the solution of a given health problem [is addressed] through the application of specific measures through single-purpose machinery’ (Risse, 2004). Horizontal programmes seek to ‘tackle the overall health problems on a wide front and on a long-term basis through the creation of a system of permanent institutions commonly known as ‘general health services’ (Risse, 2004). The history of DAH has seen broad shifts favouring one over the other. Disease-focused vertical programmes such as the malaria and smallpox campaigns dominated in the 1950s and 1960s, while a re-emphasis on primary health care shifted favour to horizontal approaches in the 1970s and 1980s, with (arguably) a return to vertical approaches driven by the response to the HIV/AIDS epidemic in the late 1990s and 2000s.

Vertical programmes have been criticized for fragmenting health systems; causing waste, duplication and inefficiency; crowding out prevention and access to general services for the majority of the population; focusing excessively on short-term, easily measured outcomes, and reducing the long-term sustainability of a programme once donor support ends. Vertical programmes have also been said to be responsive to diseases rather than to people, and to create vested interest groups that may obstruct later reforms designed to integrate services, and may be ill-suited to responding to diseases with multiple causes or co-morbidities, such as HIV, for which mobilizing other parts of the health system is required (Atun et al, 2008; Mills, 1983; Oliveira-Cruz et al., 2003). The critique that DAH had taken an excessively vertical approach arguably contributed to the creation in 2009 of a Health Systems Funding Platform between GAVI, the Global Fund and the World Bank (discussed further in Section 4 below).

On the other hand, various arguments for vertical programmes have also been advanced. These include greater service specialization and concentration, increased profile for a high-priority disease or service, better accountability, more rapid results in weak health systems and a better chance of success in weak states. Indeed, part of the appeal of vertical programmes may come from the straightforward way in which donor dollars can be linked to specific results. In addition, others have argued that vertical programmes may be needed when governments lack capacity, in order to achieve specific time-limited objectives (such as eradication or vaccination), or to generate the political mobilization necessary to sustain resource generation, as in the case of HIV/AIDS (Atun et al., 2008; Mills, 1983; Oliveira-Cruz et al., 2003). A third way has also been advocated – termed the ‘diagonal approach’ by Sepulveda and Frenk, referring to a ‘strategy in which we use explicit intervention priorities to drive the required improvements into the health system, dealing with such generic issues as human resource development, financing, facility planning, drug supply, rational prescription, and quality assurance’ (Sepulveda et al., 2006; Frenk, 2006).

Coordination

The proliferation of actors involved in DAH, particularly over the past decade, has raised concerns regarding the lack of coordination among them and an overall fragmentation of the system. The total number of major global health actors (donors, foundations, initiatives, etc.) was estimated to be at least 175 in 2008 (not accounting separately for the thousands of active NGOs) (McColl, 2008).¹⁶ Lack of coordination can be problematic for a number of reasons. Buse and Walt (1996) provide a succinct but wide-ranging assessment of the risks, arguing that lack of coordination can lead to,

inter alia: (i) inefficiencies in service delivery through duplication; (ii) geographic inequalities through the targeting of assistance to favoured areas and populations; (iii) confusion through, for example, the espousal of conflicting and changing donor policies; (iv) exacerbation of administrative inefficiencies as ministry staff devote excessive time to coping with heterogeneous and incompatible aid administration requirements; (v) displaced local priorities as donors' preferences prevail; and (vi) abrogation of recipient sovereignty over budgetary and policy processes.

Perhaps in response to this critique, the aid effectiveness discourse has heavily emphasized 'harmonization', 'coherence' and 'coordination' among donors, in addition to 'alignment' and adherence to the principle of 'country ownership'. The issue of coordination also overlaps considerably with debates regarding vertical versus horizontal programmes, programme-specific funding versus general budget support, and the additionality or fungibility of DAH.

**In 2008, there were at least 175 major global health actors.
Coordination efforts have yielded disappointing results.
Coordination faces several barriers, and some argue it is neither
feasible nor desirable**

However, some analysts point out that coordination is not as straightforward or easy to achieve as the rhetoric would suggest. Rather, it is a political act often involving the renunciation of at least some power, and it comes with costs but few individual rewards. Holzscheiter et al. (2012) observe that 'the dilemma with regard to further coordination, particularly among global partners, lies in the fact that it is very hard for actors to see incentives for collaboration and divisions of labour in an 'anarchical' terrain that is characterized by competition for visibility and leadership roles'. Fidler (2007) has argued that coordination may be oversold – and ultimately neither feasible nor desirable. He refers instead to a creative, 'open-source anarchy' among global health actors that can produce effective outcomes through processes of self-organization (akin to open-source software). Finally, Dybul et al. (2012) argue that 'the proliferation of global health institutions over half a century has been mirrored by a decade of proliferating efforts to coordinate,' but with disappointing results.

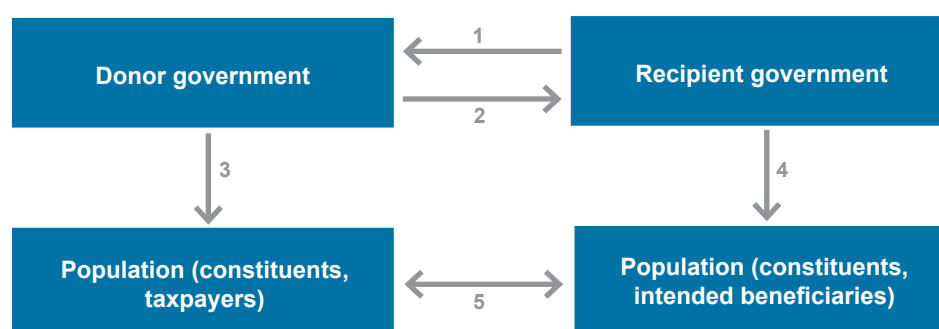
¹⁶ Acharya et al. (2006) point out that, at its origins in the US Marshall Plan for Europe post-WWII, there was effectively one donor engaged in development assistance, but that the development aid system has undergone fragmentation and witnessed a proliferation of actors continuously since then, especially since the 1970s.

Accountability

Many questions have arisen regarding the accountability of the existing DAH system, encompassing diverse issues regarding *who* should be accountable to *whom*, and for *what*. Accountability can be understood as a situation ‘in which an individual, group, or other entity makes demands on an agent to report on his/her activities, and has the ability to impose costs on the agent’ (Keohane, 2003). It can take a number of different forms, ranging from supervisory to fiscal, and from peer to reputational (Grant and Keohane, 2005). As Wild and Domingo (2010) point out, accountability ‘is about politics and power’ and requires answerability, enforceability and transparency.

Relationships of accountability can run in multiple directions, as illustrated in Figure 1.

Figure 1: Accountability relationships in development assistance for health



Note: This figure was developed collaboratively by members of Working Group 2 during the initial meeting in London, October 2012.

Discussions of accountability in development assistance have tended to focus on relationships between donor and recipient governments (relationships 1 and 2 in Figure 1). For example, a central issue in development assistance has been ensuring that recipients manage funds effectively and guard against corruption and misuse. Donors have demanded measures to address concerns regarding financial management and corruption. The Global Fund suspended or terminated grants to Uganda, Zambia and Mali over the suspected misuse of funds; and, in turn, in 2011–12 several donor countries withheld their contributions to the Global Fund, citing concerns raised by the Inspector General over missing monies. In terms of accountability for performance, as mentioned earlier, concerns about the impact of DAH have led to renewed calls for sufficient investments in monitoring and evaluation (Chan et al., 2010) and in the adoption of policies such as performance-based financing.

The notion that accountability should go both ways between donors and recipients has gained prominence, but mechanisms are scarce

Nevertheless, the notion that accountability should go both ways – from recipient to donor, as well as from donor to recipient – has also gained prominence, perhaps as a result of the many critiques of donor practices in DAH. For example, as discussed in other sections, when donors do not live up to funding commitments, disburse funds in an unpredictable manner, rapidly change priorities or fail to coordinate, there can be negative consequences for recipient countries. However, accountability mechanisms are scarce, and recipients (by definition) are almost always in a weaker position of power *vis-à-vis* donors. These concerns have perhaps

contributed to the emergence of the notions of 'shared' or 'mutual accountability', a central tenet of the 2005 Paris Declaration on Aid Effectiveness (discussed further below), suggesting a new emphasis on accountability to both recipients and donors.

All the same, some analysts have argued that holding government counterparts accountable for health improvements may be difficult, because health is affected by more than one ministry (including health, social welfare, labour, environment, agriculture and education) and responsibility for health services is likely to be shared by central and local governments (especially in decentralized systems), as well as many international actors (Dodd et al., 2007). Others have argued that the narrow focus on short-term results in performance-based financing frameworks comes at a cost to achieving longer-term, less easily quantified objectives such as building health systems (McCoy, personal communication, August 2012). In addition, critics decry the emphasis put on 'efforts most likely to show measurable results in a short-timescale, and political incentives to announce new initiatives even if that means abandoning successful policies' (Sridhar and Woods, 2010).

In addition to relationships between governments, concerns have also been raised regarding accountability between governments and their own constituents (relationships 3 and 4 in Figure 1). The accountability of donor governments to their own constituents has been the focus of increased scrutiny as foreign aid budgets have come under stress during the economic downturn, arguably increasing the demand for measurable results. The rise of the notions of 'value for money' and 'performance- or results-based financing'¹⁷ reflects this demand for accountability to taxpayers, which in turn has translated into demands by donors for greater accountability from recipients.

Furthermore, some critics have argued that aid can undermine institutions for accountability at the domestic level, making recipient governments less accountable to their own population. Alan Hudson of the OECD asked: 'How can aid be delivered and managed in a way that ensures accountability for aid but that does not lead to governments in developing countries being more accountable to external donors than to their citizens?' He argued that one way to do so would be 'by helping to build the capacity of key accountability institutions such as parliaments, political parties, civil society organizations and the media' (Hudson & GOVNET Secretariat, 2009). In a similar vein, Sridhar (2010) argues that lack of transparency regarding aid flows into a country, and/or channelling flows through NGOs, can undermine domestic accountability relationships. Tanzania's Minister of Health (as quoted in Sridhar, 2010) noted that, 'If they say, we have sent \$100 million dollars you would expect government to be accountable. But the funding is not recorded. We don't know where it goes. Much goes to civil society, and much remains in donor countries.'

Finally, as transborder social networks grow increasingly dense with globalization, and as increasing amounts of DAH are channelled outside governments, greater emphasis may be placed on accountability relationships between donors and recipients across societies (relationship 5 in Figure 1). For example, international NGOs that raise funds from the general public of their own societies to operate projects in other countries are facing increasing demands for accountability both at home and abroad (Jordan and van Tuijl, 2006).

Rationale

Debates have arisen regarding what *is* and what *should be* the rationale or justification for DAH, or, more broadly, international or global financing for health. The foundations of the existing system of DAH and ODA were built after the Second World War and decolonization, and were initially framed as 'foreign aid'. Arguably, the system has largely been built on the principles of

¹⁷ Performance-based financing can refer to all levels of health systems (e.g. when governments pay NGOs or regional governments for service delivery). We use it in the context of international financing to refer to donors linking funding to the achievement of certain goals by countries or multilateral agencies.

national interest, charity and/or enlightened self-interest. Donors sat clearly in one category and recipients in another, with a hierarchical relationship of dependence between them.

Alternative framings have since emerged. Framing international financing for health as 'cooperation' among independent states implies a more equal relationship, built on the principle of mutual benefit, and could take the form of pooled resources such as core funding to the UN system or other multilateral organizations.

The framing of 'restitution' has also been advanced – perhaps initially in relation to harms committed by colonial powers in their former colonies, and, more recently, in relation to acts of developed countries that harm developing countries.¹⁸ Thus, the notion of restitution could refer to remedy for past 'wrongs', or for ongoing 'wrongs', or for some combination of the two. Mackintosh (2007) and Mackintosh et al. (2006) have argued that adopting a restitution framework could help move the framing of DAH from 'charity to duty', and that the reality of health interdependence strengthens arguments for institutionalizing cross-border redistribution of resources. They illustrate their argument with the issue of south-to-north health worker migration – a case that they argue could also be used to test new types of arrangements for sustained cross-border financial flows for health.

The rationale for development assistance for health has been variously framed as foreign aid, cooperation, restitution and, more recently, global solidarity, implying shared responsibilities and resources. These framings are reflected in proposals for change.

Finally, the framing of global solidarity has been advanced, based on the notion of the emergence of a global society bound together by relationships of interdependence. Social globalization, human rights norms, the rise of middle-income countries and increased convergence in the health threats confronting countries can all be seen to have contributed to this new framing. The 'global solidarity' framing is built on the principle of the human right to health, which implies shared responsibilities, duties and obligations, with an implication of shared resources (Frenk and Moon, 2012). Each of these framings is visible in various reform proposals for the DAH system.

18 The creation of a Green Climate Fund, initiated in 2010 at the Cancún UN Framework Convention on Climate Change conference, could be understood to use a similar framing and rest on a similar rationale. Aiming to begin with initial financing of \$30 billion for 2010–12, and to reach \$100 billion per year by 2020, the fund was to be financed by developed countries to support mitigation of and adaptation to climate change in developing countries. At the time of this writing, the fund was in the process of being established and had not yet become operational. (See <http://gcfund.net/home.html>, last accessed 18 December 2012.)

4. PROPOSALS

We have dedicated significant attention to laying out the various critiques of the existing system before turning to proposals for change, as the diagnosis of the problem strongly influences prescriptions for solutions. This section offers brief descriptions of the proposals for alternatives that have been advanced, roughly divided into three categories: those that primarily seek to address financing issues (e.g. volumes, predictability); those that primarily seek to address governance issues within the existing DAH system (e.g. additionality, coordination, priority-setting and accountability); and those that reach beyond the DAH system. While some proposals may fit within more than one category, we have divided them in this way to facilitate analysis.

1 Financing-oriented proposals: volumes and predictability

In response to critiques regarding insufficient levels and high volatility of DAH, a number of proposals for innovative financing mechanisms have been advanced – both specifically for health and more broadly for development. As most of these have been analysed at length elsewhere,¹⁹ this paper provides only brief summaries of each in order to provide a broad picture of the type and scope of proposals put forward.

*International taxes*²⁰

Financial transaction taxes (FTTs), including currency transaction tax (CTT)

Taxes on financial transactions were originally proposed by the economist James Tobin as a mechanism to slow down global financial markets that were thought to be overheated and dangerously volatile – to ‘throw sand into the system’. More recently, FTT proposals have been reinvigorated following the 2008 financial crisis and by the search for more sustainable sources of development finance, including for global health. Taxes can be applied to a range of financial transactions, including trade in equities, bonds, currencies, derivatives or other financial instruments. The rates of existing taxes vary from a maximum of 2% to as low as 0.00001% (Beitler, 2010). FTTs have been implemented over many decades in at least 40 countries, including the United Kingdom, the United States, Brazil, South Africa and India, to raise revenue and/or regulate financial markets (Beitler, 2010). A tax of 0.005% on transactions involving stocks, bonds and currency could raise more than \$400 billion per year (Leading Group on Innovative Financing for Development, 2010). Estimates depend, of course, on the tax rate, on the traded good and on which countries implement it. The Leading Group report concluded that an FTT would be technically, legally and economically feasible.

Currency taxes, in particular, have received strong support from various quarters. The Leading Group estimated that a 0.005% tax on currency transactions (CTT) could raise \$35 billion per year for development aid, while the UN estimated that a tax at this level on all trading in the four major currencies (US dollars, euros, Japanese yen, British pounds) would generate \$40 billion per year (UN Department of Economic and Social Affairs, 2012). At the 2010 UN General Assembly, a group of 60 countries led by France proposed a CTT to help close the gap in development finance. While the United States and Switzerland were not in support, the French foreign minister argued that the tax could still be successful if implemented by the 60 countries already in agreement (Kaiser Family Foundation, 2010).

Concerns have been raised that investors would shift away from taxed instruments and/or that they would move their capital out of jurisdictions implementing FTTs, the net effect of which could be less revenue generated and a disproportionately heavy burden borne by FTT adopters

¹⁹ See, in particular, the Taskforce on Innovative Financing for Health Systems (2009), the Taskforce on International Financial Transactions and Development (2010) and UN DESA (2012).

²⁰ See also a concise discussion of a broad range of international taxes in the CEWG report, pp. 66–71.

(Leading Group, 2010). However, others have argued that FTTs can be designed to counteract or minimize these risks (Beitler, 2010).

The FTT has won political support from civil society groups, from Bill Gates, and from political leaders of a number of European countries, with particularly prominent support coming from French President François Hollande. In August 2012 France adopted the first tax on trades in stocks, levying a 0.2% tax on stocks of 109 French companies valued at more than 1 billion euros (Fouquet and Cimino, 2012). In September 2012 the European Commission proposed adopting an FTT, and in February 2013 11 of the 27 countries of the EU (France, Germany, Belgium, Austria, Slovenia, Portugal, Greece, Slovakia, Italy, Spain and Estonia) agreed to implement a tax of 0.1% on trades of shares and bonds, and a tax of 0.01% on derivatives. The EU estimated that the tax would generate €20–25 billion per year. However, whether – or how much of – any revenue raised would be dedicated to either development or health (as opposed to domestic spending) remains highly uncertain (European Commission, 2013).

'Sin' taxes

We use the term 'sin' tax to refer to proposed taxes on commodities that are (potentially) harmful to health, where a tax could contribute to achieving the joint goals of reducing consumption and generating resources for health. Such commodities include tobacco, alcohol, carbon emissions, small arms, and foods such as soda or sugar that are linked to non-communicable diseases.

Tobacco: WHO recently issued a report developing the concept of a Solidarity Tobacco Contribution (STC), in response to the recommendation made by the High-Level Taskforce on Innovative Financing for Health Systems (WHO, 2011). The recommendation of the Taskforce was to 'expand the mandatory solidarity levy on airline tickets and explore the technical viability of other solidarity levies on tobacco and currency transactions' (Taskforce on Innovative International Financing for Health Systems, 2009). WHO determined that an STC based on voluntary contributions from a 'micro-levy' on tobacco products (as part of larger national tobacco tax increases) is feasible and could raise significant amounts of additional revenue for health if the 43 countries of the G20+ implement it. According to WHO (2011), 28 countries already use tobacco taxes for health.

Among G20+ members, sample tax levels could be \$0.05 per cigarette pack for high-income countries,²¹ generating \$3.1 billion per year; \$0.03 for upper-middle-income countries,²² generating \$1.2 billion; and \$0.01 for lower-middle-income countries,²³ generating \$1.2 billion – to give total additional international health funding of \$5.5 billion per year (WHO, 2011). No specific reasons or criteria were found as to why only the G20+ countries were considered for inclusion in the proposal. It is envisaged that the first STC disbursement could occur at the end of 2012 or in early 2013. France has begun work to introduce the new additional tax on tobacco, and its minister of health has commissioned a report on 'new ways of implementing all measures recommended in the World Health Organization's Framework Convention on Tobacco Control' (Benkimoun, 2011). WHO has advocated for STC 'champions' – as was done in the successful launches of other major innovative financing mechanisms such as the International Finance Facility for Immunization (UK), UNITAID (France), and Advance Market Commitment (Italy) (Ross, 2011).

Alcohol: According to a study for WHO, increased or better-enforced taxes on alcohol could simultaneously raise revenue for health while reducing consumption (Stenberg et al., 2010). Using data from 42 countries,²⁴ Stenberg et al. (2010) found that increasing the tax rate on alcohol to at least 40% of the retail price would increase alcohol tax revenues from \$43 to \$77 billion per year. Their report concluded that low-income countries would gain the most, with new

21 High-income G20+: Australia, Austria, Belgium, Canada, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Japan, Malta, Netherlands, Norway, Portugal, Saudi Arabia, Republic of Korea, Slovakia, Slovenia, Spain, Sweden, United Kingdom and United States.

22 Upper-middle-income G20+: Argentina, Brazil, Bulgaria, Chile, Latvia, Lithuania, Mexico, Poland, Romania, Russia, South Africa and Turkey.

23 Lower-middle-income G20+: China, India and Indonesia.

24 12 low-income, 12 middle-income, 18 high-income countries.

tax revenue amounting to 38% of total current health spending. Another analysis proposed that 'with only a one-cent charge on alcohol, and a 10-cent charge on tobacco, universal access [to HIV interventions] could be funded in Nigeria, Uganda, Botswana, Thailand, Vietnam, India, Brazil, Russia, Ukraine, and China' (Hill and Sawyer, 2012); these are 10 of the 20 countries facing the highest burden of HIV.

Carbon: The UN Department of Economic and Social Affairs (UN DESA, 2012) estimates that a tax of \$25 per ton of carbon emissions could generate \$250 billion per year for development. However, given the persistent difficulties in reaching international agreement on analogous measures in climate change negotiations, it is questionable whether or how a new carbon tax could be widely implemented.

Billionaire's tax

The billionaire's tax was proposed in the UN DESA report on new sources of financing for development (UN DESA, 2012). It proposed a 1% tax on individual wealth holdings of over \$1 billion. With an estimated 1,200 billionaires in the world in 2012, with total wealth of about \$4.6 trillion, a 1% tax could raise \$46 billion per year. It is unclear how such a tax would be levied, since presumably many governments would need to adopt legislation to put it into effect.

The UNITAID airline tax, by gaining participation from both traditional donors and developing countries, can be understood as expanding the concept of development assistance for health

UNITAID air-ticket levy and analogues

The Air Solidarity Levy Tax was first suggested by President Jacques Chirac of France in 2004 as a way to support the MDGs, increase financing for development and ensure a stable supply of funds to meet global health needs. In 2005, at the UN Millennium+5 Summit, President Luiz Inácio Lula da Silva of Brazil persuaded 66 countries to support a proposal for an experimental tax at the international level and to sign the 'Declaration on Innovative Sources of Financing for Development' (Global Health Europe, 2012). These efforts resulted in the implementation of a pilot international solidarity contribution from an additional tax on air tickets to finance efforts against HIV/AIDS and other pandemics. The tax is imposed by countries on passengers travelling through their airports, and countries can adjust the tax depending on their individual circumstances and those of the travellers: for example, France taxes business-class long-haul tickets at a higher level than economy tickets; some African countries impose the tax only on international flights or on business- and first-class tickets. Funds go to UNITAID, a global health initiative founded by Brazil, Chile, France, Norway and the United Kingdom, which 'aims to improve access to treatments against HIV/AIDS, malaria and tuberculosis for the populations of developing countries, by getting lower prices of quality medicines and diagnostics which are still too expensive for these countries, and speed up their availability and delivery in the field'. Among the 29 member countries of UNITAID, those that have implemented the airline tax include Chile, France, Madagascar, Mauritius, Niger and the Republic of Korea, while Norway allocates part of its tax on CO₂ emissions from aviation fuel to UNITAID. By securing participation from both traditional donors and developing countries, the tax can be understood as expanding the concept of DAH. UNITAID has raised a total of \$2.1 billion since 2006.

Financial management mechanisms

Issuing or leveraging special drawing rights (SDRs)

The IMF could make available increased international liquidity in the form of Special Drawing Rights (SDRs), which generally are allocated proportionally to IMF contributors. Reallocating these issued SDRs to developing countries could generate \$160–\$270 billion per year by

increasing international liquidity and the availability of reserves, thereby freeing up domestic resources in developing countries for other purposes. However, UN DESA deems this outcome politically unlikely, as the wealthier countries that would need to approve such a reallocation would bear the burden of decreased access to SDRs as a result. Another approach is to leverage existing SDRs. Because reserve-rich countries effectively 'sit on' SDRs, it has been proposed that SDRs could be leveraged by making them available to back bonds that would then generate funds to be dedicated to development purposes. It is estimated that leveraging existing SDRs would potentially raise \$100 billion per year. 'Idle' SDRs could also be used to purchase long-term assets, although limits would need to be set to ensure that SDRs continued to function as a reserve (UN DESA, 2012).

International Finance Facility for Immunization (IFFIm)

IFFIm was started in 2006 with the aim of generating funds to support the GAVI Alliance. It is able to front-load investments by using long-term pledges from donor governments to sell 'vaccine bonds' in the capital markets, making large volumes of funds immediately available. It has legally binding commitments for 20 years from countries such as the United Kingdom, France, Italy, Norway, Australia, Spain, the Netherlands, Sweden and South Africa, and has allowed developing countries to 'make long-term budget and planning decisions about immunization programmes'.²⁵ IFFIm can be seen as a way to increase the short-term availability of financing, while also reducing volatility and improving the predictability of aid flows. It does not increase total amounts of aid, but rather makes larger amounts available sooner.

Advance Market Commitment (AMC)

The Advance Market Commitment (AMC) is a project of GAVI which became operational in 2009, to provide an incentive to vaccine manufacturers to develop and/or supply vaccines for use in lower-middle-income countries (specifically, in GAVI-eligible countries). Six donors (Canada, Italy, Norway, Russia, the United Kingdom and the Bill & Melinda Gates Foundation) committed a total of \$1.5 billion to finance the procurement of pneumococcal vaccines for a 10-year period. While an analysis of the AMC as an incentive mechanism for vaccine producers is beyond the scope of this paper, we mention it here as an example of a donor commitment that extends beyond the usual one-to-three-year time frame, thereby addressing the problem of volatility and uncertainty in DAH financial flows.²⁶

Securitization of aid receivables/health endowment fund/swing donor facility/health 'debit card'

Lane and Glassman analyse four proposals for reducing DAH volatility. We summarize each of these in turn, but, for more detailed analysis, see the original paper (Lane and Glassman, 2009):

- *Securitization of aid receivables*: recipients use future promises of aid as 'collateral' to access smooth, regular funding through financial markets (similar to IFFIm).
- *Health endowment fund*: donors would create an endowment that would make regular payouts to recipient countries. While such a mechanism would improve predictability, the authors conclude that locking up considerable resources in this manner would be undesirable and outweigh the benefits.
- *Swing donor facility*, or donor of last resort: A swing donor could be an institution, such as the World Bank, that would counterbalance unpredictable disbursements by individual donors in order to smooth out resource transfers. The swing donor would not commit additional funds, but rather merely smooth the flow of monies.
- *Health 'debit card'*: a small proportion of aid would be set aside into a 'stabilization pool' or 'buffer fund', and recipient countries would be able to draw from it (using their 'debit card') when needed in order to counteract short-term volatility in financial flows.

²⁵ <http://www.iffim.org/about/>.

²⁶ <http://www.gavialliance.org/funding/pneumococcal-amc/>.

These proposals require coordination and agreement from donors to allow their funding to be handled in this way.

Debt2Health and analogues

Debt2Health is an innovative financing mechanism of the Global Fund, intended to redirect funds for debt repayment to health. Debt2Health identifies debt conversion opportunities and initiates discussions between the creditor nation, the debtor nation and the Global Fund. According to the Global Fund, 'creditors forgo a portion of their claims on the condition that the beneficiary country invests an agreed counterpart amount in its national health programs, through an approved Global Fund grant'. The funding provided through Debt2Health is disbursed by the Global Fund to the beneficiary country through the Fund's normal channels. Debt2Health has signed four agreements, raising a total of 81.8 million euros for the Global Fund.²⁷ Other initiatives converting debt to resources for health include a programme for donors to buy down debt owed to the World Bank (International Development Association) in exchange for progress on polio eradication (Hecht and Shah, 2006).

Private-sector product sales (e.g. (Product) Red)

Earmarked contributions from the sale of products by the private sector can generate additional funds for health. (Product) Red, perhaps the highest-profile initiative of this type, was started in 2006 by Bono and Bobby Shriver to raise awareness and funding to combat HIV/AIDS in Africa through the Global Fund. Its mission is 'to help deliver an AIDS Free Generation by 2015 by partnering with the world's most iconic brands who contribute up to 50% of profits from (RED)-branded goods and services to the Global Fund'. Participating companies include Nike, American Express (UK), Apple Inc. and Starbucks. The Global Fund reports that the initiative has raised \$195 million since its inception.²⁸ While these funds are quite likely additional to existing public-sector DAH, the amounts comprise only 1% of total contributions to the Global Fund (see Annex 2, UN DESA table for estimates and comparisons).

2 Governance-oriented proposals within DAH system: additionality, priority-setting, coordination and accountability

Country-level coordination

Sector-Wide Approaches (SWAs), general budget support, donor specialization

The terms Sector-Wide Approaches (SWAs), general budget support (GBS) and donor specialization all refer broadly to the principle that donors coordinate within a given country and with its government to harmonize aid with country priorities, as well as with each other – either by providing funds to an entire sector such as health (SWAs) or to the government budget overall (GBS). SWAs have been defined by Foster (2000) as when 'all significant funding for the sector supports a single sector policy and expenditure programme, under government leadership, adopting common approaches across the sector and progressing towards relying on government procedures for all funds'. Alternatively, each donor may focus on a particular sector (donor specialization) so that there is some division of labour. Generally speaking, such practices imply donors giving more control over funds to recipient governments. Therefore, some of the concerns broadly linked to doing so apply here, such as the difficulty of tracing the impact of a donor's funding on any particular outputs or outcomes.

According to the OECD, donor use of SWAs began in the early 2000s, with these early efforts contributing to the framing of the 2005 Paris Declaration on Aid Effectiveness (OECD, 2011a) (see discussion of Paris below). A survey evaluating the Paris Declaration found that a number of countries had begun to implement SWAs/GBS: the evaluators found significant results in

²⁷ <http://www.theglobalfund.org/en/innovativefinancing/debt2health/>.

²⁸ <http://www.theglobalfund.org/en/about/donors/private/red/>.

some countries (e.g. in Mali, GBS has led to 'Greater operational and allocation efficiency', 'Help maintaining macroeconomic stability; help maintaining fiscal discipline (disbursements are linked to greater tax revenues); operational and allocation efficiency' and 'Strengthening of the budget process and management of public funds; greater aid coordination, exhaustiveness and consistency.') Similarly, the OECD reported that SWAps are 'helping to coordinate stakeholders and strengthen sector plans at country level', for example in Bangladesh, Ghana, Kyrgyzstan, Malawi, Nepal and Tanzania (OECD, 2011a).

Despite the successes in some countries, there have been difficulties in others, with concerns about transaction costs for donors specifically in Mozambique and Tanzania. In Ghana, Paris Declaration evaluators found mixed results, stating that 'General Budget Support and Sector Budget Support have a positive impact on the Government of Ghana's ownership over development but in terms [of] development result delivery, impact remains limited' (Wood et al., 2011). The OECD cites the examples of Bangladesh, Malawi, Mali and Mozambique as countries that have had long-established SWAps but still have a significant number of health projects not using common procedures (OECD, 2011a). In Bangladesh, Senegal, Vietnam and Zambia, Paris evaluators found some ambivalence in implementing GBS in the health sector, noting that the governments of these countries 'do not have a clear stated position on its preferred aid modalities, working with the preferences coming from the donor side' (Wood et al., 2011). Finally, calls for a greater proportion of DAH to be channelled through government budgets may have contributed to increased resources for health systems (IHME, 2011).

Three Ones (for HIV/AIDS)

'Three Ones' is an initiative started by UNAIDS in 2004 to improve national-level coordination in response to the proliferation of actors involved in the response to HIV/AIDS. The three guiding principles are: 'One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners, One National AIDS Coordinating Authority, with a broad based multi-sector mandate, One agreed country level Monitoring and Evaluation System' (UNAIDS, 2005). The Three Ones preceded, and may have been a basis of, the broader Delivering as One UN initiative (see below). We did not find any recent evaluations of the Three Ones.²⁹

One UN/Delivering as One Initiative

The One UN pilot initiative was launched in 2007, following the 'Delivering as One' report produced by several heads of state in response to a request from the UN secretary-general (UNDG, 2012). The report examined how the UN system could work more efficiently and effectively, with a focus on development, humanitarian assistance and environment (Aziz, Diogo and Stoltenberg, 2006). Eight countries – Albania, Cape Verde, Mozambique, Pakistan, Rwanda, Tanzania, Uruguay and Vietnam – volunteered to become 'Delivering as One' pilots. One UN is based on four principles: One Leader, One Budget, One Programme and One Office – with One Voice (for advocacy) and One Fund added later. The main objectives are to increase the impact of the UN system at country level by increasing national ownership of UN activities, reducing transaction costs generated by UN organizations and increasing the UN's efficiency and effectiveness. The One UN initiative is supported by the UN Development Group (UNDG), an umbrella for 33 UN funds, programmes, agencies, departments and offices. One UN has also been faced with some challenges, including change management, problems with decision-making, Resident Coordinator empowerment and the persistence of agency and project mentality (UNDG, 2012). An independent evaluation was carried out, reviewing four years of implementation, and submitted to the UN General Assembly in 2012; it concluded that moderate progress had been made on One Leader, One Budget, One Fund and One Programme, and strong progress on One Voice, but little progress on One Office. Moderate progress had been made in the medium-term goals of enhancing UN capacity and reducing competition for funding, but there had been little progress in reducing duplication or

²⁹ For an assessment of the degree to which global health initiatives are coordinating at country-level on HIV/AIDS, see Spicer et al. (2010).

fragmentation. Finally, strong progress was noted for national ownership, moderate progress for better delivery of support to countries by the UN, and little progress on reducing transaction costs (Evaluation Management Group, 2012).

International-level coordination

Paris Declaration on Aid Effectiveness (and Accra Agenda for Action)

The 2005 Paris Declaration on Aid Effectiveness was signed by more than 100 countries and international organizations, and is based on five principles: ownership, alignment, harmonization, results and mutual accountability, with the follow-up 2008 Accra Agenda for Action putting additional emphasis on ownership, 'inclusive partnerships' and results. These initiatives were a response to a range of critiques regarding development assistance, including in the health sector. Health has been singled out as a 'tracer sector', to track implementation of the Declaration. 'Declaration-style aid' has been defined as 'aid that is clearly aligned to country priorities and systems, coordinated by the country and/or provided through harmonized or multi-donor arrangements, untied, predictable and transparent' (Wood et al., 2011).

A recent evaluation of the Paris Declaration on Aid Effectiveness found that most progress had been achieved on country ownership and least on managing for results and mutual accountability

Follow-up meetings in Accra in 2008 and Busan in 2011 have assessed progress in implementing the Declaration based on an agreed monitoring and evaluation (M&E) framework. A number of assessments have been carried out (e.g. KPMG, 2011; OECD, 2011a; Save the Children, 2011; Wood et al., 2011), with a range of conclusions. For example, Save the Children concludes that progress has been particularly slow on harmonization and predictability, and that donors still largely manage 'by' rather than 'for' results (Save the Children, 2011). IHME attributes the growth in DAH dedicated to broad health-sector support (from \$0.144 billion in 2000 to \$0.542 in 2005 and to \$1.234 in 2009), at least in part, to the Paris Declaration, noting that most of the increase comes from European bilateral donors that are members of IHP+ (see below). However, IHME also notes that, 'although the US signed the Paris Declaration, the amount of DAH that it provides for health-sector support has decreased from \$158.65 million in 2005 to \$54.36 million in 2009' (IHME, 2011). Based on a study undertaken in Rwanda, Swedlund (2011) argues that despite 'country ownership' rhetoric, donors are still in charge of priority-setting in recipient countries and have sought alternative ways of influencing decision-making; in a process of 'centralized collaboration', Swedlund asserts that what is happening in Rwanda is not broad national ownership but donors working with an elite group of government policy-makers (2011). The comprehensive Phase 2 evaluation of the Paris Declaration concluded that the most progress had been achieved on country ownership, and uneven progress on alignment and harmonization, but least progress on managing for results and mutual accountability (Wood et al., 2011).

International Health Partnership (IHP+)

IHP+ was initiated in 2007 to provide better coordination for donor countries and agencies to improve health in developing countries. It was established to provide solutions to problems such as fragmented DAH, top-down vertical disease-focused programmes, weakened ministries of health and dysfunctional health systems (McCoy et al., 2011). IHP+ seeks to apply the Paris Declaration principles to the health sector (Re Action UK, 2012). The initiative 'is open to all governments, development agencies and civil society organizations involved in improving health who are willing to adhere to the commitments in the IHP+ Global Compact for achieving the health Millennium Development Goals' (IHP, 2012). There are currently 56 signatories, including developing countries and donors. The IHP+ secretariat is hosted by the World Bank

and WHO. Shorten et al. (2012) undertook a survey to assess changes in practices among IHP+ signatories, and noted progress in strengthening of national planning processes and mutual accountability, and in donors aligning their support with national budgets; however, they also found lack of progress in the use of countries' financial management and procurement systems, performance reporting frameworks and information systems.

Health 8 (H8)

The H8 is an informal group of eight health-related organizations: WHO, UNICEF, UNFPA, UNAIDS, GFATM, GAVI, the Bill & Melinda Gates Foundation and the World Bank, formed in 2007 'to stimulate a global sense of urgency for reaching the health-related MDGs. It does this by focusing on better ways of working, particularly within institutions, which can lead to the MDGs being achieved more quickly and seizing opportunities presented by renewed interest in health systems.' The leaders of the group meet twice a year.³⁰ The creation of the initiative can be seen as a response to critiques regarding coordination among global health actors. It is particularly notable for the inclusion of the Gates Foundation, the only participant in the group that is not an intergovernmental organization. One outcome of the H8 grouping appears to be the unified call for coordination on M&E, including increasing investment in health information systems, a 'common data architecture', strengthening M&E, and increased access to and use of data, all of which would be expected to enhance national monitoring capacities and respond to donor expectations of increased accountability (Chan et al., 2010).

H4+ for maternal and child health

The H4+ was created in 2010 and it is made up of WHO, UNFPA, UNICEF, UNAIDS, UN Women and the World Bank. The purpose of the group is to support 60 countries with the highest infant and maternal mortality rates worldwide, by helping them strengthen their health systems to provide better maternal and child care. According to UNFPA, H4+ works with 'a wide range of stakeholders including governments, the UN country teams, and donor partners to develop comprehensive government-led work plans to support maternal and newborn health and survival'.³¹

Priority-setting methodologies

Various attempts have been made to improve various aspects of priority-setting for public health, including for DAH. For example, the instigation of the DALY/QALY, as noted above, was aimed at making priority-setting more rational, objective and evidence-based. Another well-known example is the Disease Control Priorities Project (DCCP), 'an ongoing effort to assess priorities in disease control and produce evidence-based analysis and resource materials to inform health policy-making in developing countries' (DCPP, 2012). (Many other efforts have taken place at national level, but we focus on global-level initiatives in this paper.) Such efforts can be understood as an attempt to facilitate priority-setting and, by extension, coordination in DAH.

UN Commission on Information and Accountability for Women's and Children's Health

The UN Commission on Information and Accountability for Women's and Children's Health was established in 2010 by the UN secretary-general, in response to a demand made in the Global Strategy for Women's and Children's Health for an 'effective framework for global reporting, oversight and accountability on women's and children's health'. The accountability framework 'identifies a core set of indicators for results and resources, proposes an action plan to improve health information systems, and explores opportunities to improve access to information through information technology'. The mandate of the Commission is 'to improve transparency, ensure consistency in reporting for better results, and more effectively track resources spent on maternal, newborn and child health'. The Commission has created 10 recommendations highlighted in its report *Keeping Promises, Managing Results*, through which it hopes to

30 <http://globalhealthreport.blogspot.ca/2008/04/who-are-health-eight-or-h8.html>.

31 <http://www.unfpa.org/webdav/site/global/shared/documents/safe%20motherhood/Resource%20Kit/H4%20Pamphlet.pdf>.

strengthen accountability among stakeholders and track funding for women and children's health based on the timeliness of donations, the effective and transparent use of resources and achievement of desired goals.³² An independent Expert Review Group (running in 2012–15) was created to track progress and adherence to commitments announced in 2010, and is to report directly to the UN secretary-general.³³

Principal Financier(s)

Dybul et al. (2012) have argued for a 'radical restructuring of 20th-century institutions', in part through the establishment of one or more 'Principal Financiers' that would channel funding 'to support coherent, country-owned, national health strategies'. They argue that it is 'virtually impossible' to achieve integrated support to health systems, because of a 'tangled web' of multilateral and bilateral institutions in which organizational interests and cultures have become entrenched. The Principal Financier would channel financing to countries in a manner that provided incentives for national-level integration of currently disparate health programmes, and require transparent monitoring and evaluation of high-level population indicators as well as intervention-specific data. The authors suggest that either existing institutions could be reformed in this direction, with the World Bank and Global Fund as prime candidates, or a new institution could be created after a 'Bretton Woods-type' gathering that would re-examine and potentially reinvent the basic architecture of the existing system. Existing funders could continue to operate as potential 'healthy competitors' to the Principal Financier, should this entity fail to deliver or live up to its promise.

3 Proposals reaching beyond the existing DAH system

World health insurance/Global Social Protection Fund

Ooms et al. (2010) have argued for the creation of mechanisms for long-term resource transfers (or redistribution) to poorer countries or populations to meet basic health needs, based on an expansion of the notion of social protection beyond the nation-state. This proposal questions the fundamental assumption underlying much of DAH that resource transfers are temporary. Rather, it is based on a human rights argument – that states are obligated to respect and protect the right to health, including the immediate provision of a minimum standard of services, and that states are obligated to assist each other when other states do not have the necessary resources to do so (Ooms et al., 2006). The proposal is also based on the notion that interdependence (or, put another way, the externalities generated by decision-making in one country on other countries) forms the rationale on which sustained transfers should be based. The rationale for a global social protection fund is analogous to that for a national safety net: 'just as states have created within-country mechanisms to redistribute capital as a means of insuring those who are at the losing end of the economic marketplace, so we can create a system of protection that can travel across borders to counterbalance the resources and labour costs that travel from poor to rich countries' (Ooms et al., 2010). The authors calculate how much low-income countries would need to finance a minimum package of care, and by how much their budgets would fall short even if they dedicated 15% of government revenue to health spending; the remainder, they argue, should be supported through long-term international financial commitments.

Health-related international law

Building on the precedent established by the Framework Convention on Tobacco Control (FCTC), which was the first treaty to be negotiated under Article 19 of the WHO constitution, others have argued for the increased use of formal international law to improve global health. In some ways, asserting that health should be a subject for international lawmaking, rather than

³² <http://www.everywomaneverychild.org/resources/accountability-commissionion>.

³³ http://www.who.int/woman_child_accountability/iERG/en/index.html.

merely the object of charity, frames resource transfers for health in a slightly different light from DAH. The treaty proposals have been tabled with various degrees of elaboration. We provide brief summaries here, but refer the reader to the cited sources for greater detail.

Some have argued for increased use of formal international law to improve global health, through conventions or treaties

R&D convention

A binding international convention for biomedical R&D was initially proposed by Hubbard and Love (2004) as a way for states to overcome the collective action and ‘free-rider’ problems linked to the provision of R&D as a global public good, and the problem of how to pay for innovation without requiring high prices to recoup R&D investments (which can seriously limit access to medicines for the end user). The treaty proposal has been elaborated upon and debated by various scholars, and recently gained political momentum when the WHO Consultative Expert Working Group on Research and Development recommended that member states consider launching negotiations for such a treaty in order to build a long-term, sustainable system for sharing the burdens and benefits of R&D (Moon et al., 2012; Røttingen and Chamas, 2012; Velasquez and Seuba, 2011; WHO Consultative Expert Working Group on Research and Development (CEWG): Financing and Coordination, 2012). As of this writing, WHO member states had postponed discussions of a binding treaty until 2016, but agreed to proceed with elements of a global framework for R&D targeting areas of market failure such as the neglected diseases (Potet and Athersuch, 2012).

Alcohol convention

Sridhar (2012) has proposed that WHO member states negotiate a treaty to regulate alcohol consumption, including building alcohol policies into national laws and submitting reports on implementation and progress to WHO.

Chronic disease ‘global compact’

Magnusson has proposed a ‘global compact’ for combating NCDs such as cardiovascular disease, diabetes and cancer. He argues that international laws and standards are complements to partnerships and economic policies, all of which can contribute to more effective action against chronic diseases. His proposal largely focuses on coordination of various global health actors, who could work together in ‘semi-autonomous workstreams’ dedicated to specific areas such as trade and agriculture or consumer protection (Magnusson, 2009; Magnusson, 2010).

‘Fake’ drugs treaty

In a 2011 editorial, the *The Lancet* argued that WHO member states should consider a treaty ‘to criminalize the manufacture, export, import and trade of counterfeit medicines, effectively a global treaty against fake drugs’ (*The Lancet*, 2011a). However, the definition of ‘fake’ or ‘counterfeit’ is highly contested, as some definitions incorporate generic drugs legitimately put on the market – a conflation of terms that has raised concern among public health advocates (Clift, 2010). *The Lancet* editorial did not define in what sense it was using the term ‘counterfeit’.

Obesity convention

The Lancet suggests a framework convention on obesity in an editorial arguing that concerted government action is necessary, and that voluntary private-sector approaches will be insufficient to address this growing problem (*The Lancet*, 2011b).

Framework Convention on Global Health

In 2007 Gostin (2007) proposed the creation of a Framework Convention on Global Health (FCGH) in order to address a number of weaknesses in the current global health system, including support to health systems, priority-setting that emphasizes basic survival needs, mechanisms to engage both state and non-state actors, coordination for increased harmonization, and monitoring and evaluation. Gostin (2007) has argued that the framework

could powerfully improve global health governance. The Framework Convention would commit States to a set of targets, both economic and logistic, and dismantle barriers to constructive engagement by the private and charitable sectors. A FCGH could set achievable goals for global health spending; define areas of cost effective investment to meet basic survival needs; build sustainable health systems; and create incentives for scientific innovation for affordable vaccines and essential medicines.

Some of the above-mentioned convention proposals could, in principle, come under the umbrella of a framework convention. The Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI) was created to advocate for and further develop the proposal, including defining essential health services and delineating national and global responsibilities for providing them (Gostin et al., 2011).

It is envisaged that these goals would be achieved through an incremental process in which states begin by negotiating a broad framework of principles such as goals, institutional structures, M&E, funding and enforcement, with more ambitious or detailed obligations negotiated over time through protocols, as with the UN Framework Convention on Climate Change. Concern has been raised, however, that such an extended process could lead to loss of momentum and poor compliance with obligations. While an advantage of the framework concept is that it could be quite flexible, such flexibility may run counter to the FCGH objective of creating fundamental change that would necessarily involve addressing contentious issues.

5. CRITERIA

Inherent in many of the above-mentioned critiques and proposals is a set of criteria regarding how an ideal DAH system would function, or, to frame the issue more broadly, how global health could be financed. This section proposes criteria that could be applied in assessing proposals for change, accompanied by questions for further deliberation, organized by the three categories of proposals applied in the previous section:

1. **Financing:** the following criteria are based on the premise that the existing DAH system suffers from insufficient resources and a lack of predictability in financial flows.
 - a) *Sufficiency and additionality:* in an ideal system, there would be sufficient resources to provide at least a basic minimum standard of health care. Will the proposal lead to sufficient, or at least additional (at national and/or international level), resources for health? How much more?
 - b) *Predictability:* improving the predictability of health financing could make DAH both more effective and more efficient. Will the proposal reduce the volatility of financial flows and offer more predictability and sustainability?
2. **Governance:** the following criteria are based on the premise that the governance of the existing DAH system falls short.
 - a) *Legitimacy:* in an ideal system, decisions regarding both the ends and means of DAH would be made through processes widely deemed to be legitimate. In practice, this may mean that those most affected by such decisions are substantively involved in making them (e.g. decisions on priority-setting) and that decisions are made with a maximum degree of transparency. Will the proposal strengthen the legitimacy of decision-making?
 - b) *Priority-setting:* arguably, priority-setting requires both the consideration of objective evidence and legitimate political processes for making tough choices. Will the proposal improve priority-setting processes? If so, how?
 - c) *Efficiency and coordination:* an ideal system would make efficient use of resources by, for example, minimizing overlap or duplication of effort. Will the proposal lead to the more efficient use of scarce funds? Will it improve coordination and decrease fragmentation among key actors? How (e.g. how will it overcome disincentives for coordination)? How will it build on existing actors or systems – in other words, how would proponents address the problems of ‘path dependence’ or ‘institutional stickiness’?³⁴
 - d) *Accountability for effectiveness:* in an ideal system, DAH would achieve its intended aim (e.g. of improving health or health equity, strengthening human security, protecting human rights). Will the proposal lead to the more effective use of funds? How will accountability for the effectiveness of a new arrangement be managed? In other words, what systems for financial management, monitoring and evaluation, and what conditionalities (or sanctions for non-compliance with agreed norms), would be put in place?
 - e) *Compliance:* in an ideal system, actors would comply with agreed norms and commitments, such as those regarding financing, monitoring and transparency. Will the proposal improve actor compliance (and, by extension, effectiveness of DAH efforts), and, if so, how?
 - f) *Responsibility of national and international actors:* Arguably, an ideal system would be characterized by agreed and clearly delineated roles and responsibilities. What are the responsibilities of national and international actors

³⁴ Barriers to changing institutions once they are established, often owing to the entrenchment of certain interests or powers in the core institutional arrangements.

in the proposal? How are these decided and agreed upon? Are they relatively non-controversial, or do they require significant shifts in norms regarding national versus international responsibilities?

3. **Beyond DAH:** the following criterion is based on the premise that fundamental features of the existing DAH system need to be changed.

- a) Rationale: What is or should be the underlying value basis of the proposal: aid, cooperation, restitution, solidarity, other?

4. **Implementation:**

- a) Feasibility: how politically and/or technically feasible is implementation of the proposal? What are the greatest barriers, and how insurmountable are they?

Thorough consideration of the various proposals for change, along the lines of these criteria and questions, would provide a clearer picture of which reforms would be most likely to strengthen the system while being feasible to implement.

6. CONCLUSIONS

The past decade has witnessed significant and rapid change in the system for DAH, and we are now entering an era of major transition. This background paper offers an overview of the system and its major areas of weakness, followed by a review of a broad range of proposals to address them and criteria by which such proposals could be weighed. Many proposals are aimed at addressing one or two major concerns, rather than all. This is not necessarily problematic, as long as they are clearly recognized as such, rather than as panaceas. Nevertheless, it raises two questions: how ambitious should efforts at systemic reform be; and how interconnected are existing problems?³⁵ More specifically, if financing and governance arrangements are fundamentally inseparable, can or should they be addressed in an integrated way?

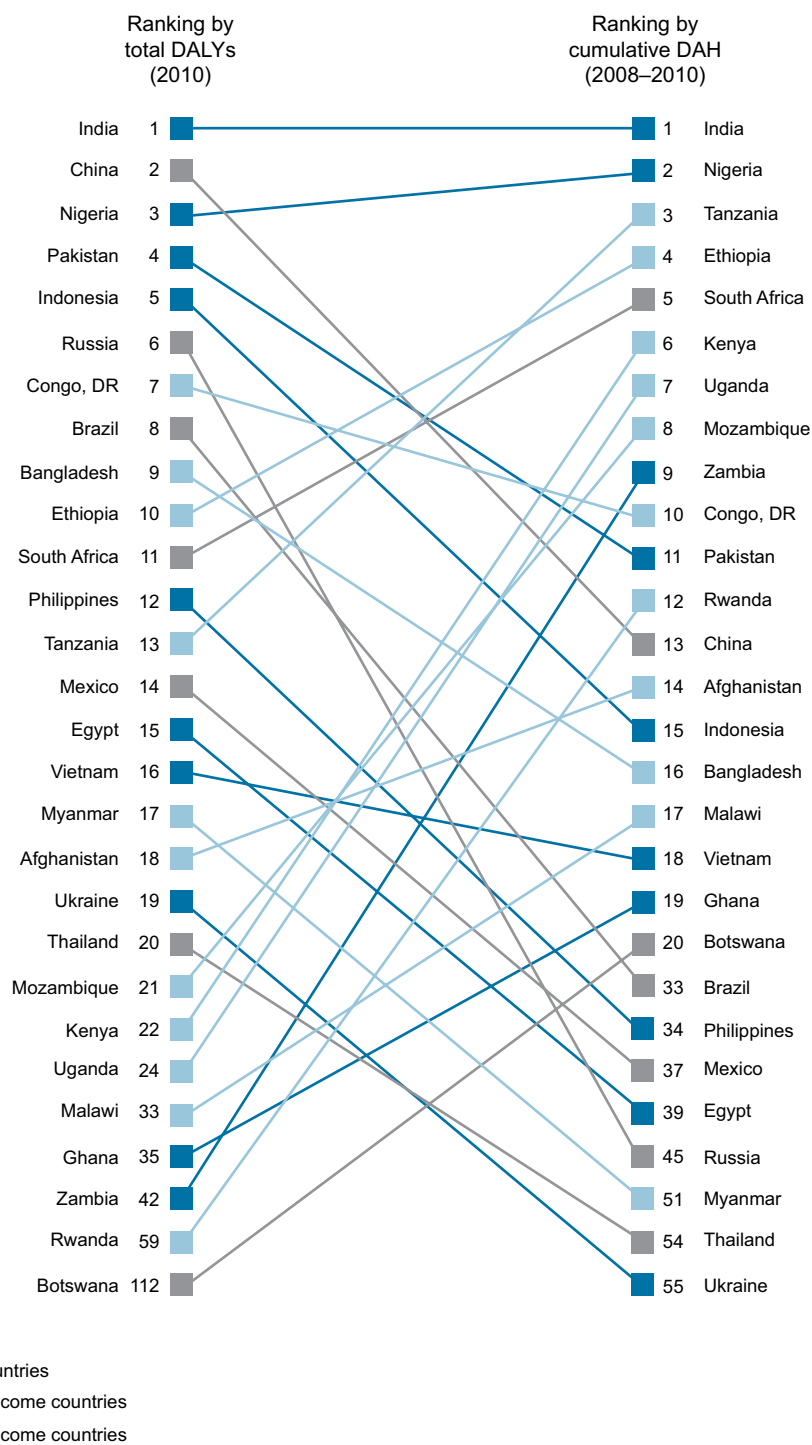
Furthermore, many of the proposals are characterized by a 'big idea', but remain nascent and would benefit from more detailed implementation plans. In particular, many proposals do not outline basic governance arrangements, such as who would have decision-making power, how decisions would be made, or how new initiatives would mesh with the existing architecture. Finally, greater consideration is warranted of the political and technical processes required to implement change, such as the minimum number of countries or other actors required to effect significant systemic change.

While it is beyond the scope of this paper to make recommendations on any specific proposal, we hope that the analysis presented here will facilitate critical and candid review of the system, with the aim of building stronger and more equitable institutions for financing global health.

³⁵ The experience of UNITAID suggests that it was not only the innovative way of raising funds (i.e. the idea of an air-ticket levy) that was compelling, but also how the money would be spent (i.e. to improve the functioning of global markets for commodities for HIV, TB and malaria), that convinced a number of key countries to launch and/or contribute to the initiative – including governments that continue to fund UNITAID through standard budgetary contributions (e.g. United Kingdom, Brazil) rather than an airline tax.

ANNEX 1: IHME COUNTRY RANKINGS BY DAH AND BURDEN OF DISEASE

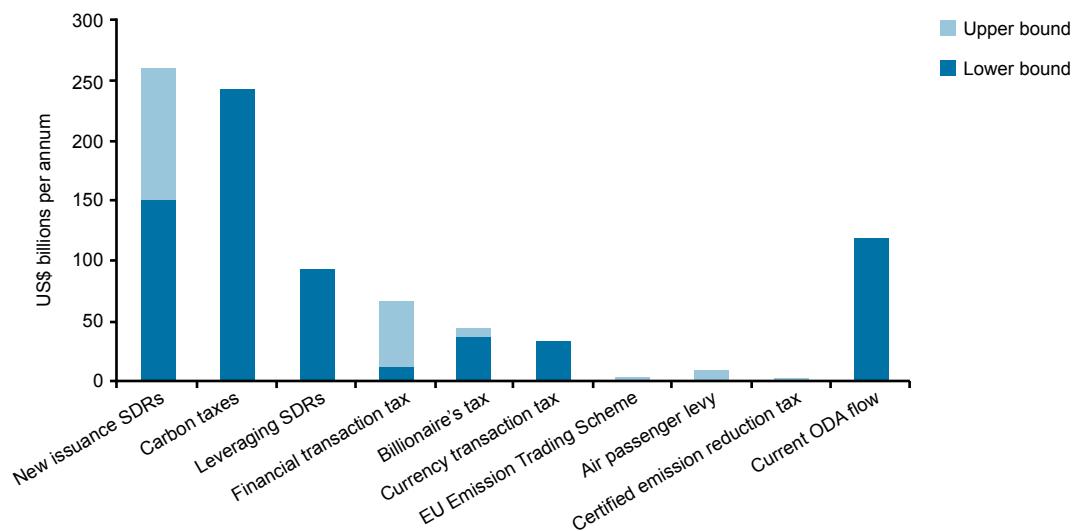
Figure A1.1: Top 20 countries by 2010 all-cause burden of disease versus cumulative 2008–2010 DAH



Source: IHME (2012), p. 23.

ANNEX 2: UN DESA ESTIMATES OF AMOUNTS GENERATED BY INNOVATIVE FINANCING MECHANISMS

Figure A2.1: The wide-ranging potential of (proposed and some existing) innovative sources of development finance



Source: UN DESA (2012), pp. vi–viii.

Table A2.1: Innovative sources of development finance and intermediation

	Description	Current level of resources (US\$ billion per year)	Approximate potential revenue (US\$ billion per year)	Comment
NEW SOURCES OF FINANCE				
<i>Public sector revenue</i>				
European Union Emission Trading Scheme (proceeds from initial allocations)	EU Governments auction: sell or allocate permits for emission allowances	0.2	1–5	Germany has agreed to allocate 15% to international climate finance. The proportion for other countries is not specified. Financing is additional to existing ODA
Proceeds from certified emission reduction (CER) trading (2% tax on new issuance)	2% tax on CERs under the Clean Development Mechanism	0.06	0.06–0.75	Additional financing for climate adaptation in developing countries
Solidarity levy on airline taxes	Small tax levied on airline tickets, proceeds earmarked for UNITAID	0.2	1–10	\$1.0 billion was raised between 2006 and 2010. Although financing is additional to existing ODA it is still accounted for as ODA by Development Assistance Committee members
Norway's tax on CO ₂ emissions from aviation fuel	Tax on CO ₂ emissions from aviation fuel in Norway	0.02	0.02	Norway contributes a portion of the proceeds of a tax on CO ₂ emissions from aviation fuels to UNITAID
Carbon tax (proposal)	Tax on use of fossil fuels and other products contributing to CO ₂ emissions	–	250	A tax of \$25 per ton of CO ₂ emissions by developed countries. Allocation of revenue for international climate financing would likely require an international agreement. Financing is additional to existing ODA
Currency transaction tax (CTT) (proposal)	Tiny tax on major currency foreign-exchange transactions	–	40	Assumes 0.005% tax. Revenue would be additional to existing ODA
Financial transaction tax (FTT) (proposal)	Tax on financial transactions, such as equity trades, bonds and derivatives. Includes CTTs	–	15–75 (excluding taxes on currencies)	A European Union FTT could raise €55 billion per year (excluding taxes on currencies), although it is unclear how much will go to development. Revenue would be additional to existing ODA
International billionaire's tax (proposal)	Tax of 1% on individual wealth holdings of \$1 billion or more	–	40–50	Proposal is not yet in any international agenda. Revenue would be additional to existing ODA
<i>Capturing global resources</i>				
New SDR issuance (proposal)	Regular annual allocations in favour of developing countries	–	160–270	Additional international liquidity would increase reserve availability and, while not a form of development financing, would free up domestic resources for development
Leveraging SDRs (proposal)	Idle SDR holdings of reserve-rich countries are leveraged for investment in development	–	100	Assumes \$100 billion of annual allocation to developed countries would be made available to international financial institutions in a way that preserves their status as reserve asset

	Description	Current level of resources (US\$ billion per year)	Approximate potential revenue (US\$ billion per year)	Comment
INTERMEDIATE FINANCING MECHANISMS				
<i>Capturing global resources</i>				
Ownership of global resources (proposal)	Charge royalties for natural resource extraction beyond 100-mile exclusive economic zones	–	Unclear	Requires agreement on regimes for managing global commons, such as the International Seabed Authority. Revenue would be additional to existing ODA
<i>Mechanisms that restructure cash flows</i>				
International Finance Facility for Immunisation (IFFIm)	Future aid flows securitized to front-load resources to finance GAVI Alliance	0.6	0.6	Between 2006 and 2011, IFFIm raised \$3.6 billion on the basis of donor commitments of \$6.3 billion. IFFIm restructures existing ODA and as a result is not additional
Debt2Health	Donors grant debt relief in exchange for a commitment by the debtor to invest half of the debt relief in Global Fund local programmes	0.02	Limited scalability	Between 2007 and 2011, Debt2Health deals worth €170.2 million were concluded, one-half of which countries contributed to the Global Fund. This is additional to existing ODA for countries that are current on their debt payments
Debt-for-nature swaps	Debt relief in exchange for local investments in the environment	0.05	Limited scalability	Has raised an estimated \$1.1 billion–\$1.5 billion since the late 1980s. This is additional to existing ODA for countries that are current on their debt payments
<i>Mechanisms to manage risk</i>				
Pilot advance market commitment for vaccines	Guaranteed future donor co-payments for vaccines	0.5	1.5 (committed)	Financing comes out of ODA budgets with small amount of additional financing provided by the Gates Foundation
Affordable Medicines Facility – malaria (AMFm)	A subsidy to drug manufacturers of malaria therapies (artemisinin-based combination therapies (ACTs))	0.2	Limited scalability	About half the financing comes from UNITAID. Based on the composition of UNITAID financing, in total, half of AMFm financing is from traditional ODA, 40% from innovative financing and 10% from philanthropy
Caribbean Catastrophe Risk Insurance Facility (CCRIF)	A regional catastrophe insurance pool	0	0.068	Donor countries and the World Bank capitalized the insurance fund. Initial payments came out of ODA budgets
<i>Mechanisms that leverage citizen or private sector resources</i>				
(Product) Red	A brand licensed to private firms	0.04	Limited scalability	Raises funds for the Global Fund. Financing comes from participating companies and is additional to ODA

Source: UN DESA, 2012, pp. vi–viii.

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ABOUT THE SERIES

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