

Foreign aid for health

Moving beyond government

Philip Stevens



Foreign Aid for Health: Moving beyond government

By Philip Stevens

June 2008

International Policy Network
Third Floor, Bedford Chambers
The Piazza
London WC2E 8HA UK
t: +4420 7836 0750
f: +4420 7836 0756
e: info@policynetwork.net
w: www.policynetwork.net

Designed and typeset in Latin 725 by MacGuru Ltd
info@macguru.org.uk

Published by International Policy Press, a division of
International Policy Network, on behalf of the Campaign
for Fighting Diseases

© International Policy Press, 2008

All rights reserved. Without limiting the rights under
copyright reserved above, no part of this publication may
be reproduced, stored or introduced into a retrieval
system, or transmitted, in any form or by any means
(electronic, mechanical, photocopying, recording or
otherwise) without the prior written permission of both
the copyright owner and the publisher.

The Campaign for Fighting Diseases

www.fightingdiseases.org

The Campaign for Fighting Diseases seeks to raise awareness of the realities of diseases suffered in the poorest regions of the world, and the need for pragmatic solutions to these diseases. Members of the CFD, including academics, NGOs and think tanks, argue for prioritisation of action at local, national and international levels, to ensure that time and money are used most effectively to save lives and achieve the best results with limited resources.

About the author

Philip Stevens is the director of policy at International Policy Network, and co-ordinator of the Campaign for Fighting Diseases. He has held research positions at the Adam Smith Institute and Reform in London, and spent several years as a management consultant. He holds degrees from the London School of Economics and Durham University.

Published in association with:

Alternate Solution Institute, Pakistan
www.asinstitute.org

Cathay Institute for Public Affairs, China
www.jiuding.org

Imani, Centre for Policy and Education, Ghana
www.imanighana.com

Initiative for Public Policy Analysis, Nigeria
www.ippa.org

Institute for Free Enterprise, Germany
www.iuf-berlin.org

International Policy Network, United Kingdom
www.policynetwork.net

Liberty Institute, India
www.libertyindia.org

Medicine and Liberty, Switzerland
www.medlib.ch

Minimal Government, Philippines
www.minimalgovernment.net

Executive summary

Since the start of the decade, the amount of government-to-government foreign aid specifically for health has increased dramatically. Approximately 10 per cent of Africa's health care expenditure is now financed directly by aid.

However, it is becoming increasingly clear that this extra spending is having very little effect on health in the poorest parts of the world. Very little progress has been made towards achieving the health-related Millennium Development Goals, and far too many people still pay out of pocket for health care.

Part of this failure lies in the current model of official foreign aid, in which the governments of rich countries hand large sums of money to governments in poor countries, in the hope that it will be effectively spent. Unfortunately, corruption and other forms of

mismanagement mean that very little of this money actually makes it to patient care.

Instead of continuing the failing strategy of subsidising government provision of health services, donors should consider radical new approaches. For instance, there currently exists vast capacity within the private sector, which could be effectively harnessed to work for the poorest.

Some donors have experimented with contracting the private sector to provide health services and private insurance. Where this has happened, the quality and quantity of health services have increased. Donors should therefore encourage far greater use of the private sector, which would allow government to focus on its strengths, such as standard setting.



Introduction

Improving health in Less Developed Countries (LDCs) has become the moral crusade of the early 21st Century. Campaigning NGOs, rock stars and politicians spent the first half of this decade circling the globe claiming that the only answer to the suffering and disease found in LDCs is a massive transfer of financial resources from rich to poor countries in the form of foreign aid. Governments of wealthy countries have responded to this campaigning by hugely increasing their spending on Official Development Assistance (ODA), much of which is now earmarked for improving health.

The debate about whether foreign aid does more harm than good is far from closed. Many scholars question its historic effectiveness, and claim that it has frequently undermined economic growth and perpetuated political repression. Nevertheless, these concerns have largely been ignored, as governments of wealthy countries have committed large and increasing sums of money to ODA, with a new emphasis on spending on health and education. However, it is not clear that this money is being spent effectively or having much impact on health indicators in LDCs. It is against this backdrop that we should examine ways of ensuring that health aid achieves what it is designed to do: improve health in LDCs.

The first section reviews the current scale and rationale for ODA, with particular reference to health. This is followed by a review of some of shortcomings of health aid, while the third section looks at some innovative approaches that might increase the effectiveness of ODA.

Foreign Aid for Health

Moving beyond government

1. Why foreign aid for health?

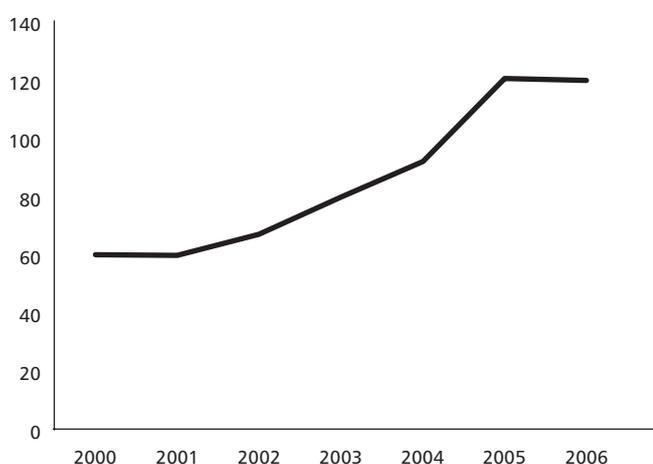
Since the early 2000s, foreign aid has undergone something of a shift, both in the quantities given and the way it is spent. Whereas aid in the 1980s emphasised 'structural adjustment' and the 1990s favoured 'conditionality', the last decade has witnessed a decisive move towards donor financing of social services such as health and education. This has been coupled with a significant increase in total flows of ODA, from US\$59.8bn in 2000 to US\$119.83bn in 2006 (Figure 1).

The move towards financing of health and education is consonant with the new global priority to meet the Millennium Development Goals (MDGs), agreed in September 2000 at the UN Millennium Summit in New

York. While the goals focus on measures relating to human well-being such as eradicating hunger and disease, the MDGs are, in essence, a reformulation of the old 'gap theory' traditionally used to justify the provision of foreign aid. This gap theory relies on the Keynesian notion that the rate of investment in a country is determined by the rate of (domestic) saving, which means that poor countries – having both low incomes and low rates of saving – are caught in a vicious 'cycle of poverty'. It is claimed that foreign aid can fill this gap, and help countries increase productivity and growth.

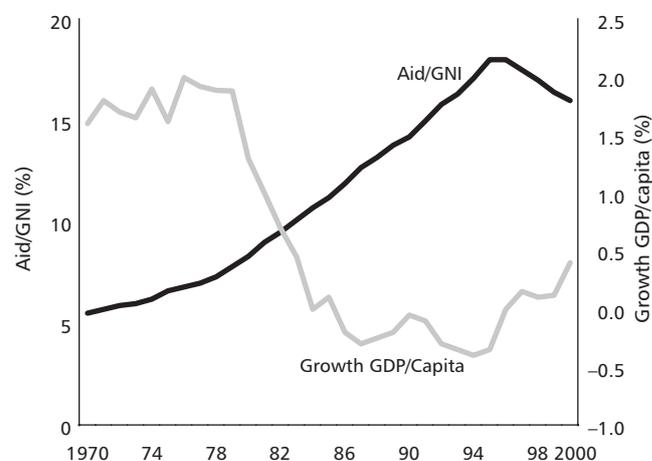
Whereas historically the gap theory was used to justify massive donor-funded physical infrastructure projects such as roads and power stations, the new focus of foreign aid – as represented by the global commitments to meeting the MDGs – is to improve *human*

Figure 1 **Total official ODA from members of the OECD Development Assistance Committee**
US\$ billions



Source: OECD

Figure 2 **Aid and growth in Africa (10-year moving average)**



Source: World Development Indicators Online

infrastructure, by investing in schools and hospitals. The thinking goes that if people are better educated and healthier, the quality and quantity of labour will improve, thereby kick starting economic growth.¹ This theory found its most authoritative official expression in the report of the World Health Organization's Commission on Macroeconomics and Health, published in 2001.

Partly as a result of such thinking, the last five years have seen a large increase in financial flows from the governments of wealthy countries to ministries of health in LDCs, for presumed spending on a range of health

priorities and interventions. OECD Development Assistance for Health (DAH) has increased from US\$ 2.5 billion in 1990 to over US\$ 14 billion in 2006. In 1990,

DAH constituted only 4.6 per cent of ODA, but by 2005 it had increased to 13 per cent.² Overall, approximately ten per cent of Africa's health care expenditure is now financed directly by donor aid.³ The USA, the world's biggest bilateral donor, has mirrored

this trend. The US government's two major health programmes, USAID's Child Survival and Health, and the President's Emergency Plan for AIDS Relief (PEPFAR), increased their combined budget from US\$1.6bn in 2001 to an estimated US\$7.57bn in 2009.⁴

“Overall, approximately ten percent of Africa's health care expenditure is now financed directly by donor aid.”

Figure 3 Progress of sub-Saharan Africa towards the health-related Millennium Development Goals

INDICATORS OF PROGRESS IN MEETING MILLENNIUM DEVELOPMENT GOALS	LATEST FIRM ESTIMATE	AVERAGE ANNUAL RATE OF REDUCTION (1990–2006)	PROGRESS TOWARDS THE MDG TARGET
MDG 1			
Underweight prevalence in children under five	28% (2000–2006)	1.1	Insufficient progress
MDG 4			
Under-five mortality rate	187 per 1,000 live births (1990); 160 per 1,000 live births (2006)	1.0	Insufficient progress
MDG 5			
Maternal mortality ratio, adjusted	920 per 100,000 live births (2005)	n/a	'Very high'*
MDG 6			
Malaria, under-fives sleeping under an insecticide-treated net	8% (2003–2006)	n/a	Yet to halt and reverse the spread of malaria
Paediatric HIV infections (children aged 1–14)	2.0 million (2005)	n/a	Yet to halt and reverse the spread of HIV
HIV prevalence among young pregnant women (aged 15–24) in capital city	9.7% (2005)	n/a	Yet to halt and reverse the spread of HIV
MDG 7			
Use of improved sources of drinking water	48% (1990); 55% (2004)	n/a	No progress
Use of improved sanitation facilities	32% (1990); 37% (2004)	n/a	No progress

*'Very high' indicates a maternal mortality ratio of 550 or more deaths of women from pregnancy-related causes per 100,000 live births.

Source: UNICEF, *Progress for Children: A World Fit for Children statistical review*, Number 6, December 2007; and *The State of the World's Children 2008*; Joint United Nations Programme on HIV/AIDS, *2006 Report on the Global AIDS epidemic*, UNAIDS, Geneva, 2006

Shortcomings of the current approach

Despite many decades in which the governments of wealthy countries have directed ODA at LDCs, the results have not been commensurate with the sums spent. Africa alone received more than US\$400bn of aid from 1970 to 2000, and yet it is not clear that this had any positive impact on GDP growth. Indeed, the opposite may be the case. (Figure 2).

Neither is it clear that ramping up aid flows is having the desired effect on population health in LDCs. At the end of 2007, the majority of sub Saharan African countries were off-track with their progress towards the health-related millennium

Development Goals (Figure 3), despite the injection of significant financial resources by donor nations. Access to essential medicines remains low in the poorest parts in the world: according to the World

“Donors have generally been happy to direct funds at pre-identified areas of need, but have historically paid less attention to the results achieved for that money.”

Figure 4 **Percentage of gross domestic product (GDP) for medical expenditures paid out of pocket in selected countries**
2002

Country	Percent paid out of pocket*
Bangladesh	64
Cameroon	69
Côte d'Ivoire	73
Cyprus	57
Democratic Republic of Congo	70
Ecuador	57
Egypt	58
Georgia	80
Ghana	59
Guinea	84
India	78
Indonesia	48
Kenya	45
Malaysia	50
Nigeria	67
Pakistan	65
Philippines	47
Sri Lanka	49
United Republic of Tanzania	38
Venezuela	46
Vietnam	62

* Includes out-of-pocket payments for people covered by both public and private insurance. Source: World Health Organization, *The World Health Report 2005: Make Every Mother and Child Count* (Geneva: WHO Press, 2005)

Health Organization (WHO), over 50 per cent of Africans lack access to essential medicines.⁵ Around the world, over 10 million children in developing countries die unnecessarily from diseases that are easily preventable and increasingly cheap to treat, such as diarrhoea, measles and malaria.⁶ Furthermore, the majority of patients in LDCs still have to pay for healthcare out of their own pockets (Figure 4), a factor which can have a grave impact on access to health.

2. Why health aid is failing

Lack of attention to output and results

Perhaps the biggest problem of the current strategy of ODA for health is the prioritization of need over outputs. Donors have generally been happy to direct funds at pre-identified areas of need, but have historically paid less attention to the results achieved for that money.

This represents something of a leap of faith for donors, the consequences of which are discussed in this section.

The Global Fund for Aids, Tuberculosis and Malaria, for instance, makes available the results of its frequent audits of its disbursements and activities. For 2006, it records the following:

- 1.1 million people are on antiretroviral drugs (ARVs) via Global Fund-supported programs.
- 30 million insecticide-treated bed nets were distributed.⁷

While this is superficially impressive, it must be noted that these are input indicators that simply demonstrate that the Fund has identified areas of needs and is directing resources in those directions. For HIV/AIDS, the Global Fund records no data on drug resistance, viral suppression rates from using drug 'x' versus drug 'y', mortality rates, co-morbidities, adherence rates, time of survival rates, and progression to AIDS-related illness. Without this crucial data, it is very difficult to tell if patients are actually benefiting from the treatment, and if treatment programmes need to be adapted to changing circumstances. Indeed, the absence of this

data permits the perpetuation of harmful treatment protocols that accelerate drug resistance and clinical failure.

In April 2007, the US Government Accountability Office (GAO) completed an audit of USAID's largest health programme, Child Survival. It found that although it knew how the 2004/5 budget of US\$675.6 million had been disbursed to the regions and individual missions, there was limited data about how the money was then allocated, and no data had been recorded about patients' outcomes.⁸ So while the programme has proved good at identifying need and allocating funds accordingly, USAID's bureaucrats have little recorded data to tell them if health is actually improving as a result of their activities.

The same is true of the public sectors in many countries, which frequently do not stipulate what is expected of hospitals, clinics and so on in return for funding. Public sectors often work on the basis of cash accounting, which means the efficiency and quality of service outputs are of secondary consideration to the requirement to demonstrate that none of the money has gone astray. This means that efficiency is rarely measured, and therefore few incentives exist to improve upon it. The same is true of equity, because public sectors rarely properly measure who is benefiting from services.

Resource tracking

A major difficulty of ensuring that aid delivers results, is the current strategy of disbursing funds directly to governments in LDCs, who are then trusted to spend the money as stipulated by the donor. In 2006, the total of such 'official' development aid given by members of the OECD's Development Assistance Committee (DAC) stood at US\$104.4 billion. Whether distributed bilaterally or via multilateral institutions, the vast majority of these funds end up in the ministries of the sectors concerned.

A significant drawback of disbursing this money directly to ministries, however, is that donors and the ministries themselves often have very little idea of what then happens to it. This is particularly true of ministries of health. But the tracking of health resources is vital if ministries are to properly allocate resources between

interventions, disease types and population target groups. It is also essential for effective management and planning, and to ensure waste is kept to a minimum.⁹ According to a study undertaken by the Center for Global Development, poor resource

tracking and inadequate data within LDC health systems "greatly impedes planning, decision making, and advocacy efforts", and therefore seriously undermines the effectiveness of donor funding.¹⁰

However, in the health systems of many LDCs, this information is incomplete. In follow up work to the Commission on Macroeconomics and Health, the WHO commissioned three studies in Sri Lanka, Cambodia and Indonesia to investigate how donor funds for health were spent at the country level. In all three studies, data to track these funds was found to be extremely limited.¹¹

Without major structural reforms in such health systems, this problem will only worsen as aid flows increase. It will be further exacerbated by the strategy of donors, such as UK's DFID, which implements the increasingly fashionable practice of general

budget support, in which funds are disbursed through the recipient government's financial management system and not earmarked for specific projects. If neither the donor nor the health ministry is properly accounting for the money, it increases its fungibility and lessens the chances it will be used to improve health. Moreover, it increases the likelihood that funds will be subverted by officials, or diverted to other government priorities – like military spending.

Corruption

Weak resource tracking in public health systems can also

“USAID’s bureaucrats have little recorded data to tell them if health is actually improving as a result of their activities.”

“A significant drawback of disbursing this money directly to ministries is that donors and the ministries themselves often have very little idea of what then happens to it.”

foster the major enemy of effective health spending – corruption. Although defenders of foreign aid claim that dealing with corrupt bureaucracies is a necessary evil if one wants to help the poor, this ignores the fact that corruption is often at such levels that it renders a great proportion of donor funding useless. According to research by Maureen Lewis, formerly of the World Bank, donors’ historic prioritisation of health needs over output is allowing corruption to flourish, and is thereby seriously jeopardising the likelihood of meeting the health-related Millennium Development Goals by 2015.¹² The anti-corruption NGO Transparency International also identifies the health sector as being especially at risk of corruption, particularly in LDCs with weak rule of law.¹³ In Ghana, for example, less than 20 per cent of donor funds make it to patient care.¹⁴

Corruption in health can take many forms. These can range from the subversion of public funds by officials for private use; abuses of procurement and supplies in hospitals, including selling pharmaceuticals on the black market; health workers demanding fees or other bribes

for purportedly free services; and institutionalised absenteeism.

Corruption, furthermore, reduces the chances of funds dispersed by donors actually making it to the local level to improve health care. One example is when high level officials of Costa Rica, including the President, were implicated in skimming nearly 20 percent off a US\$40 million international loan for health equipment.¹⁵

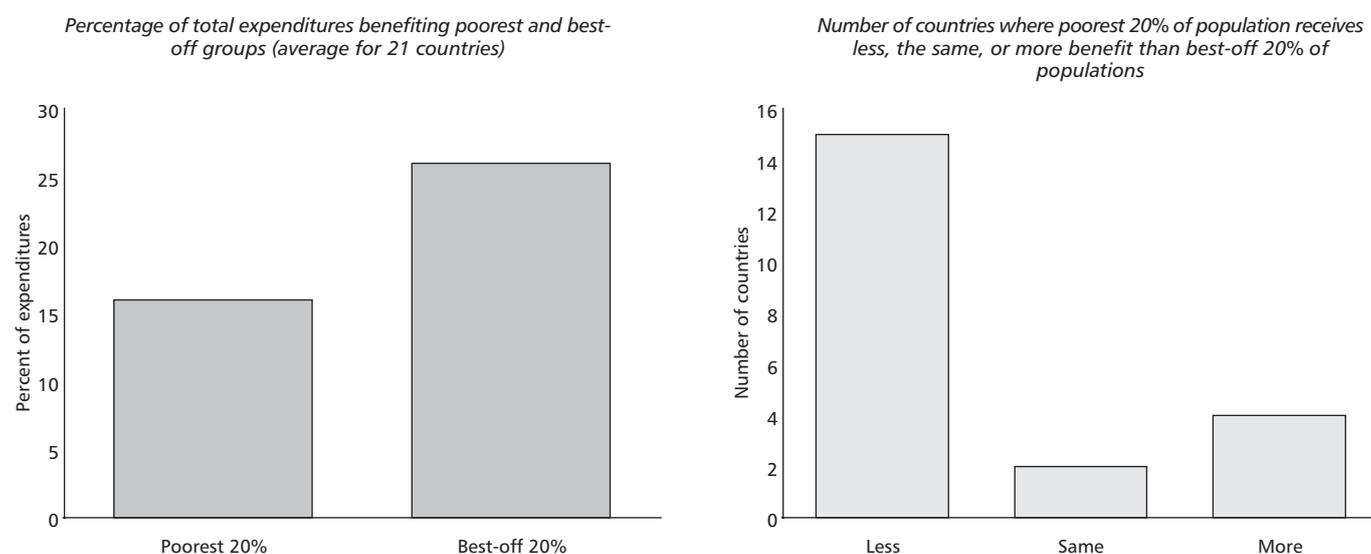
Another comes from India, where the World Bank recently released details about the corruption and mismanagement affecting all levels of the five projects it has underwritten in that country with a \$569m loan.¹⁶ As a result of such

graft, the proportion of a donor’s contribution that actually results in the delivery of healthcare services (whether they are vaccines or nurses salaries) is often very low.

As well as undermining donor funding, corruption can damage health. Studies by Transparency International showed that in the Philippines, a 10 per cent increase in

“Transparency International identifies the health sector as being especially at risk of corruption.”

Figure 5 **Distribution of benefits from government health service expenditures²⁰**
 Percentage of expenditures serving the poorest and best-off 20% of the population in 21 developing and transition countries



the extortion of bribes by medical personnel reduced the rate of child immunisation by up to 20 per cent,¹⁷ while in Cambodia, the embezzlement of public funds led certain health indicators to worsen despite increases in aid.¹⁸

The results of such failures mean that much donor funding is not helping the poor, and is instead favouring more articulate and richer parts of LDC populations. (Figure 5). And such spending is hugely inefficient. A multi-country study by World Bank economists Filmer and Pritchett showed that public spending on health has only a minute impact on mortality. The authors showed that a significant proportion of deaths of children below five years could be averted for as little as US\$10 each, even in the poorest countries, the average amount spent per child death averted is a staggering US\$50000–\$100,000.¹⁹

Unintended consequences of aid

Partly as a result of the difficulties of demonstrating the benefit of aid spent directly on health systems, donors in recent years have turned their attention to so-called ‘vertical’ diseases programmes, set up to tackle specific diseases such as malaria or HIV/AIDS. Since 2000 a number of financially well-endowed vertical programmes have been established, including the US’s PEPFAR and President’s Malaria Initiative; the Global Fund to Fight Aids Tuberculosis and Malaria; the World Bank’s multi-country AIDS programme, and its myriad other specific disease programmes; the UN’s Global Alliance on Vaccine and Immunisation (Gavi); and the WHO’s “3 by 5”, Stop TB and Global Malaria Programme. Combined private and public donor financing of HIV/AIDS, malaria and tuberculosis will total around \$110bn between 2008–2013, with financing for in-country HIV/AIDS programmes frequently exceeding national health budgets themselves.

Politically-driven donors favour these programmes because they are often able to provide quick, measurable

results. ARV treatment for HIV/AIDS, in particular, can provide visibly dramatic improvements in sick patients in a very short space of time. As the former co-ordinator of “3 by 5”, Dr Jim Kim, told the *Financial Times* in 2007: “There is a Lazarus effect with treatment. It is immediately understandable to everyone. HIV in

particular has the greatest advocates to keep it going.”²¹

Although these programmes are increasing the numbers of patients receiving ARV and malaria treatment the consensus is beginning to shift

against vertical diseases programmes. This is due to an increasing perception that such specific funding is distorting the overall performance of wider health systems.

- There are concerns that dedicating large sums of money to a single disease entity such as AIDS is leading to distortions in the provision of overall primary care: carers, clinicians and other scarce resources are diverted into these more lucrative areas, undermining basic health services.^{22,23}
- High levels of donor funding for specific diseases results in budgets, plans and operations that are separate from those of the Ministry of Health, meaning that donors have an undue influence on the direction of spending. Meanwhile, each vertical fund imposes its own reporting requirements and plans on countries, thereby adding to the strategic confusion and administrative burden faced by the government.
- Large inflows of foreign aid can also have impacts that reverberate beyond the health sector. According to the Center for Global Development: “Aid levels are already fairly high. Nearly half of the countries are receiving aid worth more than 50% of government expenditures and more than one-third above 75 per cent. Aid flows can give governments even less of a reason to go through the tedious task of building and improving tax administration if they can get more resources from donors than their own citizens.”²⁴

“Dedicating large sums of money to a single disease entity such as AIDS is leading to distortions in the provision of overall primary care.”

“When governments become dependent on foreign sources to maintain their activities, it acts to drive a wedge between them and their citizens.”

- When governments become dependent on foreign sources to maintain their activities, it acts to drive a wedge between them and their citizens, and allows often corrupt, repressive governments to remain in power. It also removes the incentives faced by governments to enact the often politically difficult reforms that are needed to promote economic development.
- In 2004, the IMF warned of the dangers of increasing aid flows for HIV/AIDS: large inflows of foreign currency raise local exchange rates, hitting exports; inflation will increase when aid funds are spent locally on “non-tradable goods”; and domestic interest rates will be pushed up, thereby squeezing social spending by raising public debt service payments.²⁵ These all hurt the poor the most.
- Moreover, disease-specific funding is currently resulting in the capture of overall Official Development Assistance by specific diseases to the detriment of other programmes. It is estimated that AIDS funding from the Government of the United States will consume more than 50 per cent of its ODA by 2016, and “squeeze out U. S. spending on other global health needs [creating] a new global entitlement.”²⁶

“Donors should consider the innovative approach of using their funds to sponsor the contracting out of services through a competitive process to commercial entities or non-profit groups.”

3. Moving forward

Instead of increased funding for vertical disease programmes, or direct support of public health system operating budgets, what is needed are policies that will actively strengthen healthcare systems and deliver the range of services needed by patients.

At the heart of this should be increasing access to the private sector, which is already well established in many LDCs and provides care to all strata of society. According to the International Finance Corporation, 60 per cent of the US\$16.7bn spent on health in SSA in 2005 was privately financed, with half of that money being spent

in the private sector (largely via out-of-pocket payments).²⁷ According to World Bank statistics, over 40 per cent of the lowest economic quintile in Nigeria, Uganda, Kenya and Ethiopia make use of the private sector.²⁸ This huge capacity and expertise is frequently overlooked by donors who prefer to work directly with government partners. If this enormous resource can be harnessed and made to work in the interests of all sections of population, it would overcome many of the hurdles donors face when spending DAH.

Contracting out health services

One obvious way to encourage this would be for donors to shift away from their historic ‘input’-lead approach to healthcare financing. Spending is far more likely to be effective if donors clearly define what they want their money to achieve before they commit it. Instead of simply identifying that Rwanda, for instance, has a need for \$100m for improving maternal health in rural populations, and trusting the money to the recipient government to spend accordingly, it would be better to make the future availability of finance contingent on maternal health in those regions actually improving. Donors and public health systems rarely pay attention to such precise outputs.

Donors should consider the innovative approach of using their funds to sponsor the contracting out of services through a competitive process to commercial entities or non-profit groups, for a defined set of health services for specified target populations. This competition should not be limited to non-profit NGOs, as some have suggested. If the economies of scale

necessary for effective competition are to be reached, it is vital that these contracts be open to any entity – including profit-making businesses – that can demonstrate they can fulfil the contract’s stipulations. Excluding for-profits would mean less competition, and

therefore a lower standard of delivery and lower health outcomes.

Payment would depend on achieving pre-defined results, therefore acting as a powerful stimulus for quality coverage. Defined outputs should be broad and goal-related, so as to avoid gaming by the contractors and micromanagement by the client. If properly drafted and enforced, output-based contracts would be less prone to political interference and graft than the often poorly-controlled public sectors within LDCs.

Contracting out has several advantages. It would bring greater focus onto achieving measurable results, while taking advantage of the private sector's flexibility and expertise. It would also decentralise the management of healthcare and provide greater autonomy for managers, while at the same time harnessing the power of competition, thereby creating greater efficiencies. It would also allow governments to focus on tasks to which they are better suited, such as maintaining regulatory frameworks and standard setting.

Contracts would also help to address the frequently heard complaint that market-based healthcare is of no use to rural or poor areas where there is little opportunity for profit (even though government-provided healthcare routinely fails in this area). Contracting could overcome this problem if contracts for rural or underserved areas have their value increased relatively, in order to incentivise providers to move into areas where their costs may be higher (for example, if they are remote). Where the underserved poor were once a headache for bureaucrats in health ministries, they could suddenly become a business opportunity.

While this approach has been used with some success in sectors such as water and electricity provision, it is still relatively experimental in health. One promising case study, however, is that of Cambodia. Donors began funding contracting with international non-profit NGOs to provide primary health services to the rural poor in 1999. This was necessary because corruption and general neglect had left the public system totally incapable of providing even basic coverage. The NGO contractors are

paid to achieve pre-defined levels of coverage, be it in delivering vaccinations or pre-natal care, or providing curative services for common ailments such as diarrhoeal diseases or chest infections. The Ministry of Health awards and administers the contracts, which are then financed by international donors. All the contracts are awarded via an international competitive bidding process.

“Where the underserved poor were once a headache for bureaucrats in health ministries, they could suddenly become a business opportunity”

According to studies undertaken by the World Bank, this innovative approach has increased primary healthcare coverage and increased uptake amongst the poor: “coverage among the poorest 20% of the population of eight basic services rose from an average of below 15% to

over 40% in two experimental districts with a total population of around 200,000.”²⁹ This was more than double the increase of two control regions that were still receiving purely government healthcare. The use of contracts has proved so successful that the Ministry of Health has, with the help of donors, now expanded the programme to cover one in ten Cambodians.

Other examples of contracting out health services show similar promise. A 2005 study published in *The Lancet* compared six contractors with government provision of the same service. In all six cases “the contractors were

more effective than the government, on the basis of several measures related to both quality of care and coverage of services”. The study went on to state that contracting was frequently cheaper than government provision, and can increase coverage in poor, remote

areas, especially when the contractor is given resources and a specific mandate.³⁰ Some of the most striking successes in contracting out come from those schemes which have sought to take advantage of economies of scale by having large numbers of beneficiaries. One contracting scheme to provide primary care in Bangladesh now covers one third of the rural population, or 30 million people.³¹

Currently, the weakness of public sector delivery is undermining the chances of meeting the Millennium

Development Goals. The private sector already has capacity and infrastructure. It would make sense for donors and governments to take advantage of this existing capacity by contracting the private sector on behalf of patients. This is currently a path being trod by even the most socially democratic countries like Sweden³², and will almost certainly be more effective than trying to enact the kind of drastic reforms that will be necessary to get public sectors to perform to acceptable standards.

Private health insurance

The ultimate goal of health-related development assistance should be to create health care systems that are self-sustaining, obviate the need for out-of-pocket payments, and are not reliant on unpredictable donor financing. If donor financing is scaled back, for example due to domestic fiscal constraints, there is no guarantee that LDC governments will continue to finance healthcare to acceptable levels. Furthermore, seeing as it is highly unlikely that public health systems will improve dramatically in the foreseeable future, it is necessary to explore ways in which people can contribute to their healthcare costs in a sustainable manner without incurring unaffordable out-of-pocket payments. The extent to which out-of-pocket payments dominate health care financing is illustrated in Figure 4 on p.6.

While high levels of out-of-pocket payments are symptomatic of the failure of public healthcare systems, they also point towards an alternative solution. High levels of uninsured private health spending suggest there is sufficient demand and funding available for an extension of private health insurance markets. As economic growth translates to higher incomes in LDCs (Less Developed Countries), there is likely to be a greater demand for private health insurance, particularly in the face of unreliable public health systems.

Private health insurance has several advantages. In the

absence of 'free' public healthcare, insurance has the advantages of allowing people to make smaller payments spread out over time, thereby avoiding catastrophic financial shocks in the event of illness. This means a family's resources can be diverted to more productive uses, such as financing education, for example or investing in seed for the next year's crop.³³ Insurance also increases the rates of utilisation of healthcare, therefore resulting in a healthier population overall.

For providers of healthcare, risk pooling schemes make revenue streams more predictable, reducing risk and permitting better forward planning and forecasting. This will in turn help providers become more efficient and better able to pass on savings to patients.

“High levels of uninsured private health spending suggest there is sufficient demand and funding available for an extension of private health insurance markets.”

However, private health insurance markets in LDCs are currently very small: outside of countries like South Africa and Namibia, they hardly exist. One study of 12 African countries showed that only 2 per cent of people participated in community insurance schemes.³⁴

Such markets are kept artificially small, however, by weak or counterproductive governance in many LDCs.

One of the major barriers to the formation of healthcare markets is poorly defined contract law. This, combined with a lack of adequate court systems and generally an absence of the rule of law, makes the enforcement of legal agreements difficult, long-winded and expensive. Health insurance takes the form of a contract in which

payment is made in advance of pay-out by the insuring company. In an environment where contracts are difficult to enforce, it is not surprising that many people are unwilling to risk paying into an insurance scheme. This specifically relates to a failure on the part of

government to create an adequate rule of law and supporting institutions.

Another reason for low levels of insurance coverage in poor countries relates to the level of regulation placed upon private health insurers. For example, insurance

companies may be required to offer certain kinds of insurance, regardless of whether or not consumers want the coverage. Governments may wish to compel insurance providers to give low premiums to low income, high risk participants. In such a case, this would pressurise low-risk participants, who normally form the backbone of an effective risk pool, to leave the pool.

In South Africa, the government has banned insurers from excluding high risk applicants, and has compelled them to include cover that is not necessarily appropriate. The South African government is also working towards establishing a system that will require well-run funds to transfer their surpluses to badly-run funds. This latter intervention will limit the ability of actuaries to balance contributions against risk. Such regulations increase the costs associated with offering insurance, which increases the price at which it is offered. As a result, relatively fewer people are able to afford insurance. Paradoxically, regulations intended to protect consumers ultimately harm them.

Donors could help improve matters by earmarking some of their ODA for helping improve the institutional environment in LDCs, and by giving technical advice on areas of legal and regulatory reform pertinent to risk pooling markets. Donors may also consider subsidising the premiums of targeted groups of individuals, which would expand coverage and help create the larger risk pools required for a sustainable model.

Even though most developed countries have opted against the use of private insurance to finance healthcare, ideological objections to insurance should not stand in the way of increasing its use in LDCs. Given that large proportions of LDC citizens already pay out-of-pocket for health, it is far better that these sums are spent in a more rational and manageable way via insurance premiums. The alternative is to wait for governments to achieve the previously impossible, and provide universal coverage via public health systems. Given the tax raising problems, resource constraints and structural inefficiencies faced by state-managed health care systems, this will simply perpetuate the unacceptable *status quo* indefinitely.

Discussion

In many other sectors, markets work well to provide people in LDCs with the services they need. Since the government of Kenya passed legislation in 1998 that allowed private companies to develop mobile phone networks, for instance, the number of private subscribers has increased from virtually zero to a situation where one in three adults now owns a mobile phone.³⁵ Many other private sector businesses are actively courting markets in LDCs, from purveyors of washing powder to computers. Markets can work in the provision of social goods as well – research conducted by James Tooley at Newcastle University has shown that poor parents in a range of developing countries prefer to send their children to local, often unregistered, private schools than risk their child’s future in frequently substandard public schools. Crucially, the profit motive and the need to retain and attract customers have forced these education providers to raise their standards consistently higher than their public sector competition.³⁶

Clearly there is a great pent up demand for healthcare in LDCs. However, governments and donors are currently pursuing a failing strategy. The funding of ‘vertical’ disease programmes stands accused of creating distortions within the wider healthcare system, while Ministries of Health have proved unequal to the task of providing quality, universal healthcare to citizens. Government to government aid has rarely demonstrated results, because it is often co-opted at the ministry level even before it makes it to the front line, where it must then contend with multiple other layers of graft and inefficiency before it can get close to patients. As a result, far too few people have access to affordable healthcare.

Enough money has been already wasted to at least consider other approaches to delivering healthcare. We should not allow ideological squeamishness to stand in the way of a wholesale adoption of market-based approaches, particularly contracting with the private sector and scaling up health insurance. Indeed, if donor agencies are to persuade taxpayers to continue financing their activities indefinitely, it will become ever more vital

“Private insurance markets are kept artificially small by counterproductive governance.”

for them to be able to demonstrate some clear returns on their investment – something they have historically been unable to do.

Notes

1. Sachs, J., McArthur, J., Schmidt-Traub, G., Kruk., M., Bahadar., Faye, M., McCord, G., (2004) “Ending Africa’s poverty trap”., *Brookings papers on economic activity*, 1
2. *The Business of Health in Africa*, (2007), International Finance Corporation, Washington DC [http://www.ifc.org/ifcext/healthinAfrica.nsf/AttachmentsByTitle/IFC_HealthinAfrica_Final/\\$FILE/IFC_HealthinAfrica_Final.pdf](http://www.ifc.org/ifcext/healthinAfrica.nsf/AttachmentsByTitle/IFC_HealthinAfrica_Final/$FILE/IFC_HealthinAfrica_Final.pdf)
3. Ibid
4. Office of Management and Budget, “Department Of State And Other International Programs”, available at <http://www.whitehouse.gov/omb/budget/fy2009/state.html>
5. World Health Organization, *World Medicines Situation*, 2004
6. Black, R., “Where and why are 10 million children dying every year?” *The Lancet*, 2003; 361: 2226–34
7. Global Fund press release, 22 May 2007, available at http://www.theglobalfund.org/en/media_center/press/pr_070522.asp
8. Government Accountability Office, Report to Congressional Committees on Global Health, April 2007
9. Powell-Jackson, T., & Mills., A., (2007), “A Review of resource tracking in developing countries”, *Health Policy and Planning*, 22(6)
10. “Following the money: toward better tracking of global health resources,” Report of the global health resource tracking working group, Center for Global Development, 2007
11. “Tough choices: investing in health for development”, World Health Organization
12. Lewis, M., (2006), “Governance and corruption in public health care systems”, Working paper 78, Center for Global Development, Washington DC
13. Transparency International, *Corruption Report 2006: special focus on Corruption and health*
14. Ye, X., & Canagarajah, S., “Efficiency of public distribution and beyond: a report on Ghana’s 2000 PETS in the sectors of primary health and education”, World Bank Africa Region Working Paper Series No 31, 2002
15. González, E., “Grand corruption in Costa Rica”, in *Global Corruption Report 2006*, Transparency International
16. World Bank uncovers ‘India fraud’, BBC News, 11th January 2008, available at http://news.bbc.co.uk/1/hi/world/south_asia/7184345.stm
17. Azfar, A., & Gurgur, T., “Local-level corruption hits service delivery in the Philippines”, in *Global Corruption Report 2006*
18. Prevenslik-Takeda, L., “Corruption in Cambodia’s health sector”, *Global Corruption Report 2006*
19. Filmer, D., & Pritchett, L., “The impact of public spending on health: does money matter?” World Bank. 1999
20. Filmer, D., “The incidence of public expenditures in health and education”, background note to *World Development Report 2004*, World Bank, Washington DC
21. “From symptom to system”, Andrew Jack, *Financial Times*, 28th September 2007, available at <http://www.ft.com/cms/s/92d94ba6-24e4-11d8-81c6-08209b00dd01,id=070928000813,print=yes.html>
22. England., R., “The dangers of diseases specific programmes for developing countries”, *British Medical Journal*, 2007;335:565 (15 September).
23. Garret, L., “The challenge of global health”, *Foreign Affairs*, January 2007
24. Todd Moss and Arvind Subramanian, “After the Big Push? Fiscal and Institutional Implications of Large

- Aid Increases". Center for Global Development, Washington, D. C., October 2005.
25. IMF, Peter Heller, et al., "Sizeable Boost in HIV/AIDS Assistance Will Challenge Low Income Countries", IMF Survey, July 12, 2004.
 26. Over, M., "Preventing Failure: The Ballooning Entitlement Burden of U. S. Global AIDS Treatment Spending and What to do About It", Center for Global Development, Washington, D. C., May 5, 2008
 27. *The Business of Health in Africa*, (2007), International Finance Corporation, Washington DC
 28. Africa Development Indicators, World Bank 2006.
 29. Schwartz, J., & Bhushan, I., (2005), "Cambodia: using contracting to reduce inequity in primary health care delivery" in *Reaching the Poor with health, nutrition and population services*, world Bank
 30. Loevinsohn, B., & Harding. A., "Buying results? Contracting for health service delivery in developing countries", *The Lancet* 2005; 366: 676–81
 31. Karim, R., Lamstein, S., Akharauzzaman, M., Rahman, K., Alam, N., "The Bangladesh integrated nutrition project community-based nutrition component endline evaluation", Institute of Nutrition and Food Sciences, University of Dhaka, Bangladesh and International Food and Nutrition Center, Tufts University, 2003
 32. "Swedish Healthcare, www.sweden-se/templates/es/factsheet_15865.aspx
 32. Xu , K., Evans , D., Kawabata, K., Zeramdini , R., Klavus , J., Murray, C., "Household catastrophic health expenditure: a multicountry analysis", *The Lancet* 2003, Volume 362 , Issue 9378 , Pages 111 – 117
 33. Ndiaye, P., Soors, W., & Criel, B., (2007), "A view from beneath: community health insurance in Africa." *Tropical Medicine and International Health*, vol. 12, no. 2
 34. Arunga, J., & Kahora, B., "The cell phone revolution in Kenya", International Policy Network, 2007
 35. Tooley, J., "Private Education is Good for the Poor – A study of private schools serving the poor, in low income countries", Cato Institute, 2005