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# Does Global Health Funding Respond to Recipients' Needs? Comparing Public and Private Donors' Allocations in 2005–2007

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**Summary.** — Adding to official development assistance (ODA), private foundations have emerged as important donors to the global health agenda. Amid this increasing funder diversity and growing global health budgets, responsiveness to recipients' needs is a central concern. Merging datasets on ODA flows in 2005–07, over 2,800 foundation grants, disease burden, and perceived priorities in 27 low- and middle-income countries, this study offers the first comprehensive national-level analysis of global health aid responsiveness. The analysis shows that national patterns of disease burden explain neither public nor private aid flows during this period. While ODA committed during these years was weakly yet significantly correlated with health priorities, private grants' responsiveness was even weaker and did not achieve ODA significance levels either.

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## 1. INTRODUCTION

Over the past five decades, bilateral as well as multilateral donors' approaches to and rationales for funding health related development challenges have varied significantly. Aid policy during the 1960s focused on macroeconomic growth and public sector capital investment projects, while the 1970s saw a move toward human development initiatives. Structural adjustment of the 1980s refocused the aid community's attention on economics, this time with an emphasis on privatization and deregulation, only to be replaced in the new millennium by a return to human development with public–private partnerships taking center stage (Périn & Attaran, 2003). During the 1990s, globalization and the framing of health as a global public good with the potential to impact the national security and economic and political interests of both developed and developing countries (Archibugi & Bizzarri, 2005; Barrett, 2004; MacKellar, 2005) increasingly turned health policy making into a supranational, rather than domestic, process (McMichael & Beaglehole, 2000).

At the turn of the millennium, awareness that the WHO's ambitious proclamation of 'Health for All by 2000' would not be achieved, coupled with disillusionment of the effectiveness of aid to low- and middle-income countries, prompted a renewed prioritization of health. Official development assistance (ODA) for health given by member countries of the Organization for Economic Cooperation and Development (OECD) has since doubled in real terms from 2000 to 2005 (Kates & Lief, 2007). US Government funding for HIV/AIDS programs in 2007 alone was around \$2.3 billion, about eight times more than in 2000 (Ravishankar *et al.*, 2009). In addition, major multilateral and bilateral funding mechanisms, such as the US President's Emergency Plan for HIV/AIDS

(PEPFAR) and The Global Fund for AIDS, Tuberculosis, and Malaria (GFATM) were established in 2003 and 2005, respectively, to respond to growing political recognition of health needs of low- and middle-income countries. At the same time, sources of aid diversified further through increased involvement of non-state donors: "From the [Bill and Melinda] Gates Foundation [BMGF] to the Clinton Global Initiative to the Millennium Project to the Make Poverty History Campaign to the Global Fund to Fight AIDS, Tuberculosis, and Malaria, there is now a flurry of global activities that tackle 'banner' diseases" (Pearlman & Roy, 2009, p. 18). Ravishankar *et al.* (2009, p. 2122) also observe that "[t]he role of NGOs in terms of spending funds from the public and private sectors has expanded tremendously, as has direct bilateral assistance to governments in low-income and middle-income countries. The shift is not only towards a smaller relative role for the UN system and the World Bank, but also for the changed status of these organizations." Also during this decade, high level policy initiatives such as the Paris Declaration and the Disease Control Priorities Project have called for aid alignment with national priorities and

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disease burdens to meet a common goal of achieving important and sustainable gains in the health of people living in low- and middle-income countries (Jamison *et al.*, 2006; OECD, 2005; Shiffman, 2006). Based on “disability-adjusted life-year” (DALY) calculations designed to measure morbidity and mortality, the *Global Burden of Disease Estimates* from 2002 was the first global attempt to inform related policy-making (Murray & Lopez, 1996; Pearson & Rawlings, 2005). Although the DALY methodology is not without critics (Arnesen & Nord, 1999), its applicability for defining and comparing disease burden across diseases and countries is apparent, and some authors have argued that the prioritization of maternal, newborn, and child health (Powell-Jackson, Borghi, Mueller, Patouillard, & Mills, 2006) and HIV/AIDS (Shiffman, 2006) provide evidence that in some areas needs do indeed trigger international financial flows. However, existing data on health expenditures equally suggests persistent imbalances and inconsistencies both globally and at the national level. Benatar, Gill, and Bakker (2009: 349) find that “[a]lmost 90% of world expenditure on health is spent on people bearing less than 10% of the global burden of disease, and 90% of expenditure on medical research is spent on diseases that account for a mere 10% of the global burden of disease.” Among the first publications to focus on allocations to developing country recipients specifically, MacKellar’s (2005) research identified wide gaps between health needs in developing countries and international funding priorities. Shiffman’s (2006) work provided further evidence that development assistance for communicable diseases and measures of disease burden are largely unaligned, and Wecker has argued that attention to diarrheal diseases, a major killer of infants, had waned dramatically since the 1980s partly as a result of changing donor priorities, which has allowed them to creep back (quoted in: Mason, 2009). At the same time, HIV/AIDS receives a seemingly disproportionate share of funding (Shiffman, 2006). This is illustrated by AIDS-related mortality figures in Nigeria and Ethiopia—Africa’s two most populous countries—in 2007 (237,000) which were “less than half the 540,000 children under 5 [in the same countries] who died of pneumonia and diarrhea” (Dugger, 2009). Yet in the same year, the US government’s budget for HIV/AIDS related interventions in Nigeria and Ethiopia “was more than the \$646 million it is spending on maternal and child health in all the world’s countries combined” (Dugger, 2009). An additional complication arises when considering that a recent World Bank report alerts that seven out of ten Bank-financed HIV/AIDS projects fail to reach their objectives while nine out of ten projects targeting diseases, such as malaria, tuberculosis, and leprosy performed satisfactorily or better (IEG, 2009).

Clearly then, donor allocations cannot be informed primarily by concerns about existing needs and the desire to improve health status in recipient countries in the most effective manner. Ravishankar *et al.* (2009, p. 2121) hypothesize “that country allocation of DAH [development assistance for health] is driven by many considerations, including income, burden of disease, political stability, and historical and political relations between specific donors and recipient countries,” thus echoing some of the arguments made by Shiffman (2006). Yet this does not imply that these factors have equal weight. Indeed, Périn and Attaran (2003) were among the first to argue that aid allocation for health is predominantly a political process determined by donor ideologies. Crane and Dusenberry (2004) emulated this point and emphasized religious underpinnings in the context of family planning and HIV prevention. More recently, Pearlman and Roy (2009, p. xiv) have reiterated this argument: “The practice of international health is political

rather than technical, political rather than bureaucratic, political rather than academic. [...] The choice between interventions is presented as a question of efficacy that can be measured and scientifically evaluated. But the world is not that simple. Choices are often based on ideology, values, and national and organizational interests.” An important process in this context is the manipulation of recipient agendas by donors (Walt, Pavignani, Gilson, & Buse, 1999) that may result from one party controlling significant resources while the other party is in serious need (Sewell, 1992). Reflecting these concerns and based on their finding that “the focus on [...] quick results [by donors] discourages investment in health systems,” Sridhar and Rajaie (2008) hypothesize that either different governance structures of the World Bank, national governments, the BMGF, and the Global Fund or ostensible comparative advantages between these agencies could explain differences in priority-setting processes.

That decision making structures matter is considered by other authors as well. Within private foundations, “the focus has been on amounts of money raised for high-visibility health problems. A large share of the new donor funding is being provided through Eichler and Levin, 2009, p. 42). The channels earmarked for specific diseases or interventions” (The BMGF specifically has been characterized as “emphasiz[ing] breakthrough technologies and cost-effective interventions instead of investing in health-system strengthening and in addressing the underlying causes of disease” (Pearlman and Roy, 2009, p. 174). Another foundation has been singled out as pursuing a specific accomplishment in the health field to celebrate an important anniversary: “Rotary International had been looking for a global target to be achieved by the centennial of its foundation in 2005” (De Quadros, 2009, p. 62). Measurability plays an important role in this content because it facilitates resource mobilization as well as the production of easily attributable success stories (Esser, 2009), which causes Eichler *et al.* (2009, p. 4) to argue rather bluntly that “[y]ou get what you pay for. And it is easier to pay for what you can easily measure.” Finally, where shifts in donor priorities can neither be traced compellingly to shifts in recipient needs nor to provider interests, Shiffman (2006) argues that processes of socialization occurring within the global policy environment could provide an alternative explanation for these shifts.” Taking a social constructivist perspective and fielding the example of emerging health alliances during the past 10 years, he posits that the decisions of one actor influences the decisions of other donors, ultimately creating a kind of global peer pressure<sup>1</sup>.

Although at least in part still hypothetical, this literature has nonetheless contributed in important ways to a deeper understanding of aid allocation. Yet the question remains *to what extent* both epidemiological profiles and subjective perceptions in recipient countries matter to different types of funders, if at all. Previous research into this aspect either did not break data down to the country level (Sridhar & Rajaie, 2008) or suffered from methodological problems. The authors of a recent BMGF-funded study that looks at both public and private sources Ravishankar *et al.* (2009, p. 2113) argue that “[t]otal DAH received by low-income and middle-income countries was positively correlated with burden of disease.” They also find that “[t]he correlation between health aid and disease burden has risen from 0.6% to 0.8% between 1997 and 2007” (2121). However, the absence of *per capita* calculations in their approach constitutes a major limitation; asserting a direct correlation between DAH and DALYs without adjusting for population size is problematic since more populous countries are likely going to have larger disease burdens as well. What follows is that the statistical analysis offered by Ravishankar

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