Global Health Governance and Financing Mechanisms

Working Paper
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Preface

Despite extraordinary successive increases in international aid, we have not achieved desired gains in health equity. There has been a tendency to focus on vertical programmes and specific diseases, rather than supporting countries to develop sustainable health financing systems that would lead to universal coverage. Despite the statements agreed to in the Paris and Accra declarations aid has in many cases reinforced the organizational and institutional health care divide between developed and developing countries.

The premise of international aid has recently changed, with the Busan Partnership for Effective Development Cooperation statement calling for greater ownership of development priorities, greater cooperation between various stakeholders for development, greater accountability for development efforts and more support for South-South and triangular cooperation. Within this framework, supporting health financing and health systems should be an important component of sustainable development. Achieving the right to health – a central goal for global health outlined in the WHO constitution – is intertwined with social, economic and environmental development.

Health equity is not the only goal, as access to processes of participation in agenda setting and cross-sectoral policy mechanisms, along with transparency and accountability are crucial. In our modern globalised system, we need to ensure that citizen’s right to participate is not undermined and that social inclusion is a primary goal.

Global Health Europe, together with World Vision International, have developed this resource based on World Health Summit sessions held in October 2011, in order to highlight key recommendations on global health governance and financing mechanisms made at this forum. Through a range of mechanisms, we are advocating for stronger multi-stakeholder and citizen engagement in policy processes for global health, and fairer and more sustainable health financing mechanisms for universal coverage.

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1. Introduction

At the 130th Executive Board session in January 2012, the World Health Organization (WHO) discussed proposals to promote engagement of the organization with a range stakeholders and the oversight of partnerships. These proposals are part of the “WHO reforms for a healthy future”, a process first initiated to consider financing mechanisms for the organisation following the global financial crisis in 2008. The scope of the reform has now broadened to include a range of goals including the improvement of relationships with stakeholders that have a role in influencing policy and priority setting for health, including foundations, partnerships, civil society organizations and the private sector (WHO 2011a). Other goals of the reform include reviewing the core business of the organisation and processes for priority setting, along with governance and management operations.

Although the reform debate is still in progress and will be revisited at the upcoming 2012 World Health Assembly (WHO 2012), WHO’s Executive Board reiterated in its last session that governance needs to be a fully inclusive process, whilst respecting the principle of multilateralism. It also established that the engagement of the WHO with other stakeholders should be guided by: (i) the predominant intergovernmental nature of WHO’s decision-making; (ii) the norm setting role of WHO, based on evidence and protected from influence by vested interests; (iii) the principle that new initiatives must have added value and (iv) building on existing mechanisms rather than creating new ones (WHO 2011b).

The landscape of global health has changed, with now a plethora of organisations, groups and foundations engaging in and funding global health activities, making leadership and coordination by any one body a difficult task. Problems arising from a lack of coherence across global health activity include resource inefficiencies, duplication, confusion and weak accountability of the global health system, especially to those in most need of assistance. Civil society stakeholders, health foundations and funding mechanisms, private sector stakeholders, professional associations and others, whilst prominent in agenda setting for global health, do not feel sufficiently included in agenda setting processes for the World Health Organisation. Concurrently, the ongoing financial crisis has led to the entire global health community reflecting upon a series of questions about the way it operates, including how overlap and duplication can be reduced and how country priorities can best be reflected in individual health programmes and specific initiatives.

The 2011 World Health Summit’s (WHS) session on “Governance for Health in the 21st Century” focused on the debate on stakeholder engagement in global health governance and health financing mechanisms through two forums, entitled “Democratising Global Health” and “Innovative Financing Models and Governance Principles”. Panels within these forums (see Annex) dealt with questions such as: What can be done to make global health governance more democratic? What are the principles that should guide the so called process of democratisation? Who are the actors that have been left out of important processes and decisions? What are the problems in health financing and what are the possible solutions? Such questions were debated with the wider audience at the summit.

The summit sessions resulted in a series of key messages on global health governance and financing which form the basis of this report. We hope that the experiences shared, opinions expressed, and key messages derived from the “Governance for Health in the 21st Century” panels and ensuing debate will provide inspiration for those working toward global health goals across various roles, organisations and sectors.
2. Democratization of Global Health Governance

*Human Rights and Health as an Underlying Principle*

**Key message:** Realisation of the ‘right to health’ should underlie global health governance and debates. The focus should be on tackling global health inequalities by addressing social determinants of health, with governance facilitating health to work with non health sectors.

One of the ideas stressed during the WHS session on ‘Democratising Global Health’ was that, in the process of global health democratization, we must focus on realising the right to health. Ms Nicoletta Dentico, Coordinator of the international platform ‘Democratising Global Health,’ highlighting that the promotion and protection of the right to health is a goal of the Constitution of the World Health Organization, the institution that has the mandate to act as the ‘directing and coordinating authority’ on global health issues.

A human rights perspective puts people at the heart of the global health debate and calls for equity not only in terms of health outcomes but also in terms of participation, transparency and accountability. This perspective is all the more important at a time of increasing global health challenges and complexity which has seen tension between global health efforts and the foreign-policy interests of individual states and the proliferation of international actors working on health policies and programmes.

A focus on the realisation of the right to health also means that people are recognised as rights-holders and not as passive recipients of health commodities and services. In this respect, Ms Nyaradzayi Gumbonyda, General Secretary of the World Young Women's Christian Association, stressed that we need a stronger rights-based approach and discourse in health. Prof Dr Ilona Kickbusch also referred to Lord Dahrendorf’s focus, not on charity, but on entitlement. He stated that in modern democracies all people should be entitled to citizenship status and have opportunities and basic rights, irrespective of their contribution to the economy – and that we should concentrate on inclusion rather than redistribution (Dahrendorf 2006). Dahrendorf argued that if this does not occur, ‘(global) capitalism can destroy (national) democracy’ (Dahrendorf 2006, p. 15).

Ms Gumbonyda particularly emphasised the need for a stronger gender based approach. She suggests that women often act as knowledge holders, providers (through voluntary labour) and are decision-makers in health, but “are normally seen as consumers of health services (patients), and not as decision-makers, innovators or part of creative processes.” Lord Nigel Crisp, House of Lords, UK, also highlighted how social enterprises and women, families as communities are a strong part of the systems and solutions in developing countries.

The equity lens of human rights obliges States and other actors to focus their global efforts on social determinants of health and to reorient their efforts towards reducing inequities. A social determinants approach is required as there is ample evidence that ‘the conditions in which people are born, grow, live, work, and age’ are the primary determinants of health and the major causes

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1 Leading German-British Sociologist and former Member of the German Parliament, European Commissioner and Member of the House of Lords, UK (now deceased).
2 http://www.who.int/social_determinants/en/
of health inequities and discrimination (WHO 2008). This approach calls for complex forms of intersectoral policy action, working across both different sectors and levels of government (WHO 2011c). The recent Mexico City Political Declaration on Universal Health Coverage (2012) affirmed the link between achievement of the right to health and the social determinants of health, as well as the importance of prevention and health promotion services and the need to focus on vulnerable groups and social inclusion in health financing systems.

The importance of taking a social determinants of health approach is underlined by recent figures suggesting that income inequality is growing across many OECD countries, with changes in taxation, globalisation and technological change helping to explain concentration of income at the high end (OECD 2012). It highlights the role of taxation and labour market systems in developing income inequality and health inequity.

When it comes to the health sector, a human rights and health approach entails the health sector integrating equity as a priority in the design and delivery of its systems, policies, programmes and services, as well as ensuring that particular attention is given to marginalized and disadvantaged groups of the population. To be consistent with human rights principles and standards, health related services should be delivered in a manner that is culturally appropriate and where availability, accessibility and quality are guaranteed for all.

**A Changing Paradigm: Embracing “Co-Development” and “Reverse Innovation”**

**Key message:** We need to think in terms of co-development between High Income Countries and Low and Middle Income Countries, and embrace 'reverse innovation', rather than always in terms of aid and international development.

Lord Nigel Crisp, Former Head of the National Health Service in the United Kingdom, emphasised that the democratisation of global health requires a remodelling of the traditional concepts of international aid and development. The changing picture of global health and shifts in the distribution of power suggest that the traditional model where a high income country provides aid to a low income country should be revisited. Further consideration should be given to the notion of “co-development,” which implies interdependence and mutual learning. This new concept embraces the idea and reality of “reverse innovation” whereby knowledge and technologies from poorer countries are “imported” by richer countries. One of the foci of the High Level Forum on Aid Effectiveness held in 2011 in Busan, Korea was the need to have recipient countries in greater control of aid and for aid to be more essentially focused on impact. The forum resulted in the Busan Partnership for Effective Development Cooperation statement (Fourth High Level Forum on Aid Effectiveness 2011), which uses the term ‘development cooperation’ rather than aid (with its connotations of charity), recognised civil society organisations as development coordinators, and supports such strategies as South-South and Triangular cooperation.

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4 See item 11.2, (i) of the Rio Political Declaration on Social Determinants of Health.
5 See item 13.2, (vii) of the Rio Political Declaration on Social Determinants of Health.
6 According to the World Bank (2012), “Triangular cooperation is a relatively recent mode of development cooperation. It normally involves a traditional donor from the ranks of the OECD’s Development Assistance Committee (DAC), an emerging donor in the South, and a beneficiary country in the South.”
Lord Crisp also provided many examples where LMICs are actually performing better than HICs in terms of health innovation, e.g. in patient management, service delivery (e.g. nursing being used for caesarean sections), policy, products and technology (e.g. use of mhealth, telemedicine).

Democratising global health is about interdependence, co-development and mutual learning, and democratising global institutions.

Lord Nigel Crisp

Although established agencies and donors, largely from western States, have created a relatively standardized approach to international development, other emerging economies such as Brazil, Russia, India, China and South Africa (BRICS countries) are now engaging in bilateral negotiations with poorer countries and proposing new concepts and solutions (Crisp 2010, p. 2010). ‘South-south’ cooperation (i.e. between developing countries) and the increasing participation of private companies and NGOs in global health initiatives are just two examples of the changes affecting traditional international aid and development. One of the actions of the Busan Partnership for Effective Development Coopeartion (2011) is to ‘broaden support for South-South and triangular cooperation, helping to tailor these horizontal partnerships to a greater diversity of country contexts and needs.’

All countries are now connected together through shared knowledge, assumptions and behaviours. Whilst western scientific medicine has dominated health institutions over the last century, the global health environment is now changing with a resurgence of interest in other ideas and research evidence (e.g. on the social determinants), demonstrating that established models cannot solve every problem and deal with every situation. Furthermore, it is increasingly acknowledged that global health is affected by the much wider considerations of economics and international relations.

There is increasing interdependence between countries across our globalised world….however we are not interdependent in terms of resources.

Lord Nigel Crisp

This changing global health environment requires a new model of development based on the notions of interdependence, mutual learning and reverse innovation. Under this new model, actors can learn from each other about different ideas, behaviours and attitudes that can help them conceive and conceptualise health differently and find new solutions to new as well as old problems. Conceiving the system in a more horizontal manner is thus an inevitable feature of the process of democratising global health.

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7 Ibid., at 10.
Multi-Actor Involvement across Different Levels of Governance

**Key message:** We need to invigorate global governance arrangements in order to incorporate a broader range of actors and ensure transparency and accountability in global health initiatives. Emphasis was given to more community, national and regional level participation processes, and greater involvement by a range of stakeholders across levels of governance. We also need to look beyond institutional processes when we think about policy processes and enable policies to be debated at local levels.

The issue of representation is arguably one of the most pertinent in discussions on the democratisation of global health. Meaningful representation is one of the core values of democracy, and those holding democratic values have constantly advocated for the increased involvement of different actors and sectors in global health decision-making and accountability processes.

Discussions at the WHS led to the conclusion that increased democracy requires new governance arrangements in order to incorporate a broader range of actors and ensure transparency and accountability in global health initiatives. It was also felt that the debate on ‘Democratising Global Health’ goes well beyond institutional processes and involves community level participation and accountability processes.

The following key messages and suggestions were put forth on the topic of enhancing representation.

**a. Civil society actors (including NGOs and the private sector)**

**Key message:** National level governments could encourage greater participation by NGOs and private organisations at international forums.

National level governments could encourage participation by NGOs and private organisations at international forums in order to enhance the engagement of such actors in global health initiatives or processes. Prof Dr Ilona Kickbusch gave the example of the World Conference on Social Determinants of Health held in Rio in October 2011, which benefited from a strong NGO presence. She also mentioned that the Swiss delegation at the UN High Level Summit on the Prevention and Control of Non-Communicable Diseases in 2011 was formed by representatives of government, private companies and NGOs.

A challenge that remains is to identify the exact roles and obligations of various actors. Private companies can provide benefits for the health of the global community, for example, by creating innovation in the field of pharmaceuticals, vaccines and medical devices; producing, selling and distributing healthier foods and safer products and creating healthier and safer places to work. Philanthropists can provide the required resources for urgent and long-term health needs as well as create new models of development cooperation to serve the health needs of people. Civil society has demonstrated the capacity for working with and alongside communities and advocating for social change (Gostin & Mok 2009).
b. Elected representatives

**Key message**: National level parliamentarians could be more involved in global health policy networks and governance processes at regional and international levels. Specific suggestions were made about the role of parliamentarians within WHO governance processes.

MP Karin Roth, Member of the German Parliament, and Lord Nigel Crisp, House of Lords, UK, discussed a greater role for national level parliamentarians within global health and global health governance. Lord Crisp talked about a cross-party backbench group on global health which he has established in the UK parliament. This group, the All-Party Parliamentary Group on Global Health (http://www.appg-globalhealth.org.uk/#) aims to inform Parliamentarians and provide reports to the UK Parliament on global health matters.

MP Karin Roth stressed that the participation of parliamentarians within the World Health Organization (WHO) governance processes should be increased. In her view, national delegates of the World Health Assembly could be elected by the individual parliaments of the organization’s Member States. MP Karin Roth also argued for greater parliamentary presence at the WHO regional committees. Each member state in a WHO region could send a delegation of its parliament, and this delegation could have one vote. In turn, the parliamentary assemblies of the WHO regional committees would elect a delegation, which would then adopt resolutions at a plenary session. These strategies would ensure that global health is once more addressed at a national level, that regional issues will be decided upon at the appropriate level through parliamentary participation at a regional level, and an oversized ‘World Health Parliament’ would be avoided.

c. Community involvement

**Key message**: We must recognise the strengths of communities: women, families and communities often play an important part in global health in LMICs through voluntary activities, advocacy, time, knowledge and counselling. At the same time, from the perspectives of LMICs, exclusion and non-participation can occur especially at an international level due to the affordability of time, money and technology required to participate.

Participants on the “Democratising Global Health” panel highlighted that the strengths of communities must be recognised in the global health debate. Ms Nyaradzayi Gumbonyda, General Secretary of the World Young Women's Christian Association, emphasised that women, families and communities often play an important part in health initiatives in low and middle income countries through voluntary activities, advocacy, time, knowledge and counselling. At the same time, from the perspectives of LMICs, exclusion and non-participation can occur especially at an international level due to the affordability of time, money and technology required to participate.

Ms Rudo Kwaramba, National Director of World Vision Uganda, outlined the role of World Vision International (WVI) in engaging with social change advocacy at the local community level, and its important links with policy processes at the global level. She provided the example of ‘Citizen Voice and Action’ in WVI, a process established to develop dialogue and advocacy between citizens, service providers and government in order to influence health services and policy. The work of WVI with ‘Citizen Voice and Action’ is linked to a global campaign of the
organization that aligns with the Millennium Development Goals 4 and 5 (on reducing child mortality and improving maternal health). The links of this local initiative with global level processes is reflected in the alliances developed by World Vision Uganda to implement the programme which include international allies such as the Partnership on Maternal and Child Health and the Inter Parliamentary Union.

There is an increasing interest in such local level advocacy initiatives as new studies demonstrate that simple rounds of meetings between communities and health providers may result in large increases in utilization and improved health outcomes, such as reduced child mortality and increased child weight (Björkman et al 2009). Most importantly, the success of such initiatives suggests that a transversal approach should be applied to foster accountability, whereby efforts from the community, local, national, regional and global levels are integrated.

**Transparency and Accountability as a Key to Better Governance**

Along with representation, transparency and accountability are the key elements of both good global health governance and democracy. In particular, transparency is required to check where funds go and why, to ensure public availability of data and to ensure clear decision making-processes and track their consequences. Transparency prevents duplication, highlights operational gaps and facilitates input and feedback between stakeholders on how to maximise impact. Furthermore, it is increasingly vital in a resource-competitive environment in order to attract and maintain donor support (Buse & Tanaka 2011), and to promote resource efficiencies.

Accountability is another essential element of good governance and it applies to the actions of both governments (across all levels) and non-state actors. In the case of global health partnerships, a formal system of accountability of partners, including work plans, deadlines, deliverables, and sanctions for non-performance, is especially important as such institutions are required to work in durable and strategic partnerships (Buse & Tanaka 2011). While there have been increased efforts to build ‘monitoring and evaluation’ systems to track the progress of various health initiatives, the lack of an enforcement mechanism generally means that monitoring and evaluation occurs on a voluntary basis (Gostin & Mok 2009). However, at the WISH forum Ms Rudo Kwaramba, WVI Uganda, discussed one example of a community level coalition that has influenced parliamentarians and increased accountability at a local level: The Uganda Civil Society Organization Coalition on Scale up Nutrition (UCOSSUN) provided messages on scaling up nutrition that influenced Ugandan delegates to the Panama Inter Parliamentary Union (IPU) summit. This influence was not only felt at the parliamentary level – it is also occurring at the district level.

The session on “Democratising Global Health” highlighted the need to invigorate international governance arrangements in order to incorporate a broader range of actors and ensure transparency and accountability in global health initiatives.
3. Health Financing for Global Health, including Innovative Financing Mechanisms

The Context

a. Health Inequalities and ‘Out of Pocket’ Expenditure

Key messages:

There is a great variety in country level spending on health (from less than 1% to over 15%). Too often, services are paid for through out of pocket payments (OPP) made at the point of service delivery.

There are approximately 50 countries with GDP < $1000 per capita which cannot generate sufficient funds domestically to develop and sustain adequate health services (noting cost of basic package $40-80 pa). Stronger mechanisms of global financing support are required linked to further progress in development of institutions of regional and global governance for Health.

At the WHS forum Dr Matthias Rompel, Head of Social Protection, Deutsche Gesellschaft für Internationale Zusammenarbeit, Germany, set the context of global health financing by referring to the most common (particularly in low and middle income countries) and least equitable form of health service expenditure: out of pocket payments (OPPs) – also known as ‘direct payments’ - made at the point of service delivery by individuals. The World Health Report on Health Systems Financing (WHO 2010a) points out that OPPs are pushing people over the poverty line and also deter people from seeking appropriate health care in the first place.

It has been estimated that a high proportion of the world’s 1.3 billion poor have no access to health services simply because they cannot afford to pay at the time they need them.

Countries must raise sufficient funds, reduce the reliance on direct payments to finance services, and improve efficiency and equity.

WHO (2010)

Associated with OPPs is the lack of sustainable financing for health systems within countries, linked to low Gross Domestic Products and lack of funding for basic health packages. Mr Mark Blecher, Acting Chief Director, Health and Social Development Public Finance, National Treasury, South Africa discussed how there are around 50 countries with less than USD1000 per capita which cannot generate funds to sustain adequate health services. Ms Rudo Kwaramba, WVI, provided the example of Uganda, which despite the Abuja Declaration which saw the commitment by the African Union to 15% funding allocation to health care, only spends 4% of its budget on health.
There are also inadequate accountability mechanisms and misdirected priorities, along with low expenditure on the social determinants of health. Many of the poorest countries need to be supported to create stronger national financial systems for health. However, one problem is that development assistance for health (DAH) is often redirected towards non health priorities (Institute for Health Metrics and Evaluation 2011).

External partners will need to increase contributions to meet their previously agreed international commitments. This act alone would close almost all the financing gap identified for 49 low-income countries...and save more than 3 million additional lives before 2015.


For every $1 of DAH (Development Assistance for Health) that governments receive, they redirect $0.56 on average from the health sector to other spending priorities.

Institute for Health Metrics and Evaluation (2011)

b. Traditional aid and the global financial crisis

Key Messages:

There is an over-dependence on traditional aid, and problems with the quality and volume of aid.

Although short term considerations of the global financial upheaval have created challenges for replenishment of funds such as Global Fund and PEPFAR, this should not detract us from a broader and more powerful long term goal of establishing improved tools and mechanisms to improve global equity and ensure basic health services for all.

The current context for global health includes the global financial crisis affecting funding to specific programmes such as the Global Fund to Fight Aids, Tuberculosis and Malaria\(^8\) and the US President’s Emergency Plan for AIDS relief (PEPFAR).\(^9\) Encouragingly, development assistance for health (DAH) has not been affected overall by the global financial crisis (Institute for Health Metrics and Evaluation 2011). In fact Development Assistance for Health rose throughout 2011, although at a slower rate than before the global recession (Institute for Health Metrics and Evaluation 2011). Whilst DAH increased rapidly for malaria and increased for maternal, newborn and child health and NCDs, funding for HIV/AIDS, tuberculosis and health sector support slowed (Institute for Health Metrics and Evaluation 2011). Funding to NGOs increased by 8% from 2010-2011, and funding from some governments such as the US are channelled through NGOs. This is noteworthy given that the Paris Declaration on Aid Effectiveness (2005) and Accra Agenda for


Action (2008)\textsuperscript{10} encourage aid to be channelled through recipient countries’ financial systems (Institute for Health Metrics and Evaluation 2011).

At the WHS forum, Dr Robert Hecht, Principal and Managing Director, Results for Development Institute, US, highlighted how there is too much dependence on traditional aid, and problems with its quality and volume. He cited the Brown-Zoellick led Task Force on Innovative International Financing for Health Systems\textsuperscript{11} which estimated that an extra 250 billion dollars is required over 7 years in order to meet the Millennium Development Goals, including 70 billion from donors. Aid is also short term and unpredictable, fragmented and channelled through parallel procurement. The focus of aid is often inputs rather than outputs and outcomes such as better health.

c. Universal Coverage and Development of Sustainable and Innovative Financing Arrangements

\textbf{Key message: } the focus of global health financing initiatives should be on financing mechanisms which strengthen sustainable health systems, support universal coverage and reduce inequities and inequalities in health.

Participants at the WHS forum emphasised the fact that the focus of global health financing initiatives should be on financing mechanisms which strengthen sustainable health systems, support universal coverage and reduce inequities and inequalities in health. Indeed universal health coverage is a goal of the WHO Member States.\textsuperscript{12} Universal coverage is an important avenue for achieving the universal human right to health (WHO 2010a, Forum on Universal Coverage 2012). Despite the aforementioned problems with Development Assistance for Health (DAH), the WHO (2010) emphasises that low income countries (LICs) will require help to achieve universal coverage at least in the short-term, and that countries should increase their expenditure from US$32 to US$60 per capita by 2015.

The WHO \textit{World Health Report on Health Systems Financing} (2010) argued that countries must raise funds to improve health, with four key strategies suggested including:

1. Increase the efficiency of revenue collection.
2. Reprioritize government budgets (e.g. meeting commitment of Abuja Declaration to spend 15\% of government budgets on health).
3. Innovative financing (e.g. increasing taxes on airline tickets, foreign exchange transactions and tobacco, levies on mobile phone calls, diaspora bonds, taxes on unhealthy food and drink. See next section for more examples.)
4. Development assistance for health (global solidarity is necessary in the form of development assistance, as only 8 of 49 LICs would be able to raise the funds domestically to achieve the MDGs by 2015).

(WHO 2010a)

\textsuperscript{10} http://www.oecd.org/document/18/0,3343,en_2649_3236398_35401554_1_1_1_1,00.html
\textsuperscript{11} http://www.internationalhealthpartnership.net/en/taskforce
Encouragingly, recent evidence shows that countries are spending increased funding on health, both domestically as well as through DAH (Institute for Health Metrics and Evaluation 2011). However, we must continue to track health expenditure to determine the most efficient use of resources and the impact of expenditure.

The recent Mexico City Political Declaration on Universal Coverage (2012) called upon governments, civil society organisations and international organisations to: include universal coverage in sustainable development agendas; promote cooperation across various stakeholders to sustain universal health coverage; to develop transparent and accountable financial systems linked to health systems performance; to promote international cooperation to support universal health coverage; and, to exchange information and best practices in order to promote capacity building to achieve sustainable universal health coverage and ultimately the right to health.

**Government investment in global health goods and services**

**Key messages:**

*Taxation and demand side financing, or government investment in global health goods and services*, should be recognised as one of the key policy instruments to tackle inequities.

*Countries should be careful to maintain counter-cyclical fiscal responses and protect social services in times of fiscal pressures. However, many of the poorest countries need to be supported through stronger financing mechanisms. Risk pooling, prepayment mechanisms and fair structures at the national level are required.*

Mr Mark Blecher discussed the need for taxation and demand side financing, which he argued should continue to be employed during fiscal pressures to create ‘counter cyclical fiscal responses.’ This is what South African has employed during the global financial crisis in order to protect social expenditure. Mr Blecher also discussed the need for risk pooling, prepayment mechanisms and fair structures (taking into account who can pay, how much and how often). This is also the strong message of the WHO (2010) *World Health Report on Health Systems Financing*. Prepayment (payments made in advance of illness) and risk pooling (i.e. pooling prepayments) are methods undertaken by countries which are approaching universal coverage for health (WHO 2010a).

Funding from a variety of sources is necessary in order to support health financing (e.g. wage based taxes at national government level as well as innovative global health financing strategies). However, in developing fair financial systems, we must recognise that 1) a proportion of the population will not be able to pay through income taxation and will need to be subsidised through pooled funds/government revenue, 2) contributions to health insurance schemes should be compulsory, and 3) pooled funding should plan to protect all of the population (WHO 2010a). Other barriers to access/health service utilisation including transport, low income (WHO 2010a) and health literacy should also be addressed.
At the WHS forum, Dr Uzziel Ndagijmana, Permanent Secretary at the Ministry of Health in Rwanda provided the example of his country’s goal of a fair and universal health system, which follows the Universal Health Coverage resolution adopted by the WHA in 2005 (along with the WHA 2011 resolution on universal coverage and the Mexico City Political Declaration on Universal Coverage 2012). Historically, in 1999 there was health insurance for those with no formal and remunerated employment, Community Based Health Insurance (CBHI); from 2001 the Rwandaise d’Assurance Maladie system (RAMA) was introduced for public and private employees and from 2000 insurance was introduced for military personnel (Military Medical Insurance). In 2010, 91% of the population had Community Based Health Insurance. The CBHI involves premiums for the population which depend on household income, government funding, funding from development partners, private and public insurance and a value added tax (consumption tax). Subsequently, health care utilisation in Rwanda has increased from 24.7% in 2001 to 87% in 2009 and the under 5 mortality rate decreased by 50% from 2005-2009.

**Innovative Financing for Global Health and Research**

**Key message:** There are many innovative financing models being tried for overseas development assistance (ODA), especially for research and development. Some ‘vertical’ approaches include advance market commitment (AMC), international finance facility for immunization (IFFIm) (to support GAVI) and success in mobilizing international solidarity levies. Some innovative strategies to increase research and development have been proposed and exist, however more risk taking sponsors are sought for initiatives.

Innovative financing is just one of the key strategies identified by the WHO (2010) as being necessary to improve health systems financing and ultimately health. However, it is important to note that ‘because they were created to fill the financial gap that threatens to compromise the attainment of the MDGs, innovative financing mechanisms are to complement and not substitute pre-existing funding sources for global health’ (Le Gargasson & Salomé 2010). Innovative financing mechanisms should not be seen or ‘as a replacement for traditional health financing’ (Michaud & Kates 2011).

It must also be recognised that countries have different priorities for aid and ‘very different preferences when it comes to the channels they choose to fund’ (Institute for Health Metrics and Evaluation 2011). There may also be a number of country level barriers to the development of innovative financing which must be addressed in order to progress such initiatives. For example, in an analysis of innovative financing mechanisms, Michaud & Kates (2011) have identified barriers for US engagement in innovative financing as being 1) the need to change US tax policy (e.g. to enable airline ticket tax, financial transaction tax, tobacco solidarity tax) and have this approved through the US House of Representatives, which is not conducive to the current political environment, and 2) the need for upfront and long term funding commitments for initiatives (e.g. Advance Market Commitment, see below), whilst discretionary funding is made and approved by Congress on a yearly basis (Michaud & Kates 2011). The US also favours ‘mixed’ innovative financing mechanisms which involve public private partnerships and stimulate private investment in global health programmes or research (Michaud & Kates 2011).
Definitions of Innovative Financing

**New sources of development financing (that) are closely linked to global public goods, and complement conventional official development assistance.**

*The Leading Group on Innovative Financing for Development (2009)*

**Non-traditional applications of overseas development assistance, joint public-private, or private mechanisms and flows that 1) support fund-raising by tapping new sources..., or 2) deliver financial solutions to development problems on the ground.**

*The High Level Taskforce on Innovative Financing for Health Systems (2008)*

At the WHS forum, Dr Robert Hecht made three key points in relation to innovative financing:

1. Innovative financing is not a silver bullet; we need to beware of false hype. However, innovative financing has demonstrated the ability to mobilize funds to help fill the health financing gap and stimulate better use of money to produce results.
2. Innovative financing can make a difference in accelerating Research and Development (R & D) and getting health products and services to the poor faster and more efficiently.
3. There are other value-adding ideas being developed – they need to be adopted and tested. However, ‘risk taking sponsors’ willing to provide funding are required in order to progress these.

Dr Hecht further discussed some hopeful innovative financing strategies in further detail. These include:

1. **Advance market commitment (AMC)**
   
   Advance market commitment is a mechanism used to support GAVI’s vaccine research, manufacturing and distribution. One AMC Pneumococcal project, led by Italy, involves a legally binding commitment to support and subsidise vaccine prices for the new pneumococcal vaccine (to the value of US$1.5 billion). Industry is also participating (4 suppliers registered, 2 more have signed). Evidence shows that it is working – AMC vaccine price is 1/10th of rich country price, post AMC ‘tail price’ is 1/20th of the HMIC price. This has led to increased global access to the vaccines – 20 + low income countries have pneumococcal applications approved by GAVI, and first deliveries are imminent.

2. **The international finance facility for immunization (IFFIm)**

   This is ‘a frontloading mechanism for long term ODA commitments from 8 donor countries that are drawn on in the form of bond issues on the international capital markets…Since the launch of IFFIm, the mechanisms has raised US $2.3 billion on the capital markets, US $1.6 billion of which being disbursed for vaccine purchase and delivery’ (see Le Gargasson & Salomé 2010). This involves funds raised in capital markets using donor contributions as assets, then deployed to support GAVI (led by the UK). Evidence that it is working – a whole range of campaigns are funded by IFFIm funds, e.g. new and underused vaccines campaign (31 % of funds go here), the health systems strengthening (16%) and polio campaigns (15%).

3. **Success in mobilizing international solidarity levies (UNITAID fund)**

   This is a financial pool with airline ticket levies, government contributions and ‘individual check offs’ – to pay for essential health commodities (led by France). Evidence that it is working –
additional funds have been provided e.g. over 1.5 billion for AIDS, TB, malaria medicines has been delivered to 72 countries. It has also led to leverage for lower prices, large discounts on ARVs have been negotiated.

Dr Hecht asked ‘What next in innovative financing for global health?’ Six key strategies were suggested:

1. Big new sources of funds: financial transaction tax, tobacco solidarity tax.
2. Seeking sponsors: prizes for R & D, social impact investment plus guarantees for late stage products. Three new and promising ideas for pooled funding for R & D which require sponsors for their development include: Product development partnership financing facility (PDP-FF)\(^{13}\), Fund for research in neglected diseases (FRIND)\(^ {14}\) and Industry research facilitation fund (IRFF)\(^ {15}\).
3. Fuller engagement of emerging economies in discussion and backing for innovative mechanisms.
4. Expanding mobilization of domestic funds for health.
5. Better targeting of donor funds: income/disease burden ration as key metric.
6. Health risk pooling (financial protection or public insurance) as the ultimate weapon in financing global health.

It should be noted that some of these innovative funding approaches (e.g. advanced market commitment) are linked to ‘vertical’ approaches (short term funding targeting specific diseases, drugs or vaccines), and that health risk pooling along with ongoing sources of funds (e.g. financial transaction tax, tobacco solidarity tax) is required for health systems strengthening (see section on marrying vertical and horizontal approaches, below).

**Financial efficiencies and evidence**

**Key message:** Resources should be focused on the best interventions to increase efficiencies and reduce wastage.

The World Health Organisation makes a conservative estimate that 20-40% of health resources are wasted, and states that greater resources efficiencies are required in order to improve health systems and ultimately health (WHO 2010a). Some of the factors in wastage of health resources include the overutilization and cost of certain drugs, poor storage and/or wastage of vaccines, inefficient use of technologies and services, medical error and corruption (WHO 2010a).

At the WHS, Mr Blecher further outlined 10 leading sources of inefficiencies in health:

1. underuse of generic medicines and higher than necessary prices for medicines;
2. use of substandard and counterfeit medicines;
3. inappropriate and ineffective use of medicines;
4. overuse or supply of equipment, investigations and procedures;
5. inappropriate or costly staff mix, unmotivated workers;
6. inappropriate hospital admissions and length of stay;
7. inappropriate hospital size;

\(^{13}\) [http://healthresearchpolicy.org/content/product-development-partnership-financing-facility-pdpff](http://healthresearchpolicy.org/content/product-development-partnership-financing-facility-pdpff)

\(^{14}\) [http://www.who.int/phi/Novartis.pdf](http://www.who.int/phi/Novartis.pdf)

\(^{15}\) [http://healthresearchpolicy.org/content/industry-rd-facilitation-fund-irff](http://healthresearchpolicy.org/content/industry-rd-facilitation-fund-irff)
8. medical errors and suboptimal quality of care;
9. waste, corruption and fraud in the health system; and
10. inefficient mix/inappropriate level of strategies for health interventions.

To increase efficiencies, strategic purchasing, whereby countries assess population needs and the mix of services required (e.g. promotion, prevention, treatment and rehabilitation), is recommended as a basis of funding over passive purchasing, where health systems simply reimburse services and funding decisions are based on previous funding allocations (WHO 2010a).

Dr Bernhard Schwartlander, Director, Evidence, Strategy and Results Department, UNAIDS, Switzerland, also discussed the purchasing and procurements strategies used by countries as being an important factor in costs for treatment. He highlighted the effectiveness of using focused interventions for HIV/AIDS treatment; one intervention which focused on workers in the sex industry showed that the disability-adjusted life years (DALYs) saved were 309.6, showing much better outcomes than interventions which focused on youth.

**Marrying vertical and horizontal approaches**

**Key message:** The current verticalism in funding approaches is not sustainable and we must also support existing health systems. We need to ‘marry’ vertical funding [i.e. funding for specific diseases or health projects] with horizontal [i.e. funding for health systems] and diagonal approaches [i.e. improvements in health outcomes through improved health systems].

Vertical approaches to funding include funding for specific health initiatives, diseases or health projects e.g. GAVI Alliance (Global Alliance for Vaccines and Immunisation) or the Global Fund to Fight Aids, Tuberculosis and Malaria. Conversely, horizontal approaches focus on funding for health systems. Vertical programmes and approaches to funding have led to fragmentation and cost inefficiencies, and a lack of comprehensive public health approach which has led to important health issues such as mental health being overlooked (Jenkins, Baingana et al 2010). Vertical approaches are often met with obstacles associated with insufficient health systems and resources within countries. For example, ‘AIDS treatment cannot be provided in isolation from health systems. A vertical approach works for a while, and then it hits the ceiling of insufficient health workers and dysfunctional health systems’ (Ooms et al 2008).

We need to adopt more diagonal approaches to funding and DAH i.e. focusing on improvements in health outcomes through improved health systems, in order to promote sustainability. At the 64th World Health Assembly, the WHO urged countries to focus on strengthening health delivery systems, and to ensure that external sources of funding do not divert from country health priorities (WHA 2011).

Focusing on health systems strengthening is also consistent with the International Health Partnership Plus (IHP+), which ensued from the *Paris Declaration on Aid Effectiveness and Accra Agenda for Action*. International Health Partnerships Plus (IHP+) mobilises donor agencies around country-initiated health strategies and plans and encourages a greater focus on strengthening health systems and capacity development for LMICs. It follows the Paris principles of
• National ownership
• Alignment with national systems
• Harmonization between agencies
• Managing for results
• Mutual accountability

The subsequent principles in the Busan Partnership for Effective Development Cooperation (2011) include:

• Ownership of development priorities by developing countries
• Focus on results
• Inclusive development partnerships
• Transparency and accountability to each other

An important focus of a diagonal approach should thus be support for capacity building, including for monitoring and accountability mechanisms and the development of human and other resources within LICs. This approach is important in the context of global initiatives such as the Political Declaration on the Prevention and Control of Non-Communicable Diseases (UNGA 2011), whereby support for country level NCD plans, monitoring and accountability mechanisms will be important to develop and monitor global NCD strategies and outcomes. Diagonal approaches should also see improved integration across programmes (including monitoring/accountability mechanisms), and less competition between disease specific programmes (Ooms et al 2008).

4. Conclusions

A strengthened WHO and linking global financial mechanisms to accountability mechanisms

Key messages:

Financial facilities and mechanisms for global health should be closely linked to accountability mechanisms, and seen in the context of democracy/human rights.

Democratising global health means having a more democratic, inclusive, transparent and accountable WHO. Several participants felt the role of the WHO has been weakened over recent years with the emergence of a plethora of new organisations. At the same time while voluntary contributions to the WHO have increased significantly they have also posed problems for this organisation in focusing on priorities set by the governing bodies. The forum would like to see the re-emergence of a stronger WHO, from the perspectives of global governance and regulation for health, coordination and financing.

At the WHS forum, Mr Mark Blecher discussed the problem of health results/outcomes not being commensurate with health resource allocations, and that governance and accountability mechanisms are critical to ameliorate this situation. He stated that more attention needs to be paid to building leadership, designing accountability arrangements and best practices, including
institutional design, design of governance arrangements, accountability to citizens and management accountability. One of the crucial issues in accountability is the lack of monitoring and accountability for health, with many countries not having vital registration systems (birth, death and cause of death data) (Institute for Health Metrics and Evaluation 2011).\textsuperscript{16} Resources and political will are required for the development of such mechanisms.

The coordinating role of the WHO has been weakened over recent years with the emergence of a plethora of new organisations. The increase in voluntary, tied contributions (@80\% of budget) to the WHO has posed problems for the organisation in focusing on the priorities set by governing bodies and the priorities of countries (e.g. 60\% of funding is for infectious diseases, and only 3.9\% for NCDs, despite most deaths being due to NCDs, see WHO 2010b). Throughout the WHO reform processes, concerns have also been raised about financing sources and potential conflicts of interests within the organisation.

The current review of the WHO is important for both global health financing and global health democracy. Participants in the WHS forum hoped that the current reform of the WHO will help to reposition the organisation to more powerfully perform its centrally important global role. The forum expressed a desire to see the re-emergence of a stronger WHO, from the perspectives of global governance and regulation for health, coordination and financing. Prof Dr Ilona Kickbusch in her summary of the session highlighted the opportunity for more transparency and accountability through the reform of the WHO. Stronger mechanisms of global financing support are required, linked to institutions of regional and global Governance for Health. Part of the strategy of the WHO reform should consider how to link governance mechanisms for global health to financing and accountability mechanisms – whilst acknowledging that universal health coverage is an important avenue for achieving health as a human right.

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Panel members of the ‘Governance for health in the 21st Century’ forum, World Health Summit, Berlin, 24th October 2011

Democratizing Global Health

The first working session on ‘Democratising Global Health’ was co-organised with World Vision International and included speakers Lord Nigel Crisp, House of Lords, UK, MP Karin Roth, Member of the German Parliament, Ms Rudo Kwaramba, National Director, World Vision International, Uganda, Ms Nyaradzaiy Gumbonzvada, World Young Women’s Christian Association, Switzerland and Ms Nicoletta Dentico, Coordination of the International Platform Democratising Global Health and Health Innovation in Practice (HIP), Italy. The forum was chaired by Professor Dr Ilona Kickbusch, co-chair of Global Health Europe, Global Health Programme at The Graduate Institute of International and Development Studies, Switzerland and Dr Stefan Germann, World Vision International, Switzerland.

Innovative Financing Mechanisms and Governance Principles

Speakers at the second working session included Dr Robert Hecht, Principal and Managing Director, Results for Development Institute, US, Dr Matthias Rompel, Head of Social Protection, Deutsche Gesellschaft für Internationale Zusammenarbeit, Germany, Dr Bernhard Schwartlander, Director, Evidence, Strategy and Results Department, UNAIDS, Switzerland, Dr Mark Blecher, Acting Chief Director: Health and Social Development Public Finance, National Treasury, South Africa and Dr Uzziel Ndagijimana, Permanent Secretary at the Ministry of Health in Rwanda. The forum was jointly chaired by Mr Martin Seychell, Deputy Director General for Consumers and Health, European Commission, Belgium and Prof Dr Ilona Kickbusch, Global Health Europe, Global Health Programme at The Graduate Institute of International and Development Studies, Switzerland.