
UNITED NATIONS ECONOMIC AND SOCIAL COUNCIL

More specifically, the meeting will add value to the discussion during the AMR and help advance the international health goals by:

- Examining in greater depth the financing aspects of health services and public health
- Assessing progress in achieving the health-related development agenda in the region and outstanding challenges, especially those that could best be addressed through regional cooperation
- Exchanging lessons learned and replicable examples of good practices
- Promote a broad range of stakeholder engagement early on in the AMR process
- Provide an opportunity to promote the launch of new partnership initiatives during the AMR July 2009 session

2. Introduction

Each year, millions of people are prevented from seeking and obtaining needed health care because of they cannot afford to pay the costs[5]. At the same time, millions more are forced to seek care and suffer severe financial problems because they need to

section. Each section also concludes with a

inequitable, and some of the instruments that governments could use to increase domestic funding for health are not fully utilized. Examples are tobacco and alcohol taxes, measures that not only raise revenue but which, more importantly, improve health. In addition, ministries of health need to develop better skills to negotiate with ministries of finance and the international financial institutions to obtain a higher share of overall government expenditure.

To illustrate, the average country in Asia devoted only 8.1% of total government expenditure to health in 2006. Although countries in this region have not agreed on a target, this is substantially less than the 15% African heads of state set as their target, for countries that are substantially poorer on average than in Asia. Seven Asian countries devoted less than 4% of total government expenditures to health, while in just under a third of the countries, government commitment to health actually declined between 2000 and 2006. This would not be expected at a time when incomes were generally increasing - people and societies have consistently shown that they are willing to invest increasing proportions of their incomes in improving or maintaining their health as their incomes rise. Increased external funding from donors, lending institutions and foundations will certainly be needed be needed for some time if universal coverage is to be achieved, but **there is room in many countries to increase domestic funding for health**.

In low-income countries taken as a group, close to 75% of total health

available, and more people employed than necessary in some activities. Often high cost, relatively low benefit interventions are used when lower cost interventions with a greater potential to improve population health are not fully employed. Whatever form the inefficiency takes, more could be achieved with the same level of resources in most settings. The incentives and disincentives inherent in the financing system are important determinants of the level of efficiency, one of the most important questions being how to pay health service providers. This is why considerable attention has recently been paid to the issue of results-based financing (sometimes called payment for performance), contractual arrangements and relationships with the non-government sector.

Many health systems are also inequitable, something that is again closely linked to the way they are financed. For example, the high prevalence of user fees gives the rich greater capacity to purchase needed services and to protect themselves from the consequences of ill-health than the poor. However, in many countries the rich also benefit disproportionably from government funded services. While it will never be possible to achieve equality in health outcomes because of variations in genetic heritages and pure chance, health financing systems need to be specifically designed to provide the appropriate access and financial protection for the poor and disadvantaged.

One deterrent to inefficiency and waste is good financial planning, management and auditing tools and systems. Good information is critical to ensuring that enough funds are raised, the poor and vulnerable groups are protected, and the available resources are used equitably and efficiently. Yet only 26 of the countries in the Asia Region have ever undertaken a full national health accounts exercise, so information on how much is spent, by whom, and on what, is often not available to decision makers, or not available in a timely manner. It is only recently that information on the extent of financial catastrophe and impoverishment linked to user fees has begun to be collated in a routine manner, and even now data are unavailable for only 100 or so countries, 23 in Asia[13]. These are but two examples, and **improving financial management systems and 3.77(T5.Tvesign-a**

demand retrenchment in the major developed countries, global industrial production and trade haven fallen in recent months, dragging down growth in many developing countries, with the accompanying risk of rising poverty rates. Financial markets remain under great strains worldwide.[15]

In East Asia, recent data shows sharp declines in exports and slowing domestic consumption and investment spending, indicating that East Asia will experience a deeper and probably more prolonged crisis than previously expected. Against the backdrop of rapidly worsening economic conditions and slowing inflation, many central banks in the region further lowered their benchmark interest rates and announced large stimulus packages. In South Asia, while economic growth is slowing, the downturn is expected to be less severe than in other developing countries. Exports account for a relatively small part of GDP and demand is forecast to hold up reasonably well.

Should these predictions prove accurate, it should still be possible to expand domestically generated resources for health in most Asian countries, especially in South Asian countries, although there may be some restrictions if countries need to seek emergency support from the IMF for their financial systems, for example. Where personal and national incomes rise, albeit at a lower rate, the resources available for health should also rise even as the proportion of total income devoted to health remains constant. But given that the proportion of income people are willing to devote to health generally rises with increasing incomes, and given that the proportion of total government expenditure allocated to health is low in many countries in the region, **the opportunities for expanding funding for health from domestic sources remain positive**.

Continued growth also allows countries to move more steadily to forms of financial risk protection involving prepayment and pooling, thereby reducing reliance on user charges and other forms of direct payment[16]. Moving in this direction requires a careful examination of the feasibility of different technical options - usually involving a mix of tax-based and insurance-based financing - establishing political consensus and commitment, and developing a plan for implementation. A number of international initiatives are under way to supplement the work of existing agencies in providing technical assistance to countries in this work, including the Providing for Health Initiative (P4H) which was announced at the G8 summit of 2007, held in Heiligendamm, Germany[17] [18]. The theme of financing was further elaborated at the G8 summit in Toyako, Japan in 2008.

While raising additional funds and moving away from direct out of pocket payments might move less rapidly because of slower than expected economic growth in Asia, they should still be able to move forward. On the other hand, it is always opportune to actively search for ways to improve the efficiency and equity of health delivery systems, and the role of various economic incentives in doing so. In fact, it is

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[15] *2009 World Economic Situation and Prospects Report, United Nations Department of Economic and Social Affairs, http://www.un.org/esa/policy/wess/wesp.html*

[16] *Carrin et al. 2008*

[17] *www.g-8.de/Content/DE/Artikel/G8Gipfel/Anlage/Abschlusserkl_C3_A4rungen/WV-afrika-en.html*

[18] *Reich and Takemi 2009*

even more important at times of economic uncertainty. Considerable information is already available about what has worked in different countries that have successfully moved away from out of pocket payments towards prepayment, and the role of financial incentives in improving efficiency and equity in service delivery, although efforts to share country experiences more widely could certainly be intensified. However, some key areas remain uncertain - for example, what are the negative as well as the positive effects of results-based financing in settings where health information systems are weak? Here, more research and learning from ongoing experiments is urgently needed.

For discussion:

- *What are the trends in the region regarding levels and sources of domestic financing?*
- *What strategies and policies can governments implement to raise adequate funds for national health systems?*
- *What mechanisms can be employed to pool risk?*
- *What actions can be taken to ensure the equitable and efficient availability and use of services?*
- *How are countries coping with the impact of financial crisis on financing of healthcare?*
- *How can public-private partnerships, domestic NGOs and local communities best complement government efforts to provide quality primary health care to all?*

4. International Finance for Health

Since the signing of the millennium de

accountability including independent monitoring of commitments in the health sector. A recent Third High Level Forum on Aid Effectiveness in Accra reviewed the application of the Paris principles in practice, showing some progress but that much remained to be done, summarized in the Accra Agenda for Action[24].

It will be more difficult to ensure that even more external resources are available for health in the current financial climate. In previous periods of financial or economic crisis in the developed world, aggregate ODA has tended to fall, although some countries have been able to continue to maintain or even increase their contributions. ODA for health has not always fallen, however, suggesting that some external funders recognize the need to continue to support the social sectors in times of economic difficulty. If the world is to have any chance of reaching the MDGs, it is important that external support does not fall during the current crisis, particularly for health and the other social sectors which provide the safety nets for the poor, the people who are likely to suffer most in economic downturns.

To this end, the role of the High Level Task Force on Innovative Financing for Health Systems assumes even more importance. It was announced in September 2008, before the full effect of the financial crisis was known. Its task is to recommend innovative ways of raising more international funding for health, building perhaps on ideas such as the International Financing Facility for Immunization (IFFIm)[25] and the domestic tax on air tickets that is used to fund an International Drug Purchase Facility for AIDS, tuberculosis, and malaria (UNITAID). Now, however, it has the more formidable challenge of ensuring that external funds for health not only do not fall, but increase at a greater rate than they have done since 2000. The Task Force will present preliminary findings to the Italian G8 summit in July 2009, and finalize its recommendations for the UN Sessions scheduled for September 2009.

For discussion:

- *What are the trends in the region regarding sources, quantity and quality of foreign aid for health?*
- *How can governments ensure that inflows of external funds support the development of the domestic financing system and institutions, rather than weaken it? What is the impact of vertical funds on national health systems?*
- *What is the impact of the current financial crisis on global funding for health care? How should it be addressed?*

[24] *http://siteresources.worldbank.org/ACCRAEXT/Resources/4700790-1217425866038/AAA-4-SEPTEMBER- FINAL-16h00.pdf*

[25] *IFFIm issues and sells bonds on the open market to raise immediate funds for immunization. Promised future flows of ODA are used to repay the bonds on maturity. This is a way of "front-loading" future ODA commitments to make them available today.*

Governance/leadership: Governance can be restored relatively quickly after a localized, sudden catastrophic event such as an earthquake, based on existing national or sub-national pathways and structures. After a generalized conflict, new systems might need to be developed, something that is complicated by the fact that the predominant health service providers during the conflict might have been traditional healers, private providers and NGOs or faith-based organizations. Re-establishing government leadership in the health sector requires active engagement with civil society and the agencies and individuals that have provided care during the crisis.

Health services: The first priority is to establish services to meet emergency health needs, and to prevent to the extent possible outbreaks of communicable diseases. In this, the health sector does not work by it

Financing: In the emergency relief phase, finance is required for the effected countries and for external partners offering humanitarian assistance. Most developed countries have the capacity to provide emergency humanitarian assistance to countries during emergencies at short notice, while UN agencies can now draw on the restructured UN Central Emergency Revolving Fund when they need to respond at short notice to humanitarian crises.

There are three complications, however, that are sometimes encountered with the inflow of external funding during crises, which have to be managed carefully[29;30].

The availability of health services is one of the most important indicators of peace and stability. The above discussion suggests that three principles need to guide activities to protect and promote health during and immediately after crises. First, it is important that governments identify clearly a long term vision for reconstruction of the heath system and each of its components, so that activities undertaken early in the relief and transition stages facilitate, rather than hinder, movement in the desired direction. Second, crises provide the opportunity to rethink goals, objectives and methods for achieving them, in health as in other areas. Some examples have been provided in the discussion of each of the building blocks above and they will not be repeated.

This is also linked to the third point. Although each building block has been considered separately in this section, they all interact, and the effectiveness of their interaction is as important as the effectiveness of each component. Moreover, the health sector cannot act in isolation during or after crises, but must work closely with other sectors. In terms of health, crises allow societies to reconsider the extent to which their health systems are consistent with the principles of primary health care (PHC) as re-endorsed in 2009 by the Executive Board of the WHO[31]. Although primary health care requires the services to be available close to people, at the first level of the health system, this is only one component of a system that also requires strong integration across the levels of care and continuity of care. PHC is, in fact, an approach to health service delivery and health system development that puts people at the centre of care, addresses health inequalities through universal coverage, integrates health into broader public policy through multi-sectoral action, and

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