

fines específicos induce a confusión a los decisores; esa forma de financiación es contraria al espíritu del enfoque sectorial; desde una perspectiva nacional, carece de sentido financiar doblemente las actividades; a menudo se pone en peligro la identificación de la

población local con la actividad; la financiación con fines específicos puede llevar a los gobiernos a aceptar intervenciones que no puedan costearse a largo plazo; y existe el riesgo de distorsionar la asignación de los recursos locales.

ملخص

هل التمويل الذي يخصصه المانحون لأغراض محددة يساعد البلدان النامية على توجيه مواردها للبرامج الصحية الأكثر نفعاً أم لا ؟

أن تعدد الأموال المخصصة لأغراض يحددها المانحون يؤدي إلى تشويش الموقف أمام أصحاب القرار السياسي؛ وأن تحديد المانحين لأوجه إنفاق الأموال المخصصة يتعارض مع روح الأسلوب القطاعي الشامل؛ وأنه من وجهة النظر الوطنية قد يكون ازدواج تمويل الأنشطة أمراً غير مقبول، وأن الشعور بملكية الأنشطة على المستوى المحلي عادة ما يكون دون المستوى المنشود؛ وأن التمويل المخصص لأغراض يحددها المانحون قد يؤدي بالحكومات إلى قبول المداخلات التي قد تعجز عن تحمّل تكاليفها على المدى الطويل؛ وأن هذا التمويل المخصص لأغراض محددة قد يربك المخصصات من الموارد المحلية.

الخلاصة: لا ينبغي أن نفترض أن الأموال المخصصة لأغراض يحددها المانحون سيؤدي بشكل تلقائي إلى زيادة الموارد التي تخصصها البلدان النامية للبرامج الصحية الأكثر نفعاً. فأحياناً يحدث ذلك وأحياناً لا يحدث، وذلك وفقاً لطريقة تخطيط التمويل. ويصدق هذا الافتراض بشكل خاص على المدى الطويل، وبعد انتهاء التمويل المخصص من المانحين. وحتى على المدى القصير فإن التمويل الكلي قد لا يزداد بالضرورة بسبب القابلية للاستبدال (أي أن الحكومات المتلقية للتمويل قد تعدل من طرق إنفاقها لتلائم الوجهة التي يفضلها المانحون). وقد استقصى الباحث في هذه الدراسة ستاً من المشكلات المتعلقة بالتمويل المخصص لأغراض يحددها المانحون، وهي:

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Round Table Discussion

Earmarking could be beneficial: cost-effectiveness is not the only criterion

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Waddington is no doubt right, there is nothing automatic about governments allocating their own funds to maximize cost-effectiveness just because donor funding is earmarked — whether or not the donor-sponsored programmes themselves yield the greatest, or even very large, health benefits. It is difficult to argue with any of the six points in her paper, except perhaps with the word “distort” to describe how donor funding for some (but not all) of the inputs to a programme causes governments to devote more of their own resources to the other inputs. That is not necessarily bad, even if it takes staff time or other locally funded inputs away from other activities. Donor funding may, in such cases, improve technical efficiency by correcting an imbalance among inputs — a rather common kind of imbalance, given the rigidities in hiring, firing and reassigning personnel that are common in low- and middle-income countries. There is also nothing automatic about such an improvement: the point is simply that earmarking may have an impact on technical as well as, or instead of, allocative efficiency, and that impact could

be beneficial. Donors presumably take some account of such effects, which in the best of cases would sometimes justify their insistence on paying for drugs but not salaries.

That local ownership is crucial to continued government support once the donor withdraws its funds or shifts them elsewhere is almost a tautology. Ownership is not a precondition for starting a donor-supported programme, however. The key question here is whether the experience with the donor-funded programme is likely to promote such ownership. The government may start by grudgingly accepting the donor's money for purely fiscal reasons, but may come to believe the programme is worth continuing to support, either because the results convince the government of its value, or because it becomes so popular with users that the government cannot let it die or cut it back without serious political repercussions. Government priorities do not have to be fixed, and indeed much donor effort is devoted, rightly or wrongly, to changing them.

Finally, the emphasis on “the greatest health benefits” implies that cost-effectiveness is the only, or at least the chief, criterion the government ought to follow in allocating its own resources. In fact, cost-effectiveness is only one of nine criteria relevant for assigning public funds among health interventions, and the different reasons for public spending can readily conflict (1). It is quite legitimate for the government to care as much or more about horizontal or vertical equity, or protecting the poor, as about maximizing health gains or benefits per dollar spent. For that matter, it is legitimate and common for donors also

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to care about those objectives, as witness the definition of the Millennium Development Goals. Whether earmarking donor funds shifts the relative importance of the different criteria for health spending is an open question in each case, but a shift away from cost-effectiveness, or a failure to emphasize it, is not invariably wrong. ■

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Earmarked funds and sectorwide approaches can encourage harmonization

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Waddington makes some very important points about the relationship between earmarked funds and other expenditures in the health sector in recipient countries. In general, her points reflect the views of the United Kingdom Department for International Development, in particular that sectorwide approaches are more likely to provide an efficient allocation of resources to the health sector in a way that reflects country priorities.

The awareness among donors of the inefficiencies and distortions of earmarked aid flows — or aid focused on projects and programmes — is reflected in the growing move towards sectorwide approaches and direct budget support, which at the same time encourages harmonization between donors and permits optimal allocation of resources at country level. But not all donors are inclined to follow the sectorwide approach, so there will always be an administrative burden on countries in dealing with multiple funding sources.

Under some circumstances, earmarked funds can be instrumental in encouraging harmonization of approaches between donors, by offering a single multilateral governance structure. Furthermore, such initiatives can provide a mechanism for enabling private sector organizations or foundations to contribute directly to public sector health services in a way that would not be feasible without the well-defined governance structure. Private foundations are unlikely to provide funds for direct budget support, but can be extremely important in funding specific objectives, as in the case of contributions from Rotary International and the Bill and Melinda Gates Foundation to the Polio Eradication Initiative, and nearly US\$ 1 billion from the private sector for the Global Alliance for Vaccines and Immunization (GAVI), well over 50% of committed funds. The earmarked structure can permit agencies such as USAID to make commitments over a number of years, in a way they cannot do for general aid flows.

Waddington rightly identifies a number of risks associated with earmarked funds, but they can offer effective mechanisms for increasing the overall funds available. Recent analysis suggests that while overall overseas development aid flows to health have declined over recent years, the decline has been more than offset by an increase in earmarked multilateral funds. Note that the decline in overseas development aid flows began before the growth of multilateral global funds, so the impact of the latter

has been broadly positive in terms of volume. Here lies the dilemma. It is argued that a major increase in aid flows (across all sectors) is required to achieve Millennium Development Goals and poverty reduction, and earmarked funds may be strong tools for increasing funds. It is equally important to try to minimize the distorting effects of such funding mechanisms, and to encourage harmonization between donors and at government level. Close coordination between funding bodies and governments is necessary to determine their priorities, so that earmarked funds can be better aligned with country needs. Country-driven mechanisms for accessing funds are vital in order to achieve country ownership and to provide channels for aligning funds with country priorities. It is possible to seek a balance between the governance benefits (to donors) of earmarking and the flexibility implied in sector-based approaches: GAVI, for example, allocates untied funds to systemwide support as part of its contribution.

The key lies in how earmarked allocations are designed in order to reap the benefits of greater resources, and in ensuring there is genuinely additional availability of resources. ■

Alma-Ata showed the route to effective resource allocations for health

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That donor funding has become the centrepiece of an international debate on national resource allocation is chilling evidence of the steep decline and fall of public health practice over the past two decades. It is a case of the tail wagging the dog so vigorously as to make it almost dysfunctional and disoriented. The word “donor” has patronizing connotations of condescension and even denigration for the poor countries of the world. Donors setting up health agendas for the poor countries is the very antithesis of the repeated, strong commitments to integration of health and health services made by WHO and its Member States in 1965 (1), at Alma-Ata in 1978, and in the “new public health” of 1995 (2). Donor funding ought to be a mere ancillary to the funds mobilized by poor countries to develop their health services in an integrated, intersectoral manner, yet donor-driven programmes have become pandemic. The question posed in the paper by Waddington should be considered the other way round. Identification of allocations that yield the greatest health benefits is a problem for health systems research: it is these findings that ought to determine the allocation of donor funding, if it is available without strings and on a long-term basis.

The Universal Immunization Programme offers an astonishing instance of an ill-conceived, scientifically inept and administratively unsustainable donor-funded programme (3). Because of these failings, in India the programme fell far short of its self-proclaimed goal of attaining a global coverage of 85%. Hundreds of millions of US\$ were wasted and national governments suffered even greater losses, apart from enormous damage to the infrastructure of their health service systems, because

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the funding agencies demanded and got top priority for the programme. The debacle was quietly forgotten. Significantly, while it was still being implemented, another global initiative launched by donors further damaged the infrastructure of countries' health systems — eradication of poliomyelitis from the world by 2000. This, too, failed to meet its objectives. Beyond costing over US\$ 9 billion, it has been tottering on the brink of collapse and causing extreme anxiety to its promoters. There appears to be something beyond mere altruism in the minds of donors: perhaps economics, politics and even the generation of employment for their people.

The bold writings on the wall finally found their place in India's National Health Policy of 2002 (4). India squarely distances itself from plunging into vertical programmes in the future, because they are far from being cost-effective, they are not sustainable and they cause immense damage to the

infrastructure of its health services. Incidentally, the WHO Commission on Macroeconomics and Health still refuses to read the writings on the wall (3). Instead of chasing the mirage that donor-driven programmes will lead to better resource allocation, the time is long overdue to follow the road map drawn up at the Alma-Ata Conference on Primary Health Care. ■

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