



Financing an Integrated Policy Package for Improved Management of Health Resources

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World Health Organization

Despite renewed commitment to improving the health of the world's poor, progress towards the MDGs is slow and uneven. To accelerate progress, increased domestic and donor funding for health are needed. At the same time, national management of health investments must be strengthened.

1. INTRODUCTION

Recent years have seen increases in development assistance for health and renewed commitment to address health and development challenges. The 2001 report of the Commission on Macroeconomics and Health (CMH) demonstrated that improved health is an input to economic development and poverty reduction, as well as a result of economic growth. The Millennium

Development Goals (MDGs) have reinvigorated the health and development agenda and have established a set of broadly-agreed health targets against which to measure progress. Estimates of the cost of needed interventions and investments in health systems in order to reach the Goals have been compiled, including by the CMH, the Copenhagen Consensus, and the United Nations Millennium Project (see Annex).

And yet, five years after world leaders agreed to undertake a global partnership to achieve the MDGs by 2015, large increases in Development Assistance for Health (DAH) have not materialized, and progress towards the Goals is slow and uneven. Worryingly, the poorest countries show the slowest progress towards the MDGs. Sub-Saharan Africa and Eastern Europe are most off-track across a number of the health-related Goals, including the relevant communicable disease targets.¹ No region of the developing world is on track to meet the child-mortality target. Moreover, national aggregates can hide important disparities in health status among different population groups, and the Goals could conceivably be met without improving the health status of the poorest.²

In most cases, the problems that constrain national progress towards the health MDGs are "upstream": limited spending on human development; insufficient and fragmented external support; poorly developed health policies; and weak institutions. Ineffective public spending on health is reflected in the levels and types of investments and the existence of high out-of-pocket spending. Large increases in external aid for the social sectors, including health, are necessary to take advantage of economic growth and globalization processes. However, a transformation in the way aid is delivered is key for financing human development in a sustainable way respectful of country priorities. At the same time, national processes for managing resources for health must be strengthened so that increases in domestic and donor funds for health can be used in a cohesive and equitable manner. Development partners can make a difference in creating the conditions for an integrated, responsive package of support for building strong health systems and institutions in developing countries.

There is a need for increased domestic resources for health, as well as greater efficiency and equity in their mobilization and use. Households are financing a large portion of essential health services out of their pockets, while public spending is directed to large capital investments in urban areas.

2. CURRENT HEALTH SPENDING

2.1 Low government health expenditure

In many developing countries, public spending on the health sector is insufficient for achieving the health MDGs. The CMH recommended that low- and middle-income countries should increase health budgets by one per cent of GNP by 2007 and two per cent of GNP by 2015. For low-

income countries, this entails an additional budgetary outlay of US\$ 23 billion by 2007 and US\$ 40 billion by 2015.³

2.2 Inefficient allocation of scarce funds

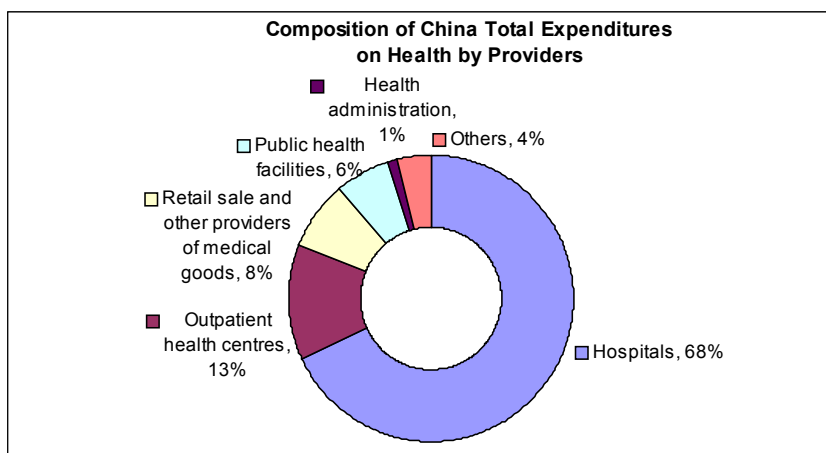


Figure 1. Source: China National Health Accounts 2004.

In addition, existing resources are not used effectively. Financial resources for the health system can be classified as capital (training of people, investment in buildings and equipment) and recurrent (labour costs, maintenance, consumables).⁴ In general, government spending on large capital investments is disproportionately high, while recurrent costs, including salaries and maintenance, are under-funded. Governments spend a large portion of their health budget on hospitals, which generally deliver personal medical services and not public goods for health. Figure 1 demonstrates that in China, hospitals account for the vast majority of total health expenditures. Countries such as Cambodia, Kenya, Malawi and Mozambique report capital expenditures of between 40 and 50 per cent of the total public health budget in one or more years.⁵

Figure 2 shows that in Yemen, on average over the period 1999-2003, around one-fourth of total government health spending was investment spending. Existing facilities are under-staffed, undersupplied, and poorly maintained.⁶

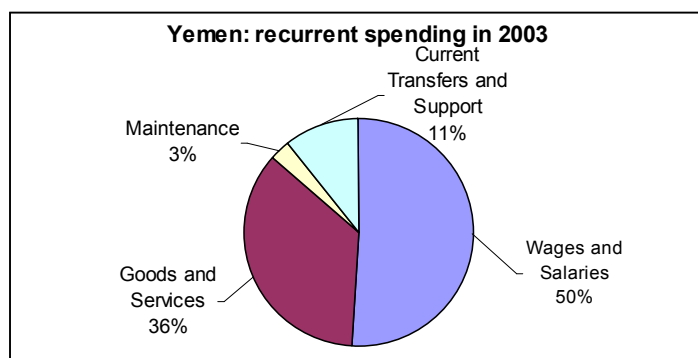
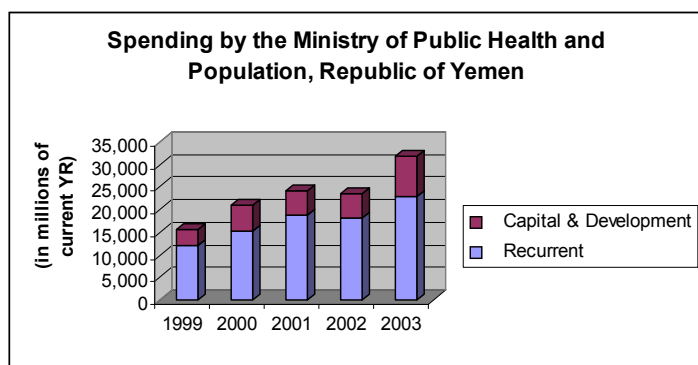


Figure 2. Source: Fairbank, A. Draft Yemen Public Health Expenditure Review, 1999-2003.

Government health expenditures tend to benefit proportionally more the wealthier segments of the population,⁷ and are focused on cities as opposed to rural areas. For example, in Ghana and Senegal, more than half the physicians are concentrated in the capital city, where fewer than 20 per cent of people live.⁸ In China, urban per capita medical expenditure was 2.27 times that in rural areas, a gap which is growing over time.⁹ Yemen, too, sees most resources and staff concentrated around urban areas.¹⁰ Ensuring efficient transfer of funds for health to the service delivery level is another challenge. Many countries have embarked upon decentralization reforms towards improving efficiency and quality of services. However, coordination between the centre and the periphery is often weak. Leakages of funds at different levels are common, as well as delays in the release of funds to the periphery. In Senegal, only 20 per cent of

total expenditure in health is utilized at the operational level.¹¹ In Malawi, funds for health at the primary level are channelled through district hospitals, where they are often diverted from their original allocation, thus never reaching primary-level health care centres.¹² It is critical that this flow of funds be streamlined to ensure that poor and rural communities are accessed.

2.3 The human resources crisis

Insufficient funding for recurrent costs in the form of salaries is a key driver of the current human resources crisis, which is being exacerbated by the HIV/AIDS epidemic. Figure 3 shows the projected decline in the health workforce in Africa over the next ten years. Developing country doctors and nurses migrate in large numbers to developed countries for higher salaries and better working conditions. Health workers who remain show poor motivation due to low remuneration, lack of training opportunities, and insufficient supplies to perform their work. In some countries, there is a serious imbalance in "staff mix", as in Sri Lanka, where there is a surplus of doctors and a shortage of nurses.¹³ Health workers are concentrated in urban centres due to lack of incentives to serve in isolated, rural areas. International financial institutions exacerbate this situation by imposing caps on salaries and staff numbers, and donors have typically neglected long-term investment in human resources in favour of short-term training or foreign technical assistance.¹⁴ Human resources are the single most important input into the health system, and their improved management will be critical for building long-term national capacity to supply public health goods.

Projection of health workforce in Africa based on current trends

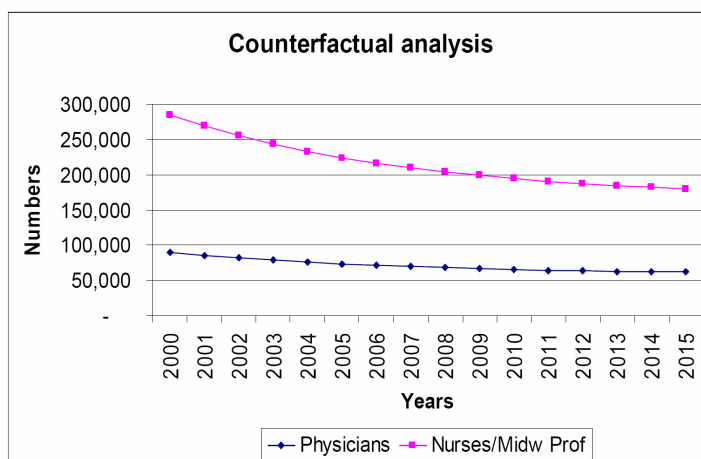


Figure 3. Source: High-Level Forum on the Health MDGs, Abuja, 2004

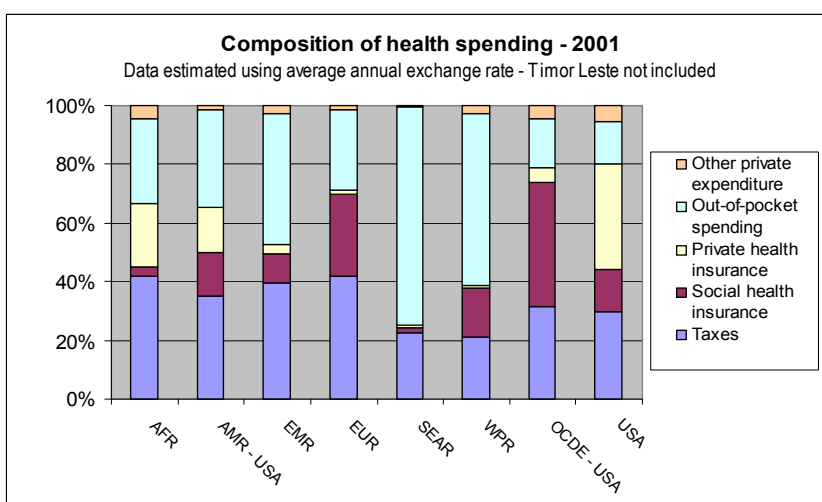


Figure 4. Source: EIP, WHO

2.4 Out-of-pocket health expenditure

The inefficiency and inequity of health financing in many countries is compounded by high levels of out-of-pocket (OOP) spending. In low-income countries, private health expenditure constitutes 73 per cent of total health expenditure (2001),¹⁵ the lion's share of which is OOP spending. The World Health Report 2000 reported that in 60 per cent of countries at incomes below US\$

1,000 per capita, OOP spending is 40 per cent or more of total health spending, where only 30 per cent of middle- and high-income countries depend so heavily on this form of financing.¹⁶ Households finance half of all health services in all but the middle-income African countries.¹⁷ The magnitude of out-of-pocket health spending versus other forms of health financing is shown in Figure 4 for different regions.

OOP health spending is a major factor leading to impoverishment. A World Bank study on India concludes that OOP health expenses (estimated at more than 80 per cent of total health expenditure) may push 2.2 per cent of the population below the poverty line each year.¹⁸ OOP expenses do not distinguish between those with greater or lesser ability to pay and there is no element of risk-sharing. OOP expenditures generally are also inefficient, in part due to an asymmetry of information between client and provider which limits clients' ability to make rational choices about health care.

Although DAH has increased, it still falls short of meeting real needs. At the same time, more effective donor funding is needed, particularly budget support for meeting recurrent costs.

3. CURRENT FLAWS IN DEVELOPMENT ASSISTANCE FOR HEALTH (DAH)

3.1 Levels of DAH

In 2002, DAH increased by \$1.7 billion, from an average of US\$ 6.4 billion (1997-1999) to US\$ 8.1 billion.¹⁹ Although this increase is encouraging, it still falls short of meeting real needs of low-income countries, suggesting the urgency of developing innovative funding mechanisms to mobilize and sustain the necessary increases in health resources. The CMH recommended that development assistance for health (DAH) should increase to US\$ 27 billion per year by 2007 and US\$ 38 billion by 2015.²⁰ Middle-income countries, on the other hand, require primarily technical assistance on how to address residual pockets of poverty and inequity in the health system.

3.2 Effectiveness of DAH

In addition to increased DAH, donors should consider the effectiveness of the assistance they are providing. Donors need to continue to work to contribute adequately to building national capacity to manage health resources. Donors traditionally have provided the bulk of their support to project-oriented, disease-specific programmes based on national geo-political interests, resulting in suboptimal allocations.

3.2.1 Alignment

Alignment is defined by a recent OECD report as "the commitment made by donors to base development assistance on partner countries' national strategies, institutions and processes."²¹ While donors do seem to be aligning on health sector strategies in many cases, it is less common to find donors' funds integrated in the sector Medium Term Expenditure Framework (MTEF).²²

The compatibility of donor programmes with other investments or their sustainability over the longer term is a key issue. While donor programmes likely have greater impact in the short-term, they may draw human and financial resources away from broader health systems. Because of their narrow targets, disease-specific approaches may fail to consider solutions that would increase the efficiency of the overall health system. Furthermore, ODA is subject to important fluctuations over time, due to

budgetary procedures, changes in priorities, decision making and administrative delays, and conditionalities attached to aid. This volatility has a serious impact on developing countries, an impact even greater than the fluctuation of developing countries' GDPs.²³ The unpredictability of donor aid may deter countries from making investments in health systems which cannot be maintained if donor preferences change. Increased predictability of aid is therefore a key pre-condition for the global increase of aid effectiveness.

3.2.2 Budget support

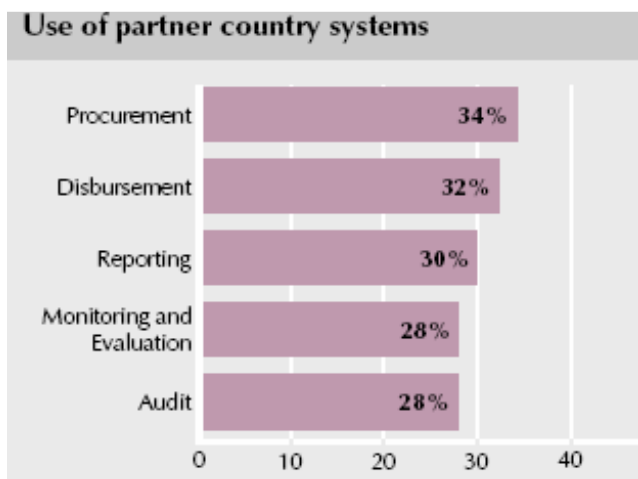


Figure 5. Source: OECD/DAC Survey on Harmonization and Alignment: Measuring Harmonization and Alignment in 14 Partner Countries.

Budget support is increasing as a share of donor support, but it still represents less than one-third of total aid flows.²⁴ Figure 5 suggests that donors make scarce use of country systems, reflecting these low levels of budget support. By bypassing governments, donors hope to circumvent weak systems and institutions and better reach recipients of aid. However, there is a pressing need for long-term financing of recurrent costs of the social sector and basic health services. If aid has to have a sustainable impact on the development of health systems, nurses and doctors need to be paid, health premises and equipment maintained in working condition and updated. These recurrent costs go often beyond the budgetary capacity of poor countries, constrained by a weak fiscal basis

and the external debt burden. It is increasingly accepted that strong health systems are necessary to help disease-specific programmes succeed. There is scope for action by donors in providing sustainable budget support and funding for recurrent costs, including human resources, in order to build national institutional capacity to supply public goods for health.

3.2.3 Harmonization

Multiple and uncoordinated activities impede the ability of governments to manage development assistance, creating high transaction, negotiation and administration costs. Recent findings coming out of country studies find that “countries continue to face the problem of coordinating large numbers of donors providing their assistance via multiple routes.”²⁵ There is little evidence that donors are streamlining conditionality at the sector level, including in health.²⁶

3.3 The Sector-wide Approach

The Sector-wide Approach (SWAp) has considerable potential for improving country ownership and streamlining donor processes in countries that are highly dependent on external aid. The SWAp rationale implies that all available external funding for a sector, e.g. health, is consolidated into one policy and expenditure programme that is subject to a regular consultation process between the recipient government and donors, it is under government leadership and managed through government procedures. The SWAp mechanism, though representing an important change in the scenario of aid

management, has not overcome all problems related to donor-recipient relations. Studies have indicated, for example, flaws such as insufficient provision of resources for a basic package of interventions, weak link to local government and budget reforms, conditionalities and excessive intrusiveness of donors in the management process.²⁷

3.4 The International Finance Facility and other mechanisms

The idea of harmonization and predictability is very much behind the concept of the International Finance Facility (IFF), which is based on the assumption that donor countries that have committed to regularly increase their contribution to ODA at the Monterrey Conference on Financing for Development will concretize sooner or later their pledges and that a mechanism can therefore be established to advance resources to developing countries through bonds issued in the financial market. Clear linkages to the need for harmonization, predictability and sustainability are also in the proposal of the Government of France to promote new forms of international financial contributions to development aid based on international taxation mechanisms. Ongoing discussions related to the OECD High Level Forum on Aid Effectiveness and to the forthcoming third High Level Forum on the Health MDGs, to be hosted by the French Government in Paris at the end of 2005, also have the potential to contribute greatly to productive processes in that direction.

National capacity-building could be addressed through a flexible "policy package" of tools for addressing "upstream" constraints, towards more effective policy-making and management of health resources. Better information for national planning underpins all four components of the package: advocacy and consensus-building; planning and costing, prioritization, and financing; monitoring and evaluation; and involvement of stakeholders.

4. A "POLICY PACKAGE" FOR IMPROVED MANAGEMENT OF HEALTH RESOURCES

4.1 "Upstream" constraints

Donor and domestic resources must be increased and also must target the removal of the "upstream" constraints which result in limited effectiveness of scarce resources for health.

In many developing countries, despite the growing body of evidence of the socio-economic benefits of good health and its impact on poverty reduction, there is a dearth of sustained political support for long-term investment in health. Health sector strategies often do not set clear priorities, are inadequately-costed and budgeted, and are developed in isolation from broader development processes. In particular, health is poorly reflected in many poverty reduction strategies. Poverty Reduction Strategy Papers (PRSPs) are the principal national planning frameworks for poverty reduction in many low-income countries, and are increasingly the basis for multilateral and bilateral funding as donors move towards budget support. Finally, there is a need to focus efforts on improvements in access to basic health services for the poor, who are typically the most expensive and difficult to reach.

4.2 Better information for health planning and financing

Better information for national health planning and financing is at the heart of addressing these constraints. Critical and neglected basic scientific research in developing countries, for example in epidemiology, health economics, health systems and health policy is crucial for improving national management of health resources.

4.3 Components of the "policy package"

Macroeconomics and Health and related work in countries have suggested essential components of a "policy package" of tools for effective policy-making and management of health resources. This package is a flexible one that countries can mould to their individual situations. The policy package consists of the support in the following main areas:

- Advocacy and consensus-building
- Planning and costing, prioritization, and financing
- Monitoring and evaluation
- Involvement of stakeholders

4.4 Advocacy and consensus-building

Advocacy and consensus-building are needed to build a sense of ownership for national health plans within ministries of finance. In countries pursuing Macroeconomics and Health follow-up, a national multi-sectoral, multi-stakeholder mechanism has been set up that lends itself to strengthening the dialogue between health and finance decision-makers (see Boxes 1 and 2). Research on the country-specific benefits of investment in health are compiled and widely disseminated. Improved coordination at the technical level of ministries for joint planning and consensus-building has also received a boost through the national mechanism. Other sectors, such as education and water and sanitation, are involved in the process.

Box 1. India NCMH

In January 2003, the Indian government set up a National Commission for Macroeconomics and Health (NCMH), co-chaired by the Minister of Health and Family Welfare and the Minister of Finance. The Commission is comprised of high level policy-makers and representatives of NGOs, academia, international organizations and civil society. The objectives are to assess the impact of increased investments in the health sector on poverty reduction and the overall economic development of India and to establish an epidemiological evidence base for long-term scaling up of essential health interventions, with a focus on the poor.

The main technical body to assist the NCMH is the sub-commission, a small group of health systems and economics experts, of the NCMH. The NCMH technical sub-commission is finishing a report that supports the argument to the Finance and Planning Ministries for investing in health and outlines necessary reforms in health delivery and financing systems in order that resources be used efficiently. The report is based on extensive data collection and analyses carried out by national and international experts to provide policy-makers an evidence base to make allocative decisions.

4.5 Planning and costing, prioritization, financing

The national mechanism also serves to catalyse and coordinate much-needed research on the national health situation and infrastructure that can inform national planning and budgeting exercises. The National Health Accounts, which provide information on the quantity of financial resources used for health, their sources and the way they are used, are an important instrument that should be continue to be developed. Emphasis is placed on disaggregating health situation and health spending data by income towards targeting health sector spending to the poor. This evidence should input into the crafting of well-planned and costed health sector strategies which can attract additional resources. Health sector plans need to identify key bottlenecks to improving access to essential health services for the poor and to sequence policies and reforms to allow for a gradual building up of absorption capacity.

4.6 Monitoring and evaluation

Health information systems for monitoring and evaluation must be put in place and maintained. The information produced should feed back into planning processes, allowing the government to adjust programmes and spending in an informed fashion. The Health Metrics Network (HMN) is one such effort that focuses on strengthening country health information systems to generate reliable data for decision-making. The HMN brings together countries and their partners around one common framework for health information, addressing both country needs for support and donor behaviours, such as fragmentation and duplication of data collection efforts.

Box 2. Ghana Macroeconomics and Health Initiative

The Ghana Macroeconomics and Health Initiative (GMHI) is working to target and scale up health services for the poor. The Initiative was launched in November 2002 and is currently finalizing a health investment plan. Ghana is focusing on a pro-poor approach to expand essential health services and close to client facilities. The investment plan is established on the collection and analysis of data on disease burden, non-financial constraints, health expenditure and poverty at the district level. The Government sees the GMHI's health investment plan as a step towards operationalising the health and health related MDGs. The plan is a key input into the revised Ghana Poverty Reduction Strategy (in which the MDGs are integrated as development targets) and the Ministry of Health programme of work for 2007-2011.

A GMHI Advisory Committee has been established as a high-level representation of key stakeholders and has fostered an enhanced position for the Ministry of Health vis à vis the Ministry of Finance. The role of the Advisory Committee is to provide guidance for the formulation of the GMHI and to play an advocacy role at the national and international levels.

4.7 Involvement of stakeholders

Finally, the national mechanism aims to involve donors and other key stakeholders at all stages of the planning process, bringing them to a consensus around one national evidence-based health sector strategy to be funded through domestic resources and donor budget support. The role of the United Nations, academia and the UN specialized agencies should be reinforced, as they provide support on technical assistance and can contribute to capacity-building in countries. Also, Civil Society Organizations (CSOs) are important partners. In some countries, such as Cambodia, international and local NGOs are the primary recipients of external funds and deliver the bulk of health services for the poor.²⁸

5. Conclusions

As funding for health increases and positive partnerships gain momentum, it is important

to support the transition to a new model for cooperation between developing and developed countries. Current national health spending is poorly managed, and donor practices have resulted in limited effectiveness of external funding. By providing financial and technical support to address key "upstream" constraints, donors can contribute to a gradual building up of national capacity towards improved and sustainable health outcomes.

As noted in the Landau report, current variations in aid are mainly due to the mutually-reinforcing problems of unpredictable donor behavior, inconsistency in recipient governments' performance, and unstable economies of poor countries.²⁹ Three major areas of concern in a number of developing countries engaged in Macroeconomics and Health activities – the insufficient level of resources, the rigid macroeconomic conditionalities attached to the current system of aid, and management problems due to the fragmentation of development assistance – reinforce the call for ingenuity in designing predictable and sustainable financing mechanisms that respond better to the needs of poor countries.

Innovative options by development partners towards building stronger, sustainable health systems and institutions are welcome. This will support developing countries to move faster towards achievement of the MDGs and to play their part in delivering global public goods for health.

Annex³⁰

Global cost estimates for scaling up health interventions and delivery

Source of estimate	Types of costs estimated	Services included	Estimated cost
1993 World Development Report	Total	Public health services, essential clinical package	US\$ 62 billion per year for all developing countries (\$15/person); \$12/person for low-income countries
2001 Commission on Macroeconomics and Health (2002 US \$)	Total and incremental, including adjustment for process of scaling up	49 priority health interventions to address major causes of avoidable mortality	Incremental costs of \$66 billion per year by 2015 for all low-income countries (\$21/person); total cost of \$34/person
2002 Costing the MDGs	Incremental	Priority preventive and clinical interventions to address infant mortality, under-five mortality, maternal mortality, HIV/AIDS, malaria and other diseases	\$20-25 billion per year (health targets) \$54-62 billion per year for all MDGs
2004 Copenhagen Consensus: Communicable Disease Challenge	Incremental	Malaria control (ITNs, IPTp, ACT) HIV/AIDS control (UNGASS package) Strengthening basic health services (WDR 1993 essential interventions)	2003 Int\$ 2.94 billion 2003 Int\$ 7.35 billion 2003 Int\$ 337 billion
2005 UN Millennium Project	Incremental	Scaling up malaria control interventions (from WHO) HIV/AIDS (from UNAIDS) Global TB control and new tool development (from Stop TB)	\$3.0 billion over period 2005-2015 \$11.6 billion in 2005, \$19.9 billion in 2007 At least \$1 billion, but this is considered an underestimate

Notes

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