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Investment in Health is an Investment in Economic Development

Note for the High Level Panel Discussion on Health Financing in Africa on "More Health for Money and More Money for Health"

I. OVERVIEW

1. In April 2001, African Heads of State and Government met in Abuja, Nigeria and made a financial commitment towards meeting the Millennium Development Goals (MDGs) by pledging to allocate at least 15 per cent of their national budgets to health. At the Kampala Summit in July 2010, the Heads of State committed themselves to taking action to "provide sustainable financing by enhancing domestic resource mobilization, including public-private-partnership and national health insurance so as to meet the 15 per cent Abuja target. This is expected to result in reduction of out-of-pocket payments and waiving of user fees, especially for pregnant women and children under five. April 2011 will mark the 10th anniversary of this landmark Abuja commitment.

2. Since 2001, Africa has been making progress in financing for health priorities and frameworks, with more African countries starting to increase the proportion of their government expenditure on health. Development assistance to health more than doubled with the emergence of The Global Fund to Fight Aids, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunization (GAVI), the Bill and Melinda Gates Foundation and recently, the International Health Partnership. This progress in health financing has contributed to improvements in child health, HIV/AIDS, tuberculosis and malaria.

3. Ten years on, the pledge remains largely unmet, as only six out of 53 African Union (AU) member States[1] have achieved the Abuja commitments on health financing. More importantly, 32 of the 53 AU member States are still investing less than half the WHO-recommended $40. Indeed, 11 of these countries are investing a mere $5 or less per capita, which can hardly tackle a combination of diverse health issues and strengthen health systems[2].

4. While the world's people are healthier, wealthier and live longer today than they did in 1990, the year of the MDG baseline values, progress has been unequal and Africa's burden of disease is disproportionate to its population size. With 11 per cent of the world's population, sub-Saharan Africa accounts for 53 per cent of maternal deaths, 50 per cent of under-five child deaths and 67 per cent of HIV/AIDS cases. While some improvement has been made in health outcomes in Africa, progress is still limited, unequally distributed both among and within countries and only a small number of African countries are on track to achieve the MDGs.

5. Maternal and newborn mortality, as an important indicator of the performance of the health system is a major source of concern and challenge to Africa. Substantial, albeit varied, progress has been made towards MDGs 4 and 5, the targets for which are a 75-per cent reduction in the maternal mortality ratio (MMR) and a two-thirds reduction in under-five mortality from 1990 to 2015. To address this situation, on 7 May 2009, the African Union Commission (AUC) launched the Campaign for Accelerated Reduction in Maternal Mortality in Africa (CARMMA), as an advocacy platform for enhanced implementation of the Maputo Plan of Action on Sexual and Reproductive Health and Rights

[1] According to Africa Public Health Alliance and 15 per cent + Campaign, they are: Rwanda 18.5 per cent, Botswan aand Niger 17.8 per cent; Malawi 17.1 per cent; Zambia 16.4 per cent and Burkina Faso 15.8 per cent.
[2] Africa Public Health Alliance and 15 per cent + Campaign

(SRHR). The CARMMA slogan is **"Africa Cares: No Woman Should Die While Giving Life".** At the Kampala Summit in July 2010, Heads of State pledged to take action to launch CARMMA and broaden it as an advocacy strategy for the promotion of maternal newborn and child health (MNCH).

6. Furthermore, investment in social determinants of health and preventive action, such as provision of clean water, improved sanitation, sustainable use of environment, and improved nutrition and food security is inadequate. Failure to invest in these health determinants can contribute to or account for as much as 10 to 40 per cent of ill health in most countries and aggravate mortality especially in infants, children and adults affected by other health conditions.

7. The political economy of disease in Africa is such that the consequences tend to combine to reinforce each other in a vicious cycle of ill health, be it HIV/AIDS, tuberculosis, malaria, malnutrition, maternal and newborn deaths or locally endemic diseases. Poverty and weak health systems also have a compounding effect.

8. Many countries have embarked on health sector reforms and are already making progress in MDGs. These efforts should be pursued and deepened. Several countries are clearly making progress in the establishment of new health sector financing mechanisms, such as performance-based financing and various forms of insurance against the financial risk of ill health. These are all aimed at raising the efficiency of health spending from both public and private sources. Strides have also been made in decentralizing taxation, improving human resource for health and combating specific diseases such as malaria. At the same time, the public finance management agenda has gained momentum and most African States are in the process of public finance reforms, with a focus on efficiency, effectiveness, transparency and accountability.

II. PROBLEM OF BUDGETARY ALLOCATION

9. Efforts to achieve the health MDGs and reduce the burden of preventable diseases and deaths are hampered by lack of increased investments and commitment by African countries and development partners alike. Notwithstanding the recent economic and financial crisis, development partners have pledged more resources to finance health in Africa, as evidenced by the $4 billion pledged at the Muskoka G-8 summit, which was increased to $40 billion[3] during the United Nations MDG Review Summit in September 2010. They also committed to be accountable, in line with the Paris Declaration and Accra Agenda for Action on Aid Effectiveness.

10. Investments in health must be more cost-effective and intra-sector allocations more efficient. Existing and additional funds from domestic and international sources will then result in increased health outputs and outcomes, and faster progress toward achievement of health MDGs. International experience shows that the inefficiencies mentioned above can be addressed if adequate measures are taken. This effort will allow for more to be achieved with already available resources, while increasing confidence in the health sector and strengthening its position in the competition for limited funds during economic crises.

[3] September 2010 UN Summit on the Millennium Development Goals; stakeholders adopted a Global Strategy for Women's and Children's Health and committed $40 billion in resources to a global effort to save the lives of 16 million women and children by 2015.

11. Nevertheless, the issue of equitable access to pledged funds remains. The 15th Ordinary Session of the Assembly of the African Union[4] requested the AUC and its partners, the G-8 included, to develop a mechanism for accessing such funds by AU member States. To this effect, the AUC is planning to hold a round table meeting of stakeholders to be hosted by Mozambique.

12. However, meeting the Abuja target of allocating at least 15 per cent of national budgets to health is the responsibility of the AU member States. In the last 18 months, two major meetings have been held to discuss the failure of most AU member States to reach the 15 per cent target in national budgets. The first meeting was held in December 2009 in Tunis, for senior officials of Ministries of Health and Finance from selected African countries[5]. The second was in July 2010 in Kampala, for Ministers of Health and Finance from selected African countries and Development Partners[6]at a side event during the AU Summit on "Maternal, Infant and Child Health and Development". Both events considered key issues such as communication and collaboration between the Ministry of Finance and the Ministry of Health to foster dialogue on health financing for health MDGs and explore new ways of working together for better health outcomes. A major reason why the 15 per cent target remains unmet in many countries is the disconnect between Ministries of Health and Finance that are attributed to the following:

(a) Different identities and cultures;
(b) Different mandates and stakeholders;
(c) Insufficient technical collaboration;
(d) Ministry of Health lack of compliance with Ministry of Finance requirements and expectations, such as budget preparation and execution process, expenditure framework, information, and emphasis on financial and efficiency considerations;
(e) Ministry of Finance view of health as an unproductive sector;
(f) Ministry of Finance unwillingness to share Ministry of Health vision/priorities within the health sector;
(g) Need for better public finance management and greater transparency and accountability for the stewardship of resources flowing into a complex health sector, with many players;
(h) Inability of Ministry of Health to make a compelling case for increased investment in health – health expenditures should be seen as an investment and not as a cost.

13. The few countries that have attained the 15 per cent Abuja Commitment have done so, in part, due to donor and partner support. The funds from most donors may be specified, and depending on the conditions attached to them, may not contribute much toward strengthening the health systems of the recipient countries. Also, there is the issue of governance and proper management of resources allocated to health. Many member States ought to introduce a policy of zero tolerance for corruption in the health sector. This is why the Heads of State in Kampala undertook to "*Provide stewardship as national Governments and achieve policy coherence by developing integrated health plans within the*

[4] Assembly/AU/Decl.1 (XV],
[5] Benin, Burkina Faso, Burundi, Ethiopia, Kenya, Madagascar, Mali, Niger, Nigeria, Rwanda, Senegal, Uganda and Zambia.
[6] Cameroon, Chad, Ethiopia, Egypt, Malawi, Nigeria, Sierra Leone, Uganda and Zambia; European Union, ECA, World Bank, Global Fund, UNAIDS, WHO-AFRO, Roll lBack Malaria, and Africa Public Health Alliance.

development plan with cross diseases and cross sector health goals and coordinate multi-sectoral actions and multi-agency partnerships".

14. Attaining the 15 per cent may not necessarily translate into sufficient resources for achieving the MDGs. The question is how countries will be able to provide better health delivery with the funds available, and at the same time allocate additional money for health. Secondly, for countries that have not yet achieved the target, what measures can be taken to do so?

15. According to the WHO World Health Report 2010, many factors contribute to the current slow progress in attaining MDGs. Apart from lack of financial resources, these factors include poor governance and accountability, underdeveloped infrastructure, weak health systems, lack of focus on results, inadequate harmonization and alignment of aid. Exogenous factors include political instability and natural disasters. The main sources of inefficiency are well known and may include, at country level, weak strategy setting, leading to inadequate resource allocation and financing options; inappropriate procurement, management and use of drugs; inappropriate staff mix coupled with a lack of performance incentives; overuse and over-funding of certain health services and leakages. Unequal access to health care also contributes to health sector inefficiency, with the better off capturing the benefits of publicly-subsidized health services. These services often remain inaccessible to the poorest, whose out-of-pocket health expenditures are enormous and account for over half of a country's total health expenditure.

III. FOCUS OF THE DIALOGUE

16. The dialogue should therefore, focus on the following broad areas and outcomes:

(a) What are the reasons for the current state of low health financing in Africa?, (underline what can be done by African countries to improve the situation, and increase allocations and achieve targets where this is not already the case)
(b) What innovative ways are there for using available resources more efficiently / effectively (for instance results-based budgeting for health)?
(c) What case can be made for health investment and financing, especially of continuum of maternal, infant and child care?
(d) What can both ministries of health and finance do to be more effective in national planning and budgeting process, implementation, monitoring and evaluation for efficient resource use?
(e) What investment case should be made, bearing in mind that investment in health is an investment in economic development?
(f) What conditions are essential to ensure that partner support is aligned with country priorities?
(g) What can be done to improve transparency and accountability within the health sector and to encourage development partners to use country systems to better integrate development assistance that is consistent with the Paris Declaration and other commitments on aid effectiveness?
(h) What opportunities are there for working more effectively with the private sector, as a key partner in improving health outcomes and making private expenditures more equitable?

17. The proposed panel discussion aims to start this dialogue.

IV. CONCLUSIONS AND LOOKING AHEAD

18. Investment in health is an investment in economic development. One key element for sustainable economic development is long-term investment in human, health and social development. The greatest asset of any society is its human capital. Human capital is crucial for the creation of wealth and employment and sustainable accumulation and transfer of knowledge and skills – a valuable prerequisite for industrial, technological and economic development. This cannot be achieved in a setting where high levels of mortality and morbidity, and low life expectancy are the norm.

19. The 10th anniversary of the Abuja Commitment and the dialogue between the Ministers of Finance and Health on Health Financing in March 2011 offer another opportunity for taking stock and decisive action on the attainment of this landmark commitment, and ensuring judicious management of financial resources allocated to the health sector. The objective is more health for money and more money for health. The world health report outlines some ways on how more health can be achieved using available resources, and also innovative ways in which more money for health can be mobilized.

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4. Africa Investment Case
5. The World Health Report 2010– Health Systems Financing, The path to universal coverage.