The Future of Financing Global Health: An Informal Conversation with John-Arne Røttingen

What funding model will be most useful to make universal health care a reality around the world, especially for those who need health care most? And how might health financing and policy leaders support both national and global responsibilities in financing mechanisms that can shape global health? These were just two key questions explored in a lively discussion about health care financing with John-Arne Røttingen, MD, PhD, MSc, MPA, at the Harvard Global Health Institute on March 26, 2014. The event was part of the Institute's Informal Conversation Series, which offers faculty and students the opportunity to engage in dialogue on cutting-edge, cross-disciplinary issues, exploring new ideas, challenges, and opportunities that impact global health. Røttingen is a physician and Professor of Health Policy at the Department of Health Management and Health Economics, Institute of Health and Society, Faculty of Medicine, at the University of Oslo. He currently serves as Visiting Professor in the Department of Global Health and Population at the Harvard School of Public Health, and as Visiting Scholar at the Harvard Global Health Institute. In addition to holding a number of leading roles in research and health governance, he was recently named Director of the Division of Infectious Disease Control in the Norwegian Institute of Public Health.

Røttingen opened the conversation with a brief description of recent work by the Chatham House Working Group on Financing for Global Health to draft a global framework for health financing. Universal health coverage at the global level is very affordable, he said, but how can we "make the future we want?" He focused on details of the framework related to six questions: Why do we need to invest in health? For what? How? Who? How much? And where? Based on a foundational approach to health as both an instrumental economic tool and essential human right, the Working Group's research corresponds closely with recent work on both global governance and investing for health, such as the recent report of the Lancet Commission on Investing in Health.

Basing estimates on a low-income country (LIC) context, Røttingen said, an adequate package of primary health care services would cost domestic governments around the world a mere $86 per capita. But many countries, lacking capacity to finance health care for domestic citizens, would need help from outside global partners to attain this goal. The Working Group — whose final report is due out soon — calls for a committed collaboration at the domestic, government, and global level, and suggests a collective coordination of some very practical solutions to close the $144 billion gap between current global health expenses and what it would take to meet this $86-per-person goal. The best system for success should be prepaid, Røttingen suggested, based on a pooled financing model, and mandatory for all nations.

The proposed framework raises at least three key questions, said Dr. Rifat Atun, Professor of Global Health Systems at Harvard School of Public Health

Resources

Suggested readings:

Development Assistance for Health: Quantitative Allocation Criteria and Contribution Norms
Working Group Paper
Trygve Ottersen, Aparna Kamath, Suerie Moon and John-Arne Røttingen, February 2014

Financing Global Health Through a Global Fund for Health?
Working Group Paper
Gorik Ooms and Rachel Hammonds, February 2014

Raising and Spending Domestic Money for Health
Working Group Paper
Riku Elovainio and David B Evans, May 2013

Development Assistance for Health: Critiques and Proposals for Change
Working Group Paper
Suerie Moon and Oluwatosin Omole, April 2013

National and Global Responsibilities for Health
Bulletin of the World Health Organization
Lawrence O Gostin, Mark Heywood, Gorik Ooms, Anand Grover, John-Arne Røttingen & Wang Chenguang, October 2010

Photos from the Conversation with John-Arne Røttingen

All photos by Christen Reardon

Atun, Professor of Global Health Systems at Harvard School of Public Health, who moderated the March 26 conversation. First, noting that the framework shifts the focus of responsibility and accountability from the state to the private sector, he asked, "What might be the mechanisms to manage the transition?" Second, given that the framework requires shared responsibilities, "How do we ensure contributions — and what is fair?" Third, how do we ensure that the financing results in universal health coverage? Governments and investors want quick proof of success; "What measures and metrics will demonstrate benefits in the short run?"

Atun’s questions led to many more from conversation participants around the table. Another big question, suggested Professor Suerie Moon, also a member of the Chatham House Working Group, is "What does that mean, a 'framework'? Are you talking about a treaty?"

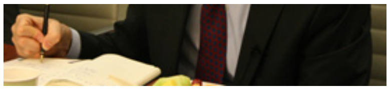
"We don’t have treaties that bind countries to financial contributions, so I do not think a treaty would be the way forward, at least for the time being," replied Røttingen. Rather, he explained, the term "framework" is intended to emphasize the importance of connectedness. "A political declaration would probably be the best and most achievable outcome," he said. Such a platform — rather similar to the Millennium Development Goals — would call for global and national consensus without binding specific nations to specific financial contributions. Targets need to be achievable, balancing idealism with pragmatism even as they support global norms.

Some participants in the conversation wondered why we need another new framework, especially when so many systems and innovative finance mechanisms already exist, and are less than successful. In response, Røttingen affirmed the critical need for interconnectedness between existing systems. "We don’t see this as creating new entities," he said. Rather, the framework could strengthen connections, for example, between initiatives and traditional financing bodies such as The Global Fund, GAVI Alliance, and The World Bank, as well as domestic tax-based funding sources (such as UNITAID) that continue to operate despite ongoing challenges.

"What is the basic package and who decides?" was another big question. Should such a system fund drugs like the new Hepatitis C treatment, recently approved by the FDA but at the cost of $1,000 per pill? Indeed the biggest challenge to the new framework is defining precisely what that $86 per person would buy. Both the package and quantification of a "fair contribution," Røttingen suggested, should be decided by individual countries based on specific national health needs, public voice, and civil society.

And what about global accountability? "Can you offer any kernels of wisdom for our students who want to talk with their parents who are not accustomed to thinking about shared global responsibilities?" asked Brittany Seymour, a faculty member at Harvard School of Dental Medicine and Inaugural Global Health Fellow at HGHI. "It’s a difficult conversation," Røttingen admitted, noting the need to respect differences between perspectives in the United States and Europe on global citizenship and global responsibility. "We need to convey that financing should not be limited to country boundaries," he insisted.

Many unresolved issues and questions remain, concluded Atun, summarizing the take-home points of the conversation in his closing comments. Further discussion across sectors and borders will help to further push creative thinking on innovative financing instruments and mechanisms that can help shape "real politics" and practical financing for a healthy world.



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