



# TOUGH CHOICES: INVESTING IN HEALTH FOR DEVELOPMENT

## QUESTIONS AND ANSWERS

### Setting the scene

#### How is the report *Tough choices: investing in health for development* related to the report of the Commission on Macroeconomics and Health?

The 2001 report of the Commission on Macroeconomics and Health (CMH) was the point of departure from which the country follow-up work, described in the *Tough choices* report, has evolved based on country situations and needs. One of the principal recommendations of the CMH was that developing and developed countries should commit significant additional resources for health, in light of health's potential to contribute to economic development. Governments requested support to investigate the relevance of the CMH findings to their countries.

The work has exhibited a 'bottom-up' approach with significant variations from country to country. As recommended by the CMH, a number of countries set up national commissions on macroeconomics and health (NCMH) (or similar bodies), whose mandates included advocacy for increased funding for health. Several examined the health-development links in their countries. Countries also emphasized strengthening the national processes involved in making choices that determine health outcomes, through building evidence and improving national planning. The overall aim was to build national capacity to allocate resources more effectively and to absorb gradual increases in funding for health.

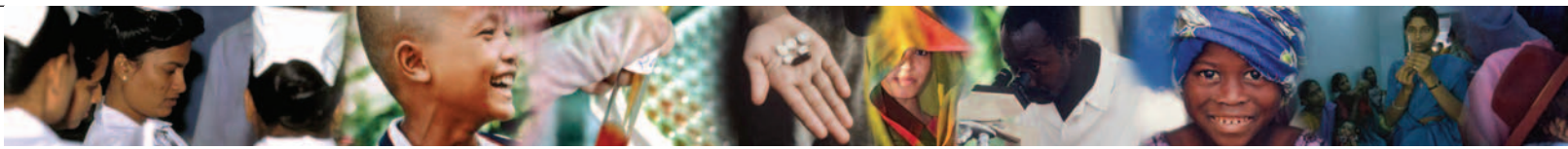
#### What was the basis for countries' participation in the follow-up work and inclusion in the *Tough choices* report?

The approximately 40 countries and several regions that undertook the follow-up work requested WHO's support to translate the CMH's recommendations into concrete actions. Their participation was also based on technical and financial resources available. The 12 experiences that are highlighted in the report (**Cambodia, the Caribbean Community, China, Ghana, India, Indonesia, Mexico, Nepal, Rwanda, Senegal, Sri Lanka and Yemen**) are those where the processes have most progressed and which provide good examples to illustrate the main issues of the work.

#### Have investments in health increased over the last few years?

Evidence shows that domestic health spending rose from 1998 to 2002 in several countries, including those that are actively involved in the macroeconomics and health follow-up work. Global advocacy has also brought in new external funds. Total commitments to development assistance for health expanded from about US\$ 7 billion in 2000 to US\$ 10.7 billion in 2003. In 2005, the European Union announced that its members would double their aid to poor countries by 2015. Also in 2005, G8 finance ministers announced a broad-based deal on debt relief under which the World Bank, the International Monetary Fund, and the African Development Fund would immediately write off all of the money owed to them by 18 countries – approximately US\$ 40 billion. Monies liberated through debt relief could be used for greater social spending, mostly to augment funding in health and education.

Despite these positive signs, health continues to be underfunded in many low- and middle-income countries. Moreover, a significant share of total health expenditure in poor countries consists of out-of-pocket payments. Such payments are generally the most regressive type of health financing and contribute to inequities in health outcomes.



### What has been the principal impact of the follow-up work?

The national processes are supporting efforts to address ‘upstream’ constraints that impede faster health progress for poor people in developing countries. The work has supported a strong stewardship role of the ministry of health to plan, cost, finance and implement an appropriate health strategy. This strategy includes strengthening health systems, ensuring equitable health financing and improving the efficiency of health investments by reallocation to more effective uses.

Through the work, countries have identified health priorities and targets, based on solid evidence of their health situations and with a focus on disadvantaged groups. The resulting health investment plans are a basis for advocating for additional domestic and external funding to the health sector. The NCMH serves as a mechanism through which convincing evidence and costed plans can effectively engage the ministries of finance and planning, as well as ensuring country management and coordination of externally-supported processes and initiatives.

### How does the follow-up work relate to other policy mechanisms and processes in countries?

In several countries, the NCMHs serve as a framework for coordinating mechanisms and processes. The work has been synergized with medium-term expenditure frameworks, multi-year national health plans and other sustained policy initiatives, including poverty reduction strategies. It has aimed to insert health more centrally in development processes, where health is often weakly represented, and to link health plans to short- and medium-term budgets.

### What is the position of this work vis-à-vis other major reports published recently?

A number of reports have been released in recent months diagnosing the constraints at country level to achieving health targets. *Tough choices: investing in health for development* adds to this body of work by presenting lessons, gleaned through real country experience, for a new way of managing health resources. The CMH follow-up complements previous work by focusing more on the challenges posed by complex political and institutional structures in countries, and the need to build up national capacity to operationalize the various technical recommendations of the other reports.

### How does the country follow-up work link with other World Health Organization initiatives and support?

Scaling up essential health interventions for increasing access and coverage requires strengthening health systems. The CMH follow-up work is contributing towards achievement of this objective. The work has involved all levels of the Organization in providing integrated support to countries, an offshoot of which is an ongoing process of building local research capacity and creating expert networks in regions and countries. The work also supports efforts to work towards greater health equity.

### Who is this report’s intended audience and what is the way forward?

*Tough choices: investing in health for development* presents early achievements in a limited number of countries, giving insight into challenges and lessons for better management of health resources that can be extrapolated to other national situations. These lessons are intended to be useful to decision-makers and technical staff in ministries of health, but also in ministries of finance, planning and other ministries that deliver inputs for health as well as to development partners. The countries described in the report are using the work in many ways, including for input into policy processes and discussions with development partners. These experiences will be integrated into the core work of WHO, and the work will be expanded to additional countries that show interest.



## Examples from countries

**What are some examples of how collaboration between ministries of health and ministries of finance and planning, and the position of health in development, have been enhanced through the work?**

The intersectoral composition of the **Ghana** Macroeconomics and Health Initiative (GMHI) has contributed to enhancing the position of the Ministry of Health vis-à-vis the Ministries of Finance and Planning. The report of the GMHI is designed to input into the Ghana Poverty Reduction Strategy and the Ministry of Health Programme of Work for 2007 to 2011 and uses associated mechanisms and planning tools. The identification of a clear link between the Ghana Poverty Reduction Strategy and the Government's annual budget was a critical new dimension prompted by the follow-up process.

In **Yemen**, the CMH follow-up work supported the United Nations Millennium Project Millennium Development Goals (MDGs) needs assessment and costing of health strategies and provided the opportunity to coordinate these efforts. The Ministry of Public Health and Population was able to present results that strengthened its relationship with the Ministry of Planning and International Cooperation, which led the process across sectors.

A number of other countries presented evidence of the links between health and economic development in their national situations, which will be used in discussions between the ministries of health and finance.

**How did the work support priority- and target-setting?**

The work of the **Caribbean** Commission on Health and Development to build a local evidence base included an assessment of determinants of health, coupled with selected studies on burden and cost of disease. The effects of epidemiological and social transitions on health priorities were considered, including non-communicable diseases and mental health, HIV/AIDS, and violence and injuries.

The **Ghana** Macroeconomics and Health Initiative, in conjunction with the Ministry of Health, reviewed the disease burden and designated a limited number of diseases as key health priorities due to their impact on mortality.

The **India** National Commission on Macroeconomics and Health (NCMH) identified 17 major classes of conditions that accounted for over 80% of the disease burden in India in 1998. Then, they established further criteria to decide the list of priority health interventions. Included in the analysis was attention to the emerging noncommunicable disease burden and an ageing population.

In **Mexico**, the NCMH examined which health goals should be chosen for the country based on a review of the health situation. With regard to the Millennium Development Goals (MDGs), they recommended moving up the time frame for specific targets; establishing targets at the sub-national level to ensure attention to the poor; and including goals not considered in the MDGs, but which are of great importance for countries like Mexico. For example, diabetes mellitus is now estimated to cause 12.6% of all deaths in Mexico, making it the primary cause of death. Only 29% of the population used at least one preventive health service in 2000.

The **Sri Lanka** NCMH called attention to the decline in the share of preventive care and public health as a percentage of actual health-care expenditures from about 11% in 1990 to 4% in 2004, while in 2004 hospital services accounted for 73%.



### Did any countries collect evidence on intra-country disparities in health status, spending and access to care?

Intra-country disparities were the particular focus of the middle-income CMH countries. The work in **China** focused on strengthening the Government's role in the health sector in order to alleviate pockets of poverty. Per capita health expenditure in urban areas was 3.29 times that in rural areas in 1998, a difference which increased to 3.64 times in 2003. Childhood mortality rates in most western provinces are three to five times higher than in developed coastal areas.

The **India** NCMH noted significant disparities in health status between women and men, between rural and urban areas, and among states. For example, there is an 18-year gap between life expectancy at birth in Kerala (74 years) and Madhya Pradesh (56 years). There are also large inter-state disparities in household spending, and public subsidies are not particularly well-targeted.

The **Mexico** NCMH report quotes that the poorest municipality of Guerrero has an infant mortality rate of 66.9 per 1 000 live births, which is similar to that of much poorer countries. By contrast, the Benito Juarez district in Mexico City, with a rate of 17.2 per 1 000 live births, has a level comparable to those of western Europe.

### Did any country examine options for overcoming human resource constraints?

The **Caribbean Commission** on Health and Development (CCHD) report quotes a 35% vacancy rate for nurses, with an estimated loss of government revenue of US\$ 16.7 million through migration of nurses whose basic training was paid for by the state. However, remittances are an important source of funds for some countries (the average for the region is approximately 5% of Gross Domestic Product in 2000). The ministers of health of the region have already endorsed a programme of 'managed migration'. The CCHD recommended further research on the factors that influence trade in nursing services and permanent migration of nurses, as well as attention to expansion of training and cost recovery from workers that choose to work outside of the region.

The **Ghana** Macroeconomics and Health Initiative's investment plan includes strategies and costs for addressing human resource constraints. It estimated that on average over 2002–2015, approximately US\$ 16 million and US\$ 53 million per year would need to be mobilized to meet the physician and nurse gap, respectively.

The **India** NCMH notes that India has an acute shortage of doctors at approximately 59 per 100 000 population (compared to nearly 200 in most developed countries). The NCMH identified weaknesses in medical education and training, among others.

### What information do the investment plans contain and how will they be used?

**Ghana's** Macroeconomics and Health Initiative (GMHI) has produced a costed plan to scale up a health package consisting of priority health interventions, a close-to-client system, investments in health systems and access to potable water and improved sanitation. The GMHI estimated a funding gap of about US\$ 5 billion between 2002 and 2015 to implement the health plan, which will contribute towards achievement of the Millennium Development Goals (MDGs).

**India's** NCMH estimated the cost of providing chosen intervention packages with different levels of coverage and presented actions that the Government can take to improve the delivery and financing, especially in ensuring that the poor are benefiting from public investments. The NCMH recommended that



public health spending should be increased from the current level of approximately 1.2% to 3% of Gross Domestic Product to achieve the MDGs, as well as the targets laid down in the National Health Policy 2002. India also costed targets for nutrition, water and sanitation, and other intersectoral inputs to health.

The follow-up work in **Yemen** strengthened the Government's capacity to complete an MDGs needs assessment and the costing of health strategies, undertaken as part of Yemen's participation in the United Nations Millennium Project. The costing based on achieving the MDG targets by 2015 resulted in an average annual needed investment of US\$ 53 per capita. The total costs to scale up towards the MDGs were estimated at approximately US\$ 14 billion.

The costing estimates in these three countries will be used for different purposes according to the country needs. In Ghana, they will be used as input into the revision of the health component of the Ghana Poverty Reduction Strategy, as well as the medium-term expenditure framework and the Ministry of Health Programme of Work. India has used the process to support a systematic analysis of health sector reform. Meanwhile, the needs-based costing in Yemen serves largely an advocacy purpose to attract more resources to the health sector.

#### **Has the work in any country examined options for expanding tax-based or social health insurance schemes?**

The **India** NCMH looked at ways to reduce out-of-pocket expenditures, which account for more than 80% of total health spending. The financial burden of health-related spending is estimated to raise the proportion of people living below the poverty line by as much as 3.3% per year. The NCMH suggested better targeting and considering alternative methods of financing, such as community-based insurance, capitation, vouchers and social health insurance.

One of the five Working Groups of the **Mexico** NCMH focused on health insurance and social protection. In Mexico, more than half of the population is excluded from social security systems and more than 90% of private health expenditures are out-of-pocket. These payments tend to be greater, as a percentage of total family income, in the poorest households. The report of the CMMS makes the case for a universal health insurance scheme as the most appropriate option to ensure equity and efficiency in the health system and outlines desirable elements that a health insurance system should provide.

Other countries that addressed insurance included **China** and the **Caribbean Community**.

#### **How will these activities improve resource management at the peripheral levels of the health system?**

Although Government investment in health in the western rural counties of **China** has increased in recent years, most of the funds have been used in the capitals, less at the township level, and almost nothing at the village level of health providers, where over half of rural patients access care. The follow-up work in China has focused on supporting a clear national strategy for health that clarifies the roles of the different levels of local government and increases the effectiveness of resource allocation.

Follow-up to the report of the **Ghana** Macroeconomics and Health Initiative will include visits to targeted districts to ensure that the GMHI recommendations are incorporated into district medium-term plans.

**Nepal's** Sub-Commission on Macroeconomics and Health has promoted district-level planning to capture the wide political, economic and geographic variations in the country.

Issues related to incomplete decentralization and flows of funds from the centre to the peripheral levels were also broached by **India** and **Sri Lanka**.



### What role did civil society organizations and the private sector play in the process?

In **Cambodia**, knowledge-sharing among civil society organizations (CSOs) has been supported via MEDiCAM— the Cambodian umbrella organization for CSOs in the health sector which has carried out an investigation into the role of CSOs in macroeconomics and health processes. The follow-up work in Cambodia emphasized the urgent need for better coordination of relevant ministries and civil society organizations, which deliver a large proportion of health services.

In **India**, expanded social participation in the management and delivery of health services is a key component of the NCMH vision. The NCMH report calls for the primary health system to be “embedded in the community” using five institutional structures. The report also explores the role of the private for-profit health sector and provides recommendations for how Government could interact more effectively with the private sector to achieve national health goals.

**Mexico’s** NCMH focused on the importance of building a social consensus around its findings to strengthen the political will on the economic and social development of the country.

### How has the work addressed the crucial issue of increasing the effectiveness of aid flows?

Three studies were commissioned to explore the flow of donor funds in **Cambodia, Indonesia, and Sri Lanka**. Data available to track external funds at the country level was found to be limited. These studies suggest the strong need for better and more timely data on the allocation of donor funds within countries, as well as the benefits of linking this information to the performance of health systems, towards improving the effectiveness of development assistance for health. The studies highlighted the fact that the share of external funds channeled ‘on-budget’ differed widely across the three countries. In Cambodia, only approximately 20% of external funds were disbursed through the treasury.

Several countries have used the macroeconomics and health work to improve alignment of donors around national plans and strategies, which will heighten the effectiveness of aid. **Ghana’s** report will be used as part of donor meetings to discuss support and financing options for its health investment plan. In **Rwanda**, representatives of the Task Force on Macroeconomics and Health participate actively in Government-donor coordination bodies. The Task Force has identified targeted research topics to inform the actions of the Government and its partners and is a forum for knowledge-sharing and transfer. The follow-up work in **Senegal** aims to enhance the efforts of the Ministry of Health to improve management of health investments at all levels, including better integration of external aid with national priorities.

### What about monitoring and evaluation?

As a next step, regular monitoring and evaluation of the implementation of health investment plans is needed. The tracking of intermediate events – shifts in health budgets or allocations, as well as the repercussions at local or district levels, for example – creates a foundation for the more effective management of health resources, but also increases the transparency of the use of funds. Likewise, the timelag between health allocations and their impact in terms of health outcomes means that carefully engineered intermediate indicators can help in understanding causes and effects more precisely and in the subsequent planning of needs-based interventions. Once identified, such a system of indicators could also be used for comparisons across countries.