The Health Systems Funding Platform: Resolving Tensions between the Aid and Development Effectiveness Agendas

Amanda Glassman and William Savedoff

Abstract

Global health aid is exceedingly complex. It encompasses more than one hundred bilateral agencies, global funds, and independent initiatives that interact with an equally complex and diverse set of institutions involved in financing and providing health care in developing countries. Numerous efforts have been made to better coordinate these activities in the interest of making them more effective. The Health Systems Funding Platform (the Platform) is one of the most recent of these initiatives. Established in 2009, the Platform has advanced farthest in two countries, Ethiopia and Nepal, and is currently expanding to several others. This paper briefly assesses the Platform and argues that the way the initiative is proceeding differs little from prior initiatives, such as sector-wide approaches and budget support. However, the initiative does represent an opportunity to make global health aid more effective if it were to deepen its commitment to improving information for policy, link funding explicitly to well-chosen independently verified indicators, and establish an evaluation strategy to learn from its experience.

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The Platform and Its First Year

Global health aid is frequently described as "complex", "anarchic" and "unruly". Sridhar (2010) estimates that there are 40 bilateral donors, 26 UN agencies, 20 global and regional funds, and 90 global health initiatives. Fragmentation and proliferation abound and show few signs of improvement over time.[i] In spite of a stable of potentially cost-effective technologies ready to deploy, governance and accountability arrangements are weak and impact diffuse and difficult to attribute. Given this situation, aid effectiveness in the health sector has been a major focus for the OECD[ii] and other international agencies, while global health governance arrangements are considered so complex that a dedicated scholarly journal was launched in 2008.[iii] In response to this situation, aid effectiveness measures such as better coordination and harmonization are frequently invoked.[iv]

In 2009, a High Level Taskforce on Innovative International Finance for Health Systems, inspired by the Paris Declaration on Aid Effectiveness, called for the creation of the Platform to coordinate health aid in low-income countries under the umbrella of the International Health Partnership.[v] The Taskforce gave the Platform a mandate to reduce recipient and donor transaction costs and accelerate progress on Millennium Development Goals (MDGs) related to maternal and child health and HIV/AIDS. The Muskoka G-8 Declaration in June 2010 endorsed the Platform as a mechanism to make health aid more efficient.

In a Platform Background Document, the initiative is described as "a mechanism to mobilize and make better use of new and existing funds."[vi] The original conception of the Platform envisioned reducing transaction costs by coordinating donor programs and, in particular, aligning their efforts with the timelines and domestic budget processes of recipient countries. This was expected to increase the effectiveness of health sector spending from domestic and foreign sources alike and, in turn, lead to improved health outcomes.

The Platform initially focused on the three largest multilateral actors involved in health system strengthening efforts – the World Bank, the Global Alliance for Vaccines and Immunization (the GAVI Alliance) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), but it was hoped that other donors would participate in or at least coordinate with the Platform efforts in each country.

In practice, the Platform has thus far taken the form of budget support to Ministries of Health. Donors that are not able to pool resources, such as USAID, are conducting parallel programs in coordination with the Platform. Funding is guided by agreements between recipient countries and participating donors on a single donor assessment[vii], a single national health plan, a single fiduciary arrangement and a single monitoring and evaluation framework. Furthermore, in 2011, the GAVI Alliance and the Global Fund will establish a single application procedure for health system strengthening activities.[viii]

Current funding for the Platform comprises currently programmed aid to participating countries and an additional $475 million in 2011-15 pledged by the governments of Australia, Norway and the United Kingdom through an expanded International Finance Facility for Immunization.[ix] In addition, a portion of the $450 million pledge from Norway and the UK for results-based programs through the World Bank is also expected to operate under the auspices of the Platform.

By the end 2010, the Platform has advanced most in two countries – Ethiopia and Nepal – with five other countries[1] in the pipeline for further development in 2011. After a year of implementation and significant investments of time and money, it is not clear that the Platform will realize its aims. The premise that coordinating and harmonizing will make aid more effective is untested and the current approach doesn't seem to differ significantly from previous efforts like Sector Wide Approaches, Budget Support, and Country Coordination.[x]

The key strength and weakness of the Platform is its reliance on coordination to effect change. This is a strength because it can reduce unnecessary duplication, keep donors and countries from working at cross purposes, and benefit from shared analysis and planning. This can be a weakness, however, if the costs of coordination are high, the chosen strategy for a given country is flawed, and if it hinders learning from experimentation and competing approaches. One way to reap the benefits of a coordinated approach without the risks of a central planning strategy is to coordinate around results rather than activities. Since the Platform aims to increase country ownership, donors could coordinate through funding results achieved by the country rather than by negotiating which activities they will finance.

To date, the Platform has approached the issue of strengthening health systems by asserting that the key constraints to scaling up and improving the effectiveness of primary health care in the poorest developing countries are inadequate public expenditure and limited technical capacities. As a result, the Platform addresses these two issues through funding (budget support) and technical assistance. While the channels and mechanisms for funding are apparent, there is no clear technical assistance strategy in the public domain and, in fact, little international agreement on how external agencies can actually improve technical capacity.

[1] Vietnam, Ghana and Uganda have carried out Joint Assessments of their national strategies, while joint missions have been carried out in Cambodia and the Democratic Republic of the Congo.

Analysis by the High Level Task Force itself noted that other factors – such as health sector governance, payment mechanisms, delivery structures, as well as factors external to health ministries such as roads, water and sanitation, electricity and others – are also critical to scaling up.[xi] In this regard, budget support and technical assistance are rather limited tools since they cannot address these other factors. In fact, the Platform's restricted focus on budget support and technical assistance is a limitation that has been faced by earlier coordination efforts. The most promising approach out of this impasse would be to link funding to progress on the desired outcomes – which have multifaceted causes – rather than insisting on funding specific interventions which are necessarily partial.

While the Platform pays attention to monitoring progress, it does so in a rather ambiguous way. The large number of goals and indicators that it monitors in National Health Plans make setting priorities and objectively assessing progress extremely difficult. A July 2010 review of National Health Plan M&E arrangements in Platform countries found that "list(s) of core indicators are generally present…however, in some cases, the lists include more than 100 indicators."[xii] The Platform has not proposed how overall progress will be assessed given that some indicators are likely to improve while others worsen in any given year.

The Platform also calls for funding releases to be conditional on progress, but without any clarity for donors or recipients about how this is to be done. Decision-making on funding releases – if tied to progress – will inevitably be subjective and difficult to analyze independently. This *ad hoc* process could contribute to unpredictability in disbursements, weakening the mutual accountability that is intended to be a centerpiece of the Platform. While it is too early to say how this model will perform empirically or if this is the modality that will be typical of Platform countries, the incentives implicit in this variant of sector-wide approach/budget support may be problematic for development effectiveness.

Nepal's Platform agreement illustrates this problem. It is set up as a Sector Wide Approach with some donors pooling funds under a health sector-specific budget support modality, while others provide parallel, off-budget support using the same reporting requirements (joint needs assessment, fiduciary proceedings, and common M&E framework). The single M&E framework is intended to cover the entire national health strategy and be reviewed periodically by government with donors. While the new Platform-related M&E framework in Nepal is not yet available to the public, the 2009 IHP National Compact between the Ministry of Health and external funders includes 87 indicators with targets, ranging from outcomes to inputs. However, most of the indicators are, indeed, input measures and critical baseline information in most cases is lacking.[xiii] Given the number of indicators, it is possible that progress might be achieved in one area while stagnating or reversing in other areas. Further, the Platform agreement has not publicly explained how its funding will be affected by the results of the M&E reports or the periodic reviews.

Taken together, the issues emerging during the first year of the Platform seem to juxtapose aid effectiveness (predictability, alignment and transaction cost reduction) with development

effectiveness (results and outcomes). Further, the current arrangements governing the Platform –with its different "tracks" and "options" described in the Evidence to Policy Initiative's Platform Primer - are complex and unclear,[xiv] endangering the achievement of both Platform objectives. Yet there is no *a priori* reason why these goals are incompatible; indeed, the creators of the Platform hoped to accomplish both.

Essentially, the Platform is addressing the same coordination problems that remain unresolved by previous efforts, without distinguishing itself in any structural way from those earlier initiatives. Nevertheless, the Platform *does* present an opportunity to incorporate a series of innovations that would build on experiences and current knowledge about aid effectiveness. It could represent a real advance if it were to endeavor to create more direct incentives to achieve health outcomes, reduce the volatility of aid flows, simplify and improve data tracking, and evaluate its own effectiveness. In particular, this paper will describe how the Platform could better attain its goals by introducing a variant of results-based funding known as Cash On Delivery Aid (COD Aid) and then address the following questions:

(1) **Can the Platform do more to create direct incentives for progress on health results?** The Platform agreement for Nepal establishes a common monitoring and evaluation (M&E) framework but does not link progress to aid flows. While results-based funding has been considered, some argue that this will further complicate the situation and distort priorities. This paper argues that linking Platform funds to health results would be better than the current approach and could offer a means for individual agencies to demonstrate that their support through the Platform contributed to achieving their agency-specific mandates.

(2) **Can the Platform reduce uncertainty and volatility of disbursements by linking funds to results?** A key concern in the debate on aid effectiveness is the predictability of resource flows. Particularly in the poorest countries – where aid can finance a significant portion of public spending on health – there is a fear that effective management of public spending requires long-run commitments and that tying funding to results may result in greater aid volatility. Yet aid disbursements are volatile historically and more volatile than a disbursement pattern based on achievements. This suggests that linking Platform funds to results may actually decrease uncertainty and volatility.

(3) **Should the Platform build a common but independent results measurement approach? Would such an approach affect country ownership?** Common approaches to measuring and tracking health outputs and outcomes would significantly reduce duplication of effort and improve the quality of information. Nevertheless, such an undertaking is controversial, resisted by people who downplay the value of information or who insist on using country health management information systems without external checks. This paper argues for a common and independent approach to results measurement that would simultaneously strengthen country information systems.

(4) **Attractive approach, but feasible?** In addition to concerns about volatility and results measurement, a feasible Platform contract will reflect the particular characteristics of a country's fiscal and health system, and will establish a protocol to select a very few outcome indicators to include. This paper describes how a results-based approach could reinforce virtuous incentives within different types of fiscal and health systems and suggests a protocol to select and update results indicators.

(5) **Should the Platform itself be evaluated relative to other aid instruments?** The Platform is an untested aid innovation built on the premise that a "monopolistic model" of development aid[xv] would be more effective than uncoordinated fragmented approaches. This model is not only untested but has also been criticized by many researchers.[xvixvii] This paper argues that the Platform should be evaluated in terms of its expected impact on transaction costs and development effectiveness.

Coordinating Aims Rather Than Means: A COD Aid Approach for the Platform

Documents describing the Platform emphasize that funding should follow results and programs have included opportunities to review various measures of progress. Nevertheless, the link between funding and results is quite ambiguous. Recipients have no assurance that funding will increase if they make substantial progress, nor that it will be jeopardized by failures. While directly linking funding to progress has its drawbacks, the approach also can solve a number of problems that are manifest in current approaches to global health aid. Birdsall and Savedoff (2010) analyze the advantages and disadvantages of linking funding to results and demonstrate features of payment structures and indicators of progress that can make such linkages effective.

COD Aid as proposed by Birdsall and Savedoff (2010) is a mechanism for restricting the relationship between donor and recipient countries. It replaces the traditional linking of disbursements to expenditures with a link between disbursements and progress toward a broad common goal, such as completion of primary school or access to potable water. The key elements of COD Aid are:[xviii]

- Payment for outcomes, not inputs. The outcomes have to be related to an objective shared by funder and recipient. Outcomes should be measurable and continuous so that incremental progress can be rewarded over time.
- Hands-off funders, responsible recipients. Funders do not specify or monitor inputs, but rather verify progress and pay for outcomes in accordance with the COD Aid contract.
- Transparency through public dissemination. Both the contract and progress measures should be as simple as possible and publicly disseminated. This increases credibility and accountability, and encourages broader social engagement in aspects of progress that are not part of the contract.

- Independent verification. Both the funder and the recipient need to have confidence in the integrity of the measurement of progress.
- Complementary with other existing aid programs. COD Aid is intended to complement and not disrupt ongoing programs, whether funded by local or external sources. A COD Aid program aims to facilitate the more effective use of available resources.

By conditioning payments on outcomes, COD Aid shares similarities with a range of initiatives already being used extensively in the health sector, including performance-based incentives (Eichler and Levine 2009); results-based financing (Musgrove 2010); performance-based financing (Soeters and others 2006); and output-based aid (GPOBA 2010). However, COD Aid differs in at least two major ways: it is focused on the relationship between donors and recipient countries and it is explicitly "hands-off."

First, COD Aid is aimed at altering the relationship between donors and recipient countries. This contrasts with most other results-oriented approaches which envision financial incentives as an instrument to influence the behavior of health personnel, facilities and districts so as to improve the quantity and quality of care or to influence families and individuals so that they engage in healthier behaviors (Musgrove 2010 and Savedoff 2011). By contrast, COD Aid is primarily envisioned as a proposal for a donor to provide payments directly to a national (or provincial) government. The recipient then has the discretion to choose its own strategy for accelerating progress. It can choose to disburse funds as incentives to districts, facilities, families or patients. It could, alternatively, choose to address national political constraints, reform institutions or engage with the private sector. By focusing on a high-level outcome –or closely related output- and transferring funds directly to the recipient government, COD Aid can address problems at a level that most other results-based approaches cannot reach: the political context within which health care personnel, communities and citizens function.

The second way in which COD Aid differs from most other results-oriented approaches is that it is explicitly "hands-off," with conditions in the contract restricted to independently verifying the outcome measure and publicly disseminating results. This differs from most other results-oriented approaches in the health field, which usually require funders and recipients to maintain close engagement in the design and operation of the program. This can lower transaction costs, allowing recipients to spend less time and effort explaining, negotiating and reporting to donors and more time and effort focused on implementing the strategies they have chosen. With COD Aid, funders can engage closely with the recipient country but only if explicitly requested by the recipient. Furthermore, recipients have full discretion over the use of funds, which can be applied inside or outside the health sector as they choose.

Thus, COD Aid is designed to achieve many of the goals for which the Platform was started. It aims to restructure aid in a way that strengthens country ownership (by being "hands off"), rewards progress, and reduces volatility. The rest of this paper shows how adopting some of the principles behind the COD Aid concept could help the Platform achieve its aims.

Can the Platform do more to create direct incentives for progress on health results?

The earlier assessment of the Platform described the ambiguous relationship between funding and progress. A simple response to this problem would be to link some or all of the new Platform funding to improvements in health outcomes. This would provide recipients with complete flexibility to use funds to strengthen their health systems in line with their institutional strategies. Donors could still be involved in policy dialogues and technical assistance, but linking disbursements to progress allows the recipient country to assume the lead role in choosing how to proceed and utilizing its local knowledge to address its problems.

The Platform has thus far avoided results-based funding approaches for a number of reasons. It would require donors to fundamentally change the way they relate to recipient countries, paying against performance whether or not they agree with the particular policies that are implemented to reach those goals. Secondly, it seems easier to get aid flowing through existing mechanisms – project assistance or budget support – than to establish a new one in light of the pressures to move disbursements. Thirdly, prominent programs, such as the Global Fund and the GAVI Alliance, have had problems that (rightly or wrongly) are ascribed to their results-based focus (see Box 1).[xix] Other concerns are that health system strengthening (HSS) investments take too long to influence health outcomes or that choosing a few specific health indicators will lead to distorted focus on specific (vertical) programs. In general, the High Level Taskforce documents and Platform agreements

Box 1: Lessons from GAVI and Global Fund results-based funding approaches

GAVI's immunization services support successfully increased immunization rates in many countries by combining traditional and innovative approaches. The traditional mechanism included purchasing inputs and providing technical support. The innovative mechanism involved paying for each additional child vaccinated with a third dose of DTP. However, the payment of this incentive was based on the number reported by administrative reporting systems which was later shown to have been over- and under-reporting vaccination coverage in different countries (see Lim et al 2008, CEPA LLP 2010). The experience confirms the value of getting independent, survey-based measures of coverage to assess and improve the accuracy of administrative reporting systems, especially in cases where funding is linked to performance.

The Global Fund is also designed to reward performance. Its agreements with recipient countries establish a set of output indicators and targets. Continued funding is contingent on adequate progress, measured in terms of outputs, expenditures and contextual information. Some observers argue that the Global Fund agreements generate strong incentives to increase outputs. Others criticize the Global Fund agreements for having too many indicators and targets, rewarding outputs that are not directly linked to health outcomes, an absence of baseline data, reliance on self-reported progress and burdensome reporting requirements. In particular, studies have recommended that the funding release decisions should be more objective and transparent. (See Oomman et al 2010; Global Fund TERG 2010).

show that participants are more comfortable with arrangements between donors and the government that pay attention to performance measurement in parallel with funding discussions, rather than creating direct links between funding and results.

Most of these concerns, however, overstate the risks of a well-designed results-based funding approach and fail to compare the results-based approach to the likelihood of success under current models. The Platform could easily embrace a results-based approach by selecting a limited number of health outcomes and outputs closely linked to health outcomes, establishing independent verification for the measures, and agreeing to pay a portion of its funds in relation to progress against a baseline. The approach would be similar to the European Commission's budget support programs that include Variable Tranches conditioned on performance but would differ in ways outlined in Birdsall and Savedoff (2010) – particularly their emphasis on outcome indicators, independent verification, and transparency.

It is beyond this paper to present a specific proposal or set of indicators for the Platform to link disbursements to results. Nevertheless, it is possible to build on other papers and identify the main outlines of a workable arrangement. In particular, Savedoff (2010) explains a number of principles for applying COD Aid to different sectors and Savedoff and Martel (2010) discuss ways to apply COD Aid in the health sector (See Box 2). A number of lessons can be extracted from these papers for the Platform, particularly those related to selecting an appropriate indicator.

Box 2: A COD Aid Proposal for Reducing Stunting

Savedoff and Martel (2011) discuss the feasibility of linking aid disbursements to improvements in maternal and child health, and reductions in the incidence of HIV/AIDs and malaria. As an illustration of how a COD Aid proposal might work in health, they provide an example for linking aid to child health improvements, using reduced stunting as a progress measure. The features of the proposal are summarized as follows:

Payments

- First 5 years, funders pay US$5 for each registered birth in order to establish baseline and improve vital registration. The fee should be large enough to create a significant incentive and provide an initial flow of unrestricted funds without creating risk of providing an incentive for increased fertility.

- First 5 years, funders pay US$25 for each child (age 1 to 5) whose height for age has a Z score of above -2.

- After 5 years, funders pay US$250 for each child (age 1 to 5) whose height for age has a Z score above -2 above the number of children whose height for age had a Z score of above -2 5 years earlier. In subsequent years, the baseline is updated annually (i.e. always measured against a 5-year lag). (Note: the agreement then has a self-limiting feature with funding declining to zero 5 years after registration stops increasing and after stunting approaches zero.)

Eligibility

Any low-income country that can meet the reporting standards would be eligible to sign an agreement up to a limit established by available funds. These reporting standards would include:
- The country has an internationally acceptable standard for reporting births and vital registration
- The country has an internationally acceptable standard for reporting height-for-age (e.g. Demographic and Health Surveys)

Countries that sign the agreement would agree to the following:
- To allow independent verification of indicator (by permitting audits and independent surveys).
- To publicly disseminate information regarding the agreement (number /share of children above a certain height-for-age, payments received, child mortality estimates, etc.)
- To assist researchers in evaluating the COD Aid agreement.

If the Platform were to adopt a COD Aid approach, it would have to begin by assessing appropriate indicators. As argued in Birdsall and Savedoff (2010), the indicators should be measuring something as close to an outcome as possible, leaving the recipient with maximum flexibility in choosing the right strategy and mix of interventions for their particular context. Of course, for the Platform, these outcomes should be ones that bear some relation to the effectiveness of health system functioning.

Additionally, the indicators chosen should be continuous and incremental rather than targets. Targets create an environment in which recipients "succeed or fail" whereas incremental measures create a situation in which recipients have "more success or less success." It also reduces pressures to extend waivers when targets are narrowly missed.

Finally, the indicator should be selected with the feasibility of measurement and verification in mind. Ideally, recipient countries would report the progress indicator from their administrative or surveillance systems. Subsequently, a third-party would be contracted to conduct an independent survey or random audit to assess the accuracy of the report. The agreement can contain explicit rewards and penalties to assure that incentives are compatible for donors and recipients for truthful reporting (see Birdsall and Savedoff 2010 for an example).

To illustrate how a COD Aid approach could be incorporated into the Platform, consider the following proposal:

- Platform funds would be split into two portions. One part would be programmed as an annual fixed tranche conditional on general performance while the remainder would be structured around disbursements linked to progress measures.

- Five indicators would be selected that are related to health system performance and recipient countries would receive payments in proportion to the positive evolution of

those indicators. For example, a country might be promised an amount (1) for each additional child surviving to age 1, (2) for each child surviving to age 5, (3) for averted deaths related to maternal causes, (4) for averted cases of HIV/AIDS and (5) for overall declines in adult mortality. Alternatively, these outcome measures could be mixed with or replaced by measures more closely related to outputs of the health system (e.g. children immunized, skilled birth attendance, and correctly treated infections).

- Each indicator would have an explicit procedure for verification by an independent agent contracted by donors.

- The agreement, procedures, and reports would all be publicly disseminated, so that citizens could know exactly why funding was higher or lower than expected and to what it is linked.

- The donors and recipient would remain engaged in discussing strategies and analyzing progress, but the country would remain firmly in charge of choosing how to allocate the results-linked funds.

When contrasted with sector-wide approaches, budget support and traditional technical assistance, this kind of approach could increase mutual accountability, create incentives for engagement of ministries outside the health sector, increase country ownership, fit firmly with existing commitments to focus on results, and strengthen health systems as a means toward better health outcomes rather than an end in itself.

Increase mutual accountability. Building on the lessons from earlier results-based funding schemes, a portion of funding can be directly linked to independently verified progress on small set of outcomes established in the National Health Plan. A contract – publicly available and trackable by civil society – can set out performance indicators, attached weights and disbursement decision rules as well as arrangements for independent measurement/verification and disbursement. The clarity and legality of a contract will reduce uncertainty (through clear disbursement conditions and schedules and by shifting the responsibility for meeting goals entirely to the recipient government) and generate reputational incentives for progress.

Create government-wide incentives for progress on health. A Ministry of Health alone, facing *ad hoc* sectoral reviews with donors that are not directly related to disbursement decisions, is less likely to leverage the multi-sectoral investments required to improve health. A COD Aid contract can create more direct incentives for Ministries of Finance not only to provide sufficient and timely budget resources to the health sector but also to assign resources to other sectors, that might be necessary complements to health system efforts such as water and sanitation, electrification, or roads. Such an approach would make good on the policy agenda related to the social determinants of health.

Enhance country ownership. Recipient governments have identified key goals in their National Health Strategies and can achieve them however their policy-makers think most appropriate. A

COD Aid approach would allow the country to spend its time focusing on its own strategy, identifying the kinds of support that it wants, and implementing rather than sitting in meetings negotiating activities and dealing with externally imposed procurement and fiduciary controls. Donors would also be freed to pay attention to measuring and paying for progress, which indirectly achieves their goal by constraining corruption and waste. It is difficult for a country to make progress if funds are permitted to be diverted and stolen.

Build on already-agreed principles of results-based funding. The GAVI Alliance, the Global Fund, the World Bank and the World Health Organization (WHO) have already agreed to five results-based funding principles: (i) country-owned reporting and reviews; (ii) explicit, transparent performance ratings; (iii) use of clear performance incentives; (iv) alignment of reporting between partners and with country cycles; and (v) joint system strengthening for performance reviews.[xx] A COD Aid approach would assure that at least some portion of Platform funding directly follows these principles.

Link health systems strengthening investments to health results. While HSS is recognized as critical to achieving health goals and the HSS emphasis responds to critiques of the distorting "verticality" of the global health partnerships,[xxi] an assessment of the input funding provided under GAVI's Health Systems Strengthening window found that support went to small-scale, short-term operational interventions whose relationship to immunization coverage improvements was unclear.[xxii] Further, the "value for money" of the GAVI HSS investments was not evident.[xxiii] By contrast, a COD Aid approach would be able to demonstrate the linkage between funding and outcomes with each annual report and payment. By creating incentives for rapid progress in improving health, another beneficial side effect of the COD Aid contract is the "natural" resulting focus on the poorest and most cost-effective strategies for extending coverage.

In addition to these benefits, a results-based approach could distinguish the Platform from other initiatives in ways that channel more funding through common pools, create demand for good quality health information, and support advocacy.

Demonstrate the value of pooled funds and thereby reduce transaction costs. Many donors remain skeptical of the Platform's ability to deliver on its aspirations for reasons already described, a situation that could result in GAVI and the Global Fund signing inconsistent HSS grant agreements with government or a diversity of results-based approaches undertaken by each individual donor agency (i.e., Global Fund on its own, GAVI on its own, etc.), increasing administrative costs, diluting impact and confusing incentives. Yet if the Platform is considered reliable, transparent and efficient, more funds are likely to be channeled through the pool, thus reducing transactions costs for both recipients and donors.

Create incentives for better quality health information systems. Under the COD Aid model, verification of progress towards outcomes should be independent to avoid distorting national

health information systems, a major risk associated with results-based funding schemes described by Meesen et al in 2006. An added advantage to independent measurement is that Ministry of Finance and Health leadership then has an incentive to improve the accuracy of their own systems to gauge their progress and the size of disbursement. Further, the survey provides information necessary for checking the accuracy of the administrative reporting systems.

Improve advocacy and global health funding prospects. Given the scrutiny that global health investments face, budget support for HSS that is only vaguely linked to health progress is a difficult sell and may affect future funding streams. In addition, those advocating for and funding the maternal and child health MDGs – reportedly $40 billion in funding commitments[xxiv] -- may be more willing to pool with the Platform if it is connected to verifiable gains in maternal and child health results.

A results-based approach, therefore, holds promise for making the Platform much more relevant and effective. Nevertheless, it is still worth asking whether such an approach is feasible. A key aspect of this feasibility is finding ways to measure the results against which payments would be disbursed. In this regard, it is interesting to note that most efforts to gauge the effectiveness of health systems recognize the limited value of input and process measures.

In 2010, both the International Health Partnership and the WHO released guidance on M&E for HSS,[xxv, xxvi] seeking to unify the M&E work of the disease-specific programs with cross-cutting HSS issues, distinguishing inputs (human resources, financing and service readiness) and outputs (numbers of registered nurses trained, for example) from coverage, quality and efficiency results. Thirty-seven illustrative indicators are provided. This work shows that coverage and impact indicators are relatively unambiguous – higher coverage and impact are associated with better performing systems. However, the service delivery examples, such as health facilities per 10,000 people, outpatient visits per person per year, or other measures of capacity, lack an empirical link to health outcomes. This is not unexpected given the complex production functions that underlie the effective coverage of health interventions nor does it negate the value of tracking these measures for management

Box 3: Criteria to assess indicators

The Global Health Indicators Working Group used the following criteria to assess prospective health system governance indicators:

- Developed and validated by an independent third party, utilizing objective and high-quality data
- Analytically rigorous and publicly available
- Broad country coverage and comparability across countries
- Direct relationship to government policy
- Equates failing with bad outcomes
- Can change over the short-term
- Directly or indirectly reflects attention to equity
- Measures performance against ability, would not bias low-income countries

purposes, but it implies that – given their number and uncertain relevance for effective coverage – they are fundamentally inappropriate for structuring a funding relationship between a donor and a recipient government.

This argues for a focus on the less ambiguous, closer to outcome measures of primary health care performance. The ultimate measures of performance of a health system are health and financial protection outcomes; such outcomes could be used for the Platform – this is the COD Aid proposal – but a common criticism is that outcomes are mediated by a number of external factors over which the government has limited control. An alternative, perhaps better suited to tying aid to shorter-term results, is to reward a government's capacity to provide quality coverage of primary health care interventions. The 2006 Global Health Indicators Working Group set out eight criteria to assess prospective indicators to measure "good government performance" in health across countries (see Box 3).[xxvii] While not all criteria are necessary for the Platform (such as cross-country comparability), the Working Group's list of indicators provides a good starting point for the design of COD Aid in the health sector. Savedoff and Martel (2011) also argue that payments for broad health outcomes that require broad investments in effective health systems – such as reduced child and maternal mortality – could effectively reward health system progress.

Can the Platform reduce uncertainty and volatility of disbursements by linking funds to results?

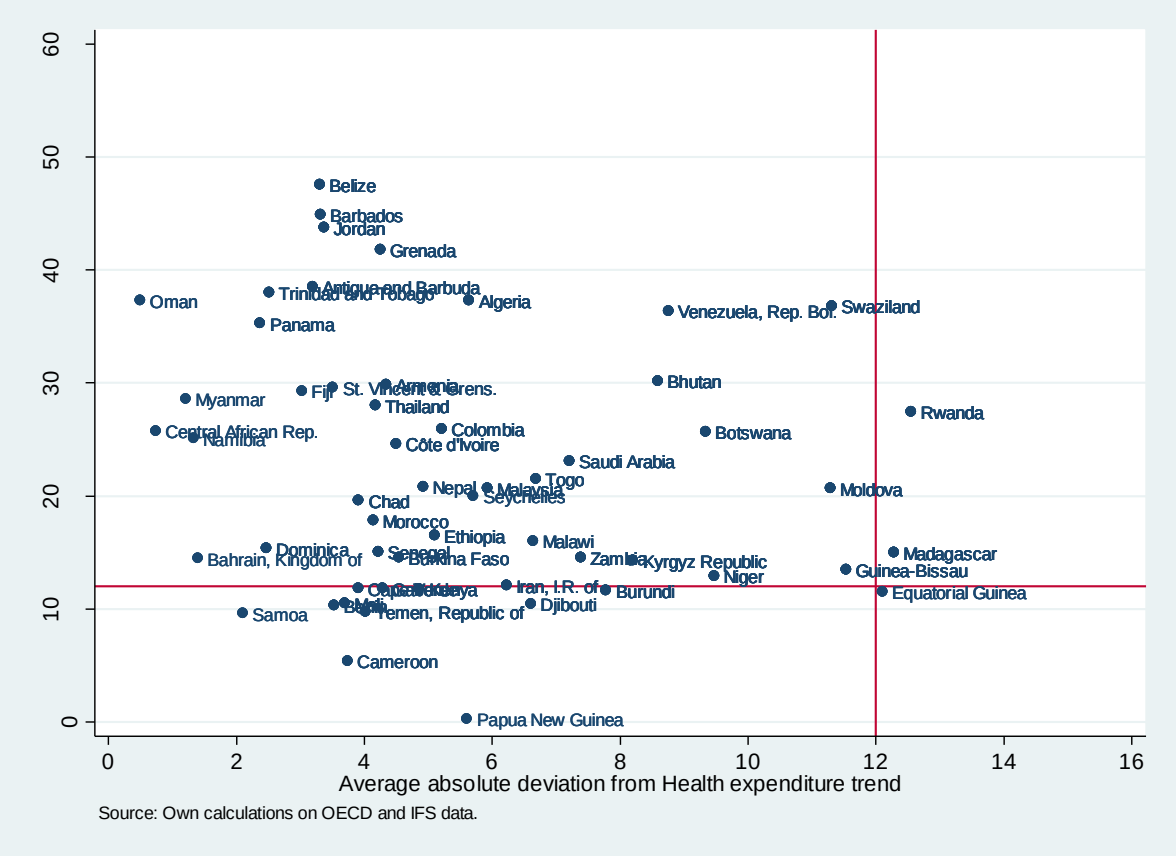
A common issue raised by critics of results-based funding is an assertion that such approaches make disbursements less predictable and more volatile. Yet the relevant issue is whether results based funding is more or less unpredictable and volatile than current approaches. This section assesses the extent of volatility in aid and domestic spending on health in the past and compares these trends to a disbursement pattern linked to progress on outcomes. It shows that contrary to the contentions raised by critics, results-linked payments are likely to be less volatile and disruptive for recipients' provision of primary health care than standard aid modalities.

Assessing the extent of this potential problem depends entirely on the counterfactual. Historically, health aid disbursements are volatile and more volatile than public spending on health in developing countries. Health aid disbursements displayed an average absolute percentage deviation from trend of 28 percent between 2002 and 2008, more than triple the deviation of government spending on health from trend.[xxviii] The median absolute deviation is only a bit lower than the average absolute deviation, suggesting that this volatility is not driven by a few spikes. Rather it indicates that most countries are experiencing significant volatility year-to-year. This finding is consistent with the broader aid effectiveness literature that finds aid to be particularly volatile.[xxix]

Figure 1 shows that most developing countries have experienced high levels of health aid disbursement volatility. Only Rwanda and Madagascar have more than a 12 percent average absolute deviation from trend during the 2002 to 2008 period for their domestic health

expenditures, but a majority of countries experience health aid disbursement volatility that exceeds this level (upper left quadrant).[2] Annex 1 describes the methodology used and provides the data tables.

Figure 1: Average absolute deviation from trends in health aid disbursement and government health expenditure



Note: Omits Argentina, Azerbaijan, St. Kitts and Nevis and Zimbabwe as countries with highly volatile health aid flows.

A number of factors drive volatility in the donor-recipient relationship.[xxx] On the donor side, commitments and disbursements increase and fall with changes in domestic priorities, geopolitical considerations and economic cycles. Bureaucratic procedures are sometimes used as excuses for these changes but sometimes introduce additional sources of volatility related to budgetary cycles and managerial interests. On the recipient side, political change, economic cycles, and external shocks can all affect the pace of program implementation and thereby alter aid disbursements.

By contrast, COD Aid disbursements rise and fall in proportion to progress on outcomes. Their trends will reflect the volatility of the outcome measures and in most situations, health indicators move steadily. Thus the scope for donors to manipulate aid flows is severely reduced.

[2] Note that Azerbaijan, Belarus and Zimbabwe have been removed as outliers. Azerbaijan and Belarus have extremely high government spending volatility, while Zimbabwe has extremely high health aid disbursement volatility.

In particular, if the COD Aid agreement is a multi-year contract, then the only way for the donor to alter disbursements would be to suspect the agreement, an unlikely occurrence. For these reasons, COD aid could be more predictable than other aid modalities.

Furthermore, even if disbursements based on outcome measures fluctuate, these outcome measures are more responsive to actions by the recipient government (e.g. progress on improving health services) than existing aid flows that are responsive to decisions by funders. The changing moods of donors have been a particular problem with budget support and policy-based loans, where determining the extent of compliance with conditions or satisfactory performance on reviews often comes down to a project team leader or management discretion. Although the World Bank defines "synchronization of disbursements with the government's budget cycle" as a key component of budget support, the overall assessment process allows for a great deal of flexibility in response to variable performance.[xxxi] Walliser (2005) finds that in eight African countries, errors in projected budget aid for any given year were close to one percent of GDP on average.

Gelb and Eifert (2005) simulate the predictability of disbursements of a performance-based system where performance is defined as the CPIA score (a more subjective measure than the health coverage and outcome measures proposed here). These authors find that "a purely performance-based system, even without multi-year pre-commitments, would be a vast improvement in terms of predictability over the current aid regime: reductions in volatility for most countries would be on the order of two thirds of their past levels."[xxxii]

A similar exercise can provide an illustration for how a COD Aid agreement in health might evolve. Comparing the trend in disbursements for Ethiopia from 2002 to 2008 versus the trend in DTP3 coverage (see Figures 2 and 3) shows that aid disbursements would have been more stable if they had been attached to vaccination coverage and would not have dropped off so sharply in 2008 when Ethiopia met its vaccination coverage goals.

Figure 2: Health aid disbursements in Ethiopia, millions of current US$, 2002-2008

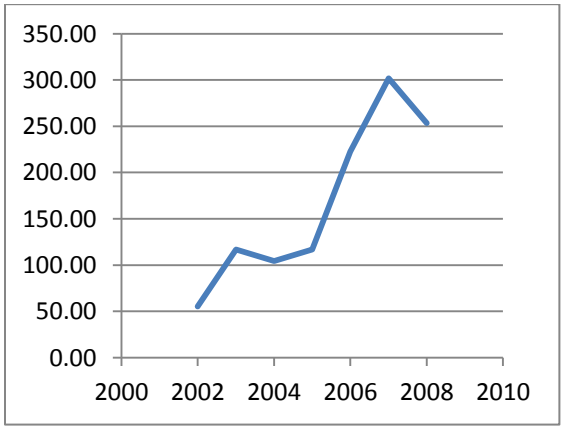
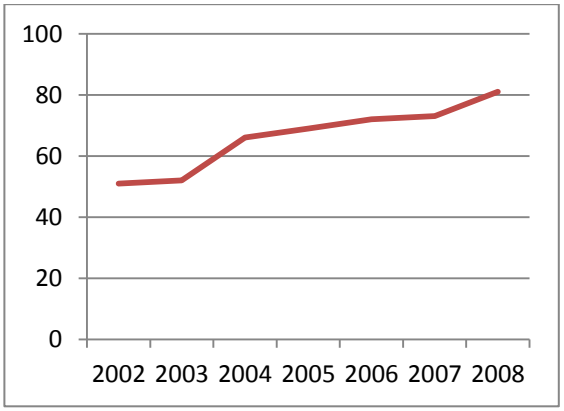


Figure 3: DTP3 coverage, Ethiopia, 2002-2008 (WHO)



A second issue relates to the potential impact of interrupted disbursements on the provision of essential health services. Given the finding that most Platform countries' own government spending is more predictable and increasing over time, the role of external assistance should be to incentivize greater public spending on a country's own stated health priorities, such that sudden stops and starts in aid will not affect the provision of essential health services. COD Aid can help by leveraging the *ex ante* allocation of a country's own spending to the agreed priority, which is by definition on budget and subject to parliamentary and civil society review, rather than substituting for this expenditure via an *ex ante* donor payment.

A third issue relates to the need for "up-front" financing in order to reach goals. No country enters the Platform process with a clean slate as there are already multiple existing aid flows in many different forms. COD Aid could leverage gains from efficiencies in existing flows that would not necessarily require "up-front" funding. It is also possible to use COD Aid as a "top up," bonus or variable tranche, complementing a fixed tranche of budget support. This latter approach is used by the European Commission in its sector budget support operations. Another option is to provide an advance to countries to begin work, with subsequent disbursements linked to progress on outcomes.

Should the Platform build a common, independent measurement approach to health results in each country? Would such an approach affect country ownership?

A major difference between COD Aid and other kinds of results-based funding in the relationship between a donor and a recipient is the independent (instead of self-reported) verification of outcomes. This section examines the case for common and independent measurement of health results in the context of the Platform and suggests that a continuous survey system to monitor health coverage and results has benefits that far outweigh the costs of building it.

While results-based funding creates an incentive to produce results, it also creates incentives to inflate reported progress. Unless achievements are independently verified, donors cannot be sure that they are paying for real progress. Furthermore, when recipients are rewarded for falsifying data, it weakens domestic governance and undermines the quality of official statistics.

Recipients do not always respond to results-based programs by falsifying numbers but the risk is there. A 2010 World Bank review of results-based funding verification practices[xxxiii] found that 8 of 10 schemes studied use recipients' self-reported administrative data to verify results achieved. Yet in the only effort to evaluate the use of administrative data for results-based funding verification, Lim et al (2008) found that discrepancies between official reports and survey-based reports of DTP3 coverage during the implementation of GAVI's results-based Immunization Services Support program were significant. The study found that less than half of

disbursements were justified by improved immunization coverage.[xxxiv] Other studies also document the problems with administrative data completeness, timeliness, representativeness and accuracy.[xxxv, xxxvi, xxxvii] Further, without independent estimates of the quality of administrative data, there is no way to know if the health information system is working well nor is there information that would suggest how to improve it.

Fortunately, verification is not as costly or difficult as is sometimes claimed. Methods based on rapid surveys, short questionnaire household surveys or continuous annual surveys, have proven to be cost-effective. The use of continuous surveys is particularly promising. Alexander Rowe (2009) has proposed integrated continuous surveys for low-income countries as a means to overcome problems with health information systems, to unify disease or condition-specific monitoring and evaluation efforts and to create permanent in-country survey expertise.[xxxviii] Continuous surveys have many similarities with national cross-sectional surveys such as the Living Standards and Measurement Surveys (LSMS) and the Demographic and Health Surveys (DHS). They differ, however, in their use of permanent data collection teams, a rolling, representative sample and real-time availability of results.

There is now significant and growing developing country experience in the design and implementation of continuous surveys. Many developing countries run monthly labor force surveys, and Bolivia and Uruguay are running continuous LSMS. In the health sector, the Peru DHS is conducted annually by the Peruvian National Institute of Statistics, is representative nationally and departmentally[xxxix] and reportedly less expensive than carrying out a DHS every five years.[xl] Other continuous surveys are under consideration by USAID in an African country, while the U.S. Centers for Disease Control Global AIDS program has been designing a small continuous household survey pilot in a district in Uganda. The “EQUIP” project in Uganda and Tanzania – funded by the EU – intends to implement continuous household and health facility surveys plus a quality improvement component to reduce maternal and newborn deaths.[xli] Of the initiatives using continuous survey methods, *Salud Mesoamerica 2015* is the only program that links the survey results to funding. Within funds from the Inter-American Development Bank in Central America and Mexico, the program will disburse funds in relation to primary health care coverage as measured in annual rapid coverage surveys.[xlii]

Rowe (2009) argues that useful information can be derived from a continuous survey that selects a new, independent sample of clusters every two months, involving fewer than half as many household contacts over the course of the year as a typical DHS in sub-Saharan Africa. Using this approach, most indicators can be estimated every two months, while mortality indicators would be estimated annually. Other options are also available to assure good quality data at low cost. Depending on the context, these might include sub-sampling within clusters, re-interviewing at least some respondents (a panel design) or a rolling sample in which some clusters or households move in and out of the sample in successive rounds.

Spillover benefits associated with continuous surveys could be significant. Real-time information could be made available to program managers to adjust strategies and improve performance.

Permanent survey teams can be created, assuring a permanent budget line item for both donors and governments. This is clearly superior to the current *ad hoc* approaches, seeking new funds each time a DHS or LSMS is proposed every 4 to 5 years. The regular presence of survey teams and dissemination of results can create positive reputational incentives for staff performance and a sense of accountability for results. Program managers and Ministry of Health staff could spend less time collecting information and more time analyzing and acting on results. Health systems and other public health research would also have valuable sources of information available.

Most importantly, a consolidated approach to survey measurement efforts may itself be a contribution to aid effectiveness. Tanzania, Egypt, Bangladesh and Uganda each have had DHS standard surveys at intervals shorter than five years, as well as AIDS Indicator Surveys, special and other interim surveys. A 2007 Health Metrics Network-sponsored meeting reviewed a number of different survey efforts and concluded that the benefits are obvious: [xliii]

> MACRO, UNICEF, WHO, CDC, World Bank and the President's Malaria Initiative (PMI) provided an overview of the ongoing and planned survey activities. MACRO increasingly includes biomarkers in surveys, and the demand for DHS surveys continues to be high with more donors providing resources. UNICEF is planning to increase the frequency of MICS surveys in selected countries to three-yearly intervals (MICS 4 round 2009-2010) but will continue to remain an effort that will collect data on a much broader range of issues than health alone through these surveys. DHS and MICS work together closely to harmonize questionnaire and to plan surveys. CDC is involved in reproductive health surveys, mostly in Eastern Europe, central Asian republics, Central America and the Caribbean. In some countries, CDC is involved in HIV/AIDS surveys. The initiative for World Bank's surveys, such as LSMS and CWIQ, are generally generated by country offices. The PMI is planning a series of national surveys, mostly with collection of blood for anemia and parasite density testing. The increased demand for data through surveys will be a challenge for efforts to improve coordination and there were concerns about overloading country statistical systems and even households.

According to the Health Metrics Network, household survey costs have ranged from $50 (UNICEF's Multiple Indicator Cluster Surveys) to $150 (Macro International's Demographic and Health Surveys-DHS) per household interviewed. This means a sample of 20,000 households could cost between $1 million and $3 million. In comparison, Rowe estimates that a continuous survey would require $3.9 million annually in a small country like Benin and that further cost savings could be expected given the consolidated approach and the elimination of the larger sample surveys that would be replaced with this approach. However, costs may in fact be much less, particularly if the frequency of sampling is reduced; the Peru continuous DHS costs $650,000 per year for an annual representative sample at the department level in a country of 24 million persons.[xliv]

The costs of continuing surveys can be offset by reduced monitoring expenditures associated with existing donor schemes.[xlv] The Global Fund spends 4 percent of $19.3 billion of approved projects on M&E, mostly Local Fund Agents. GAVI's spending on M&E is not reported publicly, but the Alliance could independently and reliably measure DTP3 coverage in an annual sample of 2,400 children 12 to 24 months old for $120,000 per country per year. To put this number in context, Afghanistan, for example, received $17.5 million in GAVI support in 2009.

A continuous survey system need not demonstrate savings in order to be a cost-effective investment. Given the important of health information system quality for better management decisions, running frequent surveys can be considered a routine and normal cost of monitoring and improving information quality, particularly if better use of information leverages greater effectiveness and efficiency. Further, costs of continuous surveys are minimal when compared to total domestic health spending or if compared to the costs of macroeconomic data collection. In 2008, for example, the Asian Development Bank provided $825,000 for a year-long program to strengthen macroeconomic data collection in Nepal.[xlvi]

Sometimes health information system strengthening is juxtaposed with surveys as a zero sum game. It is often the case that Ministries of Health view a dollar spent on surveys as a dollar not spent on the health information system. Yet these are really mutually reinforcing activities. On the one hand, savings from consolidating existing surveys and removing separate information system reporting requirements could free up greater funding for information system strengthening. In addition, rather than viewing independent information as an indication of mistrust, it should be viewed as a way to improve health information system quality (and its relationship to reality) and mutual accountability. In this way, COD Aid offers an opportunity to link household surveys more closely and explicitly to health information systems, with the result of strengthening their quality and functionality.

As the Platform partners contemplate their next moves in results-based funding, serious consideration should be given to the use of independently conducted, survey-based instruments to monitor results that will be attached to disbursements. If at all possible, a single, continuous health survey could reduce fragmentation in efforts at the country level and may be cost-effective in the context of the Platform. Surveys could also be used to conduct impact evaluations – for example, performance-based incentives and other payer-provider within-system results-based funding could be rigorously evaluated. A learning agenda alongside would help to assess costs and interactions with health information systems and develop innovations to improve on both counts.

Attractive Approach, but Practical?

While there are many reasons to consider a stronger link between aid financing and health results, a common concern is the feasibility of implementation. This section examines an adapted COD Aid within specific institutional settings and issues around the selection of results indicators that may be particularly relevant for implementation in the context of the Platform.

Dealing with differing institutional arrangements

The design of the COD Aid scheme depends on health system and fiscal structures in each country.

In a federal system, national authorities do not have direct authority over subnational authorities. For example, in Ethiopia, the federal level interacts with nine regions, each of which has budgetary authority over a sizeable share of public health expenditures. In such cases, a results-based scheme could support a federal initiative to build results incentives into the fiscal transfer system. The World Bank has experimented with such an approach with a loan to Argentina. This loan includes results-based funding in the federal to provincial relationship to improve maternal and child health, as well as results-based funding in Bank disbursements to the federal government upon verification of achievements that are negotiated

Box 4: How is the US Global Health Initiative (GHI) participating in the Platform?

The GHI seeks to scale up maternal, neonatal and child health and nutrition in focus countries, most of which overlap with the Platform countries. In those countries – which include Platform first adopters Ethiopia and Nepal – the US is a top external funder of health and nutrition activities.

In Nepal, after applying a risk matrix for use of national systems, USAID joined the Platform's Joint Financing Agreement without pooling its funds, accepting the single reporting requirements, working off of the national health strategy and exploring how the Agency can work directly with government through existing public financing mechanisms.[i] About 1% of the overall USAID/Nepal health budget goes to on-budget support for the sector plan. An additional 10% goes to technical assistance support directly linked to the on-budget funds using the same financial codes as the Government but delivered through a bilateral project that works to strengthen health systems.

While a modest effort, the USAID/Nepal contributions are a start to greater Agency engagement in direct support to national governments. USAID/Liberia has also made efforts to assess national systems in 2010 and will consider direct financing of the MOH in 2011, based on the risk matrix assessment. Ideally, USAID will participate in the upstream results-based aid that might eventually characterize the Platform that could help meet the GHI objective of "investing in sustainable systems to create a lasting effect on the health of citizens regardless of future disease initiatives" ii while better coordinating and leveraging existing money.

[i] Williams, B. "Accounting for Better Health in Nepal." USAID Impact Blog. January 18, 2011. http://blog.usaid.gov/2011/01/accounting-for-better-health-in-nepal/, accessed March 26, 2011.
ii Shah, R. "USAID @ UNGA: A Conversation with GHI "Plus" Country Leaders." USAID Impact Blog. September 10, 2010. http://blog.usaid.gov/2010/09/usaid-unga-a-conversation-with-ghi-plus-country-leaders/, accessed, March 26, 2011.

annually.[xlvii] In this case, targets include: (i) first trimester enrollment of pregnant women in prenatal care; (ii) effectiveness of neonatal and delivery care as measured by Apgar scores; (iii) proportion of enrolled pregnant women immunized and tested for sexually transmitted diseases; (iv) immunization coverage; and (v) well child visits. Inclusion of the upstream results-based funding is described as necessary to "motivate all those involved to comply with program goals" since it is not only provinces or health facility teams that can put all the inputs in place necessary to achieve the results.

In many centralized health and fiscal systems, health services have input-based budgets and are run directly by a central ministry or with regional administrative units. In such cases, linking disbursements to results at the very top of the Ministerial structure – connected to the Ministry of Finance and its budgetary management – is appropriate. Centralized systems do not separate financing from provision; therefore, the financial incentives facing lower-level directorates and facilities operate via the amount, timeliness and flexibility of budgets as they are passed on to front-line health facilities.[xlviii] In many countries, these factors are almost entirely controlled by the Ministry of Finance. In Nepal, the Ministry of Health also plays a role in releasing budget from the central level to regions and districts, as does the Ministry of Local Development. When there is not good coordination at the district level between the health and local development offices, there can be problems with effectiveness. As a result, a results-based aid scheme between donors and government – involving all three ministries – can align incentives for performance.

One further institutional arrangement common to many developing country health systems is one in which citizens are enrolled in insurance programs which reimburse health care providers. This is the case, for example, in Rwanda, where different payer agencies are purchasing health care services on behalf of their clients from NGO and district public health facilities. The appropriate arrangement for results-based funding in these situations is between the donor and the payer, i.e. the

Box 5: One approach to combining performance measures

The UK's Quality and Outcomes Framework – governing a payment relationship between regional primary care trusts and general practitioner (GP) practices – uses a point system to combine performance measures. For improvements between a minimum and maximum threshold, points are assigned for the achievement of more of whatever action is being incentivized. For example, GP practices receive points for each percentage point increase in the share of coronary heart disease patients that have blood pressure less than or equal to 150/90 mmHg. Points are tallied and a price-per-point is calculated to award GP practices according to the points accumulated over a year-long period.

Criticisms of the scheme have focused on the upper threshold for coverage that led to a performance plateau in some cases, the equal weight given to progress on all performance indicators and the complexity of the system. Advantages are similar to those observed in GAVI ISS' progress-based results scheme – rewarding progress relative to a baseline is less risky than developing targets based on imperfect projection or modeling methodologies, while assuring that there is a direct relationship between any kind of effort and reward funding.

agency that manages the insurance funds. In these systems, the need to be consistent with payer-provider incentives is critical. Upstream results-based funding might also be necessary to assure that appropriate government oversight and policy is in place.

Selecting performance indicators

A second design issue relates to the selection of indicators linked to funding. Savedoff and Martel (2011) have already analyzed the strengths and weaknesses of a number of candidate indicators for COD Aid in health.[xlix] As such, the goal of this paper is not to pre-select a given indicator but to suggest that this work, combined with the country-owned Platform agreements on M&E indicators, can be used to set up a simple COD Aid contract between donors and recipient governments based on a basket of quality and coverage outcomes.

There have been different approaches to combining a set or basket of performance measures. The UK's Quality and Outcomes Framework – governing a payment relationship between regional primary care trusts and GP practices – uses a point system described in Box 5. Other programs contracting with NGOs for a set of primary health care activities – as in Afghanistan, Cambodia and Haiti – have used a "balanced scorecard" approach.[l] Argentina's federal-level Plan Nacer pays provinces based on 18 tracer indicators of coverage and health impact. A common problem has been the large number of indicators included in these agreements. While the principles of combining multiple objectives should be considered in the design of a new Platform approach, it is probably better to focus policy attention by selecting a few key indicators.

Since there is a need to prioritize among the large number of possible results measures, candidate indicators could be selected according to the relative cost-effectiveness of the interventions measured by the indicator, where the net benefit of the indicator is defined as the monetized benefit minus the delivery cost minus the performance payment. To provide a crude example, a higher payment per unit of progress could be provided for vaccinated children (each percentage point increase in the share of children with complete and timely vaccination) ($16/DALY averted in South Asia) than for skilled birth attendance as an indicator of increased primary-level coverage of maternity care ($148/DALY averted in South Asia).[li] A protocol for assessing the relative cost-effectiveness of results or outcome indicators (or using the WHO-CHOICE or LiST estimates) and using this information to rank indicators and negotiate the results-based aid contract may be important given the competing disease/condition priorities among international agencies and programs. If donors and recipients could agree to such a protocol to select the indicators, both health and transparency might benefit.

The selection of indicators will likely drive effort and resources during the performance period. Therefore, there should be a relationship between the amount of resources invested (public and donor) and the cost of providing the incentivized services. To give an extreme example, if the amount of public and donor funds available in a given year is only sufficient to cover the costs of the first-ranked cost-effective intervention for a given objective population, then it makes sense

to limit the performance agreement to the single indicator of that intervention. While perhaps self-evident, making the connection between costs and potential performance increases the probability of "good" performance and thus the feasibility of the results-based aid scheme longer-term. Further, it may help national policy-makers in assessing priorities in the use of public expenditure in the context of the national health plan. Note however that this "cost" should not be a consideration when assessing the size of the funding tranche to attach to the results achieved in the results-based aid contract; it is simply an input to the negotiation of the indicators to be measured.

However, there are also good reasons to include "reach" indicators since the inclusion of a more ambitious agenda of performance may incentivize the (re)allocation of greater public/donor resources or improved efficiencies such that the provision of additional services becomes financially feasible.

Should the Platform Itself Be Evaluated Relative to Other Aid Instruments?

If the Platform really seeks to change the way aid is delivered, then it should be viewed as a new instrument that needs evaluation. Otherwise, years from now, we will still be in the dark. We won't know whether coordinating aid through such mechanisms is better or worse for health system development and health outcomes.

The key to evaluating programs like the Platform is to explicitly state how the program is supposed to effect change and then to collect information and data to test whether those predictions are fulfilled. Therefore, any assessment requires documenting (i) critical variables before and after the Platform begins to operate, (ii) relevant changes in context that might also influence the process, and (iii) processes, decisions, and policy changes in recipient countries and donor institutions that are plausibly related to the Platform's operation. For example, a basic assumption for the Platform is that transaction costs will be reduced and recipient country staff will have more time to focus on implementation of their program. These are quantifiable indicators that can be tracked to assess whether the Platform is working as intended.

Alongside changes in health performance linked to disbursements, Table 1 describes a list of traditional and quality-related aid effectiveness indicators that could be used to construct a baseline for the Platform. The IHP+ Results' core indicators are also available.[lii] The relevance of each type of indicator for aid effectiveness has been explored in many papers and will not be repeated here.[liii] In addition, qualitative analysis of the potential benefits described earlier will also be useful.

Table 1: Aid effectiveness indicators to assess the Platform

	Indicator	Definition	Source of data
1	Total aid for health	Sum of all ODA flows committed and disbursed to a recipient country year-to-year.	OECD
2	Fragmentation	Diversity of sources from which the recipient country obtains an aid inflow, inverse of Hirschman-Herfindal index	OECD
3	Predictability (volatility)	Extent to which the pattern of aid disbursement is irregular, using Hodrick-Prescott filter to split time series data on aid disbursements into trend and cyclical components with volatility represented by the size of the short-term cyclical deviations relative to the longer-term smoothed trend.	OECD for annual flows Government MOF for semester or quarterly flows
4	Certainty	Proportion of aid commitments included in legally-enforceable contracts including amounts to be provided and estimated disbursement date	Government MOF
5	Pooled funds as proportion of total health aid	Proportion of ODA for health that is pooled with government and other donor funding.	OECD
6	On-budget aid as a proportion of total health aid	Note that it is not clear that budget support has provided better value for money than other ways of delivering aid (UK National Audit Office 2008)	Government MOF
7	Number of aid-funded project implementation units in the health sector	Number of project implementation units within government agencies to administer ODA for health.	Government MOH
8	Proportion of health aid projects using recipient country systems or a single system for fiduciary and monitoring requirements	Proportion of ODA for health that uses recipient country systems or a single system for ODA fiduciary and monitoring requirements.	Donors
9	Donor transaction costs	Country-attributable donor administrative costs (travel, supervision, reporting, etc.). Requires more precise definition for each participating donor agency.	Donors

Given the Platform's emphasis on transaction costs, a clear definition is needed to track these costs at baseline and follow up, with a focus on both the recipient and the donor. Transaction costs of aid are defined as "the costs arising from the preparation, negotiation, implementation and enforcement of agreements for the delivery of ODA." Measures used in the literature are focused on fragmentation (number of donors and projects in a given country or in a given sector) and are included in Table 1, although several authors note that transaction costs are not fully measurable.[liv] In addition to fragmentation, from the country perspective, transaction costs can also be measured by the portion of aid pooled and on-budget, the number of project implementation units and the proportion of aid projects using country systems. From the donor perspective, transaction costs will need to be defined and measured.

Box 6: Aid effectiveness baselines in Ethiopia and Nepal

Total aid for health has increased dramatically in Ethiopia and Nepal over the last decade, while aid fragmentation has remained more or less stable since 2002. Both countries' health aid disbursements have been highly volatile between 2002 and 2006. In 2009, disbursements are 73% of commitments in Ethiopia and more than 100% of commitments in Nepal. However, the use of program-based approaches like budget support and pooled funding has been limited; only 10% of total aid for health in Ethiopia and 7% in Nepal. See Annexes 1 and 2 for tables and sources of data.

By the end of 2011, using new OECD DAC data and local information, an interrupted time-series analysis could be used to look for evidence that the Platform is having an effect on the trend in aid effectiveness measures over time, as indicated by a statistically significant result with respect to (either) the change in level (or the change in slope). While this analysis will not establish a causal relationship between the Platform and the results observed, it could provide some evidence of the approach's impact if outcomes or outputs begin to change significantly relative to earlier trends. Investigating such patterns can be useful in assessing the Platform's success and provide feedback for modifying the Platform's approach in the future.

The Platform's contribution to aid effectiveness largely depends on the ability of the three Platform funding partners to change and realign their existing structures. Otherwise it will be difficult to realize the full potential of the Platform. One other issue that is crucial for the evaluation of the Platform is that the Global Fund Board will not approve HSS funding requests before April 2012. It is thus likely that Global Fund HSS disbursements won't arrive in countries before the end of 2012/early 2013, a timeframe that will inevitably limit the results of the evaluation.[lv]

While this exercise has its uses for accountability and aid effectiveness purposes, and can be usefully complemented with qualitative studies of recipient and donor perceptions, it will ultimately be less interesting than the assessment of the Platform's performance on development effectiveness – health results and institutional incentive effects. This is because one immediately evident result of the exercise is that traditional aid effectiveness indicators may not be useful as a means to judge whether the Platform represents an improvement *vis a vis* the status quo. In past years, the volume of health aid has increased and the number of donor agencies operating ("proliferation") has also increased, and these are likely related. The

policy question is whether the modality of aid is sufficiently "cheaper" such that the increasing per-donor cost is modest or neutral. In terms of volatility, the "upwards" volatility in disbursements observed between 2002 and 2007 is probably less of a problem for financing essential health services than the "downwards" volatility observed in 2008 and 2009.

Conclusions and Recommendations

The Platform is currently a little known effort by donors to reduce bureaucracy in their health assistance to those countries most vulnerable to aid fragmentation, consistent with commitments made in the Paris Declaration. The harmonization of fiduciary and reporting requirements is likely an important achievement. Yet more could be done to push the development effectiveness agenda forward.

This paper proposes four strategies for the Platform's second year:

1. **To motivate more predictable public funding for health systems strengthening while tying aid investments to health results, link a portion of Platform funding to progress on a small basket of country-prioritized health coverage and outcomes indicators and codify in a multi-year contract.** In many Platform countries, GAVI and Global Fund health systems strengthening grants will be the only "new" money available. Countries will be submitting their harmonized proposals in 2011. Instead of a lengthy proposal on how health system strengthening will be done, proposals could focus on defining shared results, measuring a baseline, designing the COD Aid contract and its monitoring and evaluation arrangements. Further, World Bank management has proposed a new Program-for-Results lending instrument that would place direct emphasis on results by making them the basis for disbursement.[lvi] If approved by the Bank's Board, the instrument could form the basis of the Platform and serve to galvanize other donor actions around a single results contract.

   While a collective approach may be most efficient, individual platform agencies can also introduce results-based tranches within the Platform, effectively becoming the variable tranche described earlier, as a means for agencies to demonstrate that the Platform contributed to their own mandate. In this scenario, GAVI could disburse against the core immunization indicators and the Global Fund against MDG 6-related indicators.

   To avoid another donor-driven initiative that arrives already packaged to recipient country governments, the World Bank should convene the Platform countries, GAVI, the Global Fund, pooling donors and civil society to consult on this proposal and collaboratively develop a model contract that would reflect mutual goals as well as accountability between donors and recipient governments.

2. **To strengthen the quality of health information systems while generating the reliable and independent measurement that results-based financing requires, initiate**

integrated, common and independent continuous surveys to measure health results. Continuous households surveys to measure results – both as support to health information system improvements and as a mechanism of verification of the COD Aid contract – are feasible now. Even if a results-based scheme such as COD Aid is not adopted, continuous and consolidated/integrated surveys across disease priorities, donors and programs will save money, support monitoring, learning and evaluation and strengthen national priority setting and budget allocation processes.

3. **To assess whether the Platform adds value, analyze the Platform as an aid innovation and use the results to decide on extension to other countries.** Before expanding to many more countries, the Platform's sponsors should reserve time and resources to measure health results and their own transaction costs as well as other aid effectiveness indicators to determine if the Platform is adding value to an already complex health aid environment. Findings can be used to adjust and refine approaches. If a COD Aid scheme is adopted, analysis of institutional incentives on both sides of the funding relationship should be assessed as well.

   A concern is that GAVI has already replaced its existing application and review procedures with Platform procedures with immediate effect. Based on Platform processes, several countries will access HSS funding from GAVI in 2011 (most of them through the proposal form; less via national health plans). The Global Fund Board will not approve HSS funding requests before April 2012. As a result, it is clearly up to GAVI and the pooling bilateral donors to take leadership on this approach and its evaluation and adjustment.

4. **To obtain benefits from visibility and civil society participation, make financial, operational and results monitoring information on the Platform available on the web page.** There is little information on the Platform available to the public and little awareness of its existence outside of direct participants. The Nepal Joint Financing Agreement, for example, has only been provided as a press release and the amount of funding under the Agreement remains unclear. Further, the relationship to the International Health Partnership and the institutional constituencies that participate in the Platform are vague. If civil society is to be useful to the Platform – and perhaps thereby assist with fundraising and sustainability of the effort – financial, operational and results data should be made public.

ANNEX 1: Spending volatility of government versus health aid, 2002-2006

Government versus aid spend volatility in the health sector, 2002-2006

Government spend volatility	Health aid volatility				
	Low (<=12%)	High (>12%)			
Low (<=12%)	Benin	Algeria	Central African Rep.	Kyrgyz Republic	Saudi Arabia
	Burundi	Antigua and Barbuda	Chad	Malawi	Senegal
	Cameroon	Argentina	Colombia	Malaysia	Seychelles
	Cape Verde	Armenia	Cote d'Ivoire	Moldova	St. Lucia
	Djibouti	Bahrain	Dominica	Morocco	St.Vincent & Grenadines
	Gabon	Barbados	Ethiopia	Myanmar	Swaziland
	Kenya	Belarus	Fiji	Namibia	Thailand
	Mali	Belize	Grenada	Nepal	Togo
	Papua New Guinea	Bhutan	Guinea-Bissau	Niger	Trinidad and Tobago
	Samoa	Botswana	Iran	Oman	Venezuela
	Yemen	Burkina Faso	Jordan	Panama	Zambia
High (>12%)	Equatorial Guinea		Azerbaijan		
			Madagascar		
			Rwanda		
			Zimbabwe		

Descriptive statistics and volatility averages, 2002-2006 (sources below)

Variable	Average	Median	Variation coefficient	Percentile 5	Percentile 25	Percentile 75	Percentile 95
Disbursements	20.8	7.3	1.67	0.08	1.00	27.52	86.34

Variable	Average	Median	Variation coefficient	Percentile 5	Percentile 25	Percentile 75	Percentile 95
Commitments	23.5	7.2	1.75	0.04	1.20	27.45	97.38
Gross domestic product in US dollars	44,605	5,899	2.97	554	1,843	19,182	214,573
Gross domestic product in US dollars, per capita	3,296	1,775	1.27	202	493	4,515	12,107
Total expenditure on health as a percentage in millions of US dollars	2,115	339	2.28	28.8	95.0	981.8	11,992
Disbursements trend obtain using Hodrick-Prescott filter for each country.	20.8	7.6	1.62	0.1	1.0	27.3	80.8
Total expenditure on health Trend obtain using Hodrick-Prescott filter for each country.	2,115	346	2.28	29.1	97.4	998.8	11,725
Absolute deviation from disbursements trend (%)	28.8	17.6	2.95	1.2	8.1	35.2	66.6
Absolute deviation from Health expenditure trend (%)	7.2	4.2	2.74	0.5	1.9	7.5	18.1
Average deviation from disbursements trend (%)	28.8	20.8	1.48	9.7	14.3	30.2	70.7

Variable	Average	Median	Variation coefficient	Percentile 5	Percentile 25	Percentile 75	Percentile 95
Average deviation from Health expenditure trend (%)	7.2	4.9	1.70	2.1	3.7	7.8	12.6
Median absolute deviation from disbursements trend (%)	21.9	18.2	0.59	7.9	11.3	31.1	45.8
Median deviation from Health expenditure trend (%)	5.4	4.2	0.98	1.8	3.0	5.5	13.0

Sources of data used in analysis:

Description	Source	Notes	Variable
Recipient	OECD DAC		Recipient
Country code	WDI		Country code
year			year
Disbursements	OECD DAC	Disbursements gross (current USD millions); Donor (All) ; Flow Official Development Assistance ; Region (All) ; Income Group (All) ; Sector 120: I.2. Health ; Policy Objective (All) ; Type of Aid (All) ; Rio Markers (All) ; Channel (All) ; Purpose code ALL: (All)	disbursements
Commitments		Commitments (current USD millions) ; Donor (All) ; Flow Official Development Assistance ; Region (All) ; Income Group (All) ; Sector 120: I.2. Health ; Policy Objective (All) ; Type of Aid (All) ; Rio Markers (All) ; Channel (All) ; Purpose code ALL: (All)	commitments
	IFS	In National Currency	gdp
Nominal exchange rate	IFS	OFFICIAL RATE, PERIOD AVERAGE, National Currency per U.S	tcn
Population (in Millions)	IFS	Population (in Millions)	pop
Total expenditure on health as a percentage of gross domestic product	WHO		hporc
Gross domestic product in US dollars	Own calculation	Gdp/tcn	gdp_usd
Gross domestic product in US dollars, per capita	Own calculation		gdp_usd_pc
Total expenditure on health as a percentage in millions of US dollars	Own calculation		healthexp
Disbursements trend obtain using Hodrick-Prescott filter for each country.	Own calculation		hp_dis_sm

Description	Source	Notes	Variable
Total expenditure on health Trend obtain using Hodrick-Prescott filter for each country.	Own calculation		hp_health_sm
Absolute deviation from Health expenditure trend (%)	Own calculation		desvdisb
Absolute deviation from disbursements trend (%)	Own calculation		desvhealth
Average deviation from Health expenditure trend (%)	Own calculation		desvdisbm
Average deviation from disbursements trend (%)	Own calculation		desvhealthm
Median deviation from Health expenditure trend (%)	Own calculation		desvdisbmed
Median absolute deviation from disbursements trend (%)	Own calculation		desvhealthmed

Groups	Own calculation	(i) low health aid and low government spend volatility, defined as <12% average absolute deviation from trend during the time period for both variables; (ii) high health aid and high government spend volatility, defined as >12% average absolute deviation from trend during the time period for both variables; (iii) low health aid volatility (<12%) and high government spend volatility (>12%); (iv) high health aid volatility (>12%) and low government spend volatility (<12%).	Groups

ANNEX 2: Aid effectiveness in Ethiopia and Nepal

Fragmentation in health aid in Ethiopia and Nepal, 2002-2009

	All countries (Inverse Herfindahl - Hirschman Index)	Ethiopia (Inverse Herfindahl - Hirschman Index)	Nepal (Inverse Herfindahl - Hirschman Index)
2002	2.850	3.178	3.288
2003	2.911	3.262	3.435
2004	2.984	3.409	3.321
2005	2.944	3.480	3.382
2006	2.908	3.250	3.300
2007	2.980	3.436	3.217
2008	3.029	3.441	3.241
2009	3.034	3.358	3.284
Total	2.956	3.352	3.308

Note: Fragmentation is defined as the diversity of sources from which the recipient country obtains an aid inflow, inverse of Hirschman-Herfindal index
Source: OECD

Programmable health aid as a share of total health aid in Ethiopia and Nepal, 2002-2009

Country	year	Programmable Health Disbursements (current USD millions)(a)	Total Health Disbursements (current USD millions)(b)	Share programmable aid (a)/(b)
Ethiopia	2002	55.4	1152.4	0.05
Ethiopia	2003	116.8	1483.6	0.08
Ethiopia	2004	104.4	1754.1	0.06
Ethiopia	2005	117.0	1856.6	0.06
Ethiopia	2006	222.5	5733.6	0.04
Ethiopia	2007	301.8	2435.7	0.12
Ethiopia	2008	253.6	3201.7	0.08
Ethiopia	2009	360.4	3791.4	0.10
Nepal	2002	19.7	278.0	0.07
Nepal	2003	31.6	430.0	0.07
Nepal	2004	17.8	394.8	0.05
Nepal	2005	23.5	417.0	0.06
Nepal	2006	27.5	474.6	0.06
Nepal	2007	48.1	547.4	0.09
Nepal	2008	65.3	745.5	0.09
Nepal	2009	51.8	757.7	0.07

Source: OECD

Commitments versus disbursements in Ethiopia and Nepal, 2009

	year	Health Disbursements (current USD millions)	Health commitments (current USD millions)	Share of 2009 commitments disbursed
Ethiopia	2009	360.4	493.3	0.731
Nepal	2009	51.8	34	1.524

Source: OECD

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