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POLICY BRIEF

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French Overseas Development Assistance and implementation of the post-2015 development agenda: what priorities for research and actions in the area of health?

Tancrède Voituriez (Iddri and Cirad), Thierry Giordano (Cirad), Noura Bakkour (Iddri)

The year 2015 and the formulation of the sustainable development goals (SDGs) will be arriving at a time when changes in the ecosystem of official development assistance for health (DAH) are in full swing. The consensus for an ambitious "Health SDG" for 2030, targeting both diseases and health systems, precludes a *status quo* in the amounts of funding flows and makes it unlikely that the current structure of the DAH ecosystem will be maintained. The major unknown is how the existing model—designed around and for the Millennium Development Goals (MDGs) and which has proved highly effective for some of them—will transition to a model that will ensure the universal health SDGs are achieved, but which is yet to be invented. In what direction does France wish to propel this reform and how does it envision the transition from one model to the other, in harmony with the models that the other development aid players foresee? The purpose of this *Policy Brief* is to gather some initial answers to these two questions.

RESULTS AND RECOMMENDATIONS

- Health is a public good, just like education or security and its "return on investment" seems high. A key component for delivery of this public good is a combination of absolutely vital but limited public funding and private-sector financing.
- In the post-2015 agenda, it is vital to demonstrate the actionable scope of Universal Health Coverage (UHC) to facilitate its implementation. For this, further research needs to be mobilised in order to develop indicators to measure the effectiveness of health systems and services, as well as prevention. Increasing our empirical knowledge of the performance of health systems is a prerequisite for improving them.
- It would also be useful to undertake a full review of innovations in health financing (air ticket levy scheme, International Finance Facility for Immunisation, Advanced Market Commitment, debt conversions, Product (RED) initiative) and open this up to discussion in view of the new SDGs and the need for deeper involvement of the private sector.
- France could further consolidate and develop the comparative advantages of its official development assistance for health (DAH). French DAH borders on 750 million euros but is still relatively invisible and unknown to the general public. A large swathe of French aid is channelled through vertical funds, in whose stewardship France has engaged with limited human resources.

www.iddri.org

Institut du développement durable
et des relations internationales
27, rue Saint-Guillaume
75337 Paris cedex 07 France

1. AN IMPRESSIVE RECORD FOR DAH

Unquestionable progress in global health. The progress measured since the World Bank released its report *Investing in Health* (World Bank, 1993) speaks for itself. In most countries, populations have seen their life expectancy increase – even doubled in countries like China, Mexico, Ethiopia and India; at global level, the number of deaths of children under five years of age has dropped from some 12 million to fewer than 7 million, while the maternal mortality rate has been halved (*The Lancet*, 2013). Advances in healthcare have on average been more spectacular for women than for men, with the notable exception of China and India (*ibid*.).

The reasons for this progress hinge on a combination of factors: technical progress (equipment, drugs, vaccines), the inclusion of public health issues on the agendas of the least developed countries (LDCs) and middle-income countries (MICs), a spectacular rise of income in countries that have graduated to MIC status and the mobilisation of hefty amounts of official development assistance. However, the funds dedicated to health R&D rose fivefold between 1990 and 2010, 60% of which were disbursed by the private sector and mainly funnelled to non-communicable diseases (NCDs). Fewer than 2% are allocated to the infectious diseases of prime concern to LDCs and MICs.

Innovative intervention mechanisms based on measurement of results. Institutional innovations were first rolled out in R&D with the 1996 launch of the first public-private product development partnership (PPPDP) funded by the Rockefeller Foundation, followed by an injection of funds from the Bill et Melinda Gates Foundation (BMGF) and public-sector donors. Virtually absent before 2000, public-private partnerships (PPPs) now account for almost 20% of contributions in 2013. Most of this new financing is through vertical programmes aimed at combatting HIV/AIDS, tuberculosis and malaria *via* the introduction of new vaccines, which are allocated in priority to East and West sub-Saharan African geographies (*The Lancet*, 2013). Measuring the performance of cooperation initiatives in the area of health using results indicators was a determining factor for the stepping-up of financial commitments from both public donors and private actors around the MDGs 4, 5 and 6.

Large-scale political and financial mobilisation, including France. Official development assistance for health rose fivefold between 1990 and 2013 (IHME, 2013) to reach just over 31 billion dollars. Bilateral aid is still the first financing channel, varying between 50% of contributions in 1990 and about 30% during the slack years 2000–2001. France holds a significant place in this ecosystem due to its political leadership, notably in the creation of the Global Fund and International Finance Facility for Immunisation (IFFIm/GAVI). France contributes some 750 million euros comprising 80% in multilateral aid and 20% in bilateral aid.

2. POST-2015 CHALLENGES

"Finish the MDG job". As the WHO underlines, "The current trends form a good basis for intensified collective action and expansion of successful approaches to overcome the challenges posed by multiple crises and large inequalities" (WHO, 2013). However, progress is uneven both within and between countries. The countries of France's priority intervention zone[1] record the least satisfactory results, whereas their needs are constantly on the rise, driven by high demographic growth.

A thematic and geographic rebalancing of DAH. In 2011, sub-Saharan Africa received 28.6 of total DAH with nearly 9 billion dollars. By sector or theme, the HIV/AIDS item is the leading recipient, with nearly 8 billion dollars; maternal, newborn and child health is an increasing item, reaching 6 billion dollars, whereas the 377 million dollars dedicated to non-communicable diseases is derisory compared to the total. Many countries that bear the heaviest disease burden do not receive a proportional amount of attention and DAH financing (IHME, 2013). Among the top-twenty country ranking for disability-adjusted life years (DALY), only thirteen are present in the top-twenty DAH recipients.

Broadening the health agenda. The rise in "man-made" or environment-induced diseases (diabetes, hypertension, heart disease and cancer) is symptomatic of the epidemiological transition in many developing countries. The health agenda is being widened to include non-communicable diseases, sanitary issues and prevention.

Health systems are core to the post-2015 agenda. Broadening the health agenda brings the DAH model into question. The need to support health systems is becoming increasingly evident, with specific focus on all types of primary healthcare and hospitals. However, the new challenge of strengthening health systems is less easily adaptable to performance measurement *via* results indicators.

Increasing financing needs. The success of DAH places the growing ambitions for health issues on

1. Benin, Burkina Faso, Burundi, Djibouti, The Comoros, Ghana, Guinea, Madagascar, Mali, Mauritania, Niger, Central African Republic, Democratic Republic of the Congo, Chad, Togo, Senegal.

a sound footing, but meeting these ambitions will be tough if budgets are not increased. On the one hand, the uncertainty surrounding the marginal abatement cost for some diseases does not allow us to conclude, for example, that "finishing" the work begun on the MDGs 4, 5, and 6 will be possible at a cost necessarily lower than the expenditure incurred thus far. Moreover, a broadened agenda and the focus on health systems challenge not only the PPP model that has been driving recent progress but also the needs and sources of financing.

New donor fatigue. Innovative vertical funds furnished a response to emergency situations but they are not intended to be permanent. At the same time, putting a series of objectives (sustainable development goals – SDGs) involving subjects as diverse as education, hunger, agriculture, biodiversity or energy on the sustainable development agenda raises the concern that ODA operators' support for health questions could gradually wane, following ten years of increasing commitments.

Strengthening health systems and mobilising resources. As they operate in emergency situations, vertical funds have had to circumvent the difficulties linked to the shortcomings of local health systems, even if this has sometimes meant further destabilising them. What has now become urgent is to build robust and lasting health systems. This means identifying local needs in the absence of any precise definition of primary health needs, better access to services and higher service quality, improved infrastructures, the strengthening of legal frameworks, technical and administrative capacities, innovative financing models, and appropriate methods of collecting, analysing and disseminating information at local level.

Dialogue and cooperation between DAH actors. The effectiveness of the overall health aid ecosystem can be improved. Studies highlight the lack of coordination between actors, the risk of duplicating and fragmenting activities, the confusion about what the actors and communities concerned expect of the different donors' role, and a possible negative effect on national health policies (Biesma, Brugha, Harmer, Walsh, Spicer & Walt, 2009; Kerouedan, 2010; McCoy, Bruen, Hill & Kerouedan, 2012; *The Lancet*, 2013; Moon & Omole, 2013). The focus on strengthening health systems underlines the importance of a more productive dialogue on the definition of health needs, more effective donor cooperation and a real coherence between national policies and donors. The capacity to engage in dialogue is open to question in the case of standard-producing institutions like the WHO, whose regular budgets have been shrinking in real terms since 1994 (*The Lancet*, 2013; IHME, 2012; Legge, 2012), as well as in some recipient countries where changes in the budgets dedicated to health are still not correlated with their populations' growing needs.

3. THE FRENCH RESPONSES

Today, France wishes to capitalise on the lessons learnt over the past decade. It supports the implementation of the MDGs, with priority set on the fight against HIV/AIDS, tuberculosis, malaria, maternal and newborn health and the fight against neglected tropical diseases. In parallel, it is promoting a structural approach to health (health systems) that integrates the fight against pandemics and social protection floors. The emphasis is on an overall approach to health encompassing both social and environmental determinants and involving the right to health, access to drugs and healthcare though a universal health coverage (UHC). It is advocating this approach within the United Nations system to ensure that this objective becomes a focal point of the SDGs. France considers that UHC makes it possible to tackle unequal access to healthcare services and the financial risks linked to people's spending on health (MAEE, 2013*b*). However, UHC is facing hefty obstacles to its implementation and evaluation. Today, for want of a concerted international initiative, health systems are being strengthened – which is a *sine qua non* for setting up UHC – exclusively on a bilateral basis through the French Agency for Development (AFD).

The focus on UHC raises several questions:

- What can be done to strengthen the AFD's means of action to consolidate health systems, in line with France's continuing commitment to the vertical funds it has supported and which have proved their effectiveness?
- What choice of objectives and performance indicators can be suggested in the near term?
- What coordination can be set up between French action and that of the other donors?
- What budget commitments can be made to support public policies (heath and social protection), human resources development, health infrastructures and cross-sector challenges (education, water, food security, etc.)?
- To what extent are the French guidelines for health aid compatible with the priorities of recipient countries?

France proposes the use of innovative financing instruments, such as a financial transaction tax, to ensure a steady flow of funds not subject to the impact of budget cycles. And above all, the concomitant mobilisation of partner countries' national budgets, since UHC is the responsibility of each State (Araud, 2014; MAEE, 2013*b*). In terms of

instruments, it stresses the importance of technical assistance, and yet this was the victim of choice for the French aid reform (Voituriez, Giordano, Boussichas, 2014).

4. OUR RECOMMENDATIONS

Health is a public good, just like education or security. Its "return on investment" seems high (*The Lancet*, 2013). A key component for delivery of this public good, on a level with the challenges outlined in this brief, lies in a combination of absolutely vital, but limited, public funds and private-sector financing. Yet, whatever the amounts made available through these different channels, official development assistance (ODA) remains an indispensible tool as it has a triple role: catalysing funds, funding specific schemes that would never attract finance from the marketplace and providing health-related knowledge gathered over many decades.

In this setting, France has the opportunity to further consolidate and develop the comparative advantages of its development assistance for health (DAH). It could reap the benefits by:

- communicating more incisively on the its ODA funding commitments as well as on their outcomes. French DAH borders on 750 million euros but is still relatively invisible and unknown to the general public;
- investing more deeply in the governance of vertical funds: a large portion of French aid is funnelled through vertical funds, but French participation in their stewardship mobilises limited human resources, even though there is real room for influence both globally and in local-level implementation;
- making more extensive and more effective use of its high quality health expertise. For instance, no French national or French-speaker has a seat on the WHO's SAGE Committee, even though there is no lack of competencies. Likewise, the "strike force" of the health agencies is not fully exploited. What's more, France has an original health-care model in place that could well inspire other countries, even though this is in need of some reform.

For the post-2015 agenda, it is vital to demonstrate the actionable scope of Universal Health Coverage (UHC) agenda so that it can be implemented swiftly and efficiently after 2015. To this end, it is worthwhile mobilising further research to develop indicators on the effectiveness of health systems and services, as well as on prevention.

It would also be useful to undertake a full review of innovations in health financing (air ticket levy scheme, International Finance Facility for Immunisation, Advanced Market Commitment, debt conversion, Product (RED) initiative) – including but not limited to financial engineering – and open this up to discussion in view of the new SDGs and the need for deeper involvement of the private sector.

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