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Aid coordination for health sector reform: a conceptual framework for analysis and assessment

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Abstract

Recent widespread interest in health sector policy and institutional reform in lower income countries has coincided with heightened concern for aid coordination. Because the health budgets of many low income countries are highly aid dependent, donors are strongly placed to make aid conditional on health care reforms. However, given the growing number and heterogeneity of multilateral, bilateral and international non-governmental donors operating in many of these countries, there is concern that if external efforts are not coordinated, the aims of health care reform—namely improving efficiency, effectiveness and equity—will not be met. Evidence is mounting that without effective coordination arrangements, donors may weaken rather than improve fragile health systems, undermining attempts to reform those systems.

This paper traces the factors fuelling current interest in coordination, in particular with reference to its contribution to the goals of health sector reform. Aid coordination is defined and its principles elaborated. A framework is developed by which to assess the variety of coordination mechanisms which are evolving at the country level. In light of this framework, a case is made for greater and more critical analysis of aid coordination arrangements. The paper concludes that if health sector reform is to be successful in low income countries, current enthusiasm for coordination needs to be harnessed. The framework offered here provides a way of assessing the variety of coordination mechanisms currently proliferating, which could be used to enhance health sector reform.

Keywords: Health policy; Health sector reform; Aid coordination; Aid management; International assistance

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1. Introduction

As experience with health sector reform in lower income countries grows, there is increasing agreement on what is meant by the term and on the aims and strategies involved. As a result, various lessons are gradually beginning to emerge. For example, central, and perhaps competing, aims of reform are widely held to include enhancing efficiency, effectiveness and equity within the sector [1,2]. A consensus is forming around the idea that reform will not come easily [3–5], that a coordinated policy package will be more successful than a series of à la carte items, and that donors acting alone or at ideological odds with one another can frustrate or undermine the reform process [6,7]. However, enthusiasm for reform is increasingly tempered by the concern that health systems are weakened by poor coordination of external inputs. Given that many low income countries rely heavily on support from a multiplicity of donors, and that these donors often make aid conditional on reform, coordinating such inputs is important.

Concerns about lack of coordination and inadequate management of aid are not ill-founded, leading to, inter alia: (i) inefficiencies in service delivery through duplication; (ii) geographic inequalities through the targeting of assistance to favoured areas and populations; (iii) confusion through, for example, the espousal of conflicting and changing donor policies; (iv) exacerbation of administrative inefficiencies as ministry staff devote excessive time to coping with heterogeneous and incompatible aid administration requirements; (v) displaced local priorities as donors' preferences prevail; and (vi) abrogation of recipient sovereignty over budgetary and policy processes. Evidence is mounting that without effective coordination arrangements, external assistance may undermine such systemic functions as policy-making and planning, which in many aid-dependent countries, tend to be fragile ipso facto.

In this paper we argue that the improved management and coordination of external assistance can further the aims of health sector reform. We draw upon examples of the actual and potential contributions of improved external resource management to each of the central reform objectives, and illustrate how improved coordination and management may be achieved. We suggest a conceptual framework against which one can assess the variety of mechanisms currently under experimentation, and apply this framework to just one of the many coordination mechanisms which could enhance sector reform.

2. The context: what is coordination and why is it on the health policy agenda?

The concept of coordination has been embraced by the health policy community but has remained ill-defined. The expression has been used loosely and interchangeably with a number of other terms including: coherence, compatibility, cooperation, collaboration, consultation, concertation, integration, harmonization, synchronization and even control and discipline. Where attempts at definition have been made,

a variety of approaches have been adopted ranging from descriptive [8,9] to minimalist [10] to normative [11]. What these general definitions fail to address is who is coordinating whom, what and to which ends. A consideration of these questions is a prerequisite to approaching the conceptual task of developing an evaluative framework. For this purpose we propose the following working definition of country-level, health sector coordination:

> any activity or set of activities, formal or non-formal, at any level, undertaken by the recipient in conjunction with donors, individually or collectively, which ensures that foreign inputs to the health sector enable the health system to function more effectively, and in accordance with local priorities, over time.

This definition draws attention to who is involved, and recognizes that the arrangements are processes for moving toward some mutually held end, here a more effective[1] health system.

Before moving to the evaluation framework, it is useful to consider why coordination is in such vogue. It would be misleading to suggest that it is on the health policy agenda solely as a function of current interest in reform. A number of additional factors within and outside the sector are clearly at play.

Within the sector, in addition to factors associated with reform, at least five trends can be identified which have converged to raise the salience of aid coordination. The first relates to the increase in the number and diversity of external agencies. For example, in 1992 almost 600 NGOs (20% of which were international NGOs) were registered with the Bangladesh government [12]. The increase in numbers is compounded by the emergence of new varieties of actors. For example, the World Bank, a non-player until 1980, became a dominant force in the health policy and financing realm by the early 1990s [13]. Concomitantly, the proportion of external resources in health sector expenditure in low income countries increased by a factor of six between 1977 and 1990, from 0.5 to 3.0% [14,15]. While this figure may appear insignificant, external finance plays a critical role in a number of countries. According to a study of 1990 data, external assistance accounted for more than 25% of government health expenditure in twenty three sub-Saharan countries alone [16].

The increased involvement of donors escalates complexity, confusion and the potential for conflict within the sector, thereby increasing the rationale for coordination. The proliferation of projects funded by these agencies provides one of the major concerns prompting attention to coordination. It is now widely held that however worthy in their own right, [17] the multiplicity of projects overburdens the recipient ministry's capability to effectively manage them and ultimately leads to 'institutional destruction' [18]. A fifth factor relates to the shift from project to sector assistance, which both demands and benefits from improved coordination [19]. All of these trends have played a role in drawing attention to the need for improved aid management.

[1] It goes without saying that there are a host of intervening variables between good coordination and sectoral effectiveness, the key here is improved effectiveness.

At least three factors external to the sector have further exacerbated the situation. First, beginning in the early 1980s, aid came under ever greater scrutiny. A variety of studies of aid management found aid coordination wanting and recommended improvements, particularly at the country level. Concern was expressed by both donors and recipients, donors feeling they were sometimes played off against each other, recipients that donors sometimes made contradictory demands [20,21]. The second trend relates to the increasing instability and insecurity in large parts of the developing world and the concomitant increase in the diversion of aid from development to relief and rehabilitation purposes [22]. The need for improved coordination and management under these circumstances is heightened by the fact that there are usually questions surrounding the perceived legitimacy of the recipient state [23]. Consequently funds tend to be disbursed through a variety of non-governmental channels, often without the consent of government [24] and frequently without regard to any coherent or comprehensive plan [25]. Given the major role of outside institutions and financing in periods of instability and rehabilitation, the relevance of aid coordination cannot be underestimated. Another factor relates to the mounting confusion and concern over UN agency mandates [26]. This concern is clearly echoed in the health sector where there is not only significant overlap in functions and mandates [27] but in many instances open competition over leadership and coordination [28]. While both WHO and UNDP have formal mandates to coordinate, this role has been increasingly challenged (mainly covertly) by the World Bank and UNICEF at the country level.

The preceding analysis suggests that the convergence of a variety of factors may be responsible for placing coordination on the health policy agenda. The central position of coordination on that agenda is reinforced by the close relationship between coordination and health sector reform. It is to this relationship which we now turn.

3. Coordination and the aims of health sector reform

While there remains considerable debate on the strategies and modalities involved in health sector reform, there appears to be less contention around its central goals [29]. These are generally held to include the pursuit of greater efficiency, effectiveness, equity and sustainability gains from investments [30]. Widespread efforts to generate support for these goals and discussion on how best to achieve them has increased the attention paid to aid coordination and management. On the one hand, improved coordination has been found to contribute to the attainment of reform goals and on the other, where aid lacks adequate coordination, it may actually serve to undermine the reform process.

3.1. Aid coordination and efficiency

Although definitions of efficiency abound, for the purpose of this discussion,

efficiency is defined as an input-output measure. Two types of efficiency are commonly distinguished. Allocative efficiency relates to the extent of optimality in the distribution of resources among competing uses, in other words whether an activity is worth doing in reference to its social benefits and costs. This type of efficiency may be thwarted for three reasons. First, political considerations override efficiency: aid may be given as part of political leverage, and be impossible to measure in efficiency terms. Second, donors do not select the project that gives the greatest health benefit for a given cost (assuming there is an objective way to value benefits). This happens most frequently with 'tied aid' when economic criteria are relegated to secondary consideration in deference to donor commercial interests. Bollini and Reich [31] report that all but one of Italy's bilateral health sector assistance projects during the 1980s consisted of capital intensive infrastructure investments of primary benefit to Italian construction firms. Tied aid may also have deleterious subsequent recurrent cost implications which run counter to allocative efficiency. The proclivity of certain bilateral donors for hospital construction provides a fitting illustration. Third, failure to meet allocative efficiency may arise because donor judgement of benefits differs from recipient judgement (i.e. a matter of values). This occurs when donors fund predetermined activities without giving due consideration to local preferences. Failure to meet allocative efficiency criteria for either reason may not only subvert the optimal use of the aid itself but may also divert local matching resources (human, administrative, financial-including foreign and recurrent investment) from investments made according to economic criteria.

Technical (or operational) efficiency relates to the extent to which choice and utilization of input resources produce a specific health output or service at lowest cost. LaFond notes that 'health facilities in Pakistan, Nepal and Ghana were frequently overstaffed reflecting the priorities of donors' vertical programmes' as opposed to efficiency considerations. In some cases, the number of staff exceeded the average number of patients seen in a day [32]. Examples of technical inefficiency are legion: services overlap; ministry officials are often obliged to meet a succession of missions when one gathering would suffice; non-complementary technologies are employed; programmes often have multiple information, accounting and reporting systems and are subject to repetitive evaluations [33]. These are familiar characteristics of health sector aid which, if checked, would provide significant gains in technical efficiency.

3.2. Aid coordination and effectiveness

Effectiveness is commonly understood as a measure of the extent to which a project, programme or sector attains its set objectives. In this regard, external resources ought to be evaluated on the basis of their contribution to a coherent sector-wide strategy and policy framework. Health assistance has often been criticized for inducing fragmentation, as opposed to coherence, as a function of the competing, shifting, and sometimes conflicting goals, policies and programmes which are advocated and funded [34–37]. For example, in Uganda,

five national health plans were found to co-exist, each funded by a different donor [38]. Coordination can provide the means to enhance the use of external resources to reinforce the effectiveness of the sector as a whole.

3.3. Aid coordination and equity

Although the definition of equity is much debated [39,40], the concept is broadly concerned with the distribution of burdens and benefits of the health care system. On one level, that of the user, equity is about who pays for and who benefits from services. From the point of view of benefits, coordination may, for example, reduce geographical inequities. There have been reports of donor supported islands of excellence in seas of under-provision. According to Green and Matthias [41] 'there is certainly enough evidence of the wasteful duplication of facilities provided by different NGOs in specific locations, coupled with an absence in other areas.' As for the distribution of burdens, the ad hoc or uncoordinated application of payment systems may lead to some paying while others do not. A World Bank [42] review found, for example, in one West African country 'three different cost-recovery policies, each sponsored by a different donor agency' in different parts of the country. Similarly, it has proven difficult to coordinate fees between government and church facilities in Malawi as the churches do not have a uniform scale and there is a policy of non-interference among these organizations [43].

On a different level, the distribution of benefits and burdens of assistance on the service providers can be considered. For example, in Lesotho, the ministry of health reported on the effect of aid on staff morale as follows: 'Donor input into one area can cause resentment in another; better working conditions and transport facilities in donor funded projects appear in stark contrast to conditions other staff are working under' [44]. Similar effects related to inconsistencies among donor practices have been reported in Kenya [45] and in Ghana [46]. Differences in per diem payments is particularly divisive.

4. Coordination as a vehicle for advancing health agendas

One of the problems of coordinating health sector aid is that donors often approach health sector reform with differing and sometimes conflicting agendas, which can be at odds with recipient priorities and may lead to recipients manipulating aid to their own ends. In this context, coordination may be viewed as a vehicle for the advancement of certain reform programmes or policies over those favoured by others. Among the major policy actors, the World Bank has advocated its approach to health sector reform more comprehensively and persuasively than others [47], to the extent of entitling one of its health publications 'an agenda for reform' [48]. UNICEF has articulated its agenda in the health goals set at the World Summit for Children in 1990 [49]. The bilateral agencies are less explicit, but implicit agendas in health sector aid have been

brought to light in a variety of studies [50–52]. Coordination can be used as a tool to further these specific agendas.

As noted above, donors who unilaterally pursue their individual agendas may undermine the reform process supported by other donors and/or the recipient. For example, the World Bank has suggested that through their hospital construction assistance projects, both Japan and France are undermining the Bank's reform package which places salience on public health and essential clinical services. It is argued that the nature of these external investments ultimately results in a shift of subsequent recurrent expenditure from primary to tertiary health services, thereby subverting the policy aims of Bank programmes [53]. Bank-led coordination arrangements can thus be seen as disciplinary tools employed to ensure that donors adhere to the particular policy framework advocated by the Bank [54]. A senior World Bank official has stated that the Bank has an obligation to 'blow the whistle' on donors who fail to conform to an agreed reform platform, but it is unclear what this would entail [55].

Where local stakeholder acceptance of the policy and institutional reforms has proven difficult, implementation of reforms has subsequently encountered significant slippage [56,57]. In this context, coordination can be useful in ensuring ministerial compliance with conditionalities stipulated in the sector programme. Compliance may be facilitated by a common donor voice backed-up with its combined political clout. As such, coordination has been promoted as a mechanism for blocks of donors to increase their leverage over recipient ministries. Nolke [58] confirms that, in sub-Saharan Africa at least, coordination is perceived as a power-base for development agencies. Some actors, such as the European Union (EU), have been explicit in this regard: according to a EU council resolution, coordination would 'maximize the ability of the Community and its Member States to exercise an influence on the area of development' [59].

While coordination may serve to increase sector efficiency and equity, so too may it serve as a forceful tool to increase one agency's leverage over another and similarly over the recipient administration. To date, it would appear that, with few exceptions, donors have taken the lead on aid coordination and have thereby gained the upper hand in the articulation of the policy reform agenda. This draws attention to the fact that the effectiveness of coordination arrangements will remain a subjective affair; dependent on the overriding objectives it is meant to serve.

5. The evaluation framework

While the evaluation of coordination arrangements may be inherently subjective, a variety of criteria suggest themselves. First, there are the goals of health sector reform which were discussed above in relation to their coincidence with the broad goals of aid coordination. Second, one can consider arrangements in light of the principles governing aid coordination which donors have, rhetorically or otherwise,

laid down. A list of principles guiding aid coordination were agreed by the Development Assistance Committee of the OECD along with the World Bank, the International Monetary Fund and the UNDP [60]. When extrapolated to the health sector the following five principles emerge:

(1) The ministry of health should take the lead in managing and coordinating external resources.

(2) Donors should provide technical assistance to enable the ministry to assume the leadership function.

(3) External resources should be coordinated, managed and deployed as part of a national health plan.

(4) The government should encourage multilateral and bilateral agency involvement in the formation of the national plan and attempt to achieve genuine consensus on the final product.

(5) Donors should attempt to subvert their administrative requirements, commercial and other interests in pursuit of the objectives of the plan.

These principles, coupled with our working definition of coordination and the goals of health sector reform suggest a conceptual framework for evaluating the effectiveness of various aid coordination arrangements. The framework proposes that aid management strategies should be assessed according to the following thirteen broad criteria (see Table 1):

(1) The institutional leadership and *ownership* of the coordination arrangement is of fundamental concern. Does the mechanism belong to one donor, a group of interested donors? is there joint donor-recipient ownership, or has the mechanism been institutionalized in the recipient administration?

(2) Related to the first issue is that of the *scope and quality of participation* in the arrangements. Is it an exclusive club of two or three dominant actors? Is the recipient administration fully involved and does civil society have a voice? What procedures are in place to ensure that the weaker participants are listened to?

(3) A third concern relates to the *periodicity* of the instrument. Is it, for example, a one-off meeting on a particular subject? Is it sporadic, periodic or continuous?

(4) Fourth, to what extent are the mechanism and its products *integrated* with the ministerial policy and planning process?

(5) A fifth concern relates to the *realm of coordination*. Is the mechanism concerned with the development of common donor-recipient policy platforms, with operational actions such as project co-financing, or does it simply involve information sharing?

(6) The *breadth of coordination* provides another criterion for evaluation. For example, does the coordination mechanism attempt to take a sector-wide approach or is it geographically- or issue-specific?

(7) The *authority* of, and *adherence* to, the decisions taken are also of interest. Are the actors and fora involved such that there is strong adherence by *all* parties, by *some*, or do decisions have no binding authority?

(8) The impact of coordination on *sectoral efficiency* is of central concern. As proxy indicators one would look for a reduction in duplication of services, harmonization of procedures, appraisal, supervision etc., and extent to which investments are based on cost-effectiveness considerations.

Table 1
Criteria for assessing the effectiveness of coordination arrangements

Criteria	Indicators
Ownership	Does the mechanism belong to one donor or a group of donors? Is there joint donor-recipient ownership? Is the mechanism institutionalized in the recipient administration and, if not, what are the prospects, and what steps are being taken toward that end?
Participation	How many of the key actors are involved? Is the recipient administration involved? Are some key actors not represented? Is civil society represented? Do all members participate regularly? How are the views of weaker members considered? How are disputes resolved?
Periodicity	Is the process a one-off event, is it sporadically or periodically organized, or continuous?
Integration	Is the mechanism integrated with the policy process?
Realm	Is the purpose (outcome) of the instrument information sharing, operational coordination such as project co-financing, the development of common donor policy fronts, or the development of common donor-recipient platforms?
Breadth	Does the mechanism focus on one aspect of the health sector or is it comprehensive and sector-wide?
Authority and adherence	Do actors adhere fully, partially, or not at all to decisions taken in the coordination forum? To what extent do actors by-pass the procedures established?
Efficiency	Does the mechanism serve to: (i) reduce duplication of services; (ii) enhance harmonization of procedures; (iii) increase use of scientific tools in resources allocation?
Effectiveness	To what extent does the mechanism diminish fragmentation? To what extent does it decrease the number of conflicting policy signals? To what extent does it allow donors to support a sector-wide policy framework?
Equity	Does it correct geographical inequities in targeting of assistance? Does it correct inequities in the payment for services? Does it increase parity of benefits and perks for aid-supported staff?
Sustainability	Are the costs of the mechanism sustainable?
Costs	Do the benefits outweigh the costs in terms of the sector as a whole?

(9) The influence of coordination on *sectoral effectiveness* is of similar interest. To what extent, for example, can coordination diminish donor-induced fragmentation? Or alternatively, to what extent is aid marshalled through coordination mechanisms in support of a sector-wide policy framework?

(10) A tenth consideration revolves around the effect of the mechanism on *equity*. Does the mechanism correct some of the geographic and other inequities exacerbated by current aid practices, or does it have minimal or no effect?

(11) Does the mechanism promote or detract from the goal of sustainability? That is, does it ensure that resources are used to enhance the functioning of the system over time?

(12) What are the opportunity costs associated with the mechanism? Does the arrangement consume a great deal of limited recipient time and achieve little in the way of the goals elaborated above?

(13) Finally, and of critical importance, rests the issue of the extent to which the procedures laid down under the mechanism are by-passed by the actors involved.

This framework provides broad-brush criteria against which aid management arrangements may be evaluated. In particular it suggests a number of questions which should be posed of arrangements found in the field (some preliminary questions are posited in Table 1).

Elsewhere, we have developed a typology of coordination arrangements [61]. This typology distinguished between those mechanisms which are donor-driven and those which are recipient-led. On the donor-driven side we identified three groups. In the first group are those in which one donor agency assumes a *lead* responsibility for coordination. The second group comprises changes to the *forms and channels* of assistance provision which facilitate coordination. Finally, there are organizational changes in the donor institution and community which encourage greater coordination.

One of the lead agency strategies, namely sub-sectoral specialization, is set out below to demonstrate how the framework may be used in practice. In lead agency sub-sector specialization, a donor is designated a lead role for one sub-component of the broader health sector. Depending on the organization of the health services of the country in question and the donor programme areas, sub-components may comprise issues such as reproductive health or safe-motherhood, financing, human resources development, essential drugs, etc. The lead agency may fulfil a number of functions in its capacity. At a minimum it will provide overall leadership among interested donors and act as the principle conduit for liaison with the ministry of health on sub-sectoral issues. It may work with the national programme manager in question to develop the policy framework and annual plans and budgets. The lead agency may attempt to identify donors to meet specific funding gaps in the plan. It may provide a trust fund through which to manage external resource inputs to the sub-sector and account on their use. Nepal and Zambia provide different examples of this type of coordination [62,63]. According to the evaluation framework developed

Table 2
An assessment of the potential effectiveness of 'sub-sector specialization' as an aid coordination mechanism[a]

Criteria	Performance of coordination by the sub-sector lead agency model
Ownership	Donor ownership but good possibility exists for transfer of ownership to national programme manager over time
Participation	Participation may or may not be limited to donors active in sub-sector Ideally national programme staff and planners would be involved Potentially a small enough forum to achieve concrete results
Periodicity	Variable-but actors would have to meet at least quarterly for results
Integration	Ideally, the lead agency would involve the other donors together with national programme staff in an annual planning exercise which would subsequently be linked to broader sectoral health plan
Realm	May cover joint policy platforms and planning, project co-financing or simply information sharing depending on the initiative and authority of officials involved
Breadth	Limited to the narrow sub-sector area but potentially a number of sub-sector coordination groups could be linked to a macro coordination framework
Authority	May not attract high level decision-makers with authority to make binding decisions
Efficiency	Has potential to limit number of interactions between ministry and donors in the areas of remit Has potential to reduce number of discreet donor-funded projects in the sub-sector Has potential to reduce duplication of services and aid administration in the sub-sector field
Effectiveness	Greatest strength lies in its ability to reduce the number of conflicting policy signals to government and to marshal donor inputs rationally towards sub-sector goals
Equity	No discernable effects on equity
Sustainability	?
Costs	Requires secretariat for information gathering and analysis-possibly full-time staff person

[a]This table provides an illustration of the application of the framework.

above, lead agency sub-sector specialization has a number of features which might potentially lend themselves to providing for effective coordination (Table 2). Effectiveness would depend on the local situation and in particular on gradually handing over ownership to the recipient and on systematically integrating the sub-sector mechanism with a macro-sectoral coordination approach. This may be feasible given the incremental manner in which coordination mechanisms have been found to evolve elsewhere [64].

6. Conclusions

Three conclusions can be drawn from the preceding analysis. First, given the determined recognition of both donors and recipients of the need for improved management and coordination of multiple external resources and the many differing attempts being made in this regard, it is necessary to further refine the means with which to assess those arrangements which are rapidly evolving. Some have already noted the 'risk that coordination is taking on such dimensions that it is becoming counter-productive' [65]. Hence there is the need for a systematic review of coordination arrangements according to a conceptual framework as defined above.

The framework needs to be further developed based on actual experience. It takes the donor's perspective in so far as the principles upon which it rests were extrapolated from those proposed by the donor community. As a matter of priority, the views of recipients on coordination should be sought. In addition, the indicators require elaboration. They will need to be context-specific and capture complex relationships. How easy, for example, will it be to determine whether the donor or the ministry has ultimate control of the aid coordination process? The framework is intended as a starting point for thinking critically about aid management.

Finally, there remains the challenge of evolving strategies which are currently donor-led to being recipient-owned and their local institutionalization. More consideration must be given to develop the capacity within the ministry to make such a proposition feasible. Surely, the starting point is recognizing the value of improved coordination while looking critically at the means by which to achieve it.

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