

## Post 2015: What Can Be Learnt from the Impact of Health Performance on Donor Policies for Health Assistance?

### Summary

It is unclear how health will be positioned in the post-2015 development agenda. Health already plays a dominant role in the Millennium Development Goals (MDGs). Likewise, funding for health has risen considerably since 1990. For the design of a future agenda, it is important to understand the motives for the provision of health assistance and whether health MDGs have had an impact on health aid.

The key results are:

- The decision about which country to select and how much health assistance to allocate is the result of a manifold process. Health conditions in the recipient country are one aspect. Other determinants are foreign policy motives, concerns about corruption, donor preferences for health and strategic interactions among donors.
- The average donor prefers to financially support the fight against HIV/AIDS. A high HIV prevalence rate substantially increases the selection probability of a potential aid recipient and the allocation of health aid. Either donors are more sensitised about HIV/AIDS or they consider other health problems as being less important. As attention and funds are directed to HIV/AIDS, concerns about maternal or child health are crowded out.
- Child mortality and maternal mortality rates matter only for the selection decision. A high under-five mortality rate slightly increases the selection chance. A high maternal mortality rate, however, has a significantly negative effect on the selection probability.

- The definition of health objectives at the international level, represented in three MDGs, has not provoked any change in the decision pattern of the average donor for health assistance.
- At the individual level, no two donor countries follow exactly the same pattern in their decision-making process. Yet, the decision to allocate health aid is unrelated to the health performance in the recipient country in most cases. Contrary to expectations based on common beliefs in the aid literature, like-minded donors are not more strongly focused on health performance when deciding on health assistance.

In light of the debate about the post-2015 development agenda, the question is whether these health indicators are appropriate parameters. The results illustrate that even a policy in strict accordance with health performance could be argued as not being well-targeted health aid. First, many causes or multipliers are found outside the health sector such as lack of education. Second, the indicators child mortality and maternal mortality only document the (final) extreme event.

The future development agenda should be moulded in such a way that linkages between health and other sectors can be taken into account. It should also focus on measuring the quality of health and health care. The interdependencies – in particular the direction of causal relationships – need to be better understood. Particularly the request for global goals would require a clear understanding of the driving factors for good health performance at different stages of development.

## Background

In discussions about international development goals post-2015, it is being debated where health fits in. The formulation of health-related MDGs and increased funds for the health sector demonstrate the growing importance of global health in recent years. Yet, little is known about how well-targeted health assistance has been and whether the formulation of health MDGs has had an impact on health aid.

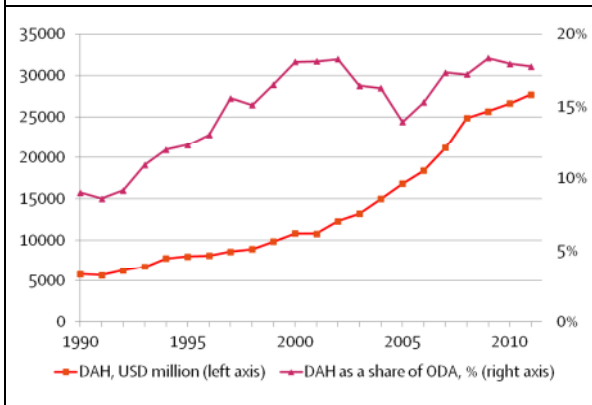
For foreign aid, two relevant decisions are: to *which sector* a donor allocates funds in a given country, and in *which country* a donor contributes to a specific sector. Focusing on the financing of the health sector, the question arises: To what extent does the knowledge about poor health performance in a recipient country affect donor decisions (as the narrative usually emphasises the recipients' needs and the poor health conditions in which the intended beneficiaries live)? As regards the decision-making process of a donor, it is commonly understood as a two-step process: first, a potential recipient is selected; second, funds are allocated to that recipient. The foreign aid literature articulates the multitude of reasons – political links, strategic reasons, economic interests, humanitarian motives and historic ties – that regularly motivate such decisions (e.g. Mavrotas / McGillivray 2009). The potential influences can be grouped into characteristics related to the donor, characteristics related to the recipient as well as characteristics related to the donor-recipient relationship.

In the recent past, global health – understood as health issues that transcend national boundaries – has emerged as an important concern on the international agenda. Unprecedented amounts of financial resources have been made available for health assistance in the form of official development assistance (ODA) directed to health, partly motivated by the rise of the HIV/AIDS epidemic in sub-Saharan Africa. Development assistance for health (DAH) more than quadrupled in size over two decades to US\$ 25.7 billion in 2009 (Figure 1). Even in the wake of the global financial crisis, resources are estimated to have grown by 4 per cent between 2009 and 2011 (IHME 2011). Health assistance accounted for 9 per cent of total aid resources in 1990. Since the millennium, up to 18 per cent of total ODA was disbursed as health aid.

In addition to more health-related funding, the importance of global health problems was boosted by the MDGs. The MDGs target a two-thirds reduction in the mortality rate of children under five between 1990 and 2015, a three-quarters reduction in the maternal mortality rate over the same period, and a halt and reverse in the spread of HIV/AIDS by 2015.

Analysing the decision-making process in terms of development assistance for health, the crucial question is to which extent the information about poor health conditions – as expressed in poor health indicators – influences the selection and allocation decisions of bilateral donors. A related question is whether donors have increasingly considered global

**Figure 1: Development assistance for health, 1990–2011**



Source: OECD (2012); IHME (2011)

health problems – as expressed in poor health indicators – in their decisions on health aid as a reaction to including health objectives on the current development agenda.

In the analysis, the indicators with the most comprehensive data were used. First, the under-five mortality rate measures child survival and also reflects the socio-economic and environmental conditions in which children live. Second, the improvement of maternal health is assessed by the maternal mortality rate, which monitors deaths related to pregnancy and childbirth. The indicator reflects the capacity of the health systems to provide effective health care to prevent and address the complications occurring during pregnancy and childbirth. Third, prevalence of HIV is a direct indicator of the burden related to HIV and reflects the prevalence of HIV among the population aged 15 to 49. The three indicators reflect the average health status of individuals in a country. For clarification, the individual health status is not identical with the status of the health sector. The individual health status is a function of biological predisposition, access to and quality of health care, and risk factors such as lack of sanitation and polluted drinking water, interacting with other factors like income and education (e.g. Skolnik 2008). Consequently, to only invest in the health sector in order to improve health performance would be a short-sighted policy, as related sectors such as education, water and infrastructure deserve attention too.

Western donors are differentiated in terms of their budgets. Some donors have an aid budget of considerable size, whereas most donors have a smaller budget available. This generally observed pattern is also visible in health (Table 1). Five donor countries account for 40 per cent of the selected recipients, which corresponds to two-thirds of allocated health aid. Apart from differences in budget constraints, bilateral donors are commonly distinguished into three groups for their different motives. Major donors (France, Germany, Japan, Spain, United Kingdom and United States) are regarded as pursuing specific interests related to politics, economics and history. Like-minded do-

nors (Canada, Denmark, Netherlands, Norway and Sweden) are rather viewed as focusing on the developmental needs of the recipient. The remaining small donors (Australia, Austria, Belgium, Finland, Greece, Ireland, Italy, Luxembourg, New Zealand, Portugal, Switzerland), in turn, do not have any specific reputation.

**Table 1: Total selection and allocation decisions for development assistance for health per donor, 1990–2007**

Donor	Selection		Allocation	
	No. of decisions	in %	in thousand US\$	in %
United States	1,354	9.27%	14,300,000	40.1%
France	1,258	8.62%	1,500,000	4.2%
Italy	1,181	8.09%	832,000	2.3%
Japan	1,058	7.25%	3,280,000	9.2%
United Kingdom	930	6.37%	3,910,000	11.0%
Belgium	906	6.21%	698,000	2.0%
Netherlands	894	6.12%	1,490,000	4.2%
Norway	885	6.06%	862,000	2.4%
Germany	859	5.88%	1,980,000	5.5%
Canada	677	4.64%	723,000	2.0%
Sweden	671	4.60%	1,210,000	3.4%
Spain	645	4.42%	1,300,000	3.6%
Finland	523	3.58%	280,000	0.8%
Denmark	517	3.54%	854,000	2.4%
Australia	498	3.41%	956,000	2.7%
Switzerland	426	2.92%	393,000	1.1%
Ireland	383	2.62%	502,000	1.4%
Austria	344	2.36%	280,000	0.8%
Greece	186	1.27%	46,400	0.1%
New Zealand	178	1.22%	46,400	0.1%
Luxembourg	165	1.13%	184,000	0.5%
Portugal	61	0.42%	75,600	0.2%
Total	14,599	100%	35,702,400	100%

Source: IHME (2009)

### Does health performance matter for the selection decision?

HIV prevalence and child mortality increase the selection probability by the *average* donor, whereas maternal mortality decreases such chances. Table 2 summarises the results. Focusing on the selection process of the average donor between 1990 and 2007, a country with a higher rate of under-five mortality is more likely to be selected as a potential recipient of health assistance. Expressed in numbers, the selection probability is changed by 0.25 per cent for every 1 per cent increase in the under-five mortality rate near the mean of 74.5‰. A higher HIV prevalence rate also significantly increases the selection probability. A 1 per cent increase of HIV prevalence near the mean prevalence rate of 2.3 per cent is associated with a 2.5 per cent increase in selection probability. Controlling for under-five mortality and HIV prevalence, however, a higher maternal mortality rate reduces the likelihood of selection. A 1 per cent increase in maternal mortality near the mean of 3.5‰ corresponds with a 2.75 per cent decrease in selection chances.

Turning to the selection decision of *individual* donors, HIV prevalence and maternal mortality have a much more pronounced effect than under-five mortality. Almost all donors select a recipient with a high HIV prevalence rate more likely. A high maternal mortality rate has a significantly negative effect on the selection decision of every second donor. Under-five mortality, however, is only important for the selec-

tion decision of a few donors, and with a much smaller magnitude than the other health indicators. Some selection decisions seem not to be influenced by health performance at all.

### Does health performance matter for the allocation decision?

Under-five mortality and maternal mortality do not influence allocation decisions for health by the *average* donor. Focusing on the motives for the allocation of health funds by the average donor for the period between 1990 and 2007, only the HIV prevalence rate significantly increases the amount of allocated aid. A one-unit increase in the HIV prevalence rate is associated with a 3.2 per cent increase in health aid, when controlling for maternal and child mortality.

The decision for health resources of both *major donors and like-minded donors* is, in most cases, unrelated to the health performance in the recipient country. Yet, some donors do consider information on health. The United Kingdom and the United States allocate more health aid resources to countries with high HIV prevalence rates. Germany allocates more health assistance to countries in which maternal mortality is higher but under-five mortality is lower. Denmark allocates more health resources to recipient countries with lower maternal mortality.

**Table 2: Overview of effect of health indicators on decisions**

	Selection		Allocation	
	Average donor	Individual donor	Average donor	Individual donor
Under-five mortality	+	(+)	n.s.	(-)
Maternal mortality	---	(--)/(---)	n.s.	(+)/(---
HIV prevalence	+++	(+)/(+++)	++	(++)

+ = significant positive effect, - = significant negative effect, n.s. = no statistical effect, ( ) = if any effect

Source: Own elaboration

### Have the MDGs changed the decision pattern?

Donors have not significantly altered their decision pattern in the wake of the Millennium Declaration, as donors do not seem to have become more selective after the MDGs were established. The decision-making pattern is similar when the general sample is restricted to the years 2002 to 2007. On average, HIV prevalence significantly increases the selection probability as well as the aid allocation. The impact of child mortality is also positive, but only a tenth as strong. Maternal mortality, however, decreases the selection probability and the aid allocation. Controlling for the three health indicators, a one-unit increase in under-five mortality corresponds with 0.8 per cent more aid allocation. A one-unit increase in the maternal mortality rate is associated with 7.8 per cent less aid, whereas a one-unit-greater HIV prevalence rate leads to 7.3 per cent more aid on average.

### Do other factors steer the decision process?

The results show that health performance is considered when selecting a potential recipient, and when actually allocating health assistance. Yet, health performance is not

the only aspect that matters. The results also reveal that other factors determine the average decisions. *Bilateral relations* influence the selection and the allocation process. In fact, economic links such as trade relations, cultural proximity such as the same dominant language or religion, or a common colonial past influence these decisions significantly on average. Yet, political ties or geographic proximity are insignificant factors for the decision-making process. In the discussion about aid effectiveness, a major issue is the sensitivity of donors as regards potential problems related to a weak *institutional environment* such as corruption. While the selection decision seems to remain unaffected by such concerns, countries that are more corrupt receive less health assistance. The level of *effort* put into national health by the recipient country is insignificant at both stages. Neither the level of public health expenditures nor the immunization coverage has any statistical effect. They do not increase or decrease either the selection chances or the allocated resources. The available evidence suggests that the *preference* of the donor for health on the national political agenda increases the provision of health assistance. The average donor does not decide independently but acts strategically. Particularly, the average donor with a large budget is inclined to complement allocations made by the United States and by multilateral donors. However, the effect is not substantial.

### And now?

The definition of health objectives at the international level, coined in the MDGs, has not caused any remarkable change in the behaviour of bilateral donors when it comes to health assistance. This implies that donors either had been targeting well – already prior to the MDGs – or have simply maintained their pattern of bad targeting in the health sector. The predominant positive significance of

HIV/AIDS may indicate that donors rather follow their own preferences.

Even if donors allocate their health funds in strict accordance with the three health indicators included in the analysis, it could be argued that their aid is not well targeted. The treatment of those infected with HIV/AIDS requires, for instance, the distribution of antiretroviral drugs. Hence, an elevated HIV prevalence rate is an indication that the respective country might need assistance in order to shoulder this burden. Yet, under-five mortality and child mortality document extreme events. Hence, the caveat of these indicators is that they do not reflect how often someone contracts a non-lethal disease. Still, non-lethal diseases can have severe consequences, for instance, when a recurrent malaria infection prevents school attendance or affects ability to work. As a conclusion, it is questionable whether these three indicators are adequate parameters.

It may well be, however, that the MDGs have initiated a more multisectoral perspective of health problems. Donors may be increasingly aware that poor health performance can have multiple causes and, hence, warrant multiple interventions to solve the same problem. When deciding about which sector to fund, a donor may take into account the many interdependencies – and not only fund the health sector, but also invest in education, infrastructure or the general development. This implies two things for the debate about the post-2015 development agenda. First, from a procedural perspective, linkages between health and other sectors should be more heavily emphasised in the design of the future agenda. Second, from an analytical perspective, the understanding of these interdependencies – and particularly the causal relationships – needs to be enhanced. In light of global development goals, a deep understanding of the driving forces at each stage of development is needed.

### DIE's post-2015 briefing paper series has so far covered the following issues:

Loewe, M. (2012): Post 2015: How to Reconcile the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs)? Bonn: German Development Institute (Briefing Paper 18/2012)

### Literature

IHME (*Institute for Health Metrics and Evaluation*) (2009): Financing global health 2009 : tracking development assistance for health, Seattle, Wash.

– (2011): Financing global health 2011 : continued growth as MDG deadline approaches, Seattle, Wash.

Mavrotas, G. / M. McGillivray (2009): Development aid: a fresh look, Houndmills, Basingstoke, Hampshire: Palgrave Macmillan

Skolnik, R. (2011): Global health 101, 2nd ed., Burlington, Mass.: Jones and Barlett

Stepping, K. (2012): The donor-intermediary interaction and the decision-making process of intermediaries for development assistance for health, Marburg: University of Marburg (Dissertation)



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