Are there simple conclusions on how to channel health funding?

In The Lancet today, Chunling Lu and colleagues\(^1\) present an important study identifying the key determinants of government spending on health in developing countries. These researchers present a nuanced and careful discussion of their findings. We worry that others will draw two rather crude conclusions. The first is that development assistance given directly to governments has a negative effect on government spending on health, and therefore funding for health should not be routed through governments. The second is that assistance given to non-governmental organisations (NGOs) has a positive effect on government spending, and therefore funding should be routed through NGOs. There are at least three reasons not to draw these conclusions. We urge you to pay attention to the caveats and suggestions for further research made by the authors themselves.

First, there are major problems with the data both on government spending on health as well as on development assistance for health, which make it difficult to draw firm conclusions. Lu and colleagues have accomplished a herculean task in generating a dataset on health spending in developing countries, yet questions remain on the validity of these data. For government health spending, the authors rely on a published dataset\(^2\) on development assistance for health, which is actually received by governments and not fully captured by government spending on health. This is offset by two additional sources of bias: a substantial amount of development assistance for health, US$13·3 billion in 2006, cannot be traced to developing countries and thus is not linked to particular governments. Finally, the database does not capture donors that are not members of the Development Assistance Committee of the Organisation for Economic Co-operation and Development, such as China, India, Saudi Arabia, and Venezuela, that make large aid contributions to developing countries although it is debatable how significant these contributions are to health.\(^3\) In view of the considerable uncertainty about the data for both government spending and development assistance, the conclusions should be carefully considered.

A second reason to be wary of simple conclusions is touched on by Lu and colleagues in their call for a careful assessment of the risks and benefits of expanded development assistance to NGOs—a hugely important point. NGOs might be an efficient mechanism to deliver vertical funds but, as Lu and colleagues note, this point has more often been hypothesised about than proved. One risk to this approach is that funding through off-budget channels bypasses the domestic systems, processes, and institutions that are meant to improve governance and sustain the effect of aid in the long term.\(^4\) The irony is that, in weak states, donors tend to give money to NGOs, which further detracts from the government’s capability and results in a perpetually weak government. The Millions Saved study by the Center for Global Development is telling: strong public-sector involvement is a key feature in all the cases examined of clear success in global health assistance.\(^5\)

Collier\(^6\) highlights another risk of funding NGOs directly by describing the severe coordination problems among NGOs that responded to Haiti’s crisis. He calls for donors to stop donating to NGOs and to stream funding into a common pool which would be overseen by the government. The coordination problem is one which health ministers know well because they often have no way of knowing where NGOs are working in their country, how much funding these groups are receiving, and what health services they are providing.\(^7\) As the Health Minister of Tanzania noted, “If they say, we have sent $100 million dollars, you would expect government to be accountable. But the funding is not recorded. We do not know where it goes. Much goes
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responsibility for setting priorities? Beware of the assumption that the international community does this well: donors neither set nor fund priorities in a rational way. Messing up good intentions are vested interests, pressures to disburse funds, a prioritising of efforts most likely to show measurable results in a short-time scale, and political incentives to announce new initiatives even if that means abandoning successful policies.

For all the above reasons, after years of negotiations, donors have agreed that national governments offer the closest approximation we have to an acceptable process for setting a country’s priorities; hence the Paris Declaration on Aid Effectiveness and its follow-up, the Accra Agenda for Action. In these agreements, more than 100 signatories—from donor and developing country governments, multilateral donor agencies, regional development banks, and international agencies—have accepted the importance of country ownership and committed themselves not only to greater harmonisation and coherence in their own policies, but also to aligning their goals and policies more closely with those of developing-country governments.

Donors have also accepted that they need to provide more predictable support, as discussed by Gorik Ooms and colleagues in The Lancet today, and that they should rely more on recipient governments’ systems, for example, by giving budget support to governments with good management systems for public expenditure.

The Paris Declaration has been signed but the problem now lies in getting donors to practise what they preach. Bilateral donors are clinging to funding disease-specific programmes, and skewing health financing towards their interests not only in donor-dependent countries in sub-Saharan Africa but also in more independent countries such as Brazil and India. Countries that have improved their management systems for public expenditure are still not receiving more budget support. In Ghana, for example, an increase in the quality of such management systems has been accompanied by an 11% decrease in the use of these systems.

In the debate about how to channel health aid, the behaviour of donors has to be taken into account. So too does the difficult question of who should decide about, and take responsibility for, how public funding is allocated within a country. We commend Lu and colleagues for presenting an important paper on
to civil society, and much remains in donor countries. In short, off-budget funding might seem tempting, especially in view of Lu and colleagues’ findings, but it is not a panacea.

Finally, we should be careful of the proposal Lu and colleagues make for the establishment of collaborative targets between donors and recipients on health spending. Their goal is appealing—to make governments spend more on health and, within their health budget, to spend more on specific priorities. But consider for a moment whether this is how a government’s health budget (or, indeed, its overall budget) should be set. Should a government’s budget follow the priorities of those international partnerships and campaigns that are most successful in mobilising funding? What if maternal mortality (still lamentably lagging among the Millennium Development Goals) is not the most successful global campaign—should antiretroviral treatments take priority over maternal health because donors have more successfully mobilised funding for HIV/AIDS? Should ministry of health budgets be increased at the expense of, say, prevention of road-traffic accidents (a serious cause of premature mortality), which might fall within the ministry of transport? More profoundly, who should decide and who takes
fungibility and development assistance. Their evidence provokes profound questions about who, in practice, is the most accountable and effective recipient of health funding. We underscore their calls for more research into this vital question.

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