ECOSOC Annual Ministerial Review

Regional Preparatory Meeting on Financing Strategies for Health Care
Colombo, Sri Lanka, 16-18 March 2009

Background Note[1]

1. Background

The Annual Ministerial Review (AMR) of the Economic and Social Council was established by Heads of State and Government at the 2005 World Summit. It was mandated as an instrument to track progress and step up efforts towards the realization of the internationally agreed development goals (IADGs), including the Millennium Development Goals, by the 2015 target date. [2] The theme for the 2009 ECOSOC Annual Ministerial Review is "*Implementing the internationally agreed goals and commitments in regard to global public health*".

The AMR process features three main elements: national voluntary presentations, country-led regional reviews and a global review, based on a comprehensive report by the Secretary-General. These elements are complemented by an innovation fair; and, prior to the session, by a global preparatory meeting and e-forums on the theme of the AMR. [3]

The first AMR was held in July 2007 and focused on poverty and hunger (MDG1). The 2008 AMR focused on sustainable development (MDG7). Both the 2007 and 2008 AMR sessions were preceded by regional consultations (in 2007, on the "*Key challenges of financing poverty and hunger eradication in Latin America*" in Brasilia, Brazil; and in 2008, on "*Sustainable Urbanization*" in Manama, Bahrain). [4] In 2009, in addition to the regional meeting in Sri Lanka, regional consultations will be held on "*Promoting Health Literacy*" in China and on "*Preventing and Controlling the Growing Burden of Non Communicable Diseases*" in Qatar.

The objective of these regional consultations is to support the global review by focusing, in addition to the progress of the region towards the health–related development goals, on a specific aspect relevant to countries in the region. The outcome of such review will contribute to the Council's deliberations in July 2009, in Geneva. Secondly, they promote stakeholder engagement early on in the process leading to the AMR session during the ECOSOC high-level segment in July.

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[1] Prepared by WHO.
[2] A/RES/60/1, Para. 155 (c).
[3] For more information, see: http://www.un.org/ecosoc/newfunct/amr.shtml
[4] The reports of the consultations are available as document E/2007/84 and E/2008/88, respectively.

More specifically, the meeting will add value to the discussion during the AMR and help advance the international health goals by:

- Examining in greater depth the financing aspects of health services and public health
- Assessing progress in achieving the health-related development agenda in the region and outstanding challenges, especially those that could best be addressed through regional cooperation
- Exchanging lessons learned and replicable examples of good practices
- Promote a broad range of stakeholder engagement early on in the AMR process
- Provide an opportunity to promote the launch of new partnership initiatives during the AMR July 2009 session

2. *Introduction*

Each year, millions of people are prevented from seeking and obtaining needed health care because of they cannot afford to pay the costs[5]. At the same time, millions more are forced to seek care and suffer severe financial problems because they need to meet the resulting costs of treatment out of their own pockets[6]. These are somee of the reasons why many countries are not yet on track to achieve the health-related Millennium Development Goals. While some of this can be explained by an absolute shortage of funds at national and household levels, linked to low national and household incomes, part is also attributable to the heavily reliance on direct out-of-pocket payments as a way of financing health services in many settings. This means that only people who can afford to pay can use the available services. Moving to the situation where health financing systems are sufficiently developed to ensure that all people have access to needed health services without the risk of financial catastrophe and impoverishment - here called **universal coverage** - may well take time in some countries, but it is important that steps are taken now to support the development of national health financing capacities and institutions capable of achieving this goal as rapidly as possible[7].

This note begins by presenting the key challenges that countries - particularly low-income countries - face in adapting their domestic health financing systems in search of this vision. Next, it discusses the way the international community can support countries as they move towards universal coverage, partly by raising more, and more predictable, international funds for health and by channeling them to recipient countries in ways that strengthen national financing systems. The final section turns to the question of health systems, particularly health financing, in crisis situations. In discussing all of these issues, it is not possible to ignore the current financial crisis and the resulting economic downturn, so their potential impacts will be addressed in each

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[5] *Onwujekwe 2005*

[6] *Xu et al. 2003*

[3] *This is the definition of universal coverage used in from the World Health Assembly Resolution 58.33, adopted unanimously by the (then) 192 Member States of the World Health Organization in 2005 see http://www.who.int/gb/ebwha/pdf_files/WHA58/WHA58_33-en.pdf.*

section. Each section also concludes with a series of questions to facilitate discussion during the meeting.

3. Domestic Financing for Health

The resources available for health in many of the world's countries remain extremely limited. Despite a welcome and substantial increase in external assistance for health since the Millennium Declaration was signed, discussed in the next section, total health expenditure per person - from all sources including external assistance and loans - remained lower than US$30 per capita in 33 of the world's countries in 2006. Among Asian countries, there is considerable diversity in national incomes and health expenditures[8]. **Eleven of the 47 countries for which data is available spent less than US$30 per person on health in 2006**, including the part funded from external assistance, while at the other extreme, six spent more than $1000 per capita.

In 2000, the Commission on Macroeconomics and Health estimated how much would be required to ensure that a core set of health interventions, including elements of promotion, prevention, treatment and rehabilitation, was universally available[9]. Updating the estimates to today's prices, the package would cost around US $40 per capita annually. That package, however, did not include a number of interventions that are now routinely undertaken, such as antiretroviral treatment for people living with AIDS. It did not include prevention or treatment for the growing epidemic of cardiovascular disease and mental health that is now endemic to low-income countries as well as in richer settings. The calculations assumed that services would be delivered with maximum efficiency.

Allowing for some inefficiency that is found in all systems, and some consumer demand for services that might not be the most cost-effective, true resource needs are considerably higher. If we take US$100 per capita as a benchmark, for example, in 2006 more than a third of the world's countries, and more than half of the countries in Asia, did not have the capacity to finance this level of expenditure even with the current inflows of external funding. The available resources are also insufficient to guarantee quality, to motivate staff, and to ensure that they treat patients with dignity and respect. **The first critical challenge, therefore, is to find ways to increase the availability of funding for health, particularly in the poorest countries.**

Domestic resources are unlikely to be sufficient in the short to medium term to meet the health needs of the populations of many of the world's poorest countries. Governments have limited ability to collect revenue (e.g. taxes and/or insurance contributions) when much of the population is poor and where many people work in the informal sector[10]. At the same time, substantial portions of the population are unable to meet the costs of services from their own pockets because they are already living under or near the poverty line. On the other hand, there is the potential to collect more resources domestically. Tax or insurance collection systems are often inefficient or

[8] www.who.int/nha
[9] www.who.int/macrohealth/background
[10] *Gottret and Schieber 2006*

inequitable, and some of the instruments that governments could use to increase domestic funding for health are not fully utilized. Examples are tobacco and alcohol taxes, measures that not only raise revenue but which, more importantly, improve health. In addition, ministries of health need to develop better skills to negotiate with ministries of finance and the international financial institutions to obtain a higher share of overall government expenditure.

To illustrate, the average country in Asia devoted only 8.1% of total government expenditure to health in 2006. Although countries in this region have not agreed on a target, this is substantially less than the 15% African heads of state set as their target, for countries that are substantially poorer on average than in Asia. Seven Asian countries devoted less than 4% of total government expenditures to health, while in just under a third of the countries, government commitment to health actually declined between 2000 and 2006. This would not be expected at a time when incomes were generally increasing - people and societies have consistently shown that they are willing to invest increasing proportions of their incomes in improving or maintaining their health as their incomes rise. Increased external funding from donors, lending institutions and foundations will certainly be needed be needed for some time if universal coverage is to be achieved, but **there is room in many countries to increase domestic funding for health**.

In low-income countries taken as a group, close to 75% of total health expenditures are still raised domestically. Asia is even less reliant on donor funding, with domestic sources accounting for over 93% of all health expenditures on average. In 40% of Asian countries in 2006, the predominant way of raising domestic funds was user fees, co-payments or other charges that patients must make directly to providers when they receive services. More than 70% of the countries could be said to rely heavily on these out of pocket payments, even if they were not the dominant funding source, raising more than 30% of domestic funds in this way. This implies low levels of prepayment and pooling of funds and, therefore, low levels of financial risk protection for the population.

Out-of-pocket payments (OOPs) at these levels prevent some people from seeking care, others from continuing care, and result in severe financial hardship for many who do need to use services, as argued earlier[11]. They are also regressive. Only the sick contribute to financing the system, and the poor pay the same as the rich for any services they receive. **If the goal of universal coverage is to be achieved, the second challenge is to move away from user fees towards some system of pre-payment based on taxes, insurance contributions, or more typically, some combination.** It will also be necessary to pool the prepaid funds, to allow people to use services when they need them without the risk of financial hardship. This second challenge is a question of how funds are raised and pooled rather than how much money is raised.

The third and final challenge for domestic financing relates to the way funds are used. Inefficiency exists in all health systems[12]. Some examples that are commonly observed are high cost medicines used when lower cost, equally effective options are

[11] *O'Donnell et al. 2008*
[12] *Jacobs et al. 2006*

available, and more people employed than necessary in some activities. Often high cost, relatively low benefit interventions are used when lower cost interventions with a greater potential to improve population health are not fully employed. Whatever form the inefficiency takes, more could be achieved with the same level of resources in most settings. The incentives and disincentives inherent in the financing system are important determinants of the level of efficiency, one of the most important questions being how to pay health service providers. This is why considerable attention has recently been paid to the issue of results-based financing (sometimes called payment for performance), contractual arrangements and relationships with the non-government sector.

Many health systems are also inequitable, something that is again closely linked to the way they are financed. For example, the high prevalence of user fees gives the rich greater capacity to purchase needed services and to protect themselves from the consequences of ill-health than the poor. However, in many countries the rich also benefit disproportionably from government funded services. While it will never be possible to achieve equality in health outcomes because of variations in genetic heritages and pure chance, health financing systems need to be specifically designed to provide the appropriate access and financial protection for the poor and disadvantaged.

One deterrent to inefficiency and waste is good financial planning, management and auditing tools and systems. Good information is critical to ensuring that enough funds are raised, the poor and vulnerable groups are protected, and the available resources are used equitably and efficiently. Yet only 26 of the countries in the Asia Region have ever undertaken a full national health accounts exercise, so information on how much is spent, by whom, and on what, is often not available to decision makers, or not available in a timely manner. It is only recently that information on the extent of financial catastrophe and impoverishment linked to user fees has begun to be collated in a routine manner, and even now data are unavailable for only 100 or so countries, 23 in Asia[13]. These are but two examples, and **improving financial management systems and ensuring good quality, timely financial information are important enabling factors that will allow a more rapid movement towards universal coverage**.

In summary, the first of the three challenges to domestic financing systems is to raise more funds for health, something that is critical in at least a third of the countries in the Asia region. The second is to reduce the reliance on out-of-pocket payments and move towards prepayment and pooling, again something that applies to a majority of the Asian countries[14]. The final challenge is to improve efficiency and equity of resource use. Undoubtedly the first two of these tasks will be more difficult in the current financial and economic crisis.

The financial crisis has already resulted in large reductions in wealth globally and is now affecting the real economy. While major developed countries had already fallen into a deep recession, developing countries are now also experiencing a significant downturn. Unemployment rates are rising at an alarming pace. As a result of the

[13] *Xu et al. 2007*
[14] *Carrin et al. 2008*

demand retrenchment in the major developed countries, global industrial production and trade haven fallen in recent months, dragging down growth in many developing countries, with the accompanying risk of rising poverty rates. Financial markets remain under great strains worldwide.[15]

In East Asia, recent data shows sharp declines in exports and slowing domestic consumption and investment spending, indicating that East Asia will experience a deeper and probably more prolonged crisis than previously expected. Against the backdrop of rapidly worsening economic conditions and slowing inflation, many central banks in the region further lowered their benchmark interest rates and announced large stimulus packages. In South Asia, while economic growth is slowing, the downturn is expected to be less severe than in other developing countries. Exports account for a relatively small part of GDP and demand is forecast to hold up reasonably well.

Should these predictions prove accurate, it should still be possible to expand domestically generated resources for health in most Asian countries, especially in South Asian countries, although there may be some restrictions if countries need to seek emergency support from the IMF for their financial systems, for example. Where personal and national incomes rise, albeit at a lower rate, the resources available for health should also rise even as the proportion of total income devoted to health remains constant. But given that the proportion of income people are willing to devote to health generally rises with increasing incomes, and given that the proportion of total government expenditure allocated to health is low in many countries in the region, **the opportunities for expanding funding for health from domestic sources remain positive**.

Continued growth also allows countries to move more steadily to forms of financial risk protection involving prepayment and pooling, thereby reducing reliance on user charges and other forms of direct payment[16]. Moving in this direction requires a careful examination of the feasibility of different technical options - usually involving a mix of tax-based and insurance-based financing - establishing political consensus and commitment, and developing a plan for implementation. A number of international initiatives are under way to supplement the work of existing agencies in providing technical assistance to countries in this work, including the Providing for Health Initiative (P4H) which was announced at the G8 summit of 2007, held in Heiligendamm, Germany[17] [18]. The theme of financing was further elaborated at the G8 summit in Toyako, Japan in 2008.

While raising additional funds and moving away from direct out of pocket payments might move less rapidly because of slower than expected economic growth in Asia, they should still be able to move forward. On the other hand, it is always opportune to actively search for ways to improve the efficiency and equity of health delivery systems, and the role of various economic incentives in doing so. In fact, it is

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[15] *2009 World Economic Situation and Prospects Report*, *United Nations Department of Economic and Social Affairs*, http://www.un.org/esa/policy/wess/wesp.html

[16] *Carrin et al. 2008*

[17] *www.g-8.de/Content/DE/Artikel/G8Gipfel/Anlage/Abschlusserkl_C3_A4rungen/WV-afrika-en.html*

[18] *Reich and Takemi 2009*

even more important at times of economic uncertainty. Considerable information is already available about what has worked in different countries that have successfully moved away from out of pocket payments towards prepayment, and the role of financial incentives in improving efficiency and equity in service delivery, although efforts to share country experiences more widely could certainly be intensified. However, some key areas remain uncertain - for example, what are the negative as well as the positive effects of results-based financing in settings where health information systems are weak? Here, more research and learning from ongoing experiments is urgently needed.

For discussion:

- *What are the trends in the region regarding levels and sources of domestic financing?*
- *What strategies and policies can governments implement to raise adequate funds for national health systems?*
- *What mechanisms can be employed to pool risk?*
- *What actions can be taken to ensure the equitable and efficient availability and use of services?*
- *How are countries coping with the impact of financial crisis on financing of healthcare?*
- *How can public-private partnerships, domestic NGOs and local communities best complement government efforts to provide quality primary health care to all?*

4. International Finance for Health

Since the signing of the millennium declaration, the OECD donor tracking system reports that commitments of official development assistance (ODA) for health more than doubled even allowing for inflation, reaching over US$16 billion in 2007 from bilateral and multilateral sources[19]. This is an underestimate because a number of foundations, countries and private contributors do not report their commitments to the OECD. The annual rate of increase from 2000-2007 was double that of the previous decade. Not only did overall contributions increase, but there was also a shift in the composition of donor funding towards health. These increases are very welcome, and have allowed more rapid scale up of health service delivery in poor countries, particularly for HIV/AIDS, tuberculosis and malaria.

Although Asia as a whole relies less heavily on external funding for health than sub-Saharan Africa, five countries obtained over 30% of their entire national health expenditures from external sources in 2006, while external funding contributing more than 10% in another 8 countries[20]. On the other hand, three of the 11 countries identified earlier as spending less than $30 per person on health each year receive relatively low levels of external support, less than 3% of their total health expenditures. This reflects an already observed tendency for donor support to be focused on particular countries, while neglecting others.

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[19] *Figures are commitments, in constant 2006 dollars, taken from the ODA reported under "health" and "population projects/programmes including reproductive health". In 2007, reported disbursements totalled $10.5 billion. Reliable disbursement data are not available from 2000.*

[20] www.who.int/nha

Despite the increases, current external flows when combined with domestic funding capacities are simply not enough to allow all countries to ensure population access to needed health services. If developed countries could meet the target they agreed in the UN that 0.7% of their Gross National Income (GNI) would be allocated to ODA, a large part of the resource gap would be met, but most of them remain far from this goal. For example, reported estimates for the OECD countries taken as a group show that the ODA they provided in 2006 amounted to only 0.31% of their GNI. More worryingly, preliminary figures from the OECD suggest that the real (after adjusting for inflation) value of total ODA actually declined in 2007 - before the current financial and economic recession hit.

Four additional issues need to be addressed when considering external funding for health. First, a large part of health ODA - over 40% in 2006 - consisted of technical assistance[21]. This form of assistance is generally used to fund nationals and institutions in the developed world. While it can make an important contribution to improving health in poor countries, it is important to note that these funds are not available for the provision of health services in the recipient countries[22]. Second, the history of external flows is that they are frequently volatile and unpredictable. This makes planning in recipient countries difficult and has also made ministries of finance reluctant to allow expenditure on activities and inputs requiring long term recurrent funding, including wages and infrastructure. Third, when such funds do arrive, they have often been tied to particular activities or diseases, sometimes, though certainly not always, distorting domestic priority-setting mechanisms and bypassing existing domestic financing institutions. Fourth, the international aid architecture has become markedly more complex over the last decade, with a substantial increase in the number of agencies and institutions through which external funds are channeled to countries. This may well have increased the transaction costs associated with external assistance at the global level and imposed increased transaction costs at country level where government must deal with an increasing number of multilateral and bilateral partners, as well as externally based foundations, charitable organizations and NGOs. **As a result, the overall shortage of funds for health is compounded by the volatility of external inflows, restrictions on how they can be used and soaring transaction costs.**

Some progress is being made. For example, the Paris Declaration on Aid Effectiveness was signed in 2005 with a view to reforming the delivery and management of aid and improving its effectiveness[23]. More than 125 partner and donor countries, and 24 development agencies, committed to a set of principles including the harmonization of activities and approaches across the agencies providing external support, alignment with country led strategies, obtaining results and mutual accountability. The International Health Partnership and Related Initiatives (IHP+) is the operational outcome of these agreements and aims to bring stronger systems of mutual

[21] http://www.oecd.org/document/44/0,3343,en_2649_34469_24670956_1_1_1_1,00.html

[22] *Reported technical assistance appears to have dropped from almost 50% of all health ODA in 2006 (it was higher for the "population programmes" component) to 10% in preliminary results for 2007. It is not yet clear if this reflects a change in the way donor countries report their disbursements, or whether the flows arriving in countries have increased.*

[23] http://www.oecd.org/dataoecd/11/41/34428351.pdf

accountability including independent monitoring of commitments in the health sector. A recent Third High Level Forum on Aid Effectiveness in Accra reviewed the application of the Paris principles in practice, showing some progress but that much remained to be done, summarized in the Accra Agenda for Action[24].

It will be more difficult to ensure that even more external resources are available for health in the current financial climate. In previous periods of financial or economic crisis in the developed world, aggregate ODA has tended to fall, although some countries have been able to continue to maintain or even increase their contributions. ODA for health has not always fallen, however, suggesting that some external funders recognize the need to continue to support the social sectors in times of economic difficulty. If the world is to have any chance of reaching the MDGs, it is important that external support does not fall during the current crisis, particularly for health and the other social sectors which provide the safety nets for the poor, the people who are likely to suffer most in economic downturns.

To this end, the role of the High Level Task Force on Innovative Financing for Health Systems assumes even more importance. It was announced in September 2008, before the full effect of the financial crisis was known. Its task is to recommend innovative ways of raising more international funding for health, building perhaps on ideas such as the International Financing Facility for Immunization (IFFIm)[25] and the domestic tax on air tickets that is used to fund an International Drug Purchase Facility for AIDS, tuberculosis, and malaria (UNITAID). Now, however, it has the more formidable challenge of ensuring that external funds for health not only do not fall, but increase at a greater rate than they have done since 2000. The Task Force will present preliminary findings to the Italian G8 summit in July 2009, and finalize its recommendations for the UN Sessions scheduled for September 2009.

For discussion:

- *What are the trends in the region regarding sources, quantity and quality of foreign aid for health?*
- *How can governments ensure that inflows of external funds support the development of the domestic financing system and institutions, rather than weaken it? What is the impact of vertical funds on national health systems?*
- *What is the impact of the current financial crisis on global funding for health care? How should it be addressed?*

[24] *http://siteresources.worldbank.org/ACCRAEXT/Resources/4700790-1217425866038/AAA-4-SEPTEMBER- FINAL-16h00.pdf*

[25] *IFFIm issues and sells bonds on the open market to raise immediate funds for immunization. Promised future flows of ODA are used to repay the bonds on maturity. This is a way of "front-loading" future ODA commitments to make them available today.*

5. Health Systems in Crisis Situations

WHO describes three types of crises that can have devastating impacts on population health:[26]

1. Sudden catastrophic events such as earthquakes, tsunamis and cyclones/hurricanes;
2. Complex and continuing emergencies, largely violent conflict; and
3. Slow onset processes, such as the gradual breakdown of institutions or health status because of a food crisis, economic crisis, or the impact of a high prevalence fatal disease such as HIV/AIDS, for example.

One in five countries suffers from some type of crisis each year under these definitions, but because some of the possible impacts of the financial crisis (which falls into the third category of crisis) have been discussed in earlier sections, this section focuses on the first two categories.

Early warning systems and disaster preparedness are important preliminary steps for all countries, involving the identification of vulnerabilities and threats that could develop into crises, as well as developing and agreeing on the desired response for each scenario. But **once a crisis happens, the first priority is to provide humanitarian and relief support, which for health means meeting the emergency health needs, often injuries, of the affected population**. At the same time, steps are taken to prevent outbreaks of communicable diseases and to protect against malnutrition, particularly for mothers and infants. Subsequently, attention will move from emergency services to longer term strengthening of the health systems in what is sometimes called the transition phase from relief to development assistance.

All components or building blocks of a health system are likely to be effected during a crisis, though the extent and nature of the necessary response will depend on the severity, extent and duration of the event[27]. An earthquake in one part of a country can have devastating effects locally, but national systems of governance, financing and service delivery still function. In post-conflict situations, especially those involving the entire country, previous government systems will have ceased to function or have been substantially weakened, at least in parts of the country, and have to be rebuilt almost entirely. While this is a major task, it also provides an opportunity to rethink the direction and nature of the system. A recent example is Afghanistan, where health service delivery post-conflict is very different to the pre-conflict situation, with the government contracting service delivery in many districts to NGOs[28]. Here, we consider each health system building block briefly in turn.

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[26] *The World Health Organization 2006*
[27] *The World Health Organization 2007*
[28] *www.globalhealth.org/conference_2008/presentations/c3_a_steinhardt.pdf*.

Governance/leadership: Governance can be restored relatively quickly after a localized, sudden catastrophic event such as an earthquake, based on existing national or sub-national pathways and structures. After a generalized conflict, new systems might need to be developed, something that is complicated by the fact that the predominant health service providers during the conflict might have been traditional healers, private providers and NGOs or faith-based organizations. Re-establishing government leadership in the health sector requires active engagement with civil society and the agencies and individuals that have provided care during the crisis.

Health services: The first priority is to establish services to meet emergency health needs, and to prevent to the extent possible outbreaks of communicable diseases. In this, the health sector does not work by itself, but engages closely with other sectors whose activities are critical to improving health, including those focusing on water and sanitation, and the availability of food, shelter and physical safety. Then attention can turn to repairing or reconstructing the routine health service delivery system. Where crises are localized, the earlier system of service delivery is frequently rebuilt, although there is an opportunity to reconsider details such as the location of health facilities, the nature of the services they offer, and relations with the non-government sector.

Health workers: Many crises result in death and injury to health workers as well as to the general population. Immediate shortages have been met by transferring staff from other parts of the country in localized crises, or by international volunteers. Extended periods of generalized conflict, however, result in fewer health worker numbers because of death, injury and migration. Where government systems have been weakened by conflict, health workers often remain unpaid, so of necessity adapt by offering private services. It may well prove extremely difficult to hire enough skilled health workers to repair or reconstruct the system in the short term, even if the funding is available. International assistance in the provision training of health workers could be required in the short to medium term.

Medical products, medicines, technologies: Particular types of medicines and equipment will be required to meet humanitarian relief needs, depending on the nature of the crisis. Funding is required to replace stock lost during the crisis and to rebuild distribution and delivery systems, something that is less complex for localized crises. Again, crises sometimes present an opportunity to reconsider past strategies and practices - whether brand name medicines could be replaced with generics, or whether the various distribution and laboratory systems linked to disease-specific programs could be combined in the search for efficiency, are but two examples.

Information: Immediately after crises, emergency information systems capable of identifying, then tracking, the health needs of the effected populations are typically established. They allow the most critical health and nutritional needs to be met rapidly, but also provide an early warning system for possible outbreaks of communicable diseases such as cholera. Decisions taken early in a crisis can influence subsequent opportunities and options for reconstruction, so it is important that the emergency tracking system is sensitive to the likely structure of the longer term health information system that will be established or re-established.

Financing: In the emergency relief phase, finance is required for the effected countries and for external partners offering humanitarian assistance. Most developed countries have the capacity to provide emergency humanitarian assistance to countries during emergencies at short notice, while UN agencies can now draw on the restructured UN Central Emergency Revolving Fund when they need to respond at short notice to humanitarian crises.

There are three complications, however, that are sometimes encountered with the inflow of external funding during crises, which have to be managed carefully[29;30]. First, there are often many more agencies channeling funds to a country during and immediately after a crisis than beforehand. This adds to the transaction costs of government, already stretched by the emergency. Moreover, donors have sometimes felt that their internal financial and reporting requirements cannot be met by governments weakened by crisis, so have channeled their funds directly to non-government agencies and private firms. While this ensures funds arrive rapidly, it is sometimes inconsistent with the need to rebuild financial governance systems and capacity in the country. Second, there is a growing tendency for donors to fund the areas in health system strengthening that produce short term, visible results. It can be difficult to find funding for longer term, less visible but equally important, health system strengthening activities during reconstruction. While this is a generalized issue with external funds for health, it is magnified in times of crisis. Third, humanitarian and development assistance funds in many donor countries come from different parts of government. In practice, there can be delays between the time the humanitarian relief is terminated and the development assistance contributions arrive, while the parts of government responsible for development assistance often have access to more limited funding that was available for humanitarian relief.

At the domestic level, it is not too difficult to reintroduce previous health financing systems following localized, short term crises. More generalized, longer term conflicts, however, often mean that existing methods of raising and pooling funds for health have broken down, as have earlier systems of service provision. Most commonly, households have had to pay for any services they have been able to obtain out of pocket.

In such situations, governments and civil society can grasp the opportunity to reconsider how best financing systems can be modified and developed with the view to moving as quickly as possible towards universal coverage. Even if the country requires inflows of external funds for some time, domestic financing institutions and structures need to be re-established and nurtured. Depending on the history and values of the country, and what types of organizations and individuals are in the best position to service population needs rapidly, various mixes between government and non-government actors are possible in each of the key financing function, raising funds, pooling them, and using them to provide services.

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[29] *Yogesh 2007*

[30] *http://siteresources.worldbank.org/EXTINFOSHOP/Resources/Health_FragileStates.doc*.

The availability of health services is one of the most important indicators of peace and stability. The above discussion suggests that three principles need to guide activities to protect and promote health during and immediately after crises. First, it is important that governments identify clearly a long term vision for reconstruction of the heath system and each of its components, so that activities undertaken early in the relief and transition stages facilitate, rather than hinder, movement in the desired direction. Second, crises provide the opportunity to rethink goals, objectives and methods for achieving them, in health as in other areas. Some examples have been provided in the discussion of each of the building blocks above and they will not be repeated.

This is also linked to the third point. Although each building block has been considered separately in this section, they all interact, and the effectiveness of their interaction is as important as the effectiveness of each component. Moreover, the health sector cannot act in isolation during or after crises, but must work closely with other sectors. In terms of health, crises allow societies to reconsider the extent to which their health systems are consistent with the principles of primary health care (PHC) as re-endorsed in 2009 by the Executive Board of the WHO[31]. Although primary health care requires the services to be available close to people, at the first level of the health system, this is only one component of a system that also requires strong integration across the levels of care and continuity of care. PHC is, in fact, an approach to health service delivery and health system development that puts people at the centre of care, addresses health inequalities through universal coverage, integrates health into broader public policy through multi-sectoral action, and which requires strong leadership from government. Although this paper has focused largely on the way health financing can contribute to universal coverage, it is important to recognize that health financing is only one of the array of armaments societies can use to improve the health and welfare of populations.

For discussion:

- *What actions can governments take to prepare for, respond to and recover from crisis, specifically with regard to health systems?*
- *How effective have humanitarian actors been in providing emergency assistance to meet urgent health needs and support health systems, in terms of capacity, predictability, effectiveness and accountability?*
- *To what extent have emergency funding mechanisms met demand and expectations? How can they be improved and adjust to the likely implications of the current financial crisis?*

[31] www.who.int/gb/ebwha/pdf_files/EB124/B124_R8-en.pdf

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