Performance Benchmarks for the Australian Aid Program

Prepared for:

Department of Foreign Affairs and Trade

Submitted by:

Name: Dr Jane Thomason

Role: Chief Executive Officer

Telephone: +61 7 3114 4600

Fax: + 61 7 3114 4661

Email: jane.thomason@abtjta.com.au

Abt JTA

Level 2, 5 Gardner Close

Milton

Queensland

Australia 4064

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SUMMARY OF RECOMMENDATIONS

1. In considering how to benchmark performance on the "traditional" domains of Australian aid, there should be a future lens applied and very clear articulation of the objectives of each aid program initiative.

   In addition to the performance benchmark categories listed, it is recommended that consideration should be given to:

   a. Adding a different and context appropriate set of benchmarks for fragile states. The typology below represents a classification of fragile states that can assist in the development of benchmarks for the aid program (See Annex One).
   b. Developing both benchmarks and measurement approaches for Australian support to "global public goods".
   c. Developing benchmarks for leverage across the aid program that looks at the tangible benefits of linking aid, trade, and financial flows and working with the private sector to accelerate development outcomes. These could include foreign direct investment and export measures.
   d. Commissioning analytic work on Australia's comparative advantage in science, technology and innovation to support middle income countries address and measure inequality.
   e. Commissioning analytic work on the relationship between different funding flows and how aid can stimulate increased trade and investment flows.
   f. Developing benchmark measures for drivers of growth (such as education, infrastructure, access to finance, participation by women and health).

2. Australia should incentivise governments and provide technical assistance and innovations to establish functioning CRVS systems so that both Australia and partner countries have accurate measures of the impact of their joint development efforts.
3. The aid program should support evidence based programs and should lead the accelerated progress of MDGs 4, 5 and 6 in our region and prioritise funding based on the submission by the Copenhagen Consensus Centre on the 16 interventions found to provide best value for money. Robust implementation monitoring of evidence based interventions is essential to their efficacy and if supported, will provide reliable and timely information to measure program performance.
4. Level the playing field for implementing partners and apply a rigorous and transparent benchmarking process to all agents of the Australian Aid Program.
5. An independent private or public agency should be engaged to collect and validate performance data, ensure all contractual obligations are met and administer or arbitrate financial rewards and penalties. The agency would be responsible to the government but needs to command the respect and trust of both public and private sector partners.

6. Context sensitive evaluation and research is needed and a benchmarking system that is able recognise the ancillary benefits accruing from the aid program.

INTRODUCTION

We welcome the opportunity to contribute to the Inquiry into Performance Benchmarks for the Australian aid program.

Abt JTA has been active in Australia's aid program for more than 10 years, perhaps best known as a contractor, but we have also contributed to two AusAID health strategies, the gender and equality strategy, served on the Aid Advisory Council, facilitated conversations with the business community and provided strategic advice over a number of years. Among our staff, we are members of the PNG Australia Business Council, International Development Contractors group, Burnett Institute Board, Asia Pacific Business Coalition on HIV AIDS, University of Queensland Advisory Council, and provide strategic advice to the WHO on the Global Strategy on Women's and Children's Health.

In addition to the aid program, we have pioneered public private partnerships with the resources sector (notably in PNG) and we are the implementing partner to Ok Tedi Mining and Ok Tedi Development Foundation for innovative community programs across Western Province.

We welcome the Government's increased engagement with the private sector and appreciate the opportunity to participate in the discussion on benchmarking and the transparent consultation process.

We submit that as the Government moves forward in developing benchmarks, it is important to consider new and innovative approaches that are likely to become part of the aid program, both due to Government policy change and the changing context of development.

Given the likely changes, in thinking about benchmarking, we suggest that the review move beyond the traditional approach to aid and its development partners and be more visionary and future looking, predicting likely changes and how to consider benchmarks in a very different context.

HOW SHOULD PERFORMANCE OF THE AID PROGRAM BE DEFINED AND ASSESSED?

FIRST DEFINE THE AID PROGRAM - THE FUTURE OF AID IS CHANGING

The benchmarking exercise should be forward looking, not only due to the Government's policy change to leverage diplomacy, trade, and development, and to focus more on private sector and economic development, but also because the whole landscape of international development is changing.

It is predicted that over the next 10 to 15 years aid will become less central to some countries in our region as domestic resources grow. Nancy Birdsall, President of the Centre for Global Development predicts a world in 2030 in which there is no longer a global poverty line and in which ODA as we know it today will have almost completely disappeared. With many poor countries predicted to graduate to middle income status in the next 15 years, the development program will need to reframe its added value and relevance. As countries in our region graduate to middle income status, there will be an increasing need for better understandings of inequality.

Based on some of these predictions, a possible future aid focus for Australia will be to:

- Continue to support fragile states in our region to enable conditions under which development can happen – this is not linear or predictable.
- Support 'global public goods' such as environmental issues and cross boarder disease threats, potentially on a multi country collaborative program basis.
- Take a "whole of government approach" to development including aid, trade, financial flows and agricultural subsidies (perhaps of most current relevance to Australia).
- Provide expert advice and innovative solutions to middle income countries to address pockets of inequity.

The consultation paper suggests that performance benchmarks could be developed at some or all of the following levels:

i. at a whole-of-aid program level (for example to measure the aid program's geographic spread, its focus on economic growth, effectiveness, and fiduciary risk)

ii. at a program level (to assess whether each country or global program is achieving progress against key performance indicators)

iii. at a partner government or implementing organisation level (to determine whether mutual obligations are being met)

iv. at a project level (to ensure that funding is directed to investments achieving the best results and poor performing projects are improved or cancelled)

Recommendation:

In addition to considering how to benchmark performance on the "traditional" domains of Australian aid, that there be a future lens applied and very clear articulation of the objectives of each aid program initiative.

In addition to the performance benchmark categories listed, it is recommended that consideration should be given to:

1. Adding a different and context appropriate set of benchmarks for fragile states. The typology below represents a classification of fragile states that can assist in the development of benchmarks for the aid program (See Annex One).
2. Developing both benchmarks and measurement approaches for Australian support to "global public goods".
3. Developing benchmarks for leverage across the aid program that looks at the tangible benefits of linking aid, trade, and financial flows and working with the private sector to accelerate development outcomes. These could include foreign direct investment and export measures.
4. Commissioning analytic work on Australia's comparative advantage in science, technology and innovation to support middle income countries address and measure inequality.
5. Commissioning analytic work on the relationship between different funding flows and how aid can stimulate increased trade and investment flows.
6. Developing benchmark measures for drivers of growth (such as education, infrastructure, access to finance, participation by women and health).

How could performance be linked to the aid budget?

Improving Measurement

You can't measure what you can't count. A critical first step in benchmarking will be to be clear on objectives and ensure they are measurable.

One particular issue in relation to measurement of the Australian aid program results that we wish to highlight is the absence of civil registration and vital statistics (CRVS) in many countries of our region. The registration of vital events in a population – births, adoptions, marriages, divorces and deaths – and reporting of those events to the national statistical system is an integral function of good governance. Without reliable statistics on vital events, governments and donors cannot make targeted interventions, nor can they accurately measure the effectiveness of investments or existing aid programs. Vital statistics also provide the denominator for crucial economic and social indicators, such as per capita measures, and therefore must be accurate and reliable.

Despite the importance of CRVS to good governance, one third of all births around the world, are not registered and two thirds of all deaths are neither registered nor given a medically certified cause. Two-thirds of these take place on Australia's doorstep in Asia and the Pacific[1].

Supporting the development of well-functioning CRVS systems in all countries that are significant recipients of the Australian aid program should be a priority. By enabling universal civil registration, we will be underpinning inclusive and sustainable development and upholding our responsibility to preserve human rights. Better vital statistics will greatly improve Australia's ability to measure the effectiveness of its aid.

Recommendation:

Australia should incentivise governments and provide technical assistance and innovations to establish functioning CRVS systems so that both Australia and partner countries have accurate measures of the impact of their joint development efforts.

Support Evidence Based Interventions

Where possible, the Australian aid program should be based on evidence based interventions.

One example is the new Global Investment Framework for Investing in Women's and Children's Health, which provides evidence based policies that could, and should be scaled up. Australian assistance to support such change will help set in train favourable social, health, and demographic trends in the countries of our region, and avert needless deaths and disability.

In the Asia Pacific region, unacceptably high rates of maternal death prevail. To illustrate, Australia's Maternal Mortality Ratio is 7 per 100,000 live births. Compare this to Cambodia (250 per 100,000 live births), Indonesia (220), Myanmar (200), Papua New Guinea (230) and Timor Leste (300). These countries also have relatively high levels of otherwise preventable infant and child deaths. Cambodia, Indonesia, Lao PDR, Myanmar, Papua New Guinea, Philippines, Solomon Islands, Timor Leste and Vanuatu are off track on one, or both, of the Millennium Development Goals (MDGs) to reduce maternal and child deaths (MDGs 4 and 5 respectively).

Australia's aid program can play a critical role in actively helping to make life better for mothers, newborns and children in this region. That is partly because expenditure on health is so low in many of these countries that a small amount of aid funding can make a big

[1] (See www.thelancet.com Vol 381 April 13, 2013, Civil Registration and vital statistics – everybody's business but nobody's business, Alan Lopez and Jane Thomason, and www.thelancet.com Vol 381 April 27 2013, Offline.

difference. Total public expenditure on health is just $US10 per person in Cambodia, compared to $US3,545 in Australia[2]. It is just $US14 in Lao PDR, $US30 in Indonesia, $US33 in Timor Leste, and $US43 in PNG. Total public expenditure on health is only $2 per person per year in Myanmar. Money will make a difference in these situations. But so will technical expertise that Australia has in several world class institutions, such as the Burnet Institute, Menzies School of Health Research, and the Centre for International Child Health, University of Melbourne.

Recommendation:

The aid program should support evidence based programs and should lead the accelerated progress of MDGs 4, 5 and 6 in our region and prioritise funding based on the submission by the Copenhagen Consensus Centre on the 16 interventions found to provide best value for money.

Robust implementation monitoring of evidence based interventions is essential to their efficacy and if supported, will provide reliable and timely information to measure program performance.

Improving Implementing Partner Performance

How can the assessment of the performance of our implementing partners be improved?

In the consultation paper, the discussion is limited to international organisations, NGOs and contractors. This classification is an historical artefact, whereby the aid program has tended to consider implementing partners in boxes and has had separate arrangements for different types of organisations.

The strengths and weaknesses of all implementing partners including academic organisations should be mapped, and rather than quarantining funds for different categories of organisations, all partners should be able to submit proposals or tenders in a transparent manner for all of the aid program. USAID allows contractors and non-government organisations to bid for work, some of which is fee bearing and some not. This should also be possible on the Australian Aid Program.

In relation to benchmarks as set out in the paper, "*at an individual project level, all major investments could be reviewed to identify which projects are currently achieving the best results (and can be scaled-up)*". This level of review should be applied to all investments above a certain threshold and should include significant university and NGO grants as well as multi-lateral programs.

[2] WHO (2013) World Health Statistics

Recommendation:

Level the playing field for implementing partners and apply a rigorous and transparent benchmarking process to all agents of the Australian Aid Program.

BE FORWARD LOOKING AND CONSIDER OTHER IMPLEMENTING PARTNERS OF THE FUTURE

We anticipate that with the current Government's interest in leveraging the private sector, new activities may be different from the traditional international set of international organisations, NGOs and contractors. In the section below, we offer some examples of opportunities to extend the impact of the aid program in the health sector through partnering with the private sector. These will require different thinking on benchmarking than traditional programs.

PNG Extractive Industry Service Delivery Partnerships

PNG is a resource rich country and there are several documented examples of resource sector partnerships in PNG previously described by Thomason and Hancock (2011) including:

The ADB HIV in Enclaves Project: ($25 million) for HIV/AIDS Prevention and Control in Rural Development Enclaves. This focused on private sector operations in rural areas and aimed to help the Government initiate partnerships with the private sector operators to set up or improve primary health care and HIV/AIDS treatment and prevention facilities. It received financing of $25 million of which Australia and New Zealand provided $3.5 million each and Government of PNG provided $3million.

Oil Search – Malaria: Oil Search in Southern Highlands has undertaken creditable programs in malaria control, and HIV/AIDS control program, in collaboration with the ADB HIV in Enclaves Program and funding from the tax credit scheme. More recently Oil Search has established a foundation to extend its health contribution to PNG, which is being funded by DFAT and the Global Fund to extend health programs in PNG.

Ok Tedi - North Fly Health Services Development Program (K20 Million): supports the local health system to deliver effective health interventions, essential infrastructure and logistics, human worker capacity, community participation and population coverage. Key achievements have included: collaboration between partners for planning and coordination of health service delivery, particularly outreach patrols; a major bed net distribution project across the North Fly District; significant progress toward increasing the number of accredited voluntary counselling and testing clinics in the district; establishment of regular delivery of essential medical supplies to remote areas that were previously under-supported; and increased immunization coverage.

Lihir Islands Community Health Plan ($7 million): is a five year plan that forms the framework for a comprehensive community health response for Lihir communities. This is funded

through the community compensation package agreed between Lihir Gold Limited and the local community. The plan incorporates curative and preventative health services and programs, promotes community responsibility for health and targets existing and potential disease burdens.

Of these examples, **only the ADB HIV in Enclaves Project was donor funded**. The other three examples were funded from private resources (although the Oil Search Foundation is now receiving funding through donor channels). Resource companies don't necessarily need donor money to improve their community health. The usual donor approach, which involves allocation of aid resources to programs, would not be the first step in a private sector partnership with the resources sector. It is important to first focus on leveraging resource sector contributions to get better outcomes or increased coverage for poor people.

Potential DFAT Partnership Opportunities

DFAT is already connecting with existing private sector service delivery initiatives such as the Oil Search Foundation. Such collaborations enable the extension of existing private sector service delivery programs to achieve greater reach and impact. However, leveraging private finance for these collaborations is an area in which the aid program could assist. DFAT could provide technical assistance necessary to support the government to enter into effective partnerships with the extractive industry. This could include technical assistance for coordinated planning, establishment of memorandum of understanding (MOUs), governance structures and application of national standards.

Furthermore, there is also a significant opportunity for DFAT to contribute to policy change to minimize the health risks associated with the extractive industries and to maximise social outcomes. For example, it is well known that there are health implications from resource sector development. Currently, PNG does not require a health impact assessment (HIA) as part of its compliance requirements for a new resource development. As a result, they are rarely done, nor is comprehensive long term health planning undertaken during project development. The operators generally only undertake their compliance requirements. They would see the health planning as the responsibility of government, although the government lacks the resources and capacity to undertake the needed health planning and risk identification and mitigation for health impacts. Inevitably, problems start to emerge during the project life, and only then are they addressed. This could be simply remedied with some initial planning support.

A valuable engagement for DFAT would be to provide technical expertise and facilitation to government to ensure that resource projects have:

1) An HIA completed to international standards.
2) A multi stakeholder long term health development plan, based on the HIA and building the existing health care delivery system, with clear roles and responsibilities, and measurable indicators.

3) A mechanism for regular reporting review and monitoring of performance.
4) Innovative funding mechanisms to provide for the implementation of the plan.

Private Health Providers

In many low income countries, 50% or more of the resources spent on health are private resources (International Finance Corporation, 2007). The OECD found that private expenditure on health and public expenditure on health produce similar outcomes (van der Gaag and Stimac, 2008). There is growing evidence that private health providers are a critical channel for extending health services to the poor, particularly in Asia, and can play a vital role in achieving the MDGs. For example, in sub-Saharan Africa and South Asia, 51 and 79 percent of mothers who sought treatment for children under five with diarrhoea, cough or fever respectively accessed care from the private sector (Private Healthcare in Developing Countries, 2008a). In relation to the unmet need for family planning, in approximately half of the 21 sub-Saharan countries with recent Demographic and Health Surveys (DHS) data (2006 or later), a third or more of modern family planning users obtained their methods from the private sector, and amongst the lowest three quintiles of women this increased to 50 percent (International Finance Corporation, 2007, Private Healthcare in Developing Countries, 2008a). Globally, approximately 40 percent of malaria patients seek treatment in the private sector (World Health Organisation, 2011).

In order to reduce the impact of infectious diseases such as TB and HIV and reach MDG 6, it will be critical to align the treatment practices of the private sector with international standards and ensure effective coordination of private sector TB services with national TB control programs. In Asia 55 percent of TB cases in 2007 occurred where a large percentage of clients utilize the private sector for care (Hazarika, 2011). A lack of coordination will lead to non-standardized TB diagnosis and treatment quality, as well as a lack of alignment with national TB program notification and control efforts. This in turn leads to increased air-borne transmission of TB, including drug-resistant strains, among the most vulnerable segments of the population such as children, pregnant women, the elderly and the HIV-infected.

These examples illustrate the importance of private sector health providers and how they can be a complementary partners in extending health outcomes to the poor. In the following section, we summarise a case study of donor engagement with the private health sector to deliver outcomes for the poor, pioneered by USAID which has been investing in strengthening the private health sector for two decades.

Currently, USAID's flagship project in this area is the Strengthening Health Outcomes through the Private Sector (SHOPS) (SHOPS Project, 2012).[3] This is a five year project working in Asia,

[3] More information on the SHOPS Project is available at www.shopsproject.org .

Africa and Latin America to increase the role of the private sector and, in particular, private health care providers in the sustainable provision of quality family planning, reproductive health, HIV, maternal and child health as well as other health products and services. The progress of the SHOPS Project provides useful lessons for the Australian aid program.

Potential DFAT Partnership Opportunities

This style of program would be applicable in Asia where there is already a large private sector servicing the poor. The forthcoming Indonesia Maternal Neonatal and Child Health Program, includes a private sector partnership component, which could be informed by the SHOPS experience. In PNG and the Pacific, where the private sector is growing, there is also an opportunity for DFAT to work with governments to develop mechanisms for creating and enforcing quality standards; enact regulations that are more encouraging of the private sector, and; improve access to capital to support private health care enterprises (International Finance Corporation, 2007).

PUBLIC-PRIVATE INVESTMENT PARTNERSHIPS

The Public Private Integrated Partnership (PPIP) is an innovative PPP in which the government enters into a long-term contract with a private operator to build, design, operate and deliver a full range of clinical services to a population. This model harnesses private capital and management expertise, while retaining public ownership and oversight of health services. Experience in other countries, particularly in Valencia, Spain and in middle income countries has shown that the model can have a significant impact on the quality and efficiency of health care *(Sekhri, Feachem, Li. Public-Private Integrated Partnerships Demonstrate the Potential to Improve Health Care Access, Quality, And Efficiency. Health Affairs. August 2011 30.8. and Trescoli, Ferrer, Torner. The Alzira model: Hospital de la Ribera, Valencia Spain. In Rechel, Erskine, etal editors. Capital Investment for health: case studies from Europe. Copenhagen. World Health Organization 2009.)*

Lesotho, is an example where a PPIP solution has been used to meet the Governments need to replace and improve the national referral hospital. Working with the IFC as transaction advisors, the Government issued an open international tender which posed a challenge to all bidders: For the same level of expenditure as Queen II, how much more could the private sector deliver in quality, breadth, and volume of health care services?

A consortium was awarded an 18 year contract to build a 425 bed hospital linked to three primary clinics, offer a full range of secondary and tertiary care (some of which had previously been referred to South Africa); integrate hospital services with primary care for Maseru; and make a major commitment to enhancing the limited human resources capacities of the

country. As in all PPIPs, the government retains ownership of the assets, and the facilities must provide services to the population originally served by the public facilities, at no additional cost to patients. The consortium is jointly owned by Lesotho doctors who also provide specialist services to the hospital, doctors and specialists from South Africa, a local firm for Basutho women, members of the local chamber of commerce, and Netcare Limited, the managing partner which is a South African private health care provider.

The new arrangement represents a major shift in role for the Ministry of Health from a provider to a purchaser of care, with responsibility for improving value for money and quality of services provided to the people of Lesotho. To assist the Ministry of Health in this unfamiliar role, an Independent Monitor has been appointed to measure compliance with the detailed performance indicators specified in the contract, with associated penalties for not achieving performance levels. Indicators cover a full range of clinical service quality, equipment, drug supply management, information technology, and staff certification and training. In addition, the hospital is required to obtain accreditation by the Council for Health Service Accreditation of South Africa.

The PPIP structure provides for co-financing of capital expenditures for construction, refurbishment and equipping the hospital and associated clinics; and also provides for an ongoing payment from the Government to the consortium for service delivery at the facilities. Both repayments are contained in a single unitary payment. This payment did not begin until after the hospital was opened and started seeing patients. This was 3 years after the contract was signed. All upfront expenses were covered by the consortium.

Under the contract Tsepong provides almost 30% more hospital admissions and 87% more outpatient visits for an estimated 7% increase in operating costs over Queen II. If service volumes exceed contracted amounts, additional fees are paid to Tsepong, but the Government must approve these increases.

The clinics and hospital were completed on time and on schedule. After one year of operation in the new hospital, maternal mortality has decreased by 50% despite treating much more complex cases. Overall patient mortality decreased from 12% to 7% and there has been a large increase in patient satisfaction. A range of clinical capabilities has been established for the first time in Lesotho, such as neonatal intensive care, thus saving lives and reducing expensive referrals to South Africa. A fully electronic medical record and reporting system has been implemented to allow detailed performance monitoring on a large set of quality and service indicators. There has been extensive training of physicians and nurses. Previous shortages of doctors and nurses have been addressed through international recruitment and the return of Basutho professionals to the country.

POTENTIAL AID PROGRAM INVOLVEMENT

The PPIP model may provide a means for the Australian aid program to provide support for major hospitals in PNG in a manner that ensures provision of quality services over time. DFAT could take a lead role as partnership broker or a lead role in the negotiating process; fund technical assistance for financial advice for the Ministry and other areas required to finalise the highly structured contract agreement. Further, DFAT could augment the Ministry's payments to private contractors to provide added assurance and incentive for potential private partners to participate. As demonstrated by the Lesotho case study, PPIPs may also be supported by IFC or World Bank as well as government and private financiers.

Recommendations:

An independent private or public agency should be engaged to collect and validate performance data, ensure all contractual obligations are met and administer or arbitrate financial rewards and penalties. The agency would be responsible to the government but needs to command the respect and trust of both public and private sector partners.

IN SETTING BENCHMARKS, BE MINDFUL THAT DEVELOPMENT IS NOT LINEAR, ESPECIALLY IN FRAGILE STATES

Complex challenges can't be understood in terms of linear cause-effect relationships. This is particularly the case in certain fragile states. It is not predictable but moves in fits and bursts, and then takes backward steps. Any benchmarking needs to be able to **c**apture both positive and negative opportunities. So, for example, where there is political will (or some other driver that is generally hard to generate) the aid program needs to move to take advantage of it. The unanticipated measures of the aid program need to be captured as well, such as responding to disease outbreaks (etc). Context sensitive evaluation and research is needed and a benchmarking system that is able to recognise the ancillary benefits accruing from the aid program. Australian support for the cholera outbreaks in PNG is one such example.

Recommendations:

Context sensitive evaluation and research is needed and a benchmarking system that is able recognise the ancillary benefits accruing from the aid program.

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ANNEX ONE

Typologies of Fragile States

Deteriorating States

Needed: stemming declines in social indicators. Investment in human capital and social protection is important.

New development programs should use non-gov't, private sector and community driven mechanisms.

Maintaining institutional capital is a key challenge, a positive role for lower level governmental service delivery works, are potential avenues

Non-governmental, private sector, and community driven mechanisms may be effective

Prolonged Crisis or Impasse

May be characterized by severe insecurity or lack of consensus on international engagement.

The World Bank (and presumably others) will typically work through small grants targeted at health and education services.

Development and development agencies play subsidiary role

Post Conflict/Crisis or Political Transition

Intl Funders will fund economic and community infrastructure, service delivery in health and education, HIV/AIDS, judicial modernization, safety nets for vulnerable groups.

It is important to find ways to deliver services and provide economic development opportunities

Aid may come from outside state delivery systems.

Gradual Improvement

- Countries in this category while often have some degree of reform elements in the government face barriers of corruption and inefficiency slowing reform and prompting setbacks.
- Governments in gradually improving countries will look to improve service provision (health/education)
- Differentiated strategies may be appropriate for varying situations in different areas of a large state.