

Detailed Responses to the First Reports of the Official Working Groups of the Taskforce for Innovative International Financing for Health Systems

Wednesday, March 18, 2009

Introduction

This paper is a detailed response from a collection of academics and non-government organisations to the reports (dated March 13) produced by the two official working groups of the Taskforce for Innovative International Financing for Health Systems.

We commend the attention being paid by the international community to the need to expand and improve financing for health systems in low-income countries (LICs), and we support much of the initial analysis and recommendations of the two working groups.

We also applaud the emphasis on innovative financing as an add-on to existing domestic and donor commitments to increase health financing [such as the Abuja Declaration to commit 15% of government budgets to health financing (net of aid) and that official development assistance reach 0.7% of donor GNI].

However, we are concerned about a number of omissions and contradictions within the papers, as well as a lack of clarity on certain issues. We hope this paper will be used by the Taskforce and members of both Working Groups to improve further analyses and deliberations, and look forward to a detailed response.

What is the financing gap?

1. We note the 'headline' calculation (by WG1) that the 'financing gap' is estimated to be \$36-49 bn (\$24-32 per capita) per annum in 2015, and that if LIC governments and donors live up to their commitments, an additional \$42 bn per annum would be available by 2015 (with \$26 bn coming from domestic funding, \$12bn from external funding and \$4 bn from private expenditure). WG1 subsequently concludes that the additional required funding would only amount to \$7bn per annum at most in 2015. However, we have a number of concerns and comments about these figures.

2. First, the methodology for calculating these figures is not described. While WG1 notes that its calculations exercise pertain to “the achievement of the health-related MDGs”, it does not describe which services and interventions have actually been costed. Moreover, we believe that the calculations should include the finances needed to achieve comprehensive PHC and not only ‘high impact interventions’. In addition, it is not stated whether the costing incorporates the target of universal coverage or the more limited 2015 coverage targets of the MDGs.
3. Second, WG1 states that the proposed increase in funding would translate into 97,000 -133,000 new health facilities and 2.2 to 3.5m new health workers, and that two-thirds of the additional funding would take the form of recurrent spending, of which 20% would be spent on the health workforce and 15% on drugs and supplies. We would like more detail on the assumptions under-pinning these figures. There is no breakdown of the type of health facilities or health workers, nor any mention as to whether the costing model accommodates the need to raise HW salaries to minimum and acceptable levels in many countries, and to ensure adequate and non-financial incentives.

The allocation of 20% of recurrent expenditure to health workers is also astoundingly low – how was this figure arrived at, and does it relate to total recurrent health expenditure or simply to external DAH? The WHO has estimated that globally, approximately 42% of government health expenditures are spent on wages, salaries and allowances.

4. Third, we would like to understand where exactly the additional \$4 bn worth of private expenditure identified by WG1 will be coming from. It is also unclear as to whether or not the costing model assumes a continuation or a reduction of current levels of out-of-pocket payments.
5. Fourth, estimating the current levels of external finance is clearly important for measuring the financing gap. An early draft of the WG1 report noted that: “Total development assistance for health (DAH) more than doubled between 2000 and 2006, from \$6.8bn to \$16.7 bn”. However, an estimate of the current volume of DAH is not provided in the most recent WG1 report. We therefore request a detailed break down of current DAH, including the estimated aggregate volume of funding as well as the individual sources and channels by which DAH flows into LICs. In addition, we would like to know if the funding gap calculation has adjusted for the fact that a considerable amount of current DAH is allocated to middle-income countries.

6. Various other organisations and analysts have estimated the size of the financing gap to be much larger than those calculated by WG1, so it is important to understand the underlying rationale and methods used by WG1 and to be clear that the true and full magnitude of the global health financing gap has not been under-estimated.

Links to rights and entitlements

7. We endorse WG1's (Para 15) explicit linkage of health systems financing to 'guaranteed benefits', a 'definition of a universal set of entitlements' and the 'universal right to health, as specified in UN conventions'. However, we would like to understand how this then relates to the apparent focus on a set of essential services linked to only the health-related MDGs, and only in low-income countries.
8. We also endorse the view that entitlements and rights can help citizens hold "governments to account for their performance in ensuring universal access to health care" (Para 15). However, we would like to see WG1 also mention the trans-national responsibilities and obligations of governments towards the fulfilling the rights and entitlements of all people, irrespective of their nationality, particularly given the current nature of globalisation. This would provide a stronger basis for proposing the expansion of global solidarity levies to support development assistance.

Country health strategies and plans

9. WG1 makes the point that country-level strategies and plans are important for harmonisation, alignment and up-scaling coverage, as well as for good health stewardship and governance. However, we are not sure why the term 'managing for results' is being used to emphasise this (Para 9). This is a term that is unclear and which suggests linking finance to a set of pre-defined and selective donor-driven indicators. Why not emphasise instead the importance of coherent national health plans backed up by transparent budgeting and effective monitoring and evaluation?
10. We fully endorse the emphasis placed on tailoring approaches to specific country contexts. This reinforces the message that health finance and budgets need to respond to local health needs assessments and health systems capacities. But we would like to see more discussion about the budget and information systems required to support coherent, needs-based and equitable health planning. One omission from both WG papers is the importance of reliable and comprehensive national health accounts (NHAs) as a basis for describing current patterns of financing, resource allocation and

expenditure within health systems. These data are vital for improving the performance and accountability of health systems. Both WGs should therefore emphasise the importance of developing financial management and information systems that embrace the public, donor and private sectors.

11. We fully endorse the emphasis on governance as key to health systems strengthening. However, there could be much more discussion about the strengths and weaknesses of different kinds of health financing arrangements in relation to aspects of good governance such as, for example, government and provider accountability, or community empowerment. Equally, it is important to recognise other requirements of good governance. These include reliable public information about health expenditure patterns; effective regulation; and concerted global and national efforts to tackle corruption.
12. We endorse WG1's statement that "where governments have sufficient planning, management and financial capacity, the strategy should be financed through general or sector budget support, or through basket funding for those unable to provide sector or budget support" (Para 30) and that "stand alone projects unrelated to the country strategy should be avoided". However, more discussion about the types of financing arrangements that result in inappropriate stand-alone, vertical programmes or projects plus the actions required to change such financing arrangements, would be useful.
13. Where existing selective health programmes for priority health interventions are working well, careful efforts should be accelerated to increase their integration and coordination with other health services as well as their contribution to health system strengthening more broadly.

Domestic Financing

14. We endorse WG1's comment (Para 21) that "the top priority is to move towards increased risk pooling" through "expanded public sources of funding" and to reduce private out-of-pocket finance (although this could be made more explicit). However, both WGs remain unclear over the appropriate role of community-based and private insurance. Nor are they explicit or clear about the importance of promoting equitable systems of health financing and provision that ensure access for the poor and for vulnerable populations.
15. While community-based health insurance (CBHI) is an improvement on direct out-of-pocket payments to providers and can (if implemented appropriately) enhance community solidarity, it offers a limited opportunity for large-scale health service improvement, risk-pooling and cross-subsidisation.

More importantly, there is no evidence-base for encouraging the promotion of for-profit private insurance schemes in LICs. In fact, there are sound arguments for strongly discouraging private health insurance.

16. The problems associated with commercialization need to be discussed, particularly given the promotion of private finance capital as an ‘innovative’ source of health finance. We note with some alarm that WG2 appears to be encouraging the generation of private capital finance without discussing the danger that this could aggravate health systems inefficiencies and inequities.
17. The role of private providers is, quite rightly, mentioned several times in the WG papers. Moving the largely unregulated private sector in the direction of equitable and quality health care is a vital requirement of most LICs. As a consequence, more detailed discussion about how health financing arrangements can improve regulation of the private sector without undermining the importance of strengthening public sector provision is required. The options and approaches available to countries to do this however, requires more detailed examination on the basis of country-specific contextual factors. But, in doing so there needs to be a disaggregation of the private sector, recognising the differences between non-profit NGOs and CBOs (which may be closely aligned to public needs and objectives) and for-profit actors (which are aligned to commercial imperatives).
18. It is also important to avoid automatically promoting the private sector as a solution to the limited capacity of the public sector, as one runs the risk of perpetuating a self-fulfilling prophecy. When WG1 states that “where the public sector has limited capacity to manage capital construction and maintenance, there may be a role for the private sector to be contracted to build and maintain primary care facilities and local hospitals, though so far this approach has been applied to mainly tertiary hospitals” (Para 25), we would also like to know the broader rationale for making this statement. We are concerned that inappropriate models of capital development that have emerged in high-income and middle-income countries (e.g. PFI schemes) are being encouraged and we would like clarity on this issue.
19. WG1 discusses a number of options that are open to country-level policy makers, planners and managers to incentivize performance within health systems. Health financing arrangements are clearly one important such mechanism. However, they must be complemented with non-financial incentives, and we would argue that the right mix of incentive mechanisms has to be determined on a country by country basis. Rather than mentioning some of the options available, it may be better to simply

highlight this as an issue that requires further examination. The key principle is to move towards more coordinated and pooled health finance together with an accountable and coherent system of planning and budgeting – subsequent work can then be conducted at the country level to create the appropriate mix of performance incentives within the health system. We would also highlight that performance-based financing (PBF) and results-based financing (RBF) are concepts that are understood differently by different agencies, and if applied, need to be carefully designed to suit local needs and capabilities, and to avoid the creation of perverse incentives.

20. Neither WG papers address the on-going problems related to fiscal and macro-economic policy originating at the International Monetary Fund and all too often acquiesced to by finance ministries, and their negative impacts on domestic and donor health financing. Imposed requirements upon low-income countries to set low inflation targets, and to reduce fiscal deficits and government budgets relative to GDP has reduced the ability of governments to make better use of existing finance for health improvement, whether domestic or donor, particularly in terms of increasing the number of health workers and ensuring that HWs are adequately remunerated. There is growing evidence of fungibility or substitution effects whereby increased donor financing typically results in lower domestic financing because of diversion to reducing foreign currency reserves and domestic debt. These overly restrictive and anti-growth macroeconomic policies must be addressed.

Scaling up domestic finance

21. Neither of the WG papers make detailed mention of how domestic financing can be increased other than in reference to increasing the allocation of public money to the health sector (e.g. the Abuja Declaration). However, many LICs have a limited public budget to begin with. Some of the reasons for this include: a) high volumes of illicit and licit capital flight from LICs; b) low proportion of GDP captured as public revenue (due to capital flight and tax evasion; inefficient tax administrations, and inappropriate tax policy); and c) high amounts of public revenue directed towards foreign currency reserves. Furthermore, domestic tax policy and administration are not only central components of improved domestic financing policy, but are also critical issues related to governance, accountability and democracy.
22. There are therefore many measures that can be undertaken to increase the public revenue of LICs. Some of these measures need to be implemented at the country level, whilst others at the international level. The failure of WG2 to discuss any of these measures is a glaring omission.

Scaling up existing international financing mechanisms for health systems

23. We endorse the support given to implementation of a currency transaction levy (CTL). We disagree, however, to the proposal being placed under the heading of ‘Global Taxes’ as this implies the need for multilateral support in order to proceed. It would be better to promote a CTL as a ‘international solidarity levy’ captured at the national or regional level, but earmarked for a Global Public Good (in a similar way to the use of aviation levies to fund UNITAID).
24. We encourage WG2 to consider other sources of sufficient and predictable finance for health over the long term. In the current financial climate this would favour the use of solidarity levies on solid revenue bases such as transport, use of carbon, financial transactions and extractive industries, as compared to private giving and frontloading. As well, we encourage WG2 to address the issue of illicit finance, as action to stem the tide of money leaving developing countries will considerably strengthen efforts to increase health spending (and general prosperity) within them.
25. Globalisation has now resulted in many economic transactions taking place beyond the reach and regulation of national governments. A number of reports including the Commission on the Social Determinants of Health and the ILO Commission on the Social Dimensions of Globalisation have described the need for an international tax authority to help improve the efficient and effective capture of public revenue. Helping to address the problems associated with low corporate tax rates and illicit outflows of capital from low-income but resource-rich countries is another added benefit that could be generated from the establishment of an international tax authority.
26. In contrast, we reject the suggestion that further tax exemptions should be promoted as a means to support additional charitable giving. The priority must be to end the huge social costs associated with tax evasion, deceitful accounting practices and tax competition, rather than recommending further tax exemptions.

Managing new global finance for health

27. A major problem faced by LICs is the existence of multiple global health funds and donors. These include bilateral donors, GHPs (particularly the Global Fund and GAVI), as well as private foundations, UN agencies and the World Bank. We strongly endorse WG2’s comment that: “There

needs to be a shift from international financing mechanisms that build on project applications approved in a development partner's global headquarters or capital, to agreed financial contributions to national health plans, where reporting and follow up of results take place at the national level". We also endorse the underlying implicit recommendation for funding to be increasingly directed towards a general service delivery platform on which the success of individual disease-specific programmes depends. A key question for WG2 is therefore how new sources of development assistance for health will be managed, used and channeled to LICs.

28. However, WG2 suggests that finance raised from a currency transaction tax could be allocated specifically to MDGs 4 and 5. We do not endorse this suggestion. Allocating new sources of finance to specific health MDGs is divisive and runs against the principle of supporting country-based health plans based on local need and priority-setting exercises. It also risks proliferating even further the existing number of global health initiatives and funding sources.
29. Instead, we endorse WG2's comment that the existing global "architecture" for health needs reform and that there should be "a radical simplification of the overall funding landscape" (page 6). However, we would like to see WG2 outlining in more concrete terms the options for 'radical simplification'.
30. One proposal that we would like the WGs to consider is recommend that bilateral donors commit themselves to greater harmonization either through use of sector-wide approaches, or by channeling a greater proportion of their funding through multilateral channels. Presently, only 25% of DAH from OECD donor countries is channeled through multilateral channels.
31. As far as multilateral channels of health funding are concerned, we would like to emphasise the benefits of using existing channels such as GAVI and the Global Fund, rather than the creation of new conduits of finance. This should include exploring the option of transforming the Global Fund or GAVI into a more generic Global Fund for Health which is mandated to support health care improvement across the board, including those associated with MDGs 4 and 5, based on the principles of country ownership, as well as coherent planning, monitoring and evaluation.
32. The view of many civil society groups is that the WB's history in health systems policy and development rules it out as a desirable conduit for supporting expanded financing for health systems development in low income countries. We are also curious about the recommendation to channel solidarity levies to the IFFIm. It seems that if solidarity levies are to be raised to support health

systems development, IFFIm would be an inappropriate recipient of this money given its focus as a commodity purchasing agent.

Capacity to effectively absorb increased funding

33. As a final point, we would like to emphasise the importance of strengthening the capacity of health systems to absorb increased funding. While there may be implicit acknowledgement of this, it is important to highlight the importance of developing comprehensive and coherent initiatives to improve human and management systems capacities within countries. In particular, the promotion of budget support and sector-wide approaches must be accompanied by plans to improve public financial management and to strengthen public accountability instruments. There are no quick and easy ‘magic bullet’ solutions to the dysfunctionality of many LIC health systems. Health financing arrangements therefore need to respond both to the urgent challenges of reducing premature mortality and medium to long-term strategies required to improve the administration and management of health systems.

Signatories

This paper has been drafted by Dr David McCoy from the Centre for International Health and Development, University College London, using extensive discussion and input from a range of civil society groups, academics and NGOs. While the full content of this submission can only be attributed to the author, the following individuals and organisations support its submission as a contribution towards further discussion between civil society, the Working Groups and the Taskforce.

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