

Improving the long-term sustainability of health aid: are Global Health Partnerships leading the way?

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Over the last decade development assistance for health has more than doubled. This increase provides an unprecedented opportunity to scale up health services, and in doing so, achieve the health Millennium Development Goals. However, sustaining scaling up will in turn require sustainable donor support until domestic health financing can substitute for it. The provision of long-term predictable finance is of particular concern in health because the bulk of costs are recurrent and many interventions require sustained, multi-year support to be successful. This is also true for health systems strengthening efforts. As the bulk of new aid resources flow through Global Health Partnerships (GHPs), their ability to make long-term commitments is critical to health systems development.

In order to better understand the constraints that prevent development partners from making long-term commitments of health aid, the World Health Organization reviewed the practices of seven major health partners in committing development assistance funds over the long term. The review found increasing evidence of long-term commitments of aid for health in each of the seven agencies. The GHPs and their funders have been at the forefront of this trend, pioneering many of the new approaches. The study concludes that all partners have scope to improve the duration of aid within existing rules and regulations, and that the main constraints to doing so are political.

Predictability is even more of a concern in current global economic circumstances, as access to resources begins to be squeezed. In this context it is important that we learn from GHPs, which have successfully tested innovative approaches to both raising and disbursing health funds. The prospects for change associated with the new administration in the United States—the largest health donor and the most unpredictable, but also a major supporter of GHPs—make this task even more urgent.

Keywords Health systems, health policy, aid

KEY MESSAGES

- The provision of long-term predictable finance is a key aspect of scaling up health services to reach the Millennium Development Goals, because the bulk of health costs are recurrent and many interventions require sustained, multi-year support if they are to be successful.
- Health donors are increasingly providing aid over the long term. The global health partnerships are at the forefront of this trend, pioneering many of the new approaches.
- However, all partners have scope to improve the duration of aid within their existing rules and regulations: the main constraints to doing so are political.
- Increased monitoring of aid duration and better incentives for donor agency staff to take on the risks and difficulties associated with making longer term commitments are needed.

Introduction

Between 2002 and 2006, Official Development Assistance (ODA) for health increased at an annual rate of 25% (Figure 1), reaching US\$16.7 billion in 2006 (OECD 2008). As the level of health aid (and overall aid) has risen, so has interest in the way in which money is provided: if aid resources are to be used effectively, it is argued, they must be provided *predictably*, and *sustained* over the long term (Clemens 2004; Heller 2005; Williams 2005; Lane and Glassman 2007).

The development community's concern with long-term predictable funding (Council on Foreign Relations 2004) is reflected in commitments of the Paris Declaration on Aid Effectiveness (OECD 2005), and the subsequent Accra Agenda for Action (Third High Level Forum on Aid Effectiveness 2008). Research into the volatility of aid flows (Hamann and Bulir 2001) suggests that aid is more volatile than fiscal revenues, particularly in highly aid-dependent countries. There is surprisingly little research into a closely related issue, the duration of aid commitments; neither on current practice, nor on the barriers to increasing the length of commitments, nor on the desirability of doing so.

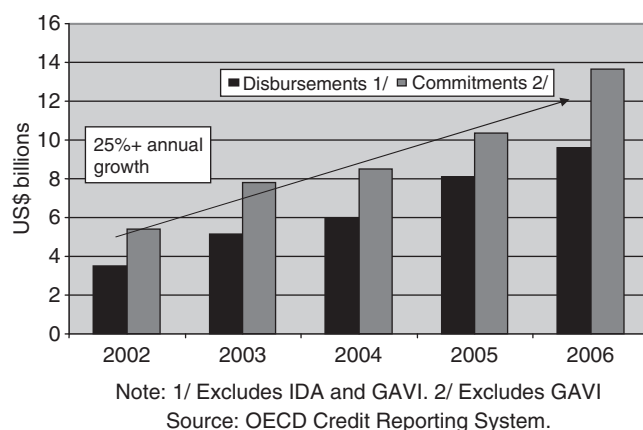


Figure 1 OECD Official Development Assistance for health and population aid activities, 2002–06

This study seeks to fill that gap. It systematically reviews current donor practice in the provision of long-term aid for health, identifies the practical constraints that agencies face in making long-term commitments, and provides 10 examples of existing good practice that could be more widely adopted. It also provides a brief overview of the arguments for and against provision of long-term aid as they are understood by the agencies that participated in this study. The purpose is not to make a judgement on the veracity of the arguments, but rather to understand the political context in which calls for long-term funding are taking place.

Since the research for this review was undertaken there has been a dramatic shift in the global economic outlook. With many developed economies now officially in recession, there is mounting uncertainty about whether the scaling up of aid flows for health can be extended or even maintained (Anonymous 2008; Holmqvist 2008; IRIN 2008). At the same time, local funding for health services may also face adverse pressures as developing economies adjust to slower domestic and global growth (Parry and Humphreys 2009). Those agencies that have secured long-term predictable funding with multi-year financing arrangements are arguably better placed to weather the financial crisis than those relying on annual funding rounds. It is therefore a particularly opportune time to consider how provision of predictable long-term funding can be extended and expanded.

Arguments for and against long-term funding in health

The provision of long-term predictable finance is of particular interest in health because the bulk of costs are recurrent and many interventions require sustained, multi-year support if they are to be successful (DFID 2004; Foster 2006). For example, expanding training programmes for skilled health personnel typically takes 8–10 years (WHO 2006). The average length of antiretroviral treatment for HIV is between 5 and 15 years for first-line drugs and 10–15 years for second-line drugs, up to 25–30 years in total. This treatment is heavily dependent

on donor resources: the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) and the President's Emergency Programme for AIDS Relief (PEPFAR) together support 1.3 million of the 2 million people receiving treatment in low- and middle-income countries (WHO 2008). Conversely, breaks in funding for health interventions can be costly. Interrupted drug treatments, aside from harming the patient, can lead to the development of drug-resistant strains (Brugha 2003).

It is legitimate to look at the longevity of health aid commitments in isolation from overall aid commitments because the bulk of health support comes specifically earmarked for the sector. Data from the OECD/DAC suggest that in 2002–06 general budget support commitments—wherein donors channel their aid directly into the budget of a recipient country and it is then mixed with domestic resources and allocated to different sectors—were equivalent to 6.4% of total ODA (excluding debt relief). Since domestic allocations to health tend to be low, particularly in poor countries, the level of resources reaching the health sector via this route is likely to be relatively small (Piva and Dodd 2009).

Short-term donor support thus poses a significant fiscal risk for recipient governments. This is particularly so in aid-dependent countries, but the set of challenges outlined is relevant to all countries receiving aid for health development (different criteria apply to emergency support). The transition from aid financing to domestic financing in low-income countries is likely to be far longer than the typical aid commitment horizon. Although many donor activities are carried out on a rolling basis, this raises concerns about the sustainability of essential services in the event that a grant is discontinued (Lane and Glassman 2007). Figure 2 illustrates this risk with a health example. It shows the financing outlook for HIV/AIDS activities in Rwanda, highlighting the extent of dependence on external financing at present and the rapid drop-off of external commitments in future years.

Against these benefits, donors engaged in the study identified a number of disadvantages to the provision of long-term financing, from their perspective. Many are unwilling to

commit funds beyond their term of office. Others are concerned about corruption and mis-management of aid resources in recipient countries, and regard a long-term commitment as a 'blank cheque'. A related point is that if recipient countries have a short planning horizon, long-term commitments may be of little benefit. New needs and challenges may arise, requiring flexibility in aid commitments. Finally, the promise of long-term support from donors could reduce the incentives for governments to raise domestic resources.

In addition to these points identified by donors themselves for our review, literature dealing with the 'politics of aid' would suggest a number of additional reasons that donor organizations may not want to commit resources over the long term. Foreign policy priorities may influence donors' funding decisions (Lancaster 2007) and donors may be reluctant to forgo the political leverage associated with relatively short funding cycles. Vocal constituencies in donor countries may also exert influence, pushing aid agencies to support certain issues over others; often these groups have greater access to aid decision-makers than do recipient countries (Mayer and Raimondos-Møller 1999; Milner 2006). Nevertheless, it is also clear that donor partners are not *only* influenced by geo-politics and self interest (Lumsdaine 1993), and in any case, foreign policy objectives and development objectives may coincide (Kassalow 2001). Donors are also influenced by norms and standards of 'good donor behaviour' associated with processes such as the Paris Declaration on Effectiveness.

This study does not seek to provide a political science critique of these various political factors influencing aid delivery. Rather, it takes at face value donors' promises to increase the longevity of their aid commitment and looks at whether they are progressing towards this target. It also considers the feasibility of further progress based on the aid instruments donors have at their disposal.

Methodology

Our study reviewed the practices of seven major health donors in committing development assistance funds over the long term: the GAVI Alliance (successor to the Global Alliance on Vaccines and Immunization); the Global Fund; Norway; Sweden; United Kingdom; United States [including PEPFAR, the Millennium Challenge Corporation (MCC) and the US Agency for International Development (USAID)]; and the World Bank. Together, these agencies account for two-thirds of country health aid disbursements and commitments provided by official donors reporting to the Organization of Economic Cooperation and Development (OECD). 'Long term' is defined as beyond 5 years and 'health' is defined as aid activities reported to the OECD under two sectors: health (general) and population (including reproductive health) (OECD, no date).

Three criteria were used to select agencies: (i) the size of health aid budget (we focused on agencies with larger budgets); (ii) covering the full range of agencies: bilateral, multilateral and Global Health Partnerships (GHPs); and, (iii) looking at the full range of approaches, including new, innovative health financing mechanisms. As much of the new

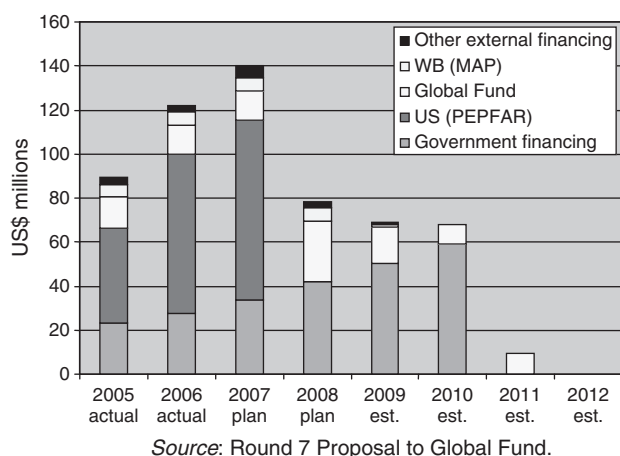


Figure 2 Rwanda: HIV/AIDS funding, plans and estimates in July 2007

aid resources for health flow through GHPs (OECD/DAC 2008), the ways in which these partners are funded, and their ability to make long-term commitments, was an area of particular interest.

The review compiled publicly available information on each agency's aid strategy, funding modalities and aid instruments. Additional qualitative and quantitative information was sourced from interviews with more than 60 staff across the seven agencies. Draft findings were discussed with individual agencies and peer reviewed at two workshops.

To better understand factors influencing the provision of long-term financing for health, we developed a model to explain the chain of aid delivery (Figure 3). The chain begins with international commitments for future aid (targets) and the terms of the funding of aid agencies (appropriations). Unsurprisingly, an agency that itself has short-term funding arrangements will find it difficult to make long-term funding commitments to aid recipients. On the delivery side, the duration of support (allocation–commitment–disbursement) is linked both to the duration of the programme being supported—such as the sector strategy—and the duration of the funding instrument used by the donor.

A review of the peer-reviewed and grey literature was also conducted. It revealed relatively little attention to the duration of aid commitments. More research has been conducted on the related issues of aid volatility and predictability. Cross-country empirical assessments find that: aid to developing countries has become more volatile during the 1980s and 1990s; slow growth countries—particularly in Africa—have higher aid volatility (Lensink and Morrissey 2000; Markandya *et al.* 2006); and aid volatility to fragile states is double that of other low-income countries (McGillivray 2006). Budget support is equally unpredictable: though the difference between projections and disbursements is relatively small when averaged over a number of years, there can be a difference of one-third in any given year. Further, aid tends to be bunched into the final quarter of the financial year (Celasun and Walliser 2006). When combined with the short-term horizon of aid commitments discussed in this paper, these characteristics of aid delivery are likely to affect the ability of recipient countries to effectively plan use of aid resources. Findings were peer reviewed by agency representatives individually and collectively, during two workshops.

Results

Aid targets

Following the chain of aid delivery described in Figure 3, the first factor to impact on the duration of aid commitments is the aid target—typically set by politicians at high-profile events such as G8 meetings—for the level of aid a donor government will provide over a given time period. Of the four bilateral agencies reviewed, three (UK, Sweden and Norway) have set long-term aid targets for aid spending. The USA does not set a formal aid target and this constrains its ability to make forward commitments. However, the US President does announce the level of expected funding over 5 years for Presidential programmes such as PEPFAR, which account for over half of US aid for the health sector. These announcements are subject to annual approval by Congress.

Funding base of development partners (appropriations)

The setting of aid targets influences the funding base of development agencies themselves, which is in turn an important determinant of agencies' ability to make long-term aid commitments. As Figure 4 shows, GHPs and the World Bank have the most stable funding base of all the agencies reviewed, more stable than the bilateral agencies which support them.

The GAVI Alliance, Global Fund and the World Bank's International Development Assistance (IDA) window have been able to obtain multi-year financing through:

- 3-year replenishment rounds (IDA and Global Fund);
- long-term pledges and innovative financing arrangements (GAVI Alliance & Global Fund);
- the ability to accumulate funds (GAVI Alliance, Global Fund and IDA).

By contrast, all four of the bilateral agencies reviewed work with 'firm' annual budgets approved by parliaments and 3- to 4-year 'indicative' funding frameworks. 'Firm' is defined as appropriated funds, while 'indicative' means subject to availability. Indicative commitments include: executive announcements which are subject to approval by the legislature (US for PEPFAR and MCC) and medium-term budget frameworks (UK, Sweden and Norway).

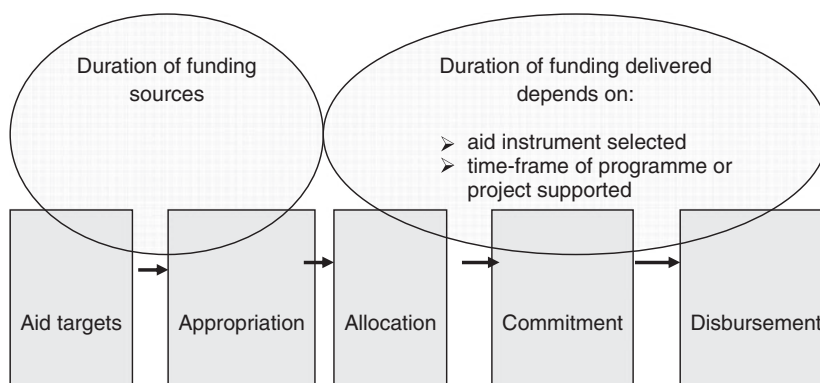


Figure 3 The chain of aid delivery

Though their own funding base is indicative, Norway and the UK are able to make *firm* 3-year commitments at the replenishment rounds of GHPs and the World Bank. The UK has also made an 8-year indicative commitment to the Global Fund and, Norway, Sweden and the UK have made 20-year commitments to the GAVI Alliance through the International Finance Facility for Immunisation (see Box 1); all considerably longer than their own indicative funding base. These commitments do require separate parliamentary approval. However, they demonstrate that, when the political circumstances are supportive, bilateral agencies are able to make longer-term financing commitments for the health sector.

The USA is a major funder of GHPs (and the largest contributor to the Global Fund) but legislative constraints prevent it from making multi-year replenishments. Moreover, while other agencies have a good record of delivering on

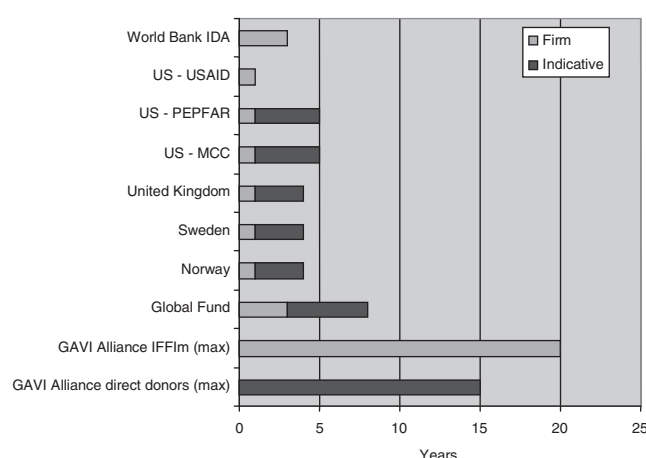
indicative commitments, the USA does not. US Treasury reports show that it had accumulated more than US\$872 million in arrears to multilateral development banks in 2008, which in part explains the reticence to make multi-year commitments to GHPs (US Department of the Treasury, no date). This means that a significant portion of GHP budgets remains uncertain and unstable year on year, which in turn impacts on the ability of these agencies to make long-term commitments to recipient countries.

Our results are consistent with an OECD review of donor practices on forward planning of aid expenditure (2007), which noted that all bilateral donors work with 'firm' annual budgets and just half of bilateral donors have 3- to 4-year 'indicative' spending plans. Multilaterals typically have a longer planning horizon, with multi-year budget frameworks ranging from 6–7 years for the European Community to 3- to 4-year replenishments for multilaterals and global funds.

While multi-year pledges are clearly preferable to annual commitments, longer-term commitments have the drawback that they 'lock in' donors at the bottom end of a desired funding scale-up. For example, the Global Fund received pledges amounting to US\$1.5 billion in 2005 against a strategic goal to increase funding to US\$6–8 billion annually. With a relatively short track record of implementation, it was unlikely to raise more at that time and therefore chose a short timeframe for the replenishment period. At the second replenishment (2008–10), pledges of close to US\$10 billion were received (GFATM, no date).

Duration of funding delivered to recipients: allocation–commitment–disbursement

There are three steps in the delivery of aid to recipient countries: the *allocation* to a country or a multi-country project (an internal procedure in each development agency); the *commitment* to the country or project (agreed in consultation with the recipient); and the actual *disbursement* or transfer of funds to the recipient or 'implementer'. The commitment step is



Notes: Firm = funds appropriated. Indicative = funds appropriated on an indicative basis, e.g. subject to availability of funds, conditions may apply.

Source: Collected by author from donor agency sources.

Figure 4 Duration of agency funding

Box 1 GAVI: pioneering innovative financing mechanisms

The GAVI Alliance has secured the strongest long-term financing arrangements of the seven agencies reviewed and therefore merits particular attention. With support from the UK government, the GAVI Alliance established the International Finance Facility for Immunisation (IFFIm) with the aim of rapidly scaling-up immunization coverage in poor countries.

Seven sovereign governments have entered into legally binding agreements to make payments to IFFIm over a 20-year period. Based on this guarantee, IFFIm issues AAA-rated bonds in the international capital markets, the resources from which go to fund GAVI programmes. On the basis of the future payments, IFFIm expects to issue bonds totalling US\$4 billion through to 2015. The first bond of US\$1 billion was issued in 2006 and the second bond of US\$223 million was issued in 2008 (IFFIm, no date).

GAVI also benefits from direct, long-term funding arrangements with Norway and the Gates Foundation: Gates pledged US\$750 million for 2000–05 followed by a further US\$750 million for 2005–15. In 2005, Norway pledged a long-term commitment through to 2015 making a total commitment of US\$1 billion for the period 2000–15.

While the IFFIm is an exceptional arrangement, requiring separate legislative approval from the parliaments of donors that support it, it has spurred interest in other innovative financing arrangements and opened the way for new approaches. GAVI also hopes to assist up to 60 countries in getting access to low-cost vaccines through the Advance Market Commitment (AMC) instrument that is underpinned by long-term commitments from the governments of Italy, the United Kingdom, Canada, Russia and Norway, and the Bill & Melinda Gates Foundation. The AMC is a mechanism to attract private sector investment in new vaccine products by guaranteeing purchase volumes at agreed prices over a period of time, largely financed by binding aid commitments (GAVI 2009).

the most important because it is at this point that figures become public, influencing recipient country planning processes.

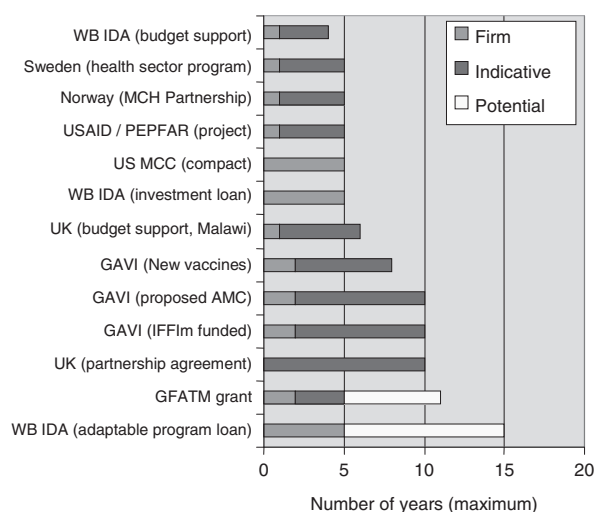
Commitments vary in strength and predictability.

- 'Firm' commitments where funds are appropriated, allocated to a country and committed, though conditions may apply to disbursement.
- 'Indicative' commitments where funding is allocated but committed on an indicative basis, e.g. subject to conditions such as the availability of funds.
- 'Potential' commitments exist when an extension phase is explicitly identified if a project or programme is first approved.

In the agencies surveyed, firm commitments range from 1 to 5 years. The addition of indicative commitments stretches the time horizon to between 4 and 10 years. Potential commitments enable the time horizon to stretch to 15 years (Figure 5).

Figure 5 shows that global partnerships and the World Bank make longer-term commitments than the bilateral agencies that support them, accounting for five of the six longest commitment periods (including indicative and potential commitments). When looking just at firm commitments, there is less difference between bilaterals and GHPs/multilaterals, as both the USA (MCC) and the World Bank are able to commit for 5-year periods. As discussed above, the process of annual budget approvals for bilaterals (Norway, Sweden, UK and USAID) prevents the firm commitment of funds from future budgets, unless exceptional parliamentary authorization has been gained.

Another reason for the longer-term commitment capacity of GHPs, the World Bank and the MCC is that they can accumulate liquid funds to back future commitments, whereas



Notes: Firm funds are appropriated, allocated to a country and committed, though conditions may apply to disbursement. Indicative means funding allocated but not committed or committed on an indicative basis, e.g. subject to availability funds, conditions may apply. Potential indicates not appropriated, allocated or committed. Extension phase or phases identified at approval.

Source: Collected by author from donor agency sources.

Figure 5 Duration of donor instruments for the health sector, at approval

bilaterals have to 'use or lose' their annual appropriations (with the notable exception of the US MCC). However, in the case of the Global Fund and IDA, future commitments are limited by financial regulations to cash and promissory notes¹ in hand, which creates two contradictory problems. The duration of firm future commitments is limited (because agencies can only commit what they have in the bank, not what they expect to receive). But at the same time, the need to accumulate large cash balances creates a problem of excessive liquidity. At the Global Fund, liquid balances of committed but undisbursed funds stood at US\$3 billion at the end of 2007, while IDA has accumulated roughly US\$18–20 billion of undisbursed funds.

Of the agencies reviewed, only Sweden systematically tracks and reports the *duration* of commitments, as part of an exercise to measure internal efficiency. The average duration of SIDA contribution agreements increased from 37 to 43 months between 2004 and 2006.

Strategies, instruments and recipients

The duration of development partner commitments is also influenced by the duration of health sector strategies being supported and the instruments through which aid is delivered.

The bilateral donors reviewed and the World Bank articulate their country health sector support through 3- to 5-year plans or strategies, albeit with varying amounts of information on the level of financial support that will be provided over this period. These donors often try to align their support with national Poverty Reduction Strategies (PRSs) and Health Sector Strategic Plans. Thus if the planning horizon of recipients is limited, the duration of support provided by these partners is also likely to be constrained.

GAVI Alliance and the Global Fund do not articulate their own country strategies but rather make funding available for proposals submitted by countries. Global Fund commitments are limited to 2- to 3-year phases within longer-term proposals, while GAVI, because of its own more stable funding base, can make firm 5-year commitments. In both cases, countries are encouraged to submit proposals which correspond to their national strategies—for immunization, HIV or health systems strengthening. Indeed, GAVI insists on this and thus the duration of its support matches the period of the country plan. This provides an incentive for countries to enter into long-term planning if they wish to receive longer-term funding.

Donors deliver their support *via* a range of financing instruments. These can be broadly split into project support, where funds are used to purchase specific goods and services, and budget or sector support, where funds are disbursed directly into the government budget in support of a health sector or poverty reduction strategy. The typical duration of a project-based approach is 5 years, with funds released periodically. Donors reviewed for this study reported that for sector or budget support the duration is shorter, typically in the range of 2–4 years with funds released annually or semi-annually. This raises a dilemma for those interested in aid effectiveness: increasing the proportion of aid delivered through government systems *and* increasing the duration of aid commitments are both aid effectiveness objectives (OECD 2003; Kenny 2006). However, our review suggests that project support is typically

longer in duration than sector and budget support, so these objectives may pull in different directions.

Emerging good practices and recommendations

Above we have described the chain of aid delivery and factors affecting the duration of aid commitments at each point in the chain. Below we highlight 10 examples of good practice that can help increase the duration of aid commitments. Each of these examples is being implemented by at least one of the donors reviewed; we make recommendations on how these could be more widely adopted. We have given particular emphasis to recommendations for the USA, because it is the largest bilateral donor in health but also the least predictable, and because we believe the new administration provides an opportunity for reform.

1. Set a strategic objective to increase long-term financing for health

GAVI's third strategic goal (of four) is to 'Increase the predictability and sustainability of long-term financing for national immunisation programs'. This provides a firm organizational mandate to move as far as possible towards longer-term financing. While other agencies formally acknowledge the importance of long-term predictable funding for health (notably the UK, Norway and Sweden), none have set institutional targets in this regard.

2. Track progress towards the strategic objective by systematically reporting on the duration of new projects and programmes

Measuring the average duration (and size) of new bilateral commitments by functional area would enable an assessment of whether donors are moving towards longer-term aid commitments. This is current practice in Sweden, while in the UK there is a legislative requirement that the Department for International Development reports annually on 'progress in specifying future allocations of aid' (Government of the United Kingdom 2006). It would also be helpful to measure the duration of funding from bilaterals to multilaterals and global partnerships, given their importance in international health.

3. Make indicative country support strategies publicly available

The World Bank and the UK publish their country support strategies together with some financial information on a consolidated country basis. GAVI, the Global Fund and the USA should consider following this practice and publishing consolidated medium-term indicative country support plans and estimated budgets. In the case of the USA, directives from the Office of Budget Management and the National Security Council that discourage aid projections would need to be revised. Ideally US plans would consolidate the operations of all US agencies supporting the health sector.

4. Define a strategy for funding long-term innovative financing instruments

A strategy that broadly articulates the circumstances under which bilateral agencies could support long-term innovative financing mechanisms for health would encourage greater use of such mechanisms.

5. More widespread use of promissory notes in replenishments

The use of promissory notes in place of funding pledges provides a stronger basis for multilaterals and GHPs to make commitments, and thus enables these agencies to make longer-term financing commitments. Bilateral donors who already use promissory notes for IDA could also consider using them for the Global Fund and GAVI (presently only the UK and France do so).

6. Adjust financing policies to permit commitments against pledges for future years at a discount that reflects the funding risk (Global Fund/World Bank)

There is a relatively low risk that funds pledged to GHPs and the World Bank will not be delivered (with the exception of funds pledged by the USA where multi-year pledges have not always been forthcoming as envisaged). Consideration could therefore be given to permitting multilaterals to make commitments against discounted pledges. For example, if there is an assessment of 90% probability that funds pledged for 2010 will be delivered, commitments up to the value of 90% of pledges could be made for 2010.

7. Specifically for the USA, set uniform terms for the commitment of funds across all channels of aid delivery

US restrictions on the use of foreign aid do not apply consistently across all aid channels. Most notably, USAID must use appropriated funds within 2 years, while MCC and PEPFAR have unlimited time to do so. In addition, PEPFAR can waive aid tying restrictions and is able to use funds to support recurrent spending, while USAID cannot.

8. Provide staff with incentives to make more use of existing, long-term instruments

The UK has stretched its normal planning horizon of 3–5 years to up to 10 years in specific cases, e.g. in Rwanda, Afghanistan, Pakistan, Sierra Leone. Similarly the World Bank's Adaptable Program Loan has provided support over a 12-year period in some countries. Although not explicitly an instrument for support of the health sector, sectoral issues are covered in these agreements. Nevertheless, these instruments remain under-used. Staff consulted for this review suggest that this is in part because they receive little encouragement or incentive to use them.

9. Align behind country multi-year plans and provide incentives for countries to develop such plans

GAVI aligns its financing for immunization and new and under-used vaccines with the duration of each country's

multi-year plan for immunization, and also aligns its health systems strengthening funding to align with health sector plans up to 2015. This provides an incentive for the country to enter into long-term planning. For agencies that have fixed-term duration instruments, notably the Global Fund, greater flexibility could be shown in aligning grant duration with country plans, following the GAVI example.

10. Make systematic use of financial sustainability plans, cost-sharing rules and exit strategies

As the duration of aid commitments increases, sustainability of resources becomes more important. MCC builds an explicit 'exit strategy' into its agreements with countries, while GAVI's has cost-sharing rules that aim to steadily increase developing country contributions to vaccine costs. There are many instances where this kind of approach is warranted, such as when donors provide health worker salary top ups and provision of antiretroviral therapies.

Discussion

In September 2008, development agencies meeting at the Third High Level Forum on Aid Effectiveness in Accra promised to increase the predictability of their aid, recognizing that this is needed 'to enable developing countries to effectively plan and manage their development programmes over the short and medium term' (Third High Level Forum on Aid Effectiveness 2008). Raising the share of aid delivered over the long term is one important aspect of increasing predictability, and should therefore be an objective for development agencies seeking to fulfil their Accra commitments.

Each of the seven agencies reviewed in this study is able to make long-term commitments of aid to the health sector, of 5 years or more, and has experience of doing so. However, the practice is not widespread, suggesting that agency staff do not have the right incentives to provide long-term support, or are not convinced of the desirability of providing such support.

Indeed, much more can be done to improve the duration of aid within existing rules and regulations. The main constraints are political: donors may not want to commit far beyond their electoral mandate; they may view making long-term commitments to countries with a poor governance or human rights record as high-risk; or they may see provision of long-term aid as counter-productive to the raising of domestic resources.

Associated with these political risks are a number of administrative hurdles: such as the process of annual budget approvals for bilateral agencies, or funding policies that limit commitments to cash and promissory notes in hand (for the Global Fund and World Bank). However, as our examples of good practice show, both administrative and political constraints can be overcome with sufficient political support.

Many of the new ideas on how to improve the longevity of financing emerged from GHPs and their financiers, and the GHPs have successfully pioneered many of the new approaches. The ability to provide long-term support is one important aspect of health systems strengthening, so, in this respect at least, GHPs will be key partners for countries seeking to reform their health systems over the medium to long term.

If such resources are to be used well, viable national (recipient) plans, procedures and processes for managing the health sector and improving health outcomes will be needed. Robust national health plans and financing strategies are key to changing the way aid is delivered to countries, including its duration and predictability. A short planning horizon in recipients may also limit the duration of aid commitments, creating a mutually-reinforcing cycle of short-term planning among donors and recipients.

Agencies therefore need to set incentives for countries to articulate longer-term goals and financing needs. Unforeseen health needs and challenges will always arise, and newer, more cost-effective interventions are continually emerging, requiring some degree of flexibility in aid commitments from donors. Even so, increasing the longevity and predictability of aid commitments should help to break the cycle of short-term planning and commitment, and provide an incentive to increase not only the duration, but also the efficiency and effectiveness of national health sector planning processes.

Endnote

¹ Promissory notes are convertible to cash on demand but usually have an encashment schedule indicating the dates the notes will be called.

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Disclaimer

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