2016

The Equitable Access Initiative

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Acknowledgements

The Equitable Access Initiative Report represents a collaborative effort by nine convening organisations - Gavi, the Vaccine Alliance; The Global Fund; UNAIDS; UNICEF; UNDP; UNITAID; UNFPA; WHO; and the World Bank - together with a high-level Expert Panel and Technical Working Group1, chaired by Pascal Lamy Donald Kaberuka.

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Note

The designations employed and the presentation of material in this publication do not imply the expression of any opinion whatsoever on the part of any specific EAI convener or Expert Panel.

[1] List and designation of Expert Panel and Technical Working Group members available in the Annex

Executive Summary

For two decades, the World Bank has classified countries as low-, middle- or high-income based on Gross National Income (GNI) per capita. As a standardised and simple proxy for factors such as wealth, the capacity of governments to provide services to their citizens, and national levels of development, GNI has been an influential yardstick to determine the eligibility of lower income countries for concessional external financing from multilateral and bilateral partners.

For decades, the classification was straightforward. A majority of newly independent countries receiving external financial development support were low-income countries — the countries that had the greatest needs were also the poorest. But in recent years the rapid increase in economic growth and inequality around the world, coupled with the rebasing of GNI by some countries, and fresh domestic economic pressures among many funding bodies and donor agencies, is creating new complications. Countries that until recently were considered low-income risk losing external support as they grow into middle-income status, even though they are still home to most of the world's poorest citizens with unmet health needs.

Presently, 105 countries are considered middle-income, but many are characterized by high-levels of inequity and are home to more than 75 per cent of the world's poor. From a global health perspective, the largest share of disease burden is now concentrated in middle-income rather than low-income countries, a reality that GNI per capita alone cannot capture. As a result, there is an increasing concern over the potential mismatch between GNI per capita and the extent of a country's health needs suggesting that policies based on income classification alone overlook important dimensions of development, such as poverty and inequality.

The recently adopted Sustainable Development Goals (SDGs) and the final communiqué from the Financing for Development summit in 2015, call for achieving ambitious development and health goals with an explicit focus on equity. The SDGs embody a renewed commitment to equality, non-discrimination and "leaving no one behind" and this requires an explicit focus on the poorest and most vulnerable. One of the unique features of the SDGs is in their relevance for all countries regardless of economic standing. But there is also a renewed commitment to "shared responsibility" in investing toward a more equitable and egalitarian world, and achieving these goals through a human-rights based approach that is rooted in giving all people the opportunity to achieve their right to life and dignity. For external health financing this could mean a greater focus on the social determinants of health, reducing health disparities and the rights of vulnerable groups and key populations.

Given such rapid socio-economic and political change, and continued global health commitments, there is need for a debate that while GNI continues to be relevant, it may be inadequate as the principal basis for classifying countries and their eligibility for external financial support for development.

The Equitable Access Initiative (EAI) was launched in early 2015 by the heads of multilateral organizations engaged in global health: GAVI, the Global Fund, UNAIDS, UNDP, UNFPA, UNICEF, UNITAID, the World Bank and WHO. The purpose was to consider alternatives to GNI as a framework to assess countries' need for external financial support for health. Currently, the convening organizations use GNI in different ways to determine key policies, including eligibility and co-financing policies.

A high level panel was established with co-chairs Pascal Lamy, former head of the World Trade Organisation, and Donald Kaberuka, former head of the African Development Bank. At the first EAI Expert Panel Meeting in February 2015, Panel members and the nine convening organisations were in agreement that the World Bank's GNI per capita country classification system, designed for World Bank lending decisions, was being used far more broadly in health-related decisions. The conveners of the Initiative commissioned four expert academic groups to develop options for a new health framework.

Based on the analyses of the four analytical teams and the co-convenors, as well as extensive consultations, this report explores a health framework that can account for health need, income levels, and health funding considerations, which could inform different stages of decision-making by the convening organizations' governing bodies or other bilateral and multilateral organizations involved in external financial support for health.

Key Findings

The analyses find that policymaking should not rely on a single variable to inform complex health financing polices on the eligibility for and the prioritisation of investments. It is proposed that policymakers consider a more comprehensive framework for decision making that accounts for countries' position on a health development continuum, based on the analysis of countries' needs, fiscal capacity and policies.

For instance, eligibility policies should not only consider the level of wealth in a society, as measured by GNI per capita, but account for health need relative to income as well as mitigate the effects of discrete thresholds that render a country ineligible for support once it passes a certain GNI per capita level. Further, in order to prioritize investments, a government's resources and policies to meet this health need should be taken into account. Finally, the analyses highlight the need to account for equity considerations, particularly within country inequity, suggesting that context-specific analyses are relevant when assessing the level and type of support to be provided.

Based on the analyses and findings of the EAI analytical work, a conceptual framework to guide policymaking in external financing for health is proposed that accounts for the following considerations:

Recommendations

- To **inform complex external health financing decisions** such as eligibility and the prioritisation of investments **with a multi-criteria framework** that takes into account income levels and health needs, in addition to domestic capacity and policies, where relevant.
- To **inform eligibility policies by health need relative to income**, and to design complimentary policies that allow for a planned gradual transition, in order to mitigate the risk of a country losing gains in health when external financing decreases rapidly in spite of significant health needs and/or limited fiscal space.[2]
- To **consider domestic fiscal capacity characteristics when prioritising investments** and to develop policies that favour improved health outcomes and increased domestic finance.

Long-term actions

- To **consider greater investments** in data collection systems towards developing a more nuanced, comprehensive framework that captures sub-national equity considerations, including the needs of key populations and vulnerable groups, through better quality and more reliable data that support the inclusion of relevant indicators.

Way Forward

A key issue that goes beyond what is explored in this report, would be to consider health impact and efficiency indicators in guiding operational and programme decision-making and to promote incentives that improve health outcomes and reduce health needs. This would be another critical element for a more comprehensive and strategic approach.

The Initiative in general and the report in particular is not focused on the implications of these findings and recommendations for specific eligibility, allocation, or co-financing policies, since this is beyond the purview of a multi-convener Initiative, nor on implications for high-income countries. The analysis, findings and recommendations may serve however as a starting point for discussions on these policies. It is recommended that as a first step, this report - and where relevant, the individual analytical groups' reports - be shared with the governance bodies of health and development organisations to inform policy and strategy deliberations.

Finally, while the analysis and recommendations are specific to health, the fundamental approach and characteristics could have relevance for other areas of development. The idea of accounting for need relative to income levels and fiscal space could be relevant to any lens that focuses on the socio-economic dimensions of development, including agriculture, education, health, nutrition, gender, and social inclusion. Further, the recommendation that thresholds and sharp cut-offs in assistance should be avoided could apply to any development area where there are high levels of need across the income spectrum and limited domestic capacity to address it.

It could therefore be of significant value to consider how a more refined and comprehensive framework that in addition to income levels, accounts for need, fiscal capacity and policies across key development sectors could be developed. While some countries may have relatively equal standing across areas of development, assessing each sector by similar factors could contribute to a more coherent analytical framework to help understand countries position along the development spectrum, and to provide better guidance for domestic and external finance towards achieving maximum impact.

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[2] While there was consensus among EAI members that where discrete thresholds are used that render a country ineligible for support once it passes a certain GNI per capita level, the risk of negative impacts on overall health financing should be mitigated by allowing for a gradual and planned transition; an additional recommendation to avoid discrete thresholds for low- and middle-income countries was not supported by the entire EAI.

Since many health organizations, multilateral and bilateral, have limited expertise or mandate in areas related to fiscal policies and domestic financing capacity characteristics, the analysis highlights the importance and need for a wider collaborative approach among development partners to jointly develop the analytical tools to inform such policies. Similarly, investments in global public goods such as national data systems and data quality require greater coordination and alignment in order to avoid duplication and achieve efficiencies.

Again, these issues highlight the need for stronger partnership and collaboration across development organizations to maximally support countries as they move along the development continuum.

Chapter 1: Key Findings and Recommendations

1.1 The use of GNI in Health Policy

The successors of the Millennium Development Goals, the Sustainable Development Goals (SDGs) mark a watershed moment in development financing: the 2030 Agenda for Sustainable Development identifies that all UN stakeholders, including State and non-State actors, have an equal and shared responsibility towards achieving these goals through a human-rights based approach that is rooted in achieving the right to life and dignity for all. The SDGs are also much more explicitly rights based than their predecessor the MDGs.

While the operationalization of the SDGs is centred on paying 'attention to the voices of the poorest and most vulnerable'[3], the premise of the health-related SDG is "to ensure healthy lives and promote wellbeing for all at all ages", whether in low-, middle-, and high-income countries. For external health financing this could mean a greater focus on reducing health disparities through rights-based approached to health which address the social determinants of health.

Against this context, there is a need for a more nuanced framework that allows financing to respond to the different health needs of people, and is better tailored to the realities of different countries across income groups.

Historically, GNI per capita has played a predominant role in informing development policy as multilateral health financers and development agencies[4] have followed the World Bank's lead in using the metric and income classification to inform key policies. Institutions that disburse about 75%[5] of available external financing for health, base their eligibility, allocation and co-financing[6] policies on the metric (Table 1).

Table 1 Use of GNI in multilateral organisations' policies

		Eligibility		Allocation Formula			Co-Financing	
	Organization	GNI per capita	Health Need	GNI per capita	Disease Burden	Performance	GNI per capita	Comments/ Other indicators
Multilateral Health Financer	Gavi	✓				✓	✓	Allocation: DTP3 for performance
	GFATM	✓	✓	✓	✓	✓	✓	Allocation: Potential Government Spending
	UNAIDS							Allocation: Population
	UNFPA	✓	✓	✓	✓	✓[7]	✓	Allocation: Population
	UNICEF	✓	✓	✓				
	UNITAID	✓		✓				
Multi-Sector Financers	IDA (World Bank)	✓		✓		✓	✓	Allocation: CPIA, PBA, and Population Eligibility: Credit worthiness
	IBRD	✓		✓		✓		Eligibility: Credit worthiness
	UNDP	✓		✓				

An advantage of GNI per capita is that it is a simple and widely available statistic. But it is coming under increasing scrutiny for its use as a basis to inform health policy, in part because of questions over its ability to represent countries' actual needs. In the past decade, rapid economic growth and statistical revisions led to

[3]Transforming our world: the 2030 Agenda for Sustainable Development: https://sustainabledevelopment.un.org/post2015/transformingourworld

[4]Including the Asian Development Bank, African Development Bank, Inter-American Development Bank, International Fund for Agricultural Development, The Global Fund and Gavi.

[5]http://apps.who.int/medicinedocs/documents/s19590en/s19590en.pdf

[6]Eligibility policies define the criteria based on which countries can access concessional financing and grants; Aid allocation are the explicit or implicit set of rules used to determine the amount of aid, and in certain cases the type of aid, that a country receives; Co-financing policies are partnership agreements with government recipients of external health financing which define the level of domestic public resources that a government would allocate either to co-invest in externally funded programs, or to co-invest more broadly in the health system.

[7] Performance is currently only considered for co-financing allocation

many countries' transition to middle-income status. The 105 countries presently classified as middle-income are characterized by high-levels of inequity and are home to more than 75 per cent of the world's poor.[8] The classification masks significant variation among countries, including widespread differences in levels of development and basic human needs.

A consequence of this transition to middle-income status has been the potential loss of financial and technical support from multilateral and bilateral partners. Countries including Ghana, India, Nigeria, Pakistan, and Vietnam will likely lose between 25 and 40 percent of their total official development assistance due to transition from major development finance institutions.[9] At risk of losing external support, many middle-income countries—and their populations—may find it more difficult to achieve or sustain gains toward internationally agreed development benchmarks including the health-related targets of the 2015-2030 Sustainable Development Goals.

From a global health perspective, the largest share of disease burden is now concentrated in middle- income rather than low-income countries, a reality that GNI per capita alone cannot capture. The potential mismatch between GNI per capita and the extent of a country's health needs suggests that income based metrics should be complimented by health indicators to guide international decision making in health and development.

Efforts to develop different country classification frameworks have however come in for criticism. Some fear that using alternative indicators may not be suited to replace GNI, posing challenges of data collection, measurement, weight, and that they may ultimately prove more complex to implement. Some have proposed that the best response would be simply to lift or change the existing eligibility thresholds. Several organizations have already put transitional arrangements in place to soften and slow the impact of the loss of external financing for countries in transition.

Generally, the calls for a wider debate over the relevance of GNI per capita as the central yardstick for external health investments, have emphasised that income metrics are not designed to capture disease specific considerations, account for the different disease-burden across countries, or accurately reflect a government's capacity to address health needs. The common driving motivation is to avoid a resurgence of disease that could undermine past progress and be detrimental to fostering improved outcomes in health and development.

Box 1. The Search for Alternative Measures

The growing reflection on the limitations of income metrics to measure human development has triggered considerable research on alternatives. Since 1990, the UN Development Programme has produced its own Human Development Report, which includes rankings for countries based on measures for children and young people including HIV, malnutrition, exclusive breastfeeding, antenatal coverage and immunisation; and, for adults, of physicians, health spending, and age-standardised death rates and obesity.

French President Nicolas Sarkozy established the Commission on the Measurement of Economic Performance and Social Progress in 2008 to examine the limits of Gross Domestic Product (GDP) as an indicator of economic performance and social progress, and to consider what other measures should be used to assess the quality of life." Chaired by Joseph Stiglitz and advised by Amartya Sen, the Commission's final report called for better information and richer measures to guide economic policy. Among other recommendations, it highlighted the need to shift emphasis from economic production to well-being; to emphasise the perspective of the household; and to give more prominence to distribution within countries.

Subsequent analyses have followed, including the Organisation for Economic Cooperation and Development's "Better Life Index" report in 2015, which captures material well-being and quality of life indicators. "National averages tell only part of the well-being story," it said, highlighting disparities within countries and the importance of metrics that are not traditionally collected.

The Social Progress Index 2015 highlights the need to achieve economic and social progress for inclusive growth. It measures social progress independent of GDP and is meant to serve as a complementary tool, highlighting the importance of outputs rather than inputs. Most recently, the World Bank established a Commission on Global Poverty on how best to measure, monitor and combat poverty, which is due to report in 2016.

[8] There are however clear differences in poverty rates between LICs and MICs: for instance, extreme poverty incidence rates in LICs are extremely high as a whole (about 47% in 2012) compared to LMICs (around 18%) and UMICs (around 5%).

[9] "The role of aid to middle-income countries: a contribution to evolving EU development policy". London: ODI, 2011.

1.2 The Equitable Access Initiative (EAI) – Developing a new framework

Against this background, the Equitable Access Initiative was convened in 2015 to explore the strengths and weaknesses of GNI, and the potential for developing alternative and complimentary measures to inform policies. At the first EAI Expert Panel Meeting in February 2015, Panel members and the nine convening organisations were in agreement that the World Bank's income country classification system was being used far more broadly to inform health-related decisions very different from the question of access to soft loans to which it was originally applied.

It was acknowledged that the use of such a classification system overlooked key considerations such as the highly-varied distribution of disease, poverty and inequality within countries, as well as the capacity of the health system. Based on the recognition that countries along a development continuum vary in terms of health need and capacity, a framework not purely based on income may be better suited to ease transitions, identify suitable health interventions, and provide incentives for mutually accountable partnerships.

The objective of the Initiative has been to develop a new health framework for analysis that takes into account a broader set of economic and health indicators to help inform international decision making in health. To conduct the analytical work, a Request for Applications was widely disseminated by the Equitable Access Initiative, and a Technical Evaluation Committee comprising experts from the convening organizations selected four analytical groups to independently explore the issue.

This report focuses on the points of agreement and elements that emerge from the analyses of the four analytical teams commissioned by the EAI, as well as inputs from the EAI consultation process, in addition to further analysis by the co-convenors, without delving into the work of any one group. The next section highlights the main findings of the four analytical groups. The full reports of the analytical teams, which discuss the methodology, approach and findings of each group, are available as accompanying documents to this report.

1.3 Findings from the EAI Expert Analytical Groups

To investigate alternatives to decision making based on income as the central criteria, the EAI commissioned four expert analytical groups to independently explore the issue. This section discusses the concepts adopted by each. The four teams were based at the University of Oxford, the University of Sheffield-Imperial College, the Norwegian Institute of Public Health (NIPH), and the Institute of Health Metrics and Evaluation (IHME) at the University of Washington. The findings of each group can be found at http://www.theglobalfund.org/en/equitableaccessinitiative/.

There is a common point of departure across the four groups. All the teams recognised limitations to using a single indicator classification system in health policy, and each proposes modifications by complimenting the GNI/capita metric with additional indicators relevant to health and financing.

Considering that a classification based on multiple indicators could guide better decisions, the groups explored different health-based frameworks that take into account country health needs, inequalities, access, financial protection and spending. In broad terms, the ideas are along a spectrum that on one end emphasises current realities such as the health burdens countries face and the resources available (Oxford and Sheffield), then moves to more normative questions of which indicators to choose and how different indicators could be taken into account (NIPH), and finally to pragmatic questions of the funding gap to reach a particular health goal (IHME).

Although their approaches differed, there were significant points of convergence between the proposals, including: the use of disease metrics to capture health need; accounting for inequity in income and health; and accounting for a government's capacity to domestically finance health. They explored the development of a continuous classification framework rather than discrete groupings of countries based on thresholds. Several used aggregate health measures such as Disease-Adjusted Life Years (DALYs) to account for health access, financial protection, and health system quality.

The methods proposed by each team generated results that differed significantly from those based on GNI alone, showing that GNI is a poor reflection of health needs and government capacity. However, all four models provided relatively similar results, which suggests that health needs and capacities may be captured by a variety of indicators.

The proposed frameworks would help better understand the health needs and capabilities in a country context. The needs assessment framework by IHME also lends itself to understanding the financial need in a health focus area towards achieving a particular target, while accounting for efficiency considerations.

Some groups provide additional data/sub-indices which could allow policymakers to analyse local characteristics, including sub-national variations, and identify specific policy responses. The framework of IHME is based on estimates of actual resources required rather than proxies, and can inform policies to incentivise more domestic financing.

1.4 A conceptual framework to guide classifications in external heath financing

The analytical work and consultations highlighted that complex policies such eligibility and the prioritisation of investments should not rely on a single criteria for decision making. Different criteria and related indicators are relevant depending on the policy objective and stage of decision-making. The findings, models, and recommendations proposed by the four groups, in addition to the input from consultations, and further analysis by the co-convenors, can be structured into an overarching conceptual framework to guide classifications in external financing for health (Figure 1). The individual findings and specific frameworks developed by the expert analytical groups are available on the EAI website[10].

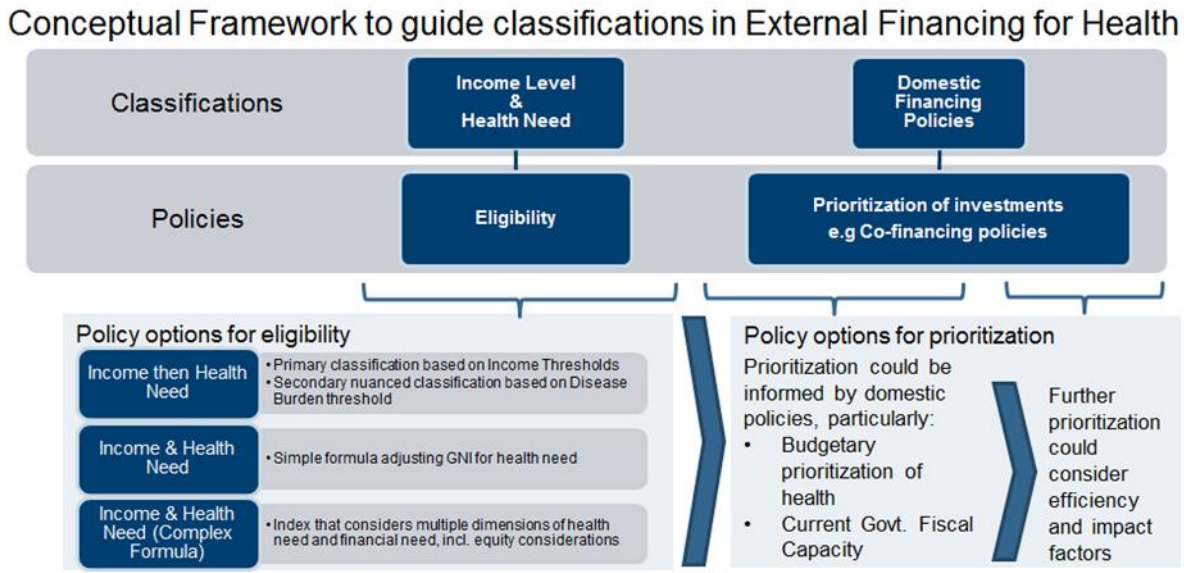

Figure 1: Conceptual Framework to guide classifications in External Financing for Health

External health financing has been guided by the principles of improving health outcomes in countries that have the least financial and structural capacity, both in terms of domestic resources and technical capability, to respond to key health needs.

These principles are operationalised through two broad sequential decision-making stages: establishing the eligibility of countries to access external financing based on 'need'; second, to prioritise where the largest investments need to be made, and what type of assistance (technical or financial) should be provided based on need, and domestic health policies including health financing. The prioritisation process also plays a key role in determining the partnership terms that external financers may have with country governments.[11] The analytical work emphasises that coordination among key development partners is however critical in order to comprehensively respond to the challenges linked with limited domestic fiscal capacity for health specifically, and development more broadly.

1.5 Health Classifications

Historically, GNI per capita has been used in classification frameworks to understand the level of wealth or financial need in a context. The analyses however demonstrates that the understanding of 'need' in health policy should be governed by additional considerations such as the disease burden. Burden of disease metrics, such as the Disability adjusted Life Years (DALY) or Quality Adjusted Life Years (QALYs) help quantify the level of disease and provide a common denominator.

[10] See http://www.theglobalfund.org/en/equitableaccessinitiative/

[11] This could include the dialogue on the policy changes needed to make certain health services available to key populations and vulnerable groups, or an agreement on the areas for domestic investment to maximise the disease response.

The first classification the analytical work explores is therefore informed by both income and health metrics, and accounts for levels of income relative to the disease burden a population should address, which could be particularly relevant for eligibility policies.

The second classification relates to process of prioritising investments, taking into account that external financing is often considered more relevant where the country's public domestic capacity is lower. Policies for external health financing should therefore consider the capacity and policies to address domestic health needs, as well as incentivize improved health outcomes and increased domestic finance.

Policies often rely on income per capita metrics to approximate a government's capacity to invest in health, but the analyses demonstrates that the metric is a better measure of the level of wealth in a society, rather than the resources available to a government for investments in health. The resources available to a government are typically smaller than the GNI levels suggest, and based on a range of factors and policies, including tax revenue, debt levels, levels, etc.

The analyses therefore recommend informing prioritisation decisions with the additional criteria of health financing policies and characteristics. Understanding health need and level of income against these strategic choices would differentiate between governments that may be at the same income level, but have different capacities and policies to respond to health needs

A classification along characteristics of domestic financing policies could be informed by the i) budgetary prioritisation of health, measured as a percentage of a government's expenditure dedicated to health; and ii) the current fiscal capacity, measured as the current government revenue minus debt service as a percentage of GDP.

A broad policy implication of such a classification would be that it could help prioritize investments, without creating what is often referred to as "perverse incentives" – the risk that external health financing could lead to a decrease in domestic public expenditures on health – through the development of co-financing policies. In addition, it could facilitate a policy dialogue with countries and cooperation among development partners on how to increase the fiscal space of governments where relevant for greater investments in health.

1.6 Equity and Human Rights in a Classification Framework for Health

The analytical groups also emphasised that across the two classification frameworks and decision-making stages, equity[12] and the health needs of key populations and vulnerable groups should be cross-cutting concerns. In consultations, stakeholders have emphasised that despite economic growth in many countries the specific health needs of key populations and vulnerable groups are not being met, a significant human rights concern.

While the analytical work attempted to include inequity measures[13], the poor quality and unreliable data prevented their inclusion in the overall framework and analysis. In the absence of reliable health inequity indicators, health financing multilaterals have also considered using measures such as the Multidimensional Poverty Index, and the inequality adjusted Human Development Index to include an overall income inequity measure. A better understanding of inequity, particularly in health access and outcomes, would however also require more detailed sub-national analyses and to account for legal and social barriers, for which there is often no regular and reliable data collection.

The 2030 Agenda for Sustainable Development identifies that 'data for several of the targets remain unavailable,' calling for, 'strengthening data collection and capacity building in Member States, to develop national and global baselines where they do not yet exist.'[14] A report[15] on the monitoring of the SDGs identified that that the greater focus on data could potentially allow policy-makers to measure and quantify multi-faceted concepts such as equity that were considered quantitatively immeasurable some years ago. SDG target 17.18 is specifically focused on enhancing capacity to collect data "disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts."[16]

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[12] Defined as a concern with the distribution of resources, services, and outcomes across individuals, groups, and populations.

[13] The Gini Index, Inequality in Life Expectancy, and Income share held by the bottom 40%.

[14] P. 57 https://sustainabledevelopment.un.org/post2015/transformingourworld

[15] Indicators and a Monitoring Framework for Sustainable Development Goals: Launching a data revolution for the SDGs http://unsdsn.org/resources/publications/indicators/

[16] https://sustainabledevelopment.un.org/?menu=1300

It is therefore recommended that in addition to the work being undertaken to capture equity of health outcomes in a single indicator, such as inequality-adjusted Life Expectancy, or DALY by wealth quintile, external financing for health should consider greater investments in data collection. Policies informed by a more nuanced classification framework that accounts for inequity could also guide incentive setting for a more equitable approach towards external financing for health.

Chapter 2: Classification by Health Need and Income

2.1 Income classification and health policy

In the last two decades the use of Gross National Income (GNI) has taken on a specific role in international development: that of indicating countries' stage of development and access to concessional financing. The advantages of using the metric to identify countries with the greatest financial need is based on it being a simple, and regularly updated measure that is considered a good proxy for factors such as wealth, the capacity of governments to provide services to their citizens, and national levels of development. Simply put, the metric has been considered a good indicator of the level of development and social well-being in a country.

However, it is increasingly apparent that improvements in national economic data do not always translate into a universal rise in individual health and welfare, do not reflect disease challenges, and the aggregate picture can disguise substantial inequalities. GNI per capita does not fully take into account inequality, governments' capacity and policy choices towards their citizens, or structural factors that underlie substantial variations in outcomes between people within countries.

Among multilateral health financers a common principle underlying financial assistance has been to improve health and population outcomes in countries that are least financially and structurally capable, both in terms of domestic resources and technical capacity, to respond to key health needs. The implication is that external financing should not play a significant role in well-functioning systems were there are adequate resources to meet its health needs.

Drawing on those principles, and the high correlation of income metrics with most health status indicators, eligibility policies have traditionally been based on income metrics as a central criterion. While other criteria relating to health needs, aid effectiveness, or inequality in outcomes are also used, these have typically been considered at decision-making stages downstream from the eligibility process.

In the past decade, with increasing concern that the benefits of macro-economic growth may not necessarily translate into better and equitable health outcomes, the ability of income classification to reflect important dimensions of development, such as poverty, inequality or health need has also been questioned. In certain cases, long due statistical revisions have resulted in countries transitioning overnight to middle-income status.

Another concern is that the income categories themselves are too broad and consist of countries that are sometimes at very different points along the development continuum. The Middle-income Countries category, which currently ranges from GNI per capita levels of $1,045 to $12,736, presently consists of a 105 countries that account for the largest global share of poverty and disease with varying levels of development, inequity, political stability, and social issues.

As demonstrated in Figure 2, between 2005 and 2013, forty-eight countries changed income categories, of which 15 moved from low-income to low-middle income status; and 22 countries from lower-middle income to upper middle-income status. Currently, based on 2015 income category thresholds, there are 18 low-income and low-middle countries whose present GNI per capita values are +/- 10% from the existing thresholds. During EAI consultations, stakeholders have stressed that countries which are just across the lower middle-income country threshold have far more in common with low-income countries than with upper middle-income countries.

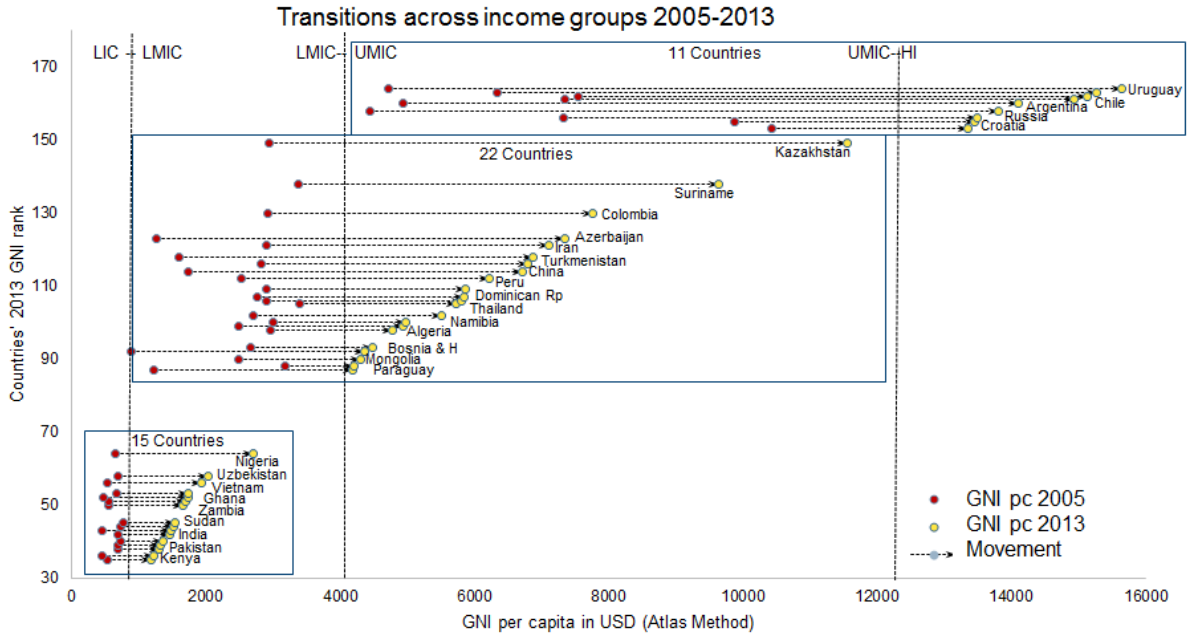


Figure 2: Transitions across income groups 2005-2013

In this context, a key concern around the discussions on transitions from one income group to another is the consequence of the potential decline or stop in financial and technical support from multilateral development and health partners based on income related eligibility criteria irrespective of the overall health need, and the rights of vulnerable groups and key populations.

The decline in assistance can also coincide with higher domestic costs for delivering key health services, since several concessional pooled procurement and trade agreements are selectively meant for low-income countries. Further, in some countries support and service delivery to vulnerable groups and key populations is entirely externally financed.

As a result, there are concerns that in the absence of mitigating policy changes, certain governments and populations may see a loss in health gains and a resurgence of disease. This suggests the need for a reflection on more effective benchmarks by which to nuance assessments for eligibility. In health policy, this has triggered a discussion on complimenting the income metric with indicators that measure the level of health need in a country, in order to better capture different disease or health-specific aspects.

2.2 Measuring health need

Measures of disease burden, which are used in epidemiological research to identify population attributable health risks, are a valuable starting point. Disease burden[17] can be measured using a variety of indicators such as mortality, morbidity or financial cost. These allow the burden of disease to be compared between different geographical units, and also makes it possible to predict future health care needs.

In health policy there are several widely accepted indicators of disease burden and summary measures of average population health, that facilitate comparison of the burden of different diseases and take into account both death and morbidity in a single measure and enable comparative assessments of broad epidemiological patterns within and across countries and different time periods. Of these, the HALE, QALY[18] and DALY[19] have been mostly widely used to quantify the level of health need in a context, and how this health need is spread between different income and social groups. These measures are most widely used and expressed in terms of the DALY/QUALY/HALE rate per 100,000 people since this allows for comparing health loss across different population sizes. However, these can also be expressed in terms of total number of HALE/QALY/DALYs lost

[17] Defined as the impact of a health problem on a given area.

[18] Quality-Adjusted Life-Years (QALY) take into account both quantity and the quality of life generated by healthcare interventions. It is the measure of the life expectancy corrected for loss of quality of that life caused by diseases and disabilities. Some health interventions do not prolong life but do significantly improve the quality of life. A year of normal health is given a QALY of 1 whilst a year of complete functional impairment (e.g. death) has a QALY of 0.

[19] Disability Adjusted Life Years (DALY) are a measure of the burden of disease and reflects the potential years of life lost due to premature death (PYLL) and equivalent years of 'healthy' life lost by virtue of being in states of poor health or disability. These disabilities can be physical or mental. One DALY can be thought of as one lost year of 'healthy' life.

by the population, and the per capita or per person health loss. The latter is less frequently used since the per capita values tend to be very small decimal values.

The most well-known assessment of disease burden is the Global Burden of Disease (GBD. The first study in 1990 by the World Bank and World Health Organization devised the concept of DALYs and sought to quantify the health effects of more than 100 diseases and injuries for eight regions of the world, generating estimates of mortality and morbidity by age, sex and region. The GBD Study is currently updated by IHME, which in 2015 released estimates of the leading causes of death in the world for 2013.

Figure 3 uses the case of South Africa to illustrate how burden of disease metrics like the DALY reflect both the mortality and morbidity in a population and can further be broken down to identify health needs by cause, risk factor and age structure. An advantage of the metric is that different health programmes can segment the burden of disease to compare investments across disease foci.

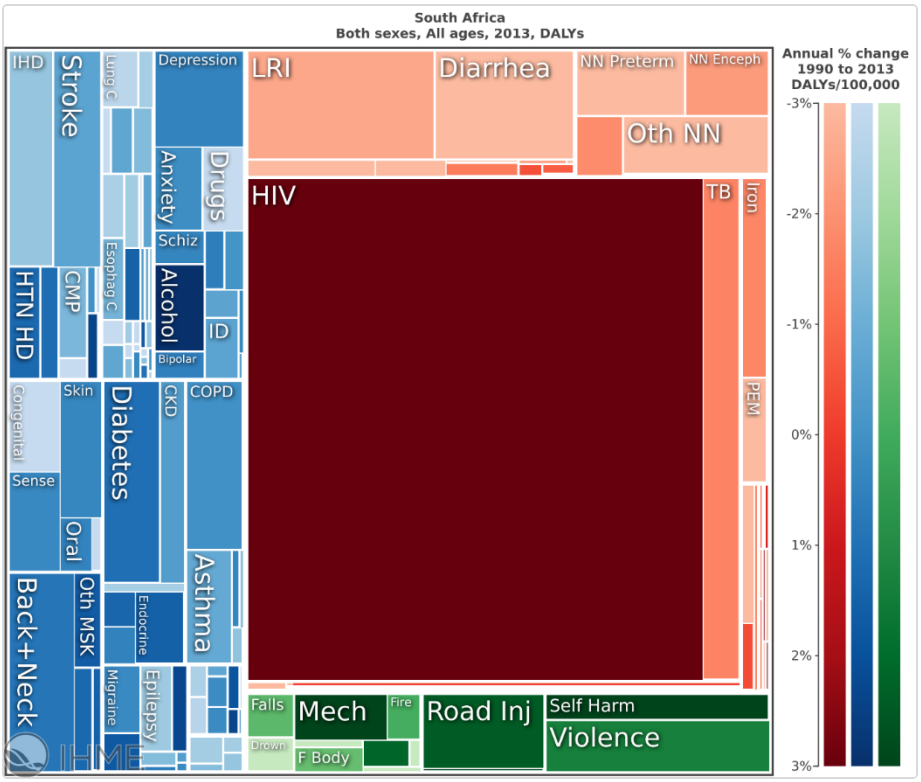


Figure 3: The DALY loss in South Africa by Cause (2013)

The first GBD report highlights the practicalities of measuring disease burden on a local and national scale, indicating that burden of disease metrics would allow policymakers in prioritizing actions in health, planning for preventive action, assessing performance of healthcare systems, and plan for future health needs. There is on-going work to capture the DALY loss among specific socio-economically vulnerable groups that can demonstrate the extent to which a health system is equitable in both access and health outcomes.
However, despite the value of considering burden of disease metrics to quantify health need, the analytical work conducted by the EAI demonstrates that a classification system based on a single indicator - be it a health burden metric or an income metric – would be insufficient to inform policies in external financing for health that aim to prioritise contexts with the highest disease burden and the lowest financial ability to respond to this disease burden. This can be demonstrated by looking at a subset of countries from across the income spectrum that have varying degrees of disease burdens.

2.3 Limitations of a single-criteria classification framework

The following section attempts to illustrate how a classification system based on a single criteria, whether it is Income or Health need, may overlook important considerations when informing eligibility policies. An eligibility policy is generally characterised by the existence of a single threshold based on which countries are

identified as being 'eligible' or 'not eligible.' Thus the actual absolute GNI values or disease burden values of a country matter less than the threshold that is applied in the policy[20].

While the analytical work of the EAI did not explore any specific thresholds, to illustrate the implications of policies based primarily on a single indicator, the following discussion examines the implications of an eligibility policy based only income per capita using World Bank thresholds[21], and a policy based only on disease burden, measured by DALYs[22], where the threshold is the median DALY value of the sample used to categorise countries into 'high' or 'low' burden.[23]

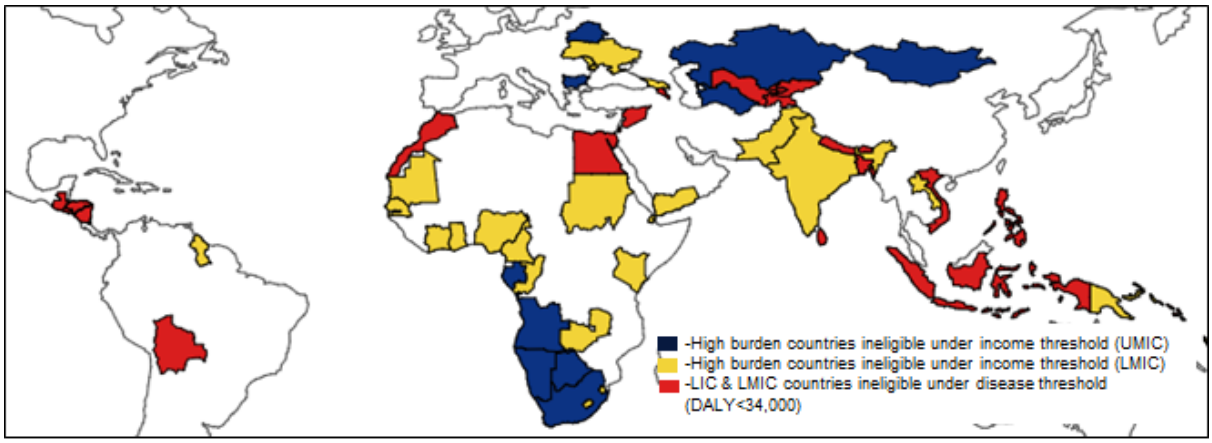


Figure 4: Implications of single-criteria eligibility policies

The above Figure 4 examines the implications of an eligibility policy informed by a single indicator. In a policy based only on an income metric, countries shaded blue and yellow (e.g. South Africa, Swaziland, and Botswana), which are middle-income economies but have a large proportion of the global communicable disease burden, particularly HIV, would potentially be ineligible and receive lower priority. This indicates that a framework determined by per capita income could ignore countries that have a disease burden likely too high to be addressed only with domestic resources given its national income level.

In the case of an eligibility policy that only accounts for Disease Burden, countries shaded red (e.g. Nepal, Bangladesh, Vietnam, and Philippines) that have a lower disease burden, but may not have the needed resources to respond to the present level of the epidemic, risk being made ineligible. In the absence of both domestic and external resources, it is likely that there would be a further increase in disease. As a result, a framework that only accounted for disease burden could overlook low-resource countries where the population and domestic system may be inadequately resourced to respond to its health need.

2.4 Classification by health need and income

The EAI analyses demonstrates that in order to adequately respond to both principles of external financing for health in policies, it is preferable to interpret income per capita relative to the level of disease burden in a country. A policy that consists of a classification by both a health metric and an income metric would help to better differentiate between countries at the same income level, or in the same income category, but with different health needs.

Used to inform eligibility, this would potentially offset the likelihood of a sudden drop in financing in high disease burden countries. For example, countries such as South Africa, Swaziland, and India that have a much higher disease burden relative to the level of income would potentially continue to be eligible in spite of their income level given their significant health need.

[20] For example, in a case where an eligibility policy is based on a threshold of 300 GNI per capita, the change in the absolute level of the indicator (e.g. from 150 to 200 GNI per capita), or a change in its rank (from 5 to 1), is likely to matter less than if the country is above or below the 300 GNI per capita threshold.

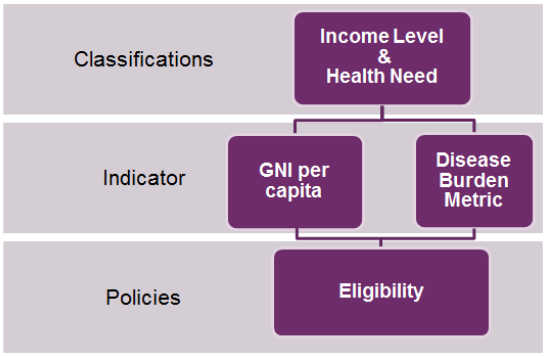
[21] Implications were explored for the threshold being at the LMI cut-off point and the UMI cut-off point.

[22] Using the example of DALYs rate attributable to "communicable, maternal, perinatal and nutritional conditions".

[23] The DALY range for the sample of countries selected is 17647 DALYs to 87948 DALYs, with the threshold for low to high burden being 34639 DALYs (the median).

At the same time, a classification by both health need and income cannot adequately inform the nature of support to be provided, whether financial or technical; for example, in countries with a relative higher income where the disease burden is high relative to income, but there may be adequate domestic resources to meet this need. While NIPH explored the possibility of including fiscal space characteristics in a classification to guide external health financing, the group found that while general and health-specific financing are important considerations, including fiscal capacity indicators in a classification that would inform eligibility can be problematic because of the resulting incentive structures. It is then recommended that these more complex decisions would need to be guided by more nuanced criteria at the level of programmatic decision-making, downstream from eligibility decisions[24]

Classification based on income and health need



The analytical work identifies two modalities of operationalising such a framework: based on developing a single composite metric, or developing an index that accounts for multiple criteria. While there are many other ways, based on the analysis from the EAI and consultations, the analytical work focused on developing a simple, easily understood, and reliable framework.

However it has also been emphasised that where possible, health need must be accounted at a micro-level, and reflect the sub-national variation in health outcomes in order to avoid overlooking vulnerable groups. Given current data limitations, the groups did not endorse any particular metric or method of capturing this variation, and the analyses instead suggests nuancing eligibility policies based on qualitative assessments and decision-making processes that explicitly factor-in the barriers faced by vulnerable groups. This also points to the need for greater investment in and alignment with national data systems, towards strengthening the use of quantitative equity indicators in decision-making.

It has been suggested that once better data on in-countries inequities in health service delivery is available, the EAI model could be revised to specifically identify how domestic inequities in health access, service delivery, and outcomes could be factored in external health financing decisions.

In the analytical work for the EAI, the groups have focused on illustrating their findings on rankings rather than specific eligibility thresholds. However, where possible, a brief discussion of possible thresholds to consider has been included in.

2.4.1. Using a single composite indicator for classification: GNI adjusted by health need

The modality of factoring both health need and income per capita would be to adjust the GNI per capita value with a measure of burden of disease. [25] This would better demonstrate populations' or subpopulations' health needs relative to their level of income, by penalising the absolute value of the income measure in countries that have a high disease burden

This method was explored using different general health outcome indicators, and disease specific indicators to adjust GNI**.** Illustrating one approach of adjusting GNI with the DALY rate[26] attributable to communicable,

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[24] While this is briefly explored in the next chapter, a thorough analysis would require covering most or the entire decision-making process, and involved an in-depth discussion of the allocation of funds, which the analyses did not address.

[25] One straightforward method for adjusting GNI per capita with a health-need indicator was employed by the NIPH team. It used common mix-max normalization giving each indicator identical range [0, 1], used equal weights for the indicators as a starting point, and used linear aggregation to combine indicator-weight products. The NIPH team emphasizes, however, that choices of these kinds can influence the final implications of the different classification frameworks. For e.g. instead of assigning equal weights of 0.5, the two indicators could be differently weighed to reflect a different prioritisation of income and disease burden.

[26] . In the examples discussed, both income and health need indicators have been equally weighed, which could be modified depending on the objectives of the classification.

maternal, perinatal and nutritional conditions[27], there are two key findings when considering the inclusion of health need for an initial classification of countries.

First, adjusting GNI in this way considerably changes countries' positions when compared to classification by income, and specifically improves the ranking of countries with unmet health needs. Figure 5 demonstrates this using a sample of countries from different income categories. If a country's adjusted rank moves up (e.g. from 20 closer to 1) this indicates that the country has greater health need than its income level would suggest, and could therefore receive **greater policy priority (highlighted in yellow).** A country may receive **lower policy priority (highlighted blue)** if it ranks downward (e.g. from Rank 1 to Rank 20) as its health need is lower than its GNI would suggest.

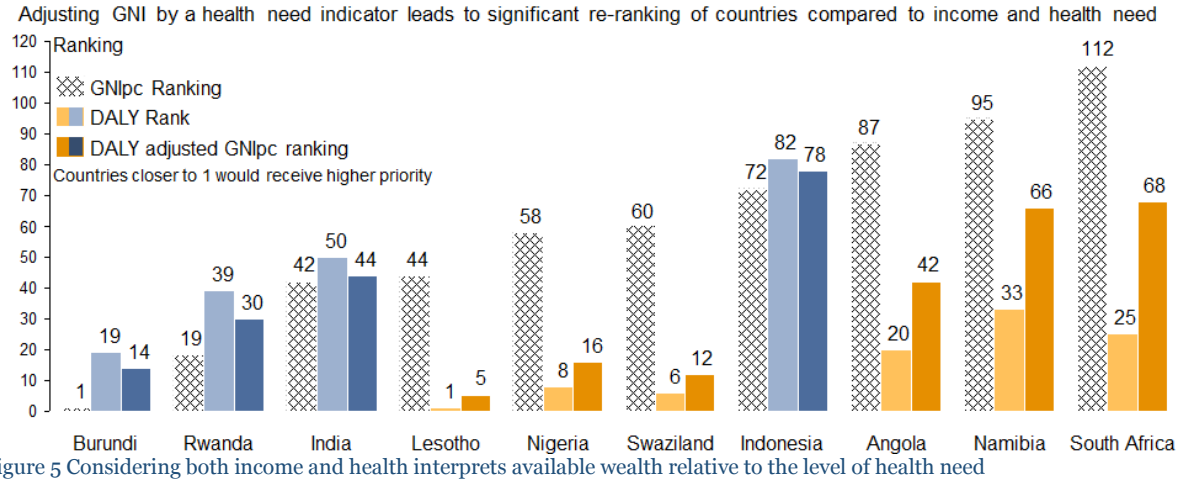


Figure 5 Considering both income and health interprets available wealth relative to the level of health need

The key implication is that a framework incorporating both income and health need dimensions will tend to give more priority to countries that have a higher disease burden, between two countries at the same income level. This can further be illustrated by looking at the re-ranking of countries across income groups (Figure 6).

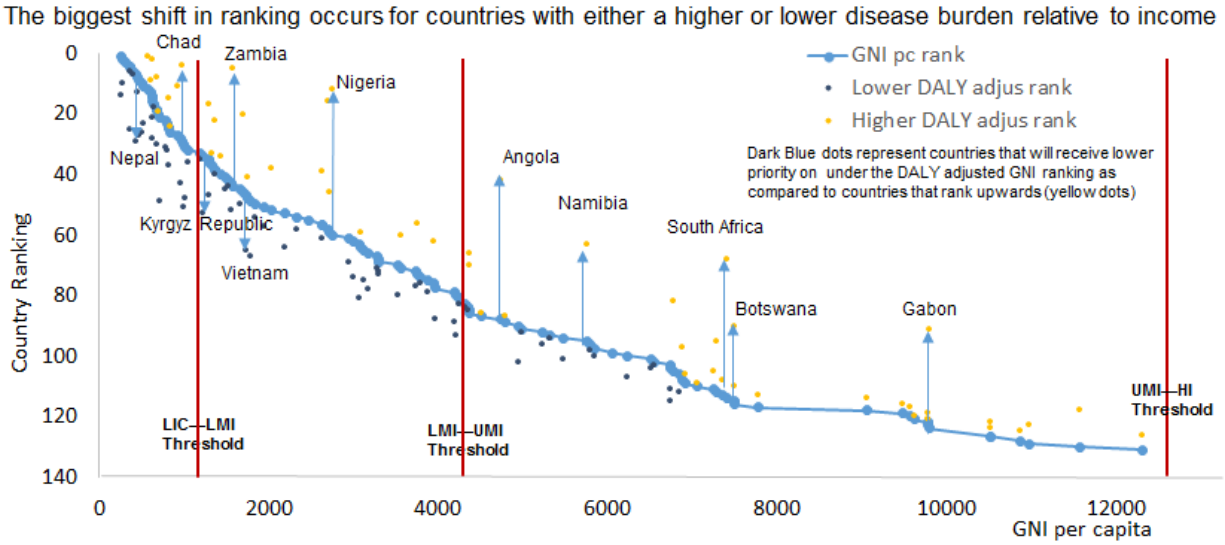


Figure 6 Adjusting GNI by a Health Need Indicator

Some Upper Middle-income countries change ranking considerably. South Africa, a country with a high number of premature deaths, and high morbidity due to HIV/AIDS and TB in younger age groups, moves up from 112 to 68 in the ranking. Swaziland moves from 60 to 12, given its high levels of morbidity and mortality from HIV/AIDS. The full list of country re-rankings is available in Annex 2.

With the current method of adjustment that places equal weights on income per capita and DALY rate, compared to an income only classification system, this would result on average in higher priority ranking for middle-income countries over low-income countries. This is because in the current global context, a number of middle-income countries have a significantly higher disease burden relative to income. Low-income

[27] An effective, functioning healthcare system is likely to have lower levels of DALYRs lost due to these preventable and treatable conditions. However, updated DALY data is not available in some countries.

countries (LICs) on average drop in priority ranking by 5 places, while upper-middle countries (UMICs) increase on average by 3 health-need ranks when moving away from GNI per capita alone.

The second finding is demonstrated in Figure 7. The choice of health need indicator used to adjust GNI would have a limited effect on the ranking i.e. prioritisation of a country, or potential eligibility of a country. However, the choice of health need metric could influence assessments of how much external support a context requires. For example, irrespective of the disease burden metric considered, countries that move up in ranking (in yellow) would be identified as having a higher need than their income level suggests. At the same time, depending on the focus on a particular health priority, e.g. on child mortality (U5MR) or Health System Quality, the level of priority given to a country could change.

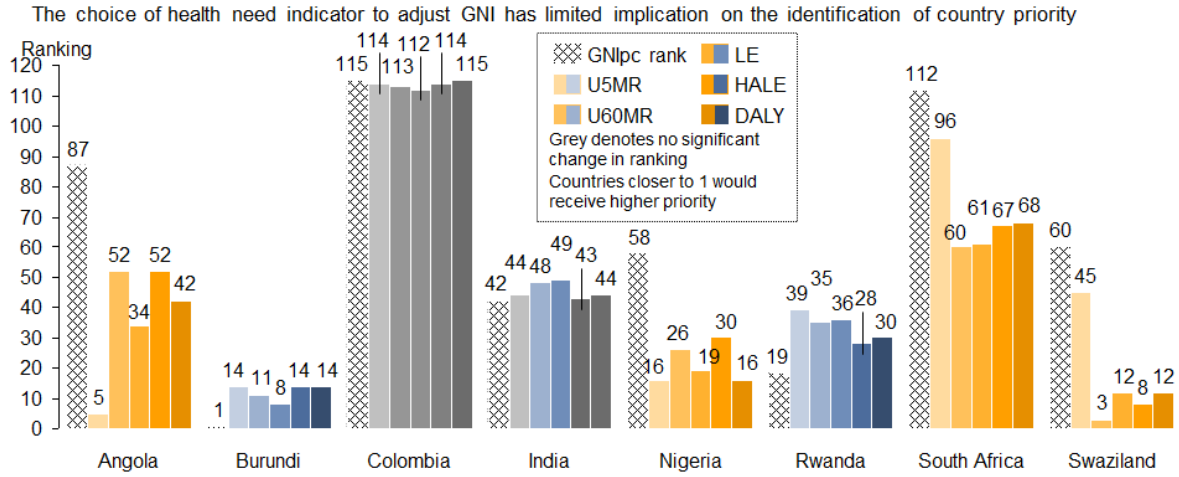


Figure 7 Implications of the choice of Health Need indicator

These findings demonstrate that a classification framework accounting for both income and health need is flexible and can be tailored to a disease-focus area or organizational priority, allowing for a differentiated prioritization of countries in different health areas. At the same time, the analyses endorse the use of a general burden of disease metric that captures both mortality and morbidity and are comparable across diseases, as is the case with metrics like HALE and DALY, which can further be broken down to identify health needs by cause, risk factor and age structure. This would allow organisations with different disease foci, and those with more general focus on health to compare investments.

Furthermore, such a classification framework could also be applied to understand the variation in health need relative to income at the subnational level. The University of Oxford has demonstrated this using the case of India and Nigeria, by focusing on the variation between different states to suggest that external health financers consider moving towards sub-national analysis for rankings where the data are available, and perhaps argues for a concerted effort to improve such data collection.

While the implications of a framework where GNI adjusted by a Health Need indicator has been explored in terms of rankings, the analyses endorse the development of income and health need specific thresholds. One suggestion is to move away from absolute thresholds, as used in the World Bank income classification, and instead develop relative thresholds based on the policy focus of different institutions.

Finally, while the income metric is the starting point of the proposed framework, it does not preclude putting less weight on GNI per capita than the health-need indicators. The actual weighting and prioritisation of one criteria over another is also a value choice that institutions will have to determine.

2.4.2 Complex Formula based Classification

An alternative option would be to combine multiple indicators in a formula or an index that accounts for different considerations around income, including the dispersion of income, and the different dimensions of health need including access, and service delivery. Potential methodologies and approaches used to derive theses formulae are available in the reports from the analytical groups.

The University of Oxford proposes a complex formula that draws from the Dalton inequality index formula, which has been used in policy to determine which wealth group in a country contributed most to the observed inequality. The group modifies the formula to capture the level of 'health inequality', as measured by the

DALY rate lost per capita, and thus penalises countries where there is an observed inequality in health outcomes.

Another approach, proposed by the University of Sheffield/Imperial College draws from the principles of Universal Health Coverage, and posits that a more nuanced way of quantifying income and health need. The group argues for interpreting financial need not in terms of income per capita but in terms of the level of financial protection that a population has. This refers to the ability of people to access health services without the risk of being impoverished by the cost of these services. To measure health need, two dimensions are identified as being important: the level of health need, as measured by the rate of DALY loss due to all causes, and the ability of the population to access basic primary health services. The latter criteria would be useful in further differentiating between countries based on the quality of their health systems. The final output is an index that compiles these measures of financial risk protection, level of health need, and quality of the health system.

2.4.3 Differentiated Classification by Income and Disease Burden

A third policy alternative that has been operationalised by certain multilaterals, classifies countries based on both income and health need levels separately towards developing differentiated eligibility criteria for different income and sub-income groups. Countries above a certain income threshold could be differentiated based on the disease burden that the system has to respond to, or only be eligible for certain forms of support, linked to their stage of development and nature of the epidemic.

For example, low-income countries and lower middle-income could be made eligible without specific restrictions regarding disease burden. On the other hand, depending on the focus of institutions and the type of support provided, upper middle-income countries could be considered eligible in cases where the disease burden is significantly high, and there is a need to partner with the government on the domestic response.

Crucially, any such classification would need to ensure that the decline in funding to countries as they move along the income classification is gradual and planned, in order to ensure that key health services are maintained. This is particularly relevant for the period between when external financing levels decline, and the government absorbs externally funded services into its budgeting processes.

2.4.4 Towards nuanced classification to inform operational decision-making

The determination of eligibility is followed by the process of assigning and determining what countries require greatest investment. This process is operationalised through different policies, specifically allocation and co-financing policies.

The analyses demonstrate that at the priority-setting stage, using income and health need alone to guide decision-making is insufficient. Certain countries that would receive greater priority because of higher health needs relative to the income levels of their population, may have the necessary public resources to meet this need domestically.

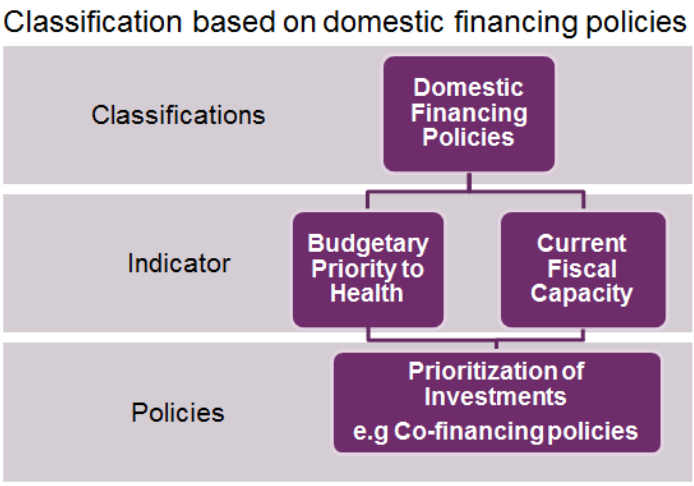
Conversely, certain low disease burden countries that would receive low priority due to the lower health need relative to income, are known to be largely dependent on external financing to fund their health systems, due to the lack of available domestic public resources. In a decision-making system that only accounted for income and health, these countries would receive lower investment priority, a “double penalty” whereby neither adequate domestic government nor external resources are channelled to meeting the population’s health needs.

The analytical work and consultations highlight the on-going debate on whether external financing for health should be considered when domestic policies do not lead to adequately addressing health need given the potential resources based on a certain income level.

In order to prioritise investments, it would therefore be relevant to better understand the level of income and health need against the government’s current health financing practices and strategy, as well as domestic policies. In a robust health system, a government is understood to be the primary driver of core public health outcomes, and thus accounting for the fiscal policies and capacity in a country becomes relevant when identifying countries that effectively have greatest need.

Chapter 3: Domestic Financing Classification

Priority-setting practices in external health financing is an umbrella term for a number of policies including: the allocation criteria, the incentive-funding policies, and the co-investment or co-financing policies of an organisation.



Together this category of policies influence a number of key processes, including: the speed and timing of a country's transition from eligibility status and the projected time horizon for external support; and the modality of external support to use, whether financial support, technical support, advocacy, or a combination.

Following the use of an eligibility framework that considers both income and health, the analyses suggest that only considering the two criteria would be inadequate for institutional priority setting practices, which include a range of decisions for which other indicators become relevant.

Given these wider set of considerations, the analyses support incorporating a classification based on domestic health-financing policies as a third fundamental criteria in the overall conceptual framework, which considers the level of income relative to health need via-vis a government's fiscal capacity to invest in health, and the level of priority it gives to health within its budget.

Differentiation based domestic health financing policies could help to further differentiate between certain contexts, while enabling policies that encourage greater domestic investments in health where possible and needed, or ensuring that the health needs of key populations or vulnerable groups are being met. For instance, low-income countries with a low disease burden may have a greater reliance on external financing to address their health needs, due to the lack of available domestic resources. Simply de-prioritising these countries could lead to a "double penalty" whereby neither domestic nor external resources are channelled to meeting the population's health needs. At the same time, policies could better address high disease burden in countries with relatively higher income, which may have the domestic resources to respond to a high disease burden, but do either not prioritise health investments in their budget or have limited fiscal space.

It should however be noted that responding to health financing characteristics and discussions on fiscal space in general, are often beyond the scope of individual multilateral health financers who tend to have a more health area or disease specific focus. Thus at best, this stage and process of classification could help guide design and coordinate individual co-financing and incentive-funding policies towards collectively encouraging policy change in certain countries, while encourage coordination between development partners on a policy dialogue to increase fiscal space for health investments where relevant.

3.1 Key indicators beyond GNI

Historically, the GNI per capita metric has been widely used as a proxy for a countries capacity to invest in health. However the analyses demonstrate that the metric is not designed to capture poverty and inequality levels, and is a better quantifier of the level of wealth in a 'society,' including the private sector, rather than the level of resources available to a government.[28] Government fiscal capacity is typically much smaller than GNI per capita levels suggest, depending *inter alia* on the levels of government revenue capture and external debt obligations.

[28] Furthermore, GNI does not differentiate between the types of health expenses in a system: WHO guidelines differentiate between public health expenditure and private health expenditure. The latter includes payments such as private insurance, charitable donations, and direct service payments by private corporations, and direct household out of pocket expenses (OOP). A system that is dependent largely on out-of-pocket payments creates discriminatory access because the costs disproportionately impact the economically weakest sections of a society. This is reflected in the highly unequal distribution of health outcomes, since the economically well-off sections will have better access and health than the poorer sections. In the last two decades, emerging economies have also made commitments to reduce the level of private health spending, and increase public spending towards equalising access to key services. This is reflected in the African Union's 2001 Abuja Declaration where member governments pledged to spend 15% of their government's total budget on health.

By taking into account current government revenue capture and government health expenditure, a health financing classification could help prioritise contexts that have greater financing need while identifying levers for increased domestic health financing. It can also assist in clarifying the type of support, whether financial or technical, that a context requires.

To quantify a government's current effort to meeting health need, Government/public expenditure on health (GHE) is an easily understood, reliable, and regularly updated indicator. The metric quantifies all the recurrent expenditures[29] a government has made in preventative and curative health services, family planning activities, nutrition activities, and does not include provision of water and sanitation. [30] Effectively, this indicator also captures the policy preference of a government, based on its choice to invest more or less in its health systems.

At the same time, there are certain limitations to using GHE, linked to the lack of uniformity in how governments' account for health spending in their expenditure tracking. Broadly, there is no standardised differentiation between expenditures that are categorised as health expenditures, and there is significant spending that impacts health but is not counted as such. For instance, several government make expenditures in health through social protection programmes that focus on specific marginalised groups but are not captured in health budgets. However, given the work in recent years undertaken by WHO to standardise National Health Accounting processes, the analyses endorse the uptake of the indicator to guide decision-making.

Understanding the current level of spending alone would present an incomplete picture however, since the metric cannot capture if the government is actualising its full capacity to invest in health. However, unlike GHE which measures current investment, there is no one agreed upon indicator or method to quantify what a government should and could spend. The next section therefore identifies two potential approaches, one using Current Government Fiscal Capacity, and the other using the Potential Government Fiscal Capacity, estimated using a more complex Data Envelopment Analysis method.

3.2 Classification by domestic health financing characteristics

The first model is a simple classification that attempts to demonstrate how much a government leverages in resources from the economy for potential investments in public goods, such as health, and how much of these resources are actually invested in health. It therefore focuses on two levers: how much a government is able to invest, as determined by the level of revenue capture net interest payments for debt; and, how it prioritises health spending in its budget.

It would be important to view these as policy choices by governments in light of a countries' position along the income spectrum, as well as its specific epidemiological profiles. For example, it is important to differentiate between the health spending and policy prioritisation of two LICs with different disease burdens, just as it is be important to compare the level to which an MIC country can domestically fund its health system compared to an LIC. For this reason, the health financing classification framework visually differentiates between countries with different disease burdens, as well as income categorisation.

In addition, while it is useful to review government expenditure in terms of proportional spending, it is also important to interpret this share in absolute dollar values. For certain low-income economies, allocating a certain percentage as per existing literature and benchmarks could still be insufficient in absolute terms to event meet basic care packages in response to the health need.

[29] Unless one adds the capital investments to it specifically.

[30] While these services are not provided by the health sector, they are considered to be population service directly relevant to health, in particular public health.

3.2.1 Mapping Health Priority and Current Government Fiscal Capacity

Box 2: Key Definitions
Health Priority can crudely be measured by the proportion of a government's total expenditures (general government expenditure) that are recurring expenditures on health, net of external financing (Government Health Expenditure (GHE)-Development Assistance to Health (DAH)/General Government Expenditure (GGE)- Official Development Assistance (ODA)).

Some policymakers may prefer including external assistance since this provides a picture of the total financing available. However, a classification system focused on domestic financing policies would be distorted if it took into account external financial support as, effectively, part of a government's expenditure.

The analyses also explored using per-capita health spending measures to quantify health priority (in PPP or otherwise) but found these problematic to use and interpret, unless per capita measures were developed after taking costing and procurement costs into account. For example, a country that could spend much higher per capita due to extremely high drug and equipment prices. These are efficiency considerations which as the analyses indicate are important, but difficult to account for in classification processes. Based on these considerations the ratio was considered, since it is dimensionless and equally applies to a per capita understanding.

The **Current Government Fiscal Capacity can** crudely be measured by calculating what proportion of a country's GDP the government collects as revenues through tax and from other sources, net of the annual interest payments it is required to make. It must however be noted that this is one of the many ways that Fiscal capacity can be estimated, and that the indicator measures what the government is currently capturing, without focusing on what resources could potentially be leveraged.

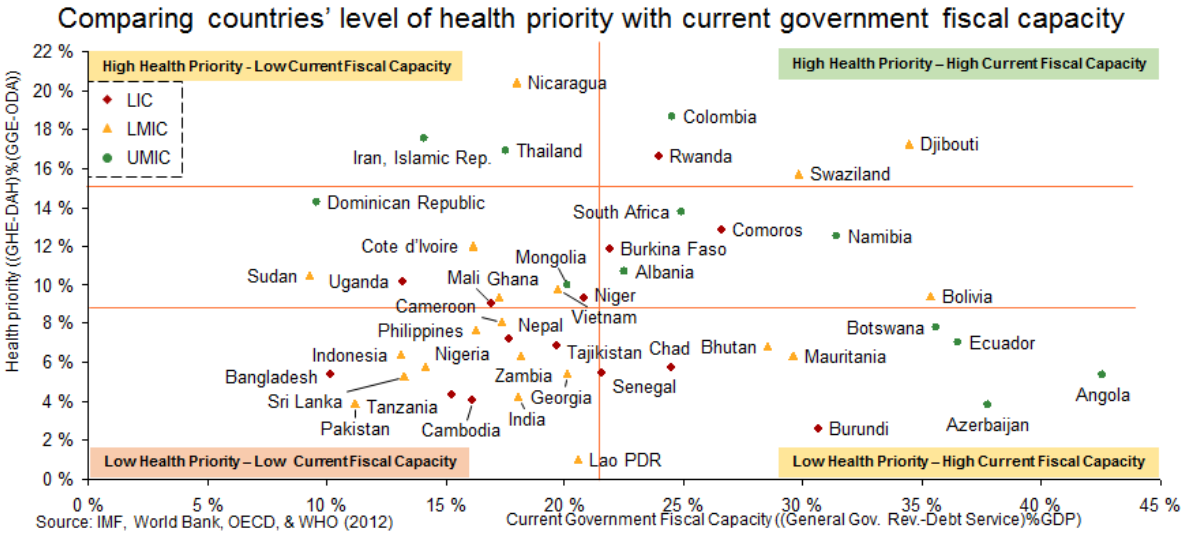


Figure 8 Health Priority and Current government fiscal capacity

Figure 8 illustrates this classification.[31] The Health Priority axis focuses on how a government prioritises health spending in its budget and has two thresholds - at 15% based on the Abuja target; and at 8% which has been recommended in academic literature for emerging economies, with the caveat that anything lower than 8% would adversely impact the health outcomes of a population.[32] The Fiscal Capacity axis focuses on the effective government resources currently being captured and has one threshold at 20%, which is the average current level of government capacity of the sample group, consisting of 106 countries.

As detailed in the earlier section, for decision-making in health, it is important to consider how much a government prioritises health, against the level of health need and income. Figure 9 and Figure 10 focus on separately mapping the health priority and current government fiscal capacity by disease burden. The mapping of health financing characteristics has been split into a 'High Burden' and "Low Burden' lens.

[31] The chart focuses on LIC, LMIC, and UMICs, and does not include conflict and fragile states, nor small island states.
[32] http://www.who.int/health_financing/documents/revenue_raising/en/

Here, the burden is measured by a country's DALY loss rate for maternal, natal, and communicable diseases, since these should typically be low in well-functioning health systems. The cut-off point for high to low burden is 32,000 DALYr, which was the median of the sample. This could however also be divided into three categories also: High, medium, and Low burden. Further, the map also visually differentiates between low-, middle-, or high income countries, per the World Bank classification.

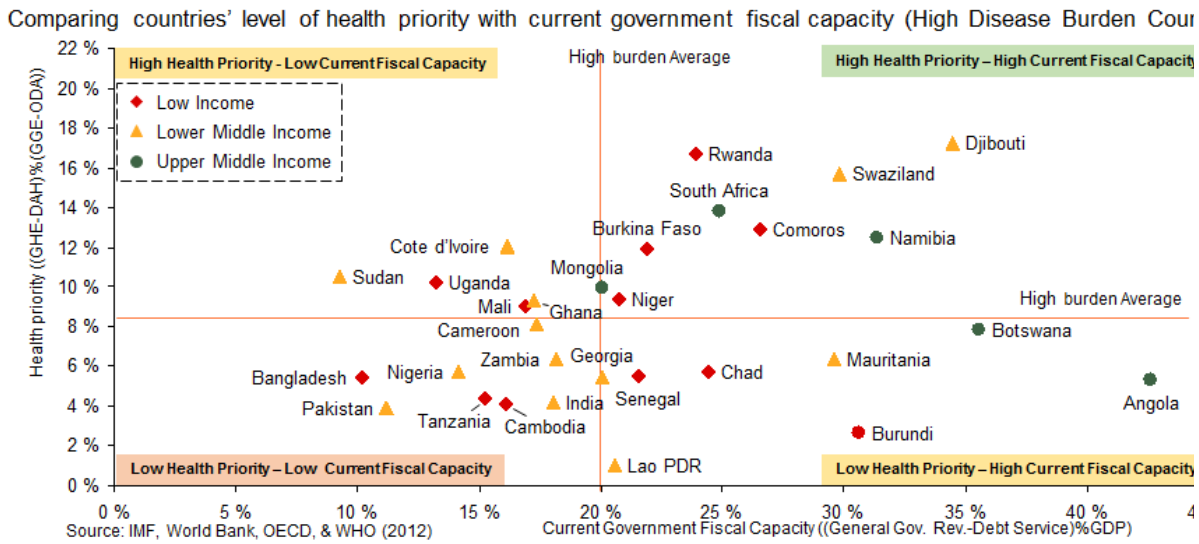


Figure 9 High Disease Burden: Comparing Health Priority and Current Government Fiscal Capacity

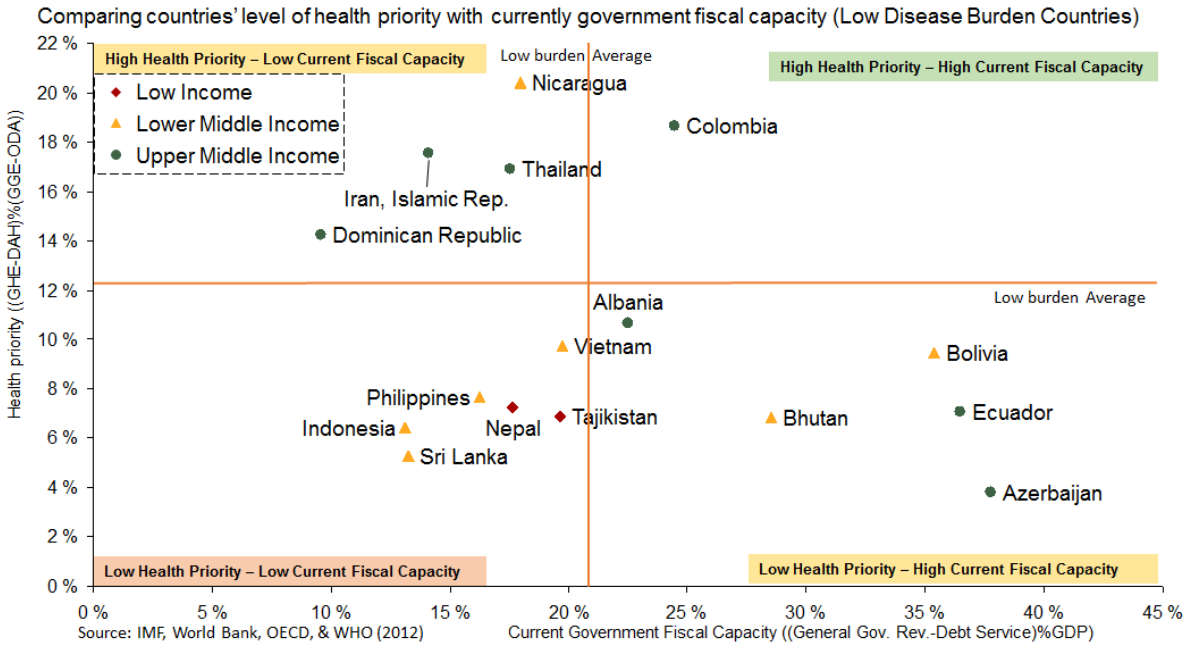


Figure 10 Low Disease Burden: Comparing Health Priority and Current Government Fiscal Capacity

3.2.2. Key Findings

Figure 9 demonstrates that several key middle-income countries with high disease burdens are spending less than the 8% threshold, with the average level of health priority being a little over the minimum 8%. On the other hand, in Figure 10, low burden countries on average allocate higher budgetary priority towards health at about 12.5%.

While both high burden and low burden groups on average leverage the same level of resources from the economy (20%), in particular high burden countries that capture significantly less in government resources may be able to increase their resource base to leverage them towards greater health spending i.e. even at the same health priority level.

Finally, the income levels of the different countries will have a pertinent role to play in the policy implications: Policies for high income countries with the available fiscal space but low priority on health in spite of a high-disease burden, may want to incentivise greater domestic expenditures towards health. On the other hand, countries that already leverage a high proportion of the economy in revenues and also prioritise health spending may require external support to address their health needs.

3.2.3 Policy Implications: Differentiated policies

An understanding of these two levers i.e. factors that influence domestic health financing, generates a classification based on an assessment of government fiscal space and levels of health expenditure and investment in a particular year (or an average across a certain years). This can be particularly useful in guiding co-financing agreements. For example, where the level of priority given to health in a government's budget is low in spite of high fiscal space and high disease burden, policies towards reallocating domestic investment to health are relevant.

There is a long history of attempting to identify how much a government should ideally leverage from the economy as public resources. Efforts to enhance fiscal capacity, that could lead to greater health investments, could be achieved through direct and indirect taxes, level of capital receipts, and debt levels. These discussions are however beyond the purview of individual multilateral health financers alone, and are policy dialogues that larger sector-wide financers like the World Bank and IMF engage with governments on, for example on how to increase tax revenues from direct and indirect taxes. Many health organizations, multilateral and bilateral, have limited expertise or mandate in this area pointing to the essential need for a coherent and collaborative framework to support countries to achieve maximum development.

In external financing for health, these classifications (high priority - low fiscal capacity; low priority - high fiscal capacity, etc.) could particularly help to inform co-financing policies, as illustrated in the table below in Table 2 on an example for a Middle-income - High burden country:

Health priority / Current Government Fiscal Space	High Health Priority	Low Health Priority
High govt. fiscal space	High level of avaliable public resources, collected taxes and high public commitment to invest in health.	High government revenue but a low budgetary commitment to health.
Policy Response	To provide incentive funding, rewarding the government's effort towards increasing domestic fiscal capacity and chanelling investments into health. It is also important to examine if the health spending is high due to inefficencies.	To develop policies which incentivise the government to re-direct available resources into health. E.g 'Matching' policy, where external investment are matched by government investment.
Low govt fiscal space	Low effort towards increasing fiscal space by generating sufficient revenue through taxes, but high priority given to health in the national budget.	Low effort to increase fiscal space, national budget not prioritizing health.
Policy Response	Incentivise governments towards increasing fiscal space and public revenues from the domestic economy and chanelling leveraged investments into allocatively efficient expenditures in health.	Encourage greater expansion of public fiscal. Incentivise government to channel newly generated resources towards investments in key health need areas

Table 2 Middle-income- High Burden: Classifying countries by Government Fiscal Capacity and Health Priority[33]

It is important to note certain caveats: This classification only considers two policy dimensions whereas a comprehensive domestic health financing assessment and classification would need to account for micro-level data on cost of delivering services, procurement, the quality of the health system, and the population specific characteristics of demand for health services. Second, the discrete thresholds described to measure government priority are value judgements. For example, the threshold at which a government is identified as giving 'lower' or 'high priority' could vary depending on the policy question and organisation conducting the classification.

3.3. Classification by Health Financing gap

[33] For definitions and indicators considered, please refer to Box 2.

An alternative dynamic model suggested by IHME is to develop a forward-looking classification based on the gap that exists between what a government is currently spending or is expected to spend on health overall or a health focus area, and what it could potentially spend on health, given its level of development.

There are three elements to the IHME framework:
First, the Needed Resources, which is the level of expenditure required to reach a specific health outcome goal. In the case study on maternal health describe below, the need is estimated using existing estimates of health burden with a prospective target based on the Sustainable Development Goals (SDGs).

Second, the Current Spend which refers to current government expenditure that targets a specific health focus area, such as spending on the prevention and treatment of HIV/AIDS, or child immunizations. IHME has also worked on developing a methodology to estimate the expected spend in the future, the modalities of which are detailed in the full group report.

The third element, Potential Spend[34] identifies the amount of resources that a government is expected to be able to pay. These estimates are also referred to as a country's ability to pay or its fiscal space, and indicate a health spending benchmark against which a country's current spending could be compared.
In situations where calculating need is impossible because of data limitations or lack of explicit goals, potential spend can itself be used as in indicator of where more funds are needed.

Because of the prospective nature of these forecasts, potential spending estimated in terms of the amount of spending per person, as a function of GDP growth and other macroeconomic factors, while the Abuja target has been used to estimate potential spend.

Understanding the potential to spend on health specifically, or a health focus area makes the framework "incentive compatible": stakeholders can differentiate between health needs that could be financed locally and the surplus health need that external partners should focus on.

This framework can be tailored to health focus areas, or for a specific disease lens, with some caveats: The amount of data needed to execute on this framework is substantive, and may not be available for every focus for each stakeholder. Additionally, while the availability and quality of cause specific and costing data is improving, it still needs substantial improvements to be considered comprehensive.

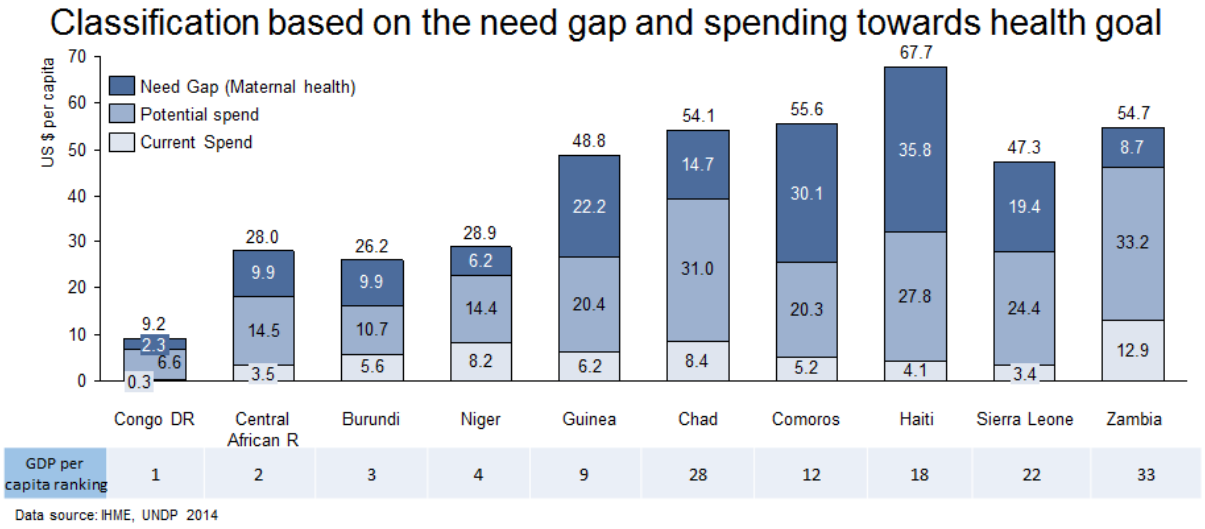


Figure 11: Comparing Current Government Spending and Potential Government Spending (Maternal Health)

3.3.1 Implications

Focusing on the need, as well as current and potential spending to maternal health for specific countries, Figure 10 illustrates that in an exclusively GNI based classification system countries could be prioritized or

34 One possible method of estimating potential spend for health using data envelopment analysis has been explored by IHME. It extrapolates how much a country could potentially invest based against a benchmark of the expenditure of the best performing income peers. The estimate of potential spend also includes other factors such as GDP growth, inflation, unemployment, the share of government expenditure given to health and the export to debt ratio. It draws on objectives such as the Abuja 15% target to identify if countries have reached their capacity to domestically invest in health.

deprioritized in a way that does not reflect the role of government priority setting in achieving health outcomes.

In figure 11, there are certain countries classified as middle-income by GNI per capita, which face significant resource gaps even if the government increased health investment to their maximum potential spending. On the other hand, certain low-income countries with weak health systems which are dependent on external financing, demonstrate greater potential to increase their spending and to partially close the gap towards meeting the maternal health goal if domestic investments were increased.

Thus, by highlighting the actual need for resources for a particular health area, and the amount expected to be spent by the government on that health area, critical financing pitfalls can be highlighted that may not be evident when only considering measures of economic development and overall levels of health financing.

Second, the analytical team highlights that understanding a country's potential to invest could determine whether policymakers will focus on advocating for greater government investment, or provide financial assistance. For example, between Nigeria and Chad, policymakers may consider accessing financial assistance for Chad, with a focus on achieving efficiencies in its current investments, since it is estimated to be at the limit of its fiscal capacity. In contrast for Nigeria policymakers may consider collaborating with technical partners towards realising its existing potential to meet health needs domestically.

The ability to classify countries by health financing characteristics or the health financing gap can thus play a valuable role in guiding operational policy and decision-making, by helping policymakers identify areas of urgent need i.e. where the gaps may be the largest, how to leverage additional resources, as well as to identify the health focus areas that need most investment in a context. By referencing dynamic health financing needs, this framework could also identify areas where upfront spending can have greater health impact and result in cost savings over time.

In the context of declining global resources to support emerging economies, this is particularly useful as it differentiates between contexts that do have the domestic potential to respond to the health needs in the system, from those that may need financial assistance in the interim while exploring more innovative financing mechanisms.

Chapter 4: Limitations and Suggestions for Further Research

4.1. Limitations

Overall, the analyses did not explore classifications by setting particularly thresholds and grouping countries accordingly, but instead highlighted the use of different indicators in terms of changes in rankings, in order to derive policy implications that suggest more recommendations applicable for both health and development organizations with different priority areas and foci.

While any classification framework depends on both the choice of underlying metric, and the choice of thresholds to group countries along common characteristics, recommending a specific thresholds or grouping of counties was beyond the scope of this multi-convenor initiative. The initiative did not analyze the impacts of discrete funding thresholds on beneficiary country health outcomes, nor did it directly address the types of policies that might be appropriate to mitigate the impacts of eligibility transition. Because these issues were not addressed, a recommendation to avoid discrete thresholds was not supported by the entire EAI, while the recommendation that where discrete thresholds are used mitigation policies should be used to smooth the transition was adopted. The findings and recommendations however can inform the deliberations in different bodies of the co-convenors, and form the basis for more specific analysis based on organisation's individual priorities and preferences.

Further, while it would be particularly important to include additional indicators for equity, as well as health needs of key population and vulnerable groups, in a classification framework for health, there is limited reliable, triangulated data available. The analytical groups identify that the proposed simple framework should be complemented with a more discretionary assessment of within-country inequalities in health and income to the extent permitted by the data; context specific in-country analyses are particularly relevant when assessing the level and type of support to be provided

Both of the proposed classification frameworks struggle to deal adequately with incentives. The basic problem is that if poorer levels of an indicator imply higher priority for external support, countries' incentives to improve on this indicator may be reduced. This is a problem for health-need indicators and inequality indicators to the extent that greater health needs and greater inequality imply higher priority. This could also be a problem for capacity indicators that are highly dependent on government policies and effort. For example, Health Priority represents the effort being undertaken by the government, but do not represent an external circumstance that is imposed on countries.

Against this background, it is recognised that incentives need to be addressed primarily in ways external to the framework for classifying countries. There are many ways of doing this, and there is a brief discussion of these options in the health financing classification section. However, a more comprehensive discussion of the policy responses and options is beyond the scope of this report.

Regarding limitations of the conceptual framework, the three policy options to capture level of health need relative to income are static, in that these are based on cross-sectional data such as a single year's data point or a retrospective average across certain years. These cannot capture the temporal element or trends, which could provide very useful insights when making policy decisions.

In case of the Prioritisation of Investments, when mapping countries by Health Financing characteristics, countries have been classified into different categories e.g. high priority- low current government fiscal capacity) based on thresholds that were defined in literature on health financing. However, it is likely that these thresholds evolve, and are updated, as well as are customised by focusing on specific country groupings.

Second, an assessment of fiscal capacity should ideally be based on the potential for raising revenue (which is typically higher for MICs than for LICs in the short term). The Health Financing gap (by health focus area) framework proposed by IHME uses the DEA method which would need to be further explored. The amount of data needed to execute on this framework is substantive, and may not be available for every focus for each stakeholder. Additionally, the availability and quality of cause specific and costing data is improving; but it still needs substantial improvements to be considered comprehensive. For anything beyond the most basic estimation, some modelling will be needed.

Finally, the analyses of Health Financing classifications are largely based on current health and economic outcomes, which are limited in that there is no reflection on the underlying country-specific constraints that give rise to these outcomes. In order to be comprehensive and capture the complex dynamics at the country level, a number of broader micro-policy factors other than domestic health-specific financing become relevant,

including considerations of cost-effectiveness, the efficiency of a system in delivering services, and the quality of national service delivery and surveillance systems.
It is important to recognize that any classification framework would be insufficient to respond to the need for this level of detail in classifying countries, and this would need to be addresses in operational policies. The potential use of impact indicators, explored by NIPH and University of Sheffield, allude to the need for policies to address these considerations. Prioritizing and allocating resources across health focus areas, countries, and subnational units is complex and should be based on objective data and objective targets.

Finally, it is important to note that one of the unique features of the SDGs is their relevance for all countries regardless of economic standing. However, an analysis of high-income countries is beyond the scope of the conveners and this Panel.

4.2. Further Research

For the Health Financing component, as noted by the analytical groups, when considering a country's current fiscal capacity, the efficiency and effectiveness[35] of investments may also be considered. This could help to inform the need for technical assistance that could enable greater efficiencies in leveraging investments, rather than relying on increased fiscal space or domestic/external finance alone. It is thus recommended that further analysis be undertaken to better understand how efficiency and effectiveness concerns can be included in a framework for external financing for health.

The Primary Health Care Performance Initiative (PHCPI) supported by the Gates Foundation, is focused on identifying better key performance indicators for primary health care and endorses using more advanced indicators which differentiate impact at a more granular level. More generally, research is required into the use of household surveys and the scope for mobile technology to help rapidly develop, collect and analyse a broader range of indicators, and for these to inform decision-making systems.

This initiative did not directly investigate the impact of specific eligibility policies on health outcomes during and after the transition period. Similarly, it did not investigate best-practice transition policies that might mitigate adverse impacts of transition. In order to further inform policies on the use of a health development continuum perspective, such studies might be appropriate.

Finally, overall the groups also explored classifications focused around equity: on inequality in life expectancy, use of the Gini index for income, the income share held by the bottom 40%, the skilled birth attendance rate, DTP3 immunization coverage, and out-of-pocket payments for health services. Analyses by the groups indicate that measures of expected impact should be considered at the programme and project levels, in the assessment of applications and during the implementation phase.

Further recommended indicators to consider in a health classification include the level of conflict, institutional quality and recent improvements in health-service coverage or health outcomes.

[35] Effectiveness is about what interventions are prioritised and is measured through outcome and impact indicators, while efficiency is focused on how interventions are implemented and focuses on outputs achieved per input. Efficiency is different from effectiveness in that it is only concerned with costs.

Chapter 5: Relevance for other areas of Development

In recent years, emergencies like the Ebola crisis reflect the increasingly complex challenges that health financers face: emergencies transcend national borders, and are intrinsically linked with global security and governance issues, making it harder for financers to focus on the country alone as a unit of investment.

EAI consultations highlighted the need that global health decision-making frameworks account for this changing reality and include criteria reflecting the "core functions" of global health.[1] The Global Health 2035 report contends that "to meet the challenges of the next generation", international collective action must increasingly focus on global functions: "provision of GPGs [global public goods] (especially R&D), management of externalities, and leadership and stewardship".[2]

The conceptual framework developed through the Equitable Access Initiative is relevant in and can be tailored to these conversations that focus on broadening the unit of investment from the national to the global.

It can further find applicability to areas of development outside the public health space, since the idea of accounting for burden and fiscal space are relevant to any lens that focuses on the socio-economic dimensions of development, including agriculture, education, health, nutrition, gender, and social inclusion. Further, the conclusion that thresholds and sharp cut-offs in assistance should be avoided could apply to any development area where there are high levels of need and limited domestic capacity to address it.

It could be of significant value to consider how more refined approaches of need and fiscal issues could be developed across key development sectors. It is not necessarily true that a country has made equal progress in each area of development, and it is possible that resources and focus across the development spectrum are not maximized. For example, it might be possible to begin with a general poverty index for all countries that is supplemented by assessments of each main sector based on need and fiscal issues to create a complete picture of a country's status along the development continuum.

Such a comprehensive approach could help to guide domestic and external finance and to increase efficiency and value for money across the areas of development to maximize the opportunity for countries to address development issues. Such an approach could also be important to realize the SDG vision of focusing on people and countries and not only on specific issues.

In a more general sense, this discussion highlights the need to focus on the more specific objectives of development, such as more health or education, as a way of discussing how to strengthen the systems that underpin them. More granular criteria could be valuable for different sorts of funders motivations, such as prioritizing the most deserving or any other group of interest, avoid certain incentives, and promote specific policies.

Finally, since the data required for detailed analysis are highly variable in availability, quality, scope, age, and other important dimensions. It is important to consider the cost of collecting more information as one trade-off for potentially better targeted decision making.

[1] There are three broad core functions 1)Supplying global public goods, which includes: Research and development for health tools; • Development and harmonisation of international health regulations; • Knowledge generation and sharing; • Intellectual property sharing; • Market-shaping activities 2) Management of cross-border externalities: Outbreak preparedness and response; • Responses to antimicrobial resistance; • Responses to marketing of unhealthful products; • Control of cross-border disease movement; 3)Exercising leadership and stewardship which includes: Health advocacy and priority setting (convening of policy makers for negotiation and consensus building for strategy and policy); Promotion of aid eff effectiveness and accountability

[2] Jamison DT, Summers LH, Alleyne G, et al. Global health 2035: a world converging within a generation. Lancet 2013; 382: 1898–955

Chapter 6: Conclusions and Recommendations

Decision-making in health policy is complex and characterized by trade-offs between the need to invest in contexts that maximise impact, and contexts that have the greatest financial and health need. Given these contrasting, and often competing goals, the use of classifications that focusing either only on financial need, or health need, would overlook the multifaceted nature of diseases, and the varied economic ability of populations and governments to respond to these.

The findings from the analysis conducted under the aegis of the Equitable Access Initiative identify that just as multi-stakeholder approaches are key to resolving public health issues, multi-criteria decision-making is required in order to identify, and then prioritise contexts. The specific questions around the application of such a framework, relating to grant management or resource distributions is beyond what could be proposed and deliberated within the mandate of the Initiative. It is however hoped that by wider engagement through the consultation processes, the governance bodies of different institutions will consider the EAI's conclusions in their own deliberations.

Finding:

External health financing has been guided by the principles of improving health outcomes in contexts that have the least financial and structural capacity, both in terms of domestic resources and technical capability, to respond to key health needs. The analyses identify that complex policies such as eligibility and the prioritisation of investments should be informed by indicators reflecting income levels, health needs and policies.

Using a comparison of countries' rankings and eligibility, measured first by income and then by health needs, the analyses illustrates significant limitations of prioritizing based on income levels measured by GNI per capita.

This is particularly relevant for eligibility polices, which, if based on income levels alone would tend to deprioritize middle-income countries where the level of disease burden continues to be too high to be domestically met, putting the population at further risk. A framework based solely on health needs would tend to deprioritize low-income countries with lower disease levels that may have insufficient resources to respond to the disease burden.

Recommendation:

The overarching recommendation is that complex external health financing decisions such as eligibility and the prioritisation of investments should be informed by a multi-criteria framework that takes into account income levels, income distribution and health needs, in addition to domestic capacity and policies, where relevant.

The analytical work emphasises the need to inform eligibility policies by both income and health metrics, and to account for levels of income relative to the disease burden a population must address. The analytical work examines a framework that accounts for health need relative to income by adjusting GNI by a general health-need indicator. Alternative ways of operationalising this recommendation for eligibility polices are explored in the report.

Is it further recommended that discrete thresholds[36] in eligibility polices, if adopted, should be supported by policies that allow for a gradual and planned transition from external financing, in order to mitigate the risk of a country losing gains in health due to rapid decreases in external health financing in spite of significant health needs and/or limited fiscal space. In the absence of policies that

[36] Thresholds and categories define the subset of contexts that fit the criteria of contexts. Income based eligibility frameworks typically have discrete thresholds i.e. a country is either above or below the threshold.

would allow for a planned transition process, countries may be at risk of too rapid transitions, potentially resulting in fiscal cliffs wherein external funding is withdrawn without sufficient planning to mitigate any interim decline in services.[37]

Finding:

In health policy, GNI per capita has also been used as a proxy to understand a government's capacity to invest in health, but the analyses demonstrates that the metric is an imperfect measure. GNI per capita is a better measure of the level of wealth in a society, rather than the resources available to a government for investments in health.

The focus on a government's capacity to finance key public health interventions responds to external financing being considered to be more relevant where a country's public domestic capacity is lower.

There has been a growing concern that external health financing policies may dis-incentivize greater domestic investments towards health, if policies support external financing for health irrespective of a countries' capacity to address domestic health needs, and the budgetary priority it allocates towards health.

A competing view however is that reducing support to countries where the government fails to use the country's capacity would adversely affect particularly key populations. Despite the continued debate over how policies could shape incentives, considering public capacity and policies in health policy making could be a first step in making the issue of incentives more explicit in decision-making for health**.**

Recommendation:

In order to prioritize external health financing by better understanding a government's domestic capacity to invest in health, a framework could compare the present and potential resource capacity of the government to invest in health with the level of priority given to investments in health.

The analytical work suggests a framework that would inform polices based on a government's health financing characteristics, with a particular focus on i) the budgetary priority that governments give to health, measured in terms of the proportion of total government expenditure that is public health expenditure; and ii) their current fiscal capacity by accounting for the tax revenues collected by a government, the level of debt, and the size of annual interest payments.

Against the concern with incentives, the analyses indicate that having an additional explicit focus on domestic policies in decision-making would be a first step in working with domestic governments, civil society, and other stakeholders to identify how low public investment in health and other barriers to achieving equitable health outcomes can be addressed.

In policy terms, understanding the level of health need vis-a-vis the level of health priority and the degree to which a government leverages its domestic capacity, would be useful 'levers' that financers could use to prioritise investments, further define the type of assistance to be provided, as well as define the co-investment agreements with domestic governments. For e.g. in contexts where the government prioritises health well and is leveraging its domestic capacity, multilaterals may partner towards identifying inefficiencies in current spending, which would optimise the use of existing resources.

Finding

It has also been emphasised that where possible, health need must be accounted for at a micro-level, and reflect the sub-national variation in health outcomes, particularly in order to avoid overlooking the needs of vulnerable groups and key populations. Legal and social barriers, or the lack of financial means, can disproportionally affect or effectively prevent certain groups from accessing vital health services. Given current data limitations, the groups did not endorse any particular metric or method

[37] While there was consensus among EAI members that where discrete thresholds are used that render a country ineligible for support once it passes a certain GNI per capita level, the risk of negative impacts on overall health financing should be mitigated by allowing for a gradual and planned transition; an additional recommendation to avoid discrete thresholds for low- and middle-income countries was not supported by the entire EAI.

of capturing this variation, and the analyses instead suggests nuancing policies based on qualitative assessments.

Recommendation

In order to improve health and development organisations' capacity to systematically track specific challenges in countries, it is recommended that greater investments in data collection systems be considered. This would be a another step towards developing a more nuanced, comprehensive framework that captures equity considerations, including the needs of key populations and vulnerable groups, through better quality and more reliable data that support the inclusion of relevant indicators.

Annex I: Summary of the EAI consultative process

First meeting: February 2015

On 23 February 2015, the Equitable Access Initiative (EAI) held its first meeting organised by the initiative's 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 WHO, the convening agencies, expert panellists and other guests met in Geneva. They discussed possible measures or indicators that could be used to better represent health needs and capacities than GNI per 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.

Experts described how the World Bank's country classification using GNI per capita was designed to inform its own lending decisions, but these groupings were being used far more broadly by many other agencies to inform health-related decisions. As economic growth shifts more countries higher on this scale, they discussed how it is increasingly difficult to use GNI per capita as a reliable indicator of disease burden or health system capacity. Increasing inequality means that poverty and ill health can persist and even grow despite improvements in aggregate indicators.

The motivation for the EAI was to produce a new starting point for considering how to classify countries, characterise disease burdens and capacities and better inform health financing decisions. The governing body of each institution or government would then be free to consider the EAI's conclusions and adopt its own approaches.

EAI members agreed with the importance of discussing health needs and ensuring equitable access. There was a need to consider the highly-varied distribution of disease, poverty and inequality within countries; and disparities including the urban-rural divide, gender and birth-order. They stressed the urgency of a discussion given high disease burdens and pressure on funding. They also highlighted the importance of considering 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 donors 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. Still others called for states to take primary responsibility for the health of their populations, and for partners to create incentives and to 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; and some countries' economic status may reverse as a result of conflict or other crises. Many that have become lower-middle-income remain "just beyond the bar" dividing them from lower income.

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 on headcount and overheads.

One option discussed was to retain the current GNI per 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 of data collection with a maximum of 3 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.

Project development and consultation: summer/autumn 2015

After the meeting, the EAI launched a tender to further explore the issues raised, and awarded contracts to four academic research groups to explore alternatives to GNI per capita for health. It held consultations with the co-convenors and the governance bodies of the different organisations. The academic groups initially developed their own models, analyses and approaches.

Given the great interest and importance of extended participation, the Equitable Access Initiative made considerable efforts to engage with a variety of stakeholders throughout the analytical work. The consultative process allowed participants to provide feedback on the strengths and weaknesses of the outputs as well as points of convergence.

Issues raised included the encouragement of shared responsibility to promote sustainability; that country capacity could be explored as a coefficient for movement along the continuum; and that a guiding principle of the health classification framework was to ensure access for the most vulnerable. They concluded that country leadership would inspire accountability for a sustainable approach.

The NIPH research team conducted 20 interviews in August to September, to gather suggestions on the framework and indicators. Participants included academics, civil society, multilateral organisations, bilateral donor and country government representatives. The interviewees generally agreed that frameworks could be useful in providing an initial orientation for decision making. Among the four areas of concern examined directly, health and health needs was clearly identified as the most important. Stakeholders also highlighted health needs and inequality as areas of concern.

The NIPH team also conducted a wider online discrete choice experiment (DCE) to map the preferences of different stakeholders. The survey focused on common criteria for guiding decisions about external financing for health, including income per capita, burden of disease, strength of the health system and health inequalities. Through a set of binary choices, survey participants indicated how important they found each of these country characteristics. A total of 285 people consented and completed the survey, with responses coming from almost ninety countries. Civil society organizations were very well represented in the sample – accounting for 44.6% of the responses.

Around the time of the UN General Assembly's SDG Summit in September 2015, there was a series of discussions including with UN policymakers and leading academics, a civil society consultation, a feedback session with the Gates Foundation's Primary Health Care Performance Initiative and a Private Sector consultation. These sessions provided an opportunity to clarify the objectives of the Initiative in person, and allowed stakeholders to voice concerns over indicators and suggest ways of improving engagement.

On 16 October, the Institut Jacques Delors hosted a discussion with Paris with 22 key representatives from the private sector, conveners, civil society, donors, academia and French government officials. The meeting focused on the potential policy impact of the EAI, highlighting the need to account for fiscal capacity as a valuable tool for guiding international organisations and country governments toward considering effective and efficient spending.

Second analytical advisory meeting: October 2015

On 28 October, technical experts from convening organisations, civil society representatives, academics and the four analytical groups gathered in Geneva. The objective was to review the individual approaches, identify a health framework, and define the trajectory of the Initiative's analytical process.

While participants in each consultation pointed out the strengths of each of the different analytical approaches, it was ultimately decided that the groups could develop common outputs during the final phase of the Initiative. Using common theoretical elements from the four approaches, points of convergence were identified in order to outline the third and final phase of the EAI, prior to the second Expert Panel Meeting in February 2016. Those present in the October consultation agreed that a robust methodology required a comprehensive model that was simple, replicable, transparent and easy to understand.

Subsequent meetings of the EAI included a Member States' Meeting on the Global Fund Board in Brussels on 10 November, and a meeting convening leading experts in Berlin organised by Expert Panel member Heidemarie Wieczorek-Zeul on 1 December to discuss political intentions and consequences of a potential new framework.

Annex II: Table of country rankings

Country	GNIpc	GNI pc rank	DALY rank	GNI DALY rank	Change
Burundi	250	1	19	14	▲
Malawi	280	2	13	10	▲
Central African Republic	310	3	5	3	=
Congo, Dem. Rep.	370	4	7	6	▲
Liberia	370	5	28	24	▲
Niger	400	6	9	7	▲
Madagascar	440	7	45	29	▲
Guinea	450	8	17	13	▲
Ethiopia	470	9	31	27	▲
Gambia, The	500	10	30	26	▲
Togo	520	11	26	23	▲
Guinea-Bissau	570	12	2	1	▼
Mozambique	600	13	11	9	▼
Uganda	620	14	23	20	▲
Eritrea	620	15	34	28	▲
Mali	630	16	3	2	▼
Burkina Faso	650	17	22	17	=
Sierra Leone	670	18	10	8	▼
Rwanda	670	19	44	30	▲
Afghanistan	690	20	21	19	▼
Nepal	720	21	79	49	▲
Benin	790	22	42	31	▲
Haiti	800	23	43	32	▲
Zimbabwe	820	24	18	15	▼
Comoros	820	25	49	38	▲
Tanzania	840	26	27	25	▼
South Sudan	920	27	12	11	▼
Cambodia	960	28	57	43	▲
Chad	980	29	4	4	▼
Tajikistan	1000	30	72	51	▲
Bangladesh	1010	31	68	48	▲
Senegal	1050	32	46	35	▲
Kenya	1180	33	41	36	▲
Kyrgyz Republic	1220	34	71	52	▲
Cameroon	1290	35	15	18	▼
Yemen, Rep.	1300	36	62	47	▲
Mauritania	1330	37	37	33	▼
Cote d'Ivoire	1360	38	16	21	▼
Pakistan	1360	39	47	40	▲
Djibouti	1430	40	35	34	▼
Lao PDR	1490	41	53	44	▲
India	1530	42	50	45	▲
Sao Tome and Principe	1560	43	66	53	▲

Lesotho	1580	44	1	5	▼
Sudan	1670	45	64	50	▲
Zambia	1700	46	14	22	▼
Vietnam	1740	47	116	62	▲
Ghana	1750	48	38	41	▼
Nicaragua	1790	49	119	67	▲
Solomon Islands	1830	50	65	54	▲
Uzbekistan	1940	51	76	57	▲
Papua New Guinea	2030	52	32	37	▼
Honduras	2190	53	103	63	▲
Bhutan	2330	54	70	59	▲
Moldova	2470	55	61	55	=
Congo, Rep.	2620	56	29	39	▼
Bolivia	2620	57	75	61	▲
Nigeria	2700	58	8	16	▼
Kiribati	2720	59	36	46	▼
Swaziland	2750	60	6	12	▼
Egypt, Arab Rep.	2940	61	78	68	▲
Morocco	2990	62	105	75	▲
West Bank and Gaza	3060	63	123	81	▲
Vanuatu	3090	64	58	58	▼
Syrian Arab Republic	3120	65	104	76	▲
Sri Lanka	3180	66	112	79	▲
Micronesia, Fed. Sts.	3270	67	77	71	▲
Guatemala	3290	68	86	73	▲
Philippines	3300	69	87	74	▲
Cabo Verde	3530	70	111	82	▲
Georgia	3560	71	59	60	▼
Indonesia	3740	72	88	78	▲
Ukraine	3760	73	48	56	▼
Armenia	3780	74	74	77	▲
El Salvador	3870	75	92	80	▲
Guyana	3940	76	55	64	▼
Samoa	3960	77	115	88	▲
Paraguay	4190	79	108	89	▲
Tunisia	4210	80	122	94	▲
Timor-Leste	4250	81	84	83	▲
Marshall Islands	4300	82	60	72	▼
Tonga	4320	83	89	85	▲
Belize	4350	84	98	86	▲
Mongolia	4360	85	51	65	▼
Fiji	4370	86	54	70	▼
Albania	4510	87	95	87	=
Angola	4730	88	20	42	▼
Bosnia and Herzegovina	4790	89	83	90	▲
Jordan	4940	90	127	103	▲

Macedonia, FYR	4980	91	99	93	▲
Jamaica	5220	92	107	97	▲
Thailand	5320	93	90	95	▲
Algeria	5470	94	113	102	▲
Namibia	5750	95	33	66	▼
Ecuador	5790	96	100	99	▲
Dominican Republic	5840	97	101	100	▲
Serbia	6050	99	91	101	▲
Peru	6230	100	118	109	▲
Cuba	6500	101	102	105	▲
St. Vincent and the Grenadines	6540	102	85	104	▲
Maldives	6730	103	128	117	▲
China	6740	104	114	113	▲
Belarus	6780	105	40	84	▼
Iran, Islamic Rep.	6840	106	125	114	▲
Dominica	6860	107	96	107	=
Turkmenistan	6880	108	63	98	▼
Iraq	6920	109	94	108	▼
St. Lucia	7060	110	97	110	=
Montenegro	7250	111	73	106	▼
Bulgaria	7280	112	52	96	▼
Azerbaijan	7350	113	81	111	▼
South Africa	7410	114	25	69	▼
Grenada	7490	115	80	112	▼
Botswana	7500	116	39	91	▼
Colombia	7770	117	106	115	▼
Romania	9050	118	69	116	▼
Suriname	9470	119	67	118	▼
Mauritius	9570	120	82	119	▼
Lebanon	9610	121	121	122	▲
Mexico	9770	122	110	121	▼
Costa Rica	9780	123	126	123	=
Gabon	9790	124	24	92	▼
Libya	10510	126	120	124	▼
Malaysia	10510	127	124	126	▼
Panama	10860	128	117	127	▼
Turkey	10970	129	109	125	▼
Kazakhstan	11560	130	56	120	▼
Brazil	12310	131	93	128	▼

Annexe III: Equitable Access Initiative Expert Panel and Technical Working Group Members

Expert Panel of the Equitable Access Initiative (EAI)

Co-chairs of the Expert Panel of the Equitable Access Initiative	
Hon. Pascal Lamy	Honorary President, Notre Europe
H.E. Donald Kaberuka	President, African Development Bank Group
EAI Expert Panel Members	
Elhadj As Sy	Secretary General, IFRC
Prof. Fred Newton Binka	President, Association of Schools of Public Health in Africa
Nancy Birdsall	Founding President, Center for Global Development
Prof. Awa Coll-Seck	Minister for Health, Senegal
Tony Elumelu, C.O.N	Founder, Tony Elumelu Foundation
Hon. Fenton Ferguson	Minister of Health, Jamaica
Prof. Lawrence Gostin	University Professor, Georgetown University
The Rt. Hon. Justine Greening MP	Secretary of State for International Development, DfID
Anand Grover	Co-Founder & Project Director, Lawyers Collective
Yan Guo	Vice President, Peking University Health Science Centre
Prof. Dean Jamison	Professor of Global Health, University of Washington in Seattle
H.E. Christine Kaseba-Sata	Goodwill Ambassador for Gender-based Violence, WHO

EAI Expert Panel Members (continued)	
Hon. Michael Kirby AC, CMG	Former Justice, High Court of Australia
Toshiro Kumakawa	Director, Department of Health and Welfare Services, National Institute of Public Health, Japan
Joanne Liu	International President, MSF
James Love	Director, Knowledge Ecology International
Hon. James Macharia	Cabinet Secretary for Health, Kenya
Graça Machel DBE	Founder, Graça Machel Trust
Lord Mark Malloch-Brown	Special Advisor, FTI Consulting and former United Nations Deputy Secretary General
Hon. Nafsiah Mboi	Chair of Board, The Global Fund to fight AIDS, Tuberculosis and Malaria
Neven Mimica	European Commissioner for International Cooperation and Development, European Commission
H.E Festus Mogae	Former President, Botswana
Luis Alberto Moreno	President, Inter-American Development Bank
Prof. Arthur Mutambara	CEO, Africa Technology and Business Institute
Mthuli Ncube	Senior Research Fellow and Project Leader at Blavatnik School of Government, University of Oxford
Hon. Ngozi Okonjo-Iweala	Minister of Finance, Nigeria
Eva Ombaka	Pharmaceutical Systems Africa
Gorik Ooms	Researcher, Institute of Tropical Medicine, Belgium

EAI Expert Panel Members (continued)	
Hon. Mari Pangestu	Professor of International Economics, University of Indonesia and former Minister of Trade, Republic of Indonesia
Hon. David Parirenyatwa	Minister of Health & Child Welfare, Zimbabwe
Hon. Joy Phumaphi	Executive Secretary, African Leaders Malaria Alliance
Peter Piot	Director, London School of Hygiene & Tropical Medicine
Prof. Nana Poku	Political Economist, HEARD
H.E. Rajata Rajatanavin	Minister of Public Health, Thailand
Hon. Sujatha Rao	Senior Leadership Fellow, Harvard School of Public Health
Prof. Hans Rosling	Professor of International Health, Karolinska Institute
Ambassador Richard Sezibera	Secretary General, East African Community
John Sewell	Senior Scholar, The Wilson Center
Gloria Steinem	Feminist Activist & Co-Founder, Ms. Magazine
Mark Suzman	President of Global Policy, Advocacy, and Country Programs, Bill & Melinda Gates Foundation
Ellen ‘t Hoen	Director, Medicines Law & Policy
Mary Ann Torres	Executive Director, ICASO
Cardinal Peter Turkson	President, Pontifical Council for Justice and Peace
Stefano Vella, MD	Chair, Center for Global Health at the Italian National Institute of Health; Advisor, Italian Ministry of Foreign Affairs
Heidemarie Wieczorek-Zeul	Vice president, Friends of the Global Fund Europe; Former Development Minister of Germany

Technical Working Group Members of the Equitable Access Initiative

EAI Conveners' Technical Working Group	
Tenu Avafia	Policy Adviser, HIV, Health and Development Practice, Bureau for Development Policy, UNDP New York
Prof. Brook Baker	Senior Policy Analyst for Health GAP (Global Access Project), Northeastern University
Manica Balasegaram	Director, Access Campaign, MSF
Elizabeth Benomar	Technical Advisor, UNFPA
Philippe Duneton	Deputy Executive Director, UNITAID
Harley Feldbaum	Head Strategy & Policy in the Office of the Executive Director, The Global Fund
Christopher Game	Chief Procurement Officer, The Global Fund
Peter Ghys	Director, Strategic Information & Evaluation Department, UNAIDS
Abdalla Hamdok	Deputy Executive Secretary, United Nations Economci Commission for Africa (UNECA)
Jose Antonio Izazola-Licea	Division Chief, Evaluation and Economics, UNAIDS
Judith Kallenberg	Head of Policy, Gavi, the Vaccine Alliance
Supon Limwatananon	Faculty of Pharmacy, Khonkaen University, Thailand
Ezra Mbogori	Executive Director, Akiba Uhaki Human Rights & Social Justice Fund, Kenya
Gabriela Flores Pentzke Saint-Germain	Health Economist, WHO
Robert Newman	Managing Director, Policy & Performance, Gavi, the Vaccine Alliance
Michael Kent Ranson	Senior Health Economist, Health, Nutrition & Population Global Practice, The World Bank Group
Ferdinando Regalia	Chief of the Social Protection and Health Division, Inter-American Development Bank
Charles Siwela	PLHIV, National Director, Youth Engage Zimbabwe
Anthony So	Director, Program on Global Health and Technology Access, Duke University