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Development assistance in health– how much, where does it go, and what more do health planners need to know? A case study of Fiji's national health accounts

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SUMMARY

This paper analyses publicly available health expenditure data to assess the contribution of external development assistance for health (DAH) in Fiji.

Development assistance is a significant and increasing contributor to the health sector in Fiji, representing nearly 9 per cent of total health expenditure.

Further analysis revealed that prevention and public health services are reliant on donors with more than 30 per cent of financing from development assistance, together with a recent increase in assistance for health administration.

The potential for development assistance to influence health priorities is a concern. As such, the reporting of allocations needs standardisation and greater detail to better inform the national health accounts (NHA).

Fiji's national health accounts now comply with international standards and could increasingly be used to provide valuable information for policy analysis, with more detail now available to review development assistance for health contributions.

However, the data on the total and precise distribution of development assistance for health is incomplete and possibly underestimated. It remains difficult to differentiate development assistance for health expenditure by technical area or health system function.

A review of publications from other countries suggests these problems are likely to occur elsewhere in the Pacific.

This paper calls for development partners to improve expenditure reporting to national governments, to support national health accounts and provide disaggregation in categories that align with local health system functions.

If government health planners refine expenditure reporting of development assistance for health, a more detailed understanding of donor spending for specific disease priorities and types of health service delivery will emerge.

Furthermore, this paper highlights the importance of increasing the use of national health accounts in policy analysis so policy-making is evidence based.

INTRODUCTION

Development assistance for health has been a large contributor to government budgets in a number of Pacific Island countries (Organisation for Economic Co-operation and Development [OECD] 2011a). This is characteristic of small island developing states and may be seen as essential to their sustainable development (Feeny and McGillivray 2010). This has been particularly true in the health sector, where a few Pacific Island countries are among the largest per capita recipients of health aid in the world (Institute for Health Metrics and Evaluation 2009). While there has been considerable work recently to develop a better understanding of the dynamics of donor health priorities (McCoy, Chand and Sridhar 2009; Piva and Dodd 2009), including the degree to which they correlate with the burden of disease (Ravishankar, Gubbins et al 2009; Shiffman 2009; Amico, Aran et al 2010), very little has been done in the Pacific region.

Understanding external financing for the health sector is critical to advancing the aspirations for country ownership that lie at the centre of the Paris Declaration and Accra Agenda for Action (OECD 2008). Transparency and predictability of external financing are vital to health sector ownership and planning and represent good aid practice. The limited existing work on financing flows for health in the Pacific region has suggested that allocations may follow donor priorities rather than domestic focuses (Negin and Robinson 2010). This emphasises the importance of tracking such influences.

A number of Pacific countries have recently been developing national health accounts to better understand the complex and diverse funding flows supporting the health sector. Health system strengthening initiatives from the regional office of the World Health Organization (WHO), with additional investments from development partners, have progressively strengthened these processes in Fiji and elsewhere (Hopkins, Irava and Kei 2011).

The national health accounts initiative aims to identify the magnitude, channel and allocation of external financing for health. Compiling these accounts in Fiji is complete with the release of two reports in early 2011 (for NHA 2007/08) and in early 2012 (for NHAs 2009/10).

This research takes the opportunity to examine these accounts for information on external funding for health in Fiji, comparing this information with other available data.

METHODOLOGY

The two most recent Fiji Government national health account reports (MOH Fiji 2010, MOH Fiji 2011) were reviewed, covering 2007-2010. These were compared to other public data presented to the OECD's multi-country review of national health account findings (Irava 2010). The analysis was supplemented by further cross-checking of publicly and locally available data on donor financing, including accounts provided by the Ministry of Health and development partners. This work was undertaken by the Centre for Health Information, Policy and Systems Research (CHIPSR) at the Fiji School of Medicine in late 2010 and verified in mid-2011.

RESULTS

Total Health Expenditure in Fiji

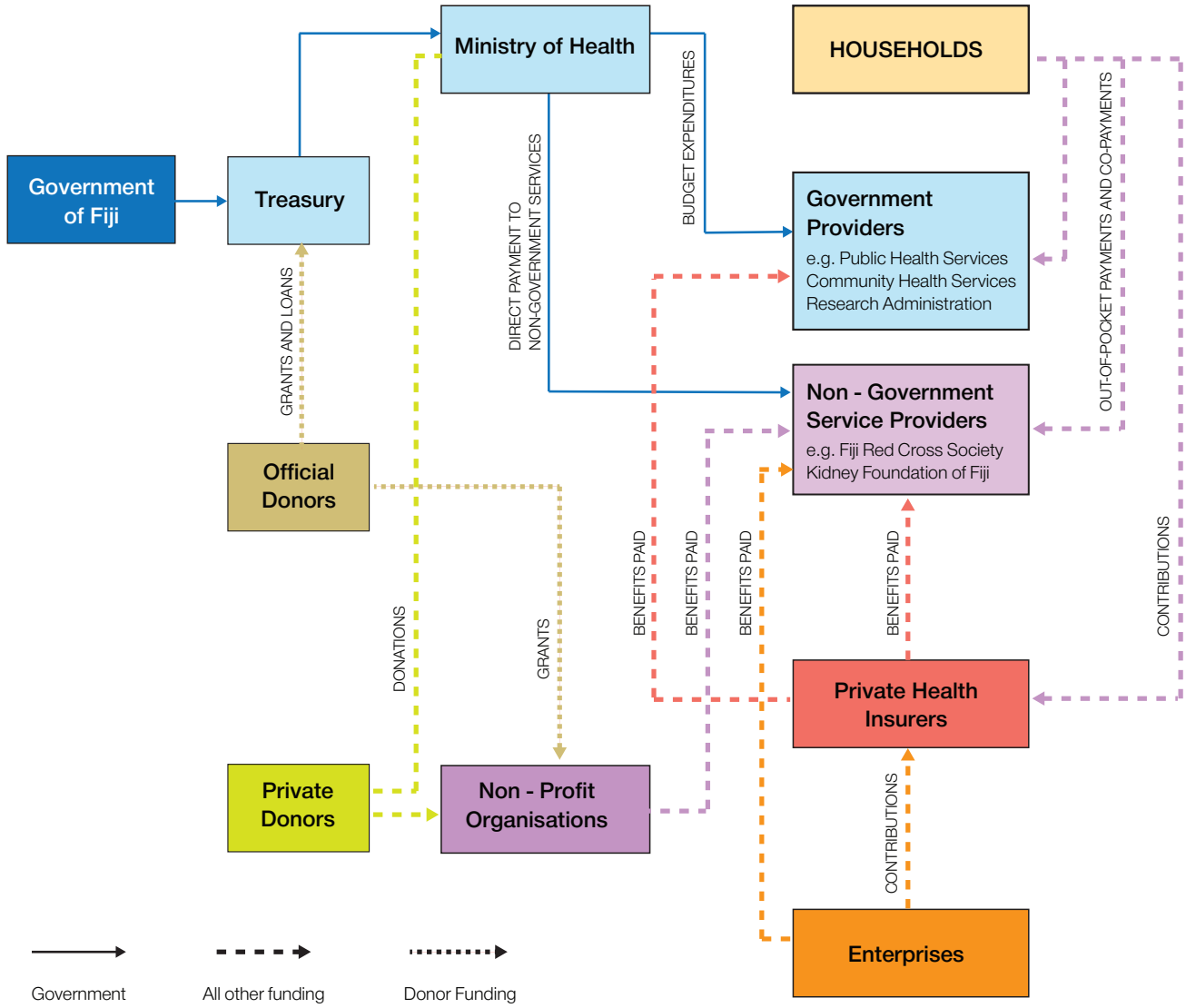
According to the Fiji reports, total health expenditure in 2008 was estimated at US$132.79 million (F$205.83 million). In 2010, it was estimated at US$129.70 million (F$250.40 million)[1], or 4.8 per cent of GDP.

Between 2007-10, total health expenditure increased in real and nominal terms. By 2010, government financing was 60.8 per cent of total health expenditure, a decrease in approximately 10 per cent over four years from 71.2 per cent in 2007. A further 30.4 per cent came from private sources and 8.8 per cent was external development assistance, both an increase over the four years.

Additional analysis of private financing of health in Fiji is provided in the NHA report, noting that in 2010, the bulk of this comes from out-of-pocket expenditure and private health insurance, with an increasing contribution from non-government organisations (not included as DAH) working in partnership with the MOH. The overall share of total health expenditure derived from out-of-pocket expenditure in 2010 was 22 per cent. (MOH Fiji 2011).

[1] Conversion rates were US$=F$1.55 in 2008 and US$1=F$1.93 in 2010.

FIGURE 1. THE FLOW OF FUNDS IN THE FIJI HEALTH CARE SYSTEM, 2010.



Source: MOH Fiji 2011.

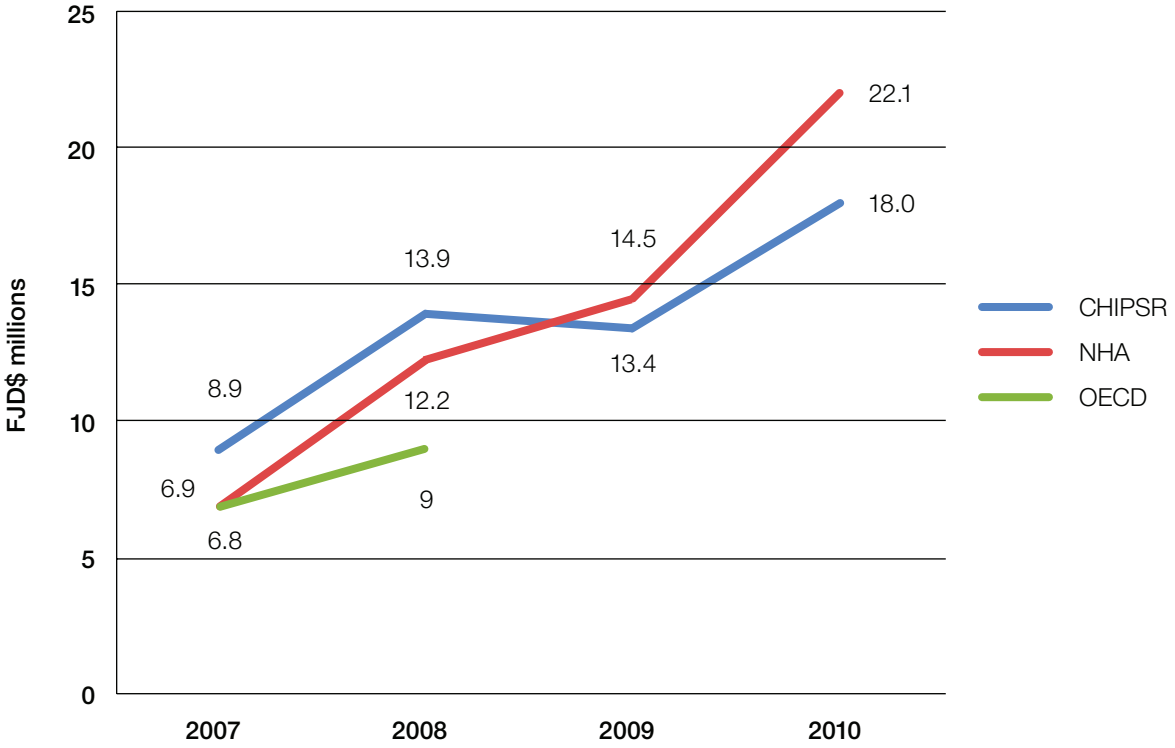
Figure 1, taken from the 2009/10 NHA report, describes the flow of funds in the Fiji health care system. This displays the place of DAH (in the figure referred to as "donor funding") in relation to other funding flows, with grants and loans supplied to government and mainly passed on to the Ministry of Health, and some grants provided to non-profit organisations.

Size of DAH: Comparing NHA with other data sources

The two Fiji NHA reports record a steady rise in DAH over the period 2007 to 2010. In absolute numbers, DAH rose from F$6.9 million in 2007 to F$22.1 million in 2010. As a share of total health expenditure, DAH more than doubled, from 3.4 per cent in 2007 to 8.8 per cent in 2010. However, there appears to be incomplete reporting in the NHA figures. NHA data collection relies both on routine reports collated by the government and on regular surveys of health providers and financing sources (including DAH), for which response rates vary.

For our own analysis, comparable health expenditure data was collected from two additional sources (see Figure 2). First, figures reported in a recent OECD/ Korea Policy Centre Technical Paper (Irava 2010) differ slightly from the NHA data, but tell the same general story. In the OECD report, external sources were listed

FIGURE 2. FIJI: TOTAL DAH BY YEAR, 2007-10



Source: Data from NHA, OECD and CHIPSR reports.

as providing F$6.8 million in 2007 (close to the NHA number) but only F$9.0 million in 2008 (compared to F$12.2 million in the NHA).

A second additional source was the CHIPSR analysis, which found that donors provided F$8.9 million in 2007 and F$13.9 million in 2008 (well above the NHA estimates) but only F$18.0 million in 2010 (well below the NHA estimates).

While these three sources of data all reflect a general upward trend in DAH in Fiji in 2007-10, the divergence in estimates in not easy to explain, except to say that the differences most likely reflect incomplete data collection in each case. The significant increase in DAH in 2010 (both NHA and CHIPSR data) is attributed mainly to additional funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. One main reason for inconsistency in the data is that the donor response to requests for expenditure data was sometimes incomplete.

Who is providing DAH?

Neither the 2007/08 NHA report nor the OECD report specified the source of external funding or the institution to which it was directed. However, the CHIPSR analysis did provide an initial description of the international origins of external financing for health in Fiji. As Table 1 indicates, the leading donor by far is AusAID. China, South Korea and the Global Fund follow as significant sources of DAH, after which are a number of multilateral and bilateral donors and other agencies. The government of Japan, which was the dominant donor in the early 2000s, is now no longer prominent.

As a result of the CHIPSR analysis, greater detail has been provided in the 2009/10 Fiji NHA report, which specifies the breakdown of contributions from various development partners. The 2009/10 report confirms AusAID as the single largest donor (F$13.3 million or 60 per cent of total DAH). The Global Fund (F$3.2 million)

TABLE 1. FIJI: DAH BY DONOR, 2007-10

Source of funds	F$ million	Per cent of total DAH
AusAID	25.84	47.7
China Aid	8.05	14.9
Korea Aid	6.74	12.4
Global Fund	4.87	9.0
WHO	1.97	3.6
UNFPA	1.48	2.7
NZAID	1.42	2.6
Government of Japan	1.10	2.0
Secretariat Pacific Community	0.64	1.2
UNAIDS	0.43	0.8
Government of India	0.36	0.7
UNICEF	0.32	0.6
QMIR - Australia	0.25	0.5
Melbourne University	0.17	0.3
Ministry of Trade	0.10	0.2
Government of Italy	0.09	0.2
Government of France	0.09	0.2
World Heart Foundation	0.08	0.1
Global Health Task Force	0.06	0.1
ANZ Bank	0.05	0.1
UNESCO	0.04	0.1
TOTAL	54.16	100.0

Source: CHIPSR analysis, as at June 2011.

and WHO (F$2.35 million) also remain significant funding sources. However, the 2009/10 NHA report shows only a small contribution by South Korea and no contribution from the Chinese government in 2010, but an increase in the contribution from the government of Japan (F$1.41 million).

How DAH is being spent

The revised procedures used in preparation of the 2009/10 NHA report make it possible also to estimate changes in the proportion of DHA being allocated through the government health sector. The data indicates an increase from less than 10 per cent of DAH in 2007 to more than 25 per cent in 2010 being channelled through the government.

Neither the NHA reports nor the CHIPSR analysis specify which disease conditions or health priorities DAH targeted or its geographic distribution.

The NHA reports do provide some data on the health sector functions to which DAH is allocated, with an increase in the amount of detail in the 2009/10 reports, following the CHIPSR analysis. The allocation of DAH to principal health system functions is listed in Table 2. In both years, the allocation is most significant as a contribution to preventive and public health services, providing more than a third of all funding in that area. In 2007, more than 60 per cent of all DAH was allocated to this area. At the same time, between 2007 and 2010

TABLE 2. ALLOCATION OF DAH FUNDING TO SELECTED HEALTH SYSTEM FUNCTIONS IN 2007 AND 2010

Health system function	2007			2010		
	F$ million	Per cent of total DAH	DAH as per cent of total for the function	F$ million	Per cent of total DAH	DAH as per cent of total for the function
Hospitals (curative care)	0.8	11.6	0.5	0.6	2.7	0.4
Prevention and public health services	4.2	60.9	37.9	3.6	16.3	34.7
Health administration and health insurance	1.7	24.6	8.4	7.2	32.6	28.9
Education/training of health personnel	0.0	0.0	..	4.0	18.1	..
Other	0.2	2.9	..	6.7	30.3	..
TOTAL	6.9	100.0	..	22.1	100.0	..

Source: 2007/8 and 2009/10 NHA reports.

there was a significant decline in hospital funding and a major increase in funding for health administration and insurance (with F$1.1 million from the Global Fund and F$$6.1 million from AusAID for the Health Sector Improvement Program) as well as education and training. The allocations categorised under health administration include contributions towards overall health service management, such as investments in improved health information.

How DAH is reported in NHA of other Pacific Island countries

This paper does not attempt a full survey of DAH contributions across Pacific Island countries. We did, however, review the Pacific Island comparisons in the Fiji 2009/10 NHA report and the NHA reports available for 2007 from Samoa (MOH Samoa 2011) and Vanuatu (MOH Vanuatu 2011) and for 2006 in Tonga (MOH Tonga 2008). The contribution of DAH to total health expenditure in each of these countries is listed in Table 3. Clearly, Fiji received significantly less DAH as a share of total health expenditure than other island countries.

The degree of detail regarding DAH contributions varies across reports, the highest level being found in the most recent Fiji NHA report. Both Samoa and Tonga provide some breakdown of the relative contributions of different donor agencies, but the Vanuatu NHA report does not. Dominant donor agencies in Samoa in 2007 are listed as the Japanese government, WHO, AusAID, New Zealand Aid and a World Bank health loan. In Tonga in 2006 the major donors are listed as a World Bank loan, WHO, AusAID, the European Union and NZAid. In both Samoa and Tonga, exact reporting of the relative contribution of different donors is not possible in the structure of these accounts. The significant increase in DAH share in Fiji is noted, and it will be important to track this for other Pacific Island countries as their NHA are updated.

None of the reports break down donor contributions by health themes and specific disease priorities, and none analyse the weight of DAH contribution to different health sector functions.

This latter element can be estimated from the data presented in NHA reports, to some degree. For example, the relative weight of DAH contribution to prevention and public health functions formed 34 per cent of this sub-sector in Vanuatu in 2007 (all for communicable disease control), 50.5 per cent of this sub-sector in Tonga in 2006 and at least 20.3 per cent in Samoa in 2007 (although due to unclear allocations, this proportion may be higher). This is consistent with the finding for Fiji.

DISCUSSION

Transparency is increasing, but further progress is needed

The NHA process now means there is increased reporting and transparency around funding flows, including external financing for the health sector. There is a successive increase in detail seen in the two Fiji NHA reports published in late 2010 and late 2011. This provides some authoritative information that can help understanding of the funding flows from DAH in the Pacific and a beginning of monitoring their influence on health programming.

TABLE 3. CONTRIBUTION OF DAH TO TOTAL HEALTH EXPENDITURE: VANUATA, TONGA, SAMOA, FIJI

	Total health expenditure (USD million)	Total health expenditure as per cent of GDP	DAH as per cent of total health expenditure
Vanuatu (2007)	20.5	3.7	16.5
Tonga (2007)	23.7	6.0	39.2
Samoa (2007)	33.0	6.2	21.4
Fiji (2007)	110.8	4.4	3.4
Fiji (2010)	134.8	4.8	8.8

Source: NHA reports

The health system functional categories in the NHA do allow assessment of the relative contribution of DAH to particular functions, although the PIC reports do not routinely calculate the relative weight of DAH in each category. This may be beneficial in the future, as our quick survey shows the heavy reliance on DAH for financing of prevention and public health programs. Our findings, which suggest that external donors provide around one-third of the total funding in this area, may correlate with a relative neglect of this area by other funding sources. These programs include some of the most cost-effective health services for disease control, primary health care and health promotion. These are important for overall population health, but may not be driven by community demand as much as curative services.

However, it is clear that additional work in this area is needed in Fiji and other Pacific Island countries in order to provide accurate data for tracking changes in funding flows and for comparison with government allocations for health. The discrepancies between NHA reports and estimates from other data sources suggest that, in some years, not all donor funds are being accounted for in the NHA. The NHA process, based on a survey sent to donors to which not all always respond, seems to have been improved in Fiji in its most recent NHA process, but is likely to benefit from further revision, as well as support from development partners, to improve government scrutiny of DAH allocations.

Tracking DAH contributions to specific priorities remains difficult

Where the level of detail on external DAH could be improved is to provide further disaggregation by technical or disease focus. This is especially important where donor agencies allocate funds to particular health priorities, such as malaria. However, the current structure of the system of health accounts does not automatically capture this. This is also difficult if weak national health information systems hamper tracking of disease-specific activities or allocations. This additional level of detail would assist in analysis of whether or how aid may be influencing health priorities (Negin 2010) and would increase accountability within health system accounting. Such detail could be a worthwhile addition to the NHA process, at least for Fiji, and it may be worth consideration in other Pacific Island countries.

Transparency and alignment in donor accounting are important

Collecting accurate data on the expenditure of development assistance for health is difficult. Despite commitment to the Paris Declaration, donor agencies and multilateral organisations are not as transparent with their funding information as they could be and not always well aligned with the accounting systems in use by partner governments. Different organisations use different financial years, count allocations in different ways and struggle to identify how much money is available in each country per year. Additionally, a significant proportion of external funding is allocated to donor-partner staff salaries, administration of donor funds or projects or fees for foreign technical assistance. It is therefore often difficult to estimate the proportions of donor funds that are inaccessible to partner governments for their health programs.

A significant improvement could be achieved through a concerted effort to align donor financial allocations and reporting with recipient government systems in two ways. Firstly by disease and health system priorities as described in government national health plans. Secondly, by functional categories as described in the government's national health accounts. This would also support calls within the Pacific (On, Bennet and Whittaker 2009) for better alignment of health information and data collection in general.

The Paris Declaration and Accra Agenda for Action (OECD 2008) call for greater use of government financial systems and more budget support. In Fiji, the government has now established a policy that all donor funds (for the health sector and otherwise) must be provided through the central treasury. While this is good for alignment, it does raise potential problems if various ministries compete for funding (sometimes with the justification of an 'emergency' in one sector or geographic area), and with the additional administration required. In terms of which agent is spending the funds, it is interesting that the 2009/10 Fiji NHA have been able to track the proportion of expenditure channelled through government systems, and it is encouraging that the trend is for an increase. It is also notable that this NHA report has been able to document the jump in administration resources that accompanies an influx of DAH funding. When funds are allocated through government systems, there is some risk

that government's own allocation to particular health priorities decreases—a major reason why additional work on tracking funding by functional allocation or disease is needed.

Although full implementation of aid effectiveness principles is still some way off, there is clear progress in the reporting for the health sector in Fiji. This has been supported by Fiji's contribution to the recent OECD survey aiming to monitor implementation of the Paris Declaration (OECD 2011b), which is Fiji's first participation in this process.

CONCLUSIONS

Lessons for policy-makers and health program managers

Several conclusions important to policy makers and managers ensue:

- The recently improved process of national health accounts in the Pacific offers new opportunities to examine trends in DAH and to monitor donor influences on health programs. For example:
  - An initial analysis shows an increase in DAH as a proportion of health expenditure in Fiji, and that DAH remains a major contributor in other countries.
  - A functional analysis shows a heavy reliance on external funding to support preventive and public health functions, which encompass some of the health sector's most cost-effective interventions.
- Some improvements in donor accounting and reporting, and in the NHA process, can help this initiative:
  - Development partners could improve expenditure reporting to national governments, to be timely and complete, to align with NHA health system categories and to provide additional disaggregation by health theme (specific diseases or other health priority).
  - Government health planners could refine their analysis of the expenditure reporting of DAH so they can better understand donor spending on specific disease priorities or types of health service delivery.

The ultimate aim of increased transparency is to improve aid effectiveness so that DAH becomes more predictable and better aligned with health priorities and systems in Pacific Island countries. This will assist governments with health sector planning and budgeting and, in turn, help development partners to contribute more effectively to areas of the health sector with the greatest need.

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