

The Long and Tortured Road to Adequate and Sustained Donor Financing for Health

Professor Brook K. Baker

Northeastern U. School of Law, Program on Human Rights and the
Global Economy

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Outline of Presentation

- Current global health spending: domestic health spending and development/donor assistance for health.
- Global health resource needs and financing gaps.
- Critical assessment of global health financing by
 - World Bank
 - PEPFAR
 - Global Fund
 - DfID, IHP+
- Campaigning for adequate and sustained donor financing for health – what should we be doing?



Health Spending in Developing Countries (92% of Global Disease Burden) is Anemic

- 2004, global health spending **\$4.1 trillion**
- 2003, developing countries health spending **\$410 billion, 12% of global total** and 5.7% of developing country GDP (developing countries = 84% global population, 92% global disease burden). World Bank Strategy for HNP Results 2007.
- 2005, health spending in Sub-Saharan Africa **\$27 billion** (11% population; 24% disease burden). GHWA Education (2008).
- Most developing country health spending is out of pocket (70% in low income countries 50% in African countries)



Health Spending by Region

Table 1

Rich in health

As countries become wealthier, they spend more publicly and less out of pocket.

(levels and composition of health expenditures in World Bank regions and income categories, population-weighted averages, 2003)

Regions	Per capita GDP (dollars) ¹	Per capita health expenditures (dollars) ¹	Per capita health expenditures (international dollar rate) ²	Total health expenditures (percent of GDP)	Per capita health expenditures			Total health expenditures		
					Public ³	Social security ⁴	Private ³	Out of pocket ⁵	Out of pocket ³	External ³
East Asia and Pacific	1,267	64 ★	276	5.1	37.5	42.8	62.5	84.2	52.7	0.9
Eastern Europe and Central Asia	2,976	194	521	6.2	62.0	43.8	38.0	81.2	30.8	1.3
Latin America and the Caribbean	3,325	225	535	6.9	49.3	33.1	50.7	72.7	36.8	1.1
Middle East and North Africa	2,360	101	289	5.7	47.4	22.6	52.6	86.4	45.4	1.1
South Asia	545	24 ★	122	4.4	26.1	8.9	73.9	95.8	70.8	2.9
Sub-Saharan Africa	608	38 ★	116	5.2	40.8	4.9	59.2	80.1	47.4	14.8
Income levels										
Low-income countries	481	22 ★	102	4.6	31.2	7.7	68.8	91.9	63.2	7.1
Lower-middle-income countries	1,659	97	342	5.6	43.6	38.3	56.4	81.1	45.7	0.6
Upper-middle-income countries	5,596	341	677	6.4	55.5	56.8	44.5	79.0	35.1	0.3
High-income countries	30,811	3,466	3,427	10.7	64.8	43.3	35.2	57.0	20.1	0.0
Global average	5,969	602	752	6.0	42.9	29.0	57.1	81.3	46.5	2.9

Sources: World Bank (2006) and World Health Organization (2006).

Note: Individual country averages are weighted by each country's population. As a result, some numbers differ from those in World Bank (2006), in which slightly different weights are used for some of the data series.

¹Adjusted by exchange rates.

²Adjusted by purchasing power parities.

³Percent of total health expenditures.

⁴Percent of public health expenditures.

⁵Percent of private health expenditures.

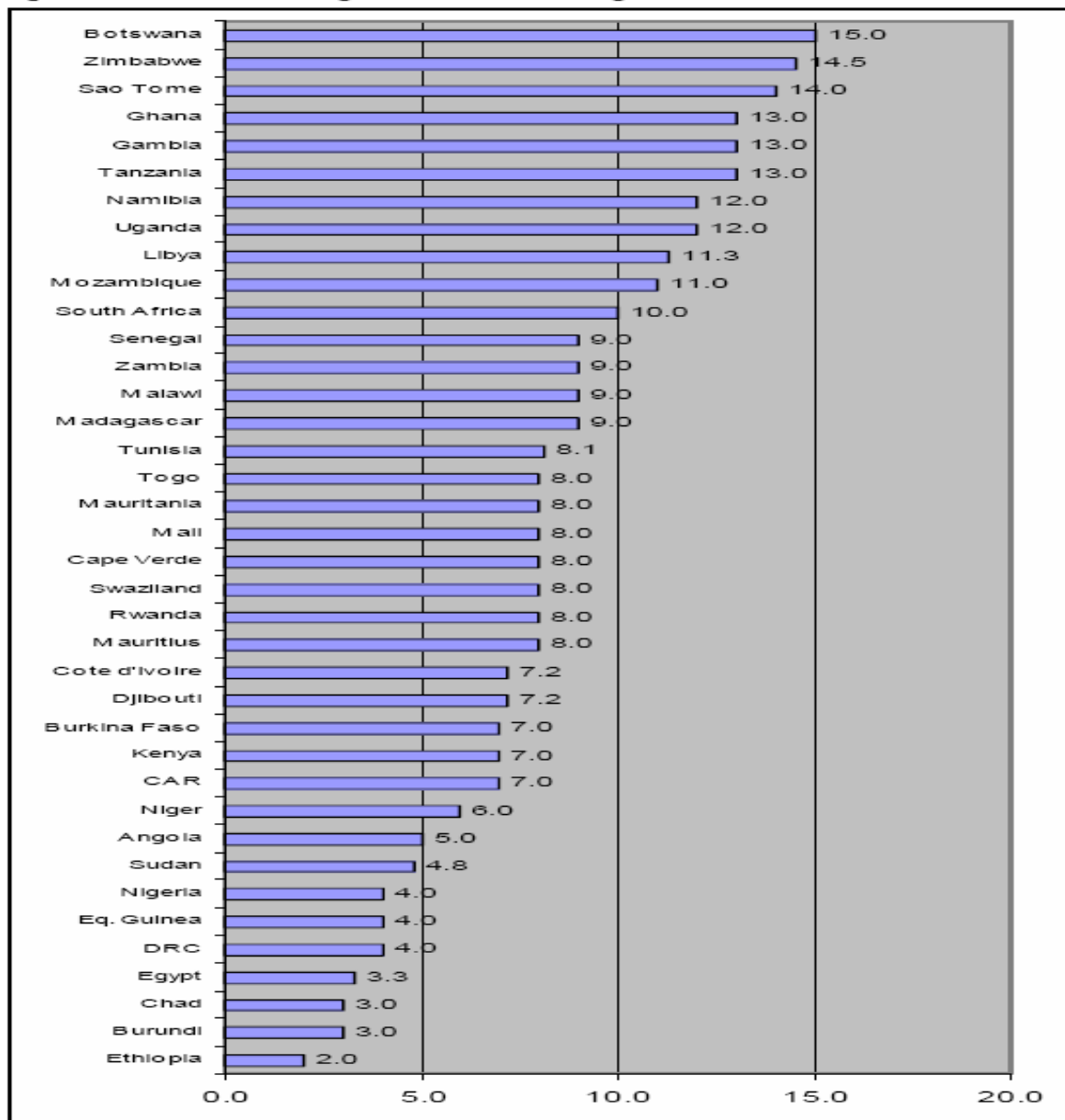


Most African Countries Fail to Meet their 15% Abuja Commitment

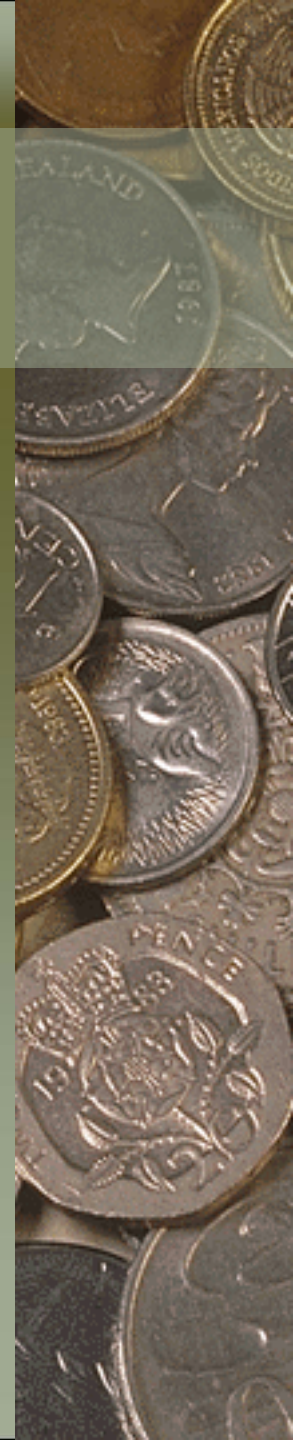
- At the end of 2007, only three African countries, Botswana, Mauritius, and the Seychelles, were meeting their 2001 Abuja Declaration commitment to spend 15% of the government's self-funded budget on health.



Figure 2.1.4.: Percentage of national budgets allocated to health sector.

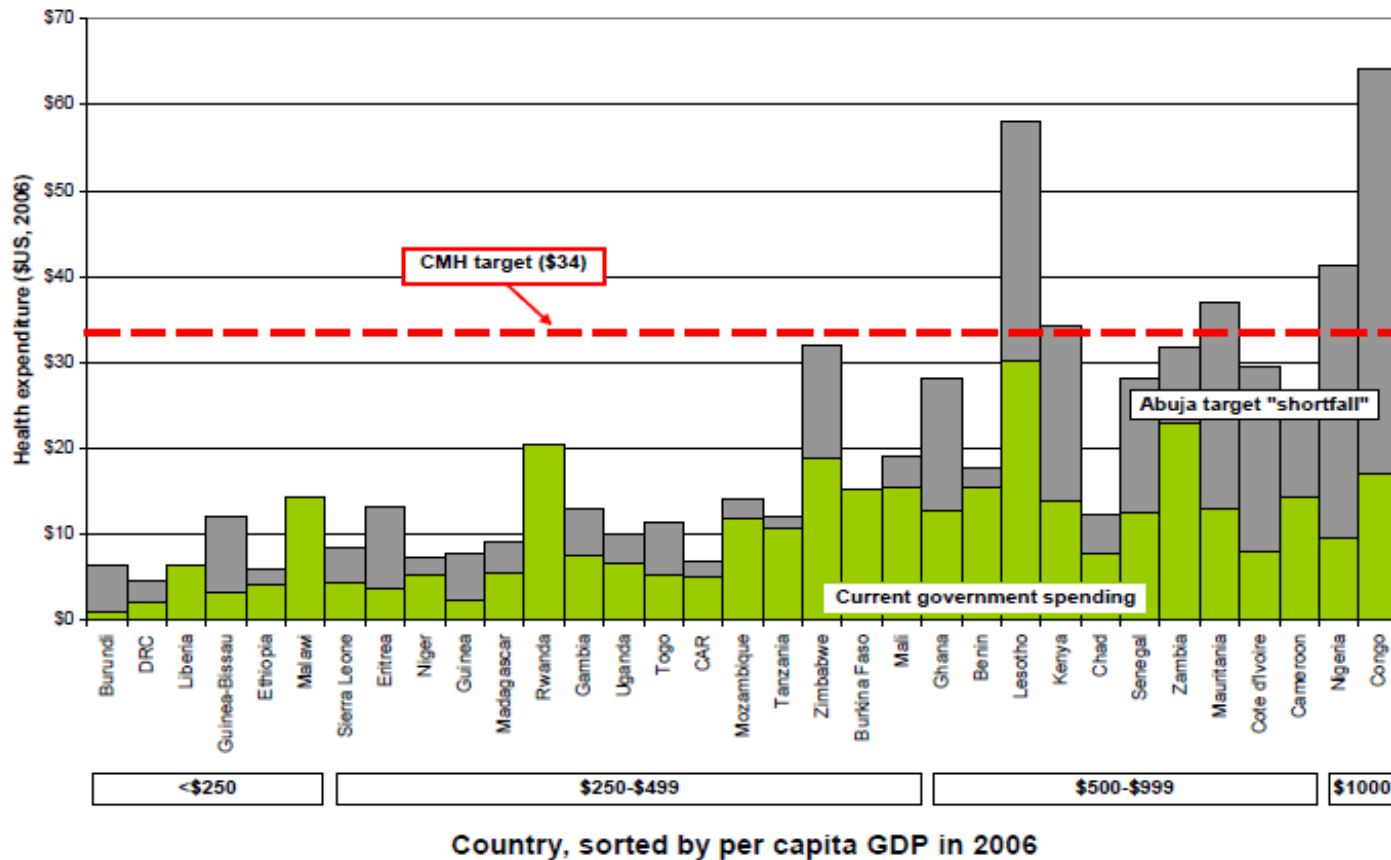


Source: African Union. Progress Report on the Implementation of the Plans of Action Abuja Declarations for Malaria, HIV/AIDS and Tuberculosis; Revised Final Draft December 2005.



Would Meeting Abuja 15% Make a Difference?

USAID Roundtable (2008)



Donor Assistance for Health is Even More Anemic

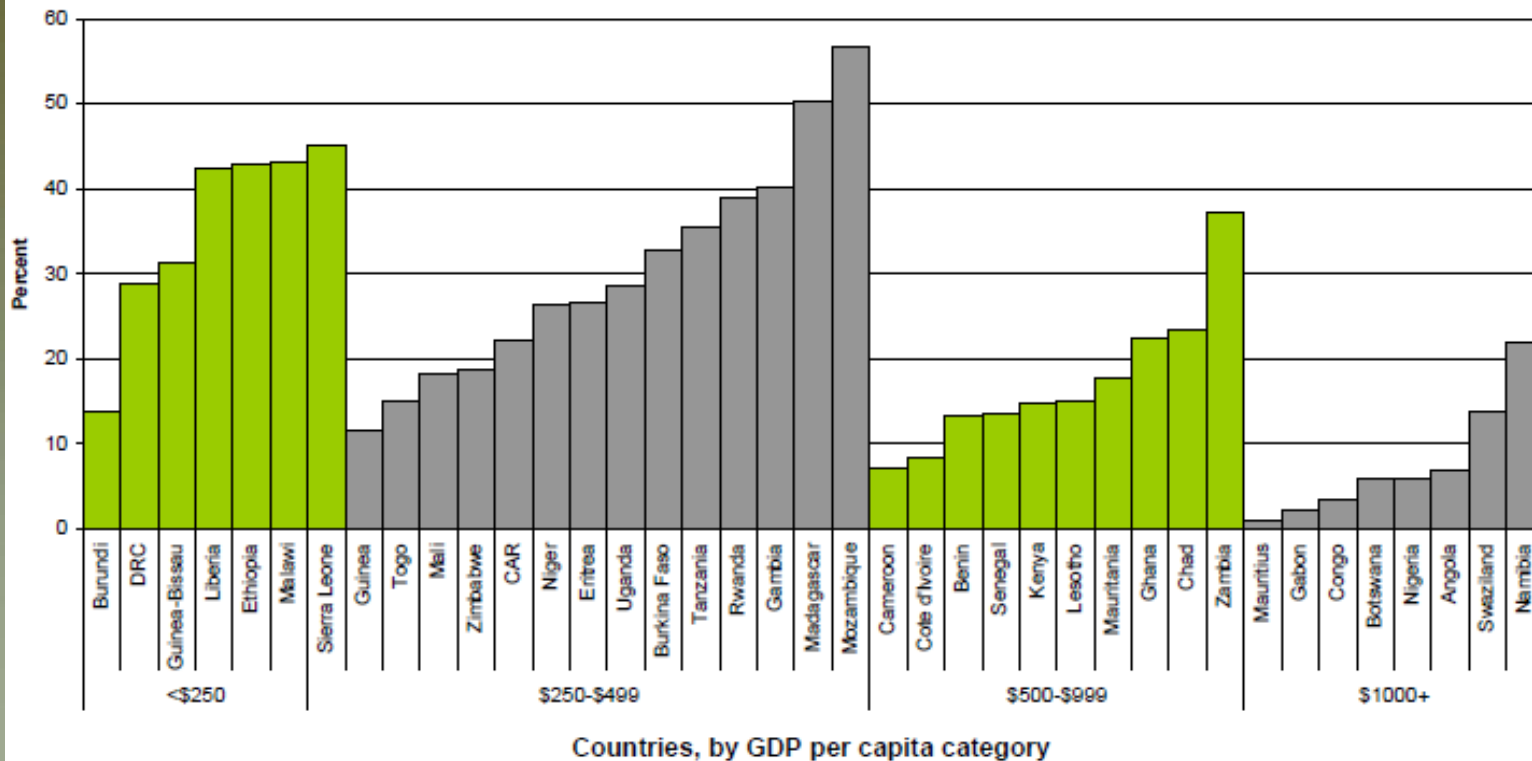
- Development/Donor Assistance for Health (DAH) accounted for only 3% of total developing country health spending in 2003.
- However, DAH as a percentage of all official development assistance grew from 4.6% in 1990 to nearly 13% in 2005.
- **In Africa DAH accounts for 15% of health spending, and 30% + in 12 countries.**



High Dependence but Still Low Funding

USAID Roundtable 2008

EXTERNAL ASSISTANCE FOR HEALTH AS PERCENTAGE OF TOTAL HEALTH EXPENDITURES, BY INCOME CATEGORY, 2006



Sources: WHOSIS database and IMF World Economic Outlook database
 Note: Countries with populations <1 million excluded.



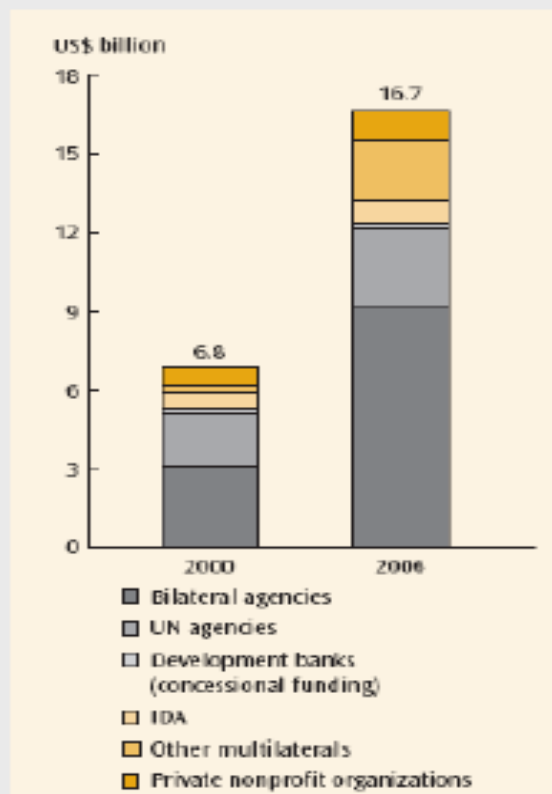
Donor Assistance for Health has Grown But is Still Grossly Inadequate

- DAH rose from \$6.8 billion in 2000 to approximately \$16.7 billion in 2006.

IHP+ Progress Rep.
(2008)

- The mix of funding sources is changing

Figure 7: New Sources of DAH, 2000 and 2006 *



Source: GMR 2008

*Note: Concessional financing only. Other multilaterals include the European Commission, GAVI, and GFATM. Data for 2006 are provisional.

Kaiser Estimates for 2006 DAH are Lower, but Reveal Sub-Sector Spending

Figure 7

Health ODA Commitments by Major Sub-Sector, 2006 (\$13.75 billion)



Percentage Growth in Sub-Sector Spending is Highly Variable

Figure 8

Contribution to Health ODA Growth by Major Sub-Sector, 2001-2006

US\$ Billions

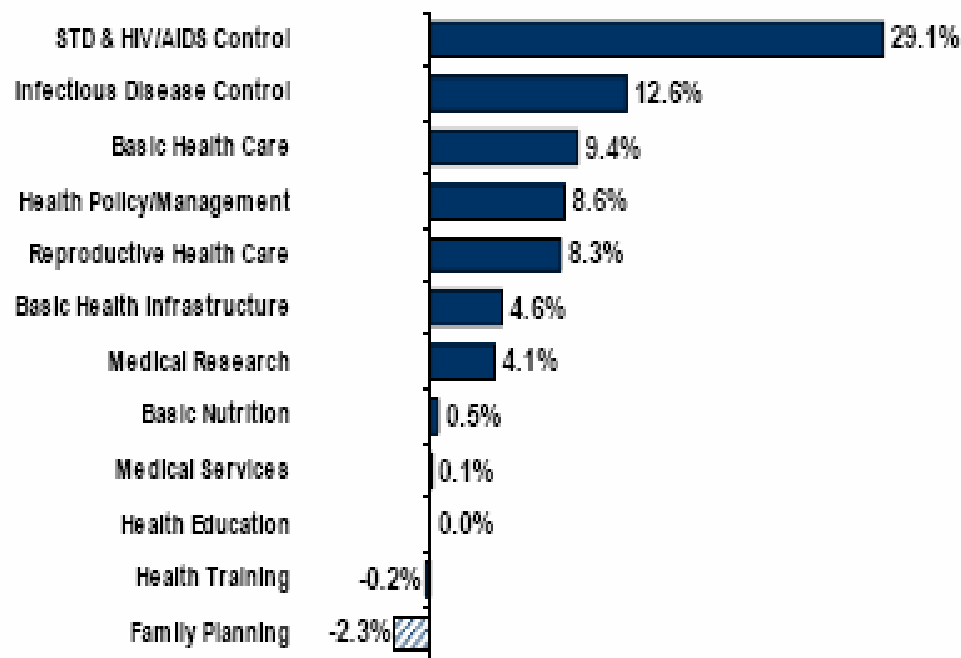


Table 3: Health* ODA by Sub-Sector, 2001 & 2006
Gross US\$ Commitments in Billions

Sub-Sector	2001 \$	2006 \$	2001-2006 +/- \$ (%)
Health/Population			
STD & HIV/AIDS Control/Social Mitigation of HIV/AIDS	1.00	4.75	+3.75 (376%)
Infectious Disease Control	0.49	2.11	+1.62 (331%)
Health Policy/Management	0.82	1.93	+1.11 (135%)
Basic Health Care	0.54	1.76	+0.8 (152%)
Reproductive Health Care	0.21	1.28	+0.2 (119%)
Basic Health Infrastructure	0.13	0.73	+0.4 (323%)
Medical Research	.03	0.56	+0.2 (874%)
Medical Services	0.18	0.20	+0.2 (95%)
Family Planning	0.48	0.19	-0.2 (-41%)
Basic Nutrition	0.08	0.14	+0.3 (414%)
Health Training/Personnel Development	0.11	0.08	-0.03 (-24%)
Health Education	.04	.03	+0.01 (21%)
Health/Population Subtotal	4.10	13.75	+9.65 (235%)



Promises, Promises

- July 2005 Gleneagles, G-8 promised that ODA would increase by \$50 billion a year by 2010, \$25 billion extra would go to Africa.
- Since DAH is only 13% of ODA, only an addition \$3.25 billion per year would go to DAH.
- Post Gleneagles, ODA actually decreased by 4.5% in 2006 and by 8.4% in 2007 (OECD Aid Targets Slipping 2008).
- Actual disbursements are consistently less than commitments.



2008 G-8 Commitments

Hokkaido Toyako Summit Leaders' Declaration, 8 July 2008.

- “We are firmly committed to working to fulfill our commitments on ODA made at Gleneagles, and reaffirmed at Heiligendamm, including increasing, compared to 2004, with other donors, **ODA to Africa by US\$ 25 billion a year by 2010.**”
- “G8 members are determined to honor in full their specific commitments to fight infectious diseases, namely malaria, tuberculosis, polio and working towards the goal of **universal access** to HIV/AIDS prevention, treatment and care by 2010.”
- “We reiterate our commitment to continue efforts, to work towards the goals of providing at least a projected **US\$ 60 billion over 5 years, to fight infectious diseases and strengthen health.**”
- To achieve quantitative and qualitative improvement of the health workforce, we must work to **help train a sufficient number of health workers**, including community health workers and to assure an enabling environment for their **effective retention** in developing countries. ... The G8 members will work towards increasing health workforce coverage towards the WHO threshold of **2.3 health workers per 1000 people**, initially in partnership with the African countries where we are currently engaged and that are experiencing a critical shortage of health workers.

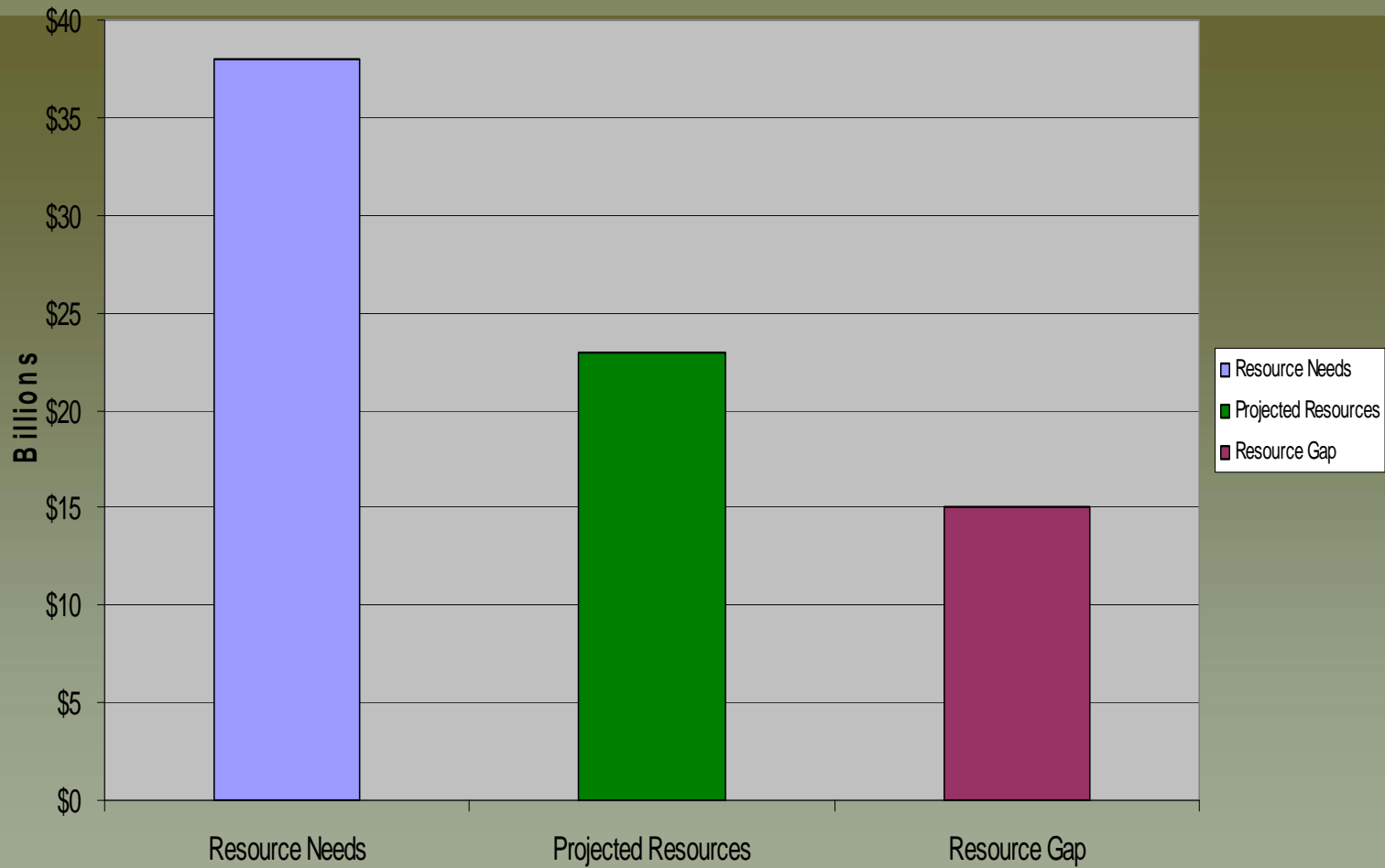


Increased Donor Assistance for Health is Essential

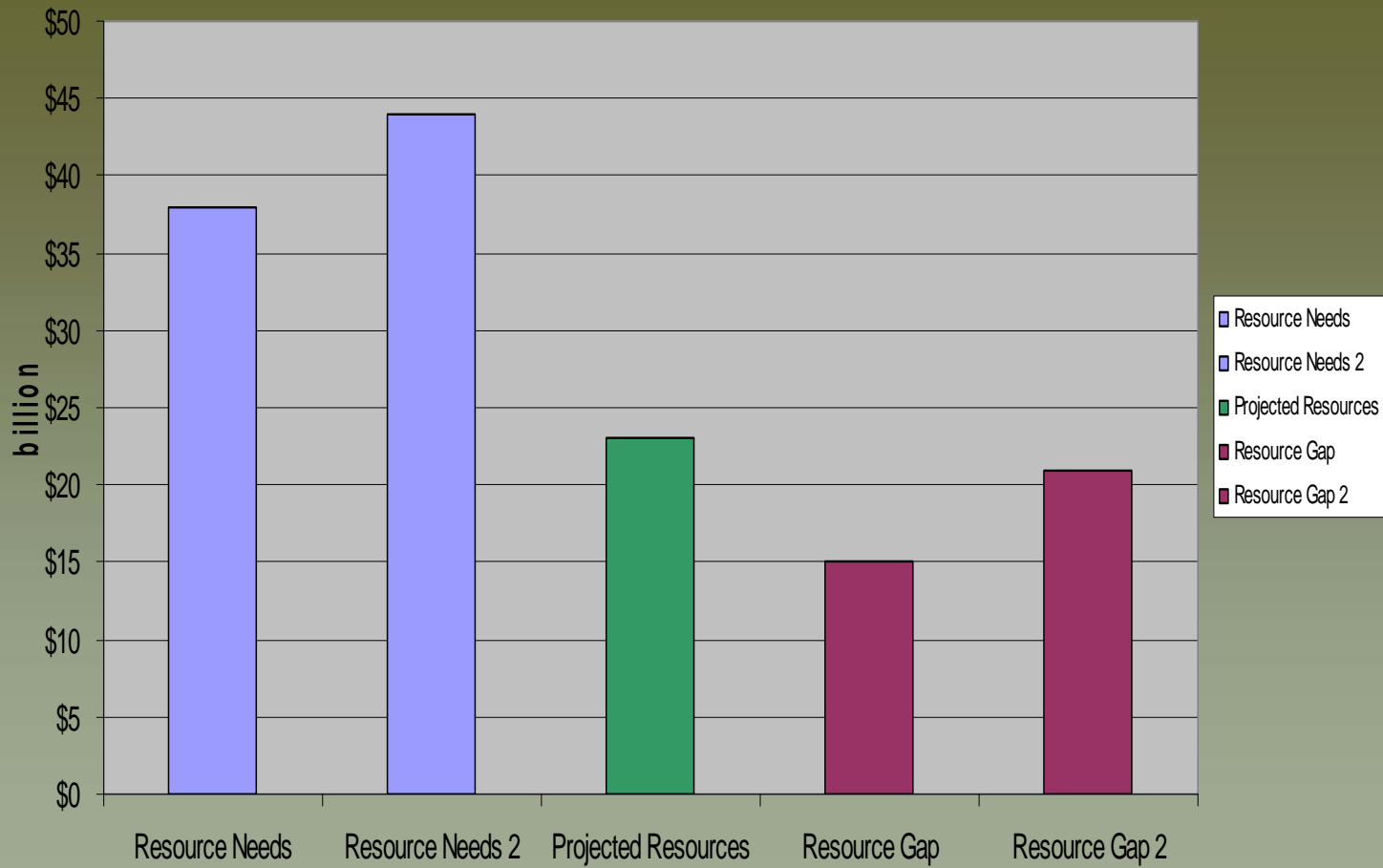
- “Massive increases in external assistance are needed” to finance MDG health goals. (WB, Health Financing Revisited 2006)
- World Bank estimates range between \$25 billion and \$70 billion in additional aid, per year, to meet MDG health goals.
- These estimates may be far too low, especially when HRH/HSS is included.



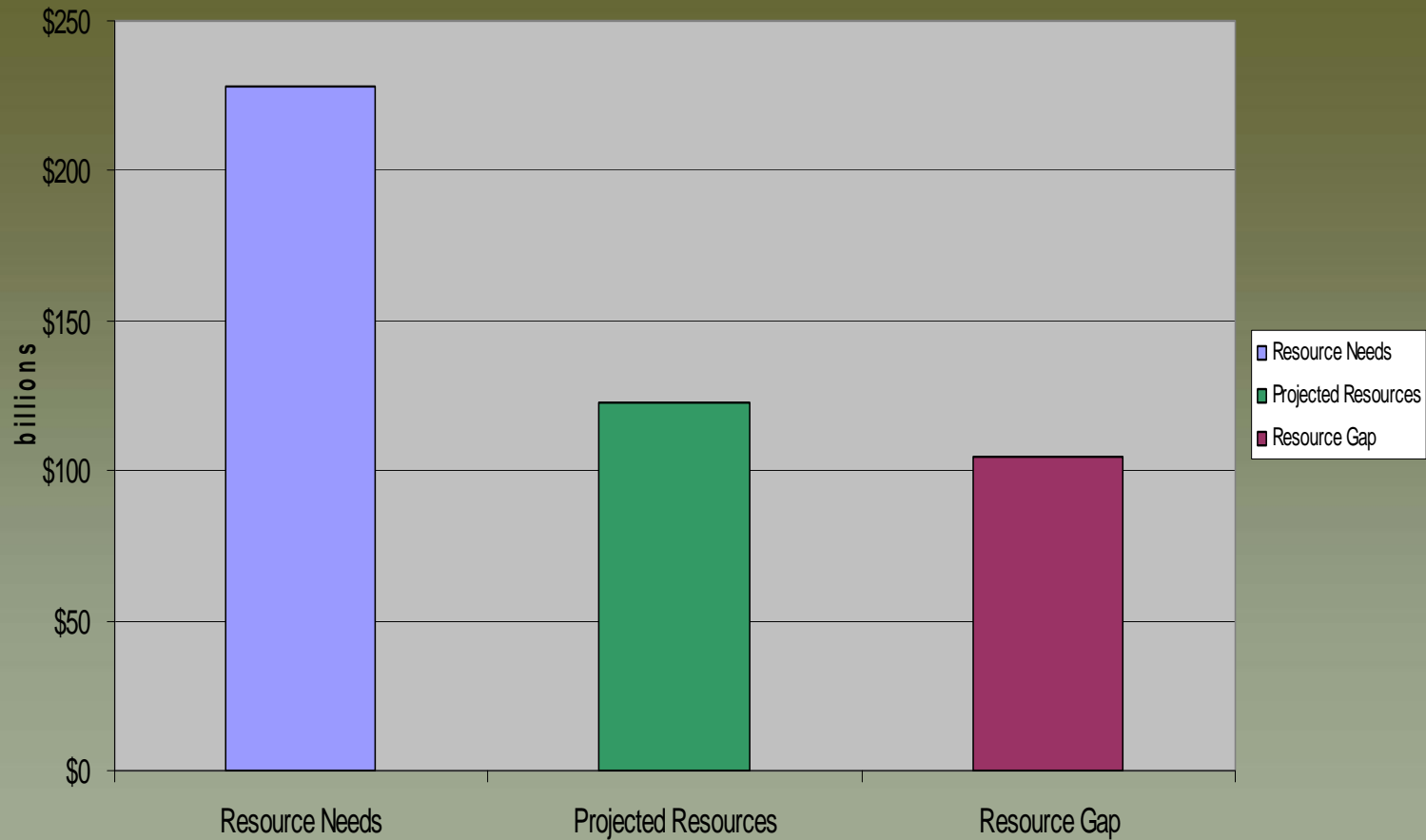
Malaria Resource Needs, Funding, and Gap 2009-2015



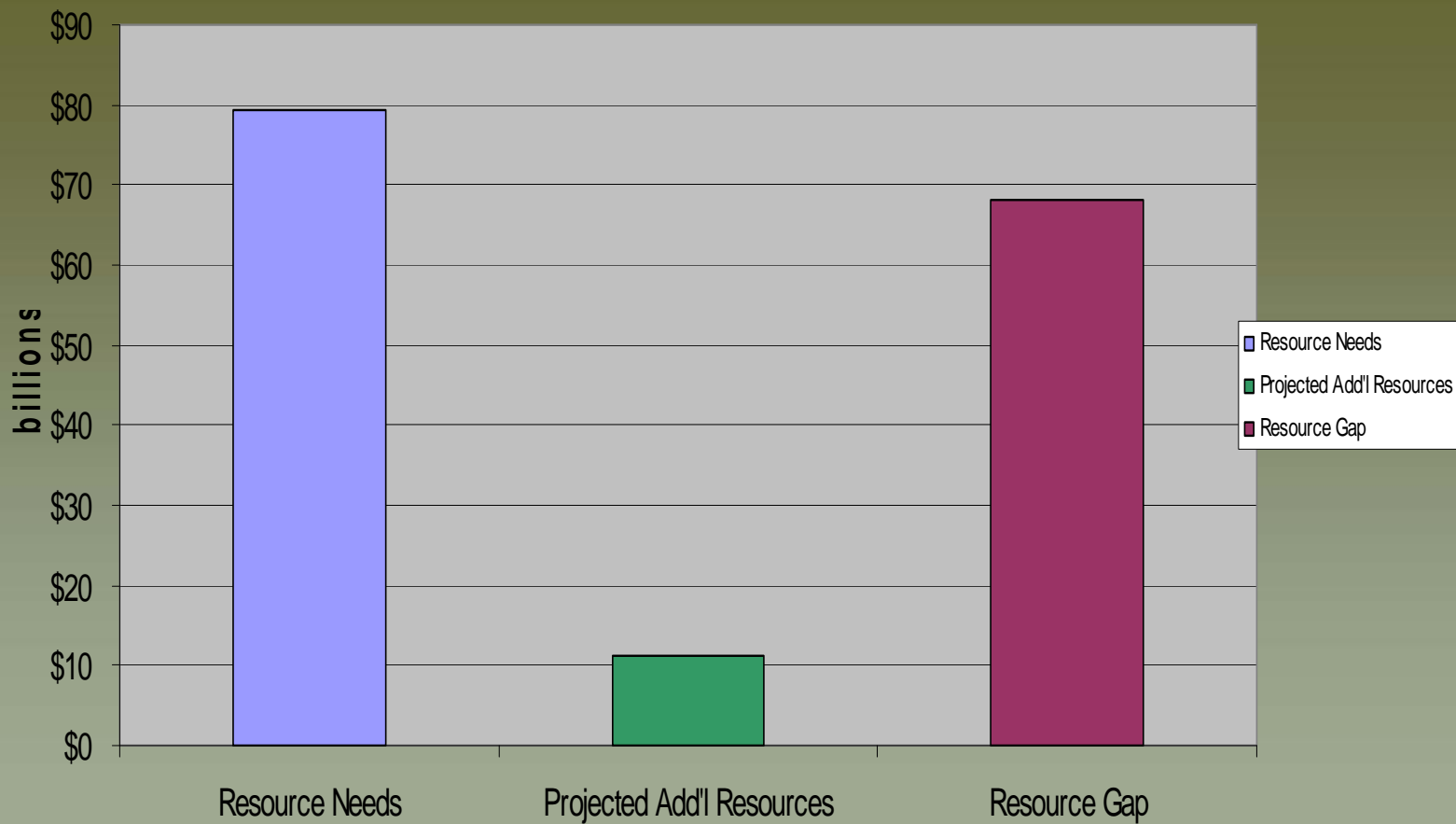
TB Control Resource Needs, Funding, Gaps 2009-2015



HIV/AIDS Resource Needs, Funding, Gap 2009-2115

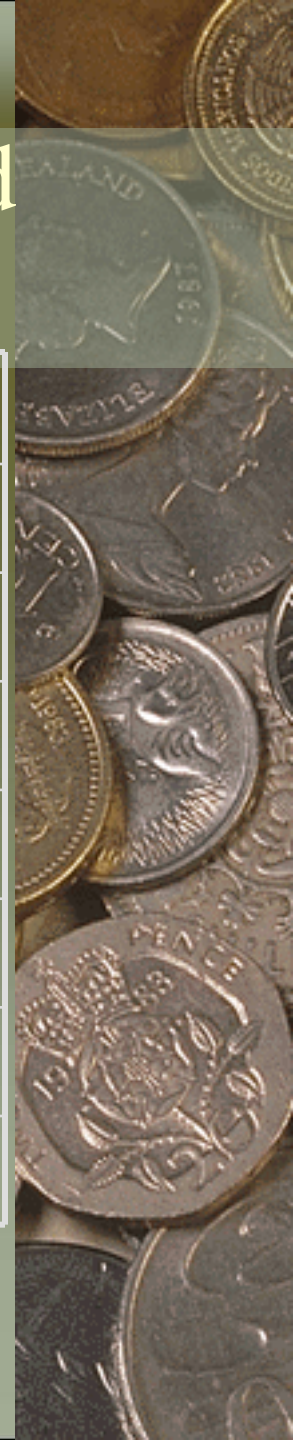


Add'l Maternal, Neonatal, Childhood, and Reproductive Health Resource Needs, Add'l Funding, and Gap: 2009-2015

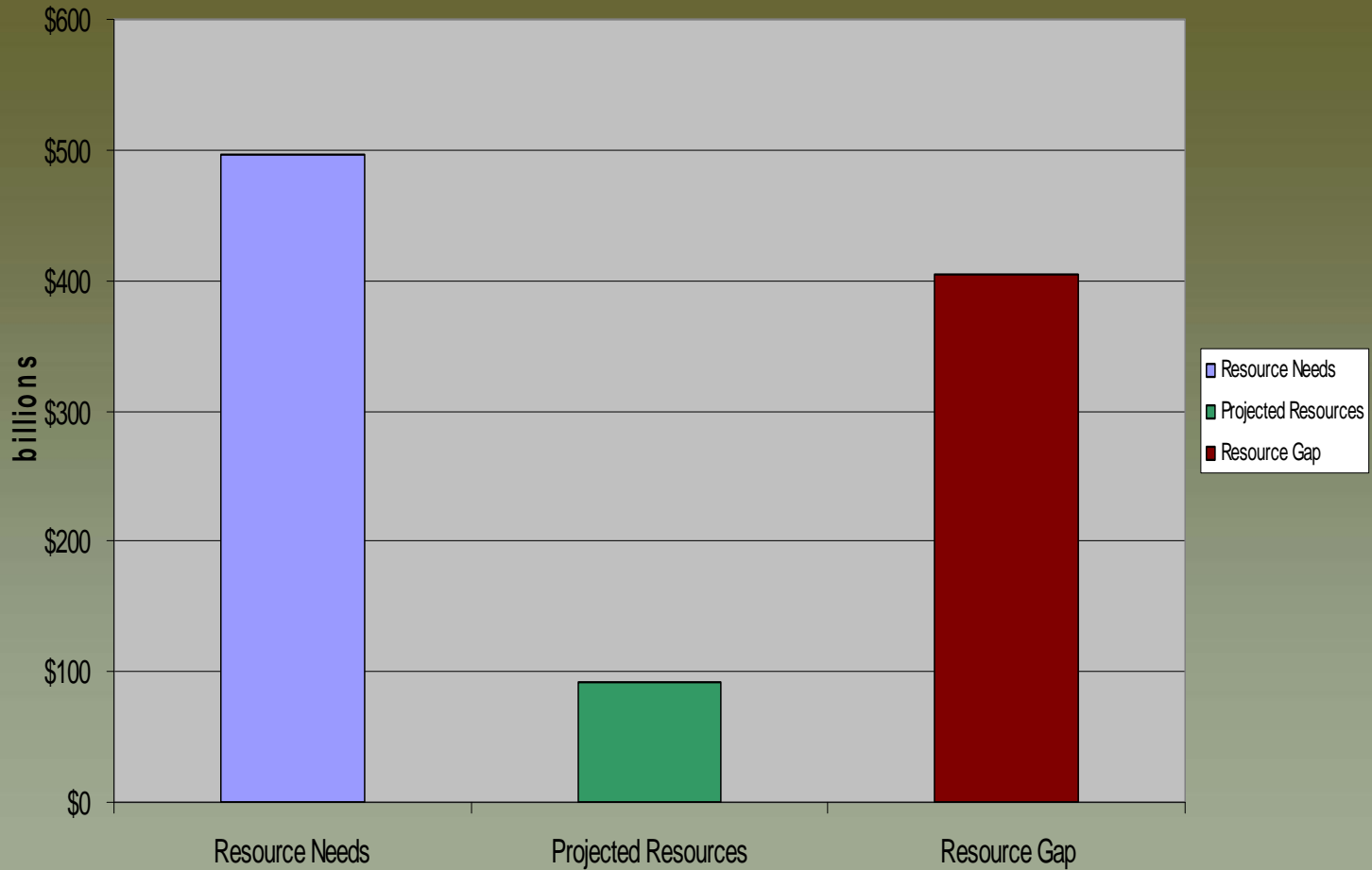


Costs for Educating Health Workers and Doubling Salaries (billions) WHO 2007

Year	Africa	Dev. Countries
2009	\$6.7	\$58
2010	\$7.5	\$64
2011	\$8.0	\$66
2012	\$9.2	\$69
2013	\$10.9	\$74
2014	\$12.7	\$80
2015	\$14.6	\$86
Total	\$69.6	\$497

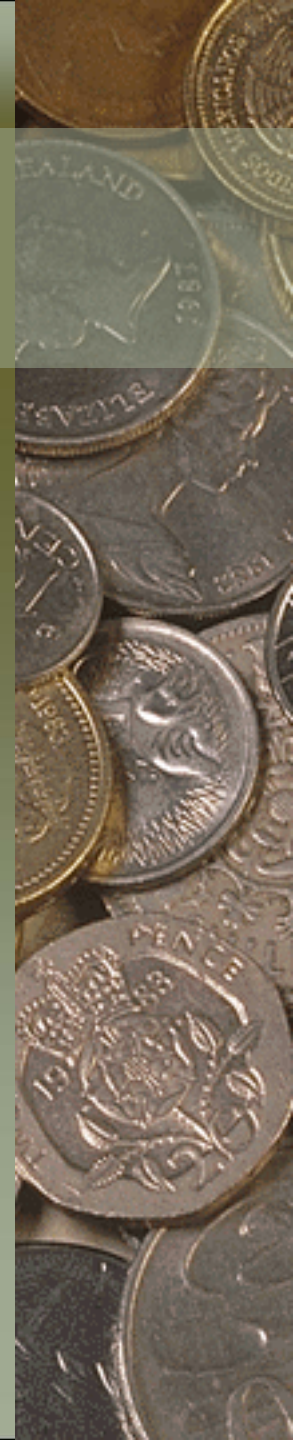


Add'l HRH Resource Needs, Funding, Gaps 2009-2015



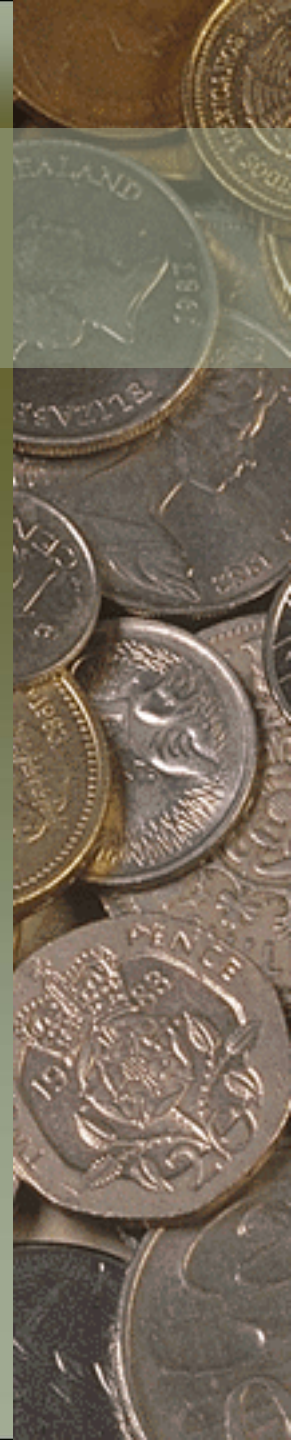
TOTAL DEVELOPING COUNTRY HEALTH RESOURCE NEEDS, PROJECTED FUNDING, & RESOURCE GAPS: 2009-2015

	Resource Needs	Projected Funding	Resource Gap
Malaria	Add'l \$38 billion	\$23 billion	\$15 billion
Tuberculosis	Add'l \$38-\$44 billion	\$23 billion	\$15-\$21 billion
HIV/AIDS	Total \$228 billion	\$123 billion	\$105 billion
Newborn, maternal, child & reproductive	Add'l \$79.4-\$137 billion	\$11 billion	\$68-\$126 billion
Chronic care, other primary care	?	?	?
HRH/HSS, inc. education and 2X salaries	Total \$497 billion	\$92	\$405 billion
Totals	\$944 billion	\$272 billion	\$672 billion



Recurrent Dilemmas in DAH

- Earmarks & conditionalities.
 - 20% to government budget support.
 - Over 50% is off budget and not available to support the health system or to pay recurrent public sector costs: staff, infrastructure, training, management, etc.
- Unpredictable, short-term and volatile.



Recurrent Dilemmas in DAH

- Lack of coordination/harmonization.
- Tied aid and technical assistance.
- Overhead losses.
- Corruption and inefficiency in recipient bureaucracies.

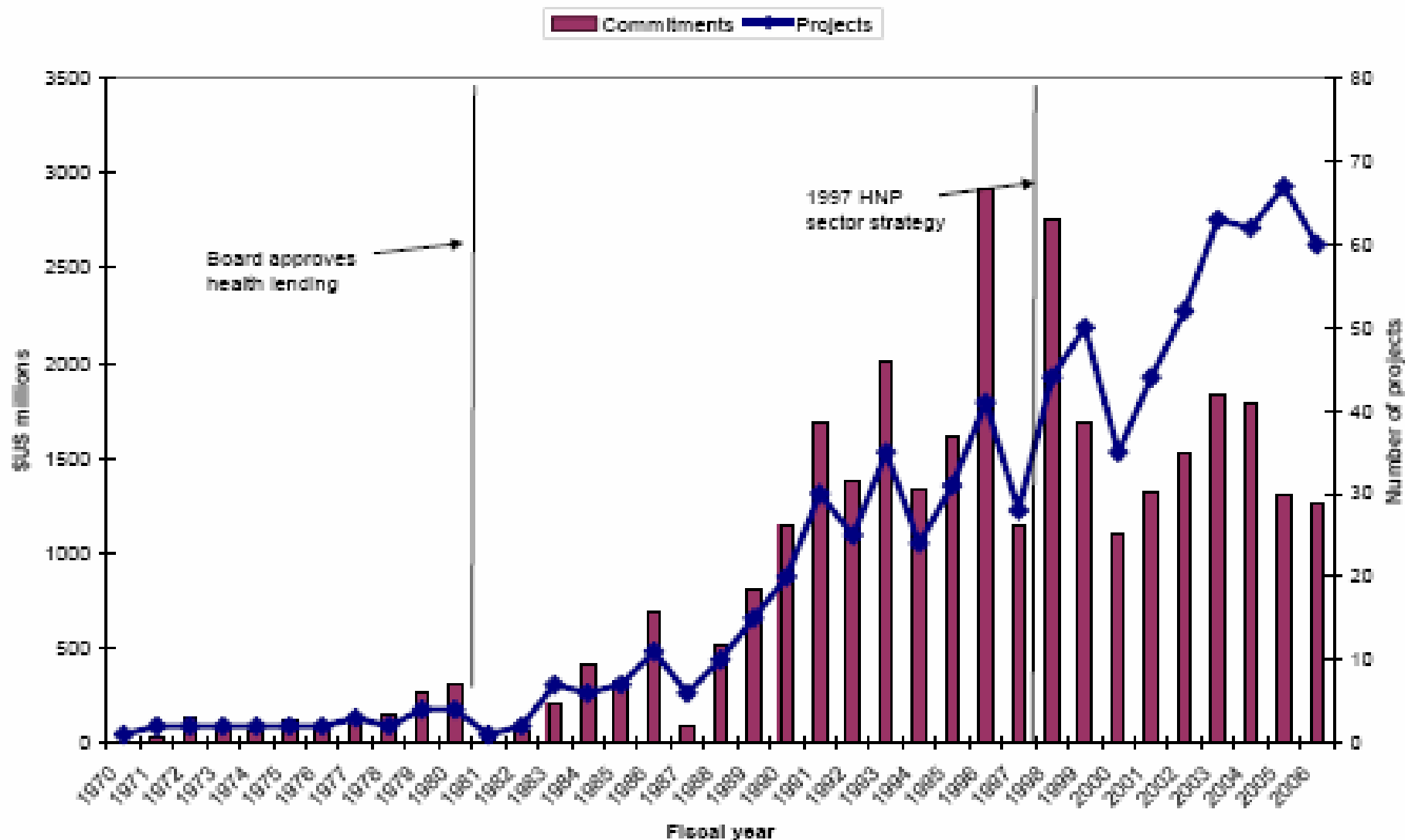


Key Donor Performance in Health Aid

- World Bank
- PEPFAR
- Global Fund
- GAVI
- UK DfID
- IHP



Figure 2. Trends in HNP commitments and project approvals, FY70-06



* The commitment for the entire project is attributed to the FY of approval and is in constant 2005 dollars.

Bank MAP (AIDS) Financing for System Strengthening 2001-06

- Ministries of Health \$22 million/\$805 million (13,181 staff trained) = 2.6%
- Civil Society Organizations \$55 million/\$805 million (47,439 staff trained) = 6.8%
- Other ministries \$55 million/\$805 million (74,793 staff trained) = 6.8%
- Other organizations, e.g., ex-pat consultants, \$244 million/ \$805 million = 30%



Loans not Grants

- IDA concessionary loans.
- Loans today, debt crisis tomorrow.
- Infrastructure vs. recurrent costs.



PEPFAR Report on Workforce Capacity and HIV/AIDS (2006):

PEPFAR's Stated Focus:

- Task shifting;
 - Information systems;
 - Training support for health workers;
 - Retention strategies; and
 - Twinning partnerships.
- Note: No real focus on expanding HRH.



PEPFAR HRH/HSS Spending

2006-08 PEPFAR Annual Reports to Congress

- FY 08 \$734 million, FY 07, \$638 million, FY 06 \$350 million spent on capacity building in public and private health sectors
- FY 08, salary support for 127,300 HCWs.
- FY 04 - FY 08, 3.7 million trainings
- Reluctance to pay recurrent costs – salaries
- Limited support for pre-service training (\$1 million per focus country FY 07, \$3 million per focus country FY 08 but \$6 million or 3% of country budget FY 09).



In PEPFAR Evaluation, Institute of Medicines' HRH/HSS-related Recommendations

- Must transition “to an emphasis on long-term strategic planning and capacity building for a sustainable response.
- Must address “**Building workforce capacity by increasing its support and including the education of new health care workers in addition to AIDS-related training for existing health care workers.**”
- Note: PEPFAR II has committed to training 140,000 (new?) health workers 2009-13.



PEPFAR II

- Tremendous victory = \$48 billion (\$39 for HIV/AIDS, \$5 for Malaria, \$4 for TB)
- Commitment to aid the hiring of 140,000 new health workers



Global Fund's Conflicted HSS Mandate

(Sources: Global Fund Progress Report 2007, Drager et al 2006)

- Mandate: support priority disease programming so as to strengthen health systems and human resource capacity.
- Priority diseases systems needs vs. long-term measures for increasing in-country capacity for scale-up.
- “The systematic, long-term development of fundamental health infrastructure is beyond the mandate and resources of the Global Fund.”



Additional Strategic HSS Guidance

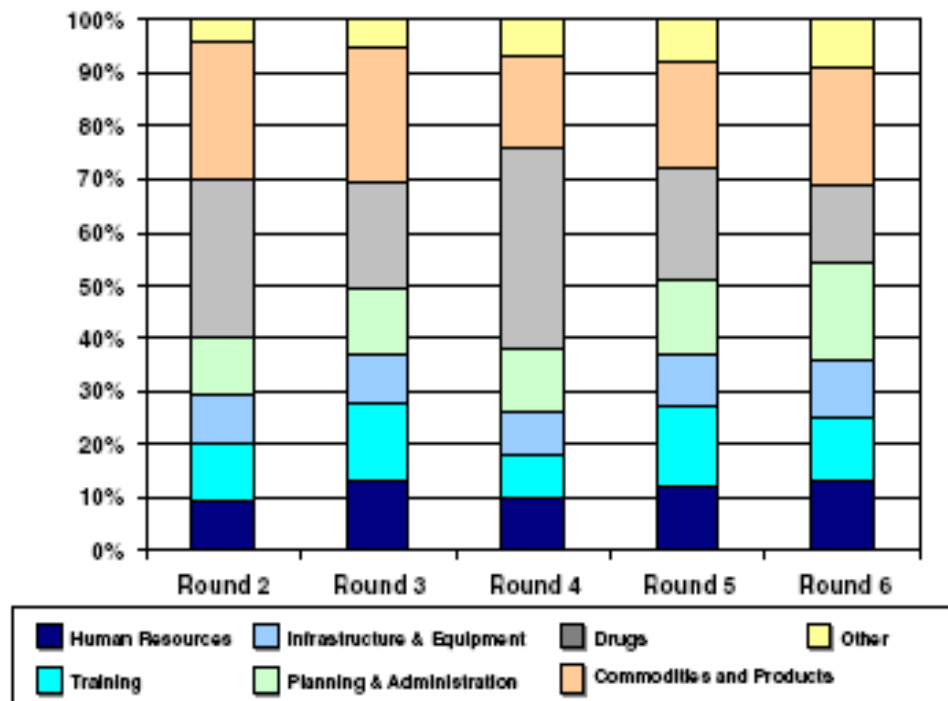
- Global Fund has adopted five strategic guidance points for HRH:
 - Scale-up of workforce planning
 - Synergize across priority programs
 - Simplify services and task shift
 - Secure health and safety of health workers
 - Foster collaboration.



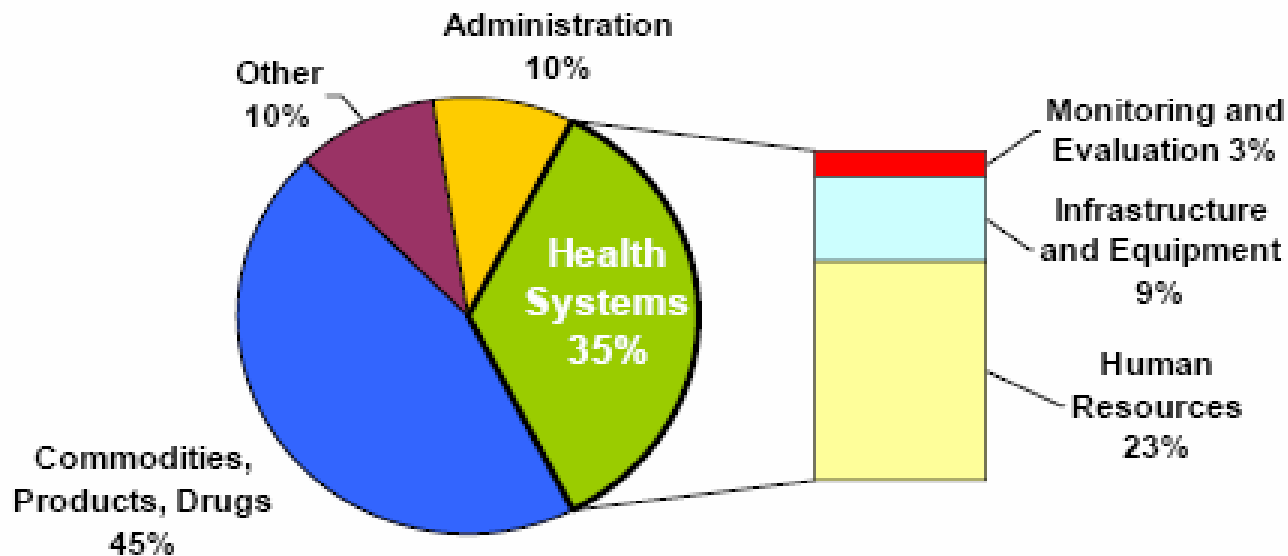
Global Fund has had a modest impact on Human Resources

- Approximately 22% of the Global Fund's portfolio Rounds 2-6 were devoted to human resources and training.

Box 1: Trends in Global Fund expenditures



Overall Health System Spending 35%



- Estimates from Global Fund Rounds 2-7 proposals
- 100% = \$5.2 billion USD

Round 7 – TRP HSS Critique

- Out of \$2.8 billion approved in Round 7, only \$363 million was targeted toward HSS.
- Proposed HSS actions focused too much on addressing obstacles to delivery of health services, and not enough on planning, financing and building health systems in the first place.
- HSS technical assistance has been problematic



Findings from Other Studies

Global Fund HSS/HRH:

- Weaknesses in HSS application guidance
- Focus is on in-service training
- Limited recruitment of new HRH
- Some proposals provide for salary support, but the bulk of proposals provide other incentives, especially for assignments in rural settings.



GAVI

- \$1.2 billion in 2008 on childhood immunization and related health systems improvements.
- Address health system bottlenecks to increase and sustain high immunization coverage – \$800 million over five years.



DfID's Global Health Strategy

- DfID focuses on: country-ownership, longer-term aid, direct budget support, and health system planning and strengthening, including expanded health workforce and mitigating the brain drain.
- 50% of DfID's aid is for basic health services.
- Focus on sexual and reproductive health



UK DfID's Global Health Strategy

Crisp, Global Health Partnerships: The UK contribution to health in developing countries 2007; DfID, Working together for better health 2007

- 2005-06, £481.4 million bilaterally and £173.6 million multilaterally on health aid.
- Increase in 2007 – close to £800 million; committed to doubling its aid budget between 2008-13.
- DfID has committed £55 million over six years to support recruitment, training and retention of health workers in Malawi.



UK's HRH/HSS Focus

- UK committed to spending \$420 million on health, including health workforce over three years in three countries.
- On June 2, 2008, DfID announced it would spend **£6 billion** over 7 years to improve health services and systems in developing countries to fight HIV/AIDS through closer integration of AIDS, TB, malaria, and SRHR, including maternal and child health services.



More from – UK Achieving Universal Access (June 2008); IHP+ Funding

- UK announced in September 2007 that it would provide £1 billion to the Global Fund between 2008 and 2015.
- £450 million for IHP+ country compacts, Sept. 2008.



“International Health Partnership-Plus” A New Focus on Coordination, \$?

- Focused on providing better coordination among donors; improving health systems, supporting the development and implementation of health plans.
- UNAIDS, UNFPA, UNICEF, WHO, World Bank; European Commission, GAVI, GFATM; Gates Foundation; Australia, Canada, Finland, UK, Norway, France, Germany, Italy, Netherlands, Portugal, Sweden;
- First-wave, focus countries: Benin, Burkina Faso, Burundi, Ethiopia, Ghana, Kenya, Madagascar, Mali, Mozambique, Niger, Zambia, Cambodia, Nepal.
- Compacts signed in Ethiopia, Mozambique, and Nepal – **no explicit promises concerning increased DAH.**



Global Campaign for the Health MDGs and other Initiatives

- The Partnership for Maternal, Newborn & Child Health
- Norway-Led Initiative – Deliver Now for Women & Children (formerly Global Business Plan)
- UNICEF/Canada and others “Catalytic Initiative to Save a Million Lives”
- Germany/France, Providing for Health Initiative



New Commitments for HSS and support of primary and child and maternal health

- Norway has pledged \$1 billion to childhood immunization through 2015
- The Netherlands has pledged \$125 euros over three years
- Canada \$105 million over 5 years, matched by UNICEF



DAH Faces Competition from Food and Fuel Shocks and Global Recession

- 2008: food prices up by 83% from 2005
- Oil by even more – over 300% since 2003 (now down)
- FAO global food policy is between \$20-30 billion a year.
- These shocks had adverse effects on imported inflation, government spending, and currency reserves
- Current financial crisis: lower remittances, lower exports, less tax revenue
- Poor countries have compelling and legitimate needs in education, infrastructure, and economic development, costing \$10s of billions/year.

