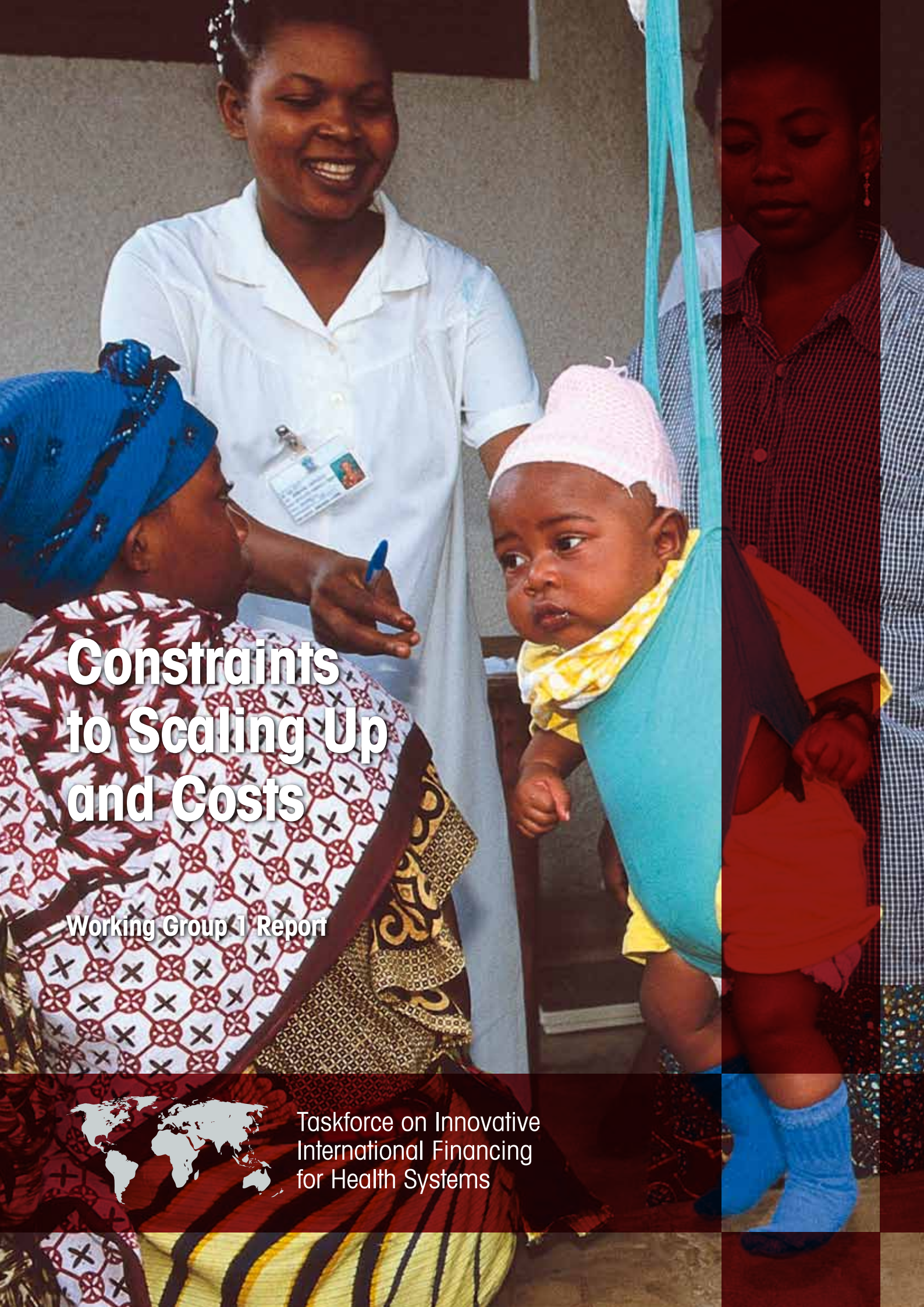

Constraints to Scaling Up and Costs

Working Group 1 Report

Taskforce on Innovative International Financing for Health Systems

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Executive summary and key messages

Since the adoption of the Millennium Declaration, total development assistance for health (DAH) 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 in developing countries by 200,000-400,000.

Progress towards all the health MDGs is impeded by insufficient funding, poor use of resources, and fragmented financing flows. Low-income countries currently spend only US$ 25 per capita on health; of this $10 comes from out-of-pocket payments, and only $6 from DAH. There is unbalanced support for different services, with more than 50% of DAH provided directly to countries in 2006 supporting MDG 6, and less than 20% supporting basic health care and nutrition.

Everyone should have access to guaranteed health benefits*. The extent of these guaranteed benefits would be determined by individual countries, but as a minimum in order for the health 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 relief of symptoms for those presenting at the primary care level; and health promotion. Effective service delivery requires a health system platform that can train and supervise the necessary health workers, provide essential drugs and supplies, channel money, and ensure accountability and transparency.

Much more money is needed from domestic and external resources to ensure that rapid progress is made towards the health MDGs, and that health systems in low-income countries can make the guaranteed benefits available to all.

Better use of domestic and external 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 coverage of high-priority services and strengthening the health system platform. The country strategy must set out how health system governance, financing and service delivery will be improved, as follows.

- 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, backed by stronger management systems including financial and human resources management.
- 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 should reflect the most cost-effective ways of providing services that are accessible, responsive to users and equitable, taking advantage of both public and private providers where appropriate.

There is no fixed and agreed approach that countries must follow to scale up interventions to meet the health MDGs. Countries are very diverse, and follow diverse paths. Two sets of analyses were undertaken to calculate costs and health impacts, reflecting two different views of how best to scale up services to meet the MDGs. The first was undertaken by WHO with collaboration from UNAIDS and UNFPA, and the other by an interagency group coordinated by the World Bank and UNICEF, with collaboration from UNFPA and the Partnership on Maternal, Newborn and Child Health, and using the Marginal Budgeting for Bottlenecks (MBB) tool. Both project the annual increase in capital and recurrent funding needed between 2009 and 2015 in order to adequately fund the interventions and supporting health system platform required to make substantial progress towards the health MDGs.

The WHO normative approach considers the amount of resources required to scale up country health systems to a level that is considered "best practice" by experts and practitioners. It reflects a more facility-based approach to service expansion and prioritizes rapid scaling up. The MBB identifies the critical constraints of existing health systems (bottlenecks) for scaling up effective interventions, and then identifies the strategies to overcome them. It assumes a delivery strategy that emphasizes full scale up of community-based services prior to expanding clinical services in 2014-15.

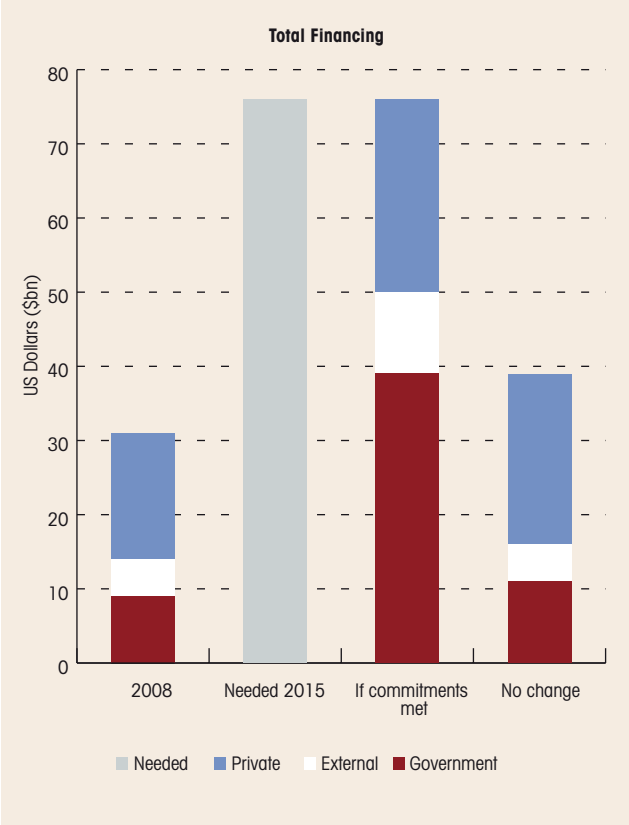
* As stated in UN conventions.

Strengthening the governance, financing and delivery of the health system to ensure rapid progress towards the health MDGs would cost, by 2015, an additional $36-45 billion* ($24-29 per capita) per annum, on top of the estimated $31 billion that is spent today in low-income countries. Between 2009 and 2015 some additional financing will become available in any event, so the funding gap in 2015 is the difference between the financing need (costs) and the additional financing. The table below shows the funding gap for 2015 under two different scenarios on additional financing: commitments met (donor and recipient governments increase support as reflected in public statements†); and no change (maintaining current relationships between GDP and health expenditures). Private expenditures are assumed to grow in line with GDP growth, and a share is assumed to be available to support health MDG achievement.

(US$2005 bn)	Sources of additional funding 2015				WHO normative 2015		MBB Medium 2015	
All countries	Government	DAH	Private	Total	Cost	Gap	Cost	Gap
Commitments met	30	7	7	44	45	1	36	-8
No change	4	0.5	4	8	45	37	36	28

If commitments are met, there is on average, across all countries, no financing gap in 2015Δ. However, donors and recipient governments are currently far from delivering on agreed targets, and the economic recession is making this more difficult. If current relationships of health spending to GDP remain unchanged, the financing gap is $28-37 billion in 2015. For sub-Saharan Africa, there is a funding gap under the "commitments met" scenario of $3-5 billion. However, non-SSA countries would be more than able to cover additional costs under the "commitments met" scenario, and a small shift of DAH from non-SSA to SSA would reduce the SSA gap. In the "no change" scenario, the funding gap for SSA in 2015 is $26-24 billion#, and for non-SSA $2-13 billion.

The figure below shows the total expenditure in 2015 under the two scenarios relative to estimated baseline levels of expenditure in 2008 and the financing need (WHO normative costs). It highlights the shortfall of expenditure under a "no change" scenario. It also highlights the importance of increasing government funding for health, and of encouraging private funding to support priority services.



If spent on high priority services and the necessary systems platform, it is estimated that the target level of health expenditure in 2015 would save the lives of around 4 million children and babies in both the WHO and MBB approaches. The WHO approach would avert up to 322,000 maternal deaths, 193,000 HIV deaths, and 265,000 tuberculosis deaths. The MBB numbers are estimated to be 259,000 (maternal), 177,000 (adult HIV), and 235,000 (TB). The WHO approach would protect more than 30 million children aged 12-59 months from stunting, and reduce unwanted births by nearly 11 million. Millions of children and adults would have their illnesses prevented or treated, averting a massive amount of morbidity. In the WHO approach an

* Constant 2005 US$.

† It should be noted that there is no stated target for the % of government expenditure on health for non-SSA countries, so a target of 12% of government expenditure was assumed.

Δ There is still a gap for the entire period 2009-2015 with the WHO normative costs, because costs increase earlier and faster than additional financing. See Annex 6 Table 11.

The MBB cost for SSA is higher than WHO's, so the gap for SSA is higher with MBB costs, unlike the all-country numbers where the gap is higher for WHO's costs.

extra 22 million women would have access to safe birth attendance and antenatal care, and their babies would receive quality care at birth and during the neonatal period. In the MBB approach an additional 17 million women would receive antenatal care in 2015, and 16 million would benefit from safe birth attendance.

Health systems would be put in place that would enable sustained health improvement into the future. Just as important, the sustained health improvement in low-income countries would increase human capital and remove the health barriers to economic growth, stimulating long-term economic development and enabling countries increasingly to fund their health systems themselves.

Capital expenditures are important for increasing system capacity to absorb more funding and would take up 40-48% of the investment, with the remainder required for ongoing health system support, including the health workforce and drugs and supplies. Health facilities would increase by 74,000-97,000, and health workers by 2.6-3.5 million. This would more than double the current numbers of facilities and workers. For additional funds to be used as intended to expand health spending, governments must agree to prioritize health within national budgets, and devote the additional resources to high impact interventions and the necessary systems support.

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 actions[1]. 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; there also needs to be a focus 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 funds[2]. Approaches must be tailored to the specifics of each country context; the pace of change must be agreed locally to ensure absorption of additional funding and a long-term, sustainable approach to strengthening the health system.

The cost of not raising additional funding is dire: 4 million children dying each year who would otherwise have been saved, and 780,000 avoidable adult deaths, including 322,000 women dying as a result of giving birth.