Sustainable health financing in the Pacific: tracking dependency and transparency

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SUMMARY

Using recently conducted national health accounts, the key questions that this working paper aims to answer are:

- How much of health sector spending is contributed by external development partners in selected Pacific Island countries?
- Are there any areas of health financing that are particularly reliant on external funding?
- Do any of these contributions represent “dependence”?

The external contribution to health sector spending is 9 per cent of total health expenditure in Fiji, 17 per cent in Vanuatu, 21 per cent in Samoa, 39 per cent in Tonga and 60 per cent in the Federated States of Micronesia (FSM). The US contribution to the health sector in FSM represents almost US$200 per person per year.

Within the health sector, prevention and public health services are relatively reliant on donors, 30 per cent of finance for this area in Fiji and 51 per cent in Tonga coming from donors. This level of spending might allow donors to influence sector priorities.

There is no set definition of “dependence”, but this brief highlights the need for more data transparency and openness in health aid investments, especially in light of recent statements by AusAID and the World Bank about the need for long-term support to the social sectors of Pacific Island countries.

Greater data transparency is needed to ensure accountability on all sides. Improved data sharing can lead to better policy making and ultimately more aid effectiveness.
The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action emphasise the need for greater coordination and transparency among development partners and with recipient countries (OECD 2012). This is mirrored in the core principles of Australia’s Partnerships for Development, signed with 11 individual Pacific countries, which highlight mutual respect, mutual responsibility, a focus on results and working together to achieve the Millennium Development Goals.

Understanding external financing for the health sector is critical to advancing the aspirations for country ownership that lie at the centre of the Paris Declaration and Accra Agenda. Transparency and predictability of external financing are vital to health sector ownership and planning and represent good aid practice.

At the same time, there has been criticism of over-reliance on donors by some PICs, with calls for more self-sufficiency (ABC Radio Australia 2012; Hughes 2012). Globally, there is a vibrant debate about developing countries reducing their domestic health spending when donor money comes in. This displacement discussion has important implications for how donor contributions are viewed and their impact on strengthening the sector. A 2010 study concluded that when governments receive international aid for health care projects, their own spending gets “crowded out” or displaced (Lu, Schneider et al 2010).

Whatever the aggregate findings from the global data, the magnitude and impact of donor dependence in the health sector in the Pacific are important to understanding sustainability, ownership and alignment with aid effectiveness principles. Despite this, little analysis has accompanied these important questions.
Recent work by the Nossal Institute for Global Health’s Health Policy and Health Finance Knowledge Hub aims to bridge the knowledge gap with regard to health financing in the Pacific.

Although there is a number of health financing data sources available, this working paper uses the recently conducted national health account (NHA) analysis in the region to answer the following questions:

- How much of health sector spending in Pacific Island countries is contributed by external development partners?
- Are there any areas of health financing that are particularly reliant on external funding?
- Do any of these contributions represent “dependence”?

NHA processes have only recently been standardised in Pacific Island countries. This paper also aims to provide an example of how NHA data can be used for rapid secondary analyses with relevance to policymakers.

**METHODOLOGY**

The analysis presented here comes from a variety of sources, most of which were supported by the Nossal Institute’s Knowledge Hub over the past few years. The main partner for this analysis has been the Centre for Health Information, Policy and Systems Research (CHIPSR) at the Fiji National University. CHIPSR has been deeply engaged in developing, supporting and analysing national health accounts (NHAs) in the region.

**BACKGROUND**

NHAs are a new source of data that has become available over the last few years and which allows a deeper analysis of the contribution to health spending from external sources against that from various domestic sources. NHAs systematically track the flow of money into and through the health system. Each transaction is classified specifically within the International Classifications for Health Accounts, which provide precisely defined, mutually exclusive classifications that allow comparability across countries.

In recent years, NHAs have been completed in Tonga, Samoa, Vanuatu and the Federated States of Micronesia, and CHIPSR has been engaged to compile NHAs for Fiji with the recent release of two reports in early 2011 (for the financial year 2007/08) and early 2012 (for FY 2009/10).

There has not been an NHA conducted in Papua New Guinea. However, in PNG the National Fiscal Economic Commission assisted the Department of Health to carry out work on the financing needs for the new National Health Plan (NHP) 2011-20 with an estimated cost of 14.17 billion kina. A forthcoming World Bank study on human resources in health, and complementary work under way on health system financing, will provide additional evidence. Alignment of the plan to the National Health Service standards would also assist in updating the actual cost of the NHP. There is still a need to carry out an NHA (or similar) to determine clearly the structural arrangements, donor contributions and PNG government contributions to the health sector. The Solomon Islands also have not conducted an NHA, but there are plans for one to be started in 2013.

NHAs are valuable to PICs because they allow countries to track the financial resource flows within their health systems, while following an internationally recognised standard methodology. The routine and timely production of NHAs can help PICs make informed decisions about the financing status of their health systems as well as assisting comparative analysis among the countries in the region. Unfortunately, while the methodology enables this to be done, the obstacles to monitoring this accurately lie in PICs’ poor health information systems and the absence of data from health providers and development partners.

This paper extracts its findings from the NHA data and analysis conducted by CHIPSR with support from the World Health Organization, the Nossal Institute and the University of Sydney.

**RESULTS**

In Fiji in 2010, government financed 61 per cent of total health expenditure, private sources (including out-of-pocket) 30 per cent and external sources 9 per cent (Fiji Ministry of Health 2010). Government spending decreased since the 2007 NHA, and the contributions from private and external sources increased (Fiji Ministry of Health 2008).
Development assistance for the health sector has risen from FJ$6.9 million in 2007 to FJ$22.1 million in 2010 and, as a share of total health expenditure, from 3.4 per cent in 2007 to 8.8 per cent in 2010.

In an extension of the traditional NHA methodology, the CHIPSR team has endeavoured to break down external funding by contributor to understand better who is providing funds to Fiji’s health sector. The 2010 report confirms that the Australian government is by far the dominant funding source, providing FJ$13.3 million, or 60 per cent of total external funds. The Global Fund (FJ$3.2 million) and WHO (FJ$2.35 million) are the next two most prominent funding sources (both of which receive substantial funding from AusAID as well). More details on sources of external funding are available in another Nossal Institute paper available on its website (Negin, Irava and Morgan 2012).

Reaching 9 per cent of total health expenditure, ODA is a considerable and increasing contributor to the health sector in Fiji. But further analysis is needed to understand whether this level represents dependence.

Comparable data are available from Samoa, Tonga, Vanuatu and FSM from their NHA reports. Using the most recent data (2007), external donors provide 16.5 per cent of total health expenditure in Vanuatu, 21.4 per cent in Samoa and 39.2 per cent in Tonga.

Tonga’s dependence on external financing is more than four times that of Fiji. Trend data are available for Fiji, Samoa, Tonga and FSM and are shown in Figure 1 as percentage of donor contribution to total health expenditure.

The situation in FSM is notable in that more than 60 per cent of total health expenditure in the country is donor funded—almost entirely from United States government grants. These grants are a long-term source of funds, with agreement for continued funding until 2023. Public financing accounts for only about 10 per cent of health expenditure, revealing that the government of FSM is entirely dependent on external funding. The risks inherent in such a situation are vast. In order to encourage the government of FSM to find alternative sources of funding and to reduce dependence, the US government is reducing the amount of funds available by 10 per cent a year. Health sector financing options for the government of FSM might include user fees, a national health insurance scheme or an employer-based private model—all of which have their own issues of equity and efficiency.

The situation in Samoa and Tonga is quite distinct from that of FSM, as there are a number of donors contributing to the health sector in these two countries. Major partners including Australia, New Zealand and
the World Bank all contribute similar amounts, thus diminishing the dependence on any one partner.

Beyond the percentage contribution by external actors, the absolute amount of the contribution is important to examine. Figure 2 shows the per capita contribution from external sources for the countries for which trend data are available. The US contribution to FSM stands out at almost US$200 per person, many times that in Tonga, Fiji and Samoa.

The NHA methodology is able to provide further information on what activities receive external funding. Specifically, 30 per cent of the financing for “prevention and public health services” in Fiji comes from external donors, suggesting some level of dependence. Similarly, the external contribution to the public health category in Vanuatu in 2007 was 34 per cent of the total, and in Tonga 51 per cent of funding for “prevention and public health services” came from donors (Negin, Irava and Morgan 2012).

DISCUSSION

NHA data show considerable diversity in external financing for health in the Pacific and in donor dependence in certain focus areas. Fiji is less dependent on external sources than Samoa and Tonga, which, in turn, are less reliant than FSM. The country-specific data are critical to understanding health sector financing and areas that possibly require alterations.

We acknowledge that the data provided are not perfect and may well not represent the complete or precise situation in the Pacific. Some contributions might be missing or not reported accurately due to the difficulty of obtaining clear data from partners. We present this information as the best available data on health financing in the region and, importantly, also to highlight the need for better data collection and funding transparency.

The implications of the large funding contribution by external partners for public health activities are considerable, as there is a risk that development assistance influences priorities. An earlier working paper published by the Nossal Institute suggested that external allocations may follow donor priorities rather than domestic focus areas or more general health system strengthening. Despite much higher mortality rates from non-communicable diseases in the Pacific, external funding for HIV was found to be considerably higher than for NCDs: from 2002 to 2009, US$68 million for HIV and US$33 million for NCDs (Negin and Robinson 2010).
The discrepancies between disease burden and external financing suggest that funds might be directed to areas that do not necessarily match PIC priorities or needs. Donor dependence in the area of public health has considerable risks, and greater discussion is needed of how these funds are allocated and to which focus areas. Globally determined funding priorities are not necessarily appropriate for the Pacific. There is currently a push by development partners for PICs to develop sub-accounts for HIV or maternal and child health but not for NCDs. This highlights the need to better track external funding, not only in terms of total value but also with regard to focus areas and source.

Much is made of the issue of alignment in the Paris Declaration on Aid Effectiveness and, in order for those principles to be met, donor funding should support the priorities of recipient countries. Where there are national health strategic plans, donor funding must align clearly with those plans in a transparent manner.

Sector wide approaches (SWAps) are one tool to facilitate information sharing and joint planning—though the results of Pacific health SWAps have been mixed (Negin and Martiniuk 2012). Additionally, rigorous analyses currently under way in PNG and the Solomon Islands, defining service standards and their costs, are necessary to ensure that NHAs and similar analyses reflect the needs of PIC governments.

The issue of donor dependence is a difficult one. There is no clear definition as to what constitutes dependence. Is it 9 per cent, as in Fiji, or only an external contribution approaching 60 per cent, as in FSM? When the Australian government notes that its funding will be a “significant feature of budgets” in some PICs, does that suggest an external contribution of 10 per cent, 30 per cent or more? Have these questions been asked? Or is dependence more an issue of influence rather than amount?

Given the size of PICs and their level of economic development, some ongoing support from partners is to be expected, but the question that arises is what level of donor support is considered “safe” and at what level the support becomes dangerous “dependence”. Do development partners ask these questions when determining their financial support to the sector?

Despite the clear benefit from having this type of financing information for planning and coordination, NHA experience has shown that it remains difficult to gather the data necessary to differentiate external funding by technical area or health system function. A considerable part of this difficulty arises from a lack of financial transparency from some donors. Despite professed commitment to the ownership and coordination principles enshrined in global aid effectiveness declarations, there continues to be a need for some development partners to improve expenditure reporting to national governments, both to comply with NHA data gathering and to provide disaggregation needed for better planning. During the NHA process, some donors were unable to provide clear funding allocations because they worked to funding cycles different from that of the government. A possible means for improving data collection would be greater incorporation of capacity building in accounting and financial management in donor health sector grants to strengthen the ability of ministries to manage external funding.

Lack of transparency can lead to inconsistencies in the data. For example, whereas the Chinese government was recognised as a significant contributor to the Fijian health sector in 2007, no comparable information was available in 2010. The data from Japan were also not as clear as desired. Not all agencies break down their data in as transparent a way as others. For example, some of the data provided by United Nations agencies might include the salaries of staff. More consistency and transparency in the methods of reporting are needed.

Efforts are being made outside of the health sector to strengthen assessment of donor funding. The World Bank’s Public Expenditure and Financial Accountability (PEFA) assessment process, which has been conducted in a number of countries in the region, includes indicators that examine donor contributions to the budget. Specific donor-related indicators include:

- predictability of direct budget support;
- financial information provided by donors for budgeting and reporting on project and program aid;
- proportion of aid that is managed by use of national procedures.

Over the past seven years, 16 PEFA assessments have been conducted in 11 countries in the Pacific region (including Timor-Leste). In those assessments, donors have received only four “A” scores (three for
Nauru alone) and one “B” score, the rest being “C” and “D”. In countries that have had multiple assessments, little progress has been seen on the donor indicators. Despite the lack of progress, assessment of donor actions will potentially bring important benefits to the transparency and clarity of contributions to the health sector specifically.

This type of analysis will become of greater importance in the Pacific as donor contributions are placed under strain due to the global financial crisis, as new donors such as China and Taiwan become more prominent and as non-state actors expand their service provision. The non-government Church Health Services have been a major health provider for some time, especially in PNG. The private sector is becoming more active in Samoa and Fiji and is predicted to provide increasing services in PNG as the economy booms. Increasing private health care provision raises concerns regarding potential inequity in health services for the population.

The data presented here on financing for health in the Pacific demand that important questions be asked about the sources and amounts of external funding, about the reliance on donors for public health funding and about sustainability. This type of information is necessary for better health sector planning and for strategic coordination among partners and governments. Specifically, this information is needed to help Northern Pacific countries prepare for changes in US funding. It would also have helped PNG respond to the recent withdrawal of Global Fund support.

Greater transparency is also needed to improve accountability. As part of aid effectiveness principles, development partners have committed to more predictable funding. For example, recommendation 16 of Australia’s Independent Review of Aid Effectiveness states: “AusAID should devote greater senior management resources to developing and managing relationships with key partners. Predictable, multi-year funding of partners should be provided and micromanagement avoided” (AusAID 2011). In order for development partners to meet this goal, more transparent statements of long-term funding are needed.

Australia’s push to fund more activities through multilateral partners complicates the needed transparency in donor funding. There is the risk of double counting if AusAID counts both its multilateral and bilateral contributions to a certain country and the multilateral partner (such as UNICEF) also counts its funding. This complexity highlights the need for more openness of who is funding what and where.

Transparency also plays a wider role in health sector collaboration in the Pacific. Beyond facilitation of health planning, a push for more openness and communication has been highlighted as critical to influencing policy in the Pacific (Brien 2011; Negin, Morgan and Condon 2012).

Above and beyond providing more transparent funding information, development partners need to strengthen the capacity of PIC government officials and civil society members to understand and analyse resource allocation and its links to health policy. The NHA and other financing information becomes influential only when it is analysed, discussed and presented. The capacity to translate this information in a manner relevant to the local health system needs to be developed. The Flagship Course on health financing and health systems that is being adapted to the Pacific region is one such mechanism that aims to build skills among PIC officials.

CONCLUSIONS

The national health accounts initiative is a start to increasing understanding of health financing in the Pacific, but it should not be seen in isolation from wider health sector financing analyses. While the initiative captures contributions, it does not yet capture what is required to fund the health system fully nor stated priorities set by national governments. A critical first step is for each country to define clearly both their national goals and objectives and the amount of funding that will be needed to meet those goals. Once that is outlined, development partners—as well as the national government—must state transparently how much funding they are providing and to which components of the national strategy.

The small economies of most PICs make it even more critical to understand the financing and payment arrangements. The NHA-style analysis being performed should be part of an overall process of strengthening systems in the Pacific. Leaders and managers should understand the financing, payments and organisational structures in the individual countries to enhance service delivery.
In line with the World Health Assembly resolutions (World Health Organization 2011) on policy development and health systems strengthening, it is critical that countries develop or update their national health sector strategies. This will encourage countries in the region to base their health interventions on evidence and enhance the capacity to lead and coordinate their health sector responses. Such health sector strategies should clearly articulate costing and map out funding arrangements to address priority health needs. Such a strategy would then serve as the foundation for harmonisation of support to the health sector by partner agencies. This of course does not guarantee that resource allocations and national strategies will match, but does provide a basis for discussion and accountability.
REFERENCES


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