

Meeting Report: Equitable Access Initiative

23 February 2015, Geneva

Summary

On 23 February 2015 the Equitable Access Initiative (EAI) held its first meeting, organized by its co-convenors Gavi, the Vaccine Alliance; The Global Fund to Fight AIDS, TB and Malaria; UNAIDS; UNICEF; UNDP; UNITAID; UNFPA; WHO; and the World Bank. Hosted by the WHO, the convening agencies, expert panellists, and other guests met in Geneva to discuss possible measures or indicators that could be used to better represent health needs and capacities than GNI/capita alone, which is commonly used by many agencies and governments to assess eligibility for health-related assistance. Terms for a tender for analytic work were discussed. EAI members will be kept informed of progress on this work and be provided several opportunities for further input to generate recommendations for discussion at the final full EAI meeting in early 2016.

The World Bank's country income classification system using GNI/capita was designed for World Bank lending decisions, but these groupings are being used far more broadly today by many other agencies to inform health-related decisions. As economic growth shifts more countries higher on this scale, it is increasingly difficult to use GNI/capita as a reliable indicator of need. It does not reflect disease burden or health system capacity. Rising inequality, poverty and ill health can persist and even grow despite improvements in aggregate indicators.

The motivation for the EAI is to produce a new starting point for considering how to assess the health development of countries, characterize disease burdens and capacities, and to better inform health financing decisions. The governing body of each institution or government may consider the EAI's conclusions and adopt its own approaches after due deliberation.

EAI members agreed with the importance of discussing health needs and assuring equitable access. There was a free exchange in which diverse views were expressed.

There is a need to consider the highly-varied distribution of disease, poverty and inequality within countries; health system capacity and drug resistance; and disparities including urban-rural, gender and birth-order. There is urgency in this effort given high disease burdens, epidemiological and demographic shifts in disease and pressure on funding to maintain progress as well as competing health priorities. There was emphasis on taking into account the needs of marginalised, vulnerable and stigmatised groups; immigrants and migrant workers; and stateless people.

Some argued that GNI/capita-based thresholds should not be used by development partners to curtail assistance. Others sought to stress the importance of considering commodity prices and other inputs, and to foster mechanisms to address them including regional groupings of countries.

Others called for states to take primary responsibility for the health of their populations, and partners to create incentives and reward efforts to invest in health. There was a desire to avoid perverse incentives that rewarded governments for doing too little and to ensure that donor funding would not "crowd out" domestic investments.

Many emphasized the need to recognise nuances: there is often a lag between growth and government spending; GDP revisions do not rapidly translate into opportunities for improved investment and may even lead to a short-term fall in income for health spending as foreign support falls while tax does not rise. Some countries' economic status may decline as a result of conflict or other crises. Many that have become lower-middle-income have done so due to statistical recalculations and remain "just beyond the bar" dividing them from lower income states.

There is additional complexity in federal states with regional governments that set their own budgets. Ministries of Health also face limited power in negotiating with Ministries of Finance, and other departments that influence health including education and sanitation. They may feel they have limited flexibility since much of their spending goes towards headcount and overheads.

One option would be to remain with the current GNI/capita criterion, but shift the "cut off" threshold higher. There might be further adjustments to reflect a heavy disease burden. An alternative would be to examine a broader range of different indicators. Suggestions included debt, poverty, access to services, disease burden, the needs gap, institutional effectiveness, ability to pay and willingness to pay.

Some wanted a large number of indicators to reflect local conditions and complexity. Others sought practicality, simplicity and a limited burden on data collection, with a maximum of three indicators. Speakers stressed the challenges of data availability and quality, especially in those countries most in need of assistance.

There were calls for a transition period for countries over 5–10 years, giving time for adjustment and acknowledging that GNI/head could slip backwards, such as during a conflict, crisis or economic downturn. Some suggested the use of a rolling 3-year average to smooth out fluctuations. In implementation, there was the desire for a "single conversation", not one for each donor or disease programme.

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Forty-two members and a large number of advisers and representatives of the expert advisory group for the EAI met on 23 February 2015. They discussed the consequences of grouping countries for health purposes using GNI/capita—a strictly economic measure—and shared views about potential alternatives and the implications of different choices.

The meeting was opened by co-chair **Donald Kaberuka**, President of the African Development Bank, who stressed that there was no search for a magic formula. “We know the problem and we can probably solve it but there’s a dilemma over how to manage it.” He highlighted the varied challenges of the current approach. Some countries are “statistically middle income” but with a heavy social burden such as Swaziland. Others such as Ghana and Nigeria have become middle income after recently rebasing their GDP for the first time in many years. But the significance of this is not clear for many citizens. “When told his country’s GDP had risen, a taxi driver replied: ‘You can’t eat GDP.’” Other countries can “suddenly go from one category to another.” These included Liberia, which had been considered as middle-income but then entered a period of conflict and war. “Any framework will have intended and unintended consequences. The technical issue is equity, inclusion, sustaining the progress we have made. I’m persuaded we can come out with something workable to try in our different ecosystems.”

Co-chair **Pascal Lamy**, President Emeritus of Notre Europe and former Director-General of the World Trade Organization, said that issue of eligibility criteria, donor support and transitions was very complex. “We hanker for something different, more in tune with the problems on the ground—not just a simple number that bureaucracies can easily apply. It is easy to recognise things should be changed but there is a risk of unintended consequences. It’s not a miracle number we’re after but something precise, that works on the ground and can be used.”

The head of one agency expressed support for the idea of aligning financial practices with realities that were different from those seen at the start of the century. Economic growth meant that 70% of the world’s poor now live in middle-income countries—“a game-changing statistic”. But there is domestic political ambivalence. An increase in GNI/capita does not automatically translate into the ability and willingness of governments to invest more in health. Eligibility criteria based solely on GNI may punish the poor. Financial crises also reduce foreign investment. Many countries need to increase domestic resources. Between 100–150 million people a year are pushed into poverty because of high healthcare costs. There is a need to incentivise governments and community participation to promote good health, she noted.

Another agency head observed that there was no criticism of the World Bank in the current discussions, but that its country income groupings were being used today by many other entities for purposes other than those for which it was originally intended. Economic growth has dramatically shifted countries to the “right” of graphs showing GNI/capita. Global Fund countries are experiencing 12%–13% growth each year. “Countries haven’t fundamentally shifted but their classification has,” he said. The disease burden has also shifted. Two-thirds of HIV is now in middle-income countries, three-quarters of tuberculosis and half of all malaria cases (see Appendix Figure 1). Those figures will increase sharply in the coming years, according to predictions. Countries are stepping up to respond but it will prove very difficult for some time. As resources go down there is a “potential sustainability gap”. He stressed the purpose of the EAI was not that all convening institutions would radically change, but to consider a different starting point for a framework. “No-one doubts that

countries should invest more and better capture revenue. We will begin to put co-factors into a model around GNI as the starting point.”

A convening agency representative observed, “Graduation puts the AIDS response in many countries under sustainability risk. AIDS is still globally the main cause of mortality for women, and for the AIDS response inclusion of the key populations is critical. Stigma and discrimination remains a major barrier to HIV care and treatment. [We believe] we have a short five-year window opportunity to change the course of AIDS epidemic. This brings a clear sense of urgency. We need to ensure that required resources are targeted towards those most affected populations so as to bridge the gap even in the case of graduation. In addition to the financial aspect there are two other aspects relating to the central issue of equity that need to be factored in. First for governance—there urgently needs to be a discussion on governance of health, and second on the development of local capacity in countries to produce health services that are made available for all.”

Others also observed that income classification transitions have been very common in the recent past (see Appendix Figure 2), although those transitions have not necessarily had any link to growing capacities in health.

One presenter argued that “in general if you have money you live longer.” He said 82% of how long people live is explained by money and that GNI remained the best indicator. But he argued there was a case to change the threshold, not to continue to use “haphazard cut-offs from the 1980s and 1990s”. He said most of the poor concentrated in middle-income countries were in states just beyond the threshold defining lower middle income. He cited GAVI and UNFPA, which have shifted their cut-off thresholds rather than abandon GNI/capita. He said high disease burden should also be taken into account, such as Botswana given very high HIV rates and Egypt for hepatitis-C virus. He argued for the growing number of richer people in lower income countries to pay an increasing share of assistance to fellow citizens. At the same time, participants noted that withdrawing funding due drops in disease may punish success and leave countries at risk of not being able to maintain the gains.

One speaker said Gavi has a “graduation phase” of five years before expecting full financing by countries. It also uses market shaping to bring down the prices of vaccines to benefit countries even once they are no longer eligible for support. It projects 22 countries will transition out by 2020 (see Appendix Figure 3). He said aspects to consider in any criteria included: strong health systems; access to appropriate prices; effective procurement; regulatory policies; strong planning, budgeting, and disbursement; robust decision making processes and policies; and strong community demand. He stressed the importance of considering urban/rural, regional, gender, birth order and education inequalities.

Wide-ranging discussion flowed around these and related presentations. Some members emphasised that a lack of resources was the biggest problem and the focus should be on the principle of care and treatment for all. They sought a rights-based approach, and argued that there was a responsibility of the global community to act on behalf of people in need of healthcare even if their own governments did not. That could come through funding directly to the population, for instance.

One speaker argued that, unlike the World Bank, UN agencies are bound by international law including the international law on universal human rights. He said that any revised formulation of the current criteria must be compliant with these obligations including the interpretation of “equitable” access.

Several mentioned the high cost of medical commodities as a barrier to ensuring access to healthcare. There was discussion of the use of regional cooperation through mechanisms such as pooled procurement to help better tackle the problem.

However, others focused on the importance of allocating scarce resources and the need for governments to take primary responsibility—including through meeting the Abuja declaration targets. One speaker stressed the need to focus on how to divide up the existing health resources “cake” rather than draft an advocacy document focused on how to increase its size. He expressed concern over current or immanent misalignment between needs and assistance. “We must search for interventions that offer appropriate incentives for additionality sustainability and responsible transition.”

He stressed the importance of focussing on where the needs are, where health outcomes are poor. “We should care about outcomes, results, sustainability. As funders, we must ensure we are not just crowding out spending by governments and civil society. We need to align incentives to encourage stable systems, not create incentives not to take responsibility.” High GNI should mean that taxation is possible, but recent IMF research suggests some Asian countries have made a policy choice to have low taxation. “We have to change focus less on resources to pay for health and more on domestic health financing, strengthening governance and management.”

Others shared the concern to avoid perverse incentives. “We need a people-centred, nuanced approach to identify those most in need, while assuring accountability, and the primary responsibility of states for the welfare of their citizens.”

However, some health officials stressed their limited ability to respond, with much of their budget committed to healthcare workers and overheads and little influence with colleagues overseeing departments that had an impact on health including education, sanitation, nutrition and transport. Most significantly, they often struggled to influence government spending decisions. “It’s not easy for ministers of health to convince ministers of finance.”

There was extensive discussion over the strengths and weaknesses of different indicators. Some speakers said that a single number might be convenient but provided a result that risked ignoring or underplaying inequality, human development, social exclusion and government and health system capacity. The dynamics were changing rapidly and there was a need to focus on those people in need. “We need to ensure continued incentives to invest more in health in an equitable manner, and ensure we don’t leave out any population groups at risk.” There was recognition that inclusion is not only an issue of poverty but relates to the most vulnerable and those who face discrimination. High-risk groups such as men having sex with men, commercial sex workers, injecting drug users, migrant populations and others should be factored into the discussion.

There was concern that when some countries’ economic status changes from low-income to lower-middle-income, there could be negative consequences for their own populations and for migrants and stateless people in their border regions. This highlighted the need to inform health and development assistance decisions with more than just aggregate economic indicators.

One speaker highlighted the wide variation of disease and income in different parts of some countries and called for time to improve governance and institutional

structures. He said there was the need for a transition period of 5–10 years before any cut off of support.

Another member pointed to a country with a very high global disease burden, noting that a recent rebasing of GDP meant “automatically a lot of things kicked in and triggered expectations in the health sector, but not more revenue”. Its aggregate figure of GDP did not do justice to variations within the country, it was noted.

Even upper middle-income countries face difficulties. In one country, for instance, 22% of the population cannot afford healthcare and nearly 20% live in poverty. Debt is high at 139% of GDP. There is limited fiscal space, and competition with other crucial sectors such as education and security. There is a fresh strain from the growing burden of non-communicable diseases. The government is seeking to respond by boosting healthcare support including through a national health insurance plan, vehicle insurance, levies on tourism, remittances, tobacco and fast food. It has also launched a national health-card to monitor and improve the efficient use of drugs.

Some argued that it was difficult to adopt a single indicator. Different organisations have different objectives; and it is not possible to compare regions: Central Africa is very different from Central Asia. One said that the definition of “low income” was highly subjective around the world: \$1,500/head for the World Bank, but \$16,000/head for Medicaid in the US, for instance.

Metrics discussed included: the number of the poor and sick, debt levels, infrastructure, access to high quality services and institutional effectiveness. Others included the capacity to finance, per capita income, wealth, and the impact of natural resources. Several cited the importance of the ability to pay and willingness to pay. Non-health indicators which have an impact on health included sanitation and hand-washing. There was some discussion of weightings to target or prioritise different types of health services, including prevention and infectious vs non-communicable diseases. Many possible indicators that could be included in the EAI were suggested in one of the presentations (see Appendix Figure 4).

There was caution over the difficulties in collecting additional data: it often did not exist, would divert resources from healthcare workers and others on the ground expected to collect it. “Those countries with the data don’t need the aid,” mentioned one panellist, noting that if eligibility were limited to countries with good data then “no country where the poor currently live will be eligible because that they don’t have that information.”

From a ministerial perspective there were often too many demands for information: in Rwanda at one point there were requests for 600 different indicators. One speaker recommended not more than three be required for any calculation. He added that if willingness to pay were an organising principle, it should operate for the providers of finance as well as the recipients with the use of a reciprocal indicator.

Others suggested that, “bad indicators can be worse than no indicators.” There were comments on the need for simple interpretation of any thresholds. “Internationally it would be more coherent to have one conversation, not just specific to particular disease programmes.”

There were calls to consider “transition planning” in any interpretation of thresholds. There was a risk of “sudden” lurches, with the suggestion of introducing a rolling average of GNI, such as over three years, to help smooth against a sudden downturn.

Many expressed urgency, given that AIDS is the main killer of adolescents in Africa and the second biggest globally. “The next five years are essential. It cannot be an intellectual exercise forever. We need a conclusion.”

In response to discussion about the operation of the EAI, one of the convenors stressed that the group would not recommend how to undertake allocations, which was a decision for the governing boards of different organisations. Precise aspects would be analysed by modellers in a process overseen by the convenors, and there would likely be two or three models examined to simulate the impacts on different countries. There would be consultations, full circulation to the expert group, feedback and likely a revised model ahead of a final report, with the aim of making recommendations early in 2016.

With respect to transparency and accountability, a question was raised about the EAI Terms of Reference and the requirement of prior approval before dissemination of EAI-related documents. There was a clarification that the presumption would be that disclosure is appropriate.

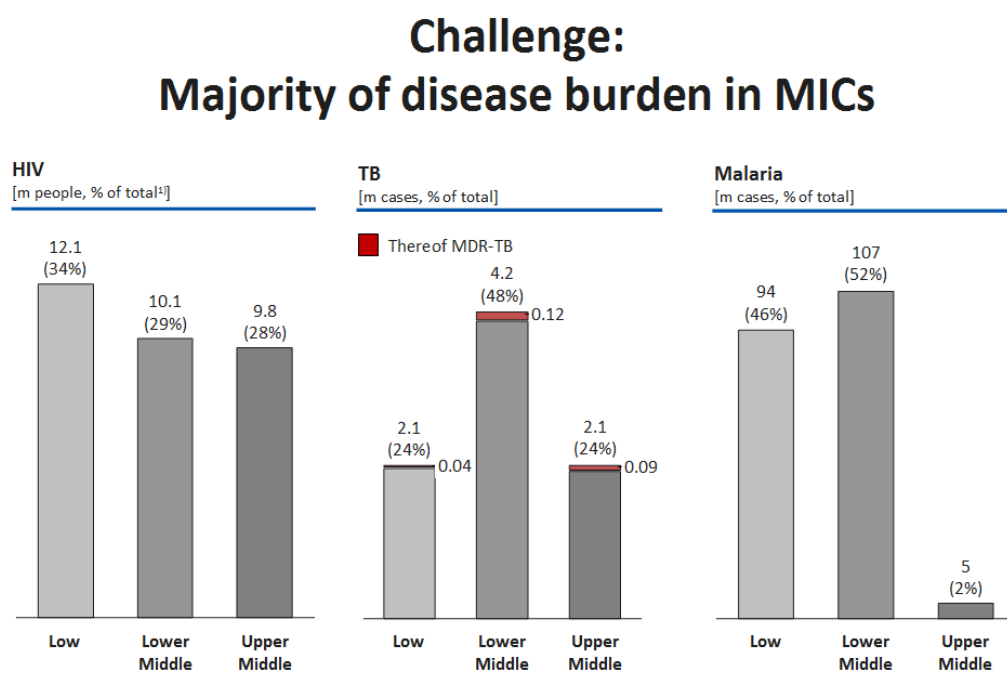
The meeting drew to a close with summary points from the co-chair, who captured the day’s discussion in four conclusions:

1. The existing use of GNI/capita was not well suited as the sole basis for the allocation of resources for health, and did not capture important dimensions of health and health-related capacities.
2. There was a need to seek alternative indicators to reflect health development needs and equitable access considerations while being conscious of their use and impact. They should reflect ability to pay, willingness to pay, relevance, reliability and sustainability.
3. The focus should be on the numbers to characterize whatever indicators are identified by the EAI. There was no intention to build a new system of governance or tackle problems of coordination. Any impact on resource allocation remained in the hands of resource providers.
4. A new framework for evaluating the health development of countries could help incentivise continued resources by focusing attention on investing in health.

Thanks were expressed to the convenors for their support, to WHO for hosting the meeting, to UNAIDS for the facilities, to the organizing team, which included logistics support from the WHO and UNITAID as well as to the Wellcome Trust, which had contributed resources.

APPENDIX

Figure 1: Burden of HIV, TB, and malaria by country income classification



1) Total global HIV estimate: 35.3 m
Notes: UNAIDS data, WHO 2012 data, Global Fund analysis – Results are indicative only and should not be used outside Global Fund bodies without prior consent.

Figure 2: Countries Changing Income Classifications

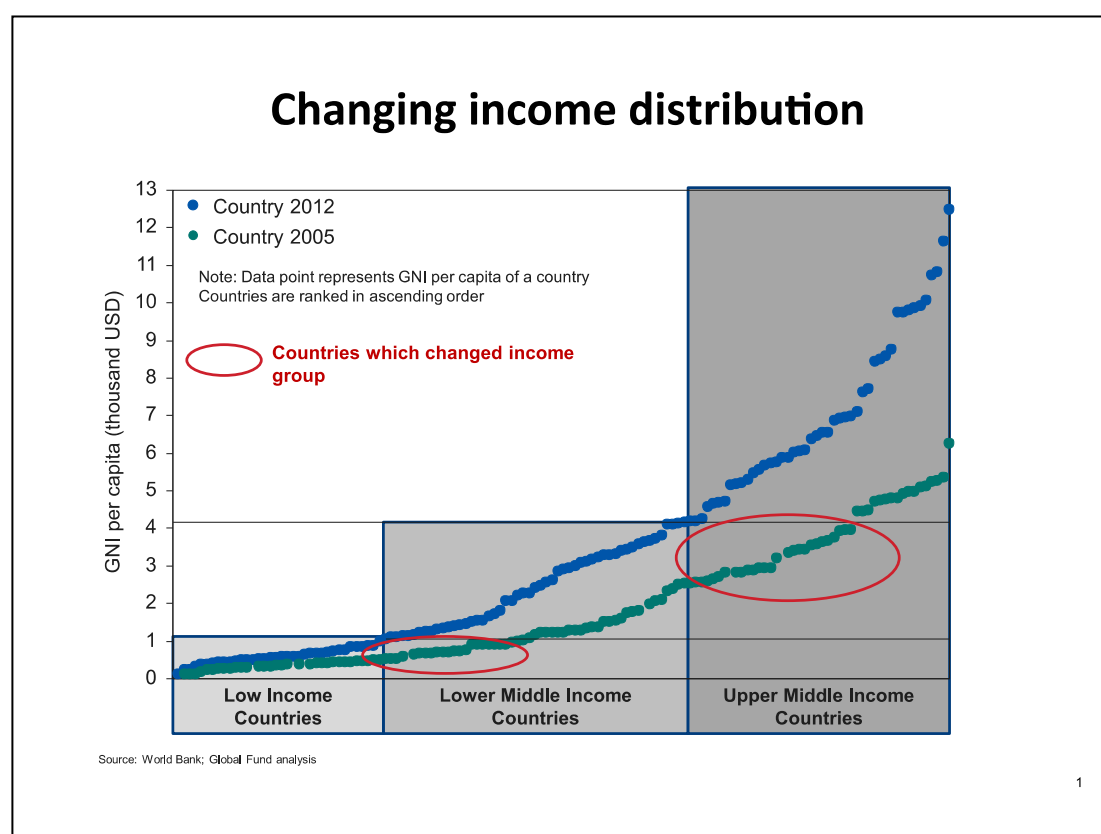


Figure 3: Countries projected to graduate from Gavi support, 2011–2022

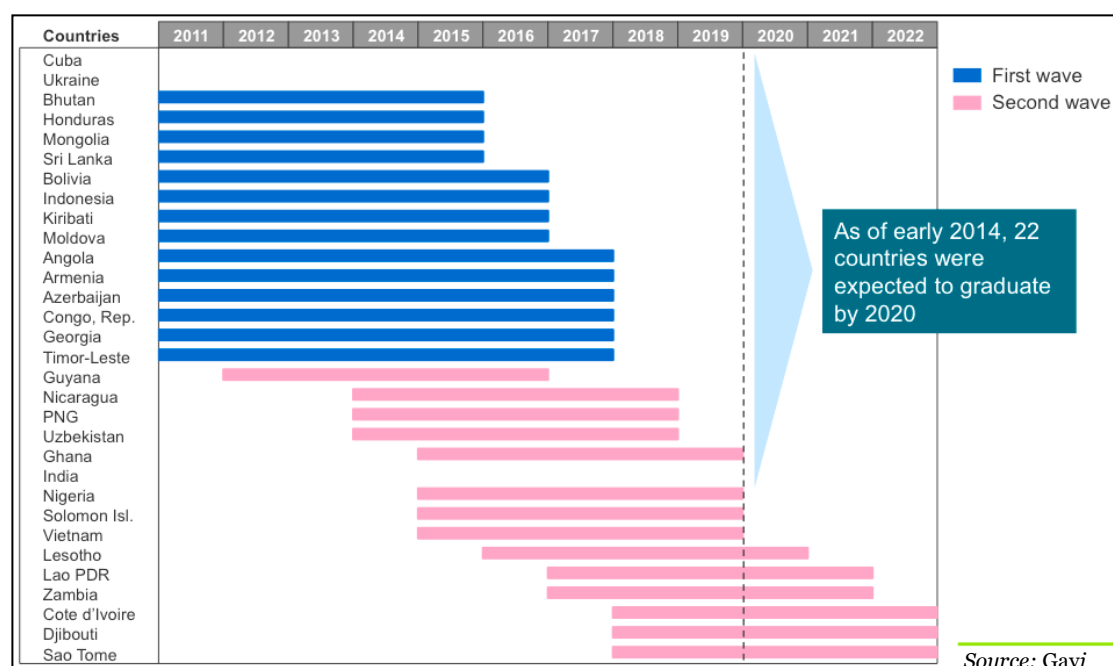


Figure 4: Indicators that could be considered for inclusion in a new metric

Sampling of Possible Indicators	
Poverty Burden <ul style="list-style-type: none"> Persons in Poverty (<\$1.25 or <\$2.00/day) Fraction of GNI held by poorest 40% Global Multidimensional poverty indicator (GMPI) Multidimension Poverty Index (MPI) Fraction of population with health insurance 	Health System Access, Readiness (e.g. SARA) <ul style="list-style-type: none"> Facilities per 10K pop. Inpatient beds per 10K pop. Maternity beds per 1000 pregnant women Health workforce per 10k pop. Fraction of births occurring in facility Outpatient visits per person/year Hospital discharges per 100 person/year
Population Health <ul style="list-style-type: none"> Life expectancy Under 5 mortality Maternal mortality Undernourishment Adolescent fertility DALY per capita Share of DALYs accruing to poorest 20% or other "disparity" measures 	