Global Action for Health System Strengthening: Key Financing Challenges

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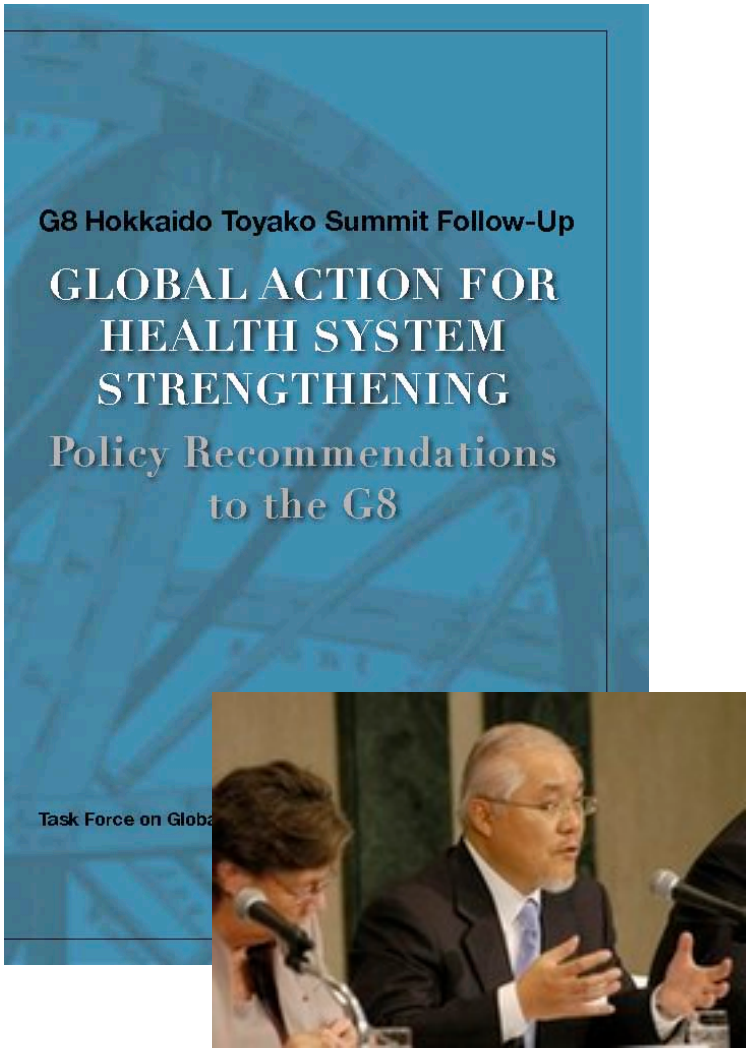
Outline

- Background to Takemi Taskforce
- Why health financing should be central to G8 agenda
- Critical policy issues in health financing
- Challenges for G8 support
- Recommendations for G8 action
- Global Financial Crisis
- Next Steps

Japanese G8 Interaction

- **G8 countries**
  - USA, Japan, Russia, Germany, UK, France, Italy Canada
- **Annual Summits since 1975**
  - 1997 First communiqué addressing partnership with Africa on development
  - 2000 Okinawa: Agreement to mobilize resources for HIV/AIDS, TB and malaria >> GFATM
  - 2008 Tokako: Innovative International Financing Taskforce established

Takemi Taskforce Process



- Follow-up to Toyako Summit in July 2008
- Takemi Taskforce mandated to develop recommendations for G8 actions to strengthen health systems
- Experts appointed to review situation in health financing, health workforce and health information
- Systematic consultations with G8 and H8 experts, MOFA and MOF Japan
- Dec 2008 – Report submitted to Government of Japan
- Jan 2009 – Report submitted to Government of Italy as Japan's recommendations to G8 in 2009
- July 2009 – Next G8 summit to discuss recommendations

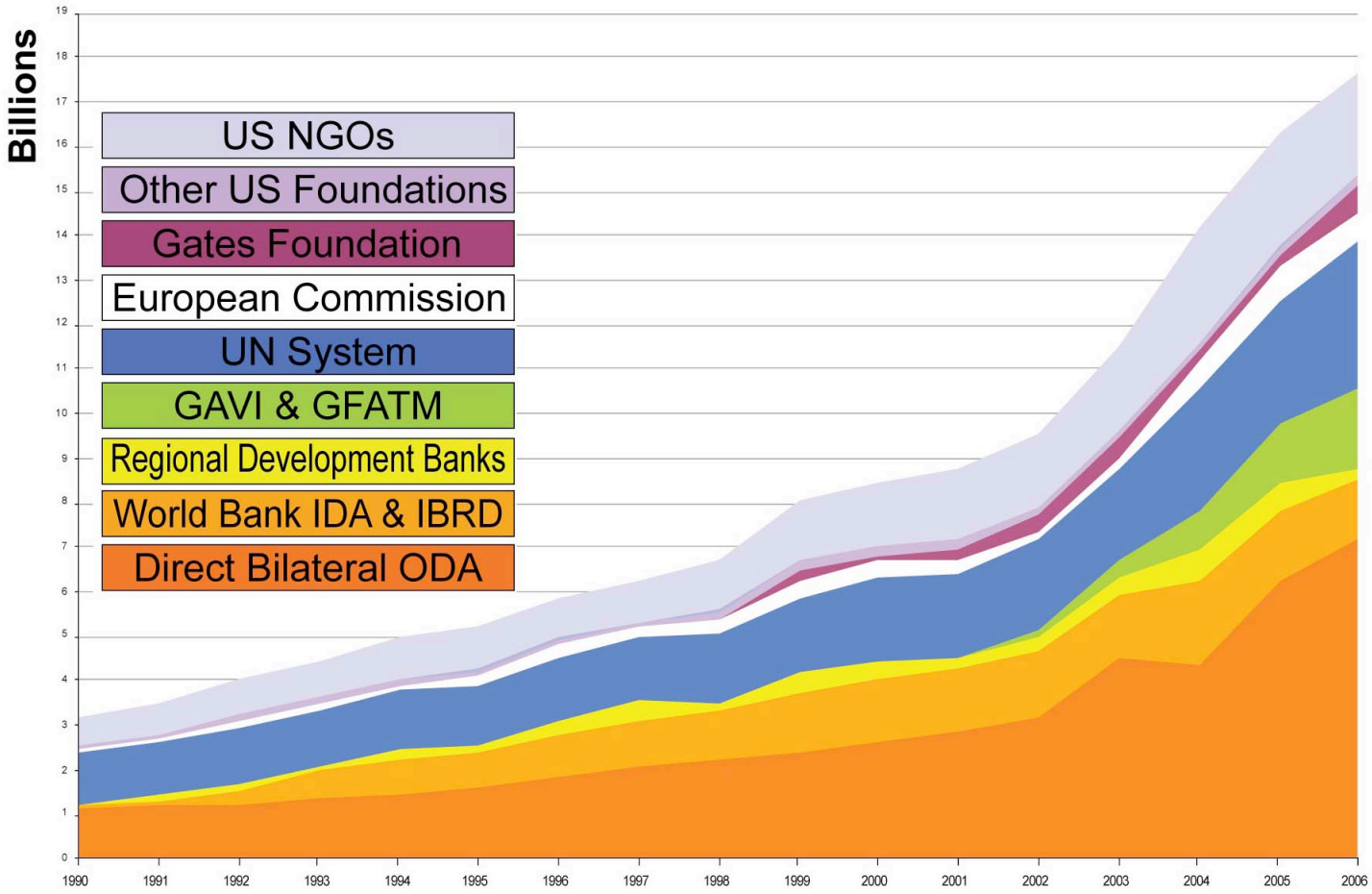
Why should global health be a priority for the G8?

- **MDGs**
  - Progress least for health MDGs
- **Alignment of health agenda with human security and social protection agendas of Japan, EU and USA**
  - Financial risks of ill-health
- **Transnational risks to health in interconnected world from failures in public health**
  - Avian flu, melamine
- **Global financial crisis**

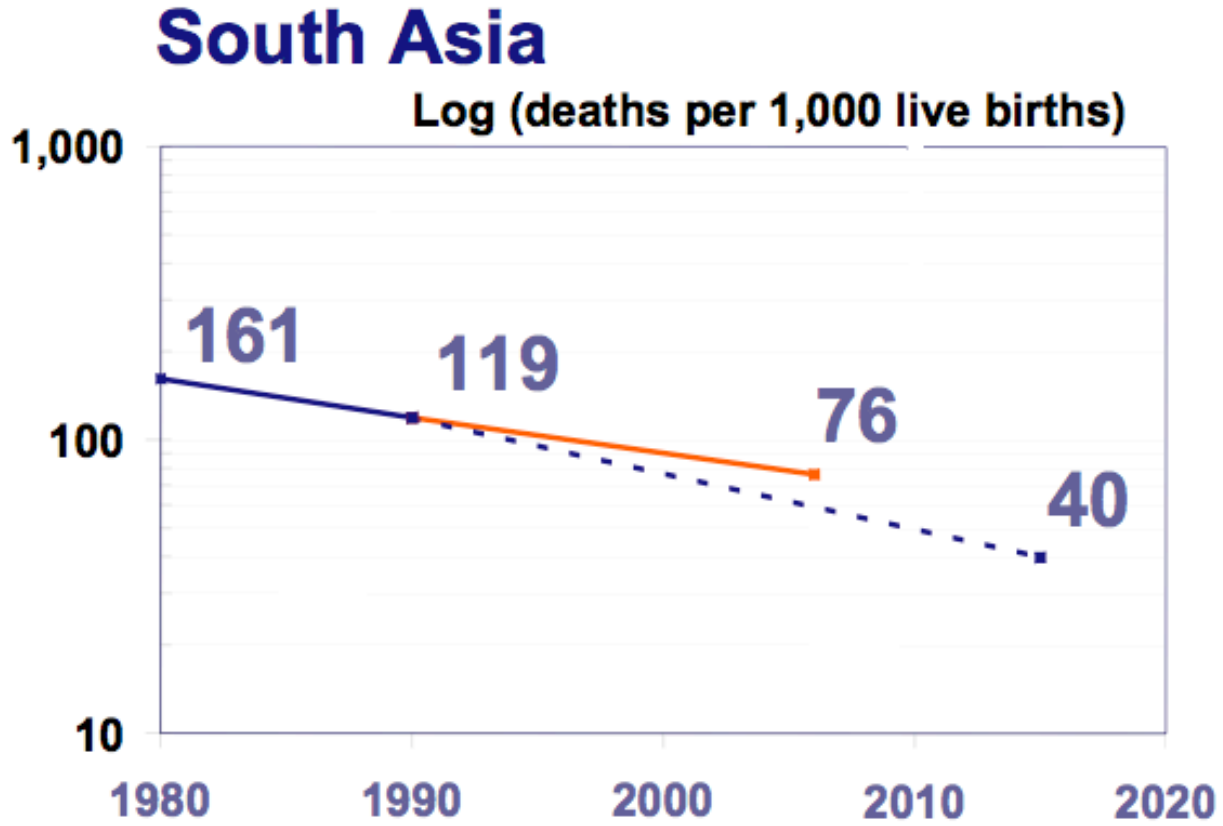
Some critical issues

- **Impoverishing impact of out-of-pocket payments for health**
  - 100 million pushed into poverty each year
  - Directly linked to reliance on out-of-pocket financing
- **Failure to translate more money into better health progress**
  - More money does not mean more health
- **Significance of funding gap as a constraint**
  - Global targets of $30 per capita unlikely
  - Shortfall does not mean MDGs/universal coverage cannot be achieved

Increasing funding for health - both ODA and domestic



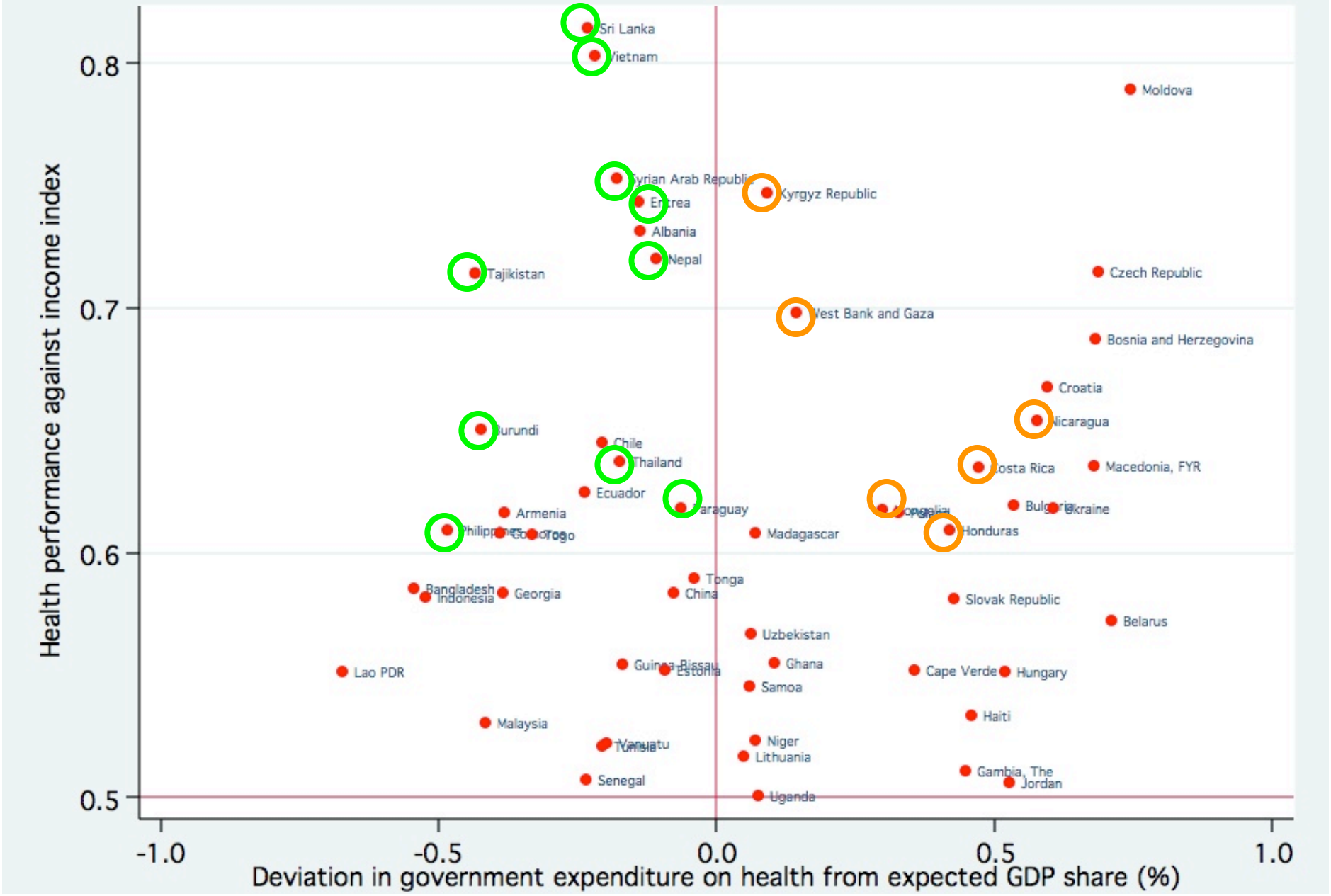
. . .but no improvement in MDGs 4, 5



Limitations of focusing only on global targets for health spending

- **Unlikely to be achieved**

- **A shortfall should not mean that MDGs and universal coverage cannot be reached**
  - Global estimates make no allowance for efficiency gains
  - Country evidence that MDGs and universal coverage are feasible in LICs for less than $10 per capita in public spending
  - Historical evidence from Africa and Asia that service coverage can be doubled without increases in level of public financing effort


Health performance against income index
0.8
0.7
0.6
0.5
-1.0
-0.5
0.0
0.5
1.0
Deviation in government expenditure on health from expected GDP share (%)
Sri Lanka
Vietnam
Moldova
Syrian Arab Republic
Kyrgyz Republic
Eritrea
Albania
Nepal
Tajikistan
Czech Republic
West Bank and Gaza
Bosnia and Herzegovina
Croatia
Nicaragua
Burundi
Chile
Thailand
Costa Rica
Macedonia, FYR
Ecuador
Paraguay
Bulgaria
Ukraine
Armenia
Madagascar
Honduras
Togo
Tonga
Bangladesh
Indonesia
Georgia
China
Slovak Republic
Belarus
Uzbekistan
Lao PDR
Guinea-Bissau
Ghana
Estonia
Cape Verde
Hungary
Samoa
Haiti
Malaysia
Vanuatu
Tunisia
Niger
Lithuania
Gambia, The
Jordan
Senegal
Uganda

Role of technical efficiency gains in Sri Lanka coverage expansion

Year	GDP (US$ 2006 per capita)	IMR	Govt. health spending (US$ 2006 per capita)	Outputs (Out-patients per capita)	Outputs (In-patients per capita)
1948	322	92	5.4	1.1	0.09
1960	352	57	6.8	2.3	0.14
12 yrs	+9%	-38%	+ 25%	+110%	+55%

Contribution of increased spending = <25%
Contribution of technical efficiency gain = >75%

Technical efficiency gains during scaling-up: Uganda

Year	GDP (US$ 1995 per capita)	IMR	Health spending (US$ 1995 per capita)	Outputs (Out-patients)	Outputs (In-patients)
1955	284	150	1.8	0.5	0.13
1969	344	112	3.7	1.2	0.40
14 yrs	+21%	-26%	+ 105%	+150%	+210%

Contribution of increased spending = <70%
Contribution of technical efficiency change = >30%

Technical efficiency gains during scaling-up: Botswana

Year	GDP (US$ 1995 per capita)	IMR	Health spending (US$ 1995 per capita)	Outputs (Out-patients)	Outputs (In-patients)
1960	287	118	5	0.4	3.1
1980	1,458	62	20	1.6	6.8
20 yrs	+408%	-48%	+ 315%	+300%	+119%

Contribution of increased spending = <0%
Contribution of technical efficiency change = >50%

Why health financing policies in countries matter

- **Health financing – key "control knob" available to policy makers**

- **Health financing critical to improve:**
  - ↑ Risk protection
  - ↑ Coverage of services - Health outcomes & Equity
  - ↑ Efficiency of service delivery

Approaches that have not worked

1. **Targeting of public services through means testing**
   - Repeatedly proven impossible to cheaply and reliably target the poor or to reduce inequalities in access
2. **Voluntary community health insurance**
   - No success in scaling-up (>10% of population)
   - Works least well in the poorest communities with low levels of social capital, with limited protection because of low incomes
   - No results from World Bank advocacy of community insurance for Africa in 1995
3. **Social health insurance without tax funding**
   - Consistently failed to extend coverage to poor, informal workers, owing to poor capacity to pay and difficulties in collection
4. **Private health insurance**
   - Fails to cover informal sector workers, the poor
   - No success in extending core coverage beyond 2-3%
   - No success from World Bank advocacy of private insurance for Africa in 1995

What do we know about health financing?

- **To improve risk protection and to ensure coverage of the poor financing must shift from out-of-pocket to public financing**

- **Public financing**
  - Tax financing
  - Social health insurance *plus* tax financing
    - *Does not imply that private financing will not contribute, but only that it cannot substitute*

* **Only tax-financed, public delivery has worked at low income - SHI only successful in middle or high-income countries**

What we don't know is the 'How?'

- How have countries made tax-financing, public delivery work in low income settings?
- How have countries managed the public-private mix in financing effectively when country capacity is weak?
- How did countries expand social insurance to rural/poor populations?
- How do some countries achieve universal coverage and MDGs at low cost?

Challenges for G8

- **ODA is only effective when countries have sound policies and institutions**
  - Conditionality only works if govts are committed to policies
  - Donors cannot impose good financing policy, but most countries still lack capacity to develop and own policies
- **Technical consensus that public financing is key, but confusion in G8 messages**
  - Lack of clarity on the centrality of public financing
  - Conflict over SHI and taxation, particularly amongst EU partners
- **Harmonizing vertical funds with HSS strategies**

Country ownership of better policy

- **Global evidence not effective if countries lack ownership over process of acquiring knowledge**
- **Politics and leadership are critical, but national technical capacity is necessary**
  - Capacity to learn and analyze
  - Capacity to assess policy options and evidence
- **Technical capacity was critical to Japan, Thailand, Mexico, … but Africa?**

Recommendations for G8

1. Complement support for *increasing money for health* with added support for *improving the value of health spending through support for better country-led health financing and systems policies.*

2. Translate technical consensus on public financing into commitment by G8 to prioritize support to countries that prioritize public financing
   - **Support for countries that abolish user fees, starting with MDG 4, 5 and 6 services**
   - **Coherent message through IHP+ and P4H**

3. Invest in the ability of developing country partners to make better health financing policy through investing in national policy capacity, supporting countries to share best practices

Global Financial Crisis

- **Crisis in market institutions often generates the political and intellectual window for better health financing**
  - Japan, Sri Lanka (1930s), Thailand/Indonesia (1990s), USA (2009)
- **2008 crisis different to the 1980s**
  - Requires boosting consumption and spending globally
  - Need for structural shift from savings to consumption in many developing Asian countries
- **Mutual interest of G8 and developing country partners in an open global economy**
  - In a crisis, workers cannot fall back on private financing
  - Publicly-financed social protection can play its role in maintaining support in hardest-hit economies

Next Steps

Alex Wong / Getty Images

- **Build consensus for 2009 G8 meeting**
  - Bridging US and partner positions and consolidating EU partners
  - Building on the joint interests of civil society, G8 governments and developing countries

Making good use of financial crisis

- Window opening for changes in policy assumptions and for increased spending
- Changed reality of Obama administration
  - Impact on policy debates on role of state, and importance of better value in health systems
  - Possibility of unified G8 position