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From commitment to action: health

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SUMMARY: THE POSITION NOW AND OUR PLAN OF ACTION

Better population health is a prerequisite if developing countries are to break out of the cycle of poverty. Improving health outcomes is dependent on making progress in many areas including economic growth, education, water, social exclusion and gender equality – any sector strategy must assess these linkages and health must be prioritised in country-led plans.

Health statistics are stark. Each year almost 11 million children die before their fifth birthday and more than 500,000 women die as a result of pregnancy or childbirth. AIDS causes more than 3 million deaths and 2 million people die of tuberculosis (TB), often adults in their most productive years. Malaria causes almost 1 million deaths. Beyond the numbers lies the long-lasting impact on individuals, families and society. AIDS is reversing past development gains in many countries.

Most of the major causes of ill health and mortality in low-income countries can be prevented or readily treated using known and affordable technologies. With universal access to basic healthcare, child mortality could be reduced by two-thirds and maternal mortality by three-quarters.

The health system faces many challenges in assuring universal access to services; long-term and severe under-funding, weak institutions and governance, and shortages of trained health workers. It also important to remove barriers to increased demand, particularly financial barriers that limit poor people's access.

A number of low-income countries have demonstrated that with commitment to expanding access to services and a focus on equity and accountability, it is possible to deliver improved health outcomes.

The WHO Commission on Macroeconomics and Health (CMH) estimated that an additional US$22 billion in aid by 2007 and US$31 billion in aid by 2015 would lead to impressive benefits; a 65% reduction in maternal deaths, 2 to 5 million fewer child deaths, 2 million fewer TB deaths each year, halving malaria deaths and 100 million fewer HIV infections.

An additional $20-25 billion donor investment in health in low-income countries by 2010, with half allocated to Africa, would represent a step change in support and would deliver proportionate improvements in health outcomes. The impact will be greater if additional aid is targeted at the poorest countries and those where the burden of disease is greatest.

Increased aid resources for health need to be matched by greater predictability and efforts to reduce transaction costs. It will be important to find the right balance between targeted investment through specific funds and long-term investment in systems building where currently progress is too little and too slow.

Donors need to demonstrate now that they are committed to increasing levels of development assistance. Only then will countries have the confidence to increase the level of ambition of existing plans to accommodate scaled up aid.

Plan of action

To turn commitment into actions and support countries in expanding access to health services will require:

1. **An increase in overall aid for health in low-income countries of at least $20 billion a year by 2010, with priority given to supporting efforts to strengthen health systems.**
   - Donors must urgently turn commitments into information on forward projections of finance at the country level. A first step will be a meeting planned alongside the World Bank Annual Meetings in September 2005 where donors will discuss aid flows and the financing challenges surrounding scaling up.
   - The additional financing would be provided through a variety of channels and wherever possible through increasing the proportion of resources channelled through budgets. This will allow for a more flexible use of resources better aligned to national plans and processes.

2. **Support to governments to develop ambitious plans once financing commitments are clear.**
   - Countries cannot be expected to invest in developing ambitious sector or development plans until they are confident and clear how and when additional resources will come, and for how long they will last.
   - Technical agencies such as the IMF, World Bank and WHO have a major role to play but need to provide consistent advice on issues such as the macroeconomic effects of increasing external financing.

3. **Donors to make real progress in implementing the Paris commitments on aid effectiveness and recommendations of the Global Task Team on AIDS, including efforts to make global health initiatives and partnerships (GHIPs) more effective.**

4. **Donors to commit to developing and piloting mechanisms to increase the predictability of development assistance for the expansion of access to services. The High Level Forum on Health will address this issue in November 2005.**

5. **Partner countries to meet their commitments to increase funding to the social sectors.**
   - The exact level will of course depend on national priorities and local economic conditions, but African countries' commitment to allocate 15% of their budget to health needs to be realised.
   - Partner countries can also use the opportunity of additional long-term financing for health to improve the performance and equity of their health systems and services.

INTRODUCTION

1. The case for investing in health is clear. It saves and improves lives, drives growth and reduces poverty. It helps address global inequalities and promotes social justice. Better health is an essential prerequisite if developing countries are to break the poverty cycle.[1] The devastating impact of AIDS adds a further urgent dimension. Healthy people are more productive and productivity boosts investment. Healthy children learn better and longer and informed adults make better use of health services. Improved health and education help lower fertility and mortality rates, slow population growth and reduce the numbers of dependents.[2] The health system is at the core of social and civic life and has enormous potential to contribute to democratic development.[3]

2. Ill health pushes people into poverty. If people cannot access services that they can afford, it creates uncertainty and anxiety about the future and leads individuals to prefer lower-risk activities; this in turn stifles innovation and prevents the poor from seizing economic opportunities.[4] Equitable financing systems can stop the downward spiral into further poverty that can be caused by the catastrophic costs of ill health.

3. The Millennium Development Goals (MDGs) set benchmarks for progress against a range of human development indicators. Most countries are falling far short of reaching their targets. With the right political commitment, even the poorest countries can make progress. We know what to do to deal with the major causes of ill health and death. We know what is affordable and effective, yet many poor people cannot get the most basic of services.[2]

4. Essential health services need to be scaled up like never before. The G8 commitments create the opportunity to fund a massive increase in access to essential health services. The UN's 2005 World Summit will focus world attention on this, and many other problems. There is a window of opportunity. However, translating commitments into improved health for populations in low-income countries will be a challenge. This is not just about more donor resources: more money from developed countries will need to be matched by commitments from developing countries to prioritise health, to stamp out corruption, and to increase accountability to their populations, and will require donors to fundamentally change the ways in which they provide development assistance.

5. This paper reviews the current situation and the challenges in scaling up access to services, and estimates the costs and benefits. It also sets out a proposed plan to translate commitments into investment for improved health outcomes.

A. WHERE ARE WE NOW?

6. Without a step change in investment most countries will fail to realise the health-related MDGs. Yet progress is possible in even the poorest countries. Bangladesh made major reductions in child mortality in the 1990s and halved fertility rates from 6.6 to 3.2 children. In the second half of the twentieth century, Sri Lanka reduced its maternal mortality ratio from 555 to 24 per 100,000 live births[5] – similar reductions have been seen in Thailand, Malaysia, Tamil Nadu and Kerala. A common factor was the priority successive governments gave to effective public expenditure on social services. Significant child survival gains have been made more recently in Tanzania and Mozambique.[6]

7. Several recent publications[5,7,8,9] have highlighted the differential progress across countries and regions, and the challenges faced in attaining the MDGs. Half of the goals are directly health-related and better health will impact upon all the MDGs. The Millennium Project Review (2005) indicates that Africa is not on track to achieve any MDG and is the only region where child malnutrition is not declining. In other regions there is progress but with widening gaps in health outcomes between the richest and poorest populations. Table 1 illustrates progress in the most 'off-track' regions – sub-Saharan Africa and Southern Asia.

Table 1: Progress towards the MDG targets in sub-Saharan Africa and Southern Asia

MDG Goals and Targets	Sub-Saharan Africa	Southern Asia
Goal 1 Eradicate extreme poverty and hunger		
Reduce extreme poverty by half	High – no change	On track
Reduce hunger by half	Very high – little change	Progress but lagging
Goal 2 – Achieve universal primary education		
Universal primary schooling	Progress but lagging	Progress but lagging
Goal 3 – promote gender equality and empower women		
Girls' equal enrolment in primary school	Progress but lagging	Progress but lagging
Girls' equal enrolment in secondary school	No significant change	Progress but lagging
Literacy parity between young women and men	Lagging	No significant change
Women's equal representation in national parliaments	Progress but lagging	Very low some progress
Goal 4 Reduce child mortality		
Reduce mortality of under-five year olds by two-thirds	Very high – no change	Progress but lagging
Measles immunisation	Low, no change	Progress but lagging
Goal 5 Improve maternal health		
Reduce maternal mortality by three-quarters	Very high	Very high level
Goal 6 Combat HIV/AIDS, malaria and other diseases		
Halt and reverse spread of HIV/AIDS	Stable	Increase
Halt and reverse spread of malaria	High	Moderate risl
Halt and reverse spread of TB	High, increasing	High, declining
Goal 7 Ensure environmental sustainability		
Reverse loss of forests	Declining	Small decline
Halve proportion without improved drinking water in urban areas	No change	Met
Halve proportion without improved drinking water in rural areas	Progress but lagging	On track
Halve proportion without sanitation in urban areas	Low access, no change	On track
Halve proportion without sanitation in rural areas	No change	Progress but lagging
Improve the lives of slum dwellers	Rising numbers	Some progress
Goal 8 A global partnership for development		
Youth unemployment	High, no change	Low, increasing

No or negative change **Progress, but too slow**
Met or on track
Source: Adapted from the UN Millennium Project Progress Report, 2005.

8. The prospects are gravest in health and the statistics are stark. Each year almost 11 million children die before their fifth birthday and more than 500,000 women die as a result of pregnancy or childbirth. AIDS causes more than 3 million deaths and 2 million people die of tuberculosis (TB); both often kill adults in their most productive years. Malaria causes almost 1 million deaths, mainly of children. A woman in a low-income country is over 100 times more likely to die in pregnancy and childbirth than a woman in a developed country. Beyond the numbers lies the long-lasting impact on individuals, families and society.

9. AIDS has halted or reversed progress in many countries, particularly in Africa, and the loss of skilled staff threatens the effectiveness of public services and private

enterprise. In many southern African countries, gains in life expectancy are being reversed by AIDS. Asia and Europe face mounting epidemics, and large countries such as India and China are already adding millions more cases to the global burden. Less than one person in five at risk has access to basic HIV prevention services[10] and, globally, funding for HIV prevention has declined despite substantial increases in AIDS spending.

10. Improving sexual and reproductive health is essential to human development and attaining the MDGs. It will save and improve lives, slow the spread of HIV and AIDS, encourage gender equality, help stabilise population growth and reduce poverty. Yet there is a severe shortage of vital reproductive health services and commodities in many countries and millions are unable to avoid unwanted pregnancy and sexually transmitted diseases including HIV.[11] UNFPA estimates that over 60% of couples in sub-Saharan Africa are unable to achieve their childbearing intentions.

11. Aggregate regional and national measures mask the lack of progress among the poorest countries and among the most excluded groups in society who are almost always worst off.[12]

Box 1: Social exclusion and the MDGs

- In India, it is estimated that discrimination against girls increases the total rate of child mortality by 20%. Caste exacerbates this – low-caste Dalits have infant mortality rates of 83 against 61 for the general population and child mortality rates of 39 against 22.
- In China 37% of the known HIV cases belong to ethnic minorities who constitute 8-9% of the population.
- The gap between male and female malnutrition in Bangladesh has risen from 19% to 26% in recent years (1996-99).
- The Dalit population of Nepal has a life expectancy almost 20 years less than the national average.
- In sub-Saharan Africa, wealthier women have five times more access to contraception than poorer women.

12. Health status is determined by many factors[13] and will not be improved by a 'single-sector' approach nor through economic growth alone**.** Improvements in basic living conditions – nutrition, sanitation, and water – have a major impact on child mortality.[5] Women's literacy is strongly correlated with child mortality. Reliable communication and effective transport systems can impact on health – in Sierra Leone it increased the number of women with major complications in childbirth reaching hospital and contributed to a 10% reduction in death rates.[14] Advances in women's equality and empowerment lead to them having an increased ability to make more informed and effective health choices.

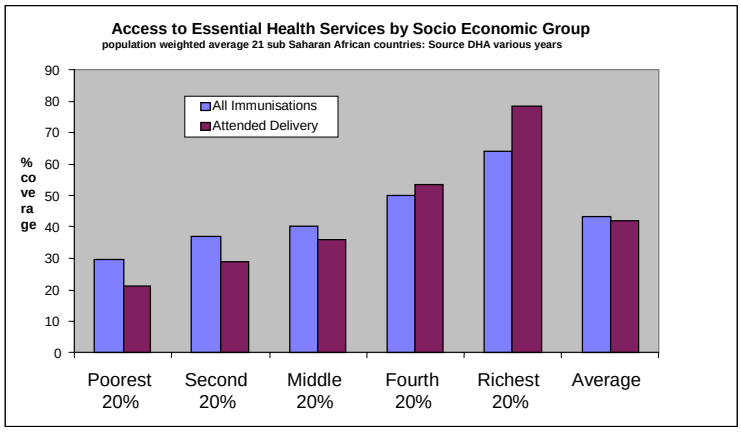
13. For most countries, however, the combined efforts of economic growth, education and access to safe water will be insufficient to make the difference between meeting and missing the health MDG targets.[5] Much of the current burden of disease in developing countries is caused by relatively few conditions that can be prevented or managed with existing affordable interventions (such as antibiotics for respiratory infections, vaccinations and skilled attendance at birth) capable of being

delivered through health services in a low-income setting. The challenge is to massively increase use of these interventions, especially by the poor. Reaching almost universal (99%) coverage with these interventions could reduce under-five deaths by almost two-thirds and maternal deaths by three-quarters.[5]

14. Meeting the health MDGs requires an effective and equitable health system that can provide universal access to basic health interventions.[13] Some low-income countries are making real progress in expanding access to services. 85% of pregnant women in Mozambique now receive antenatal care and 77% of children are immunised against measles. Efforts to ensure high coverage with basic preventive health services in remote areas have contributed to the reduction in under-five mortality from 226 per 1000 live births in 1990 to 170 in 2003.

15. Globally, however, the use of child health interventions is below 50%[5] and health services in many developing countries remain unavailable to those in most need or are available only at low quality or high cost. Global and regional data hide major differentials in access to services by different income groups. Fig 1 illustrates the differences in access to immunisation and attended delivery across 21 sub-Saharan countries.

Figure 1: Access to health services by socio-economic group



B. WHAT ARE THE CHALLENGES?

16. A range of constraints – financial, institutional, political,[15] social and systemic – contribute to poor-quality health services, that do not prioritise the most critical interventions or serve the poor and excluded. Countries consistently identify a number of key barriers to improving the performance of their health systems. These include finance, severe shortages of trained staff, limited access to essential medicines, the performance of the non-state sector, and the difficulties of managing a complex and geographically dispersed service. Weak monitoring and information systems and the large number of donors involved in health also pose particular challenges.

Challenge 1 – Balancing targeted approaches and health system strengthening

17. The global health architecture is complex and fragmented. Recent years have seen the rise of disease or issue-focused programmes (AIDS, TB, malaria, and childhood immunisation). These programmes have raised the profile of specific health issues, mobilised significant additional resources and delivered results against their specific targets. However, while they rely on a strong health system to deliver sustainable benefits they may perversely contribute to the undermining of broader heath service delivery through duplication of effort, distortion of national health plans and budgets and particularly through diversion of scarce trained staff. Yet they can complement country efforts and are adapting their operations to better integrate with local planning cycles. There is a need to find the right combination of investment in efforts to address both priority health problems and system-wide problems. Without increased attention to strengthening health systems we cannot make sustainable improvements in the health of individuals and populations.

Box 2: Expanding services to deliver a package of HIV prevention, treatment and care

With the aim of an AIDS-free generation in Africa, the G8 has committed to: 'significantly reducing HIV infections and working with WHO/UNAIDS and other international bodies to develop and implement a package for HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010.' Lack of resources has limited many nations' ability to bring comprehensive AIDS programmes to scale, and stem the tide of the epidemic. It is estimated that HIV prevention programmes reach fewer than one in five of those who need them and that only 16% of those in need are receiving treatment. However, since the launch of the '3 by 5' initiative, major advances have been made in every region in increasing access to AIDS treatment. Sub-Saharan Africa and Asia have tripled numbers since mid-2004. Fourteen low and middle-income countries have met the target of delivering treatment to half the number of those in need. Further success will depend upon a combination of political, technical and financial support, invested in ways that strengthen overall capacity to deliver essential health services, and making stronger links between treatment and prevention.

Challenge 2 – Universal access to health services will need massive increases of resources that are spent more effectively and equitably

18. Current levels of health spending in most low-income countries fall far short of the minimum to deliver universal access to services. In sub-Saharan Africa public

spending on health averaged 2.7% of GDP in 2002 (range <1% to >5%[7]) with total health spending around 6.8% of GDP. In Abuja in 2000 African governments committed to increase funding for health from an average of 8% to 15% of their budgets. However, most are far from reaching this target and in many countries health spending appears to be below what is affordable. Countries can be supported to mobilise additional domestic resources for health but additional external resources are needed to help close the gap.[5,7]

19. While the relationship between public health spending and outputs and outcomes is complex,[16] there is evidence that increased public spending does result in improved outcomes if well-targeted. Child mortality improves when health spending is focused on the poor, while the impact of public health spending increases in countries with good governance.[5]

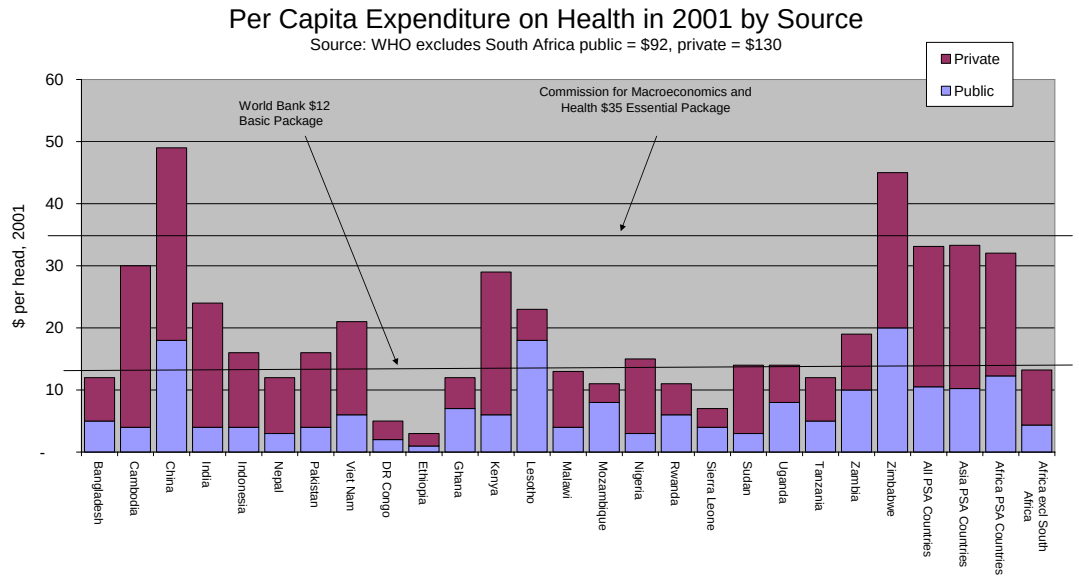
20. The Commission on Macroeconomics and Health report[1] provides estimates of the costs of expanding the supply of health services in low-income countries. It calculated the additional costs of providing a 'package' of services that deal with the main causes of ill health and death at US$30 to US$40 per person each year. This would require an additional $40-$52 billion annually by 2015 but would save 8 million lives each year. Recent exercises have also estimated the cost of meeting individual global health goals or targets –TB (US$37 billion over the next 10 years), malaria ($2.9 billion each year), [17] AIDS ($15 billion in 2006, rising to $22 billion in 2008[18] – although these costs do incorporate broader health system costs). The Global Fund to fight AIDS, TB and Malaria (GFATM) estimates a financing need of US$7.1 billion over two years;[19] maternal and newborn health ($39 billion between 2006 and 2015[3]) and reproductive health (UNFPA estimate $1.5 billion up to 2015 needed for family planning, and an additional $300 million per year for reproductive health supplies in sub-Saharan Africa).

21. Fig 2 illustrates the total health spend (public and private) across a range of DFID partner countries. The message is clear – health spending needs to be of a different order of magnitude.[13] Recent changes in the technologies and treatment available for malaria and expanding provision of AIDS treatment will increase the costs even further. Spend falls far short of the CMH estimates

22. Low-income countries have historically planned and budgeted based on resources available rather than need. Where countries have made ambitious plans, these have been scaled back due to lack of funds. In 2002 Uganda costed a package of services at $28 per capita against the available $8.4.[6,1] Estimates of the cost of achieving universal access can only be done credibly at the country level. To date, donors have not supported the development of ambitious plans – countries have understandably planned based on available resources not on need.

[1] This figure in Uganda was consistent with WHO's Commission for Macroeconomics and Health but may now be an underestimate given recent changes in policy to scale up the supply of anti-retroviral treatment (ART) for HIV and artemisinin-based combination therapy (ACT) for malaria.

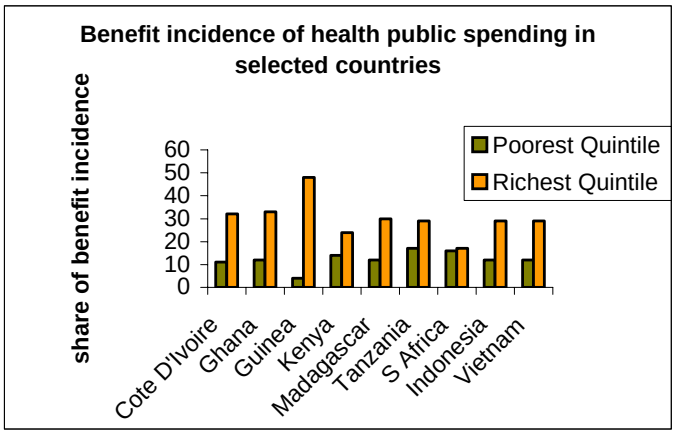
Figure 2: Per capita expenditure on health by source



23. New resources offer the potential to build more equitable, inclusive health systems and expand access to services – a prerequisite for achieving the MDGs .[13] There is also potential for greater efficiency and equity of health spend. To date, public subsidies for health have often disproportionately benefited wealthier people,[20, 21] as illustrated by Fig 3 below.

24. Uganda increased total funding for health by only 19% (from $7 to $8.4 per capita) but with improvements in allocation (more needs-based, targeted to the poorest districts),[22] in making financing fair (official user fees for health were removed) and in aid delivery (more budget support, fewer projects, sector-wide approach). Drug budgets doubled, outpatient attendance rose by 117% and immunisation coverage by 102%.[23] Spending targeted at specific groups can lead to greater returns – in terms of reductions in under-five mortality – than extra spending across –the board[5] but both approaches can improve equity.[24]

Figure 3



Source: WHO[25]

Challenge 3 – Responding to the health-staffing crisis

25. Adequate numbers of well-trained, motivated and supported health workers are essential for effective service delivery. Many countries face a deep crisis in staffing their health service. Africa has led the call for an urgent international response. These shortages are the result of chronic under-investment in staff and health systems and exacerbated by the additional burden of AIDS and outward migration.[26,27]

26. Many low-income countries, particularly in sub-Saharan Africa, struggle to provide even basic health services. Many have less than one health worker per 1000 population with many workers concentrated in urban areas or in the private sector, further limiting access by the poorest. A minimum health worker density of around 1.5 per 1000 people is associated with achieving 80% coverage for measles immunisation, and 2.5 with 80% for coverage of births with skilled attendance.[28]

Box 3: The human resource crisis in the Malawi health sector

Since the late 1990s Malawi has experienced a serious exodus of health workers from government employment. This is largely due to the inability of the government to raise the real value of the salary of health professionals and weaknesses in the health system, which mean working conditions are extremely poor. (Salary costs are typically 30-40% of the Ministry of Health's budget compared with 60-70% on average in other African countries.)

Many staff have left to work either abroad or domestically, in the private sector or in the rapidly growing donor-funded NGO sector.

AIDS is a growing problem, contributing indirectly and directly. In 1990 eight Ministry of Health workers died; in 2000 this figure reached 200 – AIDS is thought to be a key factor in this increase

Combined, these factors have led to a population-to-doctor ratio of 106,397:1 in 2004, almost 12 times the recommended ratio of 9,000:1. Vacancies among nursing cadres are over 60%. Ten of Malawi's 29 districts have no government doctor; four districts have no doctor at all. Vacancy rates are significantly higher in rural areas.

27. The Joint Learning Initiative[2] estimated that sub-Saharan Africa will need an additional 1 million health workers between now and 2015 to rise from one health worker per 1000 people to a minimum target of 2.5 per 1000. The global need is for an additional 4 million health workers. Human resources in health is a long neglected area and support is urgently needed to develop and implement comprehensive country strategies that address: recruitment and training, skill mix,[29] retention of workers,[30] performance management and productivity,[31] distribution[32] and planning.

28. Between 30% and 50%, or about $4 billion of current development assistance for health, funds human resources. Most is invested in fragmented, short-term technical assistance and training inputs that are rarely linked to an overall human resource strategy. There is great scope for more effective and coordinated interventions.

29. Low-income countries are currently subsidising high-income ones by supplying them with highly trained staff. The African Union has estimated a net outflow of about $500 million a year. Changes to international recruitment practice may help to manage the flow of migrants but migration is a symptom of a deeper malaise – planning failures, the inability to pay fairly, lack of career prospects and poor working conditions in 'source' countries, and poor planning and low investment in workforce self sustainability in 'destination' countries.

[2] Joint Learning Initiative -a programme on Human Resources for Health involving more than 150 global health leaders

Box 4: What will it cost?

The Commission for Africa estimated that an initial $0.5 billion can be spent on training and retention of health workers in Africa in 2006, but as training and health system capacity are built up, this amount could increase by $1 billion each year, rising to about $6 billion by 2011. The WHO's early estimates suggest that an additional 1 million health workers could be trained for between $0.6 billion and $1.6 billion, based on the current skill mix and depending on how well attrition rates can be driven down. This includes the costs for building and resourcing educational facilities.[1] Retention of existing health workers makes up the bulk of the additional financing required. Specific costs include improvements to salaries and other conditions, as well as opportunities for career development.

30. Increasing the supply of health workers will only impact on health outcomes in an environment where the health system functions effectively. A critical element is reliable access to safe, appropriate, affordable and high-quality medicines. WHO estimates that one in three people living in developing countries do not have regular access to essential medicines.

Challenge 4 – Harnessing the contribution of non-state service providers

31. In many settings governments are not the main providers of health services. In India 80% of out-patient treatments are delivered through the private sector.[9] Using a range of non-state providers (private sector, non-government, community organisations) offers the potential for rapid expansion in access to health services. Non-state providers may be more successful than the state at providing efficient client-orientated, responsive services,[33] but an unregulated private sector may also provide poor-quality services. Increased resources provide an opportunity for partnerships between the state and non-state providers through successful approaches such as social marketing, franchising and contracting (in Cambodia contracting has helped to increase the coverage of some key services in a short time[9]). The government's stewardship role needs to be strengthened to provide oversight and regulation of non-state providers.

32. To achieve universal access, whether through state or non-state providers, requires the removal of barriers to use of services including financial barriers – a significant proportion of current health expenditure in low-income countries is private (Fig 3). In Nigeria, 70% of total health expenditure is 'out-of-pocket'.[34] Out-of-pocket expenditure is an inefficient and inequitable way of financing health care;[35] it restricts access and denies basic care to the poor.[36] Some countries are therefore choosing to shift from reliance on out-of-pocket payment towards a greater element of risk pooling, based on tax or social insurance. Removal of user fees in Uganda[37] led to dramatic increases in service use. However, in low-income countries, irrespective of whether there are official user fees, there are other fees and charges incurred by patients that serve as significant barriers to access to basic health services. The removal of official user fees should be part of broad-based efforts to fund and deliver quality, equitable healthcare for all.

Challenge 5 – Increasing demand and accountability

33. Increased supply of health services needs to be matched by investments in demand by poor people and in strengthening the ways that institutions and service providers can be held to account. Transparent, participative processes for budget

allocation and the design of frameworks to tackle discrimination can go a long way in building systems of accountability.

34. Giving communities a greater voice in service planning, management, monitoring budgets and ensuring service quality and responsiveness increases accountability. Such approaches should aim to reduce direct and indirect costs, increase information, reduce household and cultural constraints to access, and promote greater health awareness and use of available health and education services.[38]

35. Appropriate information and communication strategies can increase poor people's knowledge of their entitlements to health, including access to exemptions,[39] tackle cultural and gender constraints, and increase knowledge of specific health and behaviour change issues to enable them to make informed decisions. There are many examples of successful mass media and community-based communication strategies in health, such as radio dramas to promote family planning in Nepal.[40]

36. Greater community participation and information sharing needs to be matched by strengthened public institutions at all levels to make them more accountable and responsive. This includes parliamentary oversight, and political processes that enable people to make demands on, and hold government to account, including supporting and encouraging tax raising, the establishment of a free and informed media and the publication of information on budgets.

37. Social transfers and demand-side financing can boost demand and use of services, particularly when combined with actions to improve quality of services. Programmes targeted at excluded groups who face systematic barriers to accessing services may be required. In Latin America, conditional cash transfer programmes increased use of preventive health services and improved nutrition.[41] Transfers that are not tied to service use, such as pensions in South Africa, have also improved the health status of the older person as well as other family members when the household pooled income.[42] Voucher schemes have been successful in increasing use of particular health services (treatments for sexually transmitted infections, skilled care at delivery, TB treatment), and have potential for expansion.[36]

Challenge 6 – **Strengthening governance**

38. The health MDGs will not be achieved by pouring money into poorly performing systems with weak institutional environments. Much poor performance in health reflects weaknesses in institutions, budgeting and public expenditure management and public spending on health is more effective where there are strong governance and effective institutions.[5] The 2005 Commission for Africa report concluded that without progress in improving governance, all other reforms would have limited impact.[8]

39. Better service delivery will require greater attention to public financial management and accountability (maintaining fiscal discipline, ensuring resources are allocated and spent in line with stated priorities and not lost through corruption or mismanagement, and used to achieve maximum impact on health outcomes).[43] Making information more accessible and promoting transparency in fees, budgets and expenditure will promote an environment where corruption can be tackled more

effectively. Better-managed services that deliver and make a real difference to the lives of poor people[9] can win and retain public support for wider reform efforts.

40. Where low-income countries have made major progress in improving health outcomes, political commitment was a common feature. Governments are more likely to prioritise health when it becomes an issue that wins or loses elections.

Challenge 7 – **Investing in better health in fragile states**

41. One-third of maternal deaths and nearly half of under-five deaths occur in fragile states,[44] those least likely to achieve the health MDGs. While such states tend to receive little aid, donors face particular challenges in engagement. Improving health is a particular challenge and an imperative. Improving service delivery in such settings can act as a catalyst to restore confidence in government.[13] Where it is difficult to work directly through governments there may be other channels, such as a UN oversight body, an umbrella fund or a variety of non-state providers (NGOs, faith-based organisations, for-profit companies and community-based providers).

42. One-third of GFATM resources have gone to fragile states with evidence of good performance. Any mechanism will need to be complemented by the development of the role of the state and its capacity to oversee and regulate service provision. States emerging from a period of fragility often have extremely weak institutional environments and it may be a long time before these countries will be able to put in place accountable institutions capable of delivering public services.[45] Such environments need creative approaches and collaborations to provide services and a balance between the short-term imperative to improve health service delivery and the longer-term aim of the development of an effective state. Many low-income countries (and particularly those emerging from a period of fragility) have extremely weak institutional environments. It is likely to be a long time before these countries will be able to put in place effective systems.

Challenge 8 – **Building effective health information systems**

43. Many policy-makers do not have access to basic information on births, deaths and disease. Only 2% of countries in WHO's Africa and South-east Asia regions have complete death registration data and national vital registration worldwide covers less than one-third of the world's estimated mortality.[46] Without such data policy-makers and managers risk making bad decisions based on bad information. There is an urgent need for better data systems to guide results-based performance monitoring, better disaggregation to allow analysis of equity and distributional issues, and better capture of quality measures.[6] Health information needs to be linked to poverty monitoring systems.

Challenge 9 – **Research into the health problems of low-income countries**

44. Only 10% of the annual $70 billion spent on global health research targets the diseases responsible for 90% of the world's health problems.[47] The CMH estimated research funding needs to be $1.5 billion annually (and a further $1.5 billion for co-ordinating and building country capacity for health research). Global advocacy has increased investment from $200 million in the 1990s to over $1 billion in 2004. However, there remains a significant gap. A recent review found

that, despite new commitments, the financing shortfall to the end of 2007 for the most urgently needed products amounts to over $ 2 billion.[1]

C. MAKING AID MORE EFFECTIVE

45. The scaled-up development assistance implied by the 2005 G8 commitment will amount to an additional 10-20% of GNI for many African countries. If used effectively, this increase could lead to a massive expansion, and near universal access to essential health services. Achieving this will, however, require donors and governments to make fundamental changes in their operations.

46. Increased development assistance for health should support country-defined priorities and strategies linked to sector planning and budgeting processes within the context of the overall national development plan.

47. The G8 commitments will likely be channelled through a range of aid instruments. Wherever possible, additional resources should be channelled through flexible programmatic instruments (poverty reduction budget support, sector budget support). While there are risks associated with this approach that need to be carefully managed, the advantages include:

- It builds on commitments made in Paris in 2005 to scale up assistance in ways which strengthen partner countries' national development strategies, ensures aid is aligned with countries' priorities and enhances government accountability to citizens for development policies and performance.
- The additional public spending needed to scale up service delivery will be largely for recurrent costs, especially human resources.
- It will allow for management of potential undesirable macroeconomic effects of higher aid volumes.
- It allows a broad-based approach to tackling the MDGs (such as the need for increased capacity in the education sector to train more health workers).

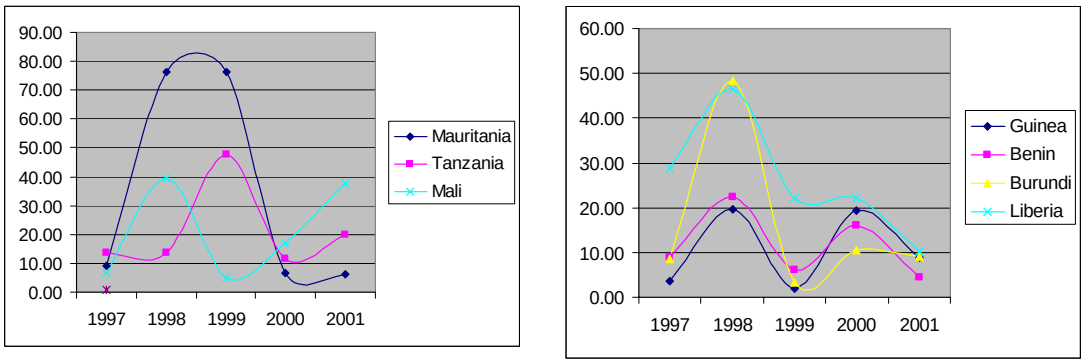
48. Development assistance for health from all external sources rose from $6.4 billion in 1997-99 to about $8.1 billion in 2002. This period also saw a proliferation of global programmes and funds aimed at increasing awareness and funding against major diseases. The major resource transfer funds, including the Global Fund , the Global Alliance for Vaccines and Immunisation (GAVI), the US President's Emergency Plan for AIDS Relief (PEPFAR), together disburse over $5 billion per year. In addition, there are more than 80 other global health initiatives and partnerships – much smaller in financial terms, mainly with a focus on advocacy and research.[48] Individually, these programmes have had a major impact yet there is a concern that their cumulative impact may undermine sector planning and financing[5] and distort sector priorities.[13] Collectively GHIPs impose transaction costs on governments, and may undermine national ownership and planning processes.

49. GHIPs will continue to play an extremely important role in developing countries – GFATM provides a substantial proportion of external assistance for AIDS (20%), TB (66%) and malaria (45%). But priorities for increased spending should be to strengthen health sector systems, with an emphasis on recurrent costs as well as investment needs. Currently less than 20% of donor disbursement is provided as budget support and less than half is available for public expenditure. The majority of development assistance continues to be committed through projects and parallel arrangements that are often imperfectly coordinated with government strategy. Governments are understandably reluctant to take politically irreversible

actions that have long-term costs, such as hiring additional staff, increasing wages to retain staff, or committing to lifelong AIDS treatment, if long-term, predictable finance is not forthcoming.

50. Development assistance is a notoriously undependable source of public finance in poor countries,[49] across all sectors. As the graphs illustrate, donor commitments for health can vary tremendously from year to year.

Figure 4: Donor commitments for health as % of total health expenditures



Source: WDI and OECD DAC donor funding database. World Bank staff estimates.

51. Bilateral aid commitments are relatively short-term (onetotwo years) and disbursements can diverge substantially. On average, less than 60% of the aid 'committed' actually makes it to programmes and there is evidence that donors' track record has deteriorated in the past five to 10 years.[49]

52. Past precedent gives countries every reason to mistrust the reliability or permanence of donor promises. Further work is urgently needed to design mechanisms that provide greater assurance of sustained long-term financial support[5] and increase the credibility of long-term commitments. Reducing the volatility of aid flows will become even more crucial where increased development assistance further increases aid dependency.

53. Increased flows of development assistance will present a number of macroeconomic challenges that need to be managed yet evidence suggests that 'aid inflows that are reasonably predictable and persistent are neither intrinsically inflationary nor do they necessarily generate macroeconomic instability'.[50]

54. Increasing aid dependency over a longer period also brings additional governance challenges. Historically, the need for governments to be responsive to taxpayer concerns has been critical in the development of improved governance. There is a risk that significantly increasing external funds inhibits the development of political legitimacy through the 'fiscal social contract' between a government and its population.[45] If aid dependency is not to become a constraint to development in itself, it must be balanced with measures to protect sovereignty, maintain the legitimacy of political leadership and the processes that broker power and to support the accountability of a state to its citizens.[9] Country-led processes and reducing conditionality will be central elements in achieving this balance.

55. Even small volumes of aid for small countries flow through hundreds of parallel bilateral, multilateral and global programme channels, each with its own negotiation, reporting, and administrative requirements. These development assistance transaction costs must be lowered**.** Mozambique has more than 100 development partners in health and Vietnam received approximately 400 separate donor missions in 2003, of which just 2% were undertaken jointly. Low-income countries are often forced to allocate limited human resources away from managing service delivery to managing donors.[7] Real and urgent progress is needed on donor harmonisation.

D. PLAN OF ACTION

56. An additional $20-25 billion donor assistance for health could permit a massive expansion in access and increase in quality, equity and responsiveness of services. Early up-front investment is needed and can be made – in training, infrastructure, policy reform, drugs and procurement processes – and will provide the basic building blocks of a more effective health system.

57. However, the funding gap for health is greater than $20-25 billion. UNAIDS estimate that the AIDS resource gap for sub-Saharan Africa is in the region of $18 billion in 2006 $13.3 billion for health and an additional $4.3 billion for AIDS services). This would achieve 50% coverage of anti-retroviral treatment (ART). To achieve universal coverage for AIDS services in 2010 would require US$10 billion a year just for AIDS-specific services in addition to resources to fund the health system.

58. Costing an expansion of access to health services can only be done credibly at the country level, linked to national priorities and comprehensive sector and broader development strategies. To date, countries have been encouraged and have understandably chosen to develop health sector plans based on available resources rather than need. Therefore accurate country-by-country estimates of how much it will cost to achieve universal access to health services are not readily available.

59. To date, the most comprehensive work to estimate the cost of expanding a 'package' of services (i.e. not just for one disease or intervention) in developing countries has been undertaken by the WHO Commission on Macroeconomics and Health[3]. The CMH estimated the additional funding needed to scale up to specific targets of coverage for 49 essential, cost effective interventions in 83 developing countries (countries with GNP (2002) of under $1200 and all sub-Saharan Africa). Annex one provides more detail on these estimates of additional resources required.

60. The CMH estimated that increasing donor assistance for health by $22billion in 2007 and $31billion in 2015, together with increased domestic funding for health would bring impressive benefits by 2015:

- a 65% reduction in maternal deaths;
- 2-5 million fewer childhood deaths each year;
- 2 million fewer TB deaths each year;
- halving malaria deaths from the current million annually and
- 100 million fewer HIV infections each year.

61. Based on the work of the CMH, it is estimated that investing an additional $25 billion by 2010 in the expansion of health services across low-income countries could make a very significant impact on health outputs and outcomes, including ensuring that each year:

- More than 14 million more women receive antenatal care;

[3] It should be noted that whilst these are the best estimates available on expanding the coverage of a package of services, they do not include all interventions that respond to a particular country's priorities e.g. they do not include all resource needs for Sexual and Reproductive Health.

- more than 33 million additional births are attended by skilled healthcare providers (a key strategy to reduce maternal deaths);
- over 130 million more children are treated for acute respiratory infections – one of the leading killers of under-fives in developing countries;
- over a million more cases of TB are diagnosed and treated; and
- coverage rates for measles immunisation for measles and other childhood immunisations could reach 73% and 81% respectively.

62. To turn commitment to actions and support countries in expanding access to health services will require:

- **An increase in overall aid for health in low-income countries of at least $20 billion a year by 2010, with priority given to supporting efforts to strengthen health systems.**
    - Donors must urgently turn commitments into information on forward projections of finance at the country level. A first step will be a meeting planned alongside the World Bank Annual Meetings in September 2005 where donors will discuss aid flows and the financing challenges surrounding scaling up.
    - The additional financing would be provided through a variety of channels and wherever possible through increasing the proportion of resources channelled through budgets. This will allow for a more flexible use of resources better aligned to national plans and processes.

- **Support to governments to develop ambitious plans once financing commitments are clear.**
    - Countries cannot be expected to invest in developing ambitious sector or development plans until they are confident and clear how and when additional resources will come, and for how long they will last.
    - Technical agencies such as the IMF, World Bank and WHO have a major role to play but need to provide consistent advice on issues such as the macroeconomic effects of increasing external financing.

- **Donors to make real progress in implementing the Paris commitments on aid effectiveness and recommendations of the Global Task Team on AIDS, including efforts to make GHIPs more effective.**

- **Donors to commit to developing and piloting mechanisms to increase the predictability of development assistance for the expansion of access to services. The High Level Forum on Health will address this issue in November 2005.**

- **Partner countries to meet their commitments to increase funding to the social sectors.**
    - The exact level will of course depend on national priorities and local economic conditions, but African countries' commitment to allocate 15% of their budget to health needs to be realised.

- Partner countries can also use the opportunity of additional long-term financing for health to improve the performance and equity of their health systems and services.

63. A process of mutual confidence building is now needed to facilitate the development and launch of scaled-up spending plans supported by flexible aid instruments. Some countries are ready and able to use increased development assistance now. Likely early responders often have a history of sector-wide working within a poverty reduction strategy and have taken steps to strengthen governance and financial management, but more fragile states should not be left behind. It will be important to deliver an effective international response in 2005–2006 to demonstrate to other countries the seriousness of the donor commitment to increase the quantity and quality of development assistance.

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ANNEX 1

1. Based on the CMH estimates, Table 1 illustrates the incremental costs, by global region and level of development, of expanding the district health system to achieve high levels of service coverage by 2015. The cost across low-income countries (LICs), where the G8 has committed to increase funding, is highlighted.

Table 1: Annual incremental costs of scaling up by region (US$ 2002)

	2007		2015	
TOTAL DOLLARS ('000 000 000, BILLIONS OF US DOLLARS)				
All countries	26	(23 - 29)	46	(40 - 52)
All low income countries	**19**	**(17 – 22)**	**33**	**(28 - 37)**
All Middle income countries	6	(6 – 7)	13	(11 - 14)
SSA	13	(11 - 15)	23	(20 - 26)
EAP	5	(5 - 6)	10	(9 - 11)
SA	7	(6 - 7)	11	(9 - 12)
EEC	0.4	(0.4–0.4)	1	(1 - 1)
LAC	0.4	(0.4 -0.5)	1	(1 - 1)
PER CAPITA ($)				
All countries	6	(5 – 7)	10	(8 – 11)
All low income countries	**7**	**(6 – 8)**	**10**	**(9 – 12)**
All Middle income countries	4	(4 – 5)	8	(7 – 9)
SSA	16	(14 – 18)	24	(21 – 27)
EAP	3	(2 – 3)	5	(5 – 6)
SA	4	(4 – 5)	7	(6 – 7)
EEC	4	(3 – 4)	7	(6 – 7)
LAC	10	(9 – 11)	16	(14 – 19)

Note: Data is presented in terms of averages, the midpoint between the top and bottom of the low-high range. Figures in parentheses are the rounded low-high range estimates for scaling-up the intervention.

2. Effective scaling up will require not only the costs of service delivery at a district level but also additional costs to support effective implementation of the scaling up process, for example, management costs, increased salaries for health workers, additional expenditure to allow for the fact that current levels of expenditure are inadequate to ensure quality services, and expenditures needed to improve absorptive capacity. The CMH estimated that these additional costs approximately doubled the total incremental costs of scaling up as shown in Table 2.

Table 2: Incremental annual costs adjusted for scaling-up process ($US 2002) from CMH report

	2007 Average estimate	2015 Average estimate
TOTAL DOLLARS ('000 000 000, BILLIONS OF US DOLLARS)		
All countries	57	94
All low income countries (least developed countries and other low income countries)	**40**	**66**
Least developed countries	17	29
Other low income countries	23	37
Low middle income countries	14	24
Upper middle income countries	3	4

Per capita ($)		
All countries	13	20
All low income countries (least developed countries and other low income countries)	**14**	**21**
Least developed countries	22	32
Other low income countries	12	17
Low middle income countries	9	15
Upper middle income countries	57	91

Source: (CMH 2001)

3. Recent developments may impact on the CMH estimates: AIDS treatment is now widely accepted and the G8 committed to ensure universal access to treatment by 2010. While the numbers on treatment will rise greatly the cost of treatment has declined substantially. Additionally, artemisinin-based combination therapies (ACTs) and rapid diagnostic tests (RDTs) for malaria, while more expensive (ACT costs projected to decline from $2.40 to $1.00), are likely to make a major impact on the epidemiology of malaria.

4. The G8 commitment of an incremental investment in health of $20-25 billion by 2010, with half for Africa, would enable a proportionate but none-the-less very significant improvement in health outcomes in low-income countries. Table 3 illustrates what could be achieved in terms of increased coverage of services across all low-income countries with an increased spend on health of £25 billion. The impact could be even greater if existing and additional resources are spent more efficiently and equitably, and in countries where the burden of disease is greatest.

Table 3: Baseline and achievable level of coverage with $25 billion (LIC)

Interventions	***Scenarios***	
	2002 **Baseline**	2010 **Minimum Coverage**
Tuberculosis		
Diagnosis and treatment	44%	57%
Malaria		
Diagnosis and treatment	31%	54%
Prevention (ITN, RIS)	2%	40%
HIV and AIDS*		
Prevention (outside health sector)	10-20%	58%
Prevention (within health sector)	< 1% - 10%	32%
Care of OI	6%-10%	33%
ART*	970,000	2,561,608**
Childhood diseases		
Vaccinations (BCG, OPV, DPT, HiB*, HepB*)	75%	87%
Vaccinations (Measles)	68%	77%
Diagnosis and treatment ARI	59%	68%
Diagnosis and treatment fever	52%	66%
Maternity related conditions		
Antenatal care	65%	77%
Skilled birth attendance	45%	72%

Notes:
* These figures are calculated on the basis of the earlier CMH estimates, however the most recent and accurate resource estimates have been done by UNAIDS[18]
** The G8 has committed to as close as possible to universal access to treatment for all those who need it by 2010, as discussed above current estimates are that achieving this will require in the region of $10 billion a year just for AIDS specific services