

Taskforce for Innovative International Financing for Health Systems

Working Group 1: Constraints and Costs

First report to Taskforce, 13 March 2009

KEY MESSAGES

1. Since the adoption of the Millennium Declaration, total development assistance for health has more than doubled and has saved the lives of millions of individuals and protected the livelihoods of their families. But most low income countries are failing to make much progress towards the child and maternal mortality MDG targets, and the financial crisis threatens to increase infant deaths by 200,000-400,000.
2. Progress towards the health-related MDGs is impeded by insufficient funding, poor use of resources, unbalanced funding of different services, and fragmented funding flows. Low income countries currently spend only \$24 per capita on health; of this \$11 comes from out-of-pocket payments, and only \$6 from external funding. In 2006, more than 50% of external funding for health provided directly to countries supported MDG6, leaving only \$2.25 per capita for everything else.
3. Everyone should have access to guaranteed health benefits¹. The extent of these guaranteed benefits would be determined by individual countries, but as a minimum for the health-related MDGs to be achieved, services should include universal coverage of interventions proven to reduce mortality among mothers, newborns and children under 5; childbirth care; reproductive health services; prevention and treatment of the main infectious diseases; diagnosis, information, referral, and palliative care for any presenting conditions; and health promotion. Effective service delivery requires a health system which can train and supervise the necessary health workers, supply the drugs and supplies, channel money, and ensure accountability and transparency.
4. Much more money is needed from domestic and external resources to ensure that rapid progress is made towards the health-related MDGs, and that health systems in low income countries can make the guaranteed benefits available to all.
5. Better use of domestic and international resources is needed to maximize the impact of all investments in health, whether existing or new, and address current problems of inequity, inefficiency, and poor quality. Countries need to develop a technically sound country health strategy and plan for scaling up to universal coverage. The country strategy must set out how health system governance, financing and service delivery will be improved:
 - Governance arrangements are critical for maximizing the impact of health spending and ensuring poor, vulnerable and marginalized groups benefit most from increased resources; strengthened leadership is vital in public organizations.
 - Financing arrangements must ensure sustainable and equitable domestic financing structures, predictable external finance, improved risk pooling over time, and effective purchasing of priority services.
 - Service delivery arrangements must take advantage of both public and private providers to ensure provision of services which are accessible, technically effective, responsive to users, efficient, equitable, and staffed by adequate numbers of appropriately skilled health workers.
6. Strengthening the governance, financing and delivery of the health system to ensure rapid progress towards the health-related MDGs would cost an additional \$36-49bn² (\$24-32 per capita) per annum in 2015. If low income country governments live up to their commitment to increase the share of government expenditure going to health, and if donors honour their promise to increase ODA to 0.7% of

¹ As stated in UN conventions

² constant 2005 \$

Taskforce for Innovative International Financing for Health Systems

GNI, an additional \$42bn per annum would be available by 2015. \$26 bn of this would come from increased domestic funding, \$12bn from external funding, and \$4 bn from private expenditure. Additional funding is thus required of at most \$7bn per annum in 2015. Two thirds of increased funding would be spent in Sub Saharan Africa.

7. This level of health expenditure in 2015 would save the lives of over 5m children and babies, provide skilled care at birth for 56m women, prolong 6m lives through ART treatment, and avert over 1m new HIV infections. Health facilities would increase by 97,000-133,000, health workers by 2.2-3.5m, and health systems would be put in place that would enable sustained health improvement into the future.
8. Capital expenditures are important for increasing system capacity to absorb more funding and would take up a third of the investment, with the remainder required for ongoing health system support including around 20% for the health workforce and 15% for drugs and supplies. For additional funds to be used as intended to expand health spending, governments must agree to prioritize health within national budgets.
9. The country health strategy, backed by high level political commitment, is critical for deploying external funding in ways that ensure country ownership, donor alignment with strategies, and harmonization of donor actions³. There must be a focus on managing for results for which countries and donors are mutually accountable, backed by systems for monitoring and evaluating progress, and a focus also on building capacity for the long term, using national systems as the first option to channel money, purchase drugs and supplies, recruit technical assistance, and report on use of funds⁴.
10. Approaches must be tailored to the specifics of each country context; the pace of change must be agreed locally to ensure effective absorption of additional funding, and a long term sustainable approach to strengthening the health system. The above investments, even more crucial at a time of economic crisis, will increase human capital and promote economic growth into the longer term, enabling countries to increasingly fund their health system themselves.

Question to the Taskforce

Does the Taskforce have views on the analysis and arguments presented?

EXECUTIVE SUMMARY

Background

11. At the UN High Level Event in New York on 25 September 2008, a *High Level Taskforce on Innovative International Financing for Health Systems* (Taskforce) was established to contribute to filling national financing gaps to reach the health MDGs in low income countries⁵ through mobilizing additional resources; increasing the financial efficiency of health financing; and enhancing the effective use of funds. This report, from Working Group 1, addresses the health systems strengthening needed to achieve the health MDGs, especially those considered to be neglected, namely MDGs 4 and 5.
12. Since the adoption of the Millennium Declaration, total development assistance for health has more than doubled. The largest share has supported specific disease control efforts, especially for HIV/AIDS, malaria and immunization, and has saved millions of lives. But health gains in low income countries still fall well short of those required. Most countries are struggling to meet the MDG targets. Half of low income countries have made insufficient progress in reducing child mortality, especially neonatal mortality, and many have made no progress at all. Almost all low income countries have high or very high maternal mortality ratios.

³ Paris Declaration

⁴ Accra Agenda for Action

⁵ 49 countries: <http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS>

Taskforce for Innovative International Financing for Health Systems

13. Funding still falls well short of the levels needed to achieve the MDG targets, and has especially overlooked the need to support the health systems platform. In 2002-6, more than 50% of all health aid provided directly to countries was absorbed by commitments relating to MDG 6, leaving only \$2.25 per capita per year for MDGs 4 and 5 and broader health system support. Yet the health system is critical for ensuring effective service delivery. It trains and supervises the necessary health workers, supplies the drugs and supplies, channels the money, and ensures accountability and transparency. It is especially critical in supplying the multi-purpose infrastructure needed to provide interventions for mothers, babies and children, as well as for treating infectious diseases.
14. The global financial crisis makes it even more important that health systems receive greater attention and support, since demands on public health services will escalate. Increased health spending will benefit not just health but also support broader development goals of poverty reduction and economic growth.

Guaranteed benefits and the health system platform

15. Defining guaranteed benefits provides the starting point for ascertaining health system needs for achieving the health-related MDGs efficiently, effectively and equitably. The definition of a universal set of entitlements reflects the actionable items of the universal right to health, as specified in UN conventions. It is also a tool for holding governments to account for their performance in ensuring universal access to health care for all their citizens.
16. Substantial prior analytical work has identified the interventions needed to achieve the health-related MDGs. These comprise interventions proven to reduce mortality among mothers, newborns and children under 5, childbirth care, reproductive health services, prevention and treatment of the main infectious diseases, responses to the conditions that people present with within primary care, and health promotion.
17. Effective delivery of this package requires a health system platform which can deliver health services through a primary health care approach; ensure financing and social protection; supply and manage the health workforce; manage logistics and supply chains; collect and analyze information; and ensure effective governance. Yet countries are currently far from being able to do this.

The constraints

18. Low income countries experience multiple constraints in strengthening their health systems. Lack of money is a fundamental constraint, but unless other constraints are recognized and addressed, countries will find it difficult to absorb and use additional finance effectively. Constraints can be analyzed in terms of the various levels of the health system, including the levels of (i) community and household; (ii) health service delivery; (iii) health sector policy and strategic management; (iv) public policies cutting across sectors; (v) environmental and contextual characteristics; and (vi) the global level. Long term solutions to inadequate coverage of health services demand action not just at that level but also at the other levels – in other words they demand a health system response.
19. Four health system inputs are critical: financing, the health workforce, drugs and supplies, and health information. In low income countries, the major source of finance for health care is out-of-pocket payments so most households have no financial protection when they fall ill. The health workforce is fundamental to both the delivery of care and its management, yet 44 of the 49 low income countries have a grossly inadequate numbers of health workers to provide essential health services, and low remuneration, poor working conditions, and lack of supportive supervision contribute to suboptimal performance. Drugs are a critical element of health services but are often unavailable through public outlets and have to be purchased through frequently unregulated outlets, and at substantial price markups. Information quantity and quality for monitoring progress and assessing health systems is poor and information systems are underfunded.

Strengthening the health system: Governance arrangements

Taskforce for Innovative International Financing for Health Systems

20. Good governance is a fundamental prerequisite for all parts of the health system to work well. Countries with higher quality policies and institutions are more effective in translating government health spending into health impact such as lower maternal mortality ratios. Successful steps that countries have taken to improve health system governance include providing leadership and strategic direction as in Ethiopia, strengthening decentralized health management as in Tanzania, supporting structures for community involvement as in Burkina Faso and Nepal, holding officials to account for how they spend their budgets as in Rwanda, and effective intersectoral advocacy as in the case of National Aids Commissions in a number of countries. Governance reforms require political commitment, leadership skills, technical capacity, and gradual implementation. They must respond to domestically driven reform agendas suited to the local context rather than to externally imposed blueprints.

Strengthening the health system: Financing arrangements

21. Out-of-pocket payments equal government funding as a proportion of total health expenditure in low income countries. Hence the top priority is to move towards increased risk pooling, as Ghana and Tanzania have done, through expanded public sources of funding. Community-based or private insurance schemes may provide limited risk pooling for specific groups, though any public subsidies should target the poorest not the less poor. Whatever the mix of funding sources, governments must set an adequate institutional framework and regulations for public and private actors.
22. When funds are pooled, health care purchasers can set priorities through financial allocations and put in place incentives to encourage the efficient, equitable and responsive provision of care. Incentives can be transmitted through resource allocation processes in hierarchical management systems, or through more market-type arrangements such as purchaser-provider separation within the public sector or contracting with NGO providers. Results-based financing, the transfer of money or material goods conditional on taking a measurable action or achieving a specified performance target, has produced promising results in specific settings including improvements in the number of mothers delivering at accredited institutions in India. A key need is to build the evidence base on RBF in low income countries.

Strengthening the health system: Service delivery arrangements

23. Delivery is the defining function of a health system –the functions of governance and financing provide back-up to health care delivery. The health workforce is critical to effective service delivery. Education and training institutions have to be scaled-up to supply the health workforce needed for achievement of the health MDGs, and to redress imbalances. There is encouraging evidence from many countries of the effectiveness, for a wide range of services, of task shifting from doctors to mid level practitioners, and from health professionals to a wide range of lay providers with targeted training. However, more health workers on their own will not be enough - better performance is also required. Effective linkages with local health facilities including regular supportive supervision are critical to maintaining an effective and motivated community-based workforce; modern telecommunications promise to revolutionize relationships. A mix of financial and non financial measures can be used to encourage good performance, improve the geographical distribution of the workforce, and support retention.
24. Comprehensive service delivery is highly desirable but may be difficult to implement quickly in very low capacity settings. Focusing on a limited number of high impact interventions through integrated delivery at the community level may therefore be appropriate as a temporary measure, but should develop over time in line with national strategies into more broadly based services. Given the extensive availability of services offered by private providers, countries need to decide how best to extend coverage through all providers, in ways that ensure improved quality of care. Training, drug packaging and franchising can help increase the benefits derived from the purchase of drugs from retail outlets, which are frequently the only source of assistance accessible to the poorest.
25. Access to guaranteed benefits requires extension of the service delivery network through building energy efficient new facilities and renovating old ones. 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

Taskforce for Innovative International Financing for Health Systems

and maintain primary care facilities and local hospitals, though so far this approach has been applied mainly tertiary hospitals.

Financing needs

26. Through the combined analytical efforts of many international agencies⁶, calculations have been made of the minimum and maximum costs of putting in place the health system needed to support achievement of the health MDGs in low income countries, likely increases in funding 2009-2015 under two sets of assumptions⁷, and the resulting funding gap.

Increased financing 2015 [2005 \$bn]				Maximum cost 2015		Minimum cost 2015	
				Funding need	Funding gap	Funding need	Funding gap
<i>Commitments met scenario</i>							
Government	ODA	Private	Total				
26	12	4	42	49	7	36	-6
<i>No change scenario</i>							
Government	ODA	Private	Total				
5	3	5	13	49	36	36	23

27. The financing gap for 2015 is a maximum of \$7 bn assuming current commitments are met, or \$23-36 bn assuming current shares of government, external and private funding remain unchanged. For Sub-Saharan Africa, funding needs are \$28-31bn, and the funding gap \$2-5bn if commitments are met, and \$21-24 bn if they are not met, since SSA would especially suffer if governments are unable to live up to their commitments. The amount shown above for increased private expenditure highlights the importance of developing domestic financing policies which can capture such spending, through insurance arrangements or increased domestic taxation.
28. This level of health expenditure in 2015 would prevent over 5m neonatal, infant and child deaths and 260,000 TB deaths, avert 1.2m HIV infections and prolong 6m lives through ART, avert 15m unwanted pregnancies, and ensure skilled care for 56m pregnancies. Health systems would be put in place that would enable sustained health improvement into the future.
29. The costs may appear high. However, the 2015 inputs would still fall short of those available now in lower middle income countries, to deal with a much lower burden of disease. For example, total health expenditure per capita would be \$57 as compared to \$74 in lower middle income countries; hospital beds/10,000 would be 22 as compared to 24, and nurses/midwives/1000 would be 2.3 as compared to 2.5. And \$57 is tiny compared to the \$4012 per person spent by the rich world on health services.

Flows of funds

30. How external funding flows to countries, and how both domestic and external funding are deployed, will be critical in ensuring stronger health systems and improved health outcomes. Key principles are funding a technically and financially sound country strategy, ensuring predictable finance, ensuring a focus on accountability for results, making use of all channels for delivering services, building capacity for the long term, and tailoring approaches to country contexts. 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. Stand alone projects unrelated to the country strategy should be avoided. The country strategy must include

⁶ WHO including its disease control partnerships, World Bank, UNAIDS, UNICEF, UNDP, UNFPA, PMNCH

⁷ *Commitments met*: 15% of government expenditure to health SSA; 12% elsewhere; 0.7% GNI to ODA and health and low income country shares maintained; 50% of private health expenditure increase available for health MDGs; IMF growth projections 29/01/09. *No change*: current government and ODA shares in total health expenditure (THE) maintained; THE grows at rate slightly faster than economic growth; 50% of private health expenditure increase available for health MDGs; IMF growth projections 29/01/09.

Taskforce for Innovative International Financing for Health Systems

strategies for both financing and the workforce, and must demonstrate government commitment to implement solutions in the areas of governance, financing and delivery that benefit the needs of poor and disadvantaged groups. Design, implementation and evaluation of innovations in national health financing could form part of the activities to be funded. Countries with weak capacity to develop a technically sound country strategy should be supported to gradually build their planning and management systems. Predictable finance will be especially critical in enabling governments to address seriously the need to implement improvements to health systems, strengthen the health workforce, and implement risk pooling arrangements.

Further work

31. Work continues to refine the estimates of costs, financing gap and health impact. Following interaction between the two working groups, scenarios will be mapped out involving different approaches to frontloading expenditure and their implications for the phasing of additional funding.

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