

**Global Health Governance:
Reconciling macroeconomic stability with a major scaling-up of aid to
combat HIV/AIDS in low-income countries.**

Report

In Sub-Saharan Africa over 25 million people are infected with HIV/AIDS. These countries need urgently to put into place healthcare systems to contain infection and treat those affected. This requires resources from the rest of the world and a huge commitment by governments and people on the continent. Global efforts at fund-raising have begun to scale-up in recent years. Yet at the core of the effort to deal with the HIV/AIDS pandemic in low-income countries lies a knotty problem.

Governments in affected countries are being pulled in two opposite directions. Health professionals estimate that these countries need massively to scale-up investment in their health sectors (WHO estimates). The scaling-up is yet larger when the actions needed to meet the broader Millennium Development Goals (MDGs) are costed. Yet at the same time, macroeconomists are warning that rapid, sharp increases in aid to countries might cause as much damage as benefit. What then should be done?

The Global Economic Governance Programme at University College and the World Health Organization brought together economists and officials working on fiscal sustainability and macroeconomic stability in Africa with health researchers and officials examining the ways investment and absorption work in the health sectors in Africa. The result was a vigorous debate, provoking the following lessons and conclusions.

What kind of 'scaling-up' is necessary?

WHO representatives presented estimates of the level of scaling-up required to achieve official health goals. Between \$80-\$96 per capita (US\$ 2002) is likely, although it could rise to \$100 per capita across all MDGs. Health is expected to consume around 30% of this figure. This would convert to a total need of around \$22.3bn per year for health alone across Sub-Saharan Africa (SSA), without including infrastructure requirements. The Commission on Macroeconomics and Health also estimates that across 46 SSA countries, the requirement will be around \$23bn per year at \$24 per capita to reach the target MDGs. In terms of scaling up HIV/AIDS specifically, WHO/UNAIDS is looking to get 3 million onto antiretrovirals by the end of 2005 (3 by 5), at a total cost of \$5bn a year for SSA by 2005.

Current resource estimates show around \$11bn available for health across SSA. Pledges in 2004 have added an extra \$1-1.5bn. Furthermore, there appears to be a widening funding gap between what resources are needed and what are available, particularly following 9/11 and an increased donor focus on security issues.

Sudhir Anand (Oxford) provided a critique of how these estimates were reached. For example, it is unclear whether the unit costs were marginal or average, how costs would change as coverage expanded, or how figures were translated across countries. A clear cost function is necessary to appropriately estimate the resources needed. Interventions provided through health systems may have multiple outputs, as well as producing economies of both scale and scope. There is a need to use appropriate unit costs in estimating the resources required for scaling up, since misestimation of costs has widespread implications. Costs to achieving incremental improvements may vary across different countries. Currently, there are few robust, reliable and comprehensive models for doing this. The subsequent discussion highlighted the need to use real data from individual countries in building aggregates.

Donor concerns about the macroeconomic consequences of 'scaling up'

Why are macroeconomists worried about new flows of aid to low-income countries? Countries are best served by implementing sound macroeconomic management. This means a medium-term expenditure framework, which matches a government's available resources from revenue, borrowing and aid, with its plans for spending. The obvious problem with large new flows targeted at specific purposes is that practically it is very difficult to integrate them into such a framework. More specifically, macroeconomists warn of five issues which need to be taken into account if large additional aid flows are to be poured into low-income countries (these were succinctly introduced by David Bevan, Oxford):

1. the need to create and maintain fiscal discipline to curb inflation and sustain growth (in discussion: the IMF is concerned that large inflows will create wage pressures which will ripple out to the rest of the economy);
2. the need to reinforce 'fiscal prudence' or living within your means (discussants suggested that the IMF is too restrictive in its interpretation of what comprises the means);
3. the damage caused by uneven, temporary flows which facilitate corruption, distort spending patterns, force up prices, and create inefficiencies in the economy. On this issue in the discussion it was noted that the IMF sees some level of variability as manageable, such as the employment consequences, which can be managed relying on short-term contracts, high attrition rates, and the possibility of importing workers. Concerning its decision to support a country's policy programme, the Fund 'has to make a judgment when countries go off-track' which can lead to reduced flows from other donors;
4. the damage caused by off-budget aid, which erodes governance and accountability within recipient countries;
5. 'Dutch disease' where a large inflow of aid causes the exchange rate to appreciate in real terms, damaging exports and distorting the local economy (the debate highlighted that this is over-emphasized in part because too often the supply-side consequences of the aid flows – helping countries to produce - are not taken into account)

In discussion, further issues regarding the IMF's priorities and constraints were outlined by Peter Heller (IMF) including the need for the IMF and World Bank to take account of debt sustainability in appraising new borrowing, knowing that many of these countries may not be able to repay in the future. The discussion drew out further issues related to this. In particular, some argued that debt relief needs to be further addressed in the context of the low-income HIV/AIDS affected countries - a large number of low-income countries are still spending 10% of their domestic resources on debt repayments.

An important task for the IMF emerged in the discussion. The IMF could usefully provide comparisons of the likely impact of different fiscal stances on the achievement of the Millennium Development Goals. If health expenditure did increase by a specific percentage, what impact would this have on poverty? This would facilitate a clearer discussion of the trade-offs between the macroeconomic concerns about scaling-up (outlined above), and the potential gains in terms of the broader human development goals.

In making an overall macroeconomic assessment of a given country, Charles Todd emphasized that it is important to consider the longer-term economic impact of HIV/AIDS and also the potential returns of investing in health. Recent research suggests that the economic benefits of better health have generally been understated by not linking changes in health to the growth in "full income" rather than GDP per capita, and economic well-being should be considered over an individual's entire lifespan (rather than just making a snapshot comparison at any given time). Conversely, applying the concept to HIV/AIDS the authors estimate that AIDS has resulted in a decline in income of 1.7% per year from 1990 to 2000 - much higher than existing estimates of impact on GDP. (see: Bloom et. al)

Recipient concerns about the macroeconomic consequences of scaling up

How much do we know about whether there might be diminishing returns or even negative effects from an increase in aid inflows beyond a certain level? Chris Adam (Oxford) introduced some of the evidence, arguing that at the most general level, the evidence most used by donors is unconvincing. In this category the 20% ceiling figure (much used by donors) derives from the work of Paul Collier and David Dollar at the World Bank ('in good policy environments negative returns do not set in until about 20% of GDP'), and the recent work by the IMF on volatility and unpredictability in aid flows (Bulir and Hamann, 2001).

Three alternatives were proposed to this approach. First, we ought to examine closely the experience of countries in receipt of debt relief under the Highly Indebted Poor Countries initiative. Second, we should look at Ethiopia and estimates of the scaling-up, which might take place in that country. World Bank estimates contrast the following figures:

- current funding 12% of GDP,
- fully funded PRSP 16% of GDP;
- meeting 'most' of MDGs => 24%;
- meeting 'all' MDGs => 27% of GDP

(Source: WB 2003). These results can be compared to the findings of the Millennium Project on Tanzania Recipient Concerns. Finally, Uganda provides an important example of a government that has sought to deal with increased aid inflows. Uganda's aid inflows (from debt relief) increased from 9% of GDP to around 13% in the years 1998-2003. The Bank of Uganda experienced difficulties in managing the monetary and exchange rate consequences of this surge in aid flows: this has strongly shaped their perceptions of the risks of increasing aid flows. Indeed, the Long-Term Expenditure Framework 2004-2014 projects a fall in aid from around 12.8% of GDP in 2003/04 to 8.4% in 2013/14.

The evidence highlights several core anxieties in the recipient community, which to a large degree mirror the donor concerns discussed above. Recipient Ministries of Finance and Central Banks are concerned about:

- a decline in the quality of public expenditure (and hence concerns about public sector absorptive capacity);
- 'conventional' Dutch disease concerns (aid-induced appreciation of real exchange rate undercuts growth in non-traditional export sector); and
- the transmission of aid volatility to macroeconomic management;
- political concerns about the intrusion of conditionality and unwelcome political oversight.

These concerns highlight the extent to which Central Banks and Ministries of Finance are dominating the debate about scaling-up. The seminar considered that if a constructive dialogue about scaling-up is to take place, it is obviously vital to bring officials from both Ministries of Health and Finance to the same table, to discuss tradeoffs and competing priorities. Some argued that the IMF should challenge the fiscal conservatism of Uganda's Finance Ministry and Central Bank.

Chris Adam offered two further reflections: (1) donors are still committing to relatively short-term time horizons; and (2) they are evaluating recipients over outcomes for which the link between input and outcome is poorly understood. This was explored more fully in a later presentation by Sudhir Anand. More robust, longer-term contracts between donors and recipients are necessary. The political dimension of this was amplified in discussion.

As ODA concentrates on issues such as HIV/AIDS around which public opinion and politicians have mobilized, the discussion shifted to a consideration of how priorities and actions of governments in low-income countries are decided. Recipient countries are likely to have the best understanding of what it needs to do most and in what order. However, donors may be driven by a different set of considerations. In particular, G8 governments and large advocacy NGOs have found it easier to mobilize and raise funding for health and education than for – say – rural infrastructure. The result is a serious risk of distorting policy at the country level. As donor-driven PRGFs pump money into social spending, longer-term income generation and infrastructural development may be neglected (as reflected by the Nicaraguan government's rejection of its last PRSP).

Other constraints on scaling-up

Kara Hanson (LSHTM) emphasized that the need for funding is not the only problem to be faced. Other constraints include:

- community & household barriers – physical, financial or social;
- health services delivery, including staff, supplies and equipment;
- weaknesses in systems or policies, incentive structures, and donor procedures
- the framework of public policies relating to the civil service, communications, and transport
- governance and environmental factors

It is thus necessary to consider the limits to health service capacity to absorb additional funding effectively and in the interests of the most vulnerable groups (including human resources available, physical infrastructure, funding channels, incentives, values and norms), and how to appropriately increase health revenues in relation to needs. A high attrition rate and long lead-time constrain the potential for increasing human resources to meet the demand of scaling up of services, since incentives at the health worker level and institutional level are affected. The specific form of spending (budgets vs. project support) may influence the degree to which constraints are found to be binding, particularly where multiple reporting systems place unnecessary burdens on management systems. There is a tension between disease priorities as reinforced by some global initiatives and the need to strengthen the health system as a whole.

Follow-up on the meeting:

Further research is needed, as indicated above, into at least three core areas:

- estimating scaling-up requirements (taking into account gains and losses in other sectors and on other human development objectives; using real country data);
- analyzing the macroeconomic versus human development trade-offs (contrasting different fiscal policy positions and their potential impacts);
- examining the experience of countries in managing previous surges or flows of foreign aid (under what conditions is this most likely to lead to the highest impact on human development?);
- country-level assessments of how to scale up, manage and accommodate significant increases in resources in public health systems; and
- defining the necessary elements of a new 'donor-recipient compact.'

A new donor-recipient compact? The discussion led to an agreement that some form of long-term, monitored donor-recipient compact on funding for HIV/AIDS is necessary, with core elements including agreement on a long time-horizon for certain funding towards priorities which are set within the country and integrated into its overall economic and social spending policies.

A working group should be convened immediately (e.g. comprising the IMF, WHO, and selected experts) to consider and report more fully on the trade-offs between the macroeconomic risks and costs of scaling-up (the 'donor concerns' reported above) and the benefits (including the joint-production gains) to economic growth of scaling-up to deal with HIV/AIDS and other diseases.

Background Papers:

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Bulir, A & A J Hamann, "How volatile and unpredictable are aid flows, and what are the policy implications?", *IMF Working Paper* (October 2001).

Poullier, J-P, Hernandez, P, Kawabata K & W Savedoff, *Patterns of Global Health Expenditures: Results for 191 Countries*, Health Systems Performance Assessment, Chapter 17

WHO/UNAIDS Funding Gap Working Group, *Estimated funding gap to reach the target of 3 million with access to antiretroviral drugs by 2005 ("3 by 5")*, Bulletin Number 1: Estimates as of 31 December 2003, WHO/UNAIDS.

World Bank, "Accelerating Progress towards the MDG" (Notes on Ethiopia to the Development Committee: Sept 2003).

Seminar Participants:

Christopher Adam (Economics Dept, Oxford)
Nick Amin (Commission for Africa)
Sudhir Anand (St Catherine's College, Oxford)
David Bevan (St John's College, Oxford)

Ngaire Woods, Global Economic Governance Programme, University College, Oxford,
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Phil Compernelle (Department for International Development)
Tim Evans (World Health Organization)
David Evans (World Health Organization)
Robert Greener (UNAIDS: The Joint United Nations Programme on HIV/AIDS)
Kara Hanson (London School of Hygiene and Tropical Medicine)
Peter Heller (International Monetary Fund)
Vivien Hendry (Global Economic Governance Programme, Oxford)
Max Lawson (Oxfam)
Steven Lee (Department for International Development)
Maureen Lewis (Center for Global Development)
Jim Melanson (Canadian International Development Agency)
Pia Schneider (Abt Associates)
Frances Stewart (Queen Elizabeth House, Oxford)
Charles Todd (Human and Social Development Unit, Directorate General for
Development, European Commission)
Kevin Watkins (Oxfam)
Ngaire Woods (University College, Oxford)

Report compiled by Ngaire Woods and Vivien Hendry
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Please send comments and suggestions to geg@univ.ox.ac.uk or
ngaire.woods@univ.ox.ac.uk

www.globaleconomicgovernance.org