

The Global Health Landscape and Innovative International Financing for Health Systems: trends and issues

Introduction

The High Level Task Force on Innovative International Financing for Health Systems (HLTF) announced at the UN High Level Event in New York on 25 September 2008 will “contribute to filling national financing gaps to reach the health MDGs through mobilizing additional resources; increasing the financial efficiency of health financing; and enhancing the effective use of funds.”¹

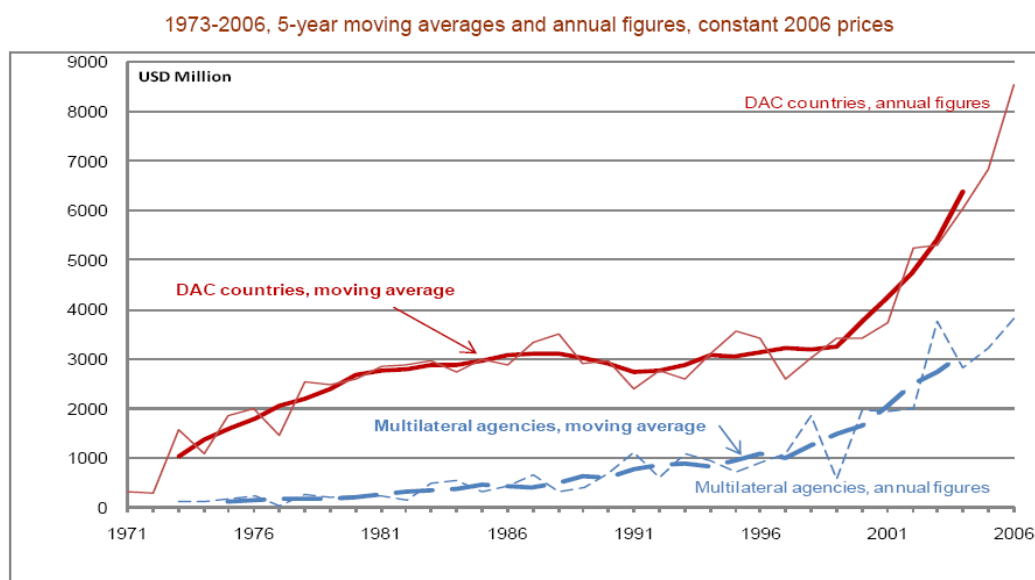
The Task force will specifically “make recommendations on the mix of innovative international financing mechanisms needed to deliver the extra resources required and promote international support for these recommendations to ensure they are implemented”.

This paper which draws heavily on existing literature (referenced) gives an overview of global health financing; a brief description of key actors and initiatives; and identifies some initial issues for discussion.

Global health financing

Overall level and distribution of health aid

Health aid is rising, and health is capturing a bigger share of all aid. After stagnating in the 1980s and 1990s, aid to health has risen sharply in recent years. In 2006, DAC countries’ bilateral aid to health amounted to USD 8.6 billion and multilateral agencies’ aid to USD 4 billion.²



Source: OECD-DAC 2008

¹ HLTF on Innovative International Financing for Health Systems – Draft Terms of Reference and Management Arrangements Final Draft 3 November 2008

² Measuring Aid to Health October 2008, OECD-DAC, www.oecd.org/dac/stats/health

The trend in aid to the health sector is set by a few donors. In 2005-2006, three-quarters of DAC members' total *bilateral* aid commitments to health were extended by the United States, the United Kingdom, the EC, the Netherlands and Germany. The data indicate an increased prioritisation of the health sector in donors' aid programmes with 16% of total DAC countries' bilateral sector-allocable aid³ dedicated to health in 2005-2006, compared with 12% in 2001-2002. As regards multilateral agencies, the increase in aid to health over the period 2002-2006 is largely due to the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), which committed USD 5.3 billion (cumulative total) over the period.² Global philanthropy not least in health is remaking the relationship between the world's rich and poor. Private aid – all aid provided by foundations, corporations, non-governmental organisations, and individuals - has doubled over the past decade and may soon overtake “official” foreign aid.⁴

Funding for MDG 6 (HIV, TB and malaria) accounts for much of the recent increase in health aid. In 2002-2006 aid for HIV accounted for almost one third (32%) of health aid. The growth in HIV funding is in part due to new initiatives such as PEPFAR (the President's Emergency Plan for AIDS Relief – USA), and the Global Fund GFATM.⁵

Although all sectors record multi-country regional activities, the volume in health is unusually high. Over the last five years 25% of health aid – and 40.7% of HIV funding - has been provided through global and regional multi-country initiatives, defined as funds channeled mostly through multi-laterals, including UN agencies, international NGOs and the private sector, for projects that cover more than one country, such as immunization, HIV/AIDS control or basic health care. This comes in addition to funds from global health partnerships such as the Global Fund or GAVI Alliance that are provided directly to countries and do not appear in this category. Only 6.3% of education aid goes through multi-country activities.⁵

Countries with comparable levels of poverty and health need receive remarkably different levels of aid. Sub-Saharan Africa has been the largest recipient region of aid to health since 1999. In 2005-2006, it received almost a half of total aid to health. Asia ranked second, and received 30% of total aid to health.² However, the 10 countries that get almost half (49.1%) of health aid only account for one fifth of the population of this group (21%). The major predictor of aid per capita in low income developing countries is HIV prevalence. In countries such as Rwanda there is evidence that these resources have a positive effect on the health systems as a whole. Countries with low HIV prevalence (but high levels of morbidity and mortality from other causes) receive much less aid and thus remain at a disadvantage. For example, Zambia receives US\$20 per person for health, Chad just \$1.59.⁵

The global financial crisis is a real threat to increased (health) aid. A recent article in the *Washington Post* discusses the importance of foreign aid during financial crises. "If history is any guide, poor nations could be hit hard as wealthy countries cope with financial bailouts and potential downturns. Stung by a stock market and real estate crash, Japan slashed aid by some 44 percent between 1990 and 1996. Although Tokyo ramped up assistance in subsequent years, it still is spending less on foreign aid now than it did in 1990, according to David Roodman, a researcher at the

³ Sector-allocable aid: in order to better reflect the sectoral focus of donors' programmes, when calculating the share of aid to health in total bilateral aid, OECD-DAC has here excluded from the denominator contributions not susceptible to allocation by sector (general budget support, actions relating to debt, humanitarian aid, administrative costs and other internal transactions in the donor country).

⁴ The California Consensus, Can Private Aid End Global Poverty? Raj Desai and Homi Kharas, Survival August-September 2008

http://www.brookings.edu/~media/Files/rc/articles/2008/08_private_aid_kharas/08_private_aid_kharas.pdf

⁵ World Health Organization, Effective Aid: Better Health, Report prepared for the Accra High Level Forum on Aid Effectiveness, September 2008 http://siteresources.worldbank.org/ACCRAEXT/Resources/4700790-1210008992554/4968817-1221157306475/Effective-Aid_Better-Health_en.pdf

Washington-based Center for Global Development. After a financial crisis struck a number of Nordic countries in 1991, Norway slashed foreign aid by 10 percent and Sweden by 17 percent. Finland, which underwent a harsher economic contraction than its neighbors, cut foreign aid about 62 percent.⁶

In conclusion, while health aid has seen a great increase in recent years, it therefore appears now more uncertain whether commitments will be delivered in a timely manner and whether the search for new funding will be successful. This might lead to stronger priority-setting and rationing of resources.

While this paper focuses on health aid, it is also important to note that aid overall represents only a small share of overall health care financing. Most health care expenditures are still borne by the people themselves through formal and informal user charges, and through national governments through their budgets.

Quality of health aid

Aid effectiveness is particularly challenging in health, not just because of the complexity of the aid architecture, but because of the large numbers of donors, the extent of unmet needs, cross-sectoral implementation challenges, private sector involvement in health services, and the long-term recurrent nature of most health needs.

In addition to the overall level of aid, the *predictability* of finance is critical to the longer-term stability and sustainability of health plans. Many health interventions require a long-term perspective and predictability of aid flows is a crucial issue in health where so many costs are recurrent such as staff salaries and long-term drug therapies for chronic illnesses.⁷ A study by the World Health Organization of seven major health donors including Norway finds increasing evidence of commitments and disbursements for health over at least five years, but says there is scope for further improvement within donors' existing rules and regulations. Although most donor governments have the necessary tools to provide longer-term commitments, long-term bilateral commitments and disbursements remain infrequent.⁷

Analysis of trends over the last ten years shows aid for health is *fragmented* into large numbers of small projects and off-budget. More than two-thirds of all commitments were for less than US\$500,000. The fragmented nature of health aid appears to be a problem that predates, and is independent of, the recent emergence of new global health funds. However the development of global health partnerships and innovative financing has contributed to reinforce and increase the complexity and fragmentation of health aid. Donor health aid is increasingly off budget (47% in 2003 and 62% in 2006)¹¹. Significant shares of aid are earmarked. This makes it harder for developing countries to influence what aid is provided for or how it is provided.⁵

Relatively little (health) aid is provided directly into countries' budgets. The amount of aid channeled through sector and budget support programmes remains low, even though it is widely thought to be one of the more efficient forms of aid. Direct budget support (DBS) commitments account for a small part of all aid: for example, in 2002–2006 DBS commitments were equivalent to 6.4% of total aid (excluding debt relief). Given that domestic allocations to health tend to be low, particularly in poor countries, the level of resources reaching the health sector via budget support is likely to be relatively small. The proportion of health aid spent on sector programmes is also limited: 7.7% of all health aid in 2002–2006.⁵

A substantial proportion of health aid is spent on technical cooperation (TC). In the period 2002–2006, 41.7% of all health aid and 43.5% of all health activities (i.e. projects) focused on TC aimed at

⁶ <http://www.washingtonpost.com/wp-dyn/content/article/2008/10/21/AR2008102102523.html>

⁷ WHO, *Donor constraints on long-term aid commitments for health*, 2008

building the “human capital” in recipient countries. This includes, for example, salaries for staff recruited locally and long-term international experts, consultants fees, training, etc. TC accounts for the lion’s share of resources (58.6%) channeled through global or regional multi-country initiatives. TC also accounts for much of the new HIV funding, accounting for 53% of HIV commitments in the period 2002–2006.⁵

All this suggests that even as the political momentum towards aid effectiveness increases at global level, the *discretion to make spending decisions at country level is still limited*, as global and regional priorities dominate aid allocation and resources to be invested flexibly in national health systems are limited.

It also suggests that monitoring financial flows is important and can provide additional insight into the donor and government behaviour and challenges and inform the debate on how aid can be made more effective.

Innovative financing

Innovative financing means different things to different people. For some, it is about raising new monies for global health work, while others consider the new mechanisms as tools to make existing aid spending more effective through various means, including: 1) changing the timing of disbursements to accelerate health results (like the International Finance Facility for Immunization); 2) increasing certainty to bring down prices of commonly-purchased medicines and goods (such as the Advance Market Commitment); and, 3) changing the incentives to recipients (through results-based aid such as the Global Fund and GAVI ISS).¹⁰

There is presently no exact overview of innovative financing flows and fundraising and disbursement are reported by each entity. OECD/DAC statistics provide only a partial picture of innovative financing to health. DAC statistics measure flows on a cash basis and DAC statistics do not therefore capture the *frontloading* feature of innovative financing. Also, while DAC statistics distinguish between official and private flows, sectoral data are available on official flows only. Work is ongoing to develop the DAC statistical systems so as to establish a more complete picture of financing for development, consisting of both official and private flows.⁸

A recent meeting organised by the Brookings Global Health Financing Initiative raised a number of useful points and questions, such as how donors can assure that funds mobilized through innovative financing are genuinely “additional” to existing aid funding; how innovative financing which to date has been focused on lowering the price of medicines and supplies to recipient countries also can address delivery challenges related to human resources, infrastructure and other inputs; and how to address that performance-based aid rewards good performers, but given for example that fighting infectious disease is a global public good, success depends on the performance of the worst performers.¹⁰

It is essential to start with defining the nature of the problem to be solved. The Brookings Global Health Financing Initiative published in August 2008 an analytical framework for analysing innovative financing options⁹. The key message is that different financing tools are suitable for different purposes, so it is essential that the problem to be solved is understood, options for financing solutions assembled, and those options ranked according to their benefits and costs. Further, it highlights that the intended outcomes for each category of innovative financing mechanism are multi-

⁸ OECD Global Forum on Development, Report from the Workshop on “Lessons for Development Finance from Innovative Financing in Health”, Paris, 7 October 2008

⁹ Innovative Financing for Global Health: Tools for Analyzing the Options, Brookings Global Economy and Development Working Paper 2, August 2008

dimensional and complex. The Working Paper lists more than twenty-five (!) examples of innovative financing. It also applies the full framework to two problems and identifies and ranks options: (1) how to get a smoother and predictable aid for health; (2) how to mobilise more resources by combining investment money and donation money.¹⁰

The conceptual framework is useful in discussing what the comparative advantage and focus of new innovative mechanisms could be:

- (a) support to service delivery within countries (through public and private sectors)
- (b) product delivery to countries
- (c) product discovery and development

In October 2008, OECD together with the Brookings Institution and the IESE Business School organised an Informal Experts' Workshop on Innovative Financing for Health as part of the OECD Global Forum for Development. OECD has indicated that it will extend its work on multilateral aid to examine innovative finance for development and keep innovative finance under review in further Global Forum on Development events.¹¹

Key actors and initiatives in global health

The global aid architecture is constantly changing and will also differ according to sector. The recent and emerging initiatives within the health and AIDS sectors illustrate this, and the number of so-called global health initiatives increases from one month to the next. Although there are a number of common characteristics, there are also major differences that may help categorize these to understand their relevance, potentials and limitations.¹²

Traditional bilateral support includes, both state-to-state and support through civil society organisations, but a more recent development is special bilateral programmes, such as the USG PEPFAR or the Norwegian MDG 4&5 Initiative. These programmes tend to have a high political momentum, clear and limited focus, a certain degree of innovativeness, and separate financing, management and reporting.

Philanthropic foundations or organisations have for a long time worked actively in different humanitarian work, but have recently become important global actors on the health and AIDS arena. The two best known are the Bill and Melinda Gates Foundation (BMGF), but also the Clinton Foundation. The BMGF has become (one of) the largest funders for global health and AIDS, and takes actively part in a number of different alliances and initiatives also at technical level. These foundations do not have representatives of other agencies in their board.

Although **international NGOs (INGOs)** are seen to represent civil society, they are normally professional global agencies with a special focus and aim addressing key issues at global, regional and country level. Their source of funding includes donor country governments, but may in principle receive funding from any source. Some of the larger ones are IPPF, World Vision, Care with more issue-specific INGOs such as IBFAN (breastfeeding), IPAS (safe abortion/SRHR) and the Int. HIV/AIDS Alliance. Civil society including NGOs can advocate or work on issues that governments

¹⁰ *Global Health Views: Donor Perspectives on Innovative Financing*, Amanda Glassman, The Brookings Institution, http://www.brookings.edu/opinions/2007/1022_global_health_glassman.aspx

¹¹ "Lessons for Development Finance from Innovative Financing in Health", Informal Experts' Workshop, OECD Headquarters, 7 October 2008 : Useful presentations and report can be found at:

http://www.oecd.org/document/12/0,3343,en_21571361_37824719_41467532_1_1_1_1,00.html

¹² The focus is here on initiatives that target the health and AIDS sectors, although similar ecosystems/landscapes/enterprises can be described for example with regard to nutrition, health research and gender equality.

do not want to address, advancing transparency and accountability, but they can also provide a significant share of service delivery.

The different **multilateral agencies** are well known (i.e. UN agencies such as WHO, UNICEF, UNFPA, UNAIDS; and the WB and regional development banks). A key finding in health is the difficulty in clear division of labour, with agencies performing unevenly in different fields or at country level. After a decade with many agencies hosting special global vertical programmes or alliances for specific purposes/diseases, such as Roll Back Malaria, Stop TB, GAVI etc., the trend is now more to go back to institutional core business and enhancing internal performance. It is here important to differentiate between the more normative roles of e.g. WHO and the role of UNFPA and UNICEF that have a more operational mandate that also includes advocacy. Some of the multilateral agencies, especially World Bank have established a number of trust funds or thematic funds, either as multi or single-donor trust funds. An important example is the multi-donor trust fund established by Norway called World Bank Result Based Funding Trust Fund (RBFTF) which is a part of the Norwegian led MDG4&5 Initiative. Other trust funds are country specific, in particular in countries in transition and rehabilitation phase (e.g. Sudan).

The World Bank defines **Global Funds** as “partnerships and related initiatives whose benefits are intended to cut across more than one region of the world and in which the partners: (a) reach explicit agreement on objectives; (b) agree to establish a new (formal or informal) organization; (c) generate new products or services; and (d) contribute dedicated resources to the program.”¹³ The prolific growth of Global Funds “is connected to the widespread political appeal in donor countries of well-focused, single-issue responses to powerful advocacy campaigns, as against more diffuse, less tangible approaches based on recipient ownership.”¹⁴

The Accra Agenda for Action recognises that “global funds and programmes make an important contribution to development” and that these are most effective when they are matched by efforts to develop the capacity of the environment and institutions within which they operate (e.g. health and education systems). As new global challenges emerge, donors have committed to first ensure that existing channels for aid delivery are used before creating separate new channels that risk further fragmentation and complicate coordination at country level.¹⁵

The largest global funds are GAVI and GFATM, established mainly as new and additional funding mechanisms for vaccines and AIDS, TB and malaria, respectively. These global funds do not have country presence, but are represented in other ways at country level. GAVI is represented by its alliance members, particularly WHO and UNICEF, whereas GFATM is represented by a so-called local fund agent. Global funds have enabled the leveraging of additional financing and have promoted and pioneered results-focus. Their contribution has also been particularly notable in institutionalizing the involvement of civil society and the private sector in both the development and implementation of country proposals. At the same time their mode of operation poses some significant challenges – both for recipient governments and for partners in-country – including the potential distortion of national priorities, fragmentation of efforts and heavy transaction costs.

A number of other **global health initiatives** have in the past decade been established aiming at advocating, increasing awareness and coordinating different aspects of health service delivery, systems or mechanisms for funding, without necessarily contributing with new funds. Examples of these are the PMNCH, GHWA, HMN, RBM and many others. These are generally partnerships consisting of

¹³ IDA, “Aid Architecture: An Overview of the Main Trends in Official Development Assistance Flows”, February 2007

¹⁴ Menocal, Alina & Simon Maxwell & Andrew Rogerson, “Background Paper”, Commonwealth Secretariat and La Francophonie Workshop: The Future of Aid: User Perspectives on Reform of the International Aid System, Dhaka, 20-21 March 2006

¹⁵ Accra Agenda for Action, www.accrahf.net/

bilaterals (countries), multilateral agencies, philanthropic foundations and civil society, some governed by boards or similar arrangements, as well as different committees, etc. Two inter-related “umbrella” global health initiatives are The Global Campaign and IHP+, both seeking to make other global health initiatives work better together at global and country level. Since 2006, global programs in education, environment, health, agriculture and urban affairs have been jointly meeting to share lessons on how to improve aid effectiveness, in response to country needs.¹⁶

Innovative financing mechanisms (discussed above) are means or mechanisms to generate additional funds for health (or AIDS) purposes. These include a variety of different innovations, from affecting market mechanisms (AMC), exchanging debt for health results (D4H), additional taxes (UNITAID) or committing long term bonds (IFFIm). Norway is active in development of many of these new financing mechanisms. Innovative financing proposals have a tendency to require new governance structures or tricky financial engineering GAVI created a new charity to facilitate the flow of front-loaded funding for immunization from the newly launched International Finance Facility for Immunization, while a whole new global health partnership, UNITAID, was created to receive contributions from the airline tax. They have however contributed to raise significant new sources of funding.

Building on lessons from SWAps, a number of new health initiatives, collectively referred to as the **International Health Partnership Plus (IHP+)** aim to both strengthen national health systems and bring greater coherence to the donor response at country level. principles: one single country health and HIV/AIDS plan; one single policy matrix and results framework; one single budget; one monitoring framework and process; and one single country-based validation process. These have results-oriented sound national plans and strategies at their centre, recognizing that all plans need to strike a careful balance between ambition and realism. They need to be sufficiently robust to facilitate partners (donors, governments and others) individually or collectively, to make funding decisions based on their assessment and the results that they aim to achieve.

The eight largest institutions in health (WHO, UNFPA, UNICEF, UNAIDS, GAVI, GFATM, the WB, The BMGF) formed in 2007 a loose network at heads of institutions level called **Health 8 (H8)** and collaborate within the context of the IHP+ processes.

¹⁶ http://siteresources.worldbank.org/ACCRAEXT/Resources/4700790-1210008992554/4968817-1218029841627/2008_GlobalProgramsLearningGroup_ActionsforAidEffectiveness.pdf

Some initial issues for clarification within the context of the HLTF

The immediate priority is to clarify the scope of the HLTF and the working groups.

1. ***The Overall Problem(s) to solve must be better specified.*** The more specific and focused from the onset, the more likely to succeed.

Is the HTLF about

- Raise *more* funding through new innovative financing mechanisms?
- Address the lack of donor funding predictability such as timing of disbursement?
- Raise more domestic resources for health?
- Make spending more efficient (for example by improving technical cooperation or procurement, or expanding anti-corruption measures)?
- Make global and national health programs more results-focused (e.g. through results based funding approaches)?
- Better match the needs of individual countries and international health AID flows?
- Build national and local capacity?
- All of the above?! Weighting of objectives is needed both for workplanning and communication!

2. ***What areas to finance and which financing gaps to estimate must be clearly identified.*** The HLTF terms of reference state that “financing gaps are being clarified in health MDG compacts that are being developed as part of the IHP+ to strengthen health sector commitments by national and international stakeholders.” However only a few countries have Compacts and only twenty or so are engaged in SWAp-type processes.

- Focus on all of the Health MDGs (1c, 4, 5 and 6), meaning on health sector plans and associated HIV/AIDS strategies? Or give special priority to MDG5 as the most neglected area – and as a potent health systems and gender equality driver?
- Give priority to certain countries/regions? (e.g. fragile states, large countries)
- How to reconcile country plans (in just a few countries) and global modelling and costing?
- Are there some strategic priority cross-cutting areas one would want to promote? Such as human resources and products (e.g. drugs, vaccines, diagnostics, bednets) are the largest cost items; or monitoring and evaluation including investment in health information systems and research are urgently needed.

3. ***Possible implications of the global financial crisis should be assessed.***

4. ***The effectiveness and comparative advantages of various channels and modalities need to be assessed.***

5. ***Norwegian added-value areas and specific contributions needs to be identified and mainstreamed into the process***

- MDG5 with link to gender equality and SRHR – including population issues, building on “Chapter 4” in the first annual GHC report¹⁷ ?
- Monitoring and evaluation including implementation research?
- Political advocacy (e.g. Network of Global Leaders)?
- Corruption mitigation?
- Service delivery in fragile states?

¹⁷ http://www.norad.no/default.asp?V_ITEM_ID=9263