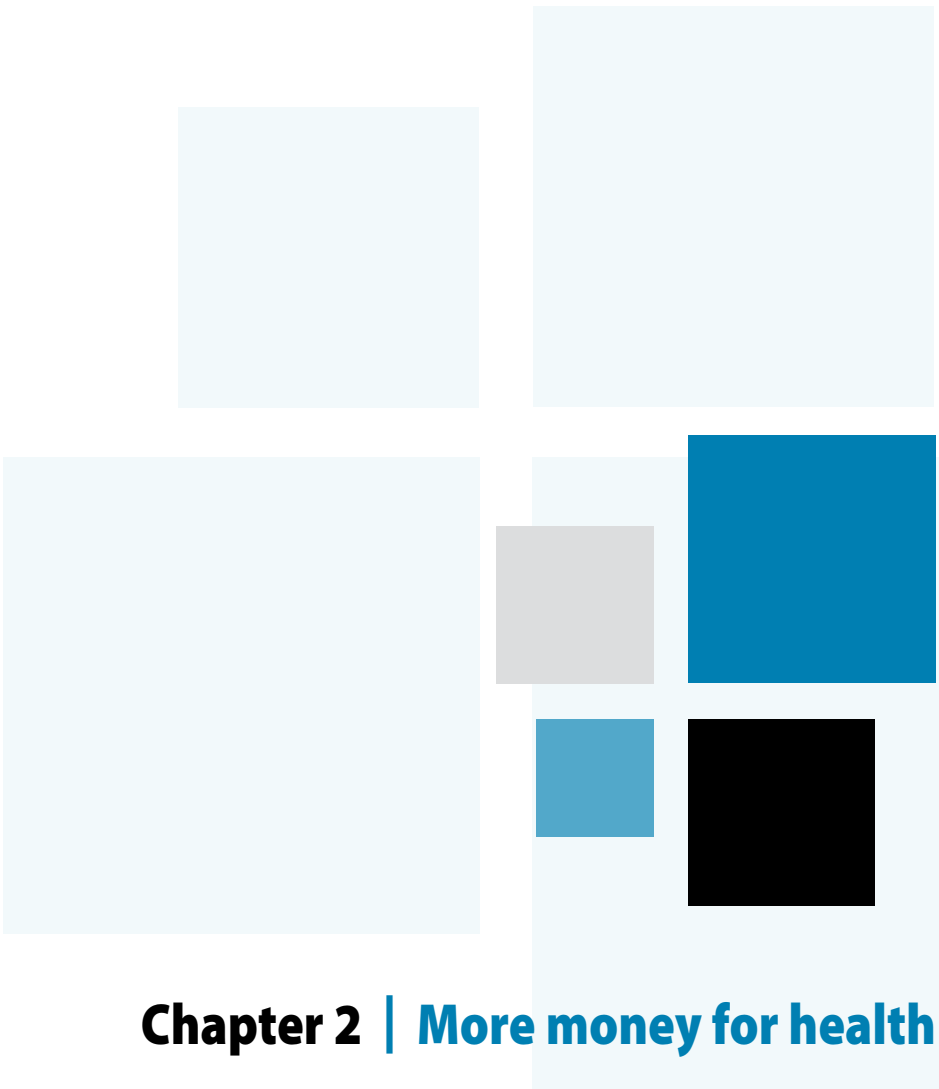


Chapter 2 | More money for health

Key messages

- No country has yet been able to guarantee everyone immediate access to all the services that might maintain or improve their health. They all face resource constraints of one type or another, although these are most critical in low-income countries.
- Every country could raise additional domestic funds for health or diversify their funding sources if they wished to.
- Options include governments giving higher priority to health in their budget allocations, collecting taxes or insurance contributions more efficiently and raising additional funds through various types of innovative financing.
- Taxes on harmful products such as tobacco and alcohol are one such option. They reduce consumption, improve health and increase the resources governments can spend on health.
- Even with these innovations, increased donor flows will be necessary for most of the poorest countries for a considerable period of time. Donor countries can also raise more funds to channel to poorer countries in innovative ways, but they should also do more to meet their stated international commitments for official development assistance (ODA) and to provide more predictable and long-term aid flows.

2

More money for health

Raising resources for health

In 2009, the British National Institute for Health and Clinical Excellence announced that the National Health Service could not offer some expensive medicines for the treatment of renal cancer because they were not cost effective (*1*). The cuts provoked some public anger (*2*) but were defended by the institute as being part of difficult but necessary moves to ration resources and set priorities (*3*). The fact is new medicines and diagnostic and curative technologies become available much faster than new financial resources.

All countries, rich and poor, struggle to raise the funds required to pay for the health services their populations need or demand (which is sometimes a different matter). No country, no matter how rich, is able to provide its entire population with every technology or intervention that may improve health or prolong life. But while rich countries' health systems may face budget limitations – often exacerbated by the dual pressures of ageing populations and shrinking workforces – spending on health remains relatively high. The United States of America and Norway both spend more than US$ 7000 per capita a year; Switzerland more than US$ 6000. Countries from the Organisation for Economic Co-operation and Development (OECD) as a group spend on average about US$ 3600. At the other end of the income scale, some countries struggle to ensure access to even the most basic services: 31 of WHO's Member States spend less than US$ 35 per person per year and four spend less than US$ 10, even when the contributions of external partners are included (*4*).

But there is scope in all countries to extend financial risk protection and access to health services in a more equitable manner. Rwanda, with per capita national income of about US$ 400, offers a set of basic services to its citizens through a system of health insurances at a cost of just US$ 37 per capita (*4*). While Rwanda benefits from the financial support of the international donor community, the government also commits 19.5% of its total annual spending to health (*4*). There are 182 WHO Member States with levels of per capita gross domestic product (GDP) that are comparable with or superior to (in some cases, vastly superior) Rwanda's, and yet many are further away from universal health coverage (*4*). This needs to change. With few exceptions, countries have no reason to delay improving access to quality health services, while at the same time increasing financial risk protection. This will cost money, and governments need to start thinking about how much is required and where it will come from.

But what does universal coverage cost?

Universal coverage is not a one-size-fits-all concept; nor does coverage for all people necessarily mean coverage for everything. As described in Chapter 1, moving towards universal coverage means working out how best to expand or maintain coverage in three critical dimensions: who is covered from pooled funds; what services are covered; and how much of the cost is covered. Within that broad framework, policy-makers must decide how funds are to be raised and administered.

Thailand offers prescription medicines, ambulatory care, hospitalization, disease prevention and health promotion free of charge to patients, along with more expensive medical services such as radiotherapy and chemotherapy for cancer treatment, surgical operations and critical care for accidents and emergencies. It manages to do all this for just US$ 136 per capita – less than the average health expenditure for lower-middle-income countries, which stands at US$ 153 (*4*). But Thailand does not cover everything. Until recently it drew the line at renal replacement therapy for end-stage renal disease, for example (Box 2.1). Other countries will draw the line elsewhere.

To know how far you can expand coverage in any of the three dimensions, you must have an idea of what services cost. In 2001 the Commission on Macroeconomics and Health estimated that basic services could be made available for about US$ 34 per person (*6*), close to what Rwanda is spending now. However, the calculations did not include the full cost of anti-retrovirals or treatment for noncommunicable diseases; nor did they fully take into account investments that might be needed to strengthen a health system so that coverage might be extended to isolated areas.

A more recent estimate of the cost of providing key health services, which was produced by WHO for the high-level Taskforce on Innovative International Financing for Health Systems, suggests that the 49 low-income countries surveyed would need to spend just less than US$ 44 per capita on average (unweighted) in 2009, rising to a little more than US$ 60 per capita by 2015 (*7*). This estimate includes the cost of expanding health systems so that they can deliver all of the specified mix of interventions. It includes interventions targeting noncommunicable diseases and those for the conditions that are the focus of the health-related

Box 2.1. Thailand redraws the line in health-care coverage

When, in 2002, Thailand introduced its universal coverage scheme, which was then called the 30 bhat scheme, it offered comprehensive health care that included not just basics, but services such as radiotherapy, surgery and critical care for accidents and emergencies. It did not, however, cover renal-replacement therapy. "There was a concern that [renal-replacement therapy] could burden the system as major health risks leading to kidney diseases, such as diabetes and hypertension, were still not well controlled," says Dr Prateep Dhanakijcharoen, deputy secretary general of the National Health Security Office that administers the scheme. Renal replacement therapy is expensive; haemodialysis costs about 400 000 baht (US$ 12 000) per patient, per year in Thailand, four times higher than the 100 000-baht per quality-adjusted life year threshold set by the security office's benefit package subcommittee for medicines and treatments within the scheme.

That said, Dhanakijcharoen believes the scheme should have covered kidney disease from the outset. This view is shared by Dr Viroj Tangcharoensathien, director of the International Health Policy Programme at the Ministry of Public Health. For Tangcharoensathien, it was simply a matter of fairness: "There are three health-care schemes in Thailand," he says. "Only the scheme did not include renal-replacement therapy. Meanwhile, half of those people in the scheme are in the poorest quintile of the Thai economy." His sense of injustice was shared by other people, such as Subil Noksakul, a 60-year-old patient who spent his life-savings on renal replacement therapy over a period of 19 years. "I once managed to save seven million baht," he says, "but my savings are now all gone." In 2006 Noksakul founded the Thai Kidney Club, which has raised kidney patients' awareness of their rights and put pressure on the National Health Security Office to provide treatment. Finally, in October 2008, the then public health minister, Mongkol Na Songkhla, included renal-replacement therapy in the scheme.

Source: Excerpt from (*5*).

Millennium Development Goals (MDGs). These figures, however, are simply an (unweighted) average across the 49 countries at the two points in time. Actual needs will vary by country: five of the countries in that study will need to spend more than US$ 80 per capita in 2015, while six will need to spend less than US$ 40[a].

This does not mean that the 31 countries spending less than US$ 35 per person on health should abandon efforts to raise resources to move closer to universal health coverage. But they will need to tailor their expansion according to their resources. It also means that although it is within their capacity to raise additional funds domestically – as we show in the next two sections – for the immediate future they will also require external help. Even with relatively high levels of domestic growth, and national budgets that prioritize health, only eight of the 49 countries have any chance of financing the required level of services from domestic resources in 2015 (*7*).

Many richer countries will also need to raise additional funds to meet constantly evolving health demands, driven partly by ageing populations and the new medicines, procedures and technologies being developed to serve them. A key aspect of this complex issue is the diminishing working-age population in some countries. Dwindling contributions from income taxes or wage-based health insurance deductions (payroll taxes) will force policy-makers to consider alternative sources of funding.

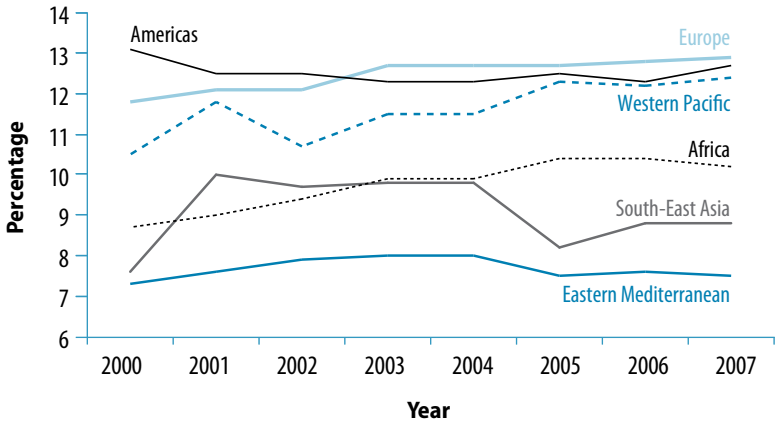
Broadly speaking, there are three ways to raise additional funds or diversify sources of funding: the first is to make health a higher priority in existing spending, particularly in a government's budget; the second is to find new or diversified sources of domestic funding; and the third is to increase external financial support. We review these options in turn, the first two being important for countries at all stages of development, rich or poor. The chapter concludes by considering development assistance for health for low- and middle-income countries.

Ensuring a fair share of total government spending on health

Even in countries where external assistance is important, its contribution is generally much less than the money for health collected domestically. In the low-income countries, for example, the average (unweighted) contribution from external sources in 2007 was a little less than 25% of total health expenditure, the rest coming from domestic sources (*4*). It is critical, therefore, to sustain and, where necessary, increase domestic resources for health, even in the poorest countries (*8*). This is just as important in higher-income settings.

Governments finance health improvements both directly, through investments in the health sector, and indirectly, through spending on social determinants – by reducing poverty or improving female education levels, for example. Although it captures only the direct component, the proportion of overall spending allocated to the health sector provides important insights into the value that governments place on health, something that varies greatly between countries. Fig. 2.1 shows the average share of government spending

Fig. 2.1. **Government expenditure on health as a percentage of total government expenditures by WHO region, 2000–2007**[a]



[a] These are unweighted averages. Government health expenditure includes health spending by all government ministries and all levels of government. It also includes spending from compulsory social health insurance contributions.

Source: (*4*).

on health by WHO region for the period from 2000 to 2007, the last year for which figures are available. The figures include contributions from external partners channelled through government budgets in both the numerator and denominator because few countries report them separately.

Governments in the Americas, the European and Western Pacific Regions, on average, allocate more to health than the other regions. African countries as a group are increasing their commitment to health as are those in the European and Western Pacific Regions. In South-East Asia, the relative priority given to health fell in 2004–2005, but is increasing again, while governments in the WHO Eastern Mediterranean Region have reduced the share allocated to health since 2003.

Some of the variation across regions can be explained by differences in country wealth. Generally, health accounts for a higher proportion of total government spending as countries get richer. Chile is a good example, having increased its share of government spending on health from 11% in 1996 to 16% a decade later during a period of strong economic growth (*9*).

But a country's relative wealth is not the only factor at play. Substantial variations across countries with similar income levels indicate different levels of government commitment to health. This can be illustrated in many ways, but here we cite the WHO Regional Office for Europe, which has countries at all income levels. In Fig. 2.2, the vertical axis shows the proportion of total government spending allocated to health, and the bars on the horizontal axis represent countries in that region, ordered from lowest to highest levels of GDP per capita.

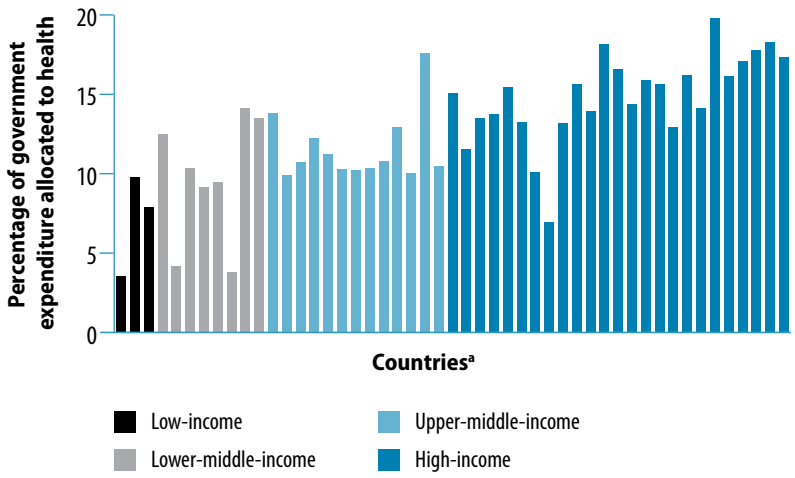
Budget allocations to health in the WHO European Region vary from a low 4% of total government spending to almost 20%. Importantly, even though the priority given to health in overall government budgets generally increases with national income, some governments choose to allocate a high proportion of their total spending to health despite relatively low levels of national income; others that are relatively rich allocate lower proportions to health.

This pattern can also be seen globally. Although government commitments to health tend to increase with higher levels of national income, some low-income countries allocate higher proportions of total government spending to health than their high-income counterparts; 22 low-income countries across the world allocated more than 10% to health in 2007 while, on the other hand, 11 high-income countries allocated less than 10%.

While the African Region does not post the lowest result in Fig. 2.1, the relatively low level of domestic investment in health in some of its countries

is cause for concern because it is in sub-Saharan Africa that the slowest progress has been made towards the MDGs (*10*, *11*). In 2007, only three African countries – Liberia, Rwanda and the United Republic of Tanzania – had followed through on the 2001 Abuja Declaration, in which African leaders pledged to "set a target of allocating at least 15% of their annual budgets to the improvement of the health sector" (*12*). Disappointingly, 19 African countries in 2007 allocated a lower proportion of their total government budgets to health than they did before Abuja (*4*).

Fig. 2.2. **The share of total government expenditure allocated to health in the WHO European Region, 2007**



[a] Ordered by GDP/capita.
Source: (*4*).

Governments have, therefore, the option to re-examine budget priorities with health in mind. Although funding needs vary with differences in costs, population age structures and patterns of disease, many governments of rich and poor countries could allocate much more to health from available resources. The gains could be substantial. Taken as a group, the low-income countries could raise (at least) an additional US$ 15 billion dollars per year for health from domestic sources by increasing the share of health in total government spending (net of external aid inflows) to 15%. For the same countries, the increased funding for the period 2009–2015 would be about US$ 87 billion (*7*).

There are several reasons countries do not prioritize health in their budgets, some fiscal, some political, some perhaps linked to the perception in ministries of finance that ministries of health are not efficient. In addition, the budget priority governments give to health reflects the degree to which those in power care, or are made to care, about the health of their people. Dealing with universal health coverage also means dealing with the poor and the marginalized, people who are often politically disenfranchised and lack representation.

This is why making health a key political issue is so important and why civil society, joined by eminent champions of universal coverage, can help persuade politicians to move health financing for universal coverage to the top of the political agenda (*13*). Improving efficiency and accountability may also convince ministries of finance, and increasingly donors, that more funding will be well used (we will return to this in Chapter 4).

Learning the language of economists and the type of arguments that convince them of the need for additional funding can also help ministries of health negotiate with a ministry of finance. It also helps them understand the complexities of changes in the way health is funded and then to take the opportunities that arise. For example, it is important that ministries of health

keep track of negotiations between donors and ministries of finance relating to debt relief and general budget support (*14–16*). They need not only to understand these processes but also be able to discuss and negotiate with the minister of finance for a share of available funds.

Diversifying domestic sources of revenue

There are two main ways to increase domestic funding for health: one is to allocate more of the existing financial resources to health, as discussed in the previous section; the other is to find new methods to raise funds or to diversify the sources.

Collecting taxes and insurance contributions more efficiently would effectively raise additional funds. Improving revenue collection is something that all countries might need to consider, though this may be problematic for many lower-income countries with large informal sectors (*17*). This does not mean, however, that it cannot be done. Though a complex and often daunting task, there have been improvements in tax collection in several settings, including countries where there is a large informal sector, Indonesia being a notable example (Box 2.2).

The type of reform undertaken by Indonesia requires investment and a level of technology and infrastructure beyond the scope of some countries. It also requires improving tax collection from corporations, not just individuals. This can again be problematic in low-income countries that host extractive industries. Low compliance by just a few large potential taxpayers can lead to considerable revenue loss.

Increasing globalization and the location of corporate assets offshore – often in tax havens –raises the potential for lost tax revenue, either through unintended legal loopholes or through the illegal use of hidden accounts by individuals. All OECD countries now accept Article 26 of the OECD model tax convention, covering the exchange of information, and more than 360 tax information exchange agreements have been signed (*19*). It is hoped that global corporations and the financial institutions that service them will be more transparent in their dealings in the future, and that the countries hosting them will get a fairer share of tax receipts, some of which, hopefully, will go into paying for health.

But tax compliance can also be fostered when citizens believe they are getting a good deal from governments. A 2009 study concluded that while the threat of detection and punishment was a key factor in compliance, perceptions of

Box 2.2. Indonesia increases tax revenues by encouraging compliance

Even before the 1997–1998 Asian crisis, non-oil tax collection in Indonesia was on the decline, reaching a low of 9.6% of GDP in 2000. The tax policy regime was complicated and tax administration weak. At the end of 2001, the Directorate General of Taxation (DGT) decided to simplify the tax system and its administration. The aim was to encourage voluntary compliance, whereby taxpayers would self-assess, then pay the tax on income declared. Voluntary compliance typically makes up 90% of total tax revenue for a country and represents a line of least resistance for governments seeking to enhance tax yields. In contrast, enforced collection tends to be arduous, labour and capital intensive, and yields relatively little return.

The DGT drafted tax laws and regulations that were clear, accessible and consistently applied, and adopted a policy of zero-tolerance towards corruption. The DGT also introduced procedures to resolve disputes quickly, cheaply and impartially, and encouraged transparency by making all actions taken by the tax administration subject to public scrutiny. Performance and efficiency were improved partly by digitizing a previously paper-based process. Positive results followed, with the tax yield rising from 9.9% to 11% of non-oil GDP in the four years after implementation. The additional tax revenues meant that overall government spending could be increased; health spending rose faster than other.

Source: (*18*).

the quality of governance were also important (*20*). Compliance was notably higher in Botswana, where government services were perceived to be good, and lower in some neighbouring countries where the quality of government services was perceived to be lower.

In the short-term, low-income countries with large informal economies will tend to focus on taxes that are relatively easy to collect, such as those on formal-sector employees and corporations, import or export duties of various types and value added tax (VAT) (*21*). Ghana, for example, meets 70–75% of funding needs for its National Health Insurance Scheme with general tax funding, notably through a 2.5% national health insurance levy on VAT, which stands at 12.5%. The rest of the funding comes from other public funds and development partners, while premiums, the traditional revenue source for insurance, account for only 3% of total income. The VAT-based National Health Insurance Scheme has been able to support an increase in total health expenditure through domestically generated pooled funds. At the same time it has lessened the system's dependence on direct payments such as user fees as a source of finance (*22*).

Chile, an upper-middle-income country, in 2003 also introduced a 1% increase in VAT to fund health. Even richer countries are being forced to diversify their sources of financing, away from the traditional forms of income tax and wage-based insurance deductions. An ageing population means a lower proportion of people in work and wage-based contributions no longer cover the full costs of health care. Germany, for example, has recently started to inject money from general tax revenues into the social health insurance system through a new central fund called the *Gesundheitsfond*. The French national health insurance scheme has been partly funded for 30 years by the *Contribution sociale généralisée*, which includes taxes levied on real estate and capital gains in addition to more traditional forms of revenue such as income taxes (*23*).

Exploring sources of domestic financing for health

The international community has taken several important steps since 2000 to raise additional funding to improve health in poor countries. They are outlined briefly here because they offer ideas for countries to raise domestic funds as well.

One of the earliest steps was the air-ticket levy used to fund Unitaid, a global drug-purchase facility for HIV/AIDS, tuberculosis and malaria (*24*, *25*). It has provided almost US$ 1 billion to date, which, when combined with more traditional development assistance, has allowed Unitaid to finance projects in 93 countries, totalling US$ 1.3 billion since 2006 (*26*). At the same time, the buying power of Unitaid has resulted in significant falls in the prices of certain products, increasing the quantities that are available to improve health. More recently, the Millennium Foundation on Innovative Financing for Health launched a voluntary solidarity levy under the name MassiveGood, whereby individuals can complement Unitaid funding through voluntary contributions when they buy travel and tourism products (*27*, *28*).

The sale of bonds guaranteed by donor countries and issued on international capital markets is estimated to have raised more than US$ 2 billion since 2006 (*29*). These funds are channelled to the International Financing Facility for Vaccines, linked to the GAVI Alliance. The governments of eight countries have pledged the funds necessary to repay these bonds when they mature, although whether this mechanism results in additional resources being raised for global health depends critically on whether the repayments are considered a part of the planned future aid disbursements or are additional to them. At the minimum, however, they allow aid to be disbursed immediately, not deferred.

More recently, the high-level Taskforce on Innovative International Financing for Health Systems reviewed a wider range of options for supplementing traditional bilateral funding for aid (*30*). The taskforce concluded that a currency transaction levy had the potential to raise the greatest amount of money globally: an annual sum in excess of US$ 33 billion, but recommended several additional options as well (*30*, *31*).

These developments have helped pinpoint new sources of funds and maintained the momentum for increased international solidarity in health financing. However, discussions on innovative financing have so far ignored the needs of countries to find new sources of domestic funds for their own use: low- and middle-income countries that simply need to raise more and high-income countries that need to innovate in the face of changing health needs, demands and work patterns.

To help this discussion, a list of options for countries seeking to increase or diversify domestic sources of funding is provided in Table 2.1, drawing on the work cited above. Not all the options will be applicable in all settings, and the income-generating potential of those that are will also vary by country, though we do make some suggestions about the likely level of funding that could be raised at the country level. For example, even though the currency transactions levy proposed by the high-level taskforce has the potential to raise large sums of money, the financial transactions and products that it would be based on are concentrated in higher-income countries. Indeed, 10 high-income countries account for 85% of the traditional foreign exchange trade (*35*). Trading volumes are light in most low- and middle-income countries, so this specific levy may not apply to most of them. There are some exceptions: India has a significant foreign exchange market, with daily turnover of US$ 34 billion (*35*). A currency transaction levy of 0.005% on this volume of trade might yield India about US$ 370 million per year if it chose to implement it.

So-called solidarity taxes on specific goods and services are another promising option, offering a proven capacity to generate income, relatively low administration costs and sustainability. With political support, they can be implemented quickly. The mandatory solidarity levy on airline tickets, for example, might require 2–12 months for implementation (*30*).

Introducing mechanisms that involve taxes can be politically sensitive and will invariably be resisted by particular interest groups. A tax on foreign exchange transactions, for example, may be perceived as a brake on the banking sector or as a disincentive to exporters/importers. When Gabon introduced a tax on money transfers in 2009 to raise funds to subsidize health care for low-income groups, some people protested that it constituted

Table 2.1. **Domestic options for innovative financing**

Options	Fund-raising potential[a]	Assumptions/examples	Remarks
Special levy on large and profitable companies – a tax/ levy that is imposed on some of the big economic companies in the country	$$–$$$	Australia has recently imposed a levy on mining companies; Gabon has introduced a levy on mobile phone companies; Pakistan has a long-standing tax on pharmaceutical companies	Context specific
Levy on currency transactions – a tax on foreign exchange transactions in the currency markets	$$–$$$	Some middle-income countries with important currency transaction markets could raise substantial new resources	Might need to be coordinated with other financial markets if undertaken on a large scale
Diaspora bonds – government bonds for sale to nationals living abroad	$$	Lowers the cost of borrowing for the country (patriotic discount); have been used in India, Israel and Sri Lanka, although not necessarily for health	For countries with a significant out-of-country population
Financial transaction tax – a levy on all bank account transactions or on remittance transactions	$$	In Brazil there was a bank tax in the 1990s on bank transactions, although it was subsequently replaced by a tax on capital flows to/from the country; Gabon has implemented a levy on remittance transactions	There seems to have been stronger opposition from interest groups to this tax than others (*32*)
Mobile phone voluntary solidarity contribution – solidarity contributions would allow individuals and corporations to make voluntary donations via their monthly mobile phone bill	$$	The global market for postpaid mobile phone services is US$ 750 billion, so even taking 1% of that would raise a lot of money; relevant to low-, middle- and high-income countries (*33*)	Establishment and running costs could be about 1–3% of revenues (*33*)
Tobacco excise tax – an excise tax on tobacco products **Alcohol excise tax** – an excise tax on alcohol products	$$	These excise taxes on tobacco and alcohol exist in most countries but there is ample scope to raise them in many without causing a fall in revenues	Reduces tobacco and alcohol consumption, which has a positive public health impact
Excise tax on unhealthy food (sugar, salt) – an excise tax on unhealthy foodstuffs and ingredients	$–$$	Romania is proposing to implement a 20% levy on foods high in fat, salt, additives and sugar (*34*)	Reduces consumption of harmful foods and improves health
Selling franchised products or services – similar to the Global Fund's ProductRED, whereby companies are licensed to sell products and a proportion of the profits goes to health	$	Selling franchised products or services from which a percentage of the profits goes to health	Such a scheme could operate in low- and middle-income countries in ways that did not compete with the Global Fund
Tourism tax – a tourism tax would be levied on activities linked largely to international visitors	$	Airport departure taxes are already widely accepted; a component for health could be added, or levies found	The gain would vary greatly between countries depending on the strength of their tourism sector

[a] $, low fund-raising potential; $$, medium fund-raising potential; $$$, high fund-raising potential.

Box 2.3. To hypothecate or not to hypothecate?

Hypothecated taxes, sometimes called earmarked taxes, are those designated for a particular programme or use. Examples include TV licence fees that are used to fund public broadcasting and road tolls that are used to maintain and upgrade roads. The Western Australian Health Promotion Foundation's Healthway was created in 1991 on this basis, funded initially out of an increased levy on tobacco products, while the Republic of Korea instituted a National Health Promotion Fund in 1995 funded partly from tobacco taxes (*40*). The Thai Health Promotion Fund, established in 2001, was financed with a 2% additional surcharge on tobacco and alcohol (*41*, *42*).

Ministries of health are often in favour of these taxes because they guarantee funding, particularly for health promotion and prevention. It is difficult for these activities to compete with curative services for funding, partly because they are perceived to be less urgent, and partly because they tend to yield results over the longer term, making them less attractive to politicians with an eye on the electoral cycle or to insurance funds interested in financial viability.

Ministries of finance, however, rarely endorse hypothecation because they feel that it undermines their mandate to allocate budgets. By taking decisions on spending away from government, hypothecating tax revenues can constrain the government's ability to deal with economic cycles.

In practice, hypothecating any particular form of tax – e.g. a tobacco tax – for health does not guarantee that overall government funding to health will increase. Most government revenues are essentially fungible; an increase in health funding from hypothecated taxes may be offset by a reduction in flows from the rest of the budget. So whether hypothecation leads to a net increase in funding for health, or for a particular activity, is an empirical question.

A pragmatic approach is likely to pay higher dividends for health than insisting on hypothecation. If governments can be persuaded to allocate any of the new funding sources discussed in this chapter to health, in their entirety, so much the better. If they cannot, there is still likely to be an increase in health funding because health usually gets a share of any increase in government spending. Though this increase might be lower than in the case of hypothecation, health advocates need to be sure that insisting on hypothecation does not result in a ministry of finance opposing the new tax totally, so that no new monies at all are received.

Source (*43*).

an exchange restriction. Gabon nevertheless imposed a 1.5% levy on the post-tax profits of companies that handle remittances and a 10% tax on mobile phone operators. Between them, the two taxes raised the equivalent of US$ 30 million for health in 2009 (*36*, *37*). Similarly, the Pakistan government has been taxing the profits of pharmaceutical companies to finance part of its health spending for many years (*38*).

Meanwhile, so-called sin taxes have the advantage of raising funds and improving health at the same time by reducing consumption of harmful products such as tobacco or alcohol. Studies in 80 countries have found that the real price of tobacco, adjusted for purchasing power, fell between 1990 and 2000. Although there have been some increases since 2000, there is great scope for revenue raising in this area, as advocated by the WHO Framework Convention on Tobacco Control (*39*).

It is not possible in this report to provide estimates of how much money could be raised by each of these innovative financing mechanisms on a country-by-country basis. But WHO has analysed the potential gains from increasing taxes on tobacco in 22 of the 49 low-income countries for which sufficient data to make the calculations are available. Excise taxes in these countries range from 11% to 52% of the retail price of the most popular brand of cigarettes, representing a nominal range of US$ 0.03–0.51 per pack of 20 (*37*). We estimate that a 50% increase in excise taxes would generate US$ 1.42 billion in additional funds for these countries – quite a substantial sum. In countries like the Lao People's Democratic Republic, Madagascar and Viet Nam, the extra revenue would represent a 10% increase or more in total health expenditure, and a more than 25% increase in the government's health budget, assuming the revenue raised was fully allocated to health (Box 2.3). Viewed another way, this simple measure could raise additional funding that would more than double the current levels of external aid to health in certain countries.

There is increasing international concern about the adverse health and economic consequences of alcohol consumption, and pricing policies can be at the core of strategies to address these concerns. For example, in Moscow,

alcohol prices were increased by 20% in August 1985 and another 25% the following year. The result was a dramatic fall (28.6%) in alcohol consumption over the next 18 months. Hospital admissions for alcohol-related mental and behavioural disorders and deaths from liver cirrhosis, alcohol poisoning and other violence decreased substantially. These measures ended in 1987 and in the subsequent period, when alcohol prices grew at a much slower rate than other prices, many of these positive trends were reversed (*44*).

Analysis of selected countries for which data are available on the consumption, taxation and pricing of alcoholic beverages shows that, if excise taxes were raised to at least 40% of the retail price, substantial additional revenue could be generated and the harmful effects of drinking alcohol reduced. For the 12 low-income countries in the sample, consumption levels would fall by more than 10%, while tax revenues would more than triple to a level amounting to 38% of total health spending in those countries (*37*).

These sums are not negligible. If all countries chose just one of the options described in Table 2.1 and also gave higher priority to health in government budgets, substantial additional amounts could be raised for health.

External financial assistance

Prior to the global economic downturn that started late in 2008, development assistance for health from richer to poorer countries was increasing at a robust rate. Low-income countries saw funding from external sources rise on average from 16.5% of their total health expenditures in 2000 to 24.8% in 2007 (*4*). According to the databases maintained by the OECD's development assistance committee, government commitments for health reported by bilateral donors jumped from about US$ 4 billion in 1995 to US$ 17 billion in 2007 and US$ 20 billion in 2008[a].

This may represent a significant underestimate given that the committee database does not capture all contributions from non-OECD governments, such as China, India and some Middle-Eastern countries; reports data for only a limited number of multilateral institutions; and does not collate funds provided by key private players in the health domain such as the Bill & Melinda Gates Foundation, other private foundations, and nongovernmental organizations. A recent study suggested that the combined contribution from all these sources might have been about US$ 21.8 billion, almost US$ 5 billion greater than reported to the OECD in 2007 (*45*).

However, in at least four key ways, the outlook for aid-recipient countries is less positive than these numbers might suggest.

First, despite the increase in external support, total health expenditures remain pitifully low – insufficient to ensure universal access to even a basic set of health services in many countries. We reported earlier that only eight of the 49 low-income countries included in the analysis for the high-level taskforce had any prospect of raising all of the resources required to meet the health goals of the Millennium Declaration from domestic sources by 2015. The other countries would require additional inputs from external sources ranging from US$ 2 to US$ 41 per capita in 2015.

Second, even though external funding has increased substantially, about half of the countries reporting their development assistance disbursements

to OECD are on track to meet the targets they have committed to internationally (for overall development, including health) (*46*). The other countries are failing to meet their pledges, some by a long way. Slow progress towards fulfilling these commitments comes at a huge human cost; three million additional lives could be saved before 2015 if all donors met their promises (*7*).

Third, the development assistance for health numbers reported above represent commitments; actual disbursements are lower. In addition, some of the funds that donors report as disbursed do not arrive in recipient countries for them to spend. A sometimes considerable proportion of aid is devoted to so-called technical cooperation. This was the case between 2002 and 2006, for example, when the committee database reported that more than 40% of health official development assistance (ODA)[b] was absorbed by technical support, often funding nationals of the donor country to provide assistance or training to recipient countries (*47*). While technical support might be useful, reported disbursements overstate the availability of funds that recipient countries can use to improve health locally.

Finally, concerns have also been expressed recently that some of the aid arriving in countries is subject to spending constraints. Macroeconomic and monetary targets set for inflation and the level of foreign exchange reserves are based on a concept of prudent macroeconomic management. Some say this prevents the disbursed aid being fully exploited because a portion of the aid that arrives in the country is believed to be withheld from circulation to avoid inflation, or is used to build up foreign exchange reserves (*48–50*).

There is currently vigorous debate about whether the targets for inflation and foreign exchange reserves set in countries are too stringent and restrict them from spending the aid that donors provide for health and development (*39*, *51*, *52*). Moreover, it is not yet clear how much additional spending might become available if macroeconomic targets were relaxed; recent work suggests that the additional spending would probably be small when compared with the extra funds that would flow from governments giving a higher priority to health when allocating their own budgets (*53*).

Re-examining the targets for macroeconomic prudence is, perhaps, one option for increasing the amount of aid that can be spent. Deficit spending is another. Countries can either borrow so that they can spend now, or perform what has been recently called quantitative easing – printing money to finance current spending. Neither is a viable long-term strategy because debt incurred now will have to be paid back, while printing money will increase inflationary pressures at some point.

A more sustainable option is for external partners to reduce the volatility of their aid flows. This would, at a minimum, allow government budget ceilings in health to be relaxed and more aid could be used to improve health. A more ambitious agenda has recently been proposed whereby donor and recipient countries would review the entire aid architecture and its governance (*54*, *55*). The objective would be to move away from viewing aid as a charity, at the total discretion of donors, towards a system of mutual global responsibility that would enable more predictable, probably larger flows of funding to populations that need it.

Effect of economic downturn on development assistance

Precisely what effect the financial and economic downturn that started in 2008 will have on development assistance for health is still unclear. However, there are concerns that the downturn may act as a brake at time when there is growing global acceptance that external financial support for health needs to rise.

Overall bilateral development assistance tends to reflect economic growth in the donor country. This does not always hold true for development assistance for health, which in some recent economic crises has been insulated, despite overall development assistance falling (*56*). However, many governments that have traditionally been major bilateral contributors of development assistance for health are now burdened with considerably more debt than they carried in past downturns, much of it incurred to soften the effects of the economic crisis and stimulate growth in their own countries. Some of those governments are now trying to reduce their debt with spending cuts.

The OECD reports that while some donors are promising to maintain their commitments to ODA for 2010, some large donors have already reduced or postponed their pledges (*46*). Overall ODA is still expected to grow in 2010 but at a lower rate than initially forecast. This is not good news, and it is to be hoped that the major donors will not only maintain their current levels of assistance to poorer countries but also increase them to the extent necessary to fulfil their international aid promises. Similarly, it is hoped that they will not respond to high levels of government indebtedness by cutting domestic health services in their own countries.

Even before the current global economic downturn, there was cause for concern about the way health aid funding moves around the globe. The channelling of aid into high-profile health initiatives while others are neglected is one such concern. Between 2002 and 2006, financial commitments to low-income countries focused on MDG 6 (combat HIV/AIDS, malaria and other diseases, including tuberculosis), which accounted for 46.8% of total external assistance for health. It has been estimated that this left only US$ 2.25 per capita per year for everything else – child and maternal health (MDGs 4 and 5), nutrition (MDG 1), noncommunicable diseases and strengthening health systems (*47*). The money required to strengthen health systems alone exceeds this figure – US$ 2.80 per capita is needed each year to train additional health workers, and this amount does not even include the funding necessary to pay their salaries (*57*).

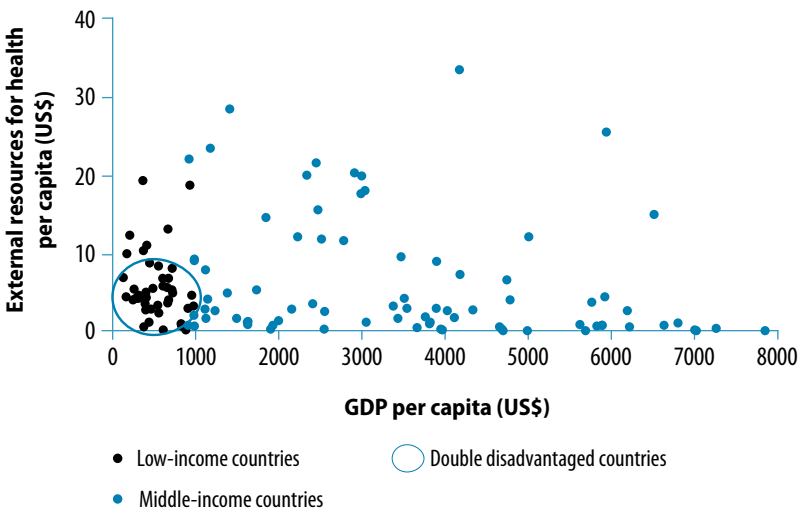
The picture is less bleak if we take into account recent efforts by the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria to support health systems development and capacity-building. Nevertheless, diseases outside these headline issues continue to be neglected by donors, as do health systems issues such as management, logistics, procurement, infrastructure and workforce development (*58*).

The imbalance in aid allocation is apparent also when broken down by country; some countries are particularly well funded while others receive

virtually nothing. Fig. 2.3 shows that the recipient countries receiving more than US$ 20 per capita in external assistance for health in 2007 were middle-income countries, while the bulk of the low-income countries received less than US$ 5 per capita. Many of the poorest countries receive substantially less development assistance for health than their much richer neighbours. For example, Namibia, a lower-middle-income country, received about US$ 34 per capita for health in 2007, compared with US$ 10 in Mozambique, US$ 4.40 in the Democratic Republic of the Congo and US$ 2.80 in the Republic of Guinea (*4*). It would appear that many other factors, in addition to need, determine aid allocations.

The high-level taskforce suggested that the focus of many external partners on a few high-profile programmes and countries ran counter to the spirit of the 2005 Paris Declaration on Aid Effectiveness, which seeks to enable recipient countries to formulate and execute their own national plans according to their own national priorities (*59*). In its report, the taskforce called for a shift away from "international financing mechanisms that build on project applications approved in a development partner's global headquarters or capital" (*60*). What is required is a refocusing on agreed financial contributions to national health plans rather than a continuation of project-based aid. We are yet to see the impact of these ideals reflected in official figures. According to a study prepared for the Norwegian Agency for Development Cooperation, between 2002 and 2007 the number of health-related projects, rather than falling, doubled to 20 000. Most of these were small, with an average disbursement of only US$ 550 000 (*61*). The need to manage, monitor and report on a multitude of small projects imposes high transaction costs on the recipient country.

Fig. 2.3. **Development assistance for health per capita by country income level, low- and middle-income countries, 2007[a]**



[a] Excluding small island states.
Source: World Health Organization national health accounts series (*4*).

The Paris Declaration also emphasized that funding should be predictable and long-term. When countries cannot rely on steady funding – in Burkina Faso, per capita development assistance for health fluctuated from US$ 4 to US$ 10 and back down to US$ 8 between 2003 and 2006 – it is virtually impossible to plan for the future. A few low-income countries have two thirds of their total health expenditure funded by external resources, making the predictability of aid flows a critical concern for them (*4*, *62*).

Some development partners are already starting to depart from traditional short-term ODA commitments in the way they structure their contributions. European Union MDG contracts are an example, offering flexible,

performance-based budget support over a period of six years. Not everyone likes this kind of commitment because it ties up future aid budgets. That said, in the Accra Agenda for Action of 2008, OECD development assistance committee donors committed to providing recipient countries with information on their "rolling three- to five-year expenditure and/or implementation plans" – the beginning perhaps of longer-term commitments (*59*).

Conclusion

Countries need to adapt their financing systems continually to raise sufficient funds for their health systems. Many high-income countries are facing a decline in the proportion of their working-age population and having to consider alternatives to traditional sources of revenue in the form of income taxes and health insurance contributions from workers and their employers. In many lower-income countries, more people work in the informal than the formal sector, making it difficult to collect income taxes and wage-based health insurance contributions.

There are several options for raising additional funds for health, a list of which is provided in Table 2.1. Not all will apply to all countries, and the income-generating potential and political feasibility of those that do will vary by country. In some cases, however, the additional income to be derived from any one or more of these options could be substantial, possibly much more than current aid inflows. These innovative and additional mechanisms are not, however, the only option. Many governments, in rich and poor countries, still give a relatively low priority to health when allocating funds. It is important, therefore, to better equip the ministries of health to negotiate with ministries of finance and planning, as well as with international financial institutions. But the message of this chapter is that every country could do more domestically to raise additional funds for health.

Innovative financing should not be seen, however, as a substitute for ODA flows from donor nations. Calls for recipient countries to use external funds more transparently and efficiently are understandable. But such concerns should not stop richer countries keeping the promises they have made in Paris and Accra. Collective action that has led to the International Financing Facility for Immunization and to the Millennium Foundation has been invaluable in financing global public goods for health, but there is no need for countries to wait for more global collaboration before acting. If the governments of donor countries kept their current international aid promises, allocating funds in ways that supported country-led national health plans, the international community would already be well advanced towards meeting the 2015 MDGs. If, in addition, each donor country adopted just one of the innovative options described here and used the revenue to supplement ODA, they would be laying the foundations for sustained movement towards universal health coverage and improved health into the future. ■

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End notes

a The high-level taskforce included interventions proven to reduce mortality among mothers, newborns and children under five; childbirth care; reproductive health services; prevention and treatment of the main infectious diseases; diagnosis, information, referral, and palliative care for any presenting conditions; and health promotion.

b Typically, the term official development assistance (ODA) is used to describe assistance provided officially by governments. Development assistance for health is broader, including ODA, plus lending and credits from multilateral development banks, transfers from major foundations and NGOs.