

Financing the Health of Every Woman, Every Child post-2015¹

Background and Progress since 2010

The Global Strategy for Women's and Children's Health, launched in September 2010 by the UN Secretary-General, has contributed to significant progress worldwide toward optimal women's and children's health. Since 2010, the number of actors committing to the improvement in women's and children's health has almost tripled, from 111 commitment-makers in 2010 to 300 in 2014 (Figure 1). This group is made up of a broad cross-section of partners ranging from academic institutions to private sector actors and foundations. The capacity of the Every Woman Every Child (EWEC) movement to attract and maintain partners over time indicates a high degree of sustained political commitment to women's and children's health.

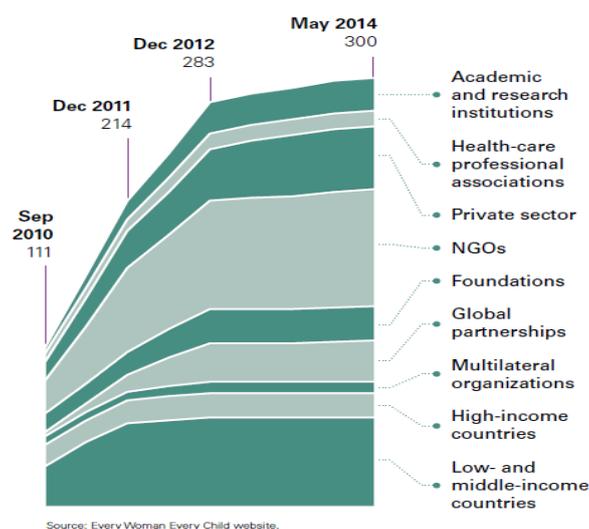


Figure 1: Global Strategy commitment-makers nearly tripled from 111 in 2010 to 300 in 2014

With more actors stepping forward, disbursement of pledged funds has seen a steady growth over time. By May 2014, almost 60% (US\$34.2 billion) of the Global Strategy financial commitments were disbursedⁱ (Figure 2). In other words, EWEC stakeholders are on track to deliver on their commitments.

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EWEC Technical Content Workstream Working Group on Financing
(24/03/2015)

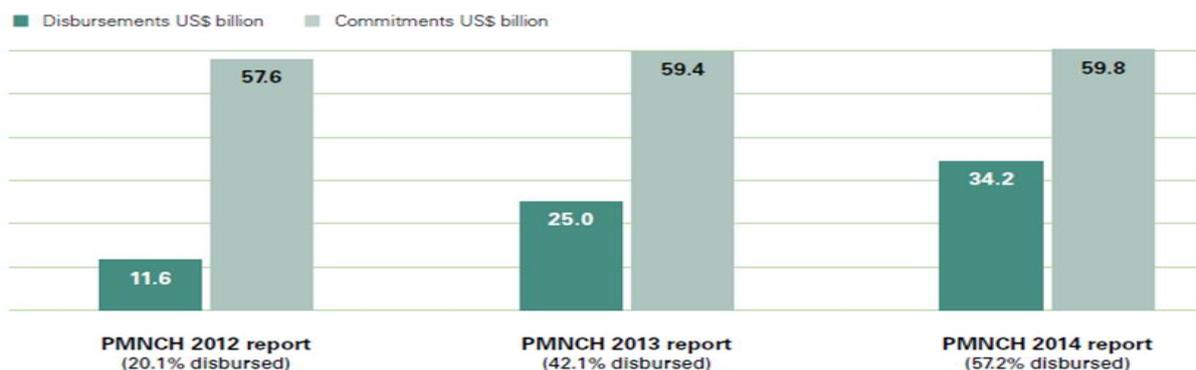


Figure 2: Trends in Global Strategy disbursements

Financial commitments to the Global Strategy are approximately US\$ 60 billionⁱⁱ (Figure 3) with 27 low income countries contributing 18%, or almost 11 US\$ Billion (Table 1).

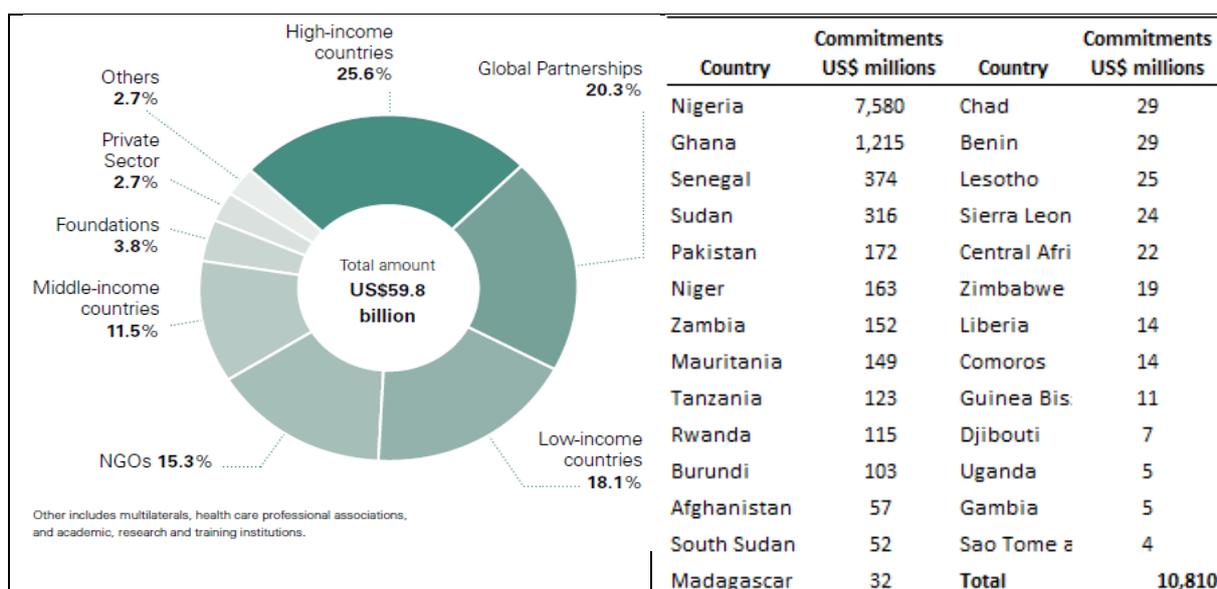


Figure 3: Financial commitments to the Global Strategy have reached almost US\$ 60 billion

Table 1: 18 percent of the 60 US\$ billion comes from low income countries

The largest commitment-makers to the Global Strategy include many different constituency groups (Table 2). These leaders in philanthropy are not just donors and foundations, which is a clear sign that the EWEC movement has been able to mobilize actors across constituencies.

Table 2: 20 largest commitment-makers to the Global Strategy

20 Largest commitment makers to the Global Strategy

Commitment-maker	Commitment, US\$ millions	Constituency group
1 GAVI	7,599	Global Partnerships
2 Nigeria	7,580	MICs
3 United Kingdom	6,590	HICs
4 The Global Fund	4,400	Global Partnerships
5 India	4,375	MICs
6 Indonesia	2,406	MICs
7 Save the Children	2,000	NGOs
8 CARE	1,800	NGOs
9 Population Services International	1,630	NGOs
10 Norway	1,621	HICs
11 Bill and Melinda Gates Foundation	1,570	Foundations
12 Australia	1,500	HICs
13 World Vision International	1,500	NGOs
14 Merck	1,349	Private Sector
15 United States of America	1,346	HICs
16 World Bank	1,300	Multilaterals
17 Ghana	1,215	MICs
18 Canada	1,058	HICs
19 Netherlands	1,011	HICs
20 Marie Stopes International	872	NGOs

Note: Constituency group has been updated to reflect 2015 World Bank income classification

Despite coming out of a worldwide economic downturn, the world has remained resolute in its commitments to the Global Strategy, with steadily increasing spending on women and children's health through continued growth in ODA disbursementsⁱⁱⁱ for RMNCH (Figure 4), with an average increase of 11% per annum.

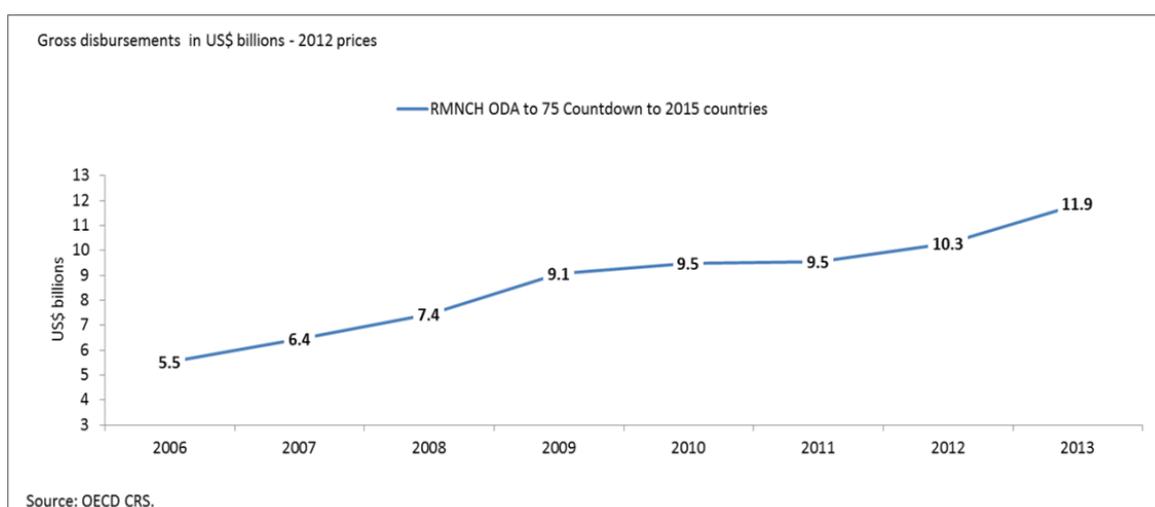


Figure 4: RMNCH ODA to 75 Countdown to 2015 countries

The Investment Case for Women and Children’s Health post-2015

The evidence is strong that we should clearly see investments in health as those generating both human and financial returns as seen in lives saved and the correlation between economic growth and healthy populations. With regard to financing from lower income countries (LICs) and lower middle-income countries (LMICs), the economic growth that they are expected to undergo will create larger domestic “fiscal space” for health financing^{iv} that will far exceed cost estimates to finance health over the 2015-2030 period. Recent estimates have noted that as much as 25% of full-income growth in low and middle income countries between 2000 and 2011 resulted from improvements in health^v.

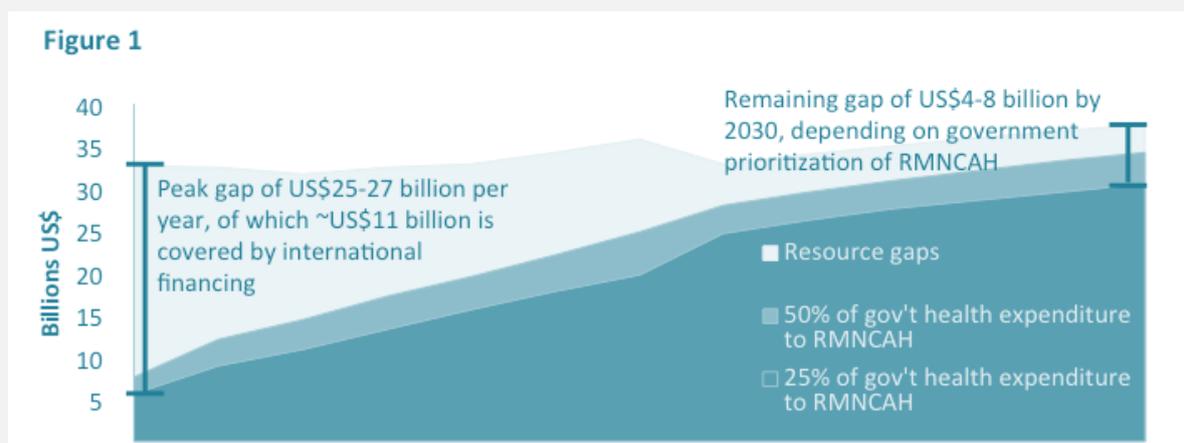
In addition, the costs of under-preparedness cannot be overemphasized, as evidenced by the recent Ebola epidemic. Had we collectively invested in stronger health delivery and surveillance systems, billions of dollars in costs could have been averted.

Investing in Every Woman, Every Child: A post-2015 Financing Framework

Needs and Gaps

Understanding the resources needed

Modelling of the resource needs for RMNCAH highlights the urgency of scaling up financing in a dramatic fashion: the resource gap in 2015 currently stands at US\$27 billion in high burden low- and lower-middle-income countries. This gap decreases over time as economic growth fuels domestic resource mobilization, although the final gap is quite sensitive to the extent to which governments prioritize financing for RMNCAH, ranging between US\$4 billion and US\$8 billion. If the current rates of domestic and ODA increases are maintained, the total need of \$198 billion for the next five years will be reduced to a remaining gap of \$30 to \$50 billion.



As the global community transitions from the Millennium Development Goals to a post-2015 world of Sustainable Development Goals, a considerable part of the agenda with regard to maternal and child health remains unfinished, despite the progress made to date as noted earlier. Far too many newborns, children, adolescents, and women still die of preventable conditions every year, and far too few have reliable access to quality health services. A large funding gap remains – US\$7.68 per

capita per year in high burden, low- and lower-middle-income countries² – that can only be addressed by dramatic increases from both domestic and international sources from the public and private sectors. Economic growth has the potential to provide considerable resources, but recent experience demonstrates that the transition from low- to middle-income status is often accompanied by widening inequities between rich and poor and insufficient prioritization of health. Poor targeting, inadequate use of evidence, and fragmented financing contribute to reducing the efficiency of existing investments. The poor state of civil registration and vital statistics systems handicaps the ability to monitor progress and base decisions on sound evidence. A lack of a fully financed health workforce, particularly at community level in many countries, robs the health system of its first line of preventive action and defence, as well as misses a crucial employment opportunity.

Transitions and Graduations

In this next phase of the Global Strategy, we expect significant shifts in the global economic picture, the health financing landscape, and the development financing landscape more broadly.

According to analysis conducted at the Bill and Melinda Gates Foundation, between 2014 and 2030, approximately 41 countries are expected to graduate from the World Bank's fund for the poorest, the International Development Association (IDA). Additionally, 15 countries are expected to graduate from the African Development Bank's "Africa Development Fund", 15 countries are expected to graduate from the Asian Development Bank's "Asian Development Fund", and as many as 38 countries are expected to graduate from the Global Alliance on Vaccines and Immunization (Gavi). Such "graduations" can be welcomed as a sign of prosperity and progress, but also must be managed carefully to ensure that those at greatest risk are not left behind.

Experience has shown that this will not occur automatically: while for low-income countries, each percentage point increase in economic growth is associated with a growth in government spending on health of more than one percentage point, this drops by more than half in lower-middle-income countries.³ The impact of this decline is compounded by the fact that as countries reach lower-middle-income status development assistance for health begins to fall as the graduation policies of donors start to take effect. These combined effects can create significant challenges for countries, particularly given that they often come at the same time that these countries are dealing with other issues such as decentralization, a greater need to address equity – including addressing "pockets of vulnerability" – and a shift to an growing burden of non-communicable diseases.

Closing the Gap

As noted in Figure 1, we estimate that the financing gap over the first five years of the Global Strategy to be approximately US\$30 billion to US\$50 billion, depending largely on estimates of domestic expenditures. There is no single solution to close the gap, and strategies will vary by country and by region. In addition, the remaining financing gap over the next five years is concentrated in low and

² World Bank, "Global Financing Facility in Support of Every Woman Every Child", [Concept Note], 2014. This estimate refers to the 63 low-and lower-middle-income high burden countries identified by the "Countdown to 2015" initiative. It builds on estimates from the Global Investment Framework for Women's and Children's Health and the Lancet Commission on Investing in Health.

³ Xu, K., et al., "The Determinants of Health Expenditure: A Country-Level Panel Data Analysis", Results for Development and the World Health Organization, 2011.

lower middle income countries, which comprise almost 75% of the financing gap. 92% of maternal deaths and 87% of all under-5 deaths occur in low income and lower middle income countries. By themselves, the lower income countries makeup 26% of the financing gap.⁴

It is important to note that while a diversification of our collective resource base is required, the role of ODA – at least in the short-to-medium term will remain essential. With ODA for RMNCH growing at an average of 11% per annum, there is wide variation across country contexts and targeting of resources to the areas of highest mortality burden and financial need. Going forward, the role of ODA in many cases is likely to shift, as its relationship to both domestic and private sources of capital must be considered. The question of how we create more diversified funding streams to support RMNCAH will be critical. For instance, development assistance (including grants, credits, loans, and guarantees) might be able to “crowd in” other sources of financing and necessitates a more nuanced conversation at country and global level. In addition, we must bear in mind that there are three ways to close a gap – raise revenue, reduce costs or increase efficiencies. ODA also has a clear role to play in helping to bring about increased efficiencies across the financing chain, for instance, through pooled procurement, risk sharing, and other means.

Domestic expenditures for health have grown over the 2010-2015 period at approximately 4.3% per annum, with wide variation across countries. The growth rate is clearly insufficient to make up the gap, and without significant reprioritization of expenditures at country level – absent significant increases in revenue - the shortfalls are unlikely to be bridged through domestic spending alone.

A range of financial instruments exist today that can assist in crafting a more nuanced and sophisticated solution to the funding gap, moving beyond has too often be a binary conversation regarding ODA and domestic funding.

Deploying these innovative financing models at the global, regional, and national levels could play a critical role in addressing funding needs, helping countries to access domestic and regional monies, and transitioning responsibly from dependence on foreign aid. Innovative financing has mobilized nearly \$100 billion for health and development between 2001 and 2013, and it has grown by about 11 percent per year.⁵ Examples of innovative financing instruments can include remittance funds, debt conversion mechanisms, solidarity and “sin” taxes, debt raising mechanisms such as Health Bonds, credit enhancements and guarantees, impact investing, and advance market commitments, among others.

Innovative financing is especially appropriate for elements of health care investment that generate considerable returns to the economy, and may potentially allow for countries to pay for a frontloaded effort over a medium- to long term period as they reap the economic benefits of their success. By investing now, countries can stimulate growth and productivity and avert future costs related, for instance, for surveillance systems, and disease elimination. For instance, frontloading investments to stop malaria drug resistance in the Asia, would help the potential loss of effective treatments, which would have devastating consequences. A similar case can be made for investing

⁴ http://www.who.int/pmnch/media/news/2013/gif_mnch_presentation.pdf?ua=1

⁵ Innovative Financing for Development: Scalable Business Models that Produce Economic, Social, and Environmental Outcomes, September 2014.

up-front in health workforce and disease surveillance systems, where a frontloaded investment could result in significant costs averted over time.

Three potential approaches that can play an important role in addressing the significant increase in financing that will be required include:

- *Strategies to raise domestic revenues.* Explore new ways to generate health revenues through taxes on international investment, debt swaps, the floating of bonds marketed to diaspora communities, and the development of domestically funded instruments, including incentives to encourage corporate donations, individual philanthropic giving, and employee contributions.
- *Shift domestic financing into the future.* Use health bonds to shift domestic financing requirements into the future and meet upfront financing needs. Such bonds could be strengthened by securing credit enhancement mechanisms (e.g., pooled financing, guarantees) through multilateral development banks or bilateral agencies and targeting endowment and sovereign wealth funds as investors, which are increasingly looking for investments with joint economic and social returns.
- *Performance-based financing.* This would include mechanisms to raise additional donor funding, including advanced market commitments and impact bonds based on country performance in meeting certain health targets, such as disease elimination.

In order to fully utilize the tools at our collective disposal, a significant strengthening of the funding dialogue at both global and country levels is required to keep pace with the financing opportunities and changing landscape. The emerging partnership around the *Global Financing Facility for Every Woman, Every Child* could serve as a broker at country, regional, and global levels to bring to bear the range of financing solutions available to close the gap, keeping each country's Investment Case at the center. For instance, following the development of each Investment Case, a "marketplace approach" could be taken to allow the fully array of public and private sector players to determine the best way for as much of the gap as possible to be closed.

Five "Strategic Shifts" Going Forward

Looking forward, this Strategy proposes five "strategic shifts" in the financing landscape for women and children's health in a post 2015 world.

First, we will actively support the Value for Money Agenda - - aiming at more health for the money, more money for health. Important pathways to achieve this are to increase the share of total health expenditures that is pooled, reduce barriers to the reallocation of these funds towards priority services and beneficiaries, and implement strategic purchasing. This requires a more effective dialogue between Ministries of Health and Finance in order to leverage more efficient and equitable domestic financing. A particular attention will be given to strengthening of countries tax capacities to expand the overall fiscal envelope, policy dialogue with Financing Ministries and sub-national bodies on priorities, and innovative financing mechanisms such as expansion of sin taxes (alcohol, tobacco, sugar etc.). Finally at global level, a tax on financial transaction could be seen as generating funding for the expansion of maternal and child health services.

Second, we suggest fostering an integrated approach to the "unfinished agenda", breaking the silos between the financing flows for women and children health and communicable diseases (HIV, TB, malaria). This will require an enhanced collaboration between the international agencies around the agenda of health system strengthening and universal health coverage in the view of reaching the hard-to-reach populations, while strengthening the funding base for those activities with clear externalities, such as the eradication of malaria. To support this agenda, we will put in place a rapid financing response platform for disease outbreaks, while also ensuring financing for health delivery and surveillance systems to prevent and respond to disease outbreaks. As evidenced by the recent Ebola outbreak, we simply cannot wait for "the next Ebola" to occur, and must put in place the financing and delivery infrastructure now for future outbreaks.

Fostering such an integrated strategic approach involves comprehensive national financing strategies with sets of clear outcomes and funding flows that are country led and developed in consultation with various stakeholders. They should go beyond development financing agencies and include government spending, private sector, individuals, business, and civil society. Institutional arrangements for pooling these funds and allocating to defined benefits for the population should be developed and implemented.

Third, we must develop a better mechanism for financing the health of women and children who live in conflict or post-conflict settings. Currently, over half of all remaining child and maternal deaths occur in areas that are in conflict or just recovering from conflict. Within our current health aid architecture, these settings tend to fall between the cracks of humanitarian assistance and development assistance. A new approach is required to finance the improved health of people in these settings, as well as to hold service providers accountable for results.

Fourth, we need to support the dialogue at country and global level to reduce regressive subsidies and reallocate the freed resources to programs targeted to the poor. The case is to be made to redirect "harmful" untargeted carbon and agriculture subsidies towards subsidies for programs for poor women and children (including conditional cash transfers and expansion of health insurance for women and children).

Fifth, we must explicitly focus on financing and incentivizing innovation. The "pipeline" of innovation is the most robust it has ever been for women and children's health. However, without clear attention to the financing and regulatory pathways that enable these innovations to be scaled, there will be substantial delays in the availability of life-saving innovations to reach those women and children who are most in need of them. We should develop pathways for private investment and innovative financing approaches to more easily scale-up access to and quality of health care. As much as possible the donor-supported programs will integrate results focused approaches (e.g., results based financing, output based aid, etc.) with much attention to integrating aid flows into country public finance management systems. The programs should include support to institution building, in particular building strong health purchasing agencies and related governance and accountability measures. While our toolbox of innovative financing options could not be fuller, there are still few examples of this financing operating at substantial scale. By actively encouraging investments, and creating a dialogue around key gaps and how innovative financing approaches might help fill them, we stand a better chance of these investments supporting large-scale impact.

Next Steps

A gap of this magnitude will not be bridged without a significant re-imagining of the way in which our various sources of financing for health care are organized, and will not be bridged through

harmonization alone, which is necessary but not sufficient. More resources are required, especially over the short-medium term, a period in which economic growth rates alone will not be sufficient to bridge the funding gap, nor will existing ODA. As a result, more creativity is required to examine the inter-relationships between existing sources of funds.

We call for an unprecedented front-loading over the coming 5-10 years to finance the next phase of the Global Strategy and to bring to bear in a collaborative fashion the entire range of financing opportunities outlined here, domestic and international, public and private, to accomplish this task. ***A clear financing plan with concomitant agreements based on Country Investment Cases, to close the overall gap would need to be in place no later than by the end of the first 12 months of the Global Strategy, and with annual high-level check-ins each year thereafter.*** While this is an ambitious call, anything short of it would result in the curve becoming too steep in future years to meet the post-2015 targets.

We would seek to reap the full benefits and financial capabilities of the multilateral development banks, such as the World Bank, Inter-American Development Bank, Asian Development Bank, and Islamic Development Bank. The emerging New Development Bank, or BRICS Bank, also presents an opportunity. Grant financing available from bilateral governments and organizations such as The Global Fund, Gavi, UNITAID and other pooled funds could be deployed in such a way that leverages the multilateral development bank platforms to bring significant additional resources to the table. Similarly, proceeds from “sin taxes” and the proposed “extractive industry” taxes can similarly be brought to the table.

The financing mobilized thus far in support of Every Woman, Every Child, and the remarkable reductions in suffering and death that is has enabled proves that success is possible. Now, we must reach even further, and bring our collective will and creativity to bear to finance not only a reduction in, but an end to, preventable child and maternal deaths by 2030, along with an end to the epidemics of HIV/AIDS, TB and malaria.

Background documents:

Financing for Development Post-2015 (October 2013), The World Bank Group
<http://www.worldbank.org/content/dam/Worldbank/document/Poverty%20documents/WB-PREM%20financing-for-development-pub-10-11-13web.pdf>

Preparatory Process for the 3rd International Conference on Financing for Development (21 January 2015)
<http://www.un.org/esa/ffd/>

The PMNCH 2014 Accountability Report - Tracking Financial Commitments to the Global Strategy for Women’s and Children’s Health
http://www.who.int/entity/pmnch/knowledge/publications/pmnch_report14.pdf?ua=1

The PMNCH 2013 Report - Analysing Progress on Commitments to the Global Strategy for Women’s and Children’s Health
http://www.who.int/entity/pmnch/knowledge/publications/pmnch_report13.pdf?ua=1

The PMNCH 2012 Report - Analysing Progress on Commitments to the Global Strategy for Women’s and Children’s Health

http://www.who.int/entity/pmnch/topics/part_publications/2012_pmnch_report_full_publication.pdf?ua=1

The PMNCH 2011 Report: Analysing commitments to advance the Global Strategy for Women's and Children's Health:

http://www.who.int/entity/pmnch/media/press/2011/2011_pmnch_report/en/index.html

ADD GFF CONCEPT NOTE AND BUSINESS PLAN HERE

ⁱ The figure refers to financial commitments only, and that in addition to these, many commitments were made to the Global Strategy that are not easily monetised i.e. more has potentially been committed than the numbers alone are showing.

ⁱⁱ The amount is for the time period 2011-2015. New commitments for period until 2020 are being made and listed on EWEC website but are not (so far) included in this estimate.

ⁱⁱⁱ The Muskoka methodology was used to calculate Official Development Assistance (ODA) for RMNCH. For background on the Muskoka method, refer to

<http://www.g8.utoronto.ca/summit/2010muskoka/methodology.html> (accessed 31 July 2014)

^{iv} Jamison, Dean et al. Global health 2035. A world converging within a generation. *Lancet*, 2013, 382: 1898–1955.

^v The Lancet Commission on Investing in Health. Global Health 2035: A world converging within a generation. *The Lancet*. December 2013. Cited in the Global Push for UHC brief prepared by our Unit.