



U.K. and Norway Agree to Nearly Half Billion in New Funding for World Bank Health Results Innovation Program.

BY LINDSAY MORGAN*

Just five years to go and there is excruciatingly little progress. Despite massive increases in donor funding for health, the outlook for meeting Millennium Development Goals (MDGs) 4 and 5, which call on countries to reduce the under-five mortality rate by two-thirds, and the maternal mortality ratio by three-quarters between 1990 and 2015, is grim.

But on September 23, 2009, world leaders announced massive new support for an innovative financing mechanism that holds promise for turning that grim reality around. Speaking at the 64th session of the United Nations General Assembly meeting in New York, British Prime Minister Gordon Brown announced that the U.K. and Norway will contribute US\$420 million to support results-based financing (RBF) programs and buy downs to improve maternal and child health. The Government of Australia will also provide AUD336 million over the next four years for performance-linked aid to help partner governments in Asia and the Pacific, a portion of which will be focused on health.

The announcement was part of a pledge by members of the High-Level Taskforce on Innovative Health Financing to commit an additional US\$5.3 billion for the health of women and children in developing countries. Co-chaired by Gordon Brown and World Bank President Robert Zoellick, the Taskforce was established in September 2008 to come up with practical proposals for innovative sources of finance for health systems and for improving the efficiency and effectiveness of aid to health.

“Innovation can be the key to making significant progress on reaching the MDGs, strengthening health systems, and improving millions of lives—especially the lives of women and children,” President Zoellick said.

A significant portion of the new funds committed for RBF will be channeled through the World Bank’s Health Results Innovation Trust Fund, which was established to support countries to design, implement, monitor and evaluate results-based financing interventions, in order to alleviate child malnutrition, under-five mortality and maternal mortality. The Trust Fund began with \$105 million from the Government of Norway, and is currently financing seven RBF pilot programs in Africa and Asia. This new injection of capital could finance additional pilots, as well as results-based buy downs—both of which will help to increase the knowledge base about what works and what doesn’t, and could improve the health of millions of poor people around the world.

Why RBF?

Between 1990 and 2007, development assistance for health quadrupled in volume from \$5.6 billion to \$21.8 billion.¹ But despite some great successes (think HIV/AIDS, malaria and immunization²), countries are still falling tragically short, particularly in areas

¹ *Financing Global Health 2009: Tracking Development Assistance for Health*, Institute for Health Metrics and Evaluation, http://www.healthmetricsandevaluation.org/resources/policyreports/2009/financing_global_health_0709.html.

² More than 3 million people in low- and middle-income countries now have access to life-saving antiretroviral treatment for HIV/AIDS; the percentage of children protected from malaria by insecticide-treated nets has increased almost eightfold in 18 African countries, from 3 percent in 2001 to 23 percent in 2006; and more children than ever are being immunized against life-threatening diseases such as hepatitis B, *Haemophilus influenzae* type b (Hib), and yellow fever.

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that require a well-functioning health system. Sub-Saharan Africa, for example, has the highest rate of maternal deaths in the world with an average of about 900 deaths per 100,000 live births. And more than 11 million children under five continue to die annually in developing countries from preventable illnesses such as malaria, diarrhea, and respiratory infection.

Donors have typically financed inputs such as medical equipment, hospitals, and health worker training—and results were expected to follow. Provider institutions in developing countries have rarely been required to guarantee that services were delivered. Instead, they have either received lump sum grants or were reimbursed for expenditures by governments and donors. This system encourages facilities and workers to devote energy to securing funds and justifying inputs rather than to improving efficiency or the quality of care.

Results-based financing turns everything upside down. RBF programs start with the results—providing incentives to individuals or healthcare providers when performance targets are achieved. Results-based buy-downs are another results-based approach, wherein donors agree to reduce a country’s loan amount, reduce the interest rate of a loan, or pay off a loan completely, once certain pre-defined results or targets have been achieved.

RBF affords greater flexibility to people on the ground, while at the same time requiring credible and accurate reporting on achievement. “Accountability is another name for RBF,” says Daniel Cotlear, Task Manager for the Results-based Financing Work Program at the World Bank.

“There is widespread recognition that you can’t solve these problems by throwing money at them,” says Julian Schweitzer, Director of the Health, Nutrition and Population Unit at the World Bank. “We are getting evidence on the ground that incentives work—increasing coverage, access and patient satisfaction.”

Questions, caveats

Results-based financing and buy downs are not without critics. Some worry that RBF schemes can lead to the neglect of services that are not rewarded; undermine intrinsic motivation; create perverse incentives; lead to corruption; or may just be too challenging and complicated to implement in some countries.

Others note that not all buy down schemes currently financed through the Bank have led to clear and unequivocal results. In Nigeria, the IDA credit for polio eradication has not yet been bought down, though the scheme began more than five years ago. Results-based buy downs could be more complicated, raising questions about countries’ ability to meet targets.

But Schweitzer, who says he shares some of the critics’ concerns, is optimistic: “I’ve yet to learn of any reform that is a panacea. The world has failed over the last twenty years to have any impact at all on, for example, maternal mortality... critics must explain how existing methodologies will do what they have failed to do for the past twenty years.”

The Urgent Need: More Health for Every Dollar

When the Taskforce was launched in September 2008, the focus was on increasing development assistance for health. Then the financial crisis hit, sending the global health community reeling. While calls for increased funding levels have continued publicly,³ in private the conversation has shifted towards defending current levels of spending. This is not without reason. Research from CGD research fellow David Roodman shows that after each previous financial crisis in a donor country since 1970, the country’s aid declined.⁴

3 See Lindsay Morgan, “What’s on the Agenda in Global Health? The Experts’ List for the Obama Administration,” CGD Note, June 2009.

4 See David Roodman, “History Says Financial Crisis Will Suppress Aid,” CGD Views From the Center (October 2008), <http://blogs.cgdev.org/globaldevelopment/2008/10/history-says-financial-crisis.php>.

For policymakers, who must justify spending in one area against other priorities, and ensure to jittery taxpayers that their money is not being wasted, health programs that demonstrate clear, measurable results are required, now more than ever.

And for the poor in developing countries, who tend to be hardest hit by economic shocks⁵, aid that works is desperately needed. The evidence is growing that results-based financing programs can improve access to health services, the quality of those services, and lead to healthier women and children. The positive spillover effects of RBF, like strengthened health systems, hold even more promise—that these improvements will be sustained over the long term.

With new, significant financial commitments from the U.K. and Norway, Schweitzer says he hopes: “in five years time that we will have a very strong inventory of experiences with RBF techniques and methods, experience with how to measure performance and avoid disincentive effects, so that any country that wants to do this can start quickly, with a rich knowledge base about what works.”

Summits, assemblies and billion-dollar commitments are great. Action—and better health—is even better.

⁵ Francisco H. G. Ferreira and Norbert Schady, “Aggregate Economic Shocks, Child Schooling and Child Health,” Policy Research Working Paper 4701, World Bank, August 2008.