Wilton Park

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Report

Financing for health: the road ahead

Sunday 28 – Tuesday 30 April 2019 | WP1666

In partnership with:

UCSF Global Health Sciences
Global Health Group

Report

Financing for health: the road ahead

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In partnership with the Global Health Group at the University of California, San Francisco and Gilead Sciences, Inc

Executive Summary

Financing for global health provides the necessary foundation by which to achieve the United Nation Sustainable Development Goal (SDG) for health, to ensure healthy lives and promote well-being for all at all ages. The amount of available funding, the source of funding, and how this funding is spent are critical questions that determine the ability of the international community to deliver on this important ambition.

In April 2019, Wilton Park hosted a small high-level convening with leaders in global health, multilateral agencies, civil society, and academia to review the most recent data on global health financing and to discuss critical questions on how to finance health to achieve the SDGs. The discussion focused on four main topics: the state of health finance; the future of development assistance for health (DAH); domestic finance for health; and innovation.

Main themes and suggested policy actions included:

- DAH must remain a necessary component of health finance, and it requires a new vision and narrative that reinforces that DAH is necessary, has unique qualities, and should be targeted and permanent. A united campaign among global health leaders should focus on international collective action, identify sources for revenue building, and revitalise global health activism.
- Domestic finance for health must increase, and out-of-pocket spending must be swept into risk pools. These reforms can be supported through a broader tax movement, evidence to make the case for investing in health, improved health sector capacity and efficiencies, and supporting civil society to hold governments to account.
- Innovative finance and digital technology have the potential to bring in new sources of financing, gain efficiencies and cost savings, and leverage the transformative reach of digital platforms. Global health leaders must harness the technology for health, develop guidelines aligned with the rights-based SDGs, and improve the evidence on the impact and implementation of digital technology for health.

Introduction

In recent decades, health financing from country governments and donors has spurred tremendous health improvements. The future forecast, however, is less secure. Total health spending in low- and middle-income countries remains too low, and too many people face catastrophic out-of-pocket fees for basic health services. Meanwhile, levels of development assistance for health (DAH) have slowed. Major global health institutions – the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria, Gavi, World Health Organization, and Unitaid – face critical replenishments in 2019 and 2020.

In April 2019, Wilton Park hosted a small high-level convening with leaders in global health from multilateral agencies, think tanks, civil society, academia, and the private sector to review the most recent data on global health financing and to discuss how to finance health to achieve the ambitious Sustainable Development Goal (SDG) for health, including universal health coverage (UHC).

The meeting aimed to:

- Review the most recent data on patterns and levels of DAH and consider how DAH can better address shifting global health needs and priorities, such as UHC, primary care, and non-communicable diseases (NCDs);
- Discuss ways to increase global solidarity and maintain (or increase) donor funding for life-saving programmes;
- Explore sustainable health financing solutions that can increase domestic health resources and reduce out-of-pocket spending (OOPs);
- Share new approaches for stable health financing in countries transitioning away from donor financing; and
- Identify opportunities for collaboration and coordination between participants and their organisations.

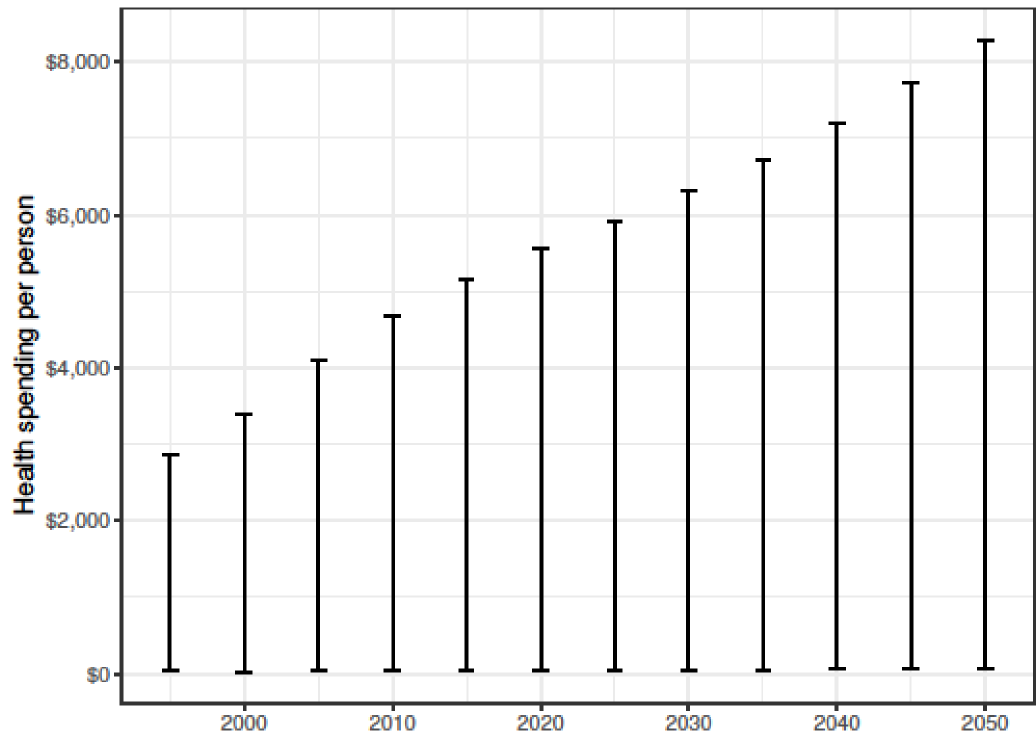
This report summarises the main themes and takeaways from the meeting, organised in the following sections: the state of health finance; the future of DAH; domestic finance for health; and innovation.

State of health finance

Large disparities in health spending

1. The latest estimates from the Institute for Health Metrics and Evaluation (IHME) found that health spending globally reached US$ 8 trillion in 2016, with 81% spent in high-income countries (HICs), 16% in upper-middle income countries (UMICs), 3% in lower-middle income countries (LMICs), and 0.4% in low-income countries (LICs) [1]. This allocation reflects large disparities in health spending, as only 17% of the global population lives in HICs and 35% in UMICs, 39% in LMICs, and 10% in LICs.
2. In 2016, total health spending per capita was US$ 5252 in HICs, US$ 491 in UMICs, US$ 81 in LMICs, and US$ 40 in LICs. Geographically, the lowest per capita spending occurred in sub-Saharan Africa (US$ 80) and South Asia (US$ 59). These countries also have the lowest proportion of government spending per total health spending, with LMICs at 32% and LICs at 26%. They also have the highest rates of OOPs, with LMICs at 56% and LICs at 42%.
3. These large disparities in health spending are expected to increase in the future (Figure 1). IHME predicts that in 2050, per capita spending on health will increase to US$ 8286 in countries currently considered HIC, US$ 1435 in UMICs, US$ 200 in LMICs, and only US$ 66 in LICs. Similar to today, the lowest levels of health spending per capita will remain in sub-Saharan Africa ($111) and South Asia ($180).

Figure 1. Health spending per person estimates, 1995-2050



Source: Ref 2

Note: This graph depicts the range of health spending per person across all countries, with low-income countries at the bottom of the whisker and high-income countries at the top.

Development assistance for health

In 2018, DAH totalled US$ 38.9 billion, with the US government contributing 33.8% of total DAH, followed by the UK government (8.4%) and the Bill & Melinda Gates Foundation (8.3%). DAH primarily focused on HIV/AIDS (24.3% of DAH), child and newborn health (20.1%), and sector-wide approaches and health sector support (14.3%). DAH represented 24.5% of total health spending in LICs.

Prioritising action on NCDs

In recent years, NCDs have achieved high-level political recognition. NCDs make up the greatest burden of disease worldwide, representing 73% of deaths in 2017, and this burden is rising [3]. The SDGs recognise NCDs in target 3.6, "By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being." In addition, in September 2018 the United Nations hosted the third High-Level Meeting on NCDs and adopted a political declaration on NCDs, which included a commitment to "mobilise and allocate adequate, predictable and sustained resources for national responses to prevent and control non-communicable diseases" [4].

However, NCDs remain a small share of DAH. In 2018, US$ 778 million in DAH was directed towards NCDs, representing just 2% of all DAH [5]. Half of DAH for NCDs came from NGOs and foundations (US$ 386 million in 2018), suggesting a low level of priority among bilateral donors. NCDs are perceived as the responsibility of countries, not donors, which may not be realistic given the high burden.

Countries are massively underinvesting in prevention. The mantra of the SDGs hasn't taken form in how countries and donors are financing health. As a result, the root causes of the NCD burden are not being addressed. NCDs must be integrated into existing global health service delivery and mechanisms. A small trust fund may provide a platform for countries to receive technical assistance on NCDs.

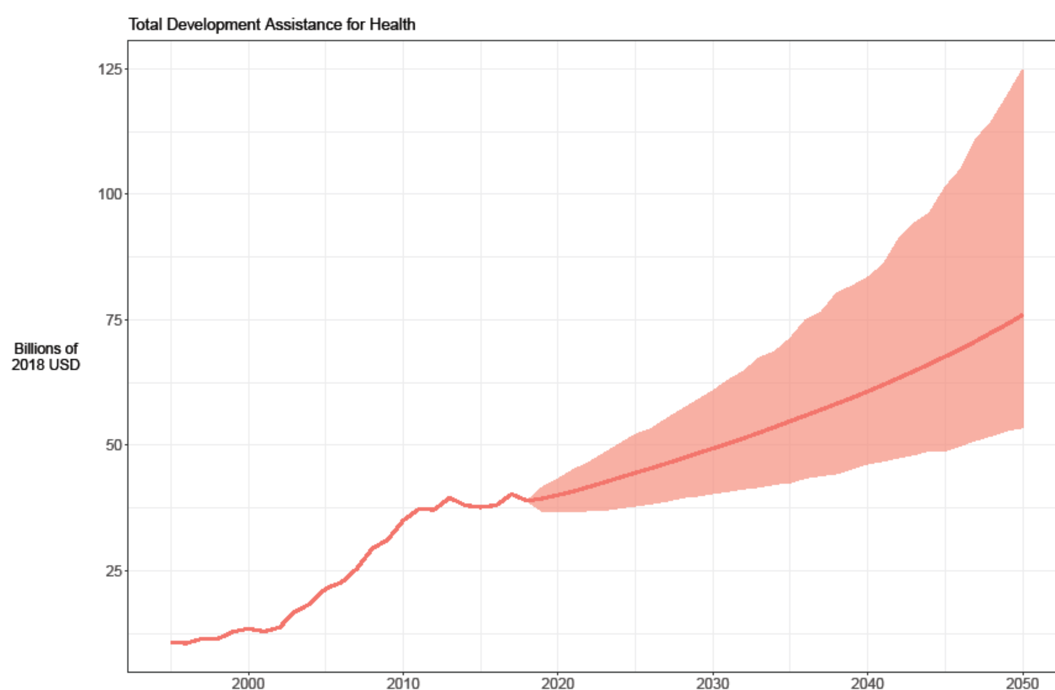
Development assistance for health

Main points of discussion:

Future levels of DAH

4. Analysis by IHME shows that during the "golden age" of global health, DAH increased 11.8% annually from 2002 to 2011 (Figure 2). From 2011 to 2018, growth slowed to 0.6% annually. The IHME anticipates DAH will continue to grow at modest levels, based on past trends. However, there are concerns that current stagnation will continue in the future, given political economy constraints. The "golden age" was an exceptional high growth period, with the initiation of the Gates Foundation, Global Fund, PEPFAR, and Gavi. Today, however, political leaders and constituencies in the US and Europe are increasingly sceptical of multilateralism. Following the development gains of the Millennium Development Goals, policymakers now seem to be complacent. In addition, there is greater competition for donor funding from other sectors, as health is one of 17 global goals.

Figure 2. Total development assistance for health



A renewed vision for DAH

5. DAH will continue to be a crucial part of health financing moving forward, but a reimagining of DAH is needed to respond to challenges. In a policy paper on the future of official development assistance (ODA), Jonathan Glennie calls for five paradigm shifts for "ODA+," a term describing ODA that includes contributions from non-OECD member sources and different varying concessional levels [6]. These shifts, some of which are already underway, are:
   - **Ambition**: Raise the international community's ambition to stretch beyond ensuring basic health coverage as an end goal to pursue equality of access and services within and between countries, aligned with the vision of the SDGs and UHC.
   - **Function**: Recognise that the function of ODA+ is not limited to filling financial gaps faced by countries, but rather ODA+ has unique characteristics that can help catalyse change and support countries in overcoming development traps to achieve sustainable finance.

- **Scope**: ODA+ should be a permanent, not temporary, feature of health financing because it is useful for countries of all income levels and for cross-border objectives, including global and regional public goods.
- **Contributors**: All countries have reason to contribute to ODA+ to support universal targets and participate in multilateral processes and decision-making.
- **Narrative**: Move from language about "foreign aid" to a "global commitment" to reduce inequality within and between countries, and engage constituencies to be part of a global movement to resolve global problems.

Optimising DAH

6. New thinking is needed on how to best spend donor financing in the SDG era. First, DAH must not substitute domestic funding. Second, DAH has an important role in supporting global, transnational priorities, including global public goods (GPGs) such as research and development, knowledge sharing, and the creation of norms and standards [7]. Focusing on GPGs can help move beyond an "aid" narrative, as all countries regardless of income level have a self-interest in ensuring GPGs are available.
7. Third, DAH can help to catalyse and mobilise action from other stakeholders. Framing DAH as serving the population's health, rather than focusing on disease verticals, may help link to broader social and public goods and present opportunities to access different sources of financing. Health must also connect across the SDGs to develop integrated approaches, for instance with climate. These strategies can facilitate greater civil society engagement, involvement of young people, and support for UHC. DAH will also be needed to support national organising from civil society, which can help increase accountability for health.

Policy actions:

- **Develop a strong, united message among global health leaders that DAH is necessary, has unique qualities, and should be targeted and permanent**. Bring together traditional, non-traditional, and emerging donors to take stock of the state of global health and DAH and identify what to build on moving forward. Harness the technology revolution.
- **Embrace a narrative on international collective action for health that builds on the principle of universality in the SDGs and addresses inequality**. Avoid paternalistic "aid" language and approach. Identify and communicate the national and global benefits of international collective action for health, including to constituents in donor countries. Use this narrative to stimulate a campaign with civil society, leveraging energy for social change. Ensure the most vulnerable and conflict settings aren't left out.
- **Identify vehicles for revenue building**, for example innovative finance, taxation of multinational corporations. Align revenue sources with new vision of DAH.
- **Revitalise global health activism**. Develop a coherent policy agenda to remake the case for global health spending. Mobilise a campaign linked with other policy priorities and social movements (for example climate change and climate finance).

Domestic finance for health

Main points of discussion:

Trends in domestic health financing

8. In many countries, the total health expenditure is far below what is necessary to purchase the basics of a health care system. In 2016, 66 countries, composed of all LICs and half of all LMICs, had a total health expenditure less than US$ 150 per capita per year – an estimate of the financing needed to operate a health system and

provide a package of services to achieve UHC [8]. Total health expenditure ranged from US$ 20-150 per capita per year, with many countries spending less than US$ 50 per capita per year. Total health expenditure in LICs and many LMICs is far too low.

9. These 66 countries are the focus of global discussions on health financing and UHC. Together they are home to 3.5 billion people – nearly half the world population. They received 82% of all DAH in 2016. In these countries, government health expenditure averaged only 33% of total health expenditure whereas out-of-pocket expenditures made up 42% of total health expenditure. Estimates by IHME project little to no change from now to 2030.

Table 1. Total health expenditure in countries spending less than US$ 150 per capita per year

	2016	2030
Number of countries with THEpc < $150	66	59
Number of people living in countries with THEpc < $150?	3.5 billion	3.7 billion
Fraction of global DAH that goes to countries with THEpc < $150	81.7%	78.5%
Average of GHE/THE for countries with THEpc < $150	33.2%	33.3%
Average of OOP/THE for countries with THEpc < $150	41.6%	41.7%
Average of DAH/THE for countries with THEpc < $150	21.0%	20.8%

Source: Refs 8 and 9

Note: THE = total health expenditure. THEpc = total health expenditure per capita per year. GHE = government health expenditure. OOP = out of pocket expenditure. DAH = development assistance for health. The averages in this table are the straight mean, not IHME's usual weighted average.

Financing UHC

10. To achieve UHC, countries must improve access to quality, affordable health care by increasing domestic health expenditure and providing financial risk protection. Countries face challenges in securing adequate resources for health, for example weak national tax systems and low political priority of health. Improved national taxation policies, including excise taxes on tobacco, alcohol, and sugary beverages, can generate domestic revenue and reduce preventable deaths [10]. There is also opportunity to improve dialogue between the ministries of finance and health. Private equity and innovative financing mechanisms are also important sources of revenue.

11. In addition, the latest data from the World Health Organization shows that too many people are still not protected against medical impoverishment, a central tenant of UHC. In 2016, median out-of-pocket spending on health represented more than 40% of total health spending in LICs, compared to less than 20% in HICs [11]. Countries must create pre-paid risk pools (public, private, and/or mixed), and ensure that there is sufficient trust in the systems to facilitate uptake and use. Civil society networks play an important role in help to promote accountability and transparency.

Improving efficiency

12. In addition to mobilising more money for health, it is necessary to achieve more health for the money. Countries are tackling the practical improvements needed to achieve more effective health spending, including defining a UHC benefits package and developing institutional capacity to fund and administer the system. Country investments must focus on quality and prevention, particularly for NCDs and to avoid health costs skyrocketing in the future. There is opportunity to use digital technology to better link spending to outcomes and ensure the value of investing in health. A solid financing foundation, with improved efficiencies in health spending, can help make the case for health to ministers of finance. There is significant variation across countries, and solutions will be country-by-country.

Systematic barriers to revenue generation

13. Global economic structures present countries with transnational, systematic, and perennial constraints to revenue generation. For example, many countries struggle with high debt payments and conditionalities set by international financing institutions. The International Monetary Fund reported that from 2013 to 2017 public debt in low-income developing countries (LIDCs) grew and more countries had increased debt vulnerabilities, with 40% of LIDCs at the highest levels of risk and debt distress [12].

14. In addition, a global 'leaky' revenue flow results in countries unable to capture wealth. It is estimated that over one-fifth of developing country trade is lost to illicit financial flows, defined as funds that are illegally earned, transferred and/or utilised across international borders [13]. Increasingly high levels of public debt and illicit financial flows limit countries' capacity to retain financial resources to invest in health and development. A strong civil society movement can help push for reform and advocate that funds are spent on health.

Policy actions:

15. Five main policy actions were identified, to be further developed country by country:

    - **Support broader tax movement**. Health taxes (taxes on alcohol, tobacco, and sugar) present a win-win for government revenue and public health. Luxury good taxes, such as Unitaid's airfare tax, can also be earmarked for health, although it can be politically challenging to ensure funds are prioritised for health.
    - **Improve evidence driven data to make the case for investing in health**. Develop the economic case for investing in health, and equip ministers of health with evidence on the loss of labour and productivity due to poor health outcomes. Link health measures with economic growth and explore cost-effectiveness. Strengthen the link between the ministries of health and finance.
    - **Create large risk pools**. Keep financial protection at the forefront of the political agenda, and ensure risk pooling is part of national health strategies.
    - **Support civil society to help hold governments to account**. Translate evidence and goals, such as the Abuja targets, into more actionable visualisations for each country. (In April 2001, the African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector and urged donor countries to scale up support.)
    - **Build financial management capacity**. Support public budget management practices. Improve systems to track allocation of money, leveraging technology platforms. Use government money to catalyse different sources of funding, and vice versa

Panel: Ghana and UHC

The landscape of health financing in Ghana is changing. In 2016, Ghana's government spending on health was 6.5% of total government expenditure [14]. This level has fluctuated substantially since 2000 and dropped from a high of 12% in 2011, showing a trend away from reaching the Abuja target of 15%. The country has experienced significant economic growth in recent decades, becoming a lower-middle income country in 2010 [15]. As a result, Ghana reached donor eligibility thresholds sooner than anticipated, and is in the process of working with Gavi and other donors to transition. In 2016, ODA represented only 13% of total health expenditure but it continues to have an important role in supporting sustainable development [16].

Ghana is advancing a number of efforts to achieve UHC. In 2003, Ghana introduced a National Health Insurance Scheme (NHIS), becoming the first sub-Saharan African country to do so. Ghana finances the NHIS through the National Health Insurance Fund, an earmarked fund sourced primarily from a national health insurance levy of 2.5% tax on selected goods and services [17]. Other sources include social security contributions, premium payments, allocations by parliament, and donor contributions. The NHIS covered approximately 35% of the population in 2017 [18].

In 2015, a 7-member committee reviewed the NHIS's challenges related to sustainability, efficiency, equity, and accountability [19]. The committee recommended that primary health care for all residents should be the primary focus of the NHIS [20]. The country is instituting a number of reforms. Ghana is working to expand access to family planning, for example, through pilots to provide modern family planning methods through the Community Based Health Planning Services [21]. The NHIS is working to improve data quality through the national identification system. In April 2019, the Ministry of Health launched a medical drone service, the biggest in Africa, to make on-demand emergency deliveries of 148 different vaccines, blood products, and life-saving medications [22].

A number of challenges remain. The fiscal space for health remains highly constrained, and challenges related lack of trust, transparency, and accountability hinder the NHIS's ability to generate revenue and expand. New technologies can help promote financial inclusion, and also allow for more sophisticated development policies, such as through tax identifiers. However, the current situation of scarce resources requires better design of benefits packages to reach target populations, provider payment reforms, and improved provider selection and contracting strategies.

Innovation

Main points of discussion:

Innovative finance

16. Innovation is needed to bring in new money for health, including from non-traditional health actors. There is a projected US$ 3.1 trillion annual shortfall in funding for the post-2015 global development goals across health, education, food security, climate change, and infrastructure. Current levels of both public and private funding cover only US$ 1.4 trillion, leaving an estimated US$ 2.5 trillion annual gap [23]. Private capital can help fill this gap in low- and middle-income countries. An analysis of 72 blended finance structures showed development funders were able to catalyse approximately US$ 4 of private sector capital for every US$ 1 of development funding [24]. There is potential for private capital mobilised through blended finance to reach US$ 252 billion by 2030, assuming current annual growth rates continue [25].

17. Work is also needed to bridge the gap between the private and public sector. Patients are moving between public and private providers, but data and the flow of money needs improvement. One challenge facing social enterprise is that they are unable to

access public markets and keep their intellectual property, forcing them to choose to scale with either private or public capital. Merck for Mothers aims to solve market failures such as these through partnerships that advance innovative financing vehicles and help bring private sector innovations to scale to have broader impact for patients.

Digital technology for health

18. Digital technology has the potential to have transformative impact on health. The World Development Report 2016 reported that more households in developing countries own a mobile phone than have access to electricity or clean water, and that among the world's poorest quintile, 7 out of 10 households own a mobile phone [26]. However, despite rapid changes and uptake of the digital revolution, the benefits for development have lagged behind.
19. Several innovations have come from the public sector. Mobile technology has the potential of zero transaction costs, which can help governments garner considerable savings. For example, a decision to eliminate paper in the member enrolment process of Ghana's National Health Insurance Scheme saved the government US$ 3 million per year, and also a transition to a biometric based enrolment saved users some costs associated with registration (for example photos) [27].
20. The government of Liberia is collaborating with Last Mile Health to strengthen its community health programmes, a critical lesson from the Ebola outbreak. Digital technology is being used to enhance data collection and deliver high-quality, on-demand reference materials for community health workers. This enhances face-to-face training, helps to integrate community health workers into the health system, and provides significant cost savings. Last Mile Health is also digitising the national curriculum and developing online training programs to build capacity of supervisors and government leaders.

Mobile money platforms

21. Mobile money platforms offer opportunity for innovation in health financing. Safaricom, the largest telecommunication company in East and Central Africa, collaborated with the PharmAccess Foundation and the Netherlands Ministry of Foreign Affairs, to create a mobile health wallet, called M-TIBA, that builds on the mobile payment platform M-PESA [28]. M-TIBA helps families save for health services and connects them with certified health care institutions and insurers. This health exchange is now a widely use pre-payment mechanism, has significantly reduced costs, and provides a platform to link private pools with the state thereby reducing fragmentation.
22. M-TIBA also provides a wealth of data on its users. Merck for Mothers is tapping into this by helping expand M-TIBA's focus on mothers and its ability to track a woman's healthcare services across sectors and providers by building on its health wallet platform [29]. This will allow for better monitoring of healthcare utilisation, costs, and outcomes. The digital solution will provide the ability to ensure adherence – by both patient and provider – to a defined package of quality care across the pregnancy continuum while auditing the healthcare delivery costs.

Key challenges for leveraging digital technology for health

- speed of government vs. private sector
- political will
- predictability
- outcomes measurement
- identification
- consistent IT connectivity
- lack of financing intermediaries
- lack of de-risking capital
- connecting to delivery system

Guidelines and evidence

23. While technology is rapidly expanding, with the potential of highly valuable data, guidelines on privacy of information and confidentiality are not yet well developed. It is unclear how to align these technology advancements and opportunities for monetisation with the rights-based framework of the SDGs, for example rights of ownership, access, and use.

24. Further, much more research is needed to understand the impact and implementation of digital technology. Evidence is needed on how to integrate and leverage digital technology into health systems for better health outcomes, increased access, and improved delivery. Further, more work is needed to understand how technology can contribute to job creation and poverty reduction.

Policy actions:

- **Facilitate investments from new sources of financing, including from private capital**.
- **Harness the technology revolution that will transform health delivery**. Create systems with lower administrative costs. Think about integration. Couple this with the difficult work of building sustainable financing platforms and creating quality delivery systems - there is no a magic bullet.
- **Develop norms, standards, and guidelines for use of digital technology for health**. Apply the rights-based framework of the SDGs.
- **Improve the evidence on digital technology for health**.

Conclusion

The Wilton Park meeting highlighted the urgent need and opportunity for a new era of health financing that matches the ambition and challenges of the SDGs. Concerning trends in DAH require a coordinated, refreshed vision and commitment on the purpose and collective benefits of donor financing. To achieve UHC, countries need increased capacity to mobilise and efficiently manage domestic resources and reduce out-of-pocket expenditures. The rapidly changing landscape of technology and private finance can also be leveraged for global health financing, and work is needed to align these innovations with the principles and needs in the SDGs. Action on these three areas – donor financing, domestic financing, and innovation – will set the foundation for the international community to achieve the SDGs.

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