



Present and potential roles of global health funds and health systems strengthening

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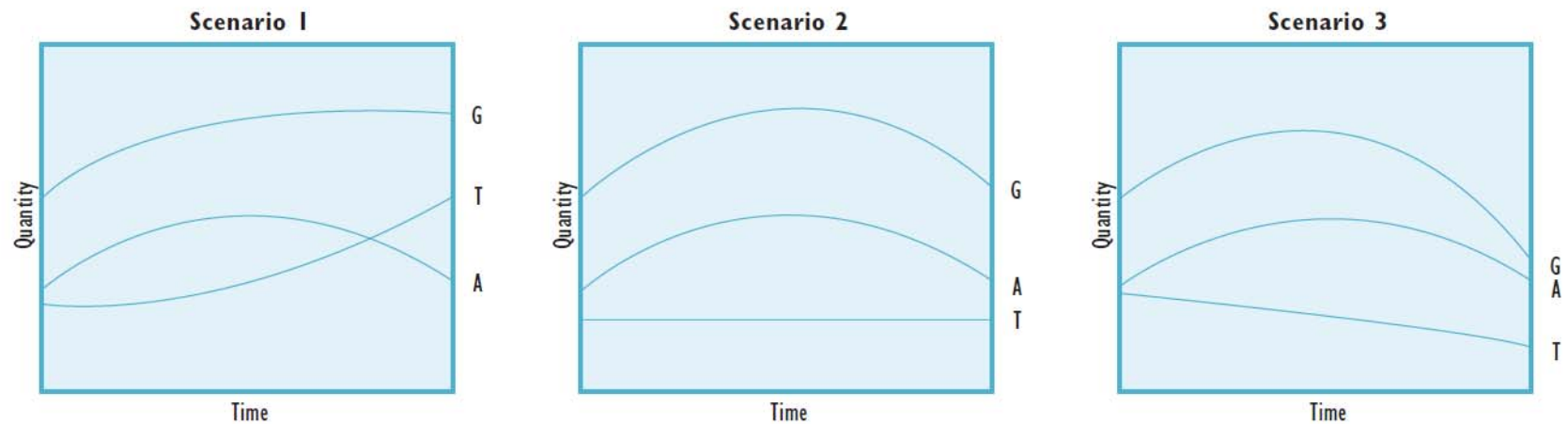
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Limited 'fiscal space'? William Gareth, Hay Roger (2005) Fiscal space and sustainability from the perspective of the health sector. In; High-Level Forum for the Health MDGs, Selected papers 2003-2005. WHO and World Bank, pp 44-66. Available from:

http://www.who.int/hdp/publications/hlf_volume_en.pdf

Figure 1 Fiscal space and sustainability under alternative scenarios for aid and domestic revenues



A = Aid volume T = Domestic revenues G = Fiscal space for government spending

The challenge is to change the 'A(id)' curve; from going up and down, to going up and staying up...

Limited 'fiscal space'? Foster Mick (2005) Fiscal space and sustainability: towards a solution for the health sector. In; High-Level Forum for the Health MDGs, Selected papers 2003-2005. WHO and World Bank, pp 67-88. Available from:

http://www.who.int/hdp/publications/hlf_volume_en.pdf

	Possible approaches to a solution	Benefits	Constraints and disadvantages
2.4	'Sector Blueprint' approach: Donors make specific commitments to finance a medium-term expenditure plan for a sector or sub-sector.	Specific inputs agreed in the MOU are guaranteed provided the programme is implemented as set out in programme documents.	Long-term plans need flexibility to adapt. Tends to favour investment rather than recurrent costs. Fragments budget management.
2.5	Longer-term (5+ years) commitments linked to rolling plan & joint institutional arrangements to achieve specific outcomes (e.g. related to a specific sector or MDG) ¹ with assurances of continued funding in long-term (10+ years) if performance is OK.	Support depends only on sector progress, with graduated response to problems: analysis, dialogue, restrictions on use, lower commitments, and finally suspension of part of aid in extreme cases. Builds on SWAP best practice.	Long-term aid commitment may reduce pressures for reform. Requires mutual trust and commitment to joint decision-making. May distort spending priorities if not part of an overall agreement on budget and aid levels.
2.6	Greater clarity on donor political and governance concerns, and increased dialogue so decisions are made with knowledge of aid consequences.	Reduces a major cause of uncertainty and reluctance to increase aid dependence.	Donor political pressures over-ride formal agreements and cannot be controlled. There may be more scope for a systematic approach to multilateral aid.

Does aid have to be unpredictable in the long run? Lane Chris, Glassman Amanda (2008) Smooth and Predictable Aid for Health: A Role for Innovative Financing? Available from: http://www.brookings.edu/~media/Files/rc/papers/2008/08_global_health_glassman/08_global_health_glassman.pdf

“This paper presents evidence that aid flows to the health sector are volatile in terms of observed outcomes and uncertain in terms of making and delivering future commitments. The aid is therefore poorly suited to fund recurrent costs associated with achieving the Health Millennium Development Goals, particularly funding of Primary Health Care (PHC) facilities that are key to achieving maternal and child health goals. Recent aid financing innovations have begun to address some of the inadequacies of the health aid architecture through more stable and long-term financing for health.”

→ Global Health Funds can provide aid that is more predictable, which is needed to finance recurrent costs, like salaries for health workers?

Are Global Health Funds providing aid for salaries of additional health workers? World Health Organization (2009) Initial Summary Conclusions: Maximizing Positive Synergies between Health Systems and Global Health Initiatives. Available from:
<http://www.who.int/healthsystems/New-approach-leaflet-ENv2-p4p.pdf>

“To date, GHI investments in human resources have been largely focused on in-service training for disease-specific programmes, task-shifting, and on increasing numbers of less qualified health workers who require limited training. These measures now need to be supplemented with more ambitious action to address long-term human resources shortages, which are keenly felt in many settings.”

→ Why?

- “Raise it, spend it, prove it”?
- ‘Division of labour’ with World Bank?
- Disease-specific objectives encourage training for specific tasks only?

More research, and perhaps soul-searching is needed

Ooms Gorik, Hercot David, Assefa Yibeltal, Van Damme Wim (2010)
 The New Dichotomy in Health Systems Strengthening and the Role of
 Global Health Initiatives: What Can We Learn from Ethiopia? Available
 from: [http://www.palgrave-
 journals.com/jphp/journal/v31/n1/pdf/jphp200954a.pdf](http://www.palgrave-journals.com/jphp/journal/v31/n1/pdf/jphp200954a.pdf)

Table 1: The new dichotomy in figures: Additional resources needed to strengthen health systems in 49 low income countries¹

<i>Additional resources by 2015</i>	<i>WHO normative</i>	<i>MBB medium</i>
Health centres	88 960	12 307
Health posts	0	57 816
Physicians	349 953	35 879
Nurses and midwives	1 699 107	203 013
Community health workers	950 705	1 642 076
Costs per annum in 2015 (US\$ billion)	45	36
Recurrent costs per annum in 2015 (US\$ billion)	43	17

→ Are Global Health Funds unintentionally leaning towards the MBB approach?