

Financing women's, children's, and adolescents' health

While global investment in women's, children's, and adolescents' health has increased in recent years, significant gaps remain. **Geir Lie and colleagues** propose five strategic

shifts in financing



Better health is not a cost; it is a benefit, and there is strong evidence that investing in health and in women, children, and adolescents yields significant benefits to society and the economy.¹⁻⁵ The primary benefits can be measured in terms not only of saved lives but also longer and healthier lives. The secondary benefits are economic and manifest themselves in productivity gains and economic progress. Recent estimates have noted that as much as 25% of growth in full income (which measures the full economic benefit of better health as valued by individuals) in low and middle income countries between 2000 and 2011 resulted from improvements in health.²

However, far too many newborns, children, adolescents, and women still die from preventable conditions every year, and far too few have reliable access to good quality health services. Scaling up from the current levels of healthcare coverage to the global convergence targets (that is, a mortality rate among under 5s of no more than 16 deaths per 1000 live births, an annual death rate from AIDS of 8/100 000 population, and an annual death rate from tuberculosis of 4/100 000 population²) currently faces a significant financing gap. The World Bank has estimated that \$33.3bn (£21.4bn; €30.4bn) would be needed in 2015 alone in the 63 high burden, low and lower middle income countries included in the "Countdown to 2015" initiative (www.countdown2015mnch.org), equivalent to \$10 per person.⁶

Methods

The paper was based on a literature review and synthesis of evidence from relevant

KEY MESSAGES

Evidence is strong that investing in women, children, and adolescents yields significant health and economic benefits. Global investment in women's, children's, and adolescents' health has risen in recent years.

There is a big gap between current levels of investment and current and future resource needs for reproductive, maternal, newborn, child, and adolescent health. Strategic shifts in the financing landscape could reduce this significant gap in a post-2015 world.

documents, including "grey" (not formally published) literature, datasets, and the latest estimates from the World Bank, the Partnership for Maternal, Newborn & Child Health, and the World Health Organization (WHO). In addition to the latest evidence, and informed by a synthesis of existing research, a consensus on the manuscript was reached by the Financing Working Group of the Global Strategy for Women's, Children's and Adolescents' Health. A draft of the paper was circulated for public consultation and was finalised in line with the comments received.

Background to the global strategy

Launched in 2010 by the secretary general of the United Nations, the Global Strategy for Women's and Children's Health has fuelled efforts to deliver the UN millennium development goals. The Global Strategy and the Every Woman Every Child advocacy movement have promoted collective action, joint messaging, and effective partnerships.

By 2014 the strategy had gathered more than 400 commitments from more than 300 partners around the world, ranging from governments, civil society organisations, foundations, and academia to professional groups, businesses, and international organisations. The Partnership for Maternal, Newborn & Child Health has estimated that financial pledges to the strategy reached almost \$60bn in 2011-15, 18% of which (almost \$11bn) was contributed by 27 low income countries.⁷ Of the 20 largest pledges, several were represented by global partnerships, countries, foundations, non-governmental organisations, multilateral organisations, and the private sector.⁷ Disbursement of these pledged funds has grown steadily, and by May 2014 almost 60% (\$34.2bn) had been disbursed. This figure relates to financial commitments only: in addition to these, many commitments made to the global strategy are not easily monetised, so potentially more has been committed than the numbers alone are showing.

Despite the global economic downturn, the world has remained resolute in its pledges to the Global Strategy for Women's and Children's health. Official development assistance disbursements for reproductive, maternal, neonatal, and child health has

risen by an average of 11% a year.⁷ (The Muskoka method⁸ was used to calculate this figure.)

Although pledges to women's and children's health remain strong on the world stage, this has not necessarily been the case at the country level. Recent (2010 to 2013) data on health expenditure show that governments in 12 countries (Benin, Burkina Faso, Cambodia, Cote d'Ivoire, Democratic Republic of the Congo, Gambia, Niger, Sierra Leone, Tajikistan, Tanzania, Togo, and Uganda) are the smallest funding source for reproductive, maternal, neonatal, and child health, at 21% of overall funding in each country, whereas external resources contribute 30%.⁹ Although in some cases "aid fungibility" (use of aid in ways not intended by the donors when disbursing the funds) may have contributed to this, by crowding out government and private sector funding, it still leaves households as the main source of funding for reproductive, maternal, neonatal, and child health, at 49% of all expenditure in these countries.

Post-2015 financing framework: understanding the resources needed

As the world transitions from the UN millennium development goals to a post-2015 world of sustainable development goals, a considerable part of the agenda for reproductive, maternal, newborn, child, and adolescent health remains unfinished, despite the progress made so far.

The current need for resourcing highlights in a dramatic way the urgency of scaling up financing. Although this scaling up can be financed by countries' expected economic growth (given that this growth will far exceed the estimated cost of financing health over the 2015-2030 period²), challenges lie ahead.

Challenges facing the financing landscape

The current gap in financing can be bridged only through dramatic increases from domestic and international sources and from both public and private sectors. However, over the next few years we expect big shifts in the global economic picture, in the health financing landscape, and more broadly in the development financing landscape.

Economic growth has the potential to provide considerable resources, but the transition of countries from low income to middle

income status is often accompanied by widening inequities between rich and poor people and by insufficient prioritisation of health. Poor targeting, inadequate use of evidence, and fragmented financing reduce the efficiency of existing investments. The poor state of civil registration and vital statistics systems hampers the ability to monitor progress and base decisions on sound evidence. The lack of a skilled health workforce, particularly at the community level in many countries, robs health systems of their first line of preventive action and defence and also a crucial employment opportunity in poor communities.

An analysis conducted by the Bill and Melinda Gates Foundation shows that between 2014 and 2030 an estimated 41 countries are expected to graduate from the World Bank's fund for the poorest countries, the International Development Association.¹⁰ Additionally, 15 countries are expected to graduate from the African Development Bank's Africa Development Fund, 15 are expected to graduate from the Asian Development Bank's Asian Development Fund, and as many as 38 are expected to graduate from the Global Alliance on Vaccines and Immunization.¹⁰ Such graduations can be welcomed as a sign of prosperity and progress but must also be managed carefully to ensure that citizens at the greatest risk are not left behind.

Experience has shown that this increased "funding for health" will not occur automatically: while in low income countries each percentage point increase in economic growth is associated with growth in government spending on health of more than one percentage point, in lower middle income countries the associated growth is less than half a percentage point.¹¹ The effect of this smaller rise in spending is compounded by the fact that, as countries reach lower middle income status, development assistance for health begins to fall, as donors' graduation policies start to take effect. These combined effects can create major challenges for countries, particularly given that they often come at the same time as the countries are dealing with other issues, such as decentralisation, a greater need to tackle inequity (including pockets of vulnerability), and a shift to a growing burden of non-communicable disease.

Five strategic shifts

We propose five strategic shifts in the financing landscape for women's, children's, and adolescents' health in the post-2015 world.

Value for money

Achieving value for money must be made a priority. Countries must increase their share

of total pooled health expenditure, reduce barriers to the reallocation of these funds towards priority services and beneficiaries, and implement strategic purchasing and performance based financing. These steps require a better dialogue between finance and health ministries to leverage more efficient and equitable domestic financing.

Countries' ability to use taxation to expand the overall fiscal envelope must be strengthened, and they must promote dialogue with their finance ministries and sub-national bodies on reducing regressive subsidies and reallocating the resources that are freed to programmes that target poor people. They could also explore new ways to generate domestic health revenues, such as through expansion of "sin taxes," debt swaps, and the floating of bonds marketed to diaspora communities.

Integrated approach

We must break down the separate silos of financing for women's, children's, and adolescents' health, including in the areas of nutrition and communicable disease. This will require enhanced collaboration between the international agencies in strengthening health systems and moving towards universal health coverage so as to reach hard to reach populations, while strengthening the funding base for activities with clear collective benefits, such as the eradication of malaria.

Conflict settings

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 child and maternal deaths occur in areas that are in conflict or just recovering from conflict. Developing new ways to finance health improvements among people in these settings, as well as to increase accountability for the results, needs to be prioritised. One approach would be to create pooled funds that transfer funding to frontline providers through performance contracts. These pools would be governed through participatory mechanisms and placed under citizens' control.

Innovative financing models

We should foster innovative financing models at the global, regional, and national levels. Innovative financing mobilised nearly \$100bn for health and development between 2001 and 2013, and such financing has grown by about 11% a year.¹² One example of innovation is to shift a portion of the domestic financing into the future by using health bonds as a bridge to meet upfront financing needs.

This would create more fiscal space in the short term for domestic expenditure,

especially in those countries facing graduation. Countries could strengthen health bonds by securing credit enhancement mechanisms (for example, guarantees and performance payments to "buy down" interest rates) through multilateral development banks or bilateral agencies (or both). In addition, such instruments could "crowd in" private capital, targeting investors such as sovereign wealth funds, corporate treasuries, and private investors, who are increasingly looking for investments with joint economic and social returns and who are willing to accept some risk for greater reward. The recently announced partnership between the Global Financing Facility and the International Bank for Reconstruction and Development, is an excellent opportunity to put this into practice, as does emerging thinking within the Global Fund to Fight AIDS, Tuberculosis and Malaria and in USAID.

Incentivising innovation

We must explicitly focus on financing and incentivising innovation. The pipeline of innovation for women's, children's, and adolescents' health is the most robust it has ever been. However, without attention to the financing and regulatory pathways that enable these innovations to be scaled up, there will be substantial delays in getting lifesaving innovations to the women, children, and adolescents who need them most. We should develop pathways for private investment and innovative financing approaches, so that the quality of health-care, and people's access to it, can be scaled up.

As much as possible, programmes supported by donors will integrate a results focused approach (such as results based financing or output based aid) with attention to building aid flows into countries' public finance management systems. Programmes should include support for institution building—in particular, strong health purchasing agencies and related governance and accountability measures. Although the toolbox of innovative financing options could not be fuller, few examples of this type of financing are yet operating on a substantial scale. By actively encouraging investment and creating a dialogue about major gaps and how innovative financing approaches might help fill them, we stand a better chance of these investments having a large scale impact.

Conclusions

The wide financing gap will not be bridged unless we completely re-imagine the way our various sources of financing for healthcare are organised—and will not be bridged

through harmonisation alone, which is necessary but not sufficient. We need more creativity in examining the inter-relations between existing sources of funds.

We call for an unprecedented funding effort over the coming 5-10 years to finance the next phase of the Global Strategy for Women's, Children's and Adolescents' Health 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. Agreements to close the overall gap would need to be discussed at a country level and included as part of the post-2015 overall monitoring framework.

Countries should seek to reap the full benefits and financial capabilities of the multilateral development banks, such as the World Bank Group, Inter-American Development Bank, African Development Bank, Asian Development Bank, and Islamic Development Bank. The emerging New Development Bank may also present an opportunity once it is up and running. Grant financing available from bilateral organisations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, Gavi (the Vaccine Alliance), UNITAID, and other pooled funds could complement the multilateral development bank platforms.

The financing mobilised so far in support of Every Woman Every Child, and the remarkable reductions in suffering and death that this 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 and AIDS, tuberculosis, and malaria.

Contributors and sources: The Financing Working Group of the Global Strategy for Women's, Children's and Adolescents' Health devised the article. GSSL, ALBS, and SB wrote the first draft. The Financing Working Group contributed to subsequent drafts. GSSL ensured that relevant feedback from the consultations for the global strategy, online consultation, and the peer review process were incorporated into the draft. All authors have read and agreed to the final version. GSSL is the guarantor. The members of the Financing Working Group are Suprotik Basu (UN secretary general's special envoy for financing the health MDGs and for Malaria, MDG Health Alliance), Pascal Bijleveld (Unicef), Elina Dale (WHO), Tore Godal (Norway), Lars Grønseth (Norway, WHO), Nicole Klingen (World Bank), Joseph Douglas Kutzin (WHO), Rama Lakshminarayanan (World Bank), Geir Sølve Sande Lie (Partnership for Maternal, Newborn & Child Health), Ingvær Theo Olsen (Norway), and Agnes L B Soucat (World Bank).

Competing interests: We have read and understood BMJ's policy on declaration of interests and have no relevant interests to declare.

The authors alone are responsible for the views expressed in this article, which does not necessarily represent the views, decisions, or policies of WHO or the institutions with which the authors are affiliated.

Provenance and peer review: Not commissioned; externally peer reviewed.

Geir Sølve Sande Lie economist, Partnership for Maternal, Newborn & Child Health

Agnes L B Soucat lead economist, global leader, World Bank

Suprotik Basu chief executive officer, Office of the UN Secretary General's Special Envoy for Financing the Health MDGs and for Malaria, MDG Health Alliance

Correspondence to: G Lie lieg@who.int

© World Health Organization 2015. Licensee BMJ

This is an open access article distributed under the terms of the Creative Commons Attribution-Noncommercial IGO License (<https://creativecommons.org/licenses/by-nc/3.0/igo/>), which permits use, distribution, and reproduction for non-commercial purposes in any medium, provided the original work is properly cited. In any reproduction of this article there

should not be any suggestion that WHO or this article endorse any specific organisation or products. The use of the WHO logo is not permitted. This notice should be preserved along with the article's original URL.

- 1 Stenberg K, Axelson H, Sheehan P, et al. Advancing social and economic development by investing in women's and children's health: a new global investment framework. *Lancet* 2014;383:1333-54.
- 2 Jamison DT, Summers LH, Alleyne G, et al. Global health 2035: a world converging within a generation. *Lancet* 2013;382:1898-955.
- 3 Guttmacher Institute. Adding it up: the costs and benefits of investing in sexual and reproductive health 2014. www.guttmacher.org/pubs/AddingItUp2014.html.
- 4 Heckman JJ. Four big benefits of investing in early childhood development. <http://heckmanequation.org/content/resource/4-big-benefits-investing-early-childhood-development>.
- 5 World Health Organization. Health for the world's adolescents: a second chance in the second decade. WHO, 2014. www.who.int/maternal_child_adolescent/topics/adolescence/second-decade/en.
- 6 World Bank. Global financing facility: business plan. May 2015. <http://pubdocs.worldbank.org/pubdocs/publicdoc/2015/7/598311437686176148/1515268-GFF-Business-Plan.pdf>.
- 7 World Health Organization. The PMNCH 2014 accountability report: tracking financial commitments to the Global Strategy for Women's and Children's Health. www.who.int/entity/pmnch/knowledge/publications/pmnch_report14.pdf?ua=1.
- 8 G8 Information Centre. Methodology for calculating baselines and commitments: G8 member spending on maternal, newborn and child health. www.g8.utoronto.ca/summit/2010muskoka/methodology.html.
- 9 World Health Organization. Global health expenditure database. www.who.int/health-accounts/ghed/en.
- 10 Salvado R, Walz J. Aid eligibility and income per capita: a sudden stop for MICs. DPAF Working Paper Series 2013/05. Bill and Melinda Gates Foundation, Development Policy and Finance Department.
- 11 Xu K, Saksena P, Holly A. The determinants of health expenditure: a country-level panel data analysis. 2011. www.who.int/health_financing/documents/cov-report_e_11-deter-he/en.
- 12 Global Development Incubator. Innovative financing for development: scalable business models that produce economic, social, and environmental outcomes. Sep 2014. www.globaldevincubator.org/wp-content/uploads/2014/09/Innovative-Financing-for-Development.pdf.

Cite this as: *BMJ* 2015;351:h4267