

Chatham House Report

Shared Responsibilities for Health

A Coherent Global Framework for Health Financing

Final Report of the Centre on Global Health Security Working Group
on Health Financing



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International Affairs

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Published working papers:

Development Assistance for Health: Critiques and Proposals for Change

Suerie Moon and Oluwatosin Omole

Raising and Spending Domestic Money for Health

Riku Elovainio and David B. Evans

Development Assistance for Health: Quantitative Allocation Criteria and Contribution Norms

Trygve Ottersen, Aparna Kamath, Suerie Moon and John-Arne Røttingen

Financing Global Health through a Global Fund for Health?
Gorik Ooms and Rachel Hammonds

Fiscal Space for Domestic Funding of Health and Other Social Services

Di McIntyre and Filip Meheus

Other background papers:

Trends in Percentages of Government Expenditures Allocated to Health in Selected African Countries and a Study of the Political Economy of Increased Expenditure Allocations to Health in Ghana and Zambia

Dyna Arhin-Tenkorang

Tax and Health – A Critical Inter-Relationship

David McCoy and Simukai Chigudu

Placing Aid within the Context of the Wider Global Political Economy

David McCoy

Global Public Goods for Health: Why We Need Them and How to Pay for Them

Suerie Moon, John-Arne Røttingen and Julio Frenk

Strategic or Structural Financing: Health Care versus Health System

Luiz Eduardo Fonseca

The Challenge of Middle-Income Countries to Development Assistance for Health: Recipients, Donors, Both, or None?

Trygve Ottersen, Suerie Moon and John-Arne Røttingen

Acronyms and Abbreviations

CMH	Commission on Macroeconomics and Health	LMIC	Lower-middle-income country
DAC	Development Assistance Committee	MDG	Millennium Development Goal
GAVI	GAVI Alliance	MIC	Middle-income country
GDP	Gross domestic product	NCDs	Non-communicable diseases
GGE	General government expenditure	NGO	Non-governmental organization
GHE	Government health expenditure	ODA	Official development assistance
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria	OECD	Organisation for Economic Co-operation and Development
GNI	Gross national income	OOPP	Out-of-pocket payment
GPGH(s)	Global public good(s) for health	R&D	Research and development
HIC	High-income country	SARS	Severe acute respiratory syndrome
HIV	Human immunodeficiency virus	THE	Total health expenditure
HLTF	(High Level) Taskforce on Innovative International Financing for Health Systems	UHC	Universal health coverage
IHP+	International Health Partnership	UMIC	Upper-middle-income country
IMF	International Monetary Fund	UNICEF	UN Children's Fund
LIC	Low-income country	WHA	World Health Assembly
		WHO	World Health Organization

Preface

In 2011 the Centre on Global Health Security at Chatham House convened a major conference to mark the 10th anniversary of the Commission on Macroeconomics and Health (CMH) chaired by Jeffrey Sachs. The meeting reviewed the significant changes in international health policies, institutions and financing that had occurred in the previous decade, and considered what should be the future priorities for improving health outcomes internationally, given today's very different economic and political circumstances.

As a result of this conference, the Centre established two working groups – on health governance and on financing. The topic chosen for the first working group was the reform of the World Health Organization (WHO). Although not central to the argument of the CMH, it picked up on its reference to the need for 'reforms and improvements' at the WHO alongside the provision of increased resources, in particular to enhance the WHO's important role in the supply of global public goods for health. In addition, the subject was – and remains – topical because of the ongoing programme of reform that was launched by the WHO itself in 2010.

This report from the second working group takes forward some of the central themes and recommendations of the CMH report: that every developing country should begin to map out a path to universal access for essential health services; that developing-country governments should increase spending on health to 2 per cent of GDP by 2015 and use these resources more efficiently; that donors should increase their support to countries to \$38 billion by 2015, and to global public goods including research and development; and that new funding mechanisms be established, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Our working group has considered how the thinking on domestic and external health financing and the financing of global public goods for health could be updated to account for the fundamental changes in the world since 2001, in particular the rise of the emerging economies and the improvement in the economic performance of most developing countries. This has also led to the situation where most people with poor access to health services now live in middle- rather than low-income countries. In addition, since 2001 there has been new thinking on promoting access, notably the growing movement for universal health coverage and debates on the best strategies for achieving this. Another emerging debate has been the need to replace the old, charity-based aid paradigm of donors and recipients. Our group also intended to make a contribution to the ongoing debate on the shaping of the post-2015 development agenda, including how targets for health and health financing might form an integral part of that agenda.

The members of the group met three times: in October 2012 at Chatham House; in April 2013 in Bangkok; and in October 2013 at Chatham House. The names of members and others involved from time to time are listed in the appendix. Several working papers were also commissioned and published. The group also benefited from the joint meetings with the members of the other Chatham House working group on governance, who gave useful and critical feedback on preliminary thinking.

Our report is the result not only of a collective enterprise, but also of a willingness to work collaboratively across different perspectives, disciplines and backgrounds. The working group brought together policy-makers and researchers, health economists and legal scholars, representatives of civil society and governmental organizations and of national and international institutions, and consisted of members from 15 different countries. There was much debate, and inevitably there were some differences in opinion. However, the desire to produce a single and shared report, and the fact that everyone shared the fundamental goal of improving health in an equitable manner worldwide, superseded some disagreements on the specifics. As a result, all members of the working group agreed to put their name to this report.

Nevertheless, it was felt important to give working group members an opportunity to express any individual views that they might have about the report. While a consensus-based report has many obvious benefits, it can also be useful and instructive to reveal where there were some tensions or differences in opinion – or where members may have wanted a slightly different emphasis. Therefore, each working group member was given the opportunity to write a brief personal reflection on the report. The contributions of the four members who took that opportunity are recorded in the appendix. It should be emphasized that the views expressed in this report are the sole responsibility of the author(s) and do not necessarily reflect views of the authors' employers or affiliations.

We hope this report will invigorate the global debate on health financing and spur fresh, innovative thinking about the needed reforms. However, debate is not enough. We also hope the report will incite bold action directly. Agreement on a coherent global framework for health financing is urgently needed and is a unique opportunity to secure universal health coverage and health for all.

John-Arne Røttingen

Chair

Working Group on Health Financing
Centre on Global Health Security

Executive Summary and Recommendations

Financing is at the centre of efforts to improve health and health systems. It is only when resources are adequately mobilized, pooled and spent that people can enjoy robust health systems and sustained progress towards universal health coverage – that is, all people receiving high-quality health services that meet their needs without exposing them to financial hardship in paying for the services.

This report, which presents the findings and recommendations of the Working Group on Health Financing in the Centre on Global Health Security at Chatham House, shows how common challenges put such progress at risk in countries across the world, and particularly in low- and middle-income countries. These challenges are common not only because they happen to be present throughout these countries, but also because globalization means the underlying causes and transitions know no borders. This calls for collective action on a global scale. Specifically, the report calls for an agreed coherent global framework for health financing capable of securing sufficient and sustainable funding and of both mobilizing and using these funds efficiently and equitably.

Progress towards such a framework can be made by revising the current approach to health financing in three areas: the domestic financing of national health systems, the joint financing of global public goods for health, and the external financing of national health systems where domestic capacity is inadequate. Progress in these areas can be achieved through a set of policy responses which can be encapsulated in 20 recommendations.

To strengthen **domestic financing of national health systems**, we conclude that:

1. Every government should meet its primary responsibility for securing the health of its own people. This involves a responsibility to oversee domestic financing for health and ensure that it is sufficient, efficient, equitable and sustainable.
2. Every government should commit to spend at least 5 per cent of gross domestic product (GDP) on health and move progressively towards this target, and every government should ensure government health expenditures per capita of at least \$86 whenever possible. Most middle-income countries should be able to reach both targets without external support.
3. Every government should ensure that catastrophic and impoverishing OOPPs are minimized. Specifically, governments should commit to the targets of OOPPs representing less than 20 per cent of total health expenditures (THE) and no OOPPs for priority services or for the poor.

4. Every government should improve revenue generation and achieve reduction of OOPPs through effective, equitable and sustainable ways of increasing mandatory prepaid pooled funds for health services. Individual contributions to the pool(s) should primarily be based on capacity to pay and be progressive with respect to income.
5. Every government should consider improved and innovative taxation as a means to raise funds for health. Promising policies include the introduction or strengthening of excise taxes related to tobacco, alcohol, sugar and carbon emissions, and these should be combined with measures to increase tax compliance, reduce illicit flows and curb tax competition among countries. Other sources of government revenue, particularly in countries rich in natural resources, should also be explored.
6. Every government should ensure that mandatory prepaid pooled funds are used with the aim of making progress towards UHC – that is, affordable access for everyone. Specifically, every government should seek to ensure a universal health system with full population coverage of comprehensive primary health care, high-priority specialized care and public health measures, and should not prioritize expanding coverage of a more comprehensive set of services for only some privileged groups in society
7. Every government, in collaboration with civil society, should formalize systematic and transparent processes for priority-setting and for defining a comprehensive set of entitlements based on clear, well-founded criteria. Potential criteria include those related to cost-effectiveness, severity and financial risk protection. The processes can build on the methods of health technology assessment and multi-criteria decision analysis, which can help translate evidence and explicit values into policy decisions.
8. Every government and other actor involved in the financing or provision of health care must continuously strive to improve efficiency. In particular, this will require action on corruption and strategic purchasing, with continuous assessment and active management of which services are purchased and what providers and payment mechanisms are used.

To strengthen **joint financing of global public goods for health** (GPGHs), we conclude that:

9. Every government should meet its key responsibility for the co-financing of GPGHs and take the necessary steps to correct the current undersupply of such goods. Among key GPGHs are health information

and surveillance systems, and research and development for new technologies that specifically meet the needs of the poor. Public funding for the latter purpose should be at least doubled compared with the current level.

10. Every government should increase its support for new and existing institutions charged with the financing or provision of GPGHs. In particular, the World Health Organization's capacity to provide GPGHs should be enhanced and adequate funds provided on a sustainable basis for that purpose.
11. Every government, international organization, corporation and other key actor should promote a global environment that enables all countries to pursue government-revenue policies that can sufficiently finance their social sectors, including health, education and welfare. This requires action on illicit financial flows, tax havens, harmful tax competition and overexploitation of natural resources.

To strengthen **external financing for national health systems**, we conclude that:

12. Every country with sufficient capacity should contribute with external financing for health. Determination of capacity should partly depend on GDP per capita. Net contributing countries should include all high-income countries and most upper-middle-income countries and not only member countries of the OECD's Development Assistance Committee (OECD-DAC).
13. High-income countries should commit to provide external financing for health equivalent to at least 0.15 per cent of GDP. Most upper-middle-income countries should commit to progress towards the same contribution rate.
14. Every provider of external financing for health, including contributing countries and international organizations, should establish clear, well-founded and publicly available criteria to guide the allocation of resources. These should be the outcome of broad, deliberative processes with input from key stakeholders, including civil society in contributing and recipient countries.
15. Every provider of external financing for health should align its support with recipient-country government priorities to the greatest extent possible. This calls for strong adherence to the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. In particular, providers of

external financing for health should encourage and comply with national plans and strategies, improve transparency and monitoring of disbursements and results, and help to build domestic governance and institutional capacity.

16. All providers of external financing for health should strive to strengthen coordination among themselves and with each recipient country, in order to improve efficiency as well as equity. In particular, they should encourage and comply with country-led division of labour, harmonize procedures, increase the use of joint and shared arrangements, and improve information sharing.
17. Every government should actively assess the existing mechanisms for pooling of external funds for health – including the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance, and the World Bank's health trust funds – and consider the feasibility of broader mandates, mergers and increased global pooling with the aim of improving efficiency and equity.

Strong **accountability** mechanisms and **global agreement** on responsibilities, targets and strategies will facilitate the implementation of the needed policy responses and a coherent global framework. We conclude that:

18. Every government and other actor involved in domestic or external financing or in the provision of health services should seek to strengthen accountability at global, national and local levels. This should be done by improving transparency about decisions, resource use and results, by improving monitoring and data collection and by ensuring critical evaluation of information with effective feedback into policy-making. Accountability should also be strengthened through active monitoring by civil society and by ensuring the broad participation of stakeholders throughout the policy process.
19. Every government and other key actor should seek to ensure that health and universal health coverage are central goals and yardsticks in the post-2015 development agenda. These actors should also seek to ensure that the responsibilities, targets and strategies of a coherent global framework for health financing are integrated to the fullest extent possible. Moreover, the agenda should make clear that health is important both for its own sake and for the sake of other goals, including poverty eradication, economic growth, better education and sustainability.

20. All stakeholders should enter into a process of seeking global agreement on key responsibilities, targets and strategies for health financing – including on the mechanisms for monitoring and enforcement – in order to expedite the implementation of a coherent global financing framework. In the short term, consultation on the post-2015 development agenda is one useful arena for building consensus, and the agenda itself can be a valuable commitment

device. In the longer term, a more specific process should be devised in one or more relevant forums, such as the UN General Assembly, the World Health Assembly, World Bank/International Monetary Fund, or a high-level stand-alone meeting.

With successful agreements, the great potential of health system strengthening and proven high-impact interventions can eventually be unleashed.

1. The Case for Action

Unprecedented transitions, and new and persisting challenges call for a new global approach to health financing. These transitions include profound changes in the global economy, changes in health and risk factors for disease, and transformation of the institutional landscape in the global health arena. Significant challenges include poor health outcomes, poor access to health services, and financial risks to patients stemming from out-of-pocket health service payments. They are compounded by profound inequalities in these three dimensions both between and within countries and by the uneven distribution of recent improvements.

Economic growth has been accompanied by accentuation of inequalities, in terms of both income and health, and between and within many countries. A result of these processes is the new phenomenon that more than 75 per cent of the world's poor now live in middle-income countries.

Health financing is central to meeting these challenges and for improving health and health systems. We believe that the current approach to health financing needs to be revised with respect to the domestic financing of national health systems, the joint financing of global public goods for health (GPGHs) and the external financing of national health systems where domestic capacity is inadequate. Only through concerted efforts in these three areas can the world move towards a global framework that is capable of securing sufficient and sustainable funding and of both mobilizing and using it efficiently and equitably. This is essential for building and sustaining momentum to reduce premature death, achieve universal health coverage (UHC) and reach the ultimate goal of a fairer and healthier global society.

This is also a particularly appropriate time to seek a coherent global framework. Led by the UN, the world is currently debating the shape of the post-2015 development agenda – i.e. the agenda to succeed the Millennium Development Goals (MDGs) when these expire in 2015. The role and content of health goals, and how to reach them, are a particular focus. The broad debate and the numerous processes informing it provide a platform for shaping the future we want, including for health financing.

Underlying transitions

Underlying the challenges in health financing, as well as the broader challenges to global health, are ongoing transitions in three areas: in the economic sphere, in health and in global health institutions. These are aspects of the broader processes of globalization which have made the world increasingly complex, interconnected and interdependent (Frenk et al. 2014). This new level of integration has created both opportunities and challenges.

The economic transition

There have been monumental economic changes over the last two decades. Economic growth rates have been impressive, not only in emerging economies (WB 2013). Many countries have moved from low-income to middle-income status, and 70 per cent of the world's population now live in middle-income countries (MICs). As a result, many countries are increasingly able to finance their own health needs without external support, and several MICs are also becoming significant contributors of external financing themselves (GHSi 2012; AidData 2013; IHME 2014). However, economic growth has been accompanied by accentuation of inequalities, in terms of both income and health, and between and within many countries (WCSDG 2004; Ortiz and Cummins 2011; UNDP 2013a). A result of these processes is the new phenomenon that more than 75 per cent of the world's poor now live in MICs (Sumner 2012; Alkire et al. 2013), and MICs account for a major share of the world's unmet health needs.

The health transition

Health outcomes have continued to improve over the last two decades. The global under-five mortality rate nearly halved, from 90 to 48 per 1,000 live births, between 1990 and 2012 (UNICEF 2013a), and the world average for female healthy life expectancy at birth increased from 58.7 healthy life years in 1990 to 63.2 years in 2010 (Salomon et al. 2012). However, there are vast inequalities between and within countries. For example, in 2010 female healthy life expectancy at birth ranged between 41.7 years in the Central African Republic to 75.5 years in Japan (Salomon et al. 2012).¹ At the same time, many countries have significant inequalities in health outcome measures across gender, socioeconomic status and place of residence, and in many countries these inequalities are increasing (CSDH 2008; UNDP 2013a; WHO 2013c).

¹ As a result of the earthquake, healthy life expectancy in Haiti was even lower (37.1 years) than in the Central African Republic.

There have also been marked changes in disease patterns. Many countries have seen a major increase in the burden of non-communicable diseases (NCDs) such as cardiovascular disease, cancer, chronic respiratory disease and diabetes. As a result, NCDs are now the major cause of premature death and disability in the world, having increased from a share of 43 per cent in 1990 to 54 per cent in 2010 (Murray et al. 2012).

However, the shifts in disease pattern and associated risk factors have only been partial in many low-income countries (LICs) and MICs. As a result, many countries are now faced with a triple burden of disease: the unfinished agenda of infections, undernutrition and reproductive health problems; a rising burden of NCDs and their associated risk factors, such as smoking and obesity; and the burdens and risks more directly linked to globalization itself, such as the threat of pandemics, the spread of pathogens resistant to antimicrobials, and the health effects of climate change and trade policies (Frenk et al. 2011; Frenk and Moon 2013).

The institutional transition in global health

The priority accorded to global health issues has increased substantially over the past two decades. External financing for health almost doubled from \$5.8 billion in 1990 to \$11.2 billion in 2001, and nearly tripled to \$31.3 billion (expressed in 2011 US dollar terms) by 2013 (IHME 2014). In parallel, there has been a proliferation of new institutions in global health that now play prominent roles (Szlezak et al. 2010; Frenk and Moon 2013). These include philanthropic organizations, such as the Bill & Melinda Gates Foundation, and public-private partnerships or hybrids, such as the GAVI Alliance (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). These have supplemented and challenged the traditional roles of national bilateral aid agencies, the UN, including the World Health Organization (WHO), and multilateral development banks, such as the World Bank. In addition, civil society organizations, private firms, professional associations, and academic institutions have come to play a much more influential role in the global health arena. Moreover, the impact on health of other institutions outside the health sector, such as the World Trade Organization (WTO), has been increasingly recognized (Frenk and Moon 2013; Ottersen, O. et al. 2014).

At the same time, the financial crisis of 2008 and its ongoing ramifications pose a threat to external financing for health, and the annual increase in such financing over the last few years fell short of that seen between 1990 and 2010 (IHME 2014).

In parallel with major changes at the global level, there are global trends in the institutional reforms taking place within countries, often in the context of pursuing universal health coverage (UHC). In particular, a 'health financing transition' is under way in numerous countries (Fan and Savedoff 2014).

Challenges in health financing

There are currently profound challenges in domestic and external financing, and in the financing of GPGHs. These challenges concern resource mobilization, pooling of funds and spending.

With respect to domestic financing of national health systems, current challenges for many or most countries include:

- *Insufficient total funds*: Total available funds for health from domestic sources are insufficient and fall short of most or all needs-based targets that have been proposed for health expenditure.
- *Over-reliance on out-of-pocket payments*: Out-of-pocket payments (OOPs) by users of the health system play too large a role, and this is particularly the case for OOPs that tend to be catastrophic and impoverishing.
- *Rudimentary mechanisms for mandatory prepayment with pooling of funds*: Mandatory prepayment mechanisms are not used to their full extent, and existing mechanisms are often inadequately designed.
- *Problematic priorities and inefficient health spending*: Priorities among groups and services are unbalanced and problematic from the perspective of UHC. At the same time, health spending is often very inefficient.
- *Inadequate accountability*: Accountability mechanisms in public financing in general and in health financing in particular are weak or lacking, something that is linked to inadequate systems for monitoring and evaluation, for stakeholder participation and for fighting corruption and economic crimes.

Global public goods are classically defined as both non-excludable and non-rivalrous. This means that, once provided, no country can be prevented from enjoying a global public good and that a country's enjoyment of the good cannot impinge on the consumption opportunities of other countries (Barrett 2007). GPGHs are public goods for health with a global reach. Examples include widely disseminated research findings, global health statistics, technology assessments, normative guidance and regulation, infectious disease surveillance and a global enabling environment for health financing. With respect to GPGHs, current challenges include:

- *Insufficient total funds*: Total available funds for GPGHs fall below what is needed.
- *Inadequate focus among countries*: Too little attention is paid to GPGHs, including to their national and worldwide benefits and the obligations to finance and provide such goods.

- *Inadequate institutions and mechanisms for collective action:* Comprehensive institutions and mechanisms for facilitating international collective action for priority-setting and the production and financing of GPGHs are weak or lacking.

With respect to external financing of national health systems, current challenges include (Moon and Omole 2013):

- *Insufficient total funds:* Total external funds are, despite increases over the last 15 years, still insufficient to support fully countries that lack the capacity adequately to address domestic health needs on their own.
- *Unsettled contribution norms:* Effective agreement on clear norms for country contributions to external financing is lacking, as are mechanisms to encourage compliance with such norms.
- *Volatility and uncertainty:* External financing is often irregular and uncertain to an extent that undermines the value of resources to recipients.
- *Fungibility:* External financing for health can partially or wholly substitute for domestic financing for health, which can undermine the objective of increasing total resources for health.
- *Inadequate priority-setting:* The distribution of external financing across countries and programmes is often not based on clear, well-founded and publicly available criteria for the allocation of funds.
- *Inadequate coordination:* The many providers of external financing for health are often poorly coordinated at both global and national levels, leading to inefficiencies from confusion, fragmentation, duplication and high transaction costs.
- *Inadequate accountability:* In many areas of external health financing, accountability mechanisms are weak or lacking, something that is linked to institutional deficiencies at both national and global levels.

- *Unclear rationale:* Among the actors involved in external financing for health, there is only partial agreement on the chief rationale for such financing.

The call for a coherent global framework

A new, broad and coherent approach to health financing is required. Specifically, the world needs an agreed framework to secure sufficient, efficient, equitable and sustainable financing to achieve health goals, including UHC.

To move towards such a framework, the challenges in the three financing areas must be effectively addressed through a range of policy responses, guided by the importance of health and the ultimate objective of achieving UHC. To promote sustained progress, agreement on clear targets and shared responsibilities should be sought on the basis of justice, solidarity and human rights. The policy responses should be anchored in the post-2015 agenda by firmly positioning health and key responsibilities, targets and strategies of the health financing framework in that agenda.

The shaping of a global framework for health financing should build on the legacy of the Commission on Macroeconomics and Health (CMH) (CMH 2001), the (high-level) Taskforce on Innovative International Financing for Health Systems (HLTF) (HLTF 2009b), the *World Health Report 2010* (WHO 2010) and several more recent reports, including those of the Lancet Commission on Investing in Health and the Lancet-University of Oslo Commission on Global Governance for Health (Jamison et al. 2013a; Ottersen, O. et al. 2014). However, there is a need to go beyond this to acknowledge ongoing changes and transitions, integrate recent experience and insights on health and development financing, and build a comprehensive normative framework with shared, yet clear responsibilities and goals.

2. The Value of Health and Universal Health Coverage

A basic premise of our report is the intrinsic and instrumental value of health and the importance of health service coverage. This premise should underpin and inform all reform efforts and the pursuit of human development, not only in the health sector, but in all sectors with an impact on health.

The importance of health

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being (UNGA 1966), and health is critical not just for its own sake, but also because of its close relationship to the attainment of economic, social and human security. Good health contributes to wellbeing and quality of life directly, as well as to opportunities for wellbeing and to human capabilities more generally (Sen 2002; Daniels 2008). For example, good health allows people to pursue education, to work and to take part in the social life of their community. For all these reasons, good health is a key aspect of human development, as its central role in the Human Development Index (HDI) illustrates (UNDP 2014).

Inequalities in health status are also a great concern (Anand 2002; Sen 2002; CSDH 2008; Daniels 2008; Norheim and Asada 2009). It is urgent that the pronounced inequalities seen today between and within countries be reduced, and the promotion of equity should guide all reform efforts in health financing.

Improved health can increase personal and national income through enhanced labour productivity, better education, increased savings and investment, improved access to natural resources and demographic changes.

Good health also has instrumental benefits for society. In particular, health improvements catalyse economic growth and poverty reduction (CMH 2001; Bloom et al. 2004; Jamison et al. 2013a). Improved health can increase personal and national income through enhanced labour productivity, better education, increased savings and investment, improved access to natural resources and demographic changes. A review of historical, microeconomic and macroeconomic studies concluded that about 11 per cent of economic growth in LICs and MICs in the period 1970–2000 resulted from reductions in adult mortality (Jamison et al. 2005). It is also possible to examine the overall contribution of health to growth

in full income – i.e. a measure that integrates GDP with a more direct valuation placed on health itself. Using such an approach, it has been shown that for LICs and MICs as a whole, health contributed to annual growth in full income to the tune of about 1.8 per cent annually of the initial value of GDP for the period 2000–11 (Jamison et al. 2013a). For sub-Saharan Africa, the annual contribution was as large as 5.7 per cent for the same period (Jamison et al. 2013b).

The impact of health on education (Bundy 2011) also has value beyond the direct economic benefits that follow, and good health can contribute to political participation, political stability, and national and global security (Kassalow 2001; Feldbaum et al. 2006; McInnes and Rushton 2010; Mattila et al. 2013). With respect to the natural environment, a healthy population may have a greater capacity to adapt to changes in climate and other environmental changes; and reduced child mortality and increased life expectancy may contribute to lower fertility rates and thereby promote a sustainable world population (Shenk et al. 2013; Stephenson et al. 2013).

The importance of health services and other determinants

Health status depends not just on the provision of health services, but also on a range of social determinants.² These determinants include, for example, education, occupation, income, housing, gender and inequality (CSDH 2008).

The value of improving the determinants of health is derived mainly from the value of improving health itself. In addition, health services can bring valuable information and reassurance to the user without providing what are ordinarily considered *health* benefits (Ryan and Shackley 1995). Moreover, family planning services can help empower women by increasing choice over childbearing and can help promote environmental sustainability by stabilizing population size (Cleland et al. 2006; Stephenson et al. 2013). Obviously, action on social determinants of health – such as education and housing – also generates a range of benefits beyond health.

The importance of health services and social determinants of health also makes their distribution highly important. Greater equality in these determinants and in access to services can promote equity in health as well as raising average health in the population (CSDH 2008; Moreno-Serra and Smith 2012). At the same time,

² Health is also influenced by natural determinants, such as genetics. Moreover, health services are strictly speaking one kind of social determinant for health, although it is often not framed in that way.

equity in health and its determinants are integral to broader issues of social justice, and equity in health care is important even for reasons that have little to do with the benefits from services. For example, equal access to health care may be the best way to express the core values of equality of opportunity and equal respect for persons (Gutmann 1981).

Universal health coverage

The imperative

UHC is defined as ‘all people receiving quality health services that meet their needs without exposing them to financial hardship in paying for them’ (WHO 2013a). UHC is motivated both by the importance of health and access to health services and by the importance of financial risk protection. Even for people who do not need services, UHC is of great value. In particular, knowledge of affordable access to quality services reduces anxiety and the fear of becoming ill and impoverished. This can also facilitate planning and productive use of resources and capital that otherwise would have to be kept in reserve in case the need arises for expensive services.

UHC affirms the importance of health coverage, but it also stresses that coverage should be for *everyone*. In other words, UHC requires inclusive health systems.

Current gaps

Today, the world is very far from universal coverage, even as regards priority services. For example, every year 46 million births are unattended by skilled personnel³ and 23 million infants still do not receive basic vaccines (WHO 2014b). Moreover, it is estimated that 150 million people suffer financial catastrophe each year because they have to pay out of pocket for health services the costs of which go beyond their economic means (WHO 2013b).

There is also profound variation in coverage between and within countries. For example, between countries, the proportion of one-year-olds who have received the third dose of diphtheria-tetanus-pertussis vaccine (DTP3) ranges from 22 per cent to 99 per cent, and the rate of births attended by skilled personnel ranges from 9 per cent to 100 per cent (WHO 2013c). Within countries, the ratio of urban-to-rural rates for skilled birth attendance is as high as 9:1, and the ratio of rates for the 20 per cent richest and the 20 per cent poorest parts of the population is even higher, at 27:1 (UNICEF 2013b).

Global momentum

There is now a global momentum for UHC that has gained traction since the release of the *World Health Report 2010* (WHO 2010). The pressing need to make progress towards UHC has been repeatedly affirmed by the World Health Assembly (WHA), in the Bangkok Statement on Universal Health Coverage (2012) and in the Mexico City Political Declaration on Universal Health Coverage (2012). In 2012 the UN General Assembly adopted a resolution emphasizing the responsibility of governments to ‘urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health-care services’ (UNGA 2012a).

Many countries are already making significant progress (Knaul et al. 2012; Lagomarsino et al. 2012; Giedion et al. 2013). One well-known example is Thailand. After a UHC scheme was introduced in 2002, usage rates improved, equity in usage increased and the incidence of impoverishing health expenditure declined (*Thailand’s Universal Coverage Scheme* 2012). For example, the number of households impoverished – defined as being pushed under Thailand’s national poverty line – as a result of OOPs fell from about 120,000 in 2002 to 40,000 in 2009 (*Thailand’s Universal Coverage Scheme* 2012).

Numerous other countries are in the process of reforming their health financing system and of strengthening their health system more generally. In particular, many countries are in a financing transition, characterized by two trends: a rise in health spending per capita and a decline in the share of out-of-pocket spending (Savedoff et al. 2012; Fan and Savedoff 2014).

Scope

UHC is about affordable access to quality services for everyone. It goes beyond a minimum package of health services and requires progressive realization of comprehensive coverage without compromising efforts in other social sectors. Emphasis should generally be put on primary health care services and high-priority referral services, and include promotive, preventive, curative and rehabilitative services. In addition, public health and population measures are essential. Some denote this as a ‘universal health system’, where ‘universal’ implies not only including everyone, but also that all components of a well-functioning health system are included, not just health care. A comprehensive approach to social protection of health has three major dimensions: protection against health risks through surveillance, and preventive and regulatory activities; protection of patients through quality

³ Calculation based on data from *The State of the World’s Children 2013* (UNICEF 2013b).

assurance of health care; and financial protection against the economic consequences of disease and injury (Knaul et al. 2012). As suggested by the first dimension in particular, the provision of national public goods and cooperation on GPGHs must be an integral part of the pursuit of UHC. Moreover, the mix of services covered must be dynamic and sensitive to changing population needs.

UHC is typically understood as a goal for the health system within countries. However, the goal of UHC is ultimately global, in that it promotes UHC in *all* countries. A key issue is therefore how countries can assist each other and act collectively in the pursuit of this ultimate goal. This issue pertains to the financing of GPGHs, the provision of external financing for national health systems, and fundamentally the concerns for global justice, global solidarity and human rights.

Path

Progress towards UHC requires a holistic approach. All parts of the financing system, including revenue collection, pooling of resources and purchasing of services should be strengthened, together with other key functions of the health system, which include generation of human and physical resources, service provision and stewardship (WHO 2000).

There is no single path to UHC that every country must follow, as no country starts from zero coverage and local context matters. To achieve UHC, however, every country must make progress in at least three dimensions. Countries must expand priority services, include more people and reduce OOPPs (WHO 2010). In particular, reliance on mandatory prepaid pooled financing is a necessary condition for achieving UHC (Fuchs 1996; WHO 2010; McIntyre and Kutzin 2012).

Prepayments are made by the potential recipient of the service prior to delivery, and typically before the need for the particular service has become evident. Mandatory or compulsory prepayments are those prepayments that are not voluntary. They include ordinary taxes and mandatory insurance premiums in the context of social health insurance, as well as several other sources of government revenue. The pooling of mandatory prepayments promotes cross-subsidization between the rich and the poor, and between the healthy and the sick. This, in turn, can ensure that the poor or the sick have access to the pooled arrangements and ensure that the rich and healthy contribute. This is an expression of solidarity and an essential prerequisite for UHC. However, to enable proper cross-subsidization, there should generally be one or a few large pools rather than multiple small, fragmented pools (WHO 2010).

As countries pursue UHC, it is crucial that they do so in a fair and efficient way. In particular, it is important that countries fairly expand priority services, fairly include

more people and fairly reduce OOPPs (WHO 2014c). Key considerations of fairness are discussed below.

While UHC is centrally concerned with health systems strengthening, it also calls for action beyond the health sector, as the means to improve access to health services and financial protection are not confined to that sector. For example, access to services and financial protection depend heavily on policies with regard to transportation, employment, education and finance. The pursuit of UHC therefore requires intersectoral action (WHO 2011; Leppo et al. 2013). In addition, the underlying aim of improving health calls for action beyond the health sector to improve health other than through service coverage. In particular, countries must address the entire range of key social and political determinants of health, including education, occupation, income, housing, gender, inequality, regulation of access to food and water, regulation of markets and trade, and action on corruption (CSDH 2008; Ottersen, O. et al. 2014).

Health and development

As the MDGs move towards their end date, the global community is debating what the post-2015 development agenda should look like. The shaping of that agenda is a great opportunity for reaching agreement on critical issues for health and health financing, and the agenda itself can be an important tool for this (Kickbusch and Brindley 2013; TT 2013; SDSN 2014). However, this requires that the central role of health and UHC in development is duly appreciated.

As described above, health contributes to development both directly and indirectly, for example by catalysing economic growth. The idea that health interventions primarily represent a drain on economic resources has been disproved (CMH 2001; Jamison et al. 2013a). In addition, the substantial pay-offs from investing in health make a strong case for increasing external financing for health.

Health is also a beneficiary of development. In fact, health is closely linked to nearly all other areas of development, and the relationships tend to run in both directions. This is the case, for example, with regard to food, water and sanitation, energy, education, employment, population dynamics, inequality, sustainability and governance. Furthermore, the level and distribution of health and health service coverage can represent useful indicators of development and social justice, for instance.

We believe that health should be centrally positioned in the post-2015 development agenda and that a principal means for achieving better health – health financing – should be integrated into that agenda.

3. The Focal Roles of Targets and Shared Responsibilities

When seeking change and progress towards a coherent global framework, clear targets and shared responsibilities are key. Together they provide direction and clarify who has to do what for whom.

The role of targets

A coherent global framework needs to be founded on clear objectives, the most important of which were described above. However, to drive progress, it is also important to have specific targets. Indeed, one of the frequently cited virtues of parts of the MDG agenda is its use of such targets (UNTT 2012; HLP 2013). But other parts of that agenda are less clear, which is why, for instance, many have criticized MDG 8 – the goal of developing a global partnership for development – on the grounds that it lacks precise and quantitative targets (UNTT 2013).

Targets should be specific and their content unambiguously defined for all relevant actors. Such targets can be particularly helpful in setting priorities among competing concerns, and they can have a particularly strong incentivizing effect on the actors to which they apply, including through peer pressure.

Progress towards specific targets can also be more easily measured than can progress towards more diffuse targets. This facilitates rigorous monitoring and evaluation of policy implementation, which in turn also can strengthen accountability. In addition, clear targets can promote and focus debate over what policy goals are the most appropriate.

Specific targets that are widely agreed can catalyse bold, transformative action and sustained effort. Building consensus around such targets is therefore key to making progress towards a coherent global framework for health financing.

It is useful to have targets linked not only to outcomes, but also to inputs and outputs. The emphasis of the MDGs on outcomes rather than on the means for achieving them has been considered a disadvantage of those goals (UNTT 2012). In the context of health financing, relevant targets pertain to domestic resources, external resources, financing of global public goods and contributions to a global enabling environment, all which are critical for the achievement of health goals.

The role of shared responsibilities

It is not sufficient that the need for change, targets and even entitlements are clear. To make progress, the corresponding responsibilities also must be spelled out. In other words,

the answer to the following question must be as specific as possible: who has the responsibility to do what for whom?

Shared responsibilities

A basic premise for the answer is that of shared responsibility. The responsibility to address the major global health challenges should be shared among all states. Such a position is, for example, expressed in the UN Millennium Declaration, which asserts that ‘[r]esponsibility for managing worldwide economic and social development, as well as threats to international peace and security, must be shared among the nations of the world and should be exercised multilaterally’ (UNGA 2000). Today, variations of this concept of shared responsibility are pervading not only discussions on environmental policy, but also discussions on development and health financing (UN 2009; Gostin et al. 2011; AU 2012; HLP 2013).

Progress towards specific targets can be more easily measured than can progress towards more diffuse targets. This facilitates rigorous monitoring and evaluation of policy implementation, which in turn also can strengthen accountability.

The rationale for globally shared responsibility is based on the importance of health and health service coverage, common risks and vulnerabilities, global interdependence, and the values of justice and solidarity. Shared responsibility is also central in the human rights framework (De Schutter et al. 2012; Friedman et al. 2013). Underlying most robust notions of shared responsibility is the explicit recognition that obligations of justice, solidarity and human rights transcend state borders (Buchanan and DeCamp 2006; Johri et al. 2012; Gostin and Friedman 2013; Ooms and Hammonds 2013).

Differentiated responsibilities

Shared responsibility does not imply that everyone must do the same. Rather, different actors have different obligations, and this can again be motivated by considerations of justice, solidarity and human rights. The idea of shared but differentiated responsibilities is analogous to that of ‘common but differentiated responsibilities’ in the context of international law and climate policy (French 2000; Stone 2004). In either case, responsibilities must be clearly and reasonably differentiated.

In particular, different *kinds* of actors typically have different obligations. For example, it is widely recognized that states have special obligations as prominent agents of

justice and as primary duty-holders under international human rights law. There is a strong and broad basis for the principle that the primary responsibility for meeting the health needs of a given person rests on the state in which he or she is an inhabitant (Buchanan and DeCamp 2006; UN 2009; Gostin and Friedman 2013; HLP 2013). Where external financing is warranted, obligations to provide such financing supplement but do not displace obligations of national governments (OHCHR 2012).

Responsibilities can be differentiated also on other grounds, and many criteria for inter-state differentiation and burden-sharing have been proposed, both in the area of international environmental policy and more generally (Ringius et al. 2002; Kuper 2005; Heyward 2007; Karlsson 2007; Miller 2007). Three criteria that are particularly relevant in the context of global health financing are those related to capacity, contribution and benefit. While terminology and exact definitions vary, the three criteria can be specified as follows.

According to the capacity criterion, the responsibility of a given state to address a given health problem, within or outside its territory, increases with the capacity of the state to address that problem (Ringius et al. 2002; Stone 2004; Miller 2005; Heyward 2007; Karlsson 2007). Accordingly, what it takes for a state to fulfil its responsibility for securing the health of its own people, and for addressing health problems abroad, depends on capacity. The former responsibility is linked to the concepts of ‘maximum available resources’ and ‘progressive realization’ in the human rights framework (UNGA 2000; Balakrishnan et al. 2011), while the latter is reflected in the well-known 0.7 per cent official development assistance (ODA)/GDP target⁴ (Pearson et al. 1969; Clemens and Moss 2007) and the scale of assessments for the apportionment of the expenses of the UN (UNGA 2012b).

According to the contribution criterion, the responsibility of a given state to address a given health problem, within or outside its territory, increases with the extent to which that state contributes to the problem (Ringius et al. 2002; Stone 2004; Barry 2005; Miller 2005). Some of these contributions may qualify as harms – as for example in the case where a state causes disease abroad as a result of its spreading of radioactive material. In environmental policy, one variant of the contribution criterion is linked to the ‘polluter pays’ principle (Ringius et al. 2002; Heyward 2007). However, the relevant contribution to the problem at hand can also be more indirect. For example, actors can contribute to health problems through their support of international rules and institutions (Pogge 2004).

According to the benefit criterion, the responsibility of a given state to address a problem that affects health in several countries increases with the benefit to the state if the problem is mitigated or eliminated (Ringius et al. 2002; Heyward 2007). For example, finding a cure to a certain disease or strengthening infectious disease surveillance in a certain area will benefit different countries to various degrees. The benefit criterion is particularly relevant for the financing of global public goods, where one reason why a given country should contribute is linked to the benefits that it can receive.

Role and responsibilities of non-state actors

While governments have the primary responsibility for ensuring adequate health financing, a range of non-state actors play an important role in health financing today. For example, with respect to domestic financing, private insurers play a major role in many countries, often through voluntary insurance. With regard to GPGHs and external financing of health systems, important non-state funders include non-governmental organizations (NGOs) and philanthropic organizations. Examples are Save the Children and the Bill & Melinda Gates Foundation. At the intersection between public and private, several public–private partnerships (PPPs) have become prominent funders, including GAVI and the Global Fund.

At the very minimum, every actor has a duty to refrain from preventing countries from securing the health of their own people.

Non-state actors also play important roles in the provision of health services and supplies (Bennett et al. 2005; Forsberg et al. 2011). In most countries, private providers are significantly present, and these can be either for-profit or non-profit, including international NGOs.

Non-state actors also play a more indirect role by shaping the environment for health financing. Specifically, private investors and corporations are crucial to economic development and growth, and thereby for providing a basis for resource mobilization for health. However, these actors can also make health financing and health protection more difficult, including through tax abuses or activities that can be directly harmful to health (IBATF 2013; Ottersen, O. et al. 2014).

All the non-state actors have some responsibilities with regard to health financing. At the very minimum, every actor has a duty to refrain from preventing countries from securing the health of their own people. At the same time,

⁴ This target is sometimes framed in terms of gross national product (GNP) or gross national income (GNI) rather than GDP.

it is the government that has the ultimate stewardship function domestically. In other words, government has the responsibility to oversee and regulate private and voluntary sectors in order to direct their energies towards efficient, equitable and sustainable health financing (UN 2011). Accordingly, these sectors must be carefully integrated in a broad, coherent framework for health financing.

Basic pattern of responsibilities

Against the background of the criteria of capacity, contribution and benefit, and the general rationale for shared responsibilities, the basic pattern of state responsibilities across the three financing areas can be outlined:

- Every country has the primary responsibility for meeting the health needs of the inhabitants in that country. This involves primary responsibility for mobilizing resources for that purpose. Exactly what is required to fulfil this responsibility varies with capacity and with what progressive realization and utilization of the maximum available resources imply.
- Every country has a responsibility to support the provision of GPGHs, and this responsibility precedes that for providing external financing for national health systems. The responsibility for GPGHs is centrally based on justice and solidarity but can also be based on the benefits that accrue to the actor itself. The amount of support required to fulfil this responsibility varies with capacity.
- Every country with the capacity to do so has a responsibility to provide external financing to countries that, despite reasonable efforts, cannot meet their priority health needs. The amount of financing required to fulfil this responsibility varies with capacity.

Every country also has important responsibilities that cut across these financing areas. In particular, each country is obliged not to hinder other countries in meeting their respective responsibilities outlined above. For example, every country should refrain from devising tax policies that unduly hamper resource mobilization in other countries. More positively, every country has an obligation to contribute to a global enabling environment – something that partly overlaps with the responsibility to support GPGHs.

4. Policy Responses

To move towards a coherent global framework, the three broad financing challenges must be effectively addressed through a range of policy responses. For these responses to be effective, it must be clear not only what is to be done, but also how it is to be done, and by whom.

Context

The effectiveness of policy responses depends crucially on their responsiveness to context.

First, any policy response should be sensitive to both the health and the 'non-health' context. Efforts to improve health, health services and systems, and health financing must take into account the many powerful determinants outside the traditional health sphere. These include social and political determinants and governance structures that can work for – as well as against – health. We address the need to strengthen and increase health financing, and to make it more efficient, equitable and sustainable. However, this needs to be done with a parallel view on other social-sector investments and with an understanding of how the policies of many sectors influence health.

Second, any policy response should be sensitive to both domestic particularities on the one hand and the global system and global political economy on the other. For example, these particularities include epidemiological profile, social needs outside the health sector, economic capacity and institutional structure. At the global level, the process of globalization has brought unprecedented complexity, interconnectedness and interdependence. This process has also brought the global, national and local levels much closer together. As a result, global structures and processes are now key determinants for both domestic and external health financing. Accordingly, some of the proposed policy responses below address these directly, thereby improving the environment and context within which the remaining policy responses can be carried out.

Domestic financing of national health systems

National health systems can be financed entirely from domestic sources or in some combination with external

financing. Domestic financing is the predominant source of financing for health in all but a few LICs. In 2012 domestic financing represented on average 70 per cent and 86 per cent of total health expenditure (THE) in LICs and lower-middle-income countries (LMICs) respectively.⁵

Nevertheless, the challenges in domestic health financing are profound. To address these, a wide range of policy responses is needed; most of these fall into the categories of mobilizing more resources, shifting from OOPs towards mandatory prepayment with pooling, and improving priority-setting and efficiency.

The overarching responsibility for addressing these challenges resides with the government. Every government has the primary responsibility for securing the health of its own people, and well-functioning domestic financing for national services is crucial for securing health. Governments therefore have a key role and responsibility in securing domestic financing of national health services.

Recommendation 1: Every government should meet its primary responsibility for securing the health of its own people. This involves a responsibility to oversee domestic financing for health and ensure that it is sufficient, efficient, equitable and sustainable.

Mobilizing more resources

Resources can be mobilized directly and by regulating the efforts of other actors – including private and social insurance schemes.

THE per capita varies enormously across the world. In 2012 it ranged from \$15 in Eritrea to \$9,100 in Norway – i.e. a ratio of 1:600.⁶ Across income categories,⁷ THE per capita ranged from \$38 in LICs to \$3,000 in high-income countries (HICs).⁸

THE is the sum of government health expenditure (GHE) and private health expenditure. GHE includes not only the resources channelled through government budgets, but also the expenditure on health by parastatals, extrabudgetary entities and mandatory health insurance schemes (WHO 2013d). As is the case for THE per capita, GHE per capita varies enormously. In 2012 it ranged from \$5 to \$7,700 between countries, and from an average of \$15 among LICs to an average of \$2,200 among HICs.⁹ At the same time,

⁵ Calculations based on data from WHO Global Health Expenditure Database. Unweighted averages, but countries with a population less than 100,000 were excluded in the analysis.

⁶ Data from WHO Global Health Expenditure Database.

⁷ Countries are categorized according to the World Bank classification for fiscal year 2014, which is based on 2012 gross national income (GNI) per capita (WB 2014). Countries with GNI per capita ≤ \$1,035 are defined as low-income countries (LICs); countries with GNI per capita \$1,036–\$4,085 and GNI per capita \$4,086–\$12,615 are classified as lower-middle-income countries (LMICs) and upper-middle-income countries (UMICs) respectively; and countries with GNI per capita ≥ \$12,616 are defined as high-income countries (HICs).

⁸ Calculations based on data from WHO Global Health Expenditure Database. Unweighted averages, but countries with a population less than 100,000 were excluded in the analysis.

⁹ Ibid.

the share of GHE in THE is by no means fixed. In 2012 this ranged from 16.6 per cent to 99.9 per cent between countries, and from an average of 42.2 per cent in LICs to 70.4 per cent in HICs.¹⁰ This demonstrates how HICs rely on government financing of health to a much larger extent than do LICs.

In many countries, THE and GHE include external financing. In 2012 external resources for health represented 30 per cent, 14 per cent, and 3 per cent of THE in LICs, LMICs and upper-middle-income countries (UMICs) respectively.¹¹

We examine whether clear and reasonable targets can be formulated for what minimum level of GHE each government should ensure. Each potential target has its weaknesses, but the weaknesses of one can often be addressed by another and vice versa. We recommend a combination of two targets: a \$86 target for GHE per capita; and a 5 per cent target for GHE relative to GDP.

The \$86 target

One important type of target refers to the absolute level of health spending per capita. There have been two well-known initiatives estimating what level is needed across a broad range of developing countries: the Commission on Macroeconomic and Health (CMH 2001) and the HLTF (HLTF 2009b). Of these, the estimates of the HLTF are more useful because of the broader range of services and the higher coverage rates included in the analysis (McIntyre and Meheus 2014).¹²

The HLTF estimated the annual cost, between 2009 and 2015, required to scale up a set of essential services in 49 LICs at \$54 per capita (expressed in 2005 US dollar terms).¹³ That set included services considered necessary to accelerate achievement of the health MDGs;

but in addition the set included services that address chronic diseases (tobacco control and salt reduction in processed foods) and essential drugs for chronic diseases, some cancers, neglected tropical diseases, mental health and general care. The HLTF analysis was also fairly comprehensive in terms of cost components and coverage rates.¹⁴ Overall, the cost estimate can be seen as representing the minimum expenditure required to ensure priority services for everyone in the context of LICs. Most of these services fall in the category of comprehensive primary care services.

We updated the \$54 estimate to 2012 US dollar terms based on changes in inflation and exchange rates since 2005. The updated estimate was \$85.6 and represents the mean for the countries included.¹⁵ The HLTF estimated THE needed. However, we believe that the \$86 figure is better seen as a target for GHE. If \$86 is supposed to approximate what minimum is needed to ensure UHC for priority services for everyone, then the \$86 needs to come from mandatory prepaid, pooled funds rather than from private spending.¹⁶ A major insight from research on financing for UHC is that mandatory prepayment with pooling is necessary to ensure *universal* access and financial risk protection (Fuchs 1996; WHO 2010; McIntyre and Kutzin 2012). There are also reasons to believe that GHE is more likely to be allocated to priority services than private expenditures are.¹⁷

In 2012 GHE per capita – from both domestic and external sources – fell short of that \$86 target in 61 countries.¹⁸ The sum of shortfalls from the \$86 target in that year – the global financing gap – was \$196 billion.¹⁹ These figures point to insufficient domestic funding in numerous countries, as well as to inadequate external financing in some countries.

¹⁰ Ibid.

¹¹ Calculations based on data from WHO Global Health Expenditure Database. Unweighted averages, but countries with a population less than 100,000 were excluded in the analysis.

¹² The CMH focused on a very limited set of services dealing with AIDS, tuberculosis and malaria (ATM diseases) as well as immunizations, acute respiratory infections, diarrhoeal diseases, maternal and perinatal conditions, and malnutrition. The CMH predicted coverage levels of only 70–80% for most services and 90% for immunizations, antenatal care and skilled birth attendance by 2015.

¹³ The initial costing estimates were based on information provided by two technical teams. One was led by the WHO and partners and used a normative approach, while the other team was led by the World Bank together with other agencies and used a 'marginal budgeting for bottlenecks' (MBB) approach (HLTF 2009a). The HLTF used the WHO estimates for its final analyses.

¹⁴ HLTF estimates included the cost of providing the necessary health system support in terms of additional facilities at various levels of care, additional health workers and managers, strengthened procurement and distribution systems for drugs and commodities, better information systems, improved governance, accreditation and regulation, and health financing reforms. Payments to pregnant women to encourage the use of safe delivery services and improved remuneration of health workers were also included. Although limited information was provided on projected coverage rates, rates of 95% to 100% coverage were referred to where specific coverage rates were mentioned.

¹⁵ The original estimates were converted into local currency units using the 2005 exchange rate, inflated using the annual inflation rates during the period 2006–12, and converted to 2012 \$ using the 2012 exchange rate. The original estimates were thus adjusted for both changes in exchange rates and inflation between 2005 and 2012. The method is further described in a separate paper (McIntyre and Meheus 2014), where a similar exercise for the original estimate by the CMH resulted in an estimate of \$71.4.

¹⁶ As noted above, GHE includes not only the resources channelled through government budgets, but also the expenditure on health by parastatals, extrabudgetary entities and mandatory health insurance schemes (WHO 2013d).

¹⁷ Working Group 1 of the HLTF assumed that 50% of increases in private spending contribute to meeting the costs of guaranteed benefits, while it noted that the evidence on the degree to which private spending purchases priority services is very weak (HLTF 2009a).

¹⁸ Calculations based on data from WHO Global Health Expenditure Database.

¹⁹ Ibid.

While the \$86 target is useful, it also has deficiencies. In particular, it is insensitive to the economic capacity of each country to mobilize domestic resources. It therefore needs to be combined with a target that can also be directly relevant to a greater number of countries.

The 5 per cent target

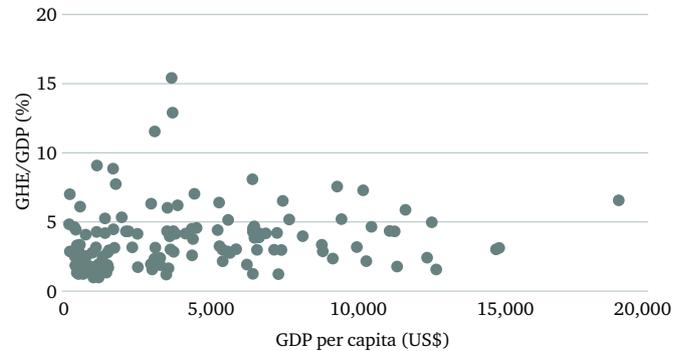
We are proposing a target for the share of GDP that GHE should represent (GHE/GDP). This has a number of advantages over an absolute target. First, it is sensitive to capacity, in terms of the size of the total economy. It is thus better aligned with the responsibility of governments to spend the maximum available resources and progressively to meet health needs and ensure UHC. While \$86 may ensure priority services for everyone, it is clearly insufficient to meet all important health needs, and GHE therefore needs to be progressively increased. Second, a spending target relative to GDP can better account for price differences between countries. In addition, it is more logical to link spending to the overall size of the economy than to other variables. For example, the target under the Abuja Declaration of allocating at least 15 per cent of general government expenditure (GGE) to the health sector (Organization of African Unity 2001) ignores the ratio between government revenue and expenditure and GDP, and thus the scope that governments have to increase that ratio through an increased revenue effort. Because GHE/GDP of 5 per cent may be insufficient to ensure priority services in poor countries, the 5 per cent target should be complemented with the \$86 target for GHE per capita.

The variations in the GHE/GDP share across LICs and MICs are substantial, as shown in Figure 1. While the GHE/GDP ratio tends to increase with GDP per capita, there is also considerable variation in that ratio between countries with similar GDP per capita. This demonstrates that the ratio is very much a question of government choice and priorities at all levels of income.

We recommend that the GHE/GDP target should be at least 5 per cent for all countries. This is a useful target for several reasons.

One is that it indicates substantial yet feasible effort for LICs and MICs. The fact that less than 20 per cent of LICs and MICs currently achieve that ratio suggests that a target of 5 per cent indicates substantial effort by today's standards.²⁰ More specifically, the target is not achieved in 94 per cent of LICs, 82 per cent of LMICs and 75 per cent of UMICs.²¹ But these same facts indicate that GHE/GDP of 5 per cent is feasible, as several countries in each category have already achieved or passed this level.

Figure 1: Share of government health expenditure (GHE) in GDP for low- and middle-income countries



Source: Data from WHO Global Health Expenditure Database.

At the same time, GHE/GDP of 5 per cent is typically needed for ensuring that health outcomes and coverage in terms of service access and financial risk protection meet some minimum standards. Some key findings in support of this are as follows (McIntyre and Meheus 2014):

- Ensuring certain health outcomes above minimum standards generally requires GHE/GDP of at least 5 per cent. For example, such a ratio appears generally required for achieving an infant mortality rate below 10 per 1,000 live births.
- Ensuring access to priority services above accepted standards generally requires GHE/GDP of at least 5 per cent. For example, such a ratio appears generally required for achieving more than 90 per cent coverage for immunizations and deliveries by skilled birth attendants.
- Ensuring financial protection at an adequate level generally requires GHE/GDP of at least 5 per cent. For example, such a ratio is generally required for limiting the proportion of OOPs to 20 per cent of THE, which in turn is generally needed for achieving low rates of catastrophic and impoverishing health expenditure.

The 5 per cent target does have some history. A 5 per cent figure of health spending as share of GDP appeared in WHO documents as early as 1981 (Savedoff 2003). However, it was then proposed as an indicator to be monitored and not as a recommended level of health spending, and no basis for the exact figure was provided. In contrast, some more recent WHO documents have supported the 5 per cent figure as a target for GHE (WHO 2009; WHO 2010).²² The target has also been recommended by the Health Thematic Group of the Sustainable Development Solutions Network in the context of the post-2015 development agenda (SDSN 2014).

²⁰ Calculations based on data from WHO Global Health Expenditure Database for 2012.

²¹ Ibid.

²² More precisely, the *World Health Report 2010* asserts that it is 'difficult to get close to universal health coverage at less than 4–5% of GDP' (WHO 2010).

There are several reasons why the target level is not set much higher than 5 per cent. One is that the target should not be unrealistic for LICs, and another is that it does not, in any case, represent a maximum. Countries above the target still have to ensure that they do enough to fulfil their responsibility for securing the health of their own people to the maximum of their ability. This indicates that HICs should be expected to invest a higher proportion of GDP in health. Today the average GHE/GDP ratio for these countries is 5.4 per cent.²³ Moreover, the target must not be so high that it unduly compromises other important sectors – such as education and welfare – and leaves no room for other national priorities.

There are also several reasons why the target level is not set lower than 5 per cent. One is that it seems reasonable that the target should reflect substantial effort by LICs and MICs. Another reason is, as described, that GHE/GDP of 5 per cent is often needed for ensuring that health outcomes and coverage in terms of service access and financial risk protection meet some minimum standards. This holds for several levels of efficiency and quality, although some countries – such as Thailand, with GHE/GDP of 3.0 per cent²⁴ – have achieved high levels of coverage with government spending on health clearly below 5 per cent of GDP (McIntyre and Meheus 2014). This suggests that the target needs to be interpreted in a local context. At the same time, reaching the 5 per cent target is unrealistic for several countries in the short term. For these countries, however, the target should represent a key mid-term goal for the quest progressively to meet health needs and ensure UHC. To be more sensitive to short-term policy and to have greater incentivizing effect, attention paid to the target itself should be combined with a focus on the improvements and path towards it. For example, the Health Thematic Group of the Sustainable Development Solutions Network has suggested an alternative target of a 50 per cent reduction in the gap between current spending levels and 5 per cent of GDP for LICs and MICs (SDSN 2014).

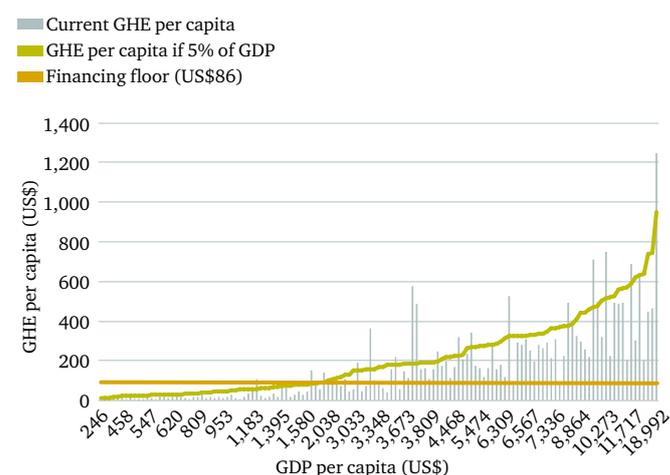
If every country met the 5 per cent target in 2012, GHE per capita would still have fallen below \$86 in 50 countries.²⁵ Among these are all LICs (33 countries) and 17 MICs. The overall number is lower than the 61 countries that actually fell below the \$86 target in 2012. The global financing gap – in terms of shortfall from the \$86 target – would then have been reduced from \$196 billion to \$65 billion.²⁶ The fact that a number of countries would fall below the \$86 target even if they met the 5 per cent target demonstrates that it is

insufficient alone, and should therefore be complemented with the \$86 target and targets for external support.

Recommendation 2: Every government should commit to spend at least 5 per cent of GDP on health and move progressively towards this target, and every government should ensure GHE per capita of at least \$86 whenever possible. Most MICs should be able to reach both targets without external support.

Figure 2 shows how the two targets relate to current spending on health. More specifically, the figure shows for every LIC and MIC actual GHE per capita; GHE per capita if 5 per cent of GDP; and the position of these figures relative to the absolute \$86 target.

Figure 2: Government health expenditure (GHE) for low- and middle-income countries



Source: Data for 2012 from WHO Global Health Expenditure Database.

While overall spending on health is important, it is only part of the current challenge for domestic health financing and only one aspect of a comprehensive framework. Beyond the total level of funds, it is crucial how those funds are mobilized, how they are pooled, and how they are spent.

Shifting from OOPs towards mandatory prepayment with pooling

How resources for health are mobilized is crucial. This ‘how’ question is central for the total sum of funds mobilized and for the wider consequences of the process itself.

²³ Calculations based on data from WHO Global Health Expenditure Database for 2012. Unweighted averages, but countries with a population less than 100,000 were excluded in the analysis.

²⁴ Data from WHO Global Health Expenditure Database for 2012.

²⁵ Calculations based on data from WHO Global Health Expenditure Database.

²⁶ Ibid.

Reducing OOPPs

OOPPs are a major obstacle to UHC. They are made by the recipient of a service to the provider or to a third party at the time of service delivery. Such payments can have several negative effects. They can impede access, especially for the poor, since a given cost generally constitutes a greater barrier for them. They can also cause severe financial strain, including catastrophic expenditures, which can push people into poverty or the poor into destitution. As described above, coverage with financial risk protection also has several benefits even for those who do not need services.

The share of OOPPs relative to total health expenditure (THE) varies widely across the world. In 2012 this share ranged from under 1 per cent to 76 per cent between countries,²⁷ and the average shares for LICs, MICs and HICs were 43 per cent, 34 per cent, and 21 per cent respectively.²⁸

Research has indicated that only when OOPPs fall below 15–20 per cent of THE does the incidence of financial catastrophe and impoverishment decline to low levels (Xu et al. 2003; WHO 2010). This is therefore a key target for countries seeking UHC. In 2012 the share of OOPPs exceeded this level in 125 countries – often by a large margin.²⁹

OOPPs can cause severe financial strain, including catastrophic expenditures, which can push people into poverty or the poor into destitution.

The overall proportion of OOPPs to THE is not, however, all that matters. It also matters how they are distributed across services and people. OOPPs should represent much less than 20 per cent, and preferably be eliminated entirely for priority services – including those services linked to the \$86 target. There is also a particularly strong case for reducing OOPPs for the services most often linked to catastrophic or impoverishing expenditures. The number of poverty cases averted for a given amount of public finance varies substantially across services (Jamison et al. 2013a). For example, a study from Ethiopia showed that tuberculosis treatment and treatment for high blood pressure can prevent the same number of deaths, but the latter averts a much larger number of cases of poverty (Verguet et al. under review). This does not, however, imply that tuberculosis treatment should have user fees while hypertensive treatment should not; and often emphasis should just be put on reducing OOPPs across the board. However, where practically feasible, differences in the

tendency of OOPPs to be catastrophic or impoverishing may be taken into account.

OOPPs should also be zero for the poor, partly because a given level of OOPP constitutes a greater barrier to care for them. This can be sought by first focusing coverage on services for conditions that disproportionately affect the poor, for example infectious diseases and tobacco-related illnesses. Low OOPPs for the poor can also be sought by targeting the poor more directly, but this often raises a number of practical challenges (Hanson et al. 2008; Witter 2009). These are also the two main strategies for fair and pro-poor progress towards UHC (Jamison et al. 2013a; WHO 2014c).

Recommendation 3: Every government should ensure that catastrophic and impoverishing OOPPs are minimized. Specifically, governments should commit to the targets of OOPPs representing less than 20 per cent of total health expenditures (THE) and no OOPPs for priority services or for the poor.

Increasing and improving mandatory prepayment

Mechanisms for mandatory prepayment with pooling of funds must be strengthened. This is essential not only for securing sufficient funds, but also for ensuring that the process of resource mobilization is fair and efficient and promotes favourable wider consequences.

The general case of mandatory prepayment

By enabling mandatory pooling of funds and risk, mandatory prepayment mechanisms can avoid many of the negative effects of OOPPs. As described above, such mechanisms can promote cross-subsidization. Greater reliance on mandatory prepayment with pooling can also help make the financing system more progressive with respect to income. Overall, such mechanisms thus promote universal access to services and universal financial risk protection. Indeed, as already described, reliance on mandatory prepaid pooled financing is a necessary condition for achieving UHC.

Experience across countries shows that there is considerable room both for expanding mandatory prepayment mechanisms and for improving existing mechanisms (Elovainio and Evans 2013). As shown above, the ratio of GHE to THE varies considerably between countries and from an average of 42 per cent in LICs to 70 per cent in HICs. There are also numerous examples of existing mechanisms that are inadequately designed. For example,

²⁷ Data from WHO Global Health Expenditure Database.

²⁸ Calculations based on data from WHO Global Health Expenditure Database. Unweighted averages, but countries with a population less than 100,000 were excluded in the analysis.

²⁹ Calculations based on WHO Global Health Expenditure Database.

mandatory prepayments can often be regressive with respect to income, unaffordable for the poor or linked to fragmented pools, which inhibits cross-subsidization (WHO 2010). Mechanisms for mandatory prepayment with pooling should therefore be expanded and existing mechanisms should be improved, and this should be done in a way that promotes an effective, equitable and sustainable financing system overall.

A particularly important requirement for such reforms is that they promote a progressive health financing system – the rich should pay proportionately more than the poor. Contributions to the system should primarily be based on ability to pay, and not on risk – a requirement that is supported both by the WHO (WHO 2000; WHO 2010) and by theories of distributive justice in health care (PC 1983; Daniels 2008).

Recommendation 4: Every government should improve revenue generation and achieve reduction of OOPs through effective, equitable and sustainable ways of increasing mandatory prepaid pooled funds for health services. Individual contributions to the pool(s) should primarily be based on capacity to pay and be progressive with respect to income.

Mandatory prepayment mechanisms rely on taxation or mandatory health insurance, often termed social health insurance. There are primarily two ways to increase the amount of health resources raised through mandatory mechanisms. One is to strengthen domestic resource mobilization, either the mobilization of general government resources or resources directly designated to health. Another is to prioritize health when allocating general resources.

While taxes are an important source of government revenue, other significant sources include property income derived from ownership of assets or natural resources and sales of goods and services. If the 5 per cent GHE/GDP target is combined with the Abuja Declaration target of 15 per cent GHE/GGE, this gives a GGE/GDP share of 30–35 per cent. This suggests that LICs and MICs should aim for approximately this share of GDP being captured as public revenue. This is around the current average of 32 per cent in the case of HICs but higher than the average for LICs – which is currently 17 per cent.³⁰

Taxation

Although discussions about taxation are often limited to its role as a source of revenue, tax systems and policies have multiple important functions, which can be described in terms of the following five ‘Rs’ (McCoy and Chigudu 2013):

- *Revenue:* As noted, tax is an important source of public revenue for the financing of health systems and other public services and goods.
- *Representation:* Tax policies and systems can strengthen democracy, promote government accountability and empower citizens to make claims on the state for the production and delivery of public services and goods.
- *Redistribution:* Progressive tax policies and systems are a key mechanism for the equitable distribution of benefits and resources across society. As noted above, UHC implies cross-subsidization of the poor. For this purpose, progressive taxation plays an important role in the establishment of equitable systems of health financing.
- *Repricing:* Taxes can also be used to influence behaviour by altering the cost of goods and services. For example, taxes on tobacco and alcohol can be used to both generate public revenue and discourage unhealthy consumption patterns.
- *Regulation:* Taxation of spheres of economic activity implies a degree of public oversight and regulation over those spheres. Some spheres of economic activity that are harmful to society or that currently lack adequate public regulation and oversight can be taxed not only to generate additional revenue, but to also help minimize harms to society and correct market failures. Spheres of economic activity that should be taxed to achieve these benefits include financial and commodity transactions (to reduce harmful speculative activity) and the arms trade.

These different – but interrelated – functions of taxation point to a need for the international health community to pay greater attention to the relationship between tax and health. Although tax reform is a complex and contentious issue, three particularly important responses are: changing the composition of taxes and subsidies; improving tax administration and tax compliance; and curbing tax competition.

Changing the composition of taxes and subsidies

Certain taxes are particularly valuable from the perspective of health financing because they can promote health in multiple ways. For example, taxes on unhealthy products such as tobacco, alcohol, salt and sugar can discourage unhealthy consumption and reduce the need for expensive treatments in the future. When combined with their revenue-generating potential, these taxes offer the potential for a ‘triple win’ from the perspective of health. As for

³⁰ Calculations based on World Bank data on indicator ‘revenue, excluding grants (% of GDP)’ for 2012.

revenue, a simulation-based study of 42 countries with varying consumption and income levels showed that the net effect of a hypothetical increase in excise tax on alcohol to at least 40 per cent of the retail price in each country could increase public revenue from \$43 billion to \$77 billion (Stenberg et al. 2010).

Taxes on fuel and carbon emissions can also help to reduce the externalization of costs associated with global warming, while taxes on the trade of small arms can help strengthen the case for the regulation of this harmful activity which causes much ill health and human suffering (McCoy and Chigudu 2013). Similarly, there is vast room for LICs to derive greater benefit from the extraction of natural resources by multinational corporations, one way of which would be to implement more effective taxation of extractive industries (IMF 2012; Africa Progress Panel 2013).

Other taxes that have been proposed include an airline ticket tax, financial transaction taxes (FTTs), luxury item taxes and taxes on mobile phone use (HLTF 2009b; Elovainio and Evans 2013; Moon and Omole 2013). Some have already been partially implemented, but all deserve serious consideration of their potential to generate public revenue and improve social wellbeing.

In many countries, public revenue for health and other social sectors can also be increased through the removal or reduction of tax subsidies, particularly for goods and services that have a negative impact on health. These include subsidies on coal, petroleum and sugar (Jamison et al. 2013a).

Overall, there is considerable room in most countries for the careful and judicious use of taxes and fiscal policy to help achieve health improvements and sustainable development.

Improving tax administration and tax compliance

In order for taxation to play a more positive role in health improvement and sustainable development, countries must have effective, accountable and transparent tax administrations. In many countries however, tax administrations are poorly staffed, governed and managed, and are undermined by corruption. This represents a key constraint on the ability of states to collect revenue (Fjeldstad and Semboja 2001; IMF 2011a; IMF 2011b; Fjeldstad 2013). Strengthening tax administration, including tackling corruption, is therefore an important strategy for improving domestic resource mobilization.

The efficiency and effectiveness of tax systems is also a determinant of the degree to which tax is evaded and avoided. These practices are aided by a lack of regulation over the international banking sector that facilitates illicit financial flows through the presence of so-called tax havens. Illicit financial flows have been defined as 'all unrecorded private financial outflows involving capital that is illegally

earned, transferred, or utilized, generally used by residents to accumulate foreign assets in contravention of applicable capital controls and regulatory frameworks' (Kar and LeBlanc 2013). So defined, it has been estimated that illicit outflows from the developing world totalled \$946.7 billion in 2011 and that these flows are growing in volume (Kar and LeBlanc 2013). This has led to calls for the curbing of illicit financial flows from LICs and MICs to be one of the important policy issues in the post-2015 development agenda. For example, the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda stressed that governments must 'co-operate more effectively to stem aggressive tax avoidance and evasion, and illicit capital flows' (HLP 2013).

Curbing harmful tax competition

Increased global mobility of finance and productive capacity has led to tax competition between countries that are trying to attract foreign investment. This has resulted in many countries reducing their corporate tax rates and offering special incentives such as tax holidays and duty-free export and import (IMF 2011a; TJN-A and ActionAid 2012; Fjeldstad 2013). The result of such tax competition is reduced revenue for many countries, as well as overall (Torvik 2009; TJN-A and ActionAid 2012). Agreement on a minimum tax rate or more full-fledged tax harmonization are potential responses, but either requires international collective action (IMF 2011a; TJN-A and ActionAid 2012).

Recommendation 5: Every government should consider improved and innovative taxation as a means to raise funds for health. Promising policies include the introduction or strengthening of excise taxes related to tobacco, alcohol, sugar and carbon emissions, and these should be combined with measures to increase tax compliance, reduce illicit flows and curb tax competition among countries. Other sources of government revenue, particularly in countries rich in natural resources, should also be explored.

Exactly what tax reforms should be pursued in each country will depend on a range of country-specific factors. At the same time, there are at least three concerns that cut across most or all of the responses above, discussed elsewhere in this report. One is the concern for greater transparency and stronger accountability mechanisms. Another is that public revenue generated through tax should be progressive with respect to income. Finally, several of the most important reforms require international cooperation.

The proposal to strengthen health financing through improved taxation also requires much stronger collaboration across different sectors and academic disciplines – including public health, banking, accounting, law and economics. Such an interdisciplinary effort will better reflect the idea that tax reform should be integral to health systems strengthening and the pursuit of UHC.

Prioritizing health

Additional resources for health can also be sought by prioritizing health when more general funds become available, or even within the existing general budget. This is indicated by the marked variation across the countries in the share of GGE allocated to health, from 1.5 per cent to 27 per cent.³¹ At the same time, the variation in averages between country categories is much less. In 2012 the average GHE/GGE ratios in LICs, MICs and HICs were 10 per cent, 11 per cent, and 13 per cent respectively.³² This suggests that while GHE/GGE is partially correlated with GDP per capita, the relative priority given to the health sector is basically a matter of choice.

Governments should seek to ensure a universal health system with coverage of comprehensive primary health care, high-priority specialized care and public health measures for the entire population, and should not prioritize expanding coverage of a more comprehensive set of services for only some privileged groups in society.

As described, investments in the health sector are generally good value for money (CMH 2001; Jamison et al. 2013a), and this makes a case for prioritizing health when new resources become available. Funds should be allocated to the health sector up to the point at which it receives a fair share of government resources – a share that must be sensitive to the funding levels and needs in other social sectors such as education. In any case, the ministry of finance must be convinced for higher allocations to take place. Actors in the health sector can facilitate this by focusing on results, efficiency and the pay-off of investing in health (Elovainio and Evans 2013; Jamison et al. 2013a; Tandon et al. 2014). It is also important that these actors carefully take the political economy into account when pushing for more resources for health (Arhin-Tenkorang 2013; Tandon et al. 2014).

Improving priority-setting and efficiency

It is crucial that available resources are used in line with reasonable priorities and are used efficiently.

Strengthening priority-setting

Priority-setting is about how resources should be distributed between services and sub-populations. Priority-setting in the context of UHC is guided by the quest for a broad range

of services, the importance of both access and financial risk protection and the central idea that there should be coverage for everyone.

As described above, UHC requires a wide range of services – most of which can be provided in a primary health care setting, but some of which are specialized services. Priorities must be set so that action on the rising burden of NCDs in many countries is combined with strong, persistent action on the unfinished agenda of infectious diseases, including HIV/AIDS and tuberculosis. In any case, the services of highest priority should first be covered for everyone, before resources are diverted to services of lower priority. Governments should seek to ensure a universal health system with coverage of comprehensive primary health care, high-priority specialized care and public health measures for the entire population, and should not prioritize expanding coverage of a more comprehensive set of services for only some privileged groups in society. For example, pooled funds should not in most cases be used to expand coverage for coronary bypass surgery before securing universal coverage for skilled birth attendance and services for fatal childhood diseases that are easily preventable or treatable.

The UHC goal that everyone should be covered has implications for what health financing system is required and how to move towards UHC. No one should be left behind, and people who are already disadvantaged should have priority. This suggests that to promote equity, countries should typically first expand coverage for low-income groups, rural populations and other groups disadvantaged in terms of service coverage or health or both (WHO 2014c).

Recommendation 6: Every government should ensure that mandatory prepaid pooled funds are used with the aim of making progress towards UHC – that is, affordable access for everyone. Specifically, every government should seek to ensure a universal health system with full population coverage of comprehensive primary health care, high-priority specialized care and public health measures, and should not prioritize expanding coverage of a more comprehensive set of services for only some, privileged groups in society.

Priority-setting is difficult and can be controversial, but it is essential for equity and efficiency in the context of comprehensive services. It is therefore important that priorities are set primarily on the basis of clear, well-founded criteria. Among the potential criteria are those related to cost-effectiveness, severity and financial risk protection (WHO 2014c). The cost-effectiveness

³¹ Data from WHO Global Health Expenditure Database for 2012.

³² Calculations based on data from WHO Global Health Expenditure Database. Unweighted averages, but countries with a population less than 100,000 were excluded in the analysis.

criterion occupies a central position in many national and international guidelines and has a robust theoretical foundation (CMH 2001; Sabik and Lie 2008; Jamison et al. 2013a; WHO 2014c). The concern for cost-effectiveness is often combined with a criterion whereby priority increases with the severity of the condition or the individual disease burden associated with it (Sabik and Lie 2008; Ottersen 2013; WHO 2014c). In the context of UHC, a criterion related to financial risk protection has also received increasing attention (Jamison et al. 2013a; WHO 2014c). As described above, the number of poverty cases averted for a given amount of public finance varies substantially across services.

The choice of criteria and the more specific priority-setting decisions should take place in systematic and transparent processes that involve the wider community and civil society. Frameworks exist for how these processes can form the core of legitimate institutions (Daniels and Sabin 2008). The processes can build on the methods of health technology assessment and multi-criteria decision analysis, which can help translate evidence and explicit values into policy decisions (Baltussen and Niessen 2006; Glassman and Chalkidou 2012; Chalkidou et al. 2013). At the same time, it is important that the mix of services covered and interventions included is dynamic and sensitive to changing population needs and new innovations. A strong system for monitoring and evaluation is needed for this purpose, and for promoting accountability and participation and the effective pursuit of UHC in general.

Recommendation 7: Every government, in collaboration with civil society, should formalize systematic and transparent processes for priority-setting and for defining a comprehensive set of entitlements based on clear, well-founded criteria. Potential criteria include those related to cost-effectiveness, severity and financial risk protection. The processes can build on the methods of health technology assessment and multi-criteria decision analysis, which can help translate evidence and explicit values into policy decisions.

Improving efficiency

Magnitude of the problem

The problem of waste and inefficient spending is huge. In the United States, for example, the total amount of unnecessary health care costs and waste in 2009 was an estimated \$750–\$765 billion, more than a third of total health care expenditures (IOM 2013). Other, multi-country estimates focusing only on fraud and corruption suggest that as much as 7 per cent of global health expenditure is

lost through these practices (Gee et al. 2014). The *World Health Report 2010* suggested that around 20–40 per cent of total health spending – which would represent around \$1.4–\$2.9 trillion in 2012³³ – might be lost through waste, corruption and other forms of inefficiency (WHO 2010). Overall, these figures indicate that the gains from tackling inefficiencies can be large.

Sources of inefficiency

Inefficiency exists everywhere in health systems. The *World Health Report 2010* lists 10 leading causes of inefficiencies that could be addressed: underuse of generic medicines and higher-than-necessary prices for medicines; use of substandard and counterfeit medicines; inappropriate and ineffective use of medicines; overuse or oversupply of equipment, investigations and procedures; inappropriate or costly staff mix and unmotivated workers; inappropriate hospital admissions and length of stay; inappropriate hospital size (low use of infrastructure); medical errors and suboptimal quality of care; waste, corruption and fraud; and inefficient mix or inappropriate level of strategies (WHO 2010).

Strategies to improve efficiency

Identifying sources of inefficiency is much easier than implementing policies to address them and improve service quality. Many changes will be resisted by interest groups that benefit from the inefficiency in question, and there will be transaction costs.

There are four main strategies for improving efficiency (Elovainio and Evans 2013):

- *Administrative methods:* This includes stronger audit systems for expenditures and clinical practice and the introduction of clinical guidelines.
- *Legislation:* This includes mandatory generic substitution at pharmacies and restrictions on doctors selling medicines.
- *Information and voluntary behaviour-change activities:* This includes campaigns to encourage people to demand generic medicines and to encourage providers to prescribe them.
- *Incentive-change activities:* This includes changes in incentives to providers or consumers, usually related to the method of paying various types of providers.

These strategies will typically be most effective when combined. One particularly important, cross-cutting one is strategic or active purchasing (WHO 2000; Figueras et al. 2005; Preker et al. 2007; WHO 2010). Central to

³³ Calculations based on THE estimates from WHO Global Health Expenditure Database.

strategic purchasing is that the purchasing organization actively assesses and manages which interventions are purchased, from whom and how, with the aim of improving performance. This can be contrasted with passive purchasing which involves, for example, simply paying bills when presented and simply allocating resources according to the funding received the previous year.

Perhaps the most important issue with regard to *how* to purchase services is the payment mechanisms to which health service providers (e.g. hospitals) should be subject. These mechanisms are critical in shaping provider incentives and thus in shaping what the providers do. For hospitals, prevalent mechanisms include global budgets, capitation payments, fees for service and payment based on diagnosis-related groups (DRG). In addition, performance- and results-based financing is increasingly being explored and evaluated, and may be useful in certain contexts (Langenbrunner et al. 2009; Lagarde et al. 2010; Witter et al. 2012). Each mechanism has its strengths and weaknesses. Countries should therefore actively consider what would be the optimal mix of mechanisms given the needs of the population. Such a proactive attitude is necessary to ensure efficiency, equity and high-quality services.

Many countries have recently taken a more active stance and reformed their provider payment system, and the initial results are promising (Elovainio and Evans 2013). Exactly what policies are most appropriate will vary with context – including political preferences, institutional setting, price levels, disease patterns and coverage levels.

Recommendation 8: Every government and other actor involved in the financing or provision of health care must continuously strive to improve efficiency. In particular, this will require action on corruption and strategic purchasing, with continuous assessment and active management of which services are purchased and what providers and payment mechanisms are used.

Joint financing of global public goods

Global public goods are classically defined as being both non-excludable and non-rivalrous. This means that no country can be prevented from enjoying a global public good provided; nor can any country's enjoyment of the good impinge on the consumption opportunities of other countries (Barrett 2007).

Textbook examples of public goods include lighthouses, traffic rules and public information. Once these goods are provided, no ship captain, driver or student can be prevented from enjoying them, and their enjoyment does not diminish the availability of each of the goods for other captains, drivers or students. However, very few goods are pure

public goods – i.e. are both strictly non-excludable and non-rivalrous. It is therefore useful to employ the term 'public goods' also for impure public goods that exhibit these two properties to a significant, although not full, extent.

Because public goods are non-excludable and non-rivalrous, individual agents will often not see it as being in their interest to contribute to the production of public goods. When evaluating the option of contributing, the agent will often judge that the costs to him or her exceed the benefits that he or she can expect, even though the latter can be substantial – especially in the longer term – in addition to the benefits to others. One reason for this is that non-excludability prevents the agent from recouping costs by charging other beneficiaries. At the same time, the agent knows that if others provide the good in question, the agent can free-ride and enjoy the benefits – again because of non-excludability. The result is often a collective action problem in which the actions of each individual agent fail to bring about a situation in which everyone would be better off.

Global public goods are public goods with a global reach or that, at least, significantly benefit people in a wide range of countries.

Key GPGHs

One particularly important category of GPGHs concerns widely disseminated knowledge and information (Kaul et al. 1999; Moon et al. 2013). This category includes, for example, research findings on the causes of disease and effective interventions. For example, the discovery that oral rehydration therapy treats diarrhoea was a great GPGH (UNDP 2001). At the same time, GPGHs include the more routine collection and analysis of health-relevant data. The statistics provided by the Institute of Health Metrics and Evaluation (IHME) are one example. Similarly, health technology assessments and guidelines can be GPGHs. The WHO-CHOICE project, for example, provides cost-effectiveness estimates for a broad set of services, and institutions such as the National Institute for Health and Care Excellence (NICE) in the United Kingdom produce appraisals that can be helpful for a wide range of countries. Finally, infectious disease surveillance is a GPGH the importance of which has been repeatedly highlighted over the last years, for example by the outbreaks of SARS, avian influenza and swine influenza.

Another important category of GPGHs is positive normative guidance and regulation (Kaul et al. 1999; Moon et al. 2013). One good in this category is guidelines, such as the WHO guidelines on HIV treatment in resource-poor settings. Other examples are standards, such as the International Classification of Diseases (ICD), regulations for reducing

antimicrobial resistance, and safety and quality regulations of pharmaceuticals. Finally, both soft norms and binding law can be GPGHs. A prominent example of the latter is the Framework Convention on Tobacco Control (FCTC) (WHO 2003).

There are numerous other important examples, and the GPGHs on which the global community decides to focus should be the outcome of a careful debate.

Incentives and responsibility

As described, the defining features of public goods predispose them to underprovision. Collective action problems linked to such goods can typically be addressed by institutions or other mechanisms facilitating cooperation. Such mechanisms are prevalent at the national level, many of which finance the provision of public goods by collecting tax revenue. At the global level, however, no institution with similar capabilities exists.

National governments and actors nevertheless have the responsibility to seek cooperation and contribute to the financing of GPGHs, and this responsibility can be seen as a higher priority than the responsibility to provide external financing for national health systems. The responsibility for GPGHs is partly motivated by the fact that better financing of such goods – especially in the context of strong cooperation – can unleash enormous benefits across the world. These benefits will partly accrue to people outside the contributing country, and can be motivated by justice, solidarity and human rights perspectives. At the same time, some benefits are also likely to accrue to people in the country that produces or co-finances the GPGHs in question. Accordingly, the responsibility to co-finance GPGHs can follow from the responsibility each government has for securing the health of its own people, as well as from a responsibility to secure health in other countries.

Addressing current gaps

Data on the total amount of resources spent on GPGHs are sparse. This is partly due to the imprecision of the concept and the difficulty of quantifying spending on the many, diverse goods. Existing data collection systems are not well suited to identifying spending on GPGHs, and new methods for monitoring need to be developed. However, an insight into the scale of funding can be gained by looking at some examples. IHME estimated that in 2011 about \$3.5 billion – of \$30.6 billion in total external funds for health – was dedicated to initiatives ‘benefiting the entire world’ (IHME 2014).³⁴ Other examples are the total investment in research and development (R&D) for neglected diseases, estimated at about \$3.2 billion in 2012 (Moran et al. 2013), and

the WHO annual budget of about \$2 billion, of which a significant proportion finances GPGHs. While there is some overlap between these figures, many types of GPGHs are not included in any of them.

The nature of public goods also makes it hard to estimate the optimal level of investment in them. Need in this context is hard to define, from both a theoretical and a practical point of view. When both current and optimal levels of investment are hard to estimate, it is difficult to assess the gaps. However, theory suggests that the absence of mechanisms to ensure cooperation leads to underprovision, and such mechanisms are scarce at the global level. Quite apart from theory, there is also a widespread recognition that the current level of financing is wholly insufficient and that GPGHs are grossly undersupplied (Kaul et al. 1999; Moon et al. 2013; Blanchet et al. 2014).

There is a widespread recognition that the current level of financing is wholly insufficient and that GPGHs are grossly undersupplied.

The general underfinancing of GPGHs is further indicated by the limited provision of specific GPGHs. In particular, knowledge about how to tackle effectively a wide range of major diseases is still lacking for many common diseases and conditions that disproportionately affect the poor. Against that background, the \$3 billion spent on neglected diseases R&D annually is rather sparse. According to both the 2012 Consultative Expert Working Group on Research and Development: Financing and Coordination and the 2013 Lancet Commission on Investing in Health, spending should be increased to \$6 billion (CEWG 2012; Røttingen and Chamas 2012; Røttingen et al. 2012; Jamison et al. 2013a).

Other important examples include health statistics and infectious disease surveillance. The know-how to make improvement in these areas is there, but not money to do so. The same is the case for numerous other GPGHs.

Recommendation 9: Every government should meet its responsibility for the co-financing of GPGHs and take the necessary steps to correct the current undersupply of such goods. Among key GPGHs are health information and surveillance systems, and R&D for new technologies that specifically meet the needs of the poor. Public funding for R&D should be at least doubled compared with the current level.

International institutions have an essential role in ensuring cooperation between countries or in providing GPGHs directly, or both. Support for such institutions is therefore a key component of countries’ responsibility to promote GPGHs.

³⁴ More specifically, this category included ‘contributions made toward health research or the creation of public goods for multiple regions or projects that donors categorized as benefiting the entire world’ (IHME 2014).

One of the most important providers of GPGHs today is the WHO. The WHO produces, for example, standards, guidelines, assessments and health statistics, and it promotes infectious disease surveillance and helps forge consensus on contentious issues. However, the level and composition of funding for the WHO restrict its ability to provide GPGHs. Many of the initiatives agreed by WHO member states end up underfunded because of the failure of member states to provide the funding necessary to back up what they agreed that the WHO should do (Clift 2014). In 2012/13, for example, only 27.6 per cent of its funding for the programme budget was flexible and not in the form of earmarked contributions (WHO 2014a). The current state of the WHO thus signals a major gap in the provision of GPGHs.

Beyond the WHO, several other institutions provide important GPGHs. These institutions include IHME, the US Centers for Disease Control and Prevention (CDC) and other similar regional and national entities, and other UN entities (Blanchet et al. 2014). In addition, several new or radically transformed institutions with a focus on GPGHs have been proposed (CEWG 2012; Moon et al. 2013).

Recommendation 10: Every government should increase its support of new and existing institutions charged with the financing or provision of GPGHs. In particular, the WHO's capacity to provide GPGHs should be enhanced and adequate funds provided on a sustainable basis for that purpose.

As suggested above, every country has a responsibility to support the provision of GPGHs. This means that every government should contribute something, and the required contributions should vary according to capacity – primarily specified in terms of GDP and GDP per capita. For example, contributions to institutions providing GPGHs – such as the WHO and other UN organizations – are based on the UN assessment scale, and it has been proposed that contributions to R&D for technologies for diseases of the poor should be defined by a target such as 0.01 per cent of GDP (CEWG 2012). Currently, it is not possible to define a specific contribution rate for GPGHs overall. However, as the need for external financing of health systems decreases in the future, the released funds should be directed towards the provision of GPGHs, thereby benefiting health in all countries.

Supporting an enabling environment

The support of GPGHs goes beyond financial support. In particular, a global enabling environment for health and health financing can itself be seen as an abstract but crucial GPGH, which can be supported in multiple ways (Kaul et al. 1999; UNTT 2013). An enabling environment will

provide room for all countries to pursue domestic policies – including tax policies – that can adequately finance their social sectors, including health, education and welfare. The creation of such an environment will, among other things, require joint action by a range of actors on illicit financial flows, tax havens, harmful tax competition and overexploitation of natural resources (HLP 2013). For example, governments have to take care that their domestic tax policies do not harm other countries.

Similarly, international financing institutions such as the World Bank and the International Monetary Fund (IMF) must take care that they do not promote macroeconomic policies that hamper countries' ability to mobilize sufficient resources for health and other social sectors. At the same time, multinational corporations have a responsibility to contribute to transparency, cooperate on tax matters and not take part in transfer mispricing or other forms of tax evasion.

A global enabling environment will also facilitate more effective, equitable and sustainable external financing for health systems. In particular, such an environment will include institutions and mechanisms to ensure coordination among contributors, and between contributors and recipients, and to ensure mutual accountability among these actors.

Recommendation 11: Every government, international organization, corporation and other key actor should promote a global environment that enables all countries to pursue government-revenue policies that can sufficiently finance their social sectors, including health, education and welfare. This requires action on illicit financial flows, tax havens, harmful tax competition and overexploitation of natural resources.

External financing of national health systems

The total amount of external financing for health has increased substantially over the past two decades. As described, it almost doubled from \$5.8 billion in 1990 to \$11.2 billion in 2001, and nearly tripled to \$31.3 billion (in 2011 dollars) by 2013 (IHME 2014). External sources in this context include governments (from national treasuries), debt repayments to international financial institutions, private philanthropists and corporate donations.

The primary role of external financing

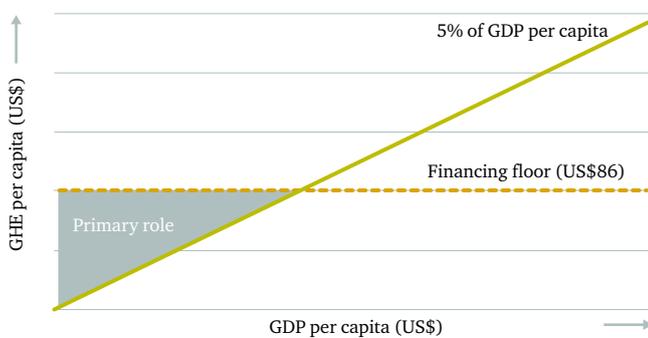
In 2012 external resources for health represented 30 per cent, 14 per cent and 3 per cent, respectively, of THE in LICs, LMICs and UMICs.³⁵

³⁵ Calculations based on data from WHO Global Health Expenditure Database. Unweighted averages, but countries with a population less than 100,000 were excluded in the analysis.

The future role of external financing has been the subject of considerable debate, but such financing is likely to remain crucial for a number of countries. As described, in 2012 GHE per capita – including both domestic and external resources – fell short of the \$86 target in 61 countries. Moreover, even if every country met the 5 per cent target for GHE/GDP in 2012, GHE per capita would still be below \$86 in 50 countries.³⁶ These figures for 2012 can be juxtaposed with the projected real GDP growth per year of 4.5 per cent for LICs in 2011–15 (Jamison et al. 2013a). Even with this growth rate, GHE as 5 per cent of GDP would imply GHE per capita below \$86 in many countries, at least in the medium term. In addition, several of the countries with currently large shortfalls from \$86 may be at particular risk of experiencing lower-than-average growth rates.

Against this background, the primary role of external financing can be seen as reducing the gap between \$86 and GHE per capita if GHE represented 5 per cent of GDP.³⁷ This is because countries with such a gap are unable to ensure priority services even if they meet the 5 per cent GHE/GDP target. This primary role of external financing is illustrated in Figure 3.

Figure 3: Primary role of external financing for health



Source: Authors.

The responsibility to fill this gap falls on every country that has sufficient capacity – i.e. capacity higher than what is needed for meeting priority health needs internally and for contributing to the co-financing of GPGHs. A central determinant of such capacity is GDP per capita. The OECD Development Assistance Committee (DAC) member countries clearly have the capacity and responsibility to address the financing gap, and so do all other HICs.

However, most UMICs also have some capacity for external financing. For example, if the UMIC with the lowest GDP per capita invested 5 per cent of GDP as GHE, GHE per capita would amount to \$187.³⁸ For countries with GHE per capita higher than this, it should be considered more important to allocate some of the marginal dollars to countries that do not have the capacity to reach even GHE per capita of \$86.

Even if the primary role of external financing is to fill what can be called the minimum-capacity gap, external financing can still play an important role for countries for which 5 per cent of GDP would represent GHE per capita of more than \$86 but whose *actual* GHE per capita is nevertheless below that level. In addition, external financing also can be important for countries that have large health needs and inequalities in health despite GHE per capita above \$86.

Recommendation 12: Every country with sufficient capacity should contribute to external financing for health. Determination of capacity should partly depend on GDP per capita. Net contributing countries should include all HICs and most UMICs, and not only OECD-DAC member countries.

Identification of contributors to external financing is, however, only part of the response to the many challenges in this area. For a robust response, there is a need to establish clear norms for country contributions to external financing, establish clear criteria for the allocation of funds, align external financing with national priorities, improve coordination and seek increased pooling of external funds.

Establishing clear contribution norms

Contribution norms specify the amount of external financing that each country is obliged to provide.³⁹ One well-known norm of that kind is the 0.7 per cent ODA/GDP target, which originated in the 1969 Pearson Report (Pearson et al. 1969).⁴⁰ Since then, numerous countries have promised to make efforts towards that target, and in 2005 15 EU member states pledged to reach the target by 2015 (Council of the European Union 2005). As of 2013, however, only five OECD-DAC member countries are meeting the target (UKAN 2014).

More effective norms are typically linked to specific institutions. One example is the UN scale of assessments for the contributions of member states to the regular budget (UN 2012; UN 2013). Another example is the

³⁶ Calculations based on data from WHO Global Health Expenditure Database.

³⁷ To the extent that the countries with such a gap also have a gap between \$86 and *actual* GHE per capita. This requirement would be relevant for otherwise applicable countries that spent more than 5% of GDP on health.

³⁸ Calculation based on data for 2012 from WHO Global Health Expenditure Database.

³⁹ Norms of contribution are sometimes described as norms for burden-sharing.

⁴⁰ More precisely, according to the original formulation, '[e]ach developed country should increase its commitments of official development assistance to the level necessary for net disbursements to reach 0.70 per cent of its Gross National Product by 1975 or shortly thereafter, but in no case later than 1980' (Pearson et al. 1969).

burden-sharing scheme for the International Development Association (IDA) – the World Bank’s main lending and grant mechanism for the poorest countries (IDA 2014a). The scheme is based on triennial, voluntary replenishments but has proved sustainable over many years. The 17th replenishment was finalized in 2013 (IDA 2014a).

It is important that contribution norms for external financing for health are clear and well founded. Only then are international agreement and compliance likely. Optimally, the norms should also lead to sufficient funds overall, while ensuring fairness among countries.

The two key elements of contribution norms are the identification of required contributors and the specification of their contribution rate. Both should be motivated by the idea of shared but differentiated responsibilities.

The countries that should provide external financing for health were described above. As for contribution rates, a minimum rate can be linked to the primary role of external financing for health – i.e. to fill the total minimum-capacity gap that was discussed above. At present, the sum of gaps, across all countries, between average GHE per capita – if GHE represents 5 per cent of GDP – and the \$86 target is \$65 billion. To fill that gap, HICs will have to contribute about 0.13 per cent of their collective GDP of \$49.77 trillion.⁴¹ Given that the idea is for a contribution norm that is relatively simple, a good and reasonable norm would be for every HIC to contribute at least 0.15 per cent of its GDP. This target is also in line with the 0.7 per cent ODA target, since external financing for health today represents approximately 19 per cent of ODA, which would be slightly above 0.13 per cent of GDP if that target were met.⁴² The \$65 billion that would result from compliance with this norm far exceeds the \$30.1 billion of external funds for health that actually was provided in 2012 (in 2011 dollars) (IHME 2014).

While adherence to the 0.15 per cent of GDP norm for external health financing can close the minimum-capacity gap under optimal circumstances, it will not exhaust the need for external financing for health. This is partly because there is likely to be sub-optimal allocation of funds between countries. In addition, as noted, there is an important secondary role of external financing for health.

To account for this, as well as to promote a fair relationship between HICs and UMICs, most UMICs should commit to progress towards the 0.15 per cent of GDP norm. With all HICs and UMICs contributing 0.15 per cent of GDP, total external funds for health would be approximately \$100 billion.

Recommendation 13: HICs should commit to provide external financing for health equivalent to at least 0.15 per cent of GDP. Most UMICs should commit to progress towards the same contribution rate.

In the long run, the need for external financing will decrease in line with the extent to which economies grow in real terms and countries meet the 5 per cent GHE/GDP target. As the overall need decreases, contributors should increasingly finance GPGHs, as discussed above. The importance of agreement on norms and the role of compliance mechanisms are discussed below.

Establishing clear allocation criteria

External financing for health is not only about the quantity of funds: it is also about quality or how those funds are used. Allocation criteria are rules meant to guide the allocation of external funds, across countries as well as action areas. These criteria are primarily used by the institutions distributing external funds. However, the extent to which these criteria are publicly available varies considerably between institutions, and among the criteria that are available there are profound variations in content (Ottersen, T. et al. 2014).

Allocation criteria should be clear and explicit. This promotes accountability and public deliberation, which are important in themselves but which also facilitate the design of better, more reasonable criteria.

Well-founded allocation criteria are critical given the large amount of resources and the high human stakes involved, and given the central role of these criteria in linking domestic and external financing.

Well-designed allocation criteria promote two key objectives: effectiveness and equity. The criteria should guide external financing towards the countries and interventions in and for which it can be most effective; and, at the same time, the criteria should promote an equitable distribution of resources among countries and people (Jamison et al. 2006; Shiffman 2006; Anderson 2008; Guillaumont 2008; Sridhar and Batniji 2008; IHME 2014; Ottersen, T. et al. 2014). With regard to countries, the promotion of equity will typically require high sensitivity to capacity and needs (Glassman et al. 2013; Ottersen et al. 2013; Basu et al. 2014; Dieleman et al. 2014; Ottersen, T. et al. 2014).

⁴¹ Calculation based on GDP data from the World Bank for 2012.

⁴² Ratio for 2011 based on estimate for total development assistance for health from the IHME (IHME 2014) and estimate for total ODA (net disbursements) from the OECD (OECD 2014).

Allocation criteria should also be clear and explicit. This promotes accountability and public deliberation, which are important in themselves but which also facilitate the design of better, more reasonable criteria. Distributors of external funds for health should therefore carefully design their allocation criteria and make these publicly available. Ideally, the allocation criteria should be the outcome of a broad, deliberative process with input from key stakeholders, directly or through representatives such as civil society organizations. Among these stakeholders are those that provide funds – which will often include the general population in the contributing country, since it has typically provided funds through the tax system. Especially when it comes to the distribution of external funds across different action areas, the population in the recipient country should also be involved. Priority-setting within health systems, and relevant processes and accountability mechanisms are discussed below.

Recommendation 14: Every provider of external financing for health, including contributing countries and international organizations, should establish clear, well-founded and publicly available criteria to guide the allocation of resources. These should be the outcome of broad, deliberative processes with input from key stakeholders, including civil society in contributing and recipient countries.

In respect of the allocation between countries, most institutions seem to employ criteria concerned with effectiveness as well as equity, where the latter is linked to capacity and needs (Ottersen, T. et al. 2014). More specifically, many institutions use an eligibility criterion linked to gross national income (GNI) per capita – a measure that is very similar to GDP per capita. However, the threshold value above which countries are deemed ineligible for aid varies considerably between institutions. For example, the IDA uses a threshold of \$1,175 (IDA 2014b), while GAVI uses one of \$1,570 (GAVI 2014) and UNICEF one of \$12,615 (UNICEF 2012). In comparison, the World Bank currently classifies LICs and HICs as having GNI per capita of less than \$1,035 and more than \$12,615 respectively (WB 2014).

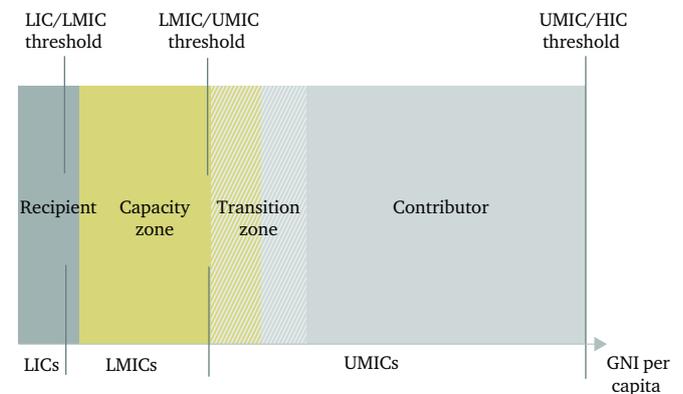
The variation in eligibility thresholds points to one of the greatest challenges to the design of allocation criteria – and to external financing for health more generally (Ottersen et al. 2013): what is the proper role of MICs in that system? Should they be recipients, contributors, both, or none?

Recent developments have changed the role and characteristics of these countries. MICs are now home to more than 75 per cent of the world’s poor and account for a major share of the world’s health needs (Sumner 2012; Alkire et al. 2013). Accordingly, MICs are on the one hand characterized by mid-level GDP per capita,

and this may suggest that MICs should be ineligible for external financing. On the other hand, many MICs are also characterized by substantial poverty and health needs, as well as by large inequalities, and this may suggest that most MICs should be eligible for external financing. Against this background, it is clear that distributors of external funds for health should pay particular attention to the role of MICs when devising allocation criteria.

We suggest that GDP per capita should have a central role in the identification of recipients of, and contributors to, external financing, but that health needs should also be taken into account. We therefore suggest that an acceptable compromise between the concerns involved can be achieved by the use of needs-driven exceptions linked to the income thresholds. The implications are likely to be that some MICs should reasonably qualify as recipients and others as contributors, while a subset of MICs should be neither recipients nor contributors. Finally, there is a limited case for certain countries to be both recipients and providers of external support, when such support goes beyond direct financial transfers.

Figure 4: Potential roles of middle-income countries (MICs) in external financing for health



Source: Authors.

This tentative role of MICs can be illustrated by way of a capacity zone, as in Figure 4. The exact threshold values in that figure are intended for illustrative purposes only. Countries below the capacity zone qualify as recipients, while countries in the capacity zone can qualify if they meet two further conditions. One is related to health needs. Specifically, countries in the capacity zone can qualify as recipients to the extent they have large absolute health needs. However, these countries should at the same time meet certain incentive-preserving conditions that can be linked to, for example, co-financing, policy changes or targeting of those most in need (Ottersen et al. 2013). Countries in the transition zone should typically be neither recipients nor contributors, as they will tend to have the

capacity to address domestic health needs but often not sufficient capacity for financing health needs abroad. Finally, countries above the transition zone will typically qualify as contributors, and these countries will include many UMICs.

Aligning external financing with national priorities

It is critical that external financing is optimally aligned with recipient countries' priorities and promotes country ownership over its development. This is important not only for respecting countries' own decision-making processes, but also for cultivating national leadership in health and for improving the effectiveness of external financing.

Several initiatives have set out how alignment and ownership can be strengthened. Prominent among these is the 2005 Paris Declaration on Aid Effectiveness and the follow-up processes in Accra in 2008 and in Busan in 2011 (Paris Declaration on Aid Effectiveness 2005; Accra Agenda for Action 2008; Busan Partnership for Effective Development Co-Operation 2011). Ownership is also emphasized in the 2002 Monterrey Consensus on Financing for Development and the follow-up declaration in Doha in 2008 (UN 2003; UN 2009).

Recipient-country governments should take the lead in developing national plans and strategies, and countries contributing external financing should encourage this process and comply with the resulting plans.

In the spirit of these initiatives, recipient-country governments should take the lead in developing national plans and strategies, and countries contributing external financing should encourage this process and comply with the resulting plans. To facilitate this and progress towards alignment and ownership more generally, recipient and contributing countries should work jointly to improve transparency with regard to disbursement and results. Monitoring mechanisms and frameworks for mutual accountability should therefore be developed or strengthened. In support of these efforts, contributing countries should also help strengthen domestic governance capacity so that recipient countries can better own and manage their overall development process.

Several initiatives have been established to help implement these guiding ideas (Balabanova et al. 2010; Moon and Omole 2013). One prominent example is the International Health Partnership (IHP+), which was launched in 2007 (IHP+ 2014). IHP+ is a group of partners that work together to put the principles of the 2005 Paris

Declaration into practice in the health sector. There are currently 59 signatory countries to the IHP+ Global Compact, including developing countries and contributors to external financing. Actual changes in practices among the signatories appear to be only partial, but progress has been found in the areas of strengthening national planning processes and mutual accountability as well as of contributors aligning their support with national budgets (Shorten et al. 2012).

When seeking to improve alignment and ownership, contributors should also assess their allocation criteria and their use of conditionality. Optimally, recipient and contributing countries should agree on a limited set of mutual conditions based on national development strategies (Accra Agenda 2008).

Recommendation 15: Every provider of external financing for health should align its support with recipient-country government priorities to the greatest extent possible. This calls for strong adherence to the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. In particular, providers of external financing for health should encourage and comply with national plans and strategies, improve transparency and monitoring of disbursements and results, and help to build domestic governance and institutional capacity.

For the sake of alignment and ownership, the majority of external resources should be channelled through government-led institutions and programmes whenever possible and in line with national plans. This is also important for strengthening governance capacity.

Improving coordination

The proliferation of actors involved in external financing has exacerbated the problem of coordination among them, with the predictable consequences of system fragmentation, inefficiencies, confusion, gaps and transaction costs (Acharya et al. 2006; Moon and Omole 2013; Bigsten and Tengstam forthcoming). For example, lack of coordination leads to duplication of effort in some areas and no effort in others. The inefficiencies arising from poor coordination add to the unnecessary high administration costs that follow from a continual creation of new initiatives with their own secretariats and governing arrangements.

There are also challenges for the coordination of external funders or providers and each recipient country (Garrett 2007; Biesma et al. 2009). These challenges go beyond those related to alignment with national priorities discussed above. Even where the aims are broadly shared, there are numerous examples of overlapping activities that lead to unnecessary duplication or even harmful competition.

Again, key responses to the coordination problems are set out in the Paris Declaration and follow-up processes in Accra and Busan. In particular, poor coordination should be addressed by strengthening country-led division of labour among different external providers, and between those and internal providers. At the same time, external funders and providers should harmonize their procedures for reporting, budgeting, and financial management and procurement; and they should look for ways to use shared arrangements, including joint assessments and joint offices and through pooling of funds. In addition, both contributors and recipients should improve information-sharing and make key information readily and publicly available. More specifically, contributors should share information on commitments and implementation plans, actual disbursements and outputs, and outcomes and assessments. For their part, recipient countries should share information about budget and planning, and monitoring and evaluation. The recipient country should also be allowed to take the lead and oversee the coordinating efforts.

Recommendation 16: All providers of external financing for health should strive to strengthen coordination among themselves and with each recipient country, in order to improve efficiency as well as equity. In particular, they should encourage and comply with country-led division of labour, harmonize procedures, increase the use of joint and shared arrangements, and improve information-sharing.

Numerous more concrete initiatives have been established to facilitate coordination, including the IHP+ (Balabanova et al. 2010; Moon and Omole 2013). In addition, it has been suggested that coordination can be improved by expanding international law, expanding global pools of funds for health, or both (Gostin and Friedman 2013; Ooms and Hammonds 2014).

Seeking increased pooling of external funds

Much external funding is already channelled to recipients through international entities, including UN agencies, the World Bank and regional development banks, and newer entities such as GAVI and the Global Fund.

Of the \$31.3 billion of external funds for health provided in 2013, \$19.7 billion (63 per cent) was channelled through entities other than bilateral development agencies (in 2011 dollars) (IHME 2014). Of this, GAVI and the Global Fund disbursed \$1.5 billion and \$4.0 billion respectively (IHME 2014).

Benefits from increased pooling

There are several potential advantages to further pooling of external funds for health, many of which are suggested by the demonstrated benefits from GAVI and the Global Fund (Ooms and Hammonds 2014). Increased pooling:

- can simplify the global health architecture, reduce administrative costs and improve coordination;
- may make funding more predictable, and this can increase the value of the funds to the recipient;
- is likely to be less influenced by the interests of particular funding sources, including contributing countries, and better aligned with health needs and effectiveness;
- may provide a good opportunity for broader mandates and a true focus on health systems strengthening, as opposed to the focus on specific diseases and interventions among today's dominant actors;
- may facilitate more effective contribution norms and fairer burden-sharing;
- may offer scope for increased transparency and accountability;
- may mobilize additional funds, partly because large-scale initiatives are helpful for advocacy and bring political attention.

Overall, increased pooling can make the use of existing funds more effective, efficient and equitable. The potential benefits are likely to generate support from recipient countries but can also generate support from contributors to the extent that these are willing to give up some control over the funds they provide (Ooms and Hammonds 2014). Large pools such as GAVI and the Global Fund have come with strong mechanisms for monitoring disbursement and results to reassure contributors that their funds are well spent.

How pooling can be increased

Pooled funding could be managed through entirely new institutions. However, the global health arena is overcrowded and, rather, in need of simplification (Sidibé and Buse 2013). It is therefore better to examine the possibilities for using existing institutions by means of expanding their mandates, mergers and attracting additional funds.

Each of the existing institutions tends to focus on a limited set of diseases or interventions, but many have more recently got at least a minor health systems strengthening component in their mandates (Hafner and Shiffman 2013). It has been suggested that some of these institutions – GAVI and the Global Fund in particular – should more fundamentally shift their focus towards financing of integrated health strategies and health systems strengthening (Ooms et al. 2008; Cometto et al. 2009; Dybul et al. 2012).

Combined with a change in mandate, the merger of some of the existing institutions could be considered. Again, GAVI and the Global Fund have been mentioned as the prominent candidates (Cometto et al. 2009). In fact, these two institutions, together with the World Bank, already collaborate on health systems financing through the Health Systems Funding Platform established in 2009 and facilitated by the WHO (HLTF 2009b; Hill et al. 2011). While not at all representing a true merger and while being only partially implemented, the underlying idea is an interesting one.

With a broader mandate, existing institutions – merged or not – can seek to attract additional funds. These could be funds that are today channelled through bilateral development agencies. However, with a broader mandate and the prospective benefits from increased pooling, these institutions should also be able to attract new funds into health systems financing.

Recommendation 17: Every government should actively assess the existing mechanisms for pooling of external funds for health – including the Global Fund, GAVI and the World Bank’s health trust funds – and consider the feasibility of broader mandates, mergers and increased global pooling with the aim of improving efficiency and equity.

5. Accountability and Global Agreement

Two issues cut across all the policy responses proposed and the entire proposed framework: accountability; and processes for achieving global agreement on the responsibilities, targets and strategies embedded in the framework.

Mutual, people-centred accountability

Poor accountability is increasingly seen as one of the major deficiencies in today's governance structures, and accountability is now high on the international agenda (HLP 2013; TT 2013; UN 2013; UNDP 2013b).

Accountability underlies fair and legitimate processes, enables public participation and promotes democratic values. It can help build trust and facilitate public deliberation, education and learning.

Accountability involves answerability and enforceability (Schedler 1999). Individuals and institutions that are held accountable should give information about their decisions and actions, justify them and be subject to sanctions in the event of misconduct. All actors that influence health financing should be accountable to the public in a meaningful way – directly or indirectly. These actors include, in particular, national and local governments, international institutions, multinational corporations, external funders and service providers. Each of these actors is part of a web of accountability relationships, and each relationship can be described in terms of *who* is accountable for *what*, to *whom* and *how*.

The importance of accountability

A well-designed accountability relationship will incentivize the agent being held accountable to improve its performance, and also has a number of other benefits (Elster 1998; Gutmann and Thompson 2004; Daniels and Sabin 2008; UN 2013). Strengthened accountability can improve decisions by making the agent more careful and disciplined, and more sensitive to a wider range of needs and values. Strengthened accountability can also make implementation more effective and efficient by encouraging results and impact, and discouraging fraud, corruption and waste. Moreover, accountability underlies fair and legitimate processes, enables public participation and promotes democratic values. It can also help build trust and facilitate public deliberation, education and learning.

Strengthened accountability is also crucial for putting the idea of shared but differentiated responsibilities into practice. It is a critical and integral component of many of

the policy responses outlined above, including those related to mandatory prepayment and taxation, priority-setting, efficiency, contribution norms, allocation criteria, alignment and coordination.

Current gaps

Many accountability relationships need to be strengthened, at both national and global levels (CSDH 2008; HLP 2013; UN 2013; UNTT 2013; Ottersen, O. et al. 2014). For example, governments are often not sufficiently held accountable to their own people through mechanisms such as elections, the media, international institutions and civil society organizations. Similarly, governments are often not sufficiently held accountable to other governments or to the public in other countries, for example with regard to external financing. At the same time, governments themselves often fail to hold other entities – such as multinational corporations, external funders and service providers – sufficiently accountable. Finally, many, if not all, international institutions are inadequately accountable to the global public.

Overall, many accountability gaps need to be closed in order to achieve people-centred, mutual accountability where all partners in health financing are accountable to one another and ultimately to the public.

Strengthening accountability

Two components are crucial to all – or nearly all – efforts to improve accountability: information and participation (CSDH 2008; Commission on Information and Accountability for Women's and Children's Health 2011; HLP 2013; UN 2013; WHO 2014c).

With regard to information, openness about the following types of information is required:

- *Information about decision-making processes:* Decision-makers should be open to the public about their decision-making processes and make the reasons for their decisions publicly available. This requirement is particularly important for national and local governments, but it also applies to international institutions, NGOs, external funders and service providers.
- *Information about decisions:* Health financing institutions should disseminate the decisions that they make, including with regard to commitments, plans and budgets.
- *Information about inputs:* Actors involved in the distribution of resources should provide clear information about how these resources have actually been allocated.

- *Information about outputs:* Service providers, and indirectly their funders, should provide clear information about what has actually been delivered.
- *Information about outcomes:* Service providers, and indirectly their funders, should provide clear information about the outcomes from service delivery.

As regards inputs, outputs and outcomes, it is important that governments not only provide information linked to specific policies, but also ensure continuous monitoring and evaluation of the level and distribution of service coverage and health outcomes in the country – the results of which should be publicly available. In order truly to strengthen accountability, it is also necessary to have mechanisms ensuring that the information feeds back into policy-making and public debate. Moreover, the accountability relationship is not a one-way street where information is simply disseminated. The accountee should have some influence over the accountant's decisions and actions. Participation, which is often linked to the concepts of voice, inclusion and empowerment, is therefore critical.

Participation can be improved by directly involving citizen representatives in the formal policy processes. Both at national and sub-national levels, there can be lay representation, for example, on regular boards and committees as well as within other decision-making or assessment bodies. This can be combined with public involvement through various participatory procedures, such as citizens' juries, citizens' panels, consensus conferences, deliberative polling and town meetings with voting (Abelson et al. 2003; Rowe and Frewer 2005; Mitton et al. 2009). In international institutions, participation by the global public can be improved by including members in the decision-making bodies who help to ensure that a wide range of interests is represented – and not just the interests of the currently or historically most powerful.

Participation can also be improved in more indirect ways. In particular, civil society organizations, and their interaction with the formal policy processes, can be strengthened. To do so, governments should enable such organizations to flourish and ensure they have effective avenues for influencing these processes.

Whatever strategy is pursued to strengthen accountability and participation, emphasis should be put on marginalized groups and the otherwise most voiceless.

The relationship between accountability and the proposed framework runs in both directions. As noted above, accountability supports the framework, and at the same time the proposed policy responses themselves contribute to strengthened accountability. This is the case, for example, with regard to taxation and explicit priority-setting. The

overall framework also contributes to accountability by specifying responsibilities, norms and targets, as clarity in these respects is a precondition for robust accountability.

Recommendation 18: Every government and other actor involved in domestic or external financing or in the provision of health services should seek to strengthen accountability at global, national and local levels. This should be done by improving transparency about decisions, resource use and results, by improving monitoring and data collection, and by ensuring critical evaluation of information with effective feedback into policy-making. Accountability should also be strengthened through active monitoring by civil society and by ensuring broad participation of stakeholders throughout the policy process.

Global agreement

Implementation of a coherent global framework would be facilitated by broad agreement on the responsibilities of governments and others to ensure adequate domestic and external financing of health systems and joint financing for global public goods.

Agreements on issues of health financing can be sought and shaped in the process of formulating the post-2015 development agenda. Every government and other relevant actor should seek to ensure that health and UHC are included as central goals and yardsticks, and that key responsibilities, targets and strategies of the proposed framework are integrated in that agenda. The level and type of integration will, of course, also depend on what general form the resulting post-2015 agenda will take. To facilitate health and UHC being assigned the central role that they should have in future development efforts, the post-2015 agenda should make clear that health is important both for its own sake and for the sake of the many other goals outlined earlier. However, also irrespective of the content of the final agenda, the preceding consultations can be valuable in themselves by preparing the ground for more comprehensive and detailed agreements in other forums at a later stage.

Recommendation 19: Every government and other key actor should seek to ensure that health and UHC are central goals and yardsticks in the post-2015 development agenda. These actors should also seek to ensure that the responsibilities, targets and strategies of a coherent global framework for health financing are integrated to the full extent possible. Moreover, the agenda should make clear that health is important both for its own sake and for the sake of other goals, including poverty eradication, economic growth, better education and sustainability.

Beyond the post-2015 agenda, many forms of specific agreement on health financing can be useful. The optimal forum and process for forging agreement will depend on a range of factors. While agreement in the form of international law has been proposed (Gostin and Friedman 2013), a more feasible option may be to seek agreement by means of a political declaration or resolution. Such an agreement for a global framework on health financing can be sought in different forums. In particular, these include global meetings of heads of state at the UN General Assembly, health ministers at the WHA, finance ministers at the World Bank/IMF, or a combination of these actors at a high-level stand-alone meeting. Alternatively, agreements can also be sought among a more limited set of stakeholders, such as the G8 or G20. One prominent historical example of a high-level stand-alone meeting is the 1944 Bretton Woods conference. A more recent example, in the context of external financing, is the 2005 Paris Declaration on Aid Effectiveness. Inspired by these or similar cases, many have called for a dedicated meeting for forging an agreement on global health financing or global health more generally (Epstein and Guest 2005; Dybul et al. 2012).

Effective monitoring mechanisms with publicly available information can promote compliance through ‘name and shame’ and pressure from peers, civil society and other actors.

When seeking agreement on a coherent global framework, it is essential also to seek agreement on monitoring and compliance mechanisms, which are relevant in the context of accountability (Hoffman and Røttingen 2012; UN 2013). In particular, effective monitoring mechanisms with publicly available information can promote compliance through ‘name and shame’ and pressure from peers, civil society and other actors. Amid many more specific mechanisms, the post-2015 agenda can also be a useful instrument for basic monitoring and for promoting compliance.

Recommendation 20: All stakeholders should enter into a process of seeking global agreement on key responsibilities, targets and strategies for health financing – including on the mechanisms for monitoring and enforcement – in order to expedite the implementation of a coherent global financing framework. In the short term, consultations on the post-2015 development agenda are one useful arena for building consensus, and the agenda itself can be a valuable commitment device. In the longer term, a more specific process should be devised in one or more relevant forums, such as the UN General Assembly, the WHA, the World Bank/IMF, or a high-level stand-alone meeting.

There are multiple reasons why the relevant actors may want to seek agreement on a coherent global framework similar to that proposed in this report. In general, countries will generally benefit from the way in which the framework promotes a global enabling environment and other GPGHs. Many countries receiving external financing will also benefit from, for example, better alignment, better coordination and increased pooling. Moreover, these countries will – together with most other actors in global health – like to see an increase in total external funds. Contributing countries, on the other hand, can be attracted to the framework through their desire for more effective external financing and for greater transparency in recipient countries. Overall, this will bring more effective, efficient, equitable and sustainable development cooperation for health. International institutions and NGOs are diverse, but most of these will find that the framework gives them an important role as well as the room and tools for effective action. Finally and fundamentally, some sources of motivation can and should move all: justice, solidarity and human rights.

6. Conclusions

Financing is at the centre of efforts to improve health and health systems. It is only when resources are adequately mobilized, pooled and spent that people can enjoy robust health systems and sustained progress towards UHC.

We have shown how common challenges put such progress at risk in countries worldwide, and particularly in low- and middle-income countries. We have made the point that these challenges are common not only because they happen to be present across these countries, but also because globalization means the underlying causes and transitions know no borders. This calls for collective action on a global scale. Specifically, it calls for an agreed coherent global framework for health financing capable of securing efficient, equitable and sustainable mobilization and use of sufficient funds.

Key elements of the proposed framework

We have described how progress towards such a framework can be made by revising the current approach to health financing in three areas: the domestic financing of national health systems, the joint financing of GPGHs and the external financing of national health systems where domestic capacity is inadequate. Progress in these areas can be achieved through a set of policy responses.

To strengthen domestic financing of national health systems, we conclude that every government should fulfil its primary responsibility for securing the health of its own people and mobilize more resources through taxation, other mandatory prepayment mechanisms and other revenue sources, while reducing catastrophic and impoverishing OOPs. Every government should also improve priority-setting and efficiency. We further identified a financing floor for priority services of at least \$86 per capita. Governments should aim for GHE of at least this level; and, in addition, commit to a target of GHE of at least 5 per cent of GDP, to a target of OOPs to represent less than 20 per cent of THE, and to have no OOPs for priority services or for the poor.

To strengthen the joint financing of GPGHs, we conclude that every government should meet its responsibility for co-financing such goods and take the necessary steps to correct the current undersupply of GPHGs. These steps include increased support for new and existing institutions charged with the financing and provision of GPGHs. Among key GPGHs are health information and surveillance systems, and R&D for new technologies that specifically meet the needs of the poor. Public funding for R&D should be at least doubled compared with the current level.

To strengthen external financing for health, we emphasize that every country with sufficient capacity should contribute. We conclude that external funders and other

relevant actors should establish clear and well-founded contribution norms and allocation criteria, and align their support with national priorities. They should, in addition, together with the recipient country seek to improve efficiency and coordination at both global and national levels. More specifically, we argue that all HICs and most UMICs – not just OECD-DAC member countries – should commit to external financing. HICs should provide the equivalent of at least 0.15 per cent of GDP, and most UMICs should progress towards that rate. We also recommend that every government should actively assess the existing mechanisms for pooling of external funds for health and consider the feasibility of broader mandates, mergers and increased global pooling, with the aim of improving efficiency and equity.

If all actors met the responsibilities and targets specified in this report, not only would the estimated global financing gap of \$196 billion be closed, but health financing would also become more efficient, equitable and sustainable.

Strong accountability mechanisms are a necessary accompaniment to these responses. We believe that accountability should be strengthened by improving transparency about decisions, resource use and results, by improving monitoring and data collection, and by ensuring critical evaluation of information with effective feedback into policy-making. We also conclude that accountability should be strengthened by means of inclusive participation of civil society and other stakeholders throughout the policy process.

If all actors met the responsibilities and targets specified in this report, not only would the estimated global financing gap of \$196 billion be closed, but health financing would also become more efficient, equitable and sustainable. This would bring better health, better health systems and bold progress towards UHC.

Next steps towards global agreement

Implementation of this new framework will be facilitated by broad agreement on the embedded responsibilities, targets and strategies. As an initial step, we believe that agreement on key issues of health financing can be sought and shaped in the process of formulating the post-2015 development agenda. Every government and other relevant actor should seek to ensure that health and UHC are included as central goals and yardsticks, and that key responsibilities, targets and strategies of the proposed framework are integrated in that agenda.

Agreement on health financing in the context of the post-2015 agenda would be an important step, but only a first step. Our key conclusion is that a more specific agreement on health financing is also needed. This can be sought in the form of a political declaration or resolution in the context of the UN General Assembly, the WHA, the World Bank/IMF, or a high-level stand-alone meeting. We encourage all stakeholders, therefore, to enter into a process of seeking agreement on a global framework for sustainable health financing. If successful, the great potential that lies in health systems strengthening and in proven high-impact interventions can eventually be unleashed.

Annex 1: Working Group Members and Participants

Name	Country	Affiliation
Working Group 2		
<i>Working group members</i>		
John-Arne Røttingen (chair)	Norway	Norwegian Institute of Public Health/University of Oslo/Harvard University
Awo Ablo	Ghana/UK	International HIV/AIDS Alliance
Dyna Arhin-Tenkorang	Ghana	Formerly Ministry of Health
Christoph Benn	Germany	Global Fund to Fight AIDS, Tuberculosis and Malaria
David Evans	Australia	World Health Organization
Luiz Eduardo Fonseca	Brazil	Fiocruz
Julio Frenk	Mexico	Harvard University
David McCoy	UK	University College, London
Di McIntyre	South Africa	University of Cape Town
Suerie Moon	United States	Harvard University
Gorik Ooms	Belgium	Institute of Tropical Medicine
Toomas Palu	Estonia	World Bank
Sujatha Rao	India	Formerly Ministry of Health
Devi Sridhar	United States	University of Oxford/University of Edinburgh
Jeanette Vega	Chile	Rockefeller Foundation
Suwit Wibulpolprasert	Thailand	Ministry of Health
Simon Wright	UK	Save the Children
Bong-Min Yang	Korea	Seoul National University
<i>Others who participated or presented</i>		
Riku Elovainio	Finland	World Health Organization
Marielle Hart	Ghana/UK	International HIV/AIDS Alliance
Churnrurtai Kanchanachitra	Thailand	Prince Mahidol University
Trygve Ottersen	Norway	University of Bergen
Heidi Tavakoli	UK	Bill & Melinda Gates Foundation

Annex 2: Individual Reflections from Working Group Members

Luiz Eduardo Fonseca

The report makes an important contribution to the discussion of health financing, but in my view it should place more emphasis on building health systems which would be public, universal and comprehensive. In this sense, the commitment of national states to achieve the goals for sustainable development should include an intersectoral and comprehensive approach. This is what will give meaning to the term 'development' and generate domestic political debate aiming to guarantee health as a right of the population, as well as education, housing, food security and transportation, among others.

Public financing based on tax collection is essential to sustain all those public services – or, in other words, to secure sustainable development. Domestic health financing depends on domestic policies, and a national health policy should apply financing for a universal health system instead of only for UHC, which is much more an outcome of the former. To achieve UHC a country needs a strong health system to plan, implement and regulate. On the other hand, to sustain the quality of its health system and its broad coverage, a country needs strong institutions such as national institutes of health and public health institutes. Thus, financing a health system also means financing the country's structural health institutions to develop domestic health research, technology and evidence-based policies, and to take advantage of global cooperation on those public goods.

'Health as a right' does not only mean medical services; it also means a comprehensive system to assure health promotion, prevention, curative and rehabilitation, as well as training, research, technology and production. Funding schemes that privilege only disease protocols and treatments aimed at increasing coverage end up favouring apolitical technical approaches that may undermine the roles played by local governments and their obligations towards their populations.

David McCoy and Di McIntyre

In our view, this report makes two important new contributions to policy debates on health financing. The first is to suggest a target for GHE of 5 per cent of GDP; and to couple this to targets to reduce the level of catastrophic household payments for health care and general out-of-pocket expenditure. The second is to propose a minimum level of per capita health expenditure (\$86) as the basis for determining systematic fiscal transfers between countries.

However, some aspects of the report are not expressed as well as we would have liked; while certain issues have been excluded.

- The target of GHE equalling 5 per cent of GDP is recognition that many low- and middle-income countries have the potential to raise much higher levels of public revenue than is currently the case. Implicit in this target is the idea that countries should aim to capture *at least* 35 per cent of GDP as public revenue in order progressively to realize *all* social and economic rights, many of which are key social determinants of health. This could be partly done by improving tax administration systems and implementing better tax policies. Ideally, this report would have placed greater emphasis on tax and other sources of government revenue (such as from strategic management of natural resources) as a priority issue for the international health community.
- Illicit financial flows cost low- and middle-income countries hundreds of billions of dollars every year. A network of unregulated banks, tax-avoiding and tax-evading corporations, corporations plundering natural resources in low- and middle-income countries, unethical accounting practices and unscrupulous individuals underlies this intolerable state of affairs. Ideally, this report would have placed more emphasis on the international health community lending its voice to efforts to fight tax havens, corruption and corporate transfer mispricing.
- The detail on *how* health finance should be managed within countries is limited in this report. The working group was clear about basing its recommendations on principles of progressive financing, equitable access to health care, and pooling finance to optimize efficiency and risk-sharing across the population. This should imply a universal, single-payer health system, a minimal or absent role for private insurance companies, and a network of public-interest providers. However, the report makes no comment about the place of private voluntary health insurance within health systems; or about the desirability or otherwise of competitive insurance or provider markets. Such questions are part of ongoing and unresolved debates about *how* universal health coverage should be delivered in low- and middle-income countries. However, the report *does* highlight ministries of health and a healthy civil society as vital and central actors in the development of universal health systems.
- The report highlights the absolute need to use public funds in the first instance for the provision of *comprehensive* primary health care services, which includes necessary referral services, for everyone. However, references to the use of cost-effectiveness analysis for priority-setting in this report may

inadvertently conjure up the notion of governments only assuming responsibility for providing minimalist ‘essential packages of care’. This would be mistaken. As economies and government revenue for health care grow, so should the range of services available to everyone. The emphasis of this report is that governments should ultimately provide *comprehensive* services with universal access that cut across all levels of care or specialization. This marks a clear distinction from the highly specified ‘packages of care’ that are prevalent in insurance-based health care financing systems.

There is a need for greater debate about priority-setting processes, including the potential for treatment guidelines, essential drug lists and other strategies to allow for the efficient and sustainable provision of comprehensive services. Most importantly, priority-setting (or conversely rationing) decisions should not be left solely to technicians relying on cost-effectiveness analyses – which are often derived from an inadequate evidence base – but also be based on equity, sound public health judgment and procedurally just citizen engagement.

Gorik Ooms

The structure of the report suggests that national health systems or services fall outside the scope of global public goods. That is appropriate considering the present thinking about global public goods – i.e. goods that are non-rival and non-excludable, across state borders. Health services are rivalrous – the attention of a nurse ‘consumed’ by one patient cannot be used by another patient – and excludable – the requirements of private payments or health insurance membership exclude many people. If health services do not qualify as public goods, they obviously do not qualify as global public goods.

But strong, efficient and therefore sufficiently funded national health systems do produce ‘externalities’ that have the characteristics of global public goods. Effective control of infectious disease reduces the risk of infection for everyone: that is a non-rivalrous and non-excludable good. Improved health allows people to use their talents better: at least some of the benefits of that are non-rivalrous and non-excludable, across state borders. Most of the recommendations made in this report are merely the implementation of international human rights law, and international cooperation in compliance with international human rights law will be essential to address other international challenges. For example, harmful tax competition is mentioned as a problem with direct negative impact on people’s health, and encouraging all states to comply with their domestic primary responsibility to finance health services would probably mitigate tax competition.

How can we promote the provision of global public goods? In the section about GPGHs, the report is unambiguous: international institutions have an essential role in ensuring cooperation across countries. Without international institutions, some states will try to ‘free-ride’ on others – i.e. enjoy the benefits of GPGHs without contributing to them. In my opinion, this logic is valid for external financing of national health systems too. Therefore, my own version of Recommendation 17 would have been stronger. Actively assessing the feasibility of broadening the mandates and merging existing mechanisms for the pooling of external funds for health should be a first step towards creating an international institution that can effectively avoid free-riding behaviour in the external and domestic financing of national health systems.

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