OECD DEVELOPMENT CENTRE

POLICY BRIEF No. 33

NEW ACTORS IN HEALTH FINANCING: IMPLICATIONS FOR A DONOR DARLING

by

Denis Drechsler and Felix Zimmermann

- Even "donor darlings" now have alternatives to ODA in financing their development.
- Developing-country ministries need new skills to monitor and co-ordinate multiple finance flows.
- Aid can help build these skills as a complement, not a substitute, to other sources of financing.

OECD DEVELOPMENT CENTRE
CENTRE DE DÉVELOPPEMENT
OCDE

POLICY BRIEF No. 33

New Actors in Health Financing: Implications for a Donor Darling

by

Denis Drechsler and Felix Zimmermann

ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

The OECD is a unique forum where the governments of 30 democracies work together to address the economic, social and environmental challenges of globalisation. The OECD is also at the forefront of efforts to understand and to help governments respond to new developments and concerns, such as corporate governance, the information economy and the challenges of an ageing population. The Organisation provides a setting where governments can compare policy experiences, seek answers to common problems, identify good practice and work to co-ordinate domestic and international policies.

The OECD member countries are: Australia, Austria, Belgium, Canada, the Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, the Netherlands, New Zealand, Norway, Poland, Portugal, the Slovak Republic, Spain, Sweden, Switzerland, Turkey, the United Kingdom and the United States. The Commission of the European Communities takes part in the work of the OECD.

OECD Publishing disseminates widely the results of the Organisation's statistics gathering and research on economic, social and environmental issues, as well as the conventions, guidelines and standards agreed by its members.

The Development Centre of the Organisation for Economic Co-operation and Development was established by decision of the OECD Council on 23 October 1962 and comprises 20 member countries of the OECD: Austria, Belgium, the Czech Republic, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Korea, Luxembourg, Mexico, the Netherlands, Norway, Portugal, Slovak Republic, Spain, Sweden, Switzerland, Turkey, as well as Brazil since March 1994, Chile since November 1998, India since February 2001, Romania since October 2004, Thailand since March 2005 and South Africa since May 2006. The Commission of the European Communities also takes part in the Centre's Governing Board.

The purpose of the Centre is to bring together the knowledge and experience available in member countries of both economic development and the formulation and execution of general economic policies; to adapt such knowledge and experience to the actual needs of countries or regions in the process of development and to put the results at the disposal of the countries by appropriate means.

The Centre is part of the "Development Cluster" at the OECD and enjoys scientific independence in the execution of its task. As part of the Cluster, together with the Centre for Co-operation with Non-Members, the Development Co-operation Directorate, and the Sahel and West Africa Club, the Development Centre can draw upon the experience and knowledge available in the OECD in the development field.

Also available in French under the title :
Les nouveaux acteurs du financement de la santé : quel impact pour un chouchou des bailleurs?

Table of Contents

Acknowledgements 4

Introduction 5

Recent Trends in Development Finance: New Actors, New Flows 5

Financing Health in Ghana – A Case in Point 11

Policy Implications: Learning from Country Evidence 20

Conclusion 27

Notes 29

Bibliography 30

Other Titles in the Series 33

Acknowledgements

The Development Centre gratefully acknowledges the financial support of the French Ministry of Foreign Affairs without which this study would not have been possible.

Introduction

With concern about how to finance the Millennium Development Goals (MDGs) widespread, recent donor pledges to raise aid volumes are welcome. However, aid alone will not suffice – bringing in new actors and sources of development finance will be essential. In many developing countries, this is already happening, creating new opportunities and challenges for their governments and donors.

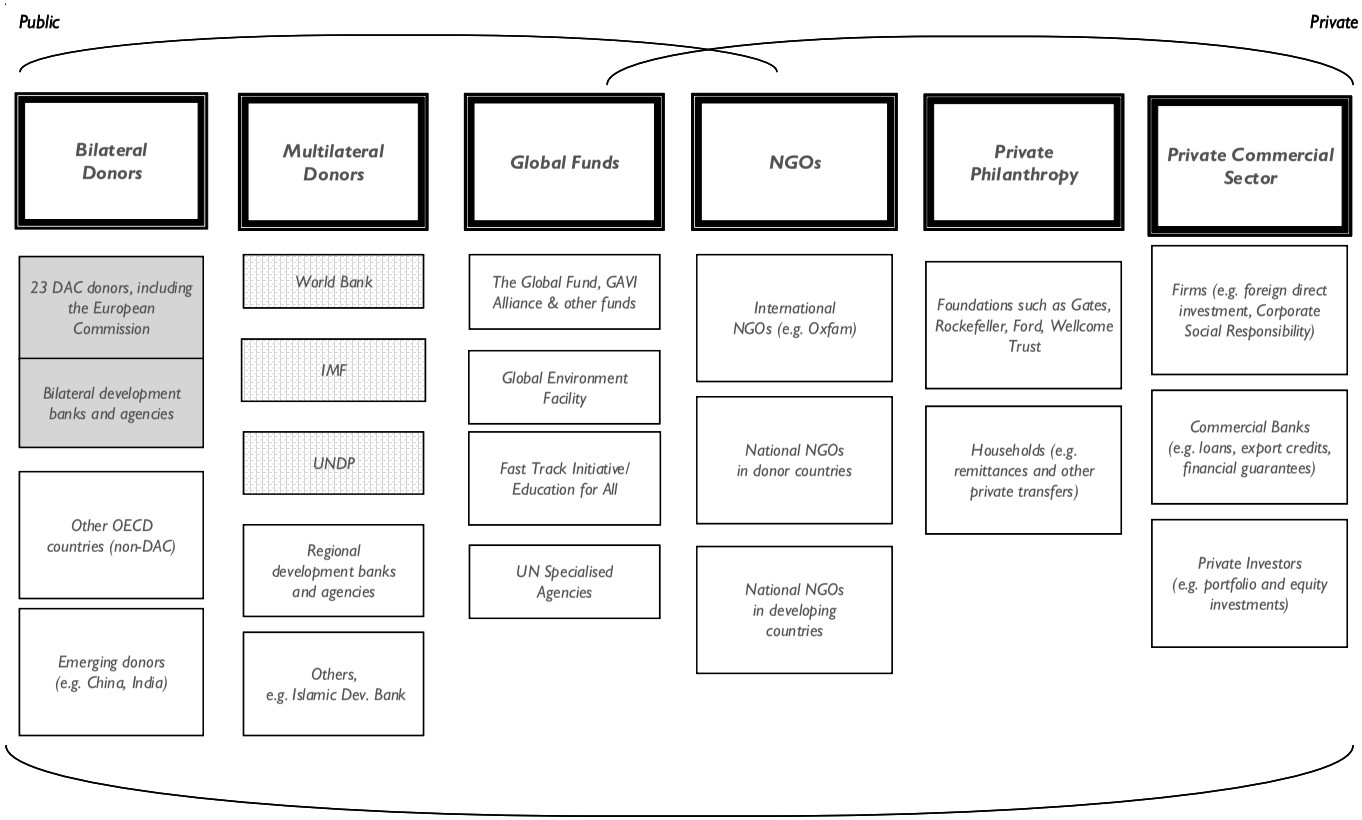
This *Policy Brief* examines trends in development finance, drawing on the experience of Ghana's health sector. It finds that, even for "donor darlings", where aid accounts for a large percentage of GDP, new sources of finance have become a credible alternative to Official Development Assistance (ODA). This has important policy implications. Though new sources of finance may have increased the overall financial envelope, they have also brought monitoring and co-ordination challenges. Indeed, findings from Ghana suggest that developing countries need stronger information systems to predict the various flows and to plan with them. For more effective finance, they also need co-ordination mechanisms that include the new funders. Finally, in order to take ownership of their own development process, developing countries must find ways to improve inter-ministerial co-operation and to address mismatches between budgets and spending.

The following section of this *Policy Brief* sketches general trends in international development finance, focussing on the emergence of important new actors and financial flows. The next section zooms in on health finance in Ghana, revealing that significant flows are not captured sufficiently by policy discussions at the country level. The penultimate section outlines three major challenges for effective development finance: strengthening information systems; improving co-ordination; and building ownership. The final section contains some concluding remarks for policy makers.

Recent Trends in Development Finance: New Actors, New Flows

By treating aid as just one of several finance flows and calling for the private sector to become more involved in development, the 2002 Monterrey Consensus and Johannesburg Declaration of the same year symbolised a shift in consciousness about international development finance. The implication and result is that important new actors, including private households, foundations and non-governmental organisations (NGOs) have joined bilateral and multilateral donors in financing development. Figure 1 gives an idea of the complexity of the new development finance system.

Figure 1. **The International Development Finance System**

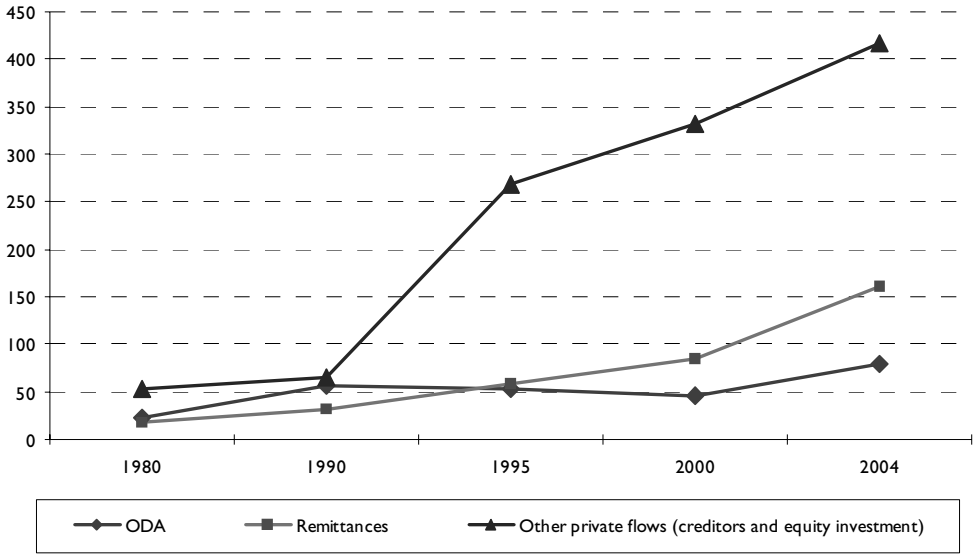


Source: OECD DAC and OECD Development Centre (2006).

Capital Inflows have Changed, but mostly in Emerging Economies

The past 25 years have seen remarkable changes in the composition of capital inflows to developing countries (Figure 2). Official Development Assistance (ODA) has almost quadrupled (from $22.4 billion in 1980 to $79.5 billion in 2004), but has fallen as a proportion of total developing country inflows, which include remittances, commercial loans and equity investment. Whilst ODA constituted around 35 per cent of total capital inflows in 1990, for example, it now accounts for less than 15 per cent.

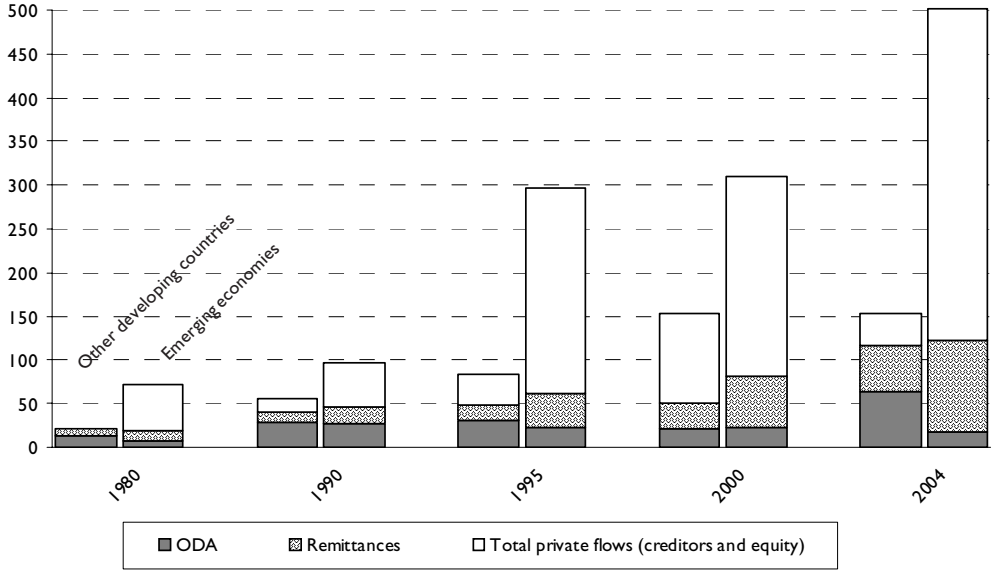
Figure 2. **Composition of Developing Countries' Capital Inflows**
(1980-2004, $ billion)



Source: Authors' illustration, based on data from World Bank, UNCTAD, IIF, OECD DAC.

However, these trends have not been experienced equally in all developing countries. Figure 3 highlights the distinction between emerging economies[1] and other developing countries (Lambert and Cogneau, 2006). Specifically, emerging economies such as Brazil, Mexico, Malaysia and Indonesia have enjoyed high levels of commercial bank loans, trade lending, and equity and portfolio investments. In poorer countries, the emergence of new flows has been less pronounced. But even there, ODA's share of total capital inflows has decreased from around 65 per cent in 1980 to just over 40 per cent in 2004.

Figure 3. **Composition of Capital Inflows in Emerging Economies and Other Developing Countries**
(1980-2004, $ billion)



Source: Authors' illustration, based on data from World Bank, UNCTAD, IIF, OECD DAC.

ODA Volumes Are Up, but Their "Real" Value Has Been Questioned

Aid remains central to international development policy, as documented by donor pledges for more and better aid at various summits in 2005. After declining throughout the 1990s, ODA has increased since the turn of the century, following the adoption of the MDGs. The OECD (2006a) reports an increase of aid to $106 billion in 2005, representing a real increase of 8.7 per cent from the previous year. This follows annual increases of 5.9 per cent, 7 per cent and 3.9 per cent between 2002 and 2004 (Pearson, 2004). In view of these developments, the OECD believes that the increase of around $50 billion to $130 billion by 2010, promised by the European Union and the G8, can be achieved.

However, a closer look at the breakdown of recent aid increases reveals that a large proportion can be attributed to debt relief and special-purpose grants (Chervalier and Zimet, 2006). Special-purpose grants are crucial for the reconstruction of damage caused by disasters such as the 2005 tsunami, but are

not necessarily targeted to the achievement of the MDGs. Similarly, debt relief – under the Heavily-Indebted Poor Countries (HIPC) initiative or Multilateral Debt Relief Initiative (MDRI) – does not necessarily free up money for development and has, for the most part, benefited a small number of large countries, including Iraq (receiving nearly $14 billion in the form of debt forgiveness grants in 2005) and Nigeria (with a little over $5 billion). As argued by the OECD (2006*a*), aid figures are blurred by this "debt relief bubble". Moreover, the fact that Iraq has benefited from increased ODA is also evidence of the growing influence of security issues on ODA allocations.

Private Actors are Entering the Scene

In addition to loans and investment, remittances from private households have emerged as a major source of capital to developing countries. Despite significant discrepancies in the data, several surveys have shown that, in some countries, remittances account for 15 per cent or more of GDP (World Bank, 2006; United Nations, 2006). There is growing evidence that they are contributing to the achievement of the MDGs: household surveys in several countries have shown that remittances are partly used to fund education, nutrition and health (Katseli *et al.,* 2006; Cox and Ureta, 2003).

Private companies and foundations are also playing an increasing role, though their contribution to international development programmes is difficult to quantify. Financial support from major foundations, for example, is mostly spent in their countries of origin. Their international support is largely channelled to developing countries indirectly, for example via multilateral organisations. This runs the risk of double-counting development finance. A contribution from a foundation may be attributed to the private sector and to the public sector, as flows from multilaterals are considered as ODA by the OECD DAC Creditor Reporting System (OECD, 2003). In order nevertheless to give an example of the magnitude of private philanthropy, the International Federation of Pharmaceutical Manufacturers and Associations reports the contributions of the ten major companies that have donated products to the Partnership for Quality Medical Donations since 1998 at $2.7 billion (IFPMA, 2004 and 2005; see also Hudson Institute, 2004; PhRMA, 2003).

Of the many philanthropic organisations active in developing countries, the Bill and Melinda Gates Foundation is perhaps the most well known, having disbursed $1.4 billion in grants by December 2005, with programmes in global

health ($843 million) and education ($284 million), as well as initiatives in global development, global libraries, financial services for the poor, agricultural development, water, sanitation and hygiene ($228 million). In terms of funds spent abroad, the Ford Foundation is the largest US foundation involved in financing development.

The Distinction Between Public and Private Financing is Blurry

NGOs are an example of organisations that bridge the divide between public and private finance. Some provide autonomous financing, raised, for example, from private donations. Others do not act as finance sources, but as implementing agencies or service deliverers in projects financed by the public sector, including ODA. In 2002, transfers to NGOs amounted to $1.2 billion in ODA, an increase of 34 per cent compared to 1992 (Epstein and Gang, 2006).

The public-private divide is also spanned by so-called global funds, public-private partnerships that have been set up over recent years to spark action around specific global challenges such as the health and education MDGs. Their budgets are now considerable. The Education for All Fast Track Initiative (EFA-FTI), for example, has disbursed $115 million to low-income countries through its Catalytic Fund, linking the initiative's funding to the MDG of universal primary education. The Global Fund to Fight Aids, Tuberculosis and Malaria ("The Global Fund") and the Global Alliance for Vaccines and Immunization ("The GAVI Alliance") have been very active in the health sector. By December 2005, the GAVI Alliance had disbursed $603 million since its launch in 2000; the Global Fund has disbursed $2.38 billion since 2002.

In spite of these large volumes, questions remain about whether global funds have increased overall flows to developing countries (Reisen, 2004). Arguably, public finances through global funds could equally have been directed through existing channels such as the World Bank. Moreover, the hope that the funds would catalyse private financial contributions has also failed to materialise. Though private contributions to global funds should not be disregarded – in the case of the GAVI Alliance, they even surpassed public sector contributions during its first two years – their funding is still composed largely of conventional bilateral and multilateral ODA. Private contributions to the Global Fund, for example, constituted only 3 per cent of total pledges in 2004, coming from foundations (e.g. Gates), multinational companies (e.g. Winterthur) and private individuals (e.g. Kofi Annan).

Financing Health in Ghana – A Case in Point

Whilst awareness of global trends in development finance is relatively high, less is known about how these trends have translated into changes at the country and sector level.

Ghana's significance as a country survey arises from its political stability and status as a low-income country that is still largely aid dependent. It is a donor darling: its ODA-GDP ratio lies at around 12 per cent (2003) and ODA easily remains the dominant capital inflow. It is also worth noting the country's strong commitment to international endeavours to improve aid effectiveness, which shows that it considers aid a high priority[2]. The health sector is of interest for a case study as the social sectors are an important target not just for ODA, but also for financial flows from new actors, including foundations and global funds. ODA for health and education, linked to the achievement of MDGs 2-6, has risen by 68 per cent between 2000 and 2004 (OECD, 2006).

Our study of health finance in Ghana offers interesting evidence that, even for a donor darling, and even in a sector that benefits from large ODA volumes, new actors and flows of development finance are manifest. Following a short overview of health performance and policies in Ghana, this section will examine the diverse sources of health financing. In doing so, it will discuss the official budget of the Ministry of Health as well as other finance flows.

An Overview of Health Performance and Policy in Ghana

Ghana pursues an agency model in the health sector, which separates policy making from service delivery. The Ministry of Health (MoH) is responsible for the overall health strategy and the monitoring of health outcomes; the Ghana Health Service (GHS) co-ordinates health care delivery and disease surveillance. The Ministry follows a five-year Programme of Work (currently 2002-2006), which spells out long-term objectives, strategies and targets for the health sector. It aims at partnership with donors, other ministries, departments and agencies, the private sector, NGOs, communities and individuals. An update of the Programme is developed annually to integrate lessons learned and readjust policy objectives.

After "relatively good health outcomes for modest expenditure of resources" (2003 Health Review, MoH, 2004), more recent reviews of Ghana's health sector performance have reported mixed results. Several improvements between 1997 and 2005 have been encouraging: under-five malaria mortality rates declined, tuberculosis cure rates improved, the proportion of supervised births increased,

and the number of recorded Guinea Worm cases fell significantly. However, the 2005 Health Review refers to "stagnation in health outcomes and service delivery volumes" (MoH, 2006). Essential health indicators like child and infant mortality rates remained stagnant, or even deteriorated. Hospital admission rates remained low, bed occupancy rates decreased, and the ratios of doctors to nurses to population declined further. This may be a symptom of brain drain in the health sector, which reflects both the high reputation of Ghanaian health workers abroad and the difficulties faced in retaining them in the country (Quartey, 2006).

Apart from human resource management, a major challenge for Ghana's health sector is the unequal distribution of health care delivery across the country. There are severe disparities among regions and districts and between rural and urban areas in terms of health care quality and access to services. As a result, diseases like malaria are significantly more prevalent in rural than in urban areas.

The recent stagnation in health indicators is particularly striking given exponential increases in the Ministry of Health's budget, which almost quadrupled between 2001 and 2005. As will be discussed below, problems are clearly not related to finance alone. The stagnation is also remarkable since the priorities set out in Ghana's health strategies appear to correspond well with the sector's major challenges. The Programme of Work identifies four main areas of intervention: Personal Emoluments, Administration, Health Services, and Investments in Health Infrastructure. As confirmed by most of our interviewees, the strategic documents prepared by the Ministry in co-operation with donors are generally of high quality and target the right challenges.

Flows and Actors in Ghana's Health Sector

Identifying and quantifying the variety of health finance flows is a challenging exercise. Where data are available, they are not collected or managed systematically as Ghana lacks a central entity responsible for carrying out these tasks. Accordingly, even the Ministry of Health acknowledges that its figures must be treated with care (MoH, 2006). Often, particularly in the case of flows that bypass the Ministry's budget, data are not even available.

The information collected for this study was gathered from a variety of sources, including the Ministry of Health, the Ministry of Finance and individual donor organisations present in Ghana. Information on foundations, NGOs and other philanthropic organisations was gathered by contacting major players from each group. As these entities – especially foundations and other philanthropic organisations – are often not physically present in Ghana, a questionnaire was sent to their international headquarters.

Two Pictures of Health Finance in Ghana

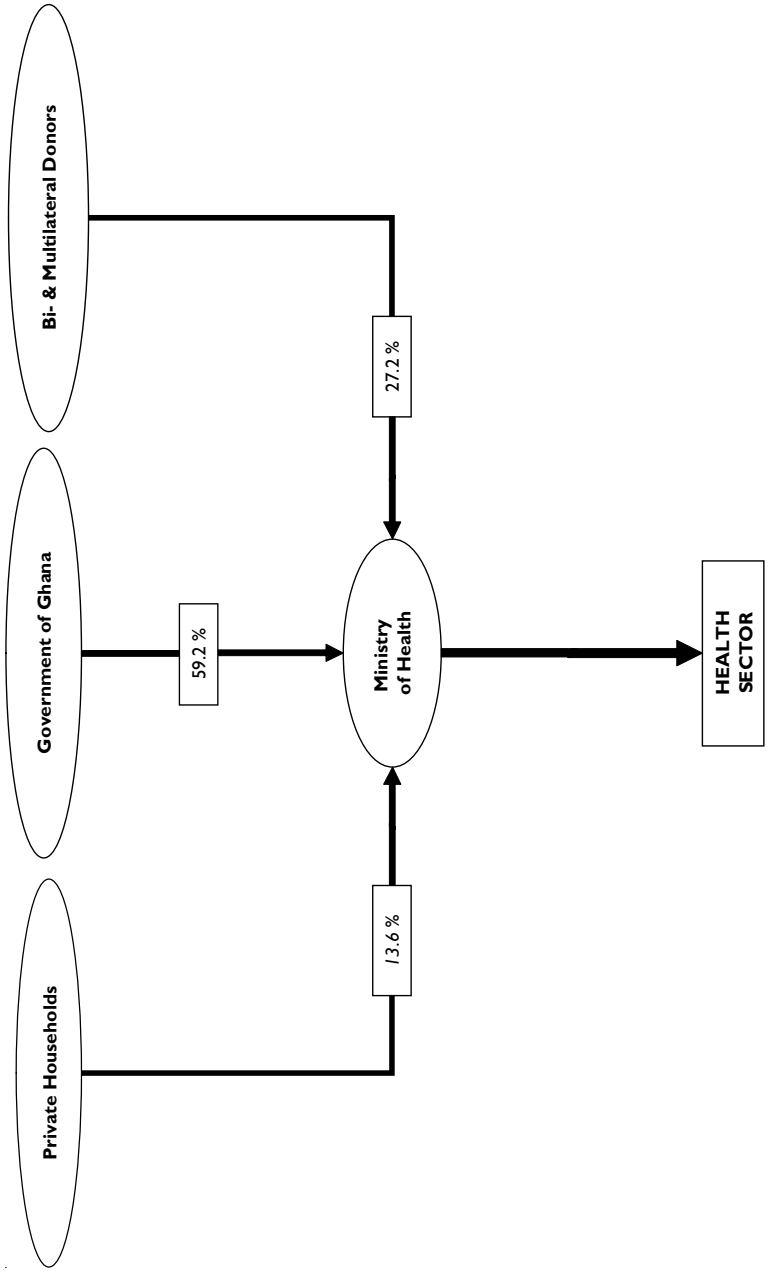
As illustrated in Figure 4, the budget of the Ministry of Health distinguishes between three sources of funding: allocations from central government (which accounted for 59.2 per cent of the Ministry's total budget of $435 million in 2005), support from bilateral and multilateral donors (27.2 per cent) and internally generated funds from private households (13.6 per cent).

The distinction between three sources of health finance, used in most government documents, paints a simplified picture, which does not capture adequately the various financing channels and actors in Ghana's health sector (Figure 5). Firstly, it is important to understand that funds from central government are derived from different sources, including foreign ones. Secondly, donors use diverse channels to achieve health outcomes. Thirdly, a large degree of private finance bypasses the Ministry of Health's budget. Finally, new actors such as foundations, global funds and NGOs have important roles to play in financing health.

Funds from Central Government are Derived from Different Sources

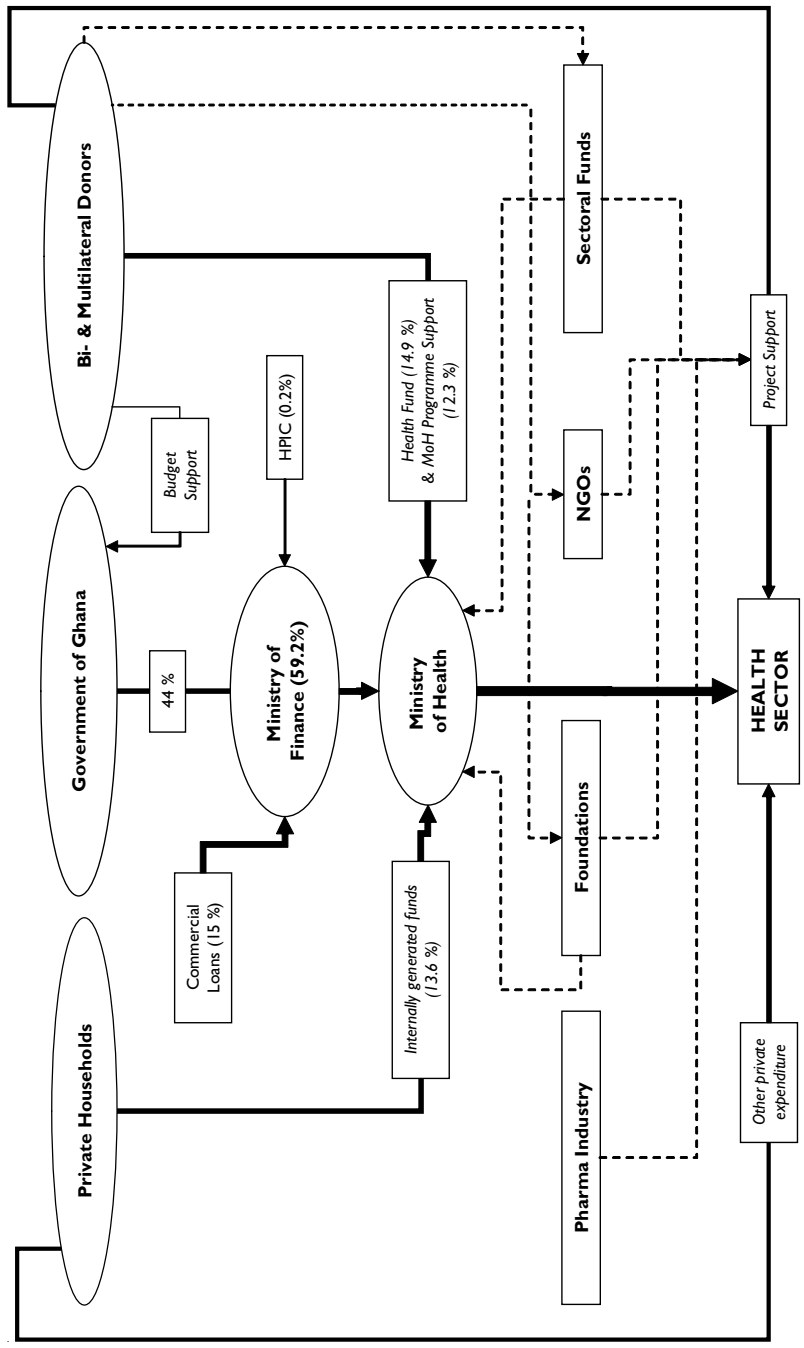
Rising allocations from central government have allowed Ghana to reach the 2001 Abuja Declaration target of allocating 15 per cent of the annual budget to improvements in the health sector. Derived mostly from national sources, these allocations are augmented by three foreign sources. To begin with, a number of donors (including the World Bank, the United Kingdom, the EU and the African Development Bank) have begun using general budget support as an aid modality through the Multi-Donor Budget Support (MDBS) initiative. As budget support has generally not been tied to specific sectors, measuring the extent of its use for health is practically impossible. The share of health finance channelled through central government is likely to increase in the future as several donors are currently considering a move to budget support. Other sources of central government allocations to the health sector include commercial lending (15 per cent) and debt relief (0.2 per cent, from the Heavily-Indebted Poor Country [HIPC] initiative).

Figure 4. **A Basic Picture: the Ministry of Health's Budget**



Source: Authors' illustration. Percentages are derived from MoH (2006*a*).

Figure 5. **A Complex Picture of Actors, Channels and Flows**



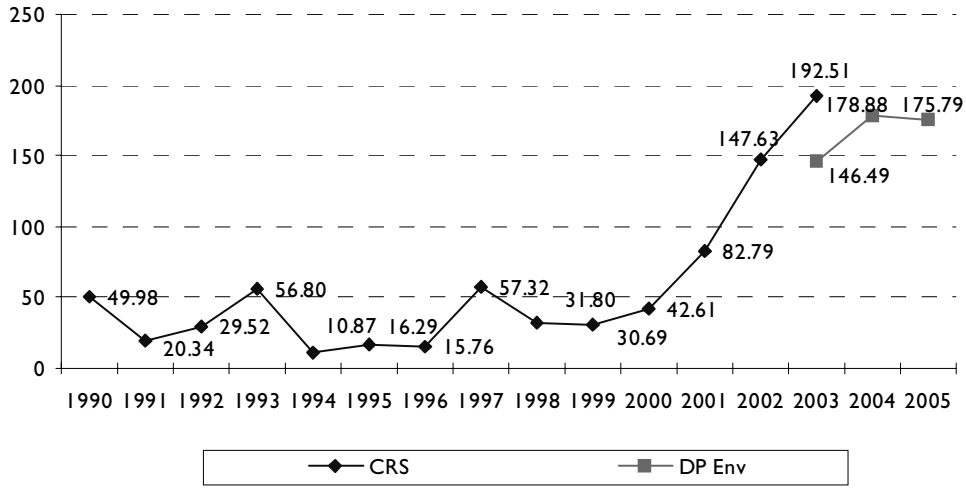
Source: Authors' illustration. Percentages are derived from MoH (2006*a*) and concern 2005.

Donors Use a Diversity of Channels for Aid

Donors have an important stake in the health care sector in Ghana, providing 27.2 per cent of the Ministry's budget. Their support for health increased six-fold between 1999 and 2003, from $30.7 million to $192.5 million (Figure 6). This can be seen as part of a larger global shift of ODA towards the social sectors, encouraged by the adoption of the MDGs and the Poverty Reduction Strategy Initiative of the World Bank.

It is worth noting, however, that the volumes actually disbursed in Ghana may differ from those pledged and reported to the DAC. In 2003, for example, ODA disbursements confirmed by local development agencies lay significantly below DAC figures (Figure 6). The primary reason behind such discrepancies is that local agencies will not necessarily have figures for aid that is not channelled through or managed by them. This may include the remuneration of experts providing technical assistance in Ghana's health sector, or scholarships to Ghanaian medical students at universities in donor countries.

Figure 6. **Official Development Assistance to Ghana's Health Sector**
($ million)



Source: Authors' calculation based on the DAC Creditor Reporting System (CRS) 2006 and Ghana Development Partner Envelope Overview (DP Env) 2006.

Of the 19 donors active in Ghana's health sector between 2003 and 2005, the largest were the World Bank ($136.9 million), the Netherlands ($103.9 million), the United Kingdom ($71.4 million), the United States ($59.9 million) and Denmark ($37.8 million). At 60 per cent of overall ODA, bilateral donors delivered more aid than multilaterals. Most donors have moved to grants to deliver aid, with loans constituting only one quarter of ODA and delivered by only four donors – the World Bank, the Nordic Development Fund, Spain and the African Development Bank.

The bulk of aid for health is now being delivered at the sector level. A Sector-Wide Approach (SWAp) includes all but two of the country's 19 donors, several of which are also pooling funds in a shared health account administered by the Ministry of Health. As Hecht and Shah (2006) argue, the Ghana Health SWAp constitutes a "prime example" of a health sector support programme.

Finally, aid for health is also being delivered further downstream in the form of project support for local implementing organisations. Indeed, some donors such as the Japan International Co-operation Agency rely exclusively on this aid channel.

Private Financing Often Bypasses the Ministry's Budget

Health financing in Ghana is partly based on a cash-and-carry system, requiring users to pay for a proportion of health services out of their own pockets. Funds from private households, in the form of user fees for drugs and other consumables, constitute 13.6 per cent of the budget of the Ministry of Health. However, WHO figures suggest that households' contributions through the Ministry's budget are dwarfed by those that bypass the budget. According to the WHO National Health Account initiative, between 1998 and 2004, private spending constituted around 65 per cent of the total expenditure on health in Ghana compared to the public sector's contribution of 35 per cent (WHO, 2005).

Remittances, the single most important private capital inflow to Ghana, have become a major contributor to household income and, indirectly, to household expenditure on health. However, figures from various sources differ greatly. For 2005, the IMF's Balance of Payments Statistics report private transfers at below $100 million, whilst the Bank of Ghana reports a vastly higher figure: $1.52 billion. The latter figure is based on household surveys, which may provide a more accurate picture as it includes informal transfer channels not captured by the IMF. Although the use of private capital inflows cannot be determined with certainty, evidence from Ghana suggests that remittances help households cover emergency expenses, for example in the case of major illnesses (USAID, 2005).

New Actors Have Begun Financing Health

Figure 5 shows new actors that have begun financing health in Ghana. We identified important flows from non-governmental organisations (NGOs), global funds, private donors, the pharmaceutical industry and private foundations, as well as private commercial capital flows.

Non-governmental organisations (NGOs): As estimated by the National Coalition of Health NGOs, 400 NGOs are active in the Ghanaian health sector, with a large majority acting as implementing agencies for donor-funded projects. This means that their self-generated financial contribution to the sector is minimal. Nevertheless, their proximity to local institutions and marginalised individuals, especially in remote areas, renders them a crucial part of the health care system. Faith-based NGOs such as the Christian Health Association of Ghana (CHAG) or the Catholic Secretariat, which represents the Catholic Church, are particularly important in Ghana.

Global Funds: Global funds have had a tremendous impact on health sector finance in recent years. The two largest global funds in the Ghanaian health sector are the Global Fund and the GAVI Alliance. Since 2000, the former has disbursed $42 million of the $93.4 million pledged in its grant agreement with Ghana, directing funds to fighting malaria (44 per cent), HIV/AIDS (36 per cent) and tuberculosis (20 per cent)[3]. The GAVI Alliance has disbursed around $20 million to Ghana since 2000, targeting hepatitis B (a total of $45 million pledged) and yellow fever ($4.5 million) in a multi-year immunisation plan (2002-2006), and providing cash support for immunisation services ($3.6 million) and injection safety ($855 000).

Private donors: It is particularly difficult to determine an exact figure for private donations. They are neither recorded systematically nor captured by national statistics. According to the Ministry of Health, it administered a total of $176 million in financial and in-kind donations between 2004 and 2005. Although these numbers must be treated with caution, they show that private donations constitute a considerable inflow to the sector; especially bearing in mind that the Ministry's total annual budget (excluding donations) amounted to only $435 million in 2005. It must also be noted that some private donors use informal financing channels, meaning that the magnitude of Ghana's total receipts is almost certainly even larger. The Catholic Secretariat, for example, reported donations of $160 000 in 2004.

The pharmaceutical industry: Of the 14 pharmaceutical companies contacted, only one (Pfizer) provided details of programme support through in-kind contributions. In 2005, the company delivered $1.6 million worth of Zithromax® to fight trachoma *[International Trachoma Initiative*] and $320 000 worth of Diflucan® to fight opportunistic infections, i.e. infections that predominantly affect people with a poorly functioning or suppressed immune system [*Diflucan® Partnership Programme*]. Pfizer also engages in Ghana through the Pfizer Foundation, which provides grants for training and capacity-building activities in the health sector. Other pharmaceutical industry activities have been captured by the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA, 2004 and 2005). Thus, GlaxoSmithKline supports malaria prevention in Ghana through the African Malaria Partnership and Merck & Co. has supported the dissemination of health care materials, together with the International Council of Nurses and Elsevier Science. Finally, Abbott Laboratories and Boehringer Ingelheim have donated Viramune® and Determine® within the framework of their joint initiative for the Prevention of Mother-to-Child Transmission of HIV.

Private foundations: Information on the activities of foundations in Ghana remains incomplete. Among the eleven foundations contacted, the Gates Foundation appears to be the largest sponsor of health-related projects. It granted $16.4 million between 2000 and 2005[4]. The Rockefeller Foundation reports $3.4 million in grants to Ghana between 1999 and 2005, including projects by the Ministry of Health, the Forum of African Women and the University of Ghana. European foundations are also gaining in importance. The UK-based Wellcome Trust, for example, granted $903 000 to Ghanaian health projects between 2000 and 2006.

Private commercial capital flows. Like many other low-income countries, Ghana has not yet attracted large amounts of private commercial capital. Although the importance of Foreign Direct Investment (FDI) is gradually growing, these investments have predominantly concentrated on the mining and manufacturing industries, with no investment projects identified in the health sector. Commercial bank loans, on the other hand, are important when used to finance health infrastructure projects. In 2005, they constituted 15 per cent of the total budget of the Ministry of Health.

Policy Implications: Learning from Country Evidence

As seen above, even those low income countries with high ODA-GDP ratios can experience a diversification of capital flows. This section argues that such a diversification requires greater consideration in policy planning and implementation. Drawing on our experiences in Ghana, it highlights three urgent challenges for developing countries and donors: strengthening information systems, improving co-ordination mechanisms and building developing country ownership. Policy implications are provided following each subsection.

Strengthening Information Systems for Better Planning

In order to craft effective policies and plan with longer time horizons, developing country governments require reliable and predictable information on development finance flows. The growing importance of new funders has increased the need for an information system that tracks both conventional and new development finance flows.

The aid community has already recognised the potential value of better information on ODA disbursements. In recent years, donors have been called upon to make their aid more predictable by extending commitments over longer time horizons and linking disbursements to more transparent performance indicators (Chowdhury and McKinley, 2006). Preliminary results from a DAC Survey indicate that a majority of DAC donors is now in a position to discuss multi-annual financial envelopes at country-level. However, these donors only account for 25 per cent of total ODA (Carey, 2006). Our evidence from Ghana is encouraging. Ghana's health SWAp has managed to align donor commitments with the Programme of Work of the Ministry of Health over a five-year period.

Global funds appear to be following suit. Several are providing more predictable financing, even though their own budget situation can be volatile, as their replenishments rely heavily on funding from aid donors. The GAVI Alliance, for instance, is able to make five-year funding commitments. However, it must be noted that the Alliance also applies a sunset clause. This means that, after five years, funding may cease, leaving developing countries with exorbitant costs if they want to continue related programmes. In another sector, the Global Environmental Facility (GEF), has been criticised for a lack of transparency following its adoption of a new resource allocation framework. The new criteria for funding do not seem to have been communicated sufficiently to local actors. In Ghana, where these criteria have led to a significant reduction in funds, implementing partners have expressed apprehension about future funding levels.

The flows of global funds are being tracked closely, largely because both governments and donors are heavily involved in their activities. The same cannot be said about financial flows from other new actors, such as NGOs, foundations and private households. On the contrary, their emergence has compounded difficulties in monitoring capital inflows. Public entities such as the Ghana Planning Commission have neither the resources nor the mandate to collect adequate information. The Ministry of Health also faces capacity constraints, particularly in monitoring private flows. As was seen above, the reliability of its figures, particularly on private donations, is highly questionable.

Of even greater concern than this inadequacy of information is the apparent reluctance, by the Ghanaian government and most donors, to acknowledge the potential value of private flows for social and economic development. Studies on Ghana have shown that remittances and private donations, for example, are strongest in times of economic turbulence, helping to reduce income volatility of households (Quartey and Blankson, 2004). Despite indications that private flows are an important contributor to health finance, several of our interviewees did not consider their value significant enough for inclusion in national policy dialogue and budget discussions.

Box 1. **The National Health Insurance Scheme in Ghana: Strengthening Domestic Resources for the Health Sector**

Households in many developing countries face the constant risk of having to finance the treatment of serious illnesses directly out-of-pocket. Health insurance systems, both public and private, based on pre-payment or risk-pooling, could help alleviate the exposure to these risks significantly (Drechsler and Jütting, 2005).

The Ghanaian government has recently introduced a National Health Insurance Scheme (NHIS), in the hope of easing the overall burden borne by private households. The law underpinning the NHIS will make membership of an insurance scheme compulsory, with households expected to make premium payments in line with their "ability to pay" (www.ghana.gov.gh). With insurance schemes so far only having existed at the community level, the ultimate aim is to make the NHIS the main purchasing mechanism for health services throughout the country.

This well-intended initiative is not yet founded on solid grounds, with doubts having been voiced regarding its financial sustainability (ILO, 2006). As stated in their interviews with us, NHIS managers believe that contribution levels may have been set at unsustainably low levels given the costs of the scheme. Determining acceptable contribution levels will be a key challenge and will rely on better information on household income. Further information would allow the government to make a better distinction between those who could pay higher contributions for quality packages, and those who must remain exempt from payments, which currently include the core poor, indigenous people and children with insured parents.

Improved information about private flows and more evidence about their impact on development could assist developing countries in policy making. In Ghana, for example, household surveys on private health spending, which is partly funded by remittances, could support the current establishment of a new private health insurance scheme (Box 1). Specifically, better measures of household income, including remittances, would allow the government to calculate contribution levels that guarantee the financial sustainability of the scheme.

Implications

- Conventional donors and new funders should continue efforts to provide forward information and extend the time horizons of their programmes;
- Governments, assisted by donors, should strengthen information systems to improve budgetary planning, including new financial flows and information from the household level.

Improving Co-ordination for More Effective Development Finance

The endorsement of the Paris Declaration on Aid Effectiveness by over 100 government and agency representatives in 2005 signalled an international consensus that, in addition to higher aid volumes, higher aid effectiveness would be needed in order to achieve the MDGs. At the heart of the Declaration lies the call for better co-ordination between stakeholders in aid.

Progress by donors in co-ordinating their activities with each other (harmonisation) and with developing countries (alignment) has been encouraging. However, these co-ordination efforts must also extend to new actors, including global funds, NGOs and foundations.

Progress in Harmonisation and Alignment is Encouraging

Many donors have ceased financing individual projects and begun using more harmonised means, such as budget and sector support, to deliver their aid. A further sign of progress has been the establishment of government-donor co-ordination bodies at country level.

In Ghana, for example, general donor co-ordination has been fostered by a Consultative Group, initiated in 1997. In November 2005, the Group agreed on an "Aid Harmonisation and Effectiveness Matrix", which details donor and government commitments, as well as targets related to harmonisation. Nine donors have entered into the new Multi-Donor Budget Support arrangements (HLF, 2006). Some donors have also begun using forms of conditionality that tie funding to agreed results and allow the government to choose its own approach in achieving them. The US Millennium Challenge Corporation is the most prominent example, having recently signed an agreement with Ghana for $547 million over five years.

At the sector level, the shared health account and health SWAp, with joint annual reviews and financial reporting, have brought welcome progress. However, further efforts are required in harmonising donor activities. The distribution of insecticide-treated bed nets in the fight against malaria in Ghana is a case in point. The US-funded Netmark partnership hopes to promote a sustainable market for bed nets by gradually transferring the cost of their purchase to consumers. Other donors, including UNICEF, are distributing bed nets free of charge. Regardless of the merits of either approach, more co-ordination between donors is imperative, as their activities are obviously contradicting each other.

Further co-ordination gaps become evident when the priorities of donors do not match the needs of recipient countries. Thus, studies on the health sector have shown that donors often favour HIV/AIDS programmes even in those countries where addressing other diseases may be a more urgent priority (MacKellar, 2005). In countries where ODA still plays a dominant role, these donor preferences have a large influence over policy making. We found evidence of this in Ghana. For example, although malaria is the single most important health problem, accounting for 40 per cent of outpatient visits, no counterpart institution to the Ghana Aids Commission has been established to address this disease.

New Actors Should Join Harmonisation and Alignment Efforts

Co-ordination efforts are more effective when all significant actors participate in them. Indeed, the Paris Declaration encourages the participation of civil society and the private sector in aid co-ordination. In the Ghanaian health sector, however, a number of interviewees claimed that progress in including NGOs and foundations in national co-ordination had been slow. Interestingly, the mechanism that received the most praise for involving the private sector was introduced by

the Global Fund, itself a new actor. The Global Fund requires recipient countries to form a Country Co-ordinating Mechanism (CCM), which brings together various stakeholders to take allocation and management decisions. By including several civil society representatives in its meetings, the CCM shows that new actors can make a positive contribution to a more effective and comprehensive development finance system.

A greater challenge for global funds relates to the co-ordination of their activities with recipient country governments and other donors. The importance of their alignment with country systems is singled out in the Paris Declaration and has been chosen as a major theme for the OECD Global Forum on Development. In Ghana, some progress is being achieved. The Education for All Fast Track Initiative, for example, appears to be aligned well with the Education Sector Strategic Plan. Similarly, the Global Fund co-ordinates closely with the Ghana Health Service and disburses funds at the sector level.

Though alignment is progressing, global funds, particularly those active in health, have attracted a large degree of criticism for contributing to a proliferation of co-ordinating bodies at country-level (McKinsey & Company, 2005). Thus, the Global Fund has been criticised for making the establishment of its CCM an *a priori* condition for financial support rather than using existing co-ordination mechanisms. The duplication of activities among various mechanisms has resulted in tensions and a lack of clarity about respective roles and responsibilities. HIV/AIDS matters, for instance, are now discussed in a proliferation of meetings, including those of the Ghana Aids Commission (GAC), the Partnership Forum, the Business Meeting, the UNAIDS Technical Working Group, the GAC Sub-Committee, the Regional Aids Committee, and the District AIDS Committees.

Implications:

- Despite progress in raising aid effectiveness, problems in reconciling mixed priorities must be addressed, both among donors and between donors and recipient countries;
- Global funds, which have exacerbated co-ordination problems at country level, should be encouraged further to adhere the principles of the Paris Declaration;
- Other new actors, such as NGOs and foundations, should participate actively in country-level co-ordination mechanisms.

Building Developing Country Ownership

As shown above, stronger information systems and better co-ordination could make development finance more effective. However, as recognised in the Monterrey Consensus and the Paris Declaration, the underlying challenge for both developing countries and donors goes beyond more and better finance. It involves raising poor countries' ownership of their development process. In Ghana's health sector, we identified two major hurdles in the pursuit of ownership. Firstly, governments must improve inter-ministerial co-ordination. Secondly, they must address mismatches between budgets and spending.

Governments Must Improve Inter-ministerial Co-ordination

The international debate on harmonisation and alignment largely revolves around the behaviour of external actors. If recipient country governments are to take the lead in managing their development finance, however, they must improve co-ordination and communication between their own national public entities. This will become even more urgent if donors move to aid systems that rely heavily on the inter-ministerial distribution of funds.

In Ghana, general budget support is expected to become the dominant instrument for aid delivery. This will have large implications for the financing of health. In contrast to the current system of sector support, the Ministry of Finance, rather than the Ministry of Health, will be the main recipient and administrator of aid for health. The Ministry of Health will therefore face competition from other line ministries and will need to communicate and negotiate more effectively with central government in order to secure funding. These are skills that were not required of the Ministry in the past, given its direct support through sector-based funding. As a consequence, inter-ministerial co-ordination has remained weak, while effective communication with the Ministry of Finance has been practically non-existent, according to our interviewees.

For the Ministry of Health, the move to budget support may thus constitute a "shock", the effects of which are difficult to foresee. On the one hand, new pressures to secure funding may prompt the Ministry to integrate better communication and negotiation skills into its day-to-day activities. On the other, as is feared by the Ministry and several donors, the move to budget support could result in a decline in funding for the health sector. In order to cushion the effects of such a decline, some donors are already considering the option of earmarking parts of their budget support for the health sector.

Governments Must Address Mismatches between Budgets and Spending

Of the twelve indicators agreed upon for monitoring the implementation of the Paris Declaration, the first is dedicated to the pursuit of ownership. It calls for developing countries to have national development strategies with clear strategic and budgeted priorities. Although such strategies are a welcome first step, it is important to recognise that true ownership has much wider implications. In particular, it implies that governments must have the capacity to implement their strategies.

Ghana's health sector possesses a strong Programme of Work, with clear and budgeted priorities that are supported by most donors. Moreover, it has been enjoying rising levels of funding. Nevertheless, health performance has begun to stagnate. This indicates that the difficulties faced by the Ministry of Health lie deeper than having a good strategy and reasonable financing.

When asked about the sector's major challenges, our interviewees agreed that inadequate finance was a problem, but thought that the mismatch between budgeting and spending was a bigger one. In fact, budget execution has been very weak in recent years, with spending on some items significantly surpassing the levels agreed upon in the Ministry of Health Programme of Work. Most notably, the government and Ministry of Health have exceeded figures budgeted for personal emoluments and administrative costs by 65 per cent.

This reallocation may be part of an effort to counter the massive emigration of health workers, which is draining the sector of two thirds of its health school graduates (World Bank, 2006). However, whilst brain drain is indeed one of the most challenging and pressing problems facing the health system, it is highly questionable whether reallocating finances will help solve the problem. Furthermore, the mismatch between budgetary planning and actual spending indicates that both government and donors appear to lack a clear and feasible strategy to address the human resource needs of the country.

Encouragingly, the Programme of Work lists the improvement of staff motivation and health worker incentives as major priorities. However, such incentives cannot be improved by salaries alone. Given the large wage gap between Ghana and anglophone OECD countries, which are the primary destination of Ghanaian migrants, even a significant increase in salaries is unlikely to entice health workers to remain in the country. Moreover, even well-paid health workers need basic equipment in order to carry out their jobs well – nevertheless, overspending on salaries has left spending on service delivery 25 per cent short of budgeted figures.

Our interviewees in Ghana tabled several alternative responses to brain drain that may allow the government to adhere to its budgetary planning. These included the temporary "bonding" of health workers to Ghana in return for their education, and the improvement of training for basic health staff, such as nurses, who are crucial for health care delivery and less likely to leave the country. Interviewees also called for more coherence between donors' development co-operation and immigration policies: if the objective of development co-operation is to improve health outcomes, then immigration policies should not undermine the health system by fuelling brain drain. Given strong demand for foreign health care workers in OECD countries, smart solutions must be found urgently. In addition to providing more aid for basic health equipment, OECD countries could for instance design visa policies that foster circular migration, providing benefits to both sending and receiving countries (Katseli *et al.* 2006*a*).

Implications:

- Ministries need new negotiation and communication skills to benefit fully from new aid delivery mechanisms;
- They must make efforts to spend according to plan, even if faced by systemic challenges like brain drain.

Conclusion

Bilateral and multilateral donors still play a prominent role in addressing financing needs, but other actors, such as global funds, foundations and NGOs, have entered the field of development finance. Private capital flows from investors (FDI), banks (commercial loans) and private households (remittances), which are particularly evident in emerging economies, are becoming significant even in low-income countries.

This new multiplicity of financing choices has provided alternatives for developing countries in financing their achievement of the MDGs. However, it has also brought major challenges. Developing countries need stronger information systems to forecast flows and design more effective policies. They also need better co-ordination mechanisms in which conventional donors and other actors can participate.

Domestically, many poor countries face capacity gaps that can not be filled by increased finance or improved effectiveness alone. These include skills shortages in ministries and unpredictable human resources in the public service, both of which undermine a country's ability to take ownership of its development process. If ownership is indeed a prerequisite for development, then addressing such capacity gaps should be an urgent priority for both governments and the donors seeking to assist them.

Finally, it is worth remembering that development finance should be regarded as a means rather than an end in itself. For governments, this implies that they must work to reduce their dependence on external assistance by raising domestic revenues and boosting the capacity of households to contribute to basic human needs. For donors, it may mean rethinking the role of aid as a complement, not a substitute, to other financial sources. Major donors are already taking note: Germany has proposed that, during its presidency of the G8 in 2007, world leaders focus on strategies to attract international private investment to Africa.

Notes

1. We follow the definition of the Institute for International Finance (IIF), which classifies 29 countries as emerging economies. By "other developing countries" we mean the 124 remaining low- and middle income countries.

2. Ghana is an active member of the OECD DAC Working Party on Aid Effectiveness, will participate in the 2006 Survey on "Monitoring the Paris Declaration", and has agreed to host the Third High-Level Forum on Aid Effectiveness in Accra in 2008. Indeed the Working Party is currently co-chaired by Helen Allotey, Executive Director in the Ghana Ministry of Finance and Economic Planning.

3. This breakdown will change in the course of the next Global Fund disbursement round: HIV/AIDS (50 per cent of funds), malaria (29 per cent) and tuberculosis (21 per cent).

4. The number is derived from considering exclusively those projects with a direct reference to Ghana. If various countries were among the target group, the amount was divided by the number of countries mentioned.

Bibliography

CAREY, R. (2006), "The Case of the 20 per cent Club: Scaling-up and Exit in Aid-dependent Countries". Presentation at Informal Experts' Workshop on Development Finance Architecture: What Flows, Channels and Pools?, Paris, 3-4 July. www.oecd.org/dev/meetings/define.

CHERVALIER, B. AND J. ZIMET (2006), *American Philanthropic Foundations: Emerging Actors of Globalization and Pillars of the Transatlantic Dialogue,* German Marshall Fund of the United States, GMF, Washington.

CHOWDHURY, A. AND T. MCKINLEY (2006), "Gearing Macroeconomic Policies to Manage Large Inflows of ODA – The Implications for HIV/AIDS Programmes", United Nations Development Programme, *Working Paper* No. 17, International Poverty Centre, UNDP, New York.

COX, A. AND M. URETA (2003), "International Migration, Remittances and Schooling: Evidence from El Salvador", *NBER Working Paper*, No. 9766, National Bureau of Economic Research, Cambridge, Massachusetts.

DRECHSLER, D. AND J. JÜTTING (2005), "Is there a Role for Private Health Insurance in Developing Countries?", Discussion Paper 517, German Institute for Economic Research, October.

EPSTEIN, G.S. AND I.N. GANG (2006), "Decentralizing Aid with Interested Parties", UNU-WIDER, Research Paper No. 2006/06.

HECHT, R. AND R. SHAH (2006), "Recent Trends and Innovations in Development Assistance for Health", *in* Jamison *et al.* (eds.), *Disease Control Priorities in Developing Countries,* 2nd ed., World Bank, Washington, pp 243-257.

HLF (2006), High Level Forum on the Health MDGs, country-specific information on Ghana from HLF website: www.aidharmonization.org.

HUDSON INSTITUTE (2004), "A Review of Pharmaceutical Company Contributions – HIV/AIDS, Tuberculosis, Malaria, and Other Infectious Diseases", Center for Science in Public Policy, Hudson Institute, Washington.

IFPMA (2004) and (2005), Building Healthier Societies through Partnerships, International Federation of Pharmaceutical Manufacturers Associations, IFPMA, Geneva.

ILO (2006), Financial Assessment of the National Health Insurance Fund, prepared by Florian Léger, International Labour Organization, Geneva.

KATSELI, L.T., R.E.B. LUCAS AND T. XENOGIANI (2006*a*), *Policies for Migration and Development: A European Perspective*, Policy Brief No. 30, OECD Development Centre, Paris.

KATSELI, L., R.E.B. LUCAS AND T. XENOGIANI (2006*b*), Effects of Migration on Sending Countries: What do We Know?, *Working Paper* No. 250, OECD Development Centre, Paris, June.

KAUFFMANN, C. (2005), "Financing SMEs in Africa", *Policy Insights* No. 7, OECD Development Centre, Paris.

LAMBERT, S. AND D. COGNEAU (2006), « L'aide au développement et les autres flux nord sud: Complémentarité ou substitution? », OECD Development Centre, *Working Paper* No. 251, June.

MACKELLAR, L. (2005), "Priorities in Global Assistance for Health, AIDS and Population (HAP)", OECD Development Centre *Working Paper* No. 244, June.

MCKINSEY AND COMPANY (2005), *Global Health Partnerships – Assessing Country Consequences*. Report presented at the High Level Forum on the Health MDGs, 14-15 November, Paris.

MoH (2006), *Pause…Get it Right…Move on* – Review of Ghana Health Sector 2005 Programme of Work, Main Sector Review Report, April, Ministry of Health, Accra.

MoH (2004), Ministry of Health Programme of Work 2003 – Report of the External Review Team, May, Ministry of Health, Accra.

OECD (2006*a*), DACNews – News and Ideas from the OECD Development Assistance Committee (DAC) Secretariat, April.

OECD (2006), *Development Co-operation Report 2005*, DAC, OECD, Paris.

OECD (2003), "Philanthropic Foundations and Development Co-operation", off-print of the DAC Journal, Volume 4, No. 3.

PEARSON, M. (2004), "Economic and Financial Aspects of the Global Health Partnerships", Global Health Partnership Study Paper 2, DFID Health Resource Centre, DFID, London.

PhRMA (2003), Global Partnerships, Humanitarian Programs of the Pharmaceutical Industry in Developing Nations, Pharmaceutical Research and Manufacturers of America, PhRMA, Washington, D.C.

QUARTEY, P. (2006), "Migration, Aid and Development – A Ghana Country Case Study", unpublished ms., ISSER/University of Ghana, Legon, OECD Development Centre, Paris.

QUARTEY, P. AND T. BLANKSON (2004), "Do Migrant Remittances Minimize the Impact of Macro-Volatlity on the Poor in Ghana?", IMF, Washington, D.C.

REISEN, H. (2004), *Innovative Approaches to Funding the Millennium Development Goals,* Policy Brief No. 24, OECD Development Centre, Paris.

UNITED NATIONS (2006), International Migration and Development Fact Sheet, UN Department of Economic and Social Affairs, Population Division.

USAID (2005), "Private Remittances Flows to Ghana; Project Country Report", Review Draft 19 October, USAID, Washington, D.C.

WHO (2005), *World Health Report, Statistical Annex,* Tables 5 and 6, WHO, Geneva.

WORLD BANK (2006), Global Economic Prospects 2006 – Economic Implications of Remittances and Migration, World Bank, Washington, D.C.

Statistical Sources:

BANK OF GHANA (2006), Capital Inflows to the Republic of Ghana, Accra, BoG.

DEVELOPMENT PARTNERS (2006), "Ghana Development Partner Envelope" (internal document of development partners in Ghana).

IIF (2006), *Emerging Markets Research*, The Institute of International Finance (online database), IIF, Washington, D.C.

MoH (2006*a*), Ministry of Health Programme of Work, Ministry of Health, Accra.

OECD DAC (2006), *Creditor Reporting System*, OECD, Paris,

UNCTAD (2006), *World Investment Directory* (online database), UNCTAD, Geneva.

WORLD BANK (2006), *World Development Indicators* (online database), World Bank, Washington, D.C,.

Other Titles in the Series

The Development Centre *Policy Briefs* can be downloaded from: www.oecd.org/dev/briefs
or obtained by e-mail : dev.contact@oecd.org

Adjustment and Equity (No. 1)
by Christian Morrisson (January 1992)

Managing the Environment in Developing Countries (No. 2)
by David O'Connor and David Turnham (January 1992)

Privatisation in Developing Countries: Reflections on a Panacea (No. 3)
by Olivier Bouin (April 1992)

Towards Capital Account Convertibility (No. 4)
by Bernhard Fischer and Helmut Reisen (April 1992)

Trade Liberalisation: What's at Stake? (No. 5)
by Ian Goldin and Dominique van der Mensbrugghe (May 1992)

Towards Sustainable Development in Rural Africa (No. 6)
by David Turnham, with Leif E. Christoffersen and J. Thomas Hexner (January 1993)

Employment Creation and Development Strategy (No. 7)
by David Turnham (July 1993)

The Disarmament Dividend: Challenges for Development Policy (No. 8)
by Jean-Claude Berthélemy, Robert S. McNamara and Somnath Sen (April 1994)

Pension Fund Investment from Ageing to Emerging Markets (No. 9)
by Bernhard Fischer and Helmut Reisen (January 1995)

What Institutional Framework for the Informal Sector? (No. 10)
by Christian Morrisson (October 1995)

The Policy Challenges of Globalisation and Regionalisation (No. 11)
by Charles Oman (June 1996)

Policies for Economic Take-off (No. 12)
by Jean-Claude Berthélemy and Aristomène Varoudakis (September 1996)

The Political Feasibility of Adjustment (No. 13)
by Christian Morrisson (October 1996)

Biotechnology Policy for Developing Country Agriculture (No. 14)
by Carliene Brenner (April 1997)

Pension Reform: Lessons from Latin America (No. 15)
by Monika Queisser (January 1999)

After the Great Asian Slump: Towards a Coherent Approach to Global Capital Flows (No. 16)
by Helmut Reisen (January 1999)

Participatory Governance: The Missing Link for Poverty Reduction (No. 17)
by Hartmut Schneider (April 1999)

Multilateral Tariff Liberalisation and the Developing Countries (No. 18)
by Sébastien Dessus, Kiichiro Fukasaku and Raed Safadi (September 1999)

Health, Education and Poverty Reduction (No. 19)
by Christian Morrisson (October 2001)

The New Regionalism in Sub-Saharan Africa: More Than Meets the Eye? (No. 20)
by Andrea Goldstein (March 2002)

Beyond Johannesburg: Policies and Finance for Climate-Friendly Development (No. 21)
by Georg Caspary and David O'Connor (August 2002)

Strengthening Participation in Public Expenditure Management: Policy Recommendations for Key Stakeholders (No. 22)
by Jeremy Heimans (October 2002)

Corporate Governance in Developing, Transition and Emerging-Market Economies (No. 23)
by Charles Oman, Steven Fries and Willem Buiter (September 2003)

Innovative Approaches to Funding the Millennium Development Goals (No. 24)
by Helmut Reisen (April 2004)

Which Policies Can Reduce the Cost of Capital in Southern Africa? (No. 25)
by Martin Grandes and Nicolas Pinaud (September 2004)

Policy Coherence Towards East Asia: Development Challenges for OECD Countries (No. 26)
by K. Fukasaku, M. Kawai, M.G. Plummer and A. Trzeciak-Duval (June 2005)

Changing Social Institutions to Improve the Status of Women in Developing Countries (No. 27)
by Johannes Jütting and Christian Morrisson (June 2006)

Migration, Aid and Trade: Policy Coherence for Development (No. 28)
by Jeff Dayton-Johnson and Louka T. Katseli (August 2006)

Natural Disaster and Vulnerability (No. 29)
by Jeff Dayton-Johnson (September 2006)

Migration and Development: Challenges for Policy Making (No. 30)
by Louka T. Katseli, Robert E.B Lucas and Theodora Xenogiani (October 2006)

After Gleneagles: What Role for Loans in ODA? (No. 31)
by Daniel Cohen, Pierre Jacquet and Helmut Reisen (October 2006)

Commodity Funds: How to Fix Them? (No. 32)
by Daniel Cohen, Thibault Fally and Sébastien Villemot (November 2006)

DEVELOPMENT CENTRE POLICY BRIEFS

In its research activities, the Development Centre aims to identify and analyse problems the implications of which will be of concern in the near future to both member and non-member countries of the OECD. The conclusions represent a contribution to the search for policies to deal with the issues involved.

The *Policy Briefs* deliver the research findings in a concise and accessible way. This series, with its wide, targeted and rapid distribution, is specifically intended for policy and decision makers in the fields concerned.

The landscape of international development finance is changing rapidly. New actors such as global funds, foundations and NGOs have emerged and private flows are on the rise. This *Policy Brief* shows how these global trends translate into changes at the country level. Even aid-dependent "donor darlings" like Ghana now have options other than ODA to finance their development. Developing countries will need stronger information systems and better co-ordination mechanisms to draw maximum benefits from these trends. Donors can support them by considering aid as a complement, rather than a substitute, to other financial flows.

OECD DEVELOPMENT CENTRE
2, rue André-Pascal,
75775 Paris Cedex 16, France
Tel.: +33 (0)1 45 24 82 00
Fax: +33 (0)1 44 30 61 49
www.oecd.org/dev/contact
www.oecd.org/dev/briefs