UK	Ethiopia, Kenya, Mozambique, and Zambia	Financial assistance	• Plans to spend at least US$420 million on health, including health workforce, over the next three years	
Russia	4 African countries	Training and education	• Trains and provides education to support strategies to control malaria and a framework for a debt-relief initiative	
Germany	7 African countries	Human capacity development	• Health worker–related programs: assists with reintegration upon return to home country after training in Germany	Spends €500 million annually to fight HIV, malaria, and tuberculosis and to strengthen health systems

Reference:
G8 Health Experts Group, *Toyako Framework for Action on Global Health—Report of the G8 Health Experts Group*, http://www.g8summit.go.jp/doc/pdf/0708_09_en.pdf.

Annex 2: Existing Health Workforce Strengthening Resources from Global Health Initiative

Organization	Target	Type of Assistance	Details	Other
Global Fund	Fight HIV/AIDS, tuberculosis, and malaria	Financial assistance: international health financing	• Committed US$11.3 billion in 126 countries to date, 23 percent for human resources and 9 percent on infrastructure and equipment	57 percent of the approved funding was contributed to Africa
World Bank	Developing countries	Financial and technical assistance	• Provides low-interest loans, interest-free credit, and grants • Invests in education, health, public administration, infrastructure, financial and private sector development, agriculture, and environmental and natural resource management in developing countries	
PEPFAR	15 countries: Botswana, Ethiopia, Haiti, Mozambique, Nigeria, South Africa, Uganda, Zambia, Côte d'Ivoire, Guyana, Kenya, Namibia, Rwanda, Tanzania, and Vietnam	Financial assistance	• Estimate investment of US$309 million for training health workers in 2008 • Plans to support 2.7 million trainings to target training and retaining of 140,000	Heaviest focus is on HIV/AIDS-related actions; however the sideways approaches also benefit health workforce strengthening
Clinton Foundation, Clinton Global Initiatives (CGI)	In partnership with 10 African countries for HRH programs	Health system assessments and financial assistance through fund raising	• Interventions include training, clinical mentoring, recruiting, capacity building, and curriculum development	Clinton HIV/AIDS Initiative works with markets and governments to make treatments more accessible in the developing world

DFID	6 African countries, Cambodia, and Nepal	Financial assistance	• Invests £450 million over the next three years to support national health plans, incorporating training of more nurses, midwives, and doctors	
USAID Capacity Project	Developing countries; build and sustain the health workforce (Latin America, Africa, Eastern Europe, and Asia)	Assessment, financial, and technical support Global leadership; generating, organizing, and communicating knowledge about HRH Provides country-level support to implement effective and sustainable HRH programs	• Supports improved workforce planning and leadership • Assists in developing better education and training programs • Assists in strengthening systems to support workforce performance • Encourages health workers to remain at their posts	Participated in the development of the HRH Action Framework, published in the 2006 *World Health Report*

References:
Global Fund, "Distribution of Funding after 7 Rounds," http://www.theglobalfund.org/en/funds_raised/distribution/.
World Bank, http://www.worldbank.org/ (accessed October 16, 2008).
PEPFAR, "Report to Congress by the US. Global AIDS Coordinator on Health Care Worker Training 2008," http://www.pepfar.gov/documents/organization/105844.pdf.
Clinton Foundation, http://www.clintonfoundation.org/what-we-do/clinton-hiv-aids-initiative/what-we-ve-accomplished.
The Capacity Project, http://www.capacityproject.org/index.php?option=com_content&task=view&id=32&Itemid=66.

Annex 3: Existing recommendations

Code of Practice on International Recruitment of Health Personnel

Upon recognizing the significance of migration of health workers for health systems, the World Health Assembly adopted resolution WHA57.19, which called for the development of a Code of Practice on the International Recruitment of Health Personnel. Web-based public hearings on the first draft code of practice were held by the WHO on September 1–30, 2008. Those who were invited to contribute to the hearing included member states, health workers, recruiters, employers, academic and research institutions, health professional organizations, and relevant sub-regional, regional, and international organizations. The initiative provided all members concerned with international recruitment of health personnel an opportunity to comment on the draft. Input has been received and published on the WHO website.

Objectives of the code

The code of practice has four main objectives:

1. Establish and promote voluntary principles, standards, and practices for the international recruitment of health personnel
2. Serve as an instrument of reference to help member states establish or improve the legal and institutional framework required for the international recruitment of health personnel and in the formulation and implementation of appropriate measures
3. Provide guidance that may be used where appropriate in the formulation and implementation of bilateral agreements and other international legal instruments, both binding and voluntary
4. Facilitate and promote international discussion and advance cooperation on matters related to the international recruitment of health personnel

Key elements of the code

The key elements of the first draft of the Code of Practice on International Recruitment of Health Personnel can be summarized into five categories: ethical and fair recruitment, partnership and mutuality of benefits, safeguarding the health workforce, monitoring of international health worker migration flows, and accession to and withdrawal from the code.

Although it is not legally binding, the framework is anticipated to promote ethical recruitment, the protection of migrant health workers' rights, and remedies for addressing the economic and social impact of health worker migration in developing countries. While several other codes of practice for the international recruitment of healthcare professionals already exist on a regional level, the WHO Code of Practice is expected be the first of its kind on a global scale for migration (WHO 2007, WHO 2008).

Source:
Resolution WHA 57.19
http://www.who.int/gb/ebwha/pdf_files/WHA57/A57_R19-en.pdf
WHO Code of Practice on International Recruitment of Health Personnel
http://www.who.int/bulletin/volumes/86/10/08-058578.pdf
Summary of comments on the code of practice
http://www.who.int/hrh/public_hearing/comments/en/print.html

Kampala Declaration and Agenda for Global Action

Endorsed by the participants of the first Global Forum on Human Resources for Health, held in Kampala, Uganda, on March 6, 2008, the Kampala Declaration and Agenda for Global Action serves to bring global attention to the worsening health worker crisis.

The contents of the Kampala Declaration consist of 12 elements calling upon:

1. government leaders to provide the stewardship to resolve the health worker crisis, involving all relevant stakeholders and providing political momentum to the process;
2. leaders of bilateral and multilateral development partners to provide coordinated and coherent support to formulate and implement comprehensive country health workforce strategies and plans;
3. governments to determine the appropriate health workforce skill mix and to institute coordinated policies, including through public-private partnerships, for an immediate, massive scale-up of community and mid-level health workers, while also addressing the need for more highly trained and specialized staff;
4. governments to devise rigorous accreditation systems for health worker education and training, complemented by stringent regulatory frameworks developed in close cooperation with health workers and their professional organizations;

5. governments, civil society, the private sector, and professional organizations to strengthen leadership and management capacity at all levels;
6. governments to assure adequate incentives and an enabling and safe working environment for effective retention and equitable distribution of the health workers;
7. while acknowledging that migration of health workers is a reality and has both positive and negative impacts, countries to put appropriate mechanisms in place to shape the health workforce market in favor of retention. The WHO will accelerate negotiations for a code of practice on the international recruitment of health personnel;
8. all countries to work collectively to address current and anticipated global health workforce shortages. Richer countries will give high priority and adequate funding to train and recruit sufficient health personnel from within their own countries;
9. governments to increase their own financing of the health workforce, with international institutions relaxing the macro-economic constraints on their doing so;
10. multilateral and bilateral development partners to provide dependable, sustained, and adequate financial support and immediately to fulfill existing pledges concerning health and development;
11. countries to create health workforce information systems, to improve research, and to develop capacity for data management in order to institutionalize evidence-based decision making and enhance shared learning; and
12. the GHWA to monitor the implementation of this Kampala Declaration and Agenda for Global Action and to re-convene this forum in two years' time to report and evaluate progress.

Besides the Kampala Declaration, the Kampala Agenda for Global Action proposed six fundamental and interconnected strategies that intend to translate political will, commitments, leadership, and partnership into effective actions in addressing the health workforce crisis:

1. Building coherent national and global leadership for health workforce solutions;
2. Ensuring capacity for an informed response based on evidence and joint learning;
3. Scaling up health worker education and training;
4. Retaining an effective, responsive, and equitably distributed health workforce;

5. Managing the pressures of the international health workforce market and its impact on migration; and
6. Securing additional and more productive investment in the health workforce.

Source:
Kampala Declaration and Agenda for Global Action:
http://www.who.int/workforcealliance/Kampala%20Declaration%20and%20Agenda%20web%20file.%20FINAL.pdf

Task shifting to tackle health worker shortage: global recommendation and guidelines

The WHO, together with PEPFAR and UNAIDS, has developed global guidelines for task shifting. These guidelines were formally launched during the first ever Global Conference on Task Shifting held in Addis Ababa on January 8–10, 2008. The conference convened health ministers and other senior government officials, opinion leaders, United Nations agencies, and NGOs from both industrialized and resource-constrained countries, and, concluded with an endorsement of the Addis Ababa Declaration on Task Shifting.

Task shifting is the name given to a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers. By reorganizing the workforce in this way, task shifting presents a viable solution for improving healthcare coverage by making more efficient use of the human resources already available and by quickly increasing capacity while training and retention programs are expanded.

Example: task shifting in Uganda

In Uganda, task shifting is already the basis for providing antiretroviral therapy. With only one doctor for every 22,000 patients and an overall health worker deficit of up to 80 percent, Uganda is making a virtue of necessity. Uganda's nurses are now undertaking a range of tasks that were formerly the responsibility of doctors. In turn, tasks that were formerly the responsibility of nurses have been shifted to community health workers, who have training but not professional qualifications. As part of the approach, Uganda has expanded its human resources for delivering HIV and AIDS services by creating a range of non-professional types of healthcare

workers. These people receive specific training for the tasks they are asked to perform.

Source:
Addis Ababa Declaration on Task Shifting
http://www.who.int/entity/healthsystems/task_shifting/Addis_Declaration_EN.pdf

Notes

1. A. Haines and D. Sanders, "Building Capacity to Attain the Millennium Development Goals," *Transactions of the Royal Society of Tropical Medicine & Hygiene* 99, no. 10 (2005):721–726; M. Chopra, S. Munro, J. N. Lavis, G. Vist and S. Bennett, "Effects of Policy Options for Human Resources for Health: An Analysis of Systematic Reviews," *Lancet* 371, no. 9613 (2008): 668–674.
2. Joint Learning Initiative, *Human Resources for Health: Overcoming the Crisis* (Cambridge: Harvard University Press, 2004).
3. World Health Organization (WHO), *World Health Report 2006: Working Together for Health* (Geneva: WHO, 2006).
4. H. Schneider, D. Blaauw, L. Gilson, N. Chabikuli and J. Goudge, "Health Systems and Access to Antiretroviral Drugs for HIV in Southern Africa: Service Delivery and Human Resources Challenges," *Reproductive Health Matters* 14, no. 27 (2006):12–23.
5. WHO, *World Health Report 2006*.
6. WHO, "The Kampala Declaration and Agenda for Global Action," http://www.who.int/workforcealliance/Kampala%20Declaration%20and%20Agenda%20web%20file.%20FINAL.pdf (accessed October 2008).
7. G8 Health Experts Group, Toyako Framework for Action on Global Health—Report of the G8 Health Experts Group, http://www.g8summit.go.jp/doc/pdf/0708_09_en.pdf (accessed October 1, 2008).
8. WHO, *World Health Report 2006*.
9. Ibid.
10. African Council for Sustainable Health Development (ACOSHED), *For as Much and With as Much: Sustaining Commitment to Africa's Human Resources and Health Systems Crisis*, forthcoming 2008.
11. Ibid.
12. M. R. Reich, K. Takemi, M. J. Roberts and W. C. Hsiao, "Global Action on Health Systems: A Proposal for the Toyako G8 Summit," *Lancet* 371, no. 9615 (2008):865–9.
13. Joint Learning Initiative, *Human Resources for Health*; WHO, *World Health Report 2006*; A. K. Rowe, D. de Savigny, C. F. Lanata and C. G. Victora, "How Can We Achieve and Maintain High-Quality Performance of Health Workers in Low-Resource Settings?" *Lancet* 366, no. 9490 (2005): 1026-1035; N. Crisp, B. Gawanas and I. Sharp (Task Force for Scaling Up Education and Training for Health Workers), "Training the Health Workforce: Scaling Up, Saving Lives," *Lancet* 371, no. 9613 (2008): 689–91.
14. T. Bossert, T. Barnighausen, A. Mitchell, D. Bowser and G. Gedick, *Assessing Financing, Education, Management and Policy Context: Strategic Planning for Human Resources for Health* (Geneva: WHO, 2007).
15. J. Connell, P. Zurn, B. Stilwell, M. Awases and J. Braichet, "Sub-Saharan Africa: Beyond the Health Worker Migration Crisis?" *Social Science & Medicine* 64, no. 9 (2007):1876–91; D. Palmer, "Tackling Malawi's Health Crisis," *Reproductive Health Matters* 14, no. 27 (2006):27–39.
16. Palmer, "Tackling Malawi's Health Crisis."
17. Global Health Workforce Alliance, *Scaling Up, Saving Lives* (Geneva: WHO, 2008).
18. Bossert, Barnighausen, Mitchell, Bowser and Gedick, *Assessing Financing, Education, Management and Policy Context*.
19. Joint Programme on Workplace Violence in the Health Sector (by ILO, ICN, WHO, PSI), *Framework Guidelines for Addressing Workplace Violence in the Health Sector* (Geneva: International Labour Organization [ILO], 2002); International Council of Nurses, *Safe Staffing Save Lives: Information and Action Tool Kit*, http://www.icn.ch/indkit2006.htm (accessed October 2008).

20 S. Anand and T. Barnighausen, "Human Resources and Health Outcomes: Cross-Country Econometric Study," *Lancet* 364, no. 9449 (2004):1603–09; S. Anand and T. Barnighausen, "Health Workers and Vaccination Coverage in Developing Countries: An Econometric Analysis," *Lancet* 369, no. 9569 (2007):1277–85.

21. Countdown Coverage Writing Group, on behalf of the Countdown to 2015 Core Group, "Countdown to 2015 for Maternal, Newborn, and Child Survival: The 2008 Report on Tracking Coverage of Interventions," *Lancet* 371, no. 9620 (2008):1247–58.
22. ACOSHED, *For as Much and With as Much.*
23. Bossert, Barnighausen, Mitchell, Bowser and Gedick, *Assessing Financing, Education, Management and Policy Context.*
24. B. Marchal, V. De Brouwere and G. Kegels, "HIV/AIDS and the Health Workforce Crisis: What Are the Next Steps?" *Tropical Medicine & International Health* 10, no. 4 (2005): 300–4.
25. K. Kober and W. Van Damme, "Public Sector Nurses in Swaziland: Can the Downturn Be Reversed?" *Human Resources for Health* 4 (2006): 13.
26. M. Vujicic and P. Zurn, "The Dynamics of the Health Labour Market," *International Journal of Health Planning and Management* 21, no. 2 (2006): 101–15.
27. H. Aiga and C. Kuroiwa, "Quantity and Distribution of Continuing Professional Education Opportunities among Healthcare Workers in Ghana," *Journal of Continuing Education in Nursing* 37, no. 6 (2006):270–9.
28. C. Hongoro and B. McPake, "How to Bridge the Gap in Human Resources for Health," *Lancet* 364, no. 9443 (2004):1451–56.
29. A. Haines, D. Sanders, U. Lehmann, et al., "Achieving Child Survival Goals: Potential Contribution of Community Health Workers," *Lancet* 369, no. 9579: 2121–31; L. Huicho, R. W. Scherpbier, A. M. Nkowane, C. G. Victora, and the Multi-Country Evaluation of IMCI Study Group, "How Much Does Quality of Child Care Vary between Health Workers with Differing Durations of Training? An Observational Multicountry Study," *Lancet* 372, no. 9642 (2008): 910–16.
30. P. M. Fenton, C. J. M. Whitty and F. Reynolds, "Caesarean Section in Malawi: Prospective Study of Early Maternal and Perinatal Mortality," *BMJ* 327, no. 7415 (2003):587; S. Bergström, "Who Will Do the Caesareans When There Is No Doctor? Finding Creative Solutions to the Human Resource Crisis," *BJOG: An International Journal of Obstetrics & Gynaecology* 112, no. 9 (2005):1168–9.
31. H. Argaw, *The Health Extension Program (HEP) of Ethiopia: Summary of Concepts, Progress, Achievements and Challenges*, WHO Ethiopia country office, 2007, http://www.aaahrh.org/2nd_Conf_2007/Cases/Ethiopia-Argaw%20Health%20Extension%20Program.doc (accessed October 23, 2008).
32. Tedros Adhanom, Minister of Health, Ethiopia, Speech given at the International Conference on Task Shifting, Addis Ababa, Ethiopia, January 10, 2008. http://www.moh.gov.et/index.php?option=com_content&task=view&id=77.
33. WHO, *Task Shifting Global Recommendations and Guidelines* (Geneva: WHO, 2008).
34. C. Kurowski, K. Wyss, S. Abdulla and A. Mills, "Scaling up Priority Health Interventions in Tanzania: The Human Resources Challenge," *Health Policy and Planning* 22, no. 3 (2007):113–27.
35. C. Goodman et al., "Retail Supply of Malaria-Related Drugs in Rural Tanzania: Risks and Opportunities," *Tropical Medical & International Health* 9, no. 6 (2004): 655–63.
36. K. McColl, "Fighting the Brain Drain," *BMJ* 337 (2008):a1496.
37. WHO, "The Kampala Declaration."
38. Joint Learning Initiative, *Human Resources for Health.*
39. ILO, *Social Dialogue in the Health Services: A Tool for Practical Guidance* (Geneva: ILO, 2005).

40. D. Y. Dovlo, "Social Dialogue in the Health Sector: Case Study Ghana," *International Labour Organization Working Paper* 234, 2005.
41. Vujicic and Zurn, "Dynamics of the Health Labour Market."
42. WHO, *World Health Report 2006*.
43. T. Martineau, K. Decker and P. Bundred, "'Brain Drain' of Health Professionals: From Rhetoric to Responsible Action," *Health Policy* 70, no. 1 (2004): 1–10; Save the Children and Medact, "Whose Charity? Africa's Aid to the NHS," http://medact.org/content/Skills%20drain/Whose%20charity%204%20page.pdf (accessed November 24, 2008).
44. D. Kline, "Push and Pull Factors in International Nurse Migration," *Journal of Nursing Scholarship* 35, no. 2 (2003): 107–11.
45. R. Cooper, T. E. Getzen, H. McKee and P. Laud, "Economic and Demographic Trends Signal an Impending Physician Shortage," *Health Affairs* 21, no. 1 (2002):140–54; J. Buchan and J. Sochalski, "The Migration of Nurses: Trends and Policies," *Bulletin of the World Health Organization* 82, no. 8 (2004):587–94; B. Pond and B. McPake, "The Health Migration Crisis: The Role of Four Organisation for Economic Cooperation and Development Countries," *Lancet* 367, no. 9520 (2006):1448–55.
46. G. Winyard, "Medical Immigration: The Elephant in the Room," *BMJ* 335, no. 7620 (2007):593–5; R. A. Cooper, "It's Time to Address the Problem of Physician Shortages: Graduate Medical Education is the Key," *Annals of Surgery* 246, no. 4 (2007):527–34.
47. B. Stilwell, K. Diallo, P. Zurn, et al., "Migration of Health-Care Workers from Developing Countries: Strategic Approaches to Its Management," *Bulletin of the World Health Organization* 82, no. 8 (2004):595–600.
48. International Organization for Migration (IOM), "IOM and Remittance: Definition, Scale and Importance of Remittance for Development and Poverty Alleviation," http://www.iom.int/unitedstates/Fact%20Sheets/PDFs/IOM%20and%20Remittances.pdf#search=%27remittance%20for%20development%20IOM%27 (accessed on October 1, 2008).
49. M. Clemens, "Do Visas Kill? Health Effects of African Health Professional Emigration," *Center for Global Development Working Paper* no. 114 (2007).
50. Global Economic Governance Program, "Setting a Developing Country Agenda for Global Health—A Preliminary Report of a High-Level Working Group" (May 2008), http://www.globaleconomicgovernance.org/docs/Working%20Group%20Report%20May%202008.pdf (accessed October 24, 2008).
51. Ibid.
52. Ibid.
53. D. Sridhar and R. Batniji, "Misfinancing Global Health: A Case for Transparency in Disbursements and Decision Making," *Lancet* 372, no. 9644 (2008): 1185–91.
54. F. Omaswa, "Human Resources for Global Health: The Time for Action is Now," *Lancet* 371, no. 9613 (2008): 625–6.
55. Connell, Zurn, Stilwell, Awases and Braichet, "Sub-Saharan Africa"; Palmer, "Tackling Malawi's Health Crisis."
56. K. Takemi, M. Jimba, S. Ishii, Y. Katsuma and Y. Nakamura (Working Group on Challenges in Global Health and Japan's Contribution), "Human Security Approach for Global Health," *Lancet* 372, no. 9632 (2008):13–4.
57. WHO, *The World Health Report 2008—Primary Health Care: Now More than Ever* (Geneva: WHO, 2008)

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Strengthening Health Financing in Partner Developing Countries

*Ravindra P. Rannan-Eliya**

The Health Challenges Confronting Developing Countries

Three serious health challenges confront developing countries and require health to remain a core issue in global development: 1) many partner developing countries are not making adequate progress toward the health-related Millennium Development Goals (MDGs), 2) large gaps in social health protection make a major contribution to impoverishment in many countries, and 3) deficiencies in health systems increasingly impair human security not only in partner developing countries but also in middle- and high-income countries.

The centrality of health in the development agenda is reflected in the fact that three of the eight MDGs are health related (MDGs 4, 5, and 6) and that G8 members have made substantial commitments in previous meetings. Nevertheless, while substantial progress is being made toward most MDGs, the most serious shortfalls that have emerged are clearly in human development and health.[1] Despite substantial progress toward the disease-focused MDG 6

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(HIV/AIDS, malaria, and other diseases), much of the developing world is off track to achieve the more general, and ultimately more important, MDGs 4 and 5 (child and maternal mortality respectively). In sub-Saharan Africa and South Asia, most people live in countries that are actually doing worse in terms of progress than before the 1990s, despite the MDG commitments.[2] Improving progress toward the health-related MDGs will require substantial increases in access to services and the performance of health systems, which is simply not possible until more effective financing policies are established in partner developing countries.

The past decade has seen growing evidence that households are likely to be confronted with catastrophic expenses when they are forced to pay out-of-pocket for healthcare. Globally, more than 100 million people each year fall into poverty because of the cost of medical treatment,[3] exacerbating and perpetuating poverty in the poorest countries. Health-related expenses remain the most important reason for households being pushed back below the poverty line, even in some of the fast-growing countries of Asia, such as China, Vietnam, and Bangladesh.[4]

The recent increased awareness of the need to improve financial risk protection from catastrophic health expenditures has forged a convergence between the previously separate agendas for health and social protection. It places the issue of health coverage directly within Japan's guiding framework of human security, and it coincides with the joint interests of EU member states to make social health protection a second pillar in EU strategies to strengthen health systems.[5] At the same time, moving toward social health protection is central to the World Health Organization's (WHO) renewed emphasis on the primary healthcare approach to strengthening health systems.[6] This shift in attention to the social protection aspects of health policy also marks an alignment in global health policy with core motivations of social protection and solidarity that have always guided health financing in the G8 nations themselves.

Alongside these developments, the growing interconnectedness of G8 members and partner developing countries as a result of globalization forces a broader view of human security that takes into account emerging transnational threats to health. With the poorest economies often being the likely foci of future pandemics,[7] as well as presenting new risks to global food and supply chains,[8] the G8 countries have a keen interest in ensuring that partner countries adequately and effectively finance core public health functions in their health systems.

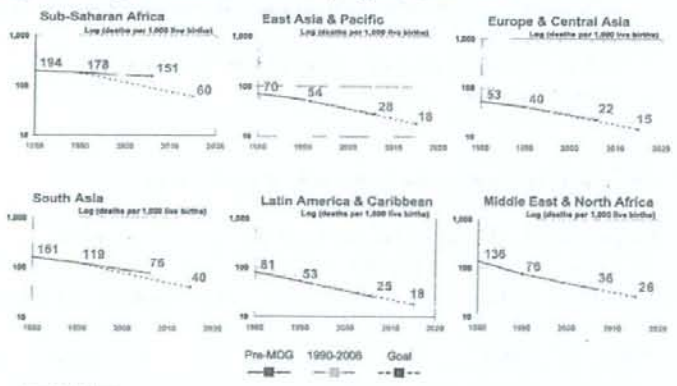
What Drives these Problems?

Progress to date

The G8 has responded to the health-related MDGs in the past decade by committing significant new resources for health sectors in developing countries. Since the 2002 Monterey Summit, external financing flows for health have been scaled up from both official partners and private sources, especially for HIV/AIDS and maternal and child health.[9] Partner developing countries have also increased domestic financing, with significant increases in Africa achieved through a mix of fiscal expansions and increased prioritization of health in government budgets.[10] Indeed, as Dr. Margaret Chan, the head of the WHO, observes, "health has never before seen such wealth."[11]

Yet, despite this scaling up of both external aid and domestic financing, rates of progress toward attaining MDGs 4 and 5 have not significantly changed, especially in the most critical regions of sub-Saharan Africa and South Asia,[12] where the recent data suggest even a slowing of progress in the years since 1990 (fig. 1).[13] In no developing region has performance dramatically improved. Money alone has proved sufficient neither to achieve better health gains, nor to reduce impoverishment from catastrophic medical bills.

Figure 1: Progress toward MDG 4 by region, 1980–2006[14]



Source : Childinfo.org

Key reasons

There are several reasons why partner developing countries have often failed to improve progress toward health goals or social protection. In failed states, the explanation is undoubtedly the lack of any functioning health system and the general disruption of normal life. In these conditions, where we may have to accept that attaining the MDGs is not feasible, the only effective response will often be external humanitarian assistance, including donor-led delivery interventions.

In the case of other developing countries, the critical problems lie at the level of the health system for the most part and require concerted policies and action by and with partner developing countries. It is no coincidence that the greatest lags in progress occur with those MDGs—4 and 5—that require improvements at a broad level across the whole health system and which are not as susceptible to disease-focused interventions as is the case with MDG 6. There are several key reasons for this:

- inadequate funding for health in many countries
- ineffective and inefficient health financing and delivery systems that give rise to significant shortfalls between what is achieved and what was potentially feasible with the funding that was available
- lack of integration between funding for vertical and horizontal programs, resulting in competition for resources and undermining national strategies and
- lack of information on what countries know about the operation of their health systems and potential solutions

Inadequate funding is critical, but how much is needed?

Despite the considerably higher burden of disease and ill health in developing countries, overall health spending in partner countries is significantly less than that in developed countries. The average G8 nation spent more than 10 percent of GDP on health in 2007, compared with 5 and 6 percent in low- and middle-income partner countries respectively.[15] Even after adjusting for purchasing differences, health spending in the poorest countries, at US$20–50 per capita, is one-thirtieth the level of that in developed countries, and less than US$30 in most of the partner countries of greatest concern. This lower level of spending buys developing countries lower levels of coverage by effective health

interventions. For example, in the typical developing country the average person is able to see a doctor only one or two times a year, while the much healthier citizens of G8 nations visit a doctor five to seven times a year on average.[16] Increasing spending can clearly help to improve coverage and access.

The clear emphasis on increasing official development assistance (ODA) for health since at least 2000 demonstrates the G8's recognition of this constraint.[17] While both G8 and partner countries have certainly delivered in terms of increased funding for health, especially in areas linked to MDGs 4, 5 and 6,[18] it is worth pausing and asking whether this has been enough.

There have been many efforts since the early 1990s by the UN, World Bank, WHO, and others to answer how much financing is required either to scale up access to basic minimum services or to achieve some or all of the health-related MDGs. Their estimates suggest that the required public and external financing in low-income countries ranges from US$30 to US$50 per capita (and higher in middle-income countries).[19] In contrast, actual public spending in low-income countries is less than US$15, of which up to 40 percent, on average, is from external financing.

Although further increases in external financing are needed, it has to be accepted that even without the current global financial crisis, achieving levels of US$30–50 per capita from both public and external sources in the poorest countries was never realistic by 2015. Such target levels of expenditure represent 10–20 percent of GDP in the poorest countries, and are, on average, much higher than their overall tax revenues, implying that the shortfall could only be met by external flows. That level of external flows would, in most countries, present serious challenges in terms of absorption and macroeconomic stability.

However, the likely shortfalls in funding compared with the global targets do not necessarily eliminate any likelihood of substantial progress toward key health goals. There are three reasons for thinking this.

First, most of the global cost estimates appear to be overestimated, when estimated using actual country data. Recent efforts have responded to such criticism by applying methods that use country-level data. Such projects by the UN, UNICEF, the World Bank, and others have tended to produce much lower estimates on required funding, of the order of US$20–35 per capita.[20]

In addition, current global cost estimates assume that future expansions in health service coverage will cost as much as current service delivery. This ignores the potential for countries to partly fund expansions in coverage by improvements in the technical efficiency of service delivery, i.e., by reducing the average unit cost of a service. This assumption not only runs counter to histori-

cal experience in Organisation for Economic Co-operation and Development (OECD) nations, where efficiency gains have typically reduced costs,[21] but it also ignores evidence of similar 1–2 percent efficiency gains in developing countries.[22] Developing countries that have been able to generate such efficiency gains in the past have been able to expand services considerably with only modest increases in spending, since a 2 percent annual increase in efficiency implies a doubling of service delivery every 20 years without any increase in funding. Past examples include Botswana, which doubled service coverage during 1960–1980 without increasing health budgets as a share of GDP, and Uganda, which financed a tripling of service delivery during 1955–1969, half through increased spending and half via efficiency gains.

Finally, several low-income and lower-middle-income developing countries have been able to achieve universal access to basic health services and also stay on track to achieve their health-related MDGs, but almost all of them have done so by spending far less than the global targets for spending. For example, Sri Lanka, a low-income country, had largely achieved universal access by 1990, with government and private spending being less than US$10 per capita each. Vietnam today is well on track with similar levels of financing.

This suggests that even if funding does not attain currently identified global targets, it does not mean that countries cannot make substantial progress toward the MDGs and in expanding access to health services. More attention, therefore, needs to be given to increasing the value obtained from current and future spending on health in developing countries.

Inefficient and ineffective health financing and delivery systems

The notion that health spending is often inefficient and that more spending does not necessarily result in better outcomes is well known to G8 nations. For example, in the United States, health spending per capita varies more than three-fold across the country, and yet higher spending does not necessarily result in better outcomes, nor does lower spending translate into lower quality, with such centers of medical excellence as the Mayo Clinic able to deliver high-quality care at half the cost or less of other centers.[23] Problems of how money is transformed into effective, accessible, quality healthcare are also well documented in many developing countries.[24] These problems of inefficiency fall into two types: allocative and technical. Allocative inefficiency is the suboptimal distribution of available public resources across the potential uses or programs. For example, in many developing countries, preventive health services

may be underfunded, while another service, such as family planning, may receive disproportionately more resources despite there being a similar need.

Technical inefficiencies further impair the effectiveness of money invested in programs or interventions. Such inefficiencies might mean that providers do not use the least-cost method for delivering a service or provide the best quality for any given level of resources. Examples include the use of antibiotics when oral rehydration solution is sufficient for cases of diarrhea, procurement systems' failure to purchase medicines at the lowest available prices, or an inefficient mix of medicines and personnel being used to provide a service. Technical inefficiencies can also be due to low productivity of healthcare workers, who see fewer patients than they might. The impact of such inefficiencies can be large, and, in some countries, can be seen in as much as a tenfold variation in the unit cost of delivering similar services at different facilities.[25]

The existence of such inefficiencies, and the potential they imply for improving the results from health spending, have been recognized since the early 1990s, for example in the World Bank's *World Development Report 1993* and by the WHO Commission on Macroeconomics and Health.[26] However, not much weight was placed on addressing this problem—in contrast to that of inadequate funding—since it was felt that not enough was known about what actions could be taken.[27] While this may have been a sensible strategy in the 1990s, it has not been without consequence. The problem of inefficiency has largely been neglected for the past decade, with minimal efforts being made to understand the problem and identify possible solutions. Now that funding levels have improved, and the variation in the value that different countries achieve for their spending is even clearer, the time is long overdue focus attention on this area.

Lack of integration between health systems and vertical programs

Frustration at the difficulties of rapidly expanding health systems coverage, considerations about the efficiency of different approaches to delivering critical interventions, as well as changing priorities in health, have led to the development of vertical health programs in many countries. However, while these initiatives have certainly been successful in promoting specific communicable diseases on the global health agenda, vertical programs have themselves created three major problems. First, the selective, external financing of such programs often leads to distortions within health systems, as better-funded vertical programs compete for and deprive other parts of the health system of critical

inputs, such as staffing. Second, vertical programs often make it harder for countries to effectively plan the development of an integrated health service delivery system, which must remain at the core of any sustainable expansion in overall health services coverage. Third, such programs may fail to benefit from the synergies of integrated services.[28]

These problems are not new. The original Alma Ata Declaration of 1978 with its commitment to integrated health service delivery, a commitment that is encapsulated in the WHO concept of primary healthcare, was a reaction to the perception that investments in selective primary healthcare and other vertical interventions had undermined the development of developing country health sectors. In the 1990s, the pendulum swung back, as growing frustration with actual progress in developing primary healthcare, and the apparent inability to deal with increases in devastating and costly communicable diseases, led to increased investments in vertical programs. The G8 has been on both sides of this debate, committing to supporting overall health systems but also investing heavily in vertical programs through such channels as the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the US President's Emergency Plan for AIDS Relief (PEPFAR). However, it is now readily apparent that greater focus is needed to assist countries to strengthen their overall health systems and integrated delivery, as the Global Fund and other initiatives run up against the limitations of weak health systems with often restricted capacity for scaling up. This is a significant motivation for the WHO's new call to refocus on primary healthcare in its *World Health Report 2008* and is reflected concretely in the International Health Partnership and Related Initiatives (IHP+) and Providing for Health (P4H) initiatives that stress harmonization and health system strengthening.

Lack of information and evidence to manage health systems effectively

Inadequate information and evidence are critical constraints to improving the performance of health systems. Problems exist in two areas. First, health information systems in most developing countries continue to be weak and cannot provide health managers with the information required to effectively monitor and improve service delivery and financing strategies. Common deficiencies include 1) the lack of reliable information systems, such as national health accounts, to track overall spending, whether it be public financing, external resource flows, or private spending;[29] 2) the lack of routine information systems to track equity in health services, which are