UHC2030 Technical Working Group on Sustainability, Transition from Aid and Health Systems Strengthening

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uhc2030
International Health Partnership

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1. Introduction

The International Health Partnership for UHC2030 (UHC2030) was established in 2016. The partnership is co-hosted by WHO and the WB and work is facilitated by a small secretariat. The objectives of UHC2030 are to:

1. Contribute to improved coordination of HSS efforts for UHC at a global level, including synergies with related technical networks;
2. Strengthen multi-stakeholder policy dialogue and coordination of HSS efforts in countries, including adherence to IHP+ principles and behaviours in countries receiving external assistance;
3. Facilitate accountability for progress towards HSS and UHC that contributes to a more integrated approach to accountability for SDG3; and
4. Build political momentum around a shared global vision of HSS for UHC and advocate for sufficient, appropriate and well-coordinated resource allocation to HSS.

Sustainability, health system strengthening and transition from external financing were identified as topics where the new partnership might add value by facilitating linkage and synergy of ongoing work streams. It was subsequently agreed that a UHC2030 working group should be set up and included in the work plan approved by the UHC2030 Transitional Steering Committee in December 2016.

The first face-to-face meeting of the new UHC2030 Technical Working Group on Sustainability, Transition from Aid and Health System Strengthening was held 30–31 March 2017. The meeting was chaired by Midori de Habich, former Minister of Health of Peru, and Kara Hansen, Professor of Health System Economics at LSHTM. The aims of the meeting were to:

1. Present and discuss some of the major ongoing work related to transition planning; and
2. Map out priority areas, key outputs and products for inclusion within a work plan for the working group on transition.

Box 1. Membership of the working group

- International Health Partnership for UHC2030 hosting organizations:
  - WB
  - WHO
- Countries: South Africa, Indonesia, Estonia, Kenya, others tbc
- Bilateral: EC, Japan, Germany, USAID, Australia, DFID, others
- GAVI, GF
- BMGF
- Civil society
- Academia/think tanks (Johns Hopkins, LSHTM, R4D, Center for Global Development, others)

Aim: To explore roles, responsibilities and opportunities for collaboration among DPs, expert networks and countries to enhance efforts to sustain increased effective coverage of priority interventions with financial protection, in countries transitioning from receiving aid.

2. Excecutive summary

2.1 Findings from a rapid background mapping – key messages

To facilitate discussions in this first meeting, a rapid mapping of work on transition supported by the working group members was undertaken. Findings include:

- Diversity of definitions and understanding of the **'transition concept'** was evident among working group members.
- Definitions of **'sustainability'** are also varied but most tend to have a focus on increased coverage and health outcomes/impact.
- Limited work on the effects of **multiple exits or transitions** in one country.
- Limited evidence of the **effectiveness of transition policies over time** across programmes focusing on the whole health sector.
- **Evolving consensus** to work towards a focus on 'sustained coverage of priority interventions in the sector' rather than focusing on 'programme sustainability'.
- **Transition provides opportunities** and an entry point to identify what health system strengthening is needed (what to continue, where to integrate and adapt systems to increase efficiency).
- **Limited advocacy on UHC at country level and political engagement** on implications of sector-wide transition is underdeveloped.
- Recognition of the **importance of strengthening institutions and capacity** and that this takes time, but it is not always clear how this translates at country level by the various partners.

2.2 Feedback from the countries – key messages

- There are multiple transitions from external finance ongoing with **multiple transition assessments** and there is a need for the process to be more orderly. Countries are interested in how to **use the resources – domestic and external – in a more efficient manner that would benefit the population as a whole** and would like to learn from countries like Thailand and Estonia about their progress towards UHC. Transition countries are interested in a more coordinated approach led by government and **partnerships for capacity strengthening**, as well as a means of strengthening UHC monitoring, accountability and advocacy.
- Generally, donor priorities need to follow country priorities but in some instances **external funding may help convince a government on certain priorities, for example working with marginalized groups. Low-cost sharing can increase the risk of compromising cost efficiency.** Governance needs to involve those expected to continue work after external finance ends. Capacity of the recipient country is most important and **sustainability should be regarded as the ability to achieve the agreed health system objectives.**

- For many countries, the **main issues related to transition from external finance are not financial but rather are related to the value of technical assistance, opportunities for cross-country learning on UHC, and advocacy opportunities for UHC.** Technical capacity and national systems need to be continuously improved and there is a need to build mechanisms in relation to transition that will ensure this. Another important issue is **the ability of partners to work with non-state actors, for example regarding HIV. There are currently no regulatory frameworks to cater for financing non-state actors within the public health system in some countries. For long-term sustainability, capacity at the district level can be critical,** ensuring minimum standards, and programme and managerial capacity.

- Transition and sustainability is **first and foremost a matter of national ownership and therefore the government would like to be in the driving seat.** These processes can be successful only if all stakeholders become part of them – including the different line ministries and sectors, civil society, both public and private providers, and above all, the citizens concerned – and push hard for health for all rather than focusing on single programmes. **Accountable leadership needs to coordinate all these efforts, and design an orderly transition process with the emphasis on strengthening the capacity of institutions and optimally linking with the wider system.**

2.3 Concepts and unit of analysis – key messages

- Transition away from donor financing needs to be viewed in the context of the overall health financing, macro-fiscal, political, and institutional dynamics within a country. On average, **the critical issue in most transition countries will not be the availability of funds. Rather, more attention needs to be paid to how all funds are allocated and used in the system.** Even in countries with resource constraints, a differentiated transition financing strategy is not justified. Instead, **all countries should work to diversify and strengthen domestic resource mobilization and improve efficiency to get more from their health spending.** Doing so will involve policy interventions that are tailored to each country's specific context. Understanding the macro-fiscal context in terms of willingness and ability of governments to increase public financing for health will be critical.

- The challenges faced by countries that will undergo transition go well beyond financing and pertain to how donor support has evolved. The MDG era of donor financing resulted in a verticalization of health programmes focused in large part on specific diseases or interventions and resulted in separate plans, budgets, funding, procurement, and other systems by programme or donor. The SDGs face the same risk, unless opportunities are seized to build UHC as an umbrella, moving away from silos to a stronger focus on efficient use of resources and increasing tax revenues**.** As donor support declines, this fragmented organizational approach will be left behind in countries and it is therefore the responsibility of partners to support ways of mitigating resulting inefficiencies.

- UHC brings a system-wide lens that is needed to tackle the challenges related to sustainability and transition. This stresses that all programmes and priority interventions fall within the overall health system and are part of coverage objectives. Therefore, the discussion around

transition focuses on sustaining increased effective coverage of priority interventions towards UHC. This perspective is needed because while specific health programmes might be well run, if they duplicate functional responsibilities (e.g. contracting with providers, procurement systems, etc) they impose high costs on the system as a whole. **It is important to develop a consensus among countries and partners on this point – the unit of analysis should be the system and not a specific programme or disease.**

- Focus should be strengthened on **how incentives are established at the design phase of any interventions.** Institutional frameworks can be at odds with stated policy objectives. **There is a need to (re)focus funding early to strengthen underlying systems and for financing to develop a better understanding of constraints and enablers for integrating priority services into basic benefit packages.**

- Transition provides a political opportunity. Collective financing for health is driven by taxpayer's choices and citizen voice for health. Efficiency, on the other hand, is driven by systems of accountability. The latter includes, among others, regulatory and legal frameworks that help govern public financial management, rights and entitlements, procurement, accreditation, etc. For transition support strengthening, the governance capacity of the ministry of health, which is sometimes weakened by parallel governance structures, is central. **In transition countries, strengthening national institutions is at the core of health system strengthening.**

Box 2. Scope of work for the group as per TOR

- **Build consensus around core issues and objectives in response to the transition from aid**, exploring revenue and health system efficiency considerations, as well as approaches to strengthening accountability for results.
- **Develop guidance and principles for good practice** pertaining to countries transitioning from ODA support, with regard to financial, programmatic and capacity issues, including but not limited to, for example, how to develop country-specific transition plans to balance the transition schedules of multiple funding partners.
- **Explore the types of reforms and investments needed to support an effective transition process**, particularly in relation to building strong and unified underlying support systems, such as for procurement, supply chain, information, as well as capacity for evidence-informed priority-setting processes.
- **Define an annual work plan** for the group, outlining key outputs and products and help convene parties to review progress.

2.4 Suggested role and potential areas of work for the group

Mapping country experience

The group could:

- Collect country experience during transition to inform transitional approaches and behaviours (e.g. country case studies); and
- Build on the mapping done for this meeting and select a subset of countries and **do mappings of transition experiences from country perspectives.** The issues arising from this should inform the operational planning for the group.

Identifying major pressure points

- As contexts vary widely between countries, the group could classify the most pertinent types of issue, as these will vary widely according to context, UMIC and LIC, etc.
- The group could develop **an overview of the main pressure points** related to external finance transition and sustaining coverage of priority interventions and help organize work streams around addressing these.

Build consensus on core issues

The group could:

- Help forge a **consensus on core concepts including the correct framing for the 'sustainability question', pushing the technical agenda towards a better understanding of the guiding principles and core issues;**
- **Push for appropriate design of external finance** that takes into consideration incentives for domestic budget response and fungibility (from the perspective of the system rather than the programme);
- Work on **ways of building national capacity** for comprehensive engagement between the ministries of finance and health (rather than many approaching MOF with separate disease programme issues) and a focus on fundamentals rather than undue fascination with innovation and quick fixes;
- Help facilitate a consensus on areas where more conceptual clarity is needed, for example public and personal health services and harmonization of incentives, and advocate for the importance of capacity building and work on strengthening underlying subsystems; and
- Develop and agree **a glossary of key terms** in relation to transition.

Development of lesson learning and guidance

The group should:

- **Develop guidance and best practice** on how successful transition should happen at country level. What are the barriers and enabling factors for the focus to be on the system as a whole and sustaining coverage of priority interventions?
- Share country lessons and develop guidance and good practice on **social contracting;**
- Facilitate better support to countries for improving the planning for transition, at the national level, as countries are in some cases "falling off a cliff", and preparation is often not sufficient. There are also opportunities to **develop principles for a more harmonized way of working at country level** as multiple assessments are ongoing. A stronger focus is needed on what happens after assessments, and best practices on strengthening institutional capacity;
- Help to look at **thresholds and graduation policies;**
- Share available work on experiences of **integrating areas previously supported by ODA, for example immunization and TB into BBP** incentives and disincentives, and understanding the needed sequence of steps to strengthen institutional capacity;
- Help link countries together for **peer-to-peer learning** on transit from external finance and the interface of this and moving forward towards UHC; and
- **Highlight gaps in health system support** and help efforts to streamline this.

Joint action at country level

- A lot of coordination among partners happens at the global level but this is often not reflected at country level. Therefore, the recommendation is **to identify countries for joint action** and try to provide assistance not only on technical issues but also on political influence and making things happen.

Techncial and political influencing

The group has a role in:

- **Linking** the work on sustainability and transition to the **higher political level for more effective follow-up at the institutional level** among the different actors;
- Adding value by helping to **bring the 'programme' and 'system' communities together**, and influencing the political aspect of needed changes both at international and national levels;
- Sharing learning from country experience, for example **generating political priority for health** in complex transitions; and
- Identifying new and common technical issues for learning, for example integration, efficiency.

Advocacy

- There is a perceived **lack of advocacy for health systems** as opposed to advocacy for a programme or specific disease, and the group could have this as a subtopic to focus on ways of stepping this up. Civil society has contributed significantly on advocacy for various disease control efforts but its engagement on HSS horizontal issues and community strengthening has been less supported and hence weaker.

Areas suggested the group will *not* work on

- Harmonizing all tools for assessment and transition
- New tools
- Studies without related capacity building
- Building a pool of experts on transition.

3. Day one: Transition from external finance and country perspectives

3.1 Discussion on ongoing work related to transition

Findings from a rapid background mapping

Veronica Walford and Clare Dickinson, International Health Partnership for UHC2030 consultants

An overview was provided of the rapid mapping of group member policies and definitions on transition. This highlighted the diversity of definitions and understanding of 'transition' among working group members. Definitions of 'sustainability' are also varied but most tend to have a focus on increased coverage and health outcomes/impact. The policies of working group members on transition also varied. Global Health Initiatives (GHI) have formal policies that include objective criteria and roadmaps for transition with country guidelines in place. GF and GAVI also have fairly long timelines for transition, growing domestic finance share, regular monitoring and recognition of the need to embed transition early on in programme design. Their policies also underline alignment with health plans and the need to fund the health sector overall. Bilateral partners have less formal policies; triggers for transition can include various factors, not just funding ability. When bilateral funding ends, other modalities for engagement through pooled technical assistance (TA) and centrally managed funds continue. The WB and WHO tend to have a sector perspective on transition and focus on the bigger picture.

For the majority of members, sustainability means increased effective coverage of priority interventions to progress to UHC rather than sustainability of particular programmes. Health financing transition work focuses on improving efficiency while ensuring service coverage and reducing out-of-pocket (OOP) reliance. For other members – including academia, BMGF and civil society – transition work is a priority; however, explicit policies are not in place and the focus is on a variety of analytical work and the development of tools to inform policies and influence political engagement on transition. For BMGF, work has focused on developing systematic transition finance mechanisms to support countries transitioning from different funding partners.

Broadly, three categories of transition work can be seen: (1) programme-level work, for example preparedness and assessment tools; (2) health system assessments and support, for example health technology assessment (HTA), fiscal space analysis, public financial management (PFM) alignment to financing systems; and (3) conceptual thinking and learning for policy development, for example reviews in most cases focusing on one funding source. While there is consensus on some of the elements of a successful transition, multiple tools and planning processes are sometimes required of countries – at times in an uncoordinated way. All recognize that building capacity takes time and there is a need for a system perspective but it is not clear if this translates into direct work on integrating and supporting systems for prioritization.

Apparent gaps include scarcity of reviews that look at multiple exits in one country and limited evidence on the effectiveness of policies over a period of time. Advocacy on UHC at country level appears to be limited and political engagement on implications on sector-wide transition is underdeveloped in many countries.

Opportunities exist to link transition to work on different parts of health system efficiency and forging collaborations across the system. There are also opportunities to develop principles for more harmonized ways of working at country level and provide a stronger focus on what happens after assessments, and best practices on strengthening institutional capacity.

Institutions for transition towards UHC

Agnes Soucat, Director, Health Systems Governance and Financing, WHO

> *'Defining transition in which the per capita amount of external financing declines while indicators of (1) overall population and health and (2) overall access to health services do not decline'*
> William Savedoff

Data show that in LIC, including in fragile states, external finance constitutes about a quarter of THE, whereas in MIC this is often <5% of THE. Looking at LMIC countries where typically partners are withdrawing and taking the subset of countries graduating from GF and GAVI as an example, data show that while progress can be made in improving government prioritization of health, public health expenditure per capita is higher than the LMIC average. Transition from external finance is therefore both about revenues and efficient use of resources. Dialogue with a MOF cannot be done on a programme-by-programme basis; the focus needs to be on streamlining architecture across programmes and investing in underlying systems for best results, as well as effective domestic revenue generation and allocation at sector level. Critically, this needs to be accompanied by efforts to strengthen institutions and processes that support and enable system efficiency and performance.

WHO articulates three categories of health system support: support to health system foundations, strengthening institutions, and transformation support. The MDG era saw many vertical funding streams, with separate planning, budgeting, procurement and monitoring at times stimulating domestic fragmentation. The SDGs face the same risk, unless opportunities are seized to build UHC as an umbrella, moving away from silos to a stronger focus on efficient use of resources and increasing tax revenues for the sector. **In transition countries, strengthening domestic institutions is at the core of health system strengthening. Collective financing for health is driven by taxpayer's choices and citizen voice for health. Efficiency, on the other hand, is driven by systems of accountability. The latter includes, among others, regulatory and legal frameworks that help govern public financial management, rights and entitlements, procurement, accreditation, etc. For transition support strengthening, the governance capacity of the ministry of health, which is sometimes weakened by parallel governance structures, is central.** This includes, for example, institutional capacity for HTA and strategic purchasing, systems for strengthening evidence-informed policy, standard setting, and importantly, implementation capacity. Evidence-based comprehensive health sector strategies, developed in a participatory manner, should reflect overall health system objectives of integrating priority programmes with key subsectors such as human resources, pharmaceuticals and others.

Discussion

Citizen engagement is very important and here disease programmes like the HIV programme can share their experiences in engaging not only civil society but also parliament to strengthen citizen voice. There needs to be clarity of timelines for transition and coordination between partners on this. GDP is not necessarily an ideal trigger for transition that instead should be based on performance of the system.

3.2 Country perspectives

Sustainability and transition – why? how? when? The Estonian case

Triin Habicht, Senior Adviser to the Ministry of Health, Estonia

Estonia outlined its experiences of transition from three types of external finance: (1) a GF HIV/AIDS grant, (2) EC structural funds focusing on infrastructure, and (3) a Norwegian grant focusing on the mental health of children.

For the GF experience, the Country Coordination Mechansism (CCM)as a multi-sector structure was helpful as this would have been difficult to initiate without an external stimulus. Some of the practices related to linking the procurement closely to the national health action plan; more rigorous monitoring (e.g. through periodic surveys) also helped strengthen parts of national systems. After the funding ended, the existence of a multisectoral HIV strategy accompanied by a multi-sector agreement with the various ministries involved was important, and WHO follow-up and reviews of the strategy after transition were also helpful. Last but not least, funding ended prior to the financial crisis when political commitment and favourable conditions to overtake financial commitments still existed. EC funds were mostly used for infrastructure investment and perhaps there were lost opportunities to direct the funding to restructure service delivery models but this may also need a different type of investment to an extent. A small part was used for public health (PH) services, which helped raise their profile post-financial crisis. Lastly, the Norwegian funds helped make the political case for a challenging area and stimulated cross-sector work.

Generally, we can say that donor priorities need to follow country priorities; but in some instances, external funding may help convince a government on certain priorities, for example working with marginalized groups. Low-cost sharing can increase the risk of compromising cost efficiency. Governance needs to involve those expected to continue work after external finance ends. Capacity of the recipient country is most important and sustainability should be regarded as the ability to achieve the agreed health system objectives.

Discussion

Some generic lessons can be drawn from the recent financial crisis where many countries had to cut public financing for health. One aspect was the interphase between health financing and institutional arrangements. In times of financial crisis, strong institutional arrangements for finance serve to protect core services whereas those outside such systems, for example public health services, were harder hit as they were in the general budget. How can we offer that protection? Countries that were already running a budget deficit at the start of the finance crisis were harder hit by the crisis but countercyclical measures would have helped.

How funds flow can impact how hard different services are hit during a financial crisis: Greece, for example, made blanket cuts across services that hit hard small separately funded services like needle exchange, triggering an IDU-driven surge in the incidence of HIV infection. Therefore, when considering the sustainability of priority interventions, the structure of a country's public finance system matters.

Moving towards UHC: the role of external finance for health in South Africa

Aquina Thulare, Technical Specialist, Health Economics, National Health Insurance, South Africa
Nellie Malefetse, Director of International Relations for Health, South Africa

THE as a percentage of GDP in South Africa is relatively high: 8.8% (2014). Funds are roughly half public and half private. Government allocation as part of overall government funding is also quite high. GINI coefficient reflecting inequity is 0.69 – among the highest in the world. Most of the private funding covers only 15% of the population. South Africa is an UMIC and external finance constitutes less than 1.4% of THE, and 2.9% of public finance for health, the large majority of which is earmarked for HIV. The burden of NCDs has for some years exceeded that of communicable disease and the country has four colliding epidemics: NCD, HIV/TB, RHMNCH, and violence and injury.

Development coordination structures are in place but fragmentation persists. For some areas there is a multiplicity of partners, for example information systems. If the Ministry of Health does not watch closely there is a risk of fragmentation: at times, partners have gone directly to the provinces and interventions supported have not had interoperability with other key parts of the system, which has resulted in poor use of valuable resources.

South Africa is an UMIC and this status triggers many partners to shift from offering grants to offering loans instead. There are multiple transitions from external finance ongoing with multiple transition assessments and there is a need for the process to be more orderly. South Africa is interested in how to use its considerable national resources more efficiently to benefit the population as a whole and would like to learn from other countries – like Thailand and Estonia – about their progress towards UHC. For transition, there is interest in better ways of coordinating partnerships for capacity strengthening as well as a means of strengthening UHC monitoring accountability and advocacy.

Discussion

Regarding ways in which efficiency could be improved, South Africa is in the process of finance reforms sequencing different steps, including benefit design. Health technology assessments have also been carried out, but there is a need to strengthen technical capacity at the governmental level. With regard to revenue raising, both VAT changes and sin taxes have been discussed; however, earmarking is not looked well upon at the national level.

Transitioning externally funded health programmes – country experience: Indonesia

Pungkas Bahjuri Ali, Director of Community Health and Nutrition, Ministry of National Development Planning, Indonesia

Indonesia has been a middle-income country for several years and is projected to become a UMIC within next two years. National revenues were 17% of GDP in 2013, a small proportion both in regional and income group context. THE and public health expenditure (PHE) as a percentage of GDP are both low (3.6% and 1.1% respectively) and health is only allocated 5.9% of the national budget. OOP was 45% in 2014 but has reduced from 55% in 2010. The majority of revenues are raised at central level while more than 50% of expenditures occur at the district level. Inter-governmental transfers are complex and in some cases fragmented. There is a large informal sector and the system is highly decentralized.

The Indonesian Health Insurance System (JKN) was established in 2015 and since then coverage has increased from 68 million to 179 million (69% of the population). The aim is to expand coverage to the whole population by 2019. The JKN is the largest single payer system in the world.

External finance constitutes a minimal part of THE, but reliance on external funds within particular programmes like HIV, TB, Malaria and Immunization can be between 40% and 60%, although this is reducing. Several partners are phasing out. **The main issues related to transition from external finance are not financial but are related to the value of technical assistance, opportunities for cross-country learning on UHC, and advocacy opportunities for UHC. Technical capacity needs to be continuously improved and there is a need to build mechanisms in relation to transition that will ensure this. Another important issue is the ability of partners to work with non-state actors, for example regarding HIV. There are currently no regulatory frameworks to cater for financing non-state actors within the public health system. For long-term sustainability, capacity at the district level is critical, ensuring minimum standards, and programme and managerial capacity.**

Indonesia is working with the WB on a transition strategy through support from a multi-donor trust fund. Transition should be about increasing coverage of priority interventions. There is a need not only for advocacy to MOH, but also for MOF and other ministries to increase fiscal space for health. To sustain coverage for HIV/TB/malaria, regulation that enables contracting of non-state actors needs to be created. Other needs are to integrate activities into public finance planning and budgeting processes and the health insurance package, to explore public–private partnerships and, last but not least, to improve efficiency.

Discussion

Indonesia's system is decentralized and strengthening district capacity is an important priority. Our externally supported pilots have been useful but because they have been well resourced with staff and capacity it has been difficult to apply lessons for scale-up to the wider system that does not have the same type of resources.

Indonesia is an example of a country where it is not the funding that is the main issue but more how the funding flows and the transition towards social health insurance that is expanding. The need is to understand better what should be done to incentivize previously donor-supported interventions, for example immunization, towards integration within such systems.

Kenya – leadership, multiple assessments, and fragmentation in health sector planning

Regina Ombam, Deputy Director, HIV Investments, National Aids Control Council, Kenya

The annual number of HIV infections in Kenya peaked in 1995 and has since been reducing. Around 70% of funding for the HIV response is external – 16% from public sources and 14% from private sources – and PEPFAR constitutes the largest share of the 70%. For Kenya, preparing for a possible donor withdrawal is a matter of both generating adequate domestic revenue and building the appropriate mechanisms and institutions for smooth transition and sustainability.

The National AIDS Control Council (NACC) in Kenya has done detailed analysis of possible sources for increased domestic financing as well as examining the options for channelling funds and purchasing services, including the potential to set up a separate HIV fund. This was met with quite some resistance from different directions, both at sector level and from other programmes.

Although Kenya is not expected to transition from external aid for its HIV response in the near future, there has been a plethora of offers by different partners to help the country with planning for its transition and sustainability – in most cases these offers are not coordinated among partners and are being proposed without prior discussions with the government.

For the Government of Kenya, transition and sustainability is first and foremost a matter of national ownership and therefore the government would like to be in the driving seat. These processes can be successful only if all stakeholders become part of them – including the different line ministries and sectors, civil society, both public and private providers, and above all, the citizens concerned – and push hard for health for all rather than focusing on single programmes

Accountable leadership needs to coordinate all these efforts, and design an orderly transition process with the emphasis on strengthening the capacity of institutions and optimally linking with the wider system. We look to WHO and the WB to help us with the linkage to the national-level system and strengthening institutions.

Discussion

There were hopes that a new health financing strategy would help deter competition for individual earmarking: the global financing facility (GFF) was supposed to help move in this direction but progress has been slower than expected.

There is a need to get better at thinking through political sequencing of reforms; often there is an overemphasis on assessments and studies but too little thought about a strategy for implementation.

The elephant in the room is that aid can be rent seeking, with vested interests. This underscores the need to focus on domestic finance and that a health finance strategy needs continued engagement and cannot be a zoom in–zoom out activity.

3.3 Partner and regional perspectives

Some of the first work on collaboration among stakeholders on transition and sustainability was started by UNAIDS and the WB through the HIV Economic Reference Group (ERG). The experience and lessons learned from the ERG can give useful insights on the scope of work and modes of working for this working group.

Such groups comprise a mix of academics and professionals from different agencies and countries and can serve as important forums for different stakeholders coming together to discuss innovative ideas and develop a common understanding, and coordinate to the extent possible. A mechanism for coordinating transition efforts among UNAIDS, GF, PEPFAR/USAID was born out of the ERG and this cooperation is continuing even after the ERG has been terminated.

With the right mix of stakeholders around the table, influencing policy is possible – as has been the case, for instance, with UNAIDS strategy for positioning HIV into the UHC efforts or GF transition and sustainability policy. Participation of country representatives in these groups is of paramount importance – they critically bring experiences and country insights and can also take ideas generated and explore their appropriateness and adaptation within country policies and strategies.

Finally, these groups can be important communities of practice that can provide tailored technical assistance to countries when needed. **A lot of coordination among partners happens at the global level but this is not always reflected at country level. Therefore in order to move forward, the main recommendation is to identify countries for joint action and to provide assistance not only on technical issues but also on political influence and making things happen.**

The WHO PAHO region is very diverse with a wide range of economic contexts including some of the BRICs such as Brazil. For several countries, fiscal capacity is low with public expenditure from GDP considerably lower than in the EC, for example. Fiscal prioritization is also low with many countries falling below the 15% expenditure level on health from public budgets. Very few countries in the region have above 6% of GDP allocated to health and only three are in Latin America and the Caribbean (LAC). OOP is on average 32% of THE and only six countries are below 20% OOP as part of THE. With regard to work on sustainability and transition, some action has been taken on the different dimensions of sustainability and examining some determinants of sustainability but a theoretical framework has not been developed. **WHO has supported fiscal space studies in 14 countries and some of the findings highlight that formalizing the economy has the largest potential to increase fiscal space, followed by VAT changes. Moving forward on sustainability will include increasing focus on prevention and early detection of chronic disease, strengthening first level of care, increase in public funds for health, promoting pooled financing and reducing incidence of catastrophic payment, as well as supporting integrated service provision and improving efficiency.**

4. Day two: Sustainability, transition, unit of analysis and priority areas of work

4.1 Rethinking the discussion on sustainability and transition

Financial sustainability challenges in transitioning from external sources of financing

Ajay Tendon, Lead Economist, World Bank

A WB-run multi-donor trust fund (MDTF) was launched a year and a half ago. As countries develop economically the share of external finance naturally reduces. The fund focuses on a selection of LMIC in East Asia and the Pacific but within this group there is still huge diversity in dependency on external finance, ranging from close to 25% to 1% of THE in countries like Indonesia. There are different financial sustainability implications: firstly, in some countries ODA reduces as economy grows but it can also go the other way; secondly, there is a transition towards more pre-paid pooled financing mechanisms and reduced reliance on OOP.

Transition from external finance should be considered within the context of countries moving towards UHC. Sustainability in the context of transition could be the ability to maintain or increase coverage of priority interventions after the end of support. We conceptualize programmatic aspects of transition that focus on how service delivery and governance are configured, for instance how well externally financed programmes are integrated into national systems and financial aspects that focus on revenue and expenditure, for example the ability to replace external finance. Results can be monitored through current WB/WHO/UHC dashboard indicators that reflect various aspects of service coverage as well as financial protection.

There is also a need to place transition within macro-economic context. The share of public health expenditure per capita that eventually translates into health outcomes is derived from GDP per capita, public expenditure as part of GDP and health as part of government allocation. It is important also to look at trends and projections in economic growth over a few years. South East Asia has had robust growth in a number of countries whereas the Pacific countries covered under the MDTF have had much more fluctuation. Trends in economic growth can project the number of years it will take for the economy to double. In Myanmar, this could be ten years and clearly introduction of new taxes would not be the way forward in its case, whereas in other countries where doubling of the economy will take more than a 100 years things may look different. Influencing the public expenditure part of GDP lies outside the health sector. Priority of health in government budgets also matters and how resources are prioritized among sectors differs widely between countries, ranging from 1% to 30%. In advocating for increased allocations, political economy considerations are important and generally having the focus on efficient spending of resources may be more effective than only focusing on advocating for government budgetary targets. Earmarked taxes are sometimes used to increase health share of the budget – social health insurance is one way of earmarking, and tobacco tax another – but it is important to understand where this is going to be helpful and also monitor trends as the increase can diminish. Debt and deficit ratio by GDP also come into play.

Thinking through sustainability and transition

Joe Kutzin, Health Financing Coordinator, WHO

Transition from external finance has brought a flurry of interest in financial sustainability. WHO is well placed to play a neutral technical advisory role as it will not transition its support and is not a donor agency. The importance of good targeting of external finance is receiving increased focus, and various programmes are preparing investment scenarios and are interested in new innovative finance or earmarked taxes. Experience, however, shows that the net increase in resources to health can be short lived. For example, in Ghana an earmarked VAT initially increased resources for health but this effect diminished over time. Similarly, former Soviet countries introduced earmarked payroll tax but eventually a net reduction in resource allocation to health was observed.

In thinking about the concept of financial sustainability, it is important to recognize that this is not a goal *per se* but rather a constraint, i.e. we are trying to maximize health system goals and move towards UHC within the constraints provided by the budget. Both service coverage and financial protection vary greatly between countries with similar public health expenditure levels, which underscores the importance of efficient spending. Determinants of public health spending are in part a political choice: it is a government decision how much it chooses to spend on health, influenced by both public policy priorities and fiscal capacity.

When applying the concept of sustainability, there should be clarity on what we are aiming to sustain. Rather than trying to sustain a programme for MCH/TB or HIV, the aim should be to sustain increased coverage of priority interventions: programmes can be well run *per se* but they may have duplications and inefficiencies from the sector perspective. Hence, the aim should not be to sustain three different information systems, five procurement systems and distorted human resource incentives but a sustained coverage of priority interventions. **It is important to develop a consensus among countries and partners on this point – the unit of analysis should be the system and not a specific programme or disease.**

Transition from external financing is a political opportunity as strengthening domestic resource mobilization and improving efficiency of health spending should be high on the agenda for countries regardless of whether they are transitioning in some way from external finance or not.

This group could have a role to push for appropriate design of external finance that takes into consideration incentives for domestic budget response and fungibility (from the perspective of the system rather than the programme). It could also look at ways of building national capacity for comprehensive engagement between the ministries of finance and health (not many approaching MOF with separate disease programme issues) and focus on fundamentals – rather than have undue fascination with innovation and quick fixes that sometimes draws attention away from work on efficiency gains. As a multi-partner platform, the group should reach out to the political level of the various institutions and build a consensus on getting the question of what we are trying to sustain right, and ensure the unit of analysis is correct. The group can also help develop a consensus on core guiding principles of health finance for UHC.

Discussion

In considering the context for transition it is important also to factor in income distribution; averages can hide differences in reliance on external finance. Absolute numbers also matter and percentages can be misleading. Demographic changes also come into play, for example in some countries in Africa fertility is falling.

Countries with similar levels of income can have different ratios for ODA dependency; it is important to understand what the contributing factors are. Implicit rationing often disproportionately impacts the poor.

MOH engagement with MOF on revenues can be fine, but the large gains lie in increasing national capacity to raise revenues. Social sectors could join forces to work with MOF on opportunities for revenue raising.

For the group, a key issue is support to countries in improving planning for transition, at the national level, as countries are in some cases “falling off a cliff”, and preparation is far from sufficient. The group should focus on ways to support comprehensive transition planning.

Cross-programmatic inefficiencies: breaking the silos

Susan Sparkes, Health Systems Governance and Financing, WHO

This session presented work that has analysed health programmes, including how they are financed, governed, their use and generation of inputs to deliver priority services in the context of the system efforts to achieve outcomes. Through this an effort has been made to identify where incentives are misaligned or conceptual issues that need clarifying. Case studies from three countries are under development: Estonia, Ghana and South Africa.

In Estonia, a somewhat artificial divide between public health services and individual health services translates into 95% of the population being covered by an insurance fund but with separate finance of TB, HIV and drug abuse services, whereas in Ghana HIV- and TB-positive people have free National Health Insurance Fund (NHIF) enrolment but TB and HIV services are explicitly excluded from the benefit package.

Policies can explicitly have integration as an objective but structure and incentives may pull in a different direction. For example, South Africa has a national policy that aims to integrate services but 20% of the public health budget is earmarked for an HIV conditional grant; and the 12 HIV sub-programmes each budget separately for staff, and information systems are separate for HIV, TB and the district health information system. Estonia’s policy states that HIV and TB services should be provided by family medicine. The National Institute of Health Development (NIHD) has contracts with specialists and NGOs and pays specialists a fee for a service arrangement to test and treat HIV, while family medicine is expected to do the same on a per capitation payment mechanism.

Transition from external finance needs to be regarded within the overall finance context, for example GF and GAVI push for payment of arrears in a context where the NHIF has not been able to pay bills for some time. In South Africa, HIV conditional grant funds have increased while no increase on general budgets has been possible.

Observations from this work highlight the importance of thinking about the incentives established at the design phase of any interventions. Institutional frameworks can be at odds with stated policy objectives. There is a need to (re)focus funding early to strengthen underlying systems and for financing to develop a better understanding of constraints and enablers for integrating priority services into basic benefit packages.

The group could add value by helping bring the 'programme' and 'system' communities together, and influence the political aspect of needed changes both at international and national levels. The group could also help facilitate a consensus on areas where more conceptual clarity is needed, for example public and personal health services and harmonization of incentives, and advocate for importance of capacity building and work on strengthening underlying subsystems.

Discussion

Indeed, services within the NHIF in Estonia are protected because of the mechanism of how they are financed but an extra motivation to fund some parts of the services separately has been that it is a good way to raise additional funds for the system. The health system and the insurance fund are a hard sell at MOF level. There is value in a mixed approach and it can provide a win–win situation.

In South Africa, a high level of earmarking for HIV does indeed contribute to fragmentation of services and this in turn leads to a breakdown of continuity of care. Demand for attribution is then reflected in increasingly inflexible systems. At the international level, risk management has in some cases proven an effective way to advocate for more resources for health system work.

Populations are aging and chronic diseases and multi-morbidity increasingly present the majority of the disease burden as reflecting an epidemiological transition. What are the implications for continuing to have a selected set of diseases and conditions funded separately from pooled finance mechanisms?

(Re-)building an enabling legal environment for UHC

David Clarke, Health Systems Governance and Financing, WHO

Exploring further health system sub-areas in relation to UHC and transition, health laws are an important part of the enabling environment for moving towards UHC. This can be direct through legal and regulatory frameworks, for example procurement laws, trade law issues related to transition, laws governing health technology assessments, or laws to cover social contracting already mentioned in relation to transition. Other relevant areas include, for example, health insurance laws or laws pertaining to regulation of NCD risk factors like tobacco, alcohol and sugar.

Legal frameworks also form part of the enabling environment for public participation in health policy processes, accountability and transparency. Implementation enforcement and compliance with laws is the third area that often requires more targeted focus.

Legal infrastructure for health is therefore an important area to consider for strengthening capacity of institutions to sustain and increase coverage of priority interventions. UNDP and GF have done specific work on legal environments for TB, HIV and malaria and there may be benefit in linking this work with other efforts to strengthen the legal environment of UHC and health security.

Discussion

Value added may include mapping key pressure points related to legal frameworks, transition and UHC and to see if some of these could be anticipated. Experience from Eastern European work on transition highlights that many issues need addressing, for example human resource laws and various issues related specifically to the HIV and TB legal environment. Health insurance laws and decentralization are sometimes in conflict and at times laws governing budgeting processes are themselves part of the barrier to improving efficiency. Availability of national health lawyers is a critical element for further work on this, and capacity building in that area is important.

Towards Access 2030

Gilles Forte, Essential Medicines and Health Products, WHO

Pharmaceutical systems are an important area for efficiency in the health sector. The whole pharmaceutical value chain – from production and marketing, selection, procurement and supply to prescribing, dispensing and medicine use – are all possible areas of efficiency gains. Many countries face a high burden of NCD and are grappling with high costs of drugs, for example for cancer, while an unfinished agenda of communicable diseases remains. Issues regarding access to essential medicines remain, including for major communicable diseases like TB, HIV and malaria. The need to strengthen regulatory systems is high on the agenda to combat counterfeit medicine but here there are human and financial capacity issues. There are many actors in this subsector and fragmentation due to verticalization. Evidence-based selection and use of drugs including antimicrobials is also high on the agenda compounded by the rise in antimicrobial resistance.

Discussion

There are many issues in countries related to transition and procurement, and also some initiatives dealing with these but more efforts are needed to strengthen capacity of national institutions. There are also many issues related to quality, including domestic production and weak regulatory mechanisms. In thinking about complexity of fund flows within the pharmaceutical systems, the question of what should be done to simplify these needs to be addressed.

Civil society perspectives

Bruno Rivalan, Director of Action Santé Mondiale/Global Health Advocates (remotely connected)

Civil Society (CS) has several issues to raise related to processes for transitioning away from external finance. They include the need to revisit the criteria for eligibility as the current use of GNI often does not reflect a country's ability to sustain and scale up services. We also believe the goal of transition needs to be clearer and criteria for the process should reflect this. There is also a need for more clarity on support needs before, during and after transitioning away from external finance. Social contracting is an area where more work is needed directly related to CS work in many countries. There is acknowledgement of the importance of political commitment for addressing issues coming up in relation to transition but limited work has been done on this. For whatever reasons, countries are sometimes unaware that they will be transitioning until it actually happens and, critically, parliamentarians are not involved. We have seen epidemics return when support to

marginalized populations is reduced. The group could add value by sharing experience at country level in supporting system level advocacy. Currently, advocacy happens more by programme, but there is a need for more horizontal advocacy on social accountability and community mobilization.

Annex one: Participants at the UHC2030 Technical Working Group on Sustainability, Transition from Aid and Health Systems Strengthening meeting

Participant	Title and organization
Mr Pungkas Bahjuri ALI	Director of Community Health and Nutrition Ministry of National Development Planning National Planning Agency Indonesia
Dr Anshu BANERJEE	Director (Global Coordination) Office of the Assistant Director-General, Family Women's and Children's Health World Health Organization
Mr Michael BOROWITZ	Head, Strategic Investments and Partnerships Global Fund to Fight AIDS, Tuberculosis and Malaria
Mr Michael CHAITKIN	Senior Program Officer Results for Development Institute United States of America
Dr Camilo CID	Advisor, Health Economics and Financing Pan American Health Organization/World Health Organization (PAHO/WHO)
Mr David CLARKE	Health Systems Adviser (legal) Health Systems Governance and Financing World Health Organization
Dr Santiago CORNEJO	Senior Specialist, Immunization Financing GAVI
Ms Corrine DURIAUX	Coordinator, Strategic Initiative on Sustainability and Transition Global Fund to Fight AIDS, Tuberculosis and Malaria
Dr David EVANS	Health Financing Expert Health, Nutrition and Population World Bank
Dr Gilles FORTE	Coordinator, Essential Medicines and Health Products World Health Organization
Mr Mohamed GAD	Technical Analyst – Health Economics Institute for Global Health Innovation Imperial College United Kingdom
Dr Midori DE HABICH	Independent Consultant, Health Systems Peru
Ms Triin HABICHT	Senior Adviser to the Ministry of Health Estonia
Dr Kara HANSON	Professor of Health System Economics London School of Hygiene and Tropical Medicine United Kingdom

Participant	Title and organization
Mrs Xiao Xian HUANG	Expanded Programme on Immunization Plus Immunization, Vaccines and Biologicals World Health Organization
Mr Thomas HURLEY	Deputy Director, Multilateral Partnerships Group Bill and Melinda Gates Foundation United States of America
Dr Joseph KUTZIN	Coordinator, Health Financing Health Systems Governance and Financing World Health Organization
Ms Ariane LATHUILLE	Health Policy Officer Ministry of Foreign Affairs, France Permanent Mission of France to the UN in Geneva
Mr Matthew MACGREGOR	Fund Portfolio Manager Global Fund to Fight AIDS, Tuberculosis and Malaria
Ms Nellie MALEFETSE	Director, International Relations for Health Department of Health South Africa
Dr Awad MATARIA	Regional Adviser, Health Economics and Financing WHO Regional Office in the Eastern Mediterranean
Dr Shin-ichiro NODA	Medical Officer Department of Global Network and Partnership National Center for Global Health and Medicine Japan
Ms Meghan O’CONNELL	Program Officer Results for Development Institute United States of America
Ms Regina OMBAM	Head, Strategy Development National AIDS Control Council Kenya
Dr Tim POLETTI	Health Adviser Permanent Mission of Australia to the UN Switzerland
Mr Claudio POLITI	Health Adviser Permanent Mission of Australia to the UN Switzerland
Dr Matthias REINICKE	Health Sector Advisor, Europe Aid European Commission Belgium
Mr Bruno RIVALAN	Director, Action Santé Mondiale/Global Health Advocates’
Ms Katja ROLL	Senior Advisor – Team Leader Health Funds Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH Germany
Dr William SAVEDOFF	Senior Fellow Center for Global Development United States of America

Participant	Title and organization
Dr Zubin SHROFF	Technical Officer Alliance for Health Policy and Systems Research World Health Organization
Dr Agnes SOUCAT	Director, Health Systems Governance and Financing World Health Organization
Dr Susan SPARKES	Technical Officer Health Systems Governance and Financing World Health Organization
Dr Ajay TANDON	Lead Economist Health Nutrition and Population World Bank United States of America
Dr Nertila TAVANXHI	Technical Adviser Evaluation and Economics Division Joint United Nations Programme on HIV/AIDS (UNAIDS)
Dr Aquina THULARE	Technical Specialist, Health Economics National Health Insurance Department of Health South Africa
Mrs Diana WEIL	Coordinator Policy, Strategy and Innovations Global TB Programme World Health Organization
Ms Clare DICKINSON	Senior Consultant United Kingdom
Ms Diane LE CORVEC	Consultant, International Health Partnership for UHC2030 Health Systems Governance and Financing World Health Organization
Ms Marjolaine NICOD	Joint Lead, International Health Partnership for UHC2030 Core Team Coordinator, Health Systems Governance and Financing World Health Organization
Mrs Victoria PASCUAL	Team Assistant, International Health Partnership for UHC2030 Health Systems Governance and Financing World Health Organization
Dr Finn SCHLEIMANN	Health Systems Advisor, International Health Partnership for UHC2030 Health Systems Governance and Financing World Health Organization
Dr.Maria SKARPHEDINSDOTTIR	Technical Officer, International Health Partnership for UHC2030 Health Systems Governance and Financing World Health Organization
Ms Veronica WALFORD	Senior Consultant United Kingdom
Dr Akihito WATABE	Health Financing Officer Health Systems Governance and Financing World Health Organization

Annex two: Provisional agenda of the first face-to-face meeting of the UHC2030 Technical Working Group on Sustainability, Transition from Aid and Health System Strengthening

30–31 March 2017
Hotel Beau Rivage, 13 Quai du Mont Blanc, Geneva, Switzerland

Day 1: Transition from external finance and country perspectives

1. Discussion on ongoing work related to transition	
08.30–09.00	Registration and welcome coffee
09.00–09.15	Welcome and opening remarks • Marjolaine Nicod, WHO Coordinator for International Health Partnership for UHC2030 • Midori de Habich, former Minister of Health of Peru, Co-Chair • Kara Hanson, Professor of Health System Economics, London School of Hygiene and Tropical Medicine, Co-Chair
Chair/moderator: Kara Hanson	
09.15–09.35	Findings from a rapid background mapping • Veronica Walford, International Health Partnership for UHC2030 consultant • Clare Dickinson, International Health Partnership for UHC2030 consultant
09.35–10.00	*Feedback and implications for action/next steps*
10.00–10.20	Institutions for transition towards UHC • Agnes Soucat, Director, Health Systems Governance and Financing, WHO
10.20–10.40	*Feedback and implications for action/next steps*
10.40–11.10 COFFEE BREAK	
2. Country perspectives	
Chair/moderator: Midori de Habich	
11.10–11.35	Sustainability and transition – why? how? when? The Estonian case • Triin Habicht, Senior Adviser to the Ministry of Health, Estonia
11.35–12.00	*Feedback and implications for action/next steps*
12.00–13.00 LUNCH	
13.00–13.30	Moving towards UHC, the role of external finance • Aquina Thulare, Technical Specialist, Health Economics, National Health Insurance, South Africa • Nellie Malefetse, Director of International Relations for Health, South Africa

13.30–13.50	*Feedback and implications for action/next steps*
13.50–14.10	Indonesia • Pungkas Bahjuri Ali, Director of Community Health and Nutrition, Ministry of National Development Planning, Indonesia
14.10–14.30	*Feedback and implications for action/next steps*
14.30–14.50	Leadership, multiple assessments, fragmentation in health sector planning • Regina Ombam, Deputy Director, HIV Investments, National AIDS Control Council, Kenya
14.50–15.10	*Feedback and implications for action/next steps*
15.10–15.30	Perspectives on sustainability and transition from aid at country level • Bruno Rivalan, Director, Action Santé Mondiale/Global Health Advocates
15.30–15.40	*Feedback and implications for action/next steps*
15.40–16.10	COFFEE BREAK
Chair/moderator: Bruno Rivalan	
16.10–16.30	Regional perspectives • Camilo Cid, Advisor, Health Economics and Financing, PAHO/WHO Regional Office for the Americas • Awad Mataria, Regional Adviser, Health Economics and Financing, EMRO/WHO Regional Office for the Eastern Mediterranean
16.30–17.00	Partner perspectives *Support to transition from ODA at country level: what needs to change?* • Nertila Tavanxhi, Technical Adviser, Evaluation and Economics Division, UNAIDS • Michael Borowitz, Global Fund to Fight AIDS, Tuberculosis and Malaria • Santiago Cornejo, Senior Specialist, Immunization Financing, GAVI • Julia Watson, Senior Economic Adviser, DFID • Thomas Hurley, Deputy Director, Multilateral Partnerships Group, BMGF
17.15–19.00	Welcome reception at the Beau Rivage

Day 2: Sustainability, transition and unit of analysis and priority areas of work

3. Rethinking the discussion on sustainability and transition	
09.00–09.15	Recap from day one – Clare Dickinson
Chair/moderator: Triin Habicht	
09.15-10.15	Raising revenues while managing expenditure growth: a balancing act for sustainability and transition • Joe Kutzin, Health Financing Coordinator, WHO • Ajay Tandon, Lead Economist, World Bank Discussant: Bill Savedoff, Senior Fellow, Center for Global Development
10.15–11.00	*Feedback and implications for action/next steps*
11.00–11.30	COFFEE BREAK
Chair/moderator: Matthias Reinicke, European Commission	
11.30–12.30	Transition for institution strengthening towards UHC • Susan Sparkes, WHO: Cross-programmatic inefficiencies: breaking the silos • David Clarke, WHO: Legal frameworks and UHC • Gilles Forte, WHO: Strengthening procurement and pharmaceutical systems • Bruno Rivalan, Director of Action Santé Mondiale/Global Health Advocates
12.30–13.00	*Feedback and implications for action/next steps*
13.00–14.00 LUNCH	
Discussion on priority work areas – agenda for action	
14.00–14.30	Purpose of afternoon session: to clarify role and start to develop work plan UHC2030 core team to recap • Objectives of International Health Partnership for UHC2030 • Scope of the STWG
14.30–15.00	Identifying STWG added value and areas of work Facilitators: Veronica Walford and Clare Dickinson, International Health Partnership for UHC2030 consultants • Feedback on added value of the STWG • Review of ideas so far for STWG activities from discussion • Constituents' views and consensus on suggested activities
15.00–15.15	COFFEE BREAK
15.15–16.15	Discussion on scope of each activity area (to focus on four points: purpose of proposed activity, who to involve, how to develop, next steps)
16.15–17.00	Feedback/summary on each activity area Next steps, round up and close meeting

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