Development Assistance for Health: Donor Commitment as a Critical Success Factor

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ABSTRACT

In 1970, led by Canada, the world's richest nations pledged 0.7% of their gross national income (GNI) to official development assistance (ODA). Although this pledge has been renewed several times, with the exception of only five countries, ODA allocations have lagged chronically behind this commitment. Put more bluntly, our rhetoric outpaces our actions. For example, spending only 0.3% GNI on development, Canada performs at about 40% of its pledge. The good news is that development assistance for health has improved over the past two decades, mostly due to private development assistance (PDA) and favourable shifts within bilateral and multilateral funding, but clearly more must be done to enhance this effort. Actions in support of the Millennium Development Goals and the Paris Declaration on Aid Effectiveness should make a difference, subject to monitoring and evaluation, and Canada's Muskoka Initiative also is a step in the right direction. However, while success in meeting international development and global health goals depends on donor and recipient nations working as partners through such mechanisms, the relevance of the developed world as a force for global health will be measured in part by how well its governments keep their development commitments.

Key words: World health; public policy; economics; program evaluation; human rights

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On retiring from Canadian politics, former Prime Minister Lester B. Pearson, in 1968, accepted an invitation from Robert McNamara, World Bank President, to chair the Commission on International Development.¹ Following consultations with over 70 donor and recipient nations, the Pearson Commission (as it became known) released its report "Partners in Development" in October 1969. The report provided convincing analysis in support of recommendations for donor nations to be more generous with economic aid. In 1970, the world's wealthiest nations promised to commit 0.7% of their gross national income (GNI) to official development assistance (ODA).² Our government recommitted to the goal in 1975, but has not met it to this day. The target was reiterated at: the 2002 International Conference on Financing for Development in Mexico; the 2002 World Summit on Sustainable Development, South Africa; and in 2005, in Scotland, when European Union G8 members recommitted to reach it by 2015. That five nations have met or surpassed the challenge (Table 1) reveals that this is more about priority setting and political will than feasibility.

In light of the 2010 G8 meeting in Canada, let us reflect on these sober facts:

- Four decades since the 0.7% target was set, only 5 OECD nations have met it.
- No G8 nation has achieved this target (current range UK=0.52%; Italy=0.16%).
- The G8 collective performance is below other OECD nations (Table 1).
- Canada ranks 15th among 23 OECD nations monitored, and 6th among the G8.

Globally, the value of ODA is about US \$70-100 billion annually. While portrayed as generous by rich nations, this is only half what was promised. "Generosity" is relative. For example, Europe, the USA and Japan spend 4-5 times this on agricultural subsidies, even though this undercuts global markets for poor nations to export their way out of poverty.⁴ As Nobel Prize economist Joseph Stiglitz and colleague Andrew Charleton observed, "For years... governments of many developed countries... argued that 'trade not aid' is the answer to the problems of... developing countries. (Their) insincerity... has been revealed in successive rounds of trade negotiations in which they have been reluctant to open their markets".⁵ And as Kofi Annan stated, "Developing countries need aid for trade and such aid must not come at the expense of aid for development."^{5, pg.8}

The arms trade offers a more extreme reference point. The end of the Cold War was to usher in a new era, with global development a key beneficiary. Western leaders promoted the "peace dividend" to describe a purported economic benefit of reduced military spending. But military and development statistics reveal a different real-

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http://www.phabc.org/userfiles/file/Frank_White_CPHA_CentennialWebinar_2010.pdf

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Table 1. OECD Nations in Rank Order by Net ODA as Percent of GNI 2009³

Rank	Nation	%GNI	Rank	Nation	%GNI	Rank	Nation	%GNI
1.	Sweden	1.12	7.	Finland	0.54	13.	Germany	0.35*
2.	Norway	1.06	8.	Ireland	0.54	14.	Austria	0.30
3.	Luxembourg	1.01	9.	United Kingdom	0.52*	15.	Canada	0.30*
4.	Denmark	0.88	10.	Switzerland	0.47	16.	Australia	0.29
5.	Netherlands	0.82	11.	France	0.46*	17.	New Zealand	0.29
6.	Belgium	0.55	12.	Spain	0.46	18.	Portugal	0.23
						19.	United States	0.20*
						20.	Greece	0.19
						21.	Japan	0.18*
						22.	Italy	0.16*
						23.	Korea	0.10

Note: G8 nations are denoted by an asterisk. Missing from this list is Russia, not a member of the OECD.

ity: G8 nations in particular remain locked into much the same old post-colonial mentality, captive to the defense industry. In 2009, global military expenditure exceeded US \$1.5 trillion, an increase of 6% over 2008, and 49% since 2000. The USA accounted for 46.5%, distantly followed by China, France, UK and Russia (range 3.5-6.6%).⁶ How military spending is applied or justified (or otherwise) could fill another commentary. However, savings in this area could be legitimately applied to many areas of unmet need, such as to uplift the living conditions of Aboriginal peoples, to invest in green solutions for the planet, or to more effectively address deficiencies in public pensions. In our context, even if only 5% of the money going into the arms trade were reallocated to development, it would double ODA, bringing it closer to the 0.7% pledged. Ironically perhaps, from the perspective of global leadership, the aforementioned five nations are permanent members of the UN Security Council.

It is a truism that many poor nations contribute to their misfortunes. Corruption is more endemic in countries deficient in good governance. But governance is a work in progress everywhere, including donor countries, some of whose aid ethics and accounting practices can be challenged. For example, many donor nations require their own products and services to be used. The result of this “tied aid” is that only about half of ODA is genuinely available to recipients; it is nonetheless counted in official statistics while recycled within the donor's economy. Also, as donors have their own motivations, priorities and management styles, competition and conflict arise in many settings, revealing a need to improve donor coordination. Clearly aid is not simply about the quantum of resources; it is also about making better use of those resources.

In response to these longstanding conflicts, the Paris Declaration on Aid Effectiveness issued in 2005,⁷ committed both donors and recipients to principles (ownership, alignment, harmonization, results, mutual accountability) for multilateral and bilateral aid, and set 2010 as a timeline for improvement of practice. This was followed in 2008 by the Accra Agenda for Action (promoting predictability and use of country systems, and reductions in conditionality and relaxing of tied aid). The main focus of these linked initiatives is to make better use of donor and country resources. How well all this is being implemented requires rigorous, independent and ongoing monitoring and evaluation.

Meanwhile, the impetus for development financing has drifted significantly towards private development assistance (PDA).⁸ This refers to the role of NGOs (e.g., CARE, OXFAM, Red Cross) largely supported by citizen donors, philanthropic entities (e.g., Gates Foundation, Packard Foundation, Aga Khan Development Network), educational and research institutes (universities mostly), and corporate entities (as donors, coalition members and development partners). The financial value is difficult to estimate, but is large. For example, PDA from the United States is more than double that of its ODA. PDA is also qualitatively different from ODA, such as

building “people to people” relationships, rather than nation to nation. It is less bound by national or global policies than ODA, which can have advantages (more flexibility) and disadvantages (leadership, managerial and technical expertise are more variable).

While PDA is driven by its own unique motivations, emerging evidence suggests that its overall effectiveness in the health sector may be superior to ODA.⁹ However, even if confirmed, this does not mean that ODA should be phased out, especially now that its effectiveness may improve under renewed scrutiny, e.g., Accra Agenda. However, if PDA is superior in some respects, this would strengthen the rationale to channel more ODA through NGOs.

Developed nations also have another consideration: health is enshrined in the Universal Declaration of Human Rights,¹⁰ and is thereby a core element of democracy which we in the west are said to uphold, and to promote elsewhere. Organized public health interprets this as the social justice goal of health equity, namely to reduce “differences in health that are not only unnecessary and avoidable, but in addition unfair and unjust.”¹¹ However, to achieve this in any society requires policy development and investment in programmatic interventions, in other words “development assistance for health”.

Development assistance for health has responded to advocacy, especially from the 1978 Alma Ata Declaration on Primary Health Care (PHC) and the People's Charter of Health, Dhaka 2000 which reflected a groundswell of disillusionment over historic failures to adequately address the broader needs of the world's poor.⁸ “Health for all by the Year 2000” itself faltered because it lacked an action plan and committed resources, and because it was promptly overtaken by selective disease control initiatives preferred by donors (so-called “vertical programming” usually driven from the top, with little effort to integrate efforts with more broadly based community programming, the approach that lay at the core of Alma Ata). However, the Charter movement shows how “civil society” can keep the broader vision alive, as reflected by the UN which, also in 2000, issued the Millennium Development Goals (MDGs). Nonetheless, when wealthy nations continue to fall short of their pledges, even these limited goals remain at risk of failure. Will the global community, especially wealthy nations, live up to these new commitments?

For example, according to Prime Minister Stephen Harper, Canada's pledge of \$1.1 billion to the Muskoka Initiative on Maternal, Neonatal and Child Health was “disproportionate” compared with other G8 countries.¹² This is sadly factual: total G8 funds pledged came to US \$5 billion over 5 years, from nations whose collective wealth is two thirds the world's total. The G8 pledge deeply disappointed many stakeholders, as it is only one eighth the estimated US \$40 billion required to fund the Global Strategy for Women's and Children's Health,¹³ with which the Muskoka Initiative is aligned. Having spearheaded Muskoka, Canada now has a duty to hold it accountable for performance. It is therefore doubly relevant

that Prime Minister Stephen Harper co-chairs the UN Commission on Information and Accountability for Women's and Children's Health. Will Canada and other G8 nations now fully align aid with their commitments?

CONCLUSION

Development assistance for health has improved over two decades, mostly due to favourable trends in PDA and priority shifts within bilateral and multilateral funding. However, while success in meeting international development and global health goals depends on donor and recipient nations working as partners, the relevance of the developed world to this process will be measured by how well its governments keep their promises.

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RÉSUMÉ

En 1970, sous l'égide du Canada, les pays les plus riches ont annoncé une contribution de 0,7 % de leur revenu national brut (RNB) à l'aide publique au développement (APD). Cette promesse a été renouvelée plusieurs fois. Pourtant, à l'exception de cinq pays seulement, les montants consentis à l'APD ont été en décalage chronique par rapport à cet engagement. Pour parler franc, nos discours creux ont pris le pas sur nos actions. Par exemple, en ne consacrant que 0,3 % de son RNB au développement, le Canada n'en est qu'à environ 40 % de sa contribution annoncée. La bonne nouvelle est que l'aide au développement en santé augmente depuis les 20 dernières années, surtout grâce à l'aide au développement privée et à des transferts favorables entre le financement bilatéral et multilatéral, mais il est clair qu'il faut en faire plus pour améliorer cet effort. Les actions à l'appui des objectifs du Millénaire pour le développement et de la Déclaration de Paris sur l'efficacité de l'aide devraient peser dans la balance, à condition de faire l'objet d'un suivi-évaluation; l'Initiative de Muskoka du Canada est aussi un pas dans la bonne direction. Cependant, si l'atteinte des objectifs de développement international et de santé mondiale dépend de la collaboration entre pays donateurs et pays bénéficiaires à la faveur de tels mécanismes, la pertinence des pays développés comme une force pour la santé mondiale se mesurera en partie par la façon dont les gouvernements de ces pays tiendront leurs engagements en matière de développement.

Mots clés : santé mondiale; politique publique; économie; évaluation de programme; droits homme