1. Background

The world is changing and nowhere is it more obvious than in international development assistance. We are currently seeing new trends particularly in the area of support for health. This needs to be viewed against a backdrop of general improvements in the lives of most people both economically and in terms of their health; there has been sustained and reasonably high economic growth particularly in a number of African and Asian countries.

There are, of course, many challenges: overall improvement hides growing inequity; progress is not inevitable; and threats such as new diseases and environmental changes face humankind. Africa faces continued threats from malaria, and in many countries there are long term needs in treating people who are HIV positive. Improvements in life expectancy have been slowed due to the AIDS epidemic. Specifically in Southern and Eastern Africa there have actually been reversals in this indicator.

Currently, there is not enough money globally to meet health needs. The gap between what is needed and what the international community is willing to provide will widen. This can only be addressed through increased domestic funding. Furthermore, unless there are clear signs of domestic commitment to health, especially given the economic growth many low and middle-income nations, it will become more difficult to mobilise donors. The Lancet Commission notes “We are also in an era in which the landscape of global health financing is undergoing major changes. After a decade of rising aid for health – a ‘golden age’ for global health assistance – development assistance budgets are strained”.

Countries need support in developing a domestic response to health, including to AIDS, tuberculosis and malaria, and to move beyond programming silos. Health and Finance ministries, who will be at the fore-front of the fight against AIDS, tuberculosis and malaria will need to be supported and have stronger engagement.

2. Trends in health financing

Health care is a moral imperative, but it also yields economic, social and political benefits by increasing productivity. There is also increasing evidence showing that a higher level of population health, and a demonstrated public commitment to maintaining it, is associated with a higher level of foreign direct investment (FDI), which has in turn been shown to be a key driver of economic growth and development in low and middle-income countries.

From 2000 until recently, in particular as a result of the AIDS epidemic, massive amounts of international funding were raised to support and scale up AIDS programmes in low and middle-income countries, particularly in Africa. The massive increase in investments in
health over the past 10 years, including the resources that were channelled to AIDS, tuberculosis and malaria programs through the Global Fund, have resulted in positive health outcomes across the African continent, including significant reductions in maternal and child mortality, increased life expectancy and progress towards the Millennium Development Goals (MDGs). To protect these health gains and turn the tide on the epidemics, investments in health must continue to grow.

Yet, as the demand for health financing increases, external resources are now plateauing and may even sharply decline with the economic downturn in donor countries and the decreased prominence of health in the post-MDGs agenda. At the same time, while funding for health as well as for AIDS, tuberculosis and malaria from domestic public sources has been increasing steadily as the economies of low and middle income countries in Africa experience unprecedented levels of growth, many countries are still struggling to meet their commitments, for instance with the ‘Abuja Declaration’ which states that African Governments should spend 15% of government expenditure on health. The very low baseline in terms of domestic allocations to health, weak health systems and infrastructure, competing priorities and other development challenges are only some of the difficulties often cited as the impediments to maximising the impact and better leveraging of domestic resources towards health.

Today, we need to demonstrate more than ever that the responsibility for health continues to be a shared one. But for this to work, it is essential that the Governments of implementing countries demonstrate that they are taking on more and more responsibility for the health of their people.

3. Key Challenges

**Value for money:** The Taskforce on Innovative International Financing for Health Systems summed up the key challenge in their 2009 publication “More money for health and more health for the money”, calling both for increased funding and for major improvements in health efficiency and effectiveness. Inevitably neglected during the years of expanding resource availability, particularly for HIV, programme efficiency and effectiveness has become a major focus.

**Domestic advocacy:** It is clear in the current environment that a large part of any increase in public funding will need to come from the governments of low and middle-income countries, whose citizens will need to know that their money is being wisely spent in areas of high priority. A key challenge is therefore to develop a convincing advocacy case for increased public commitment to health programmes of proven effectiveness. Advocacy with the governments of high-income countries has been very effective in the case of HIV, but there now needs to be a similar focus on the governments of hitherto recipient countries.

**Sustainability:** While domestic public spending in low and middle-income countries has steadily increased in recent years, and is set to continue as economic growth continues, it is also clear that the ambitious targets that have been set in various global fora cannot be met without sustained external financing from high-income countries. Sustainability is not synonymous with a domestic takeover of programmes – this will not be possible in low-income countries for many years.
4. Making the case for increased domestic health financing

A recent Chatham House paper points out the health outcome benefits associated with higher government spending on health, as well as the issues of financial protection for low-income households, and suggests a target for government spending of 5% of GDP – and only 25%-30% of countries in the world would currently meet that target. In the low-income countries in sub-Saharan Africa, the average level of public health expenditure is only 2.9% of GDP (ranging from less than 1.5% to as high as 6% in a few countries). By comparison, the average level in the European Union is 7.8% of GDP and 8.2% in the United States.

There are economic, social and political benefits from having a healthy nation. Not only is there less expenditure on health care but people have the potential to be more productive and it can lead to a demographic dividend when the ratio of working age people to dependents increases.

According to the Lancet Commission, “Reductions in mortality account for about 11% of recent economic growth in low-income and middle-income countries as measured in their national income accounts”. They conclude “in the allocation of finite budgetary resources, making the right investments in health improves social welfare and stimulates economic growth”. The report then went on to discuss how better health can increase full income and sustainable wealth.

The importance of health for the well-being of citizens cannot be questioned. Its role in economic growth is more complicated. The importance in increasing foreign direct investment (FDI) is cited by the Lancet with regard, particularly, to malaria.

Providing health care is one of the responsibilities of the state. The mix of health care will vary but there is a minimum package. The question is not whether government should invest in health but how much and how. In this regard, African governments have made a decisive commitment to increase domestic funding for health, and this has already become a reality in some countries. Between 2006 and 2011 global domestic investment has doubled spending on AIDS, tuberculosis and malaria. African countries are closer to reaching the agreed Abuja target, allocating 15% of their total government expenditure to health. There remain, however, large inequities between country’s contributions and ability to pay in the low and middle-income countries, where the three diseases are concentrated. To translate commitments into concrete measures that will have an overall positive effect on domestic health financing across the African continent, all stakeholders, from governments to Parliaments, Private Sector, Civil Society and Regional Economic Bodies need to work more closely together.

Part of this work will need to focus on ensuring that all stakeholders, particularly Governments, recognize the importance of investing public funds in health:

**Domestic funding for health brings high economic returns.** High prevalence in the three diseases results in large reductions of economic growth rates, whereas for instance a rapid acceleration of investments in malaria control at the level of 10% annual growth over five years could increase the annual gross domestic product in Africa by more than $20-30 billion. A scaling-up in health funding would also save twice as many lives for every dollar spent.
**Foreign Direct investment (FDI) promotes economic development and enhances productivity.** Healthy workforce is more productive, leading to better economic performance and higher overall Gross Domestic Product (GDP). A higher level of population health (and a demonstrated public commitment to maintaining it) is associated with a higher level of foreign direct investment (FDI), which has in turn been shown to be a key driver of economic growth in low and middle-income countries. This will also help to build a business case for increased investment in health through the lens of the CEOs of private sector organizations, so that the private sector can leverage their investment position and advocate with governments.

**More domestic funding means country ownership and sustainability.** Increased domestic contribution to health programmes leads to greater national ownership and sustainability of the health and disease-specific programmes. Poor resource allocation can often result from a country’s lack of control over resources, with international donors pushing for their own priorities. Countries (or aid organisations) are often constrained to adjust their plans, or spending based on the goals of the donor. On the other hand, national strategies that are more based on demand rather than supply or donor driven agendas are more likely to produce more results and achieve impact.

In addition, external funding tends to vary, and in donor countries budget constraints and pressure from the public to spend money domestically have lately resulted in widening funding gaps, endangering entire programmes in low and middle income countries. More funding coming from implementing countries can help tackle the risks linked to external funding volatility and guarantee the sustainability of health systems and programs.

**Investments benefit the entire system.** All the costs saved by scaling up the response to the three diseases could allow health sector resources to be devoted to other diseases, and every dollar invested in health infrastructure linked to the three pandemics is strengthening the entire health system.

**Increasing domestic investments is a powerful political sign to the international community.** Domestic spending signals a paradigm shift in the partnerships between implementing countries and donors and honours commitments taken during the 21st African Union Summit, reiterated through the Abuja Declaration of 2001, the Kampala Declaration of 2010 and the Abuja+12 Declaration of 2013, all underlines a sense of ownership for a new development paradigm where African implementing countries now shared responsibility as part of the global solidarity.

**Increased domestic funding also helps to leverage additional external funding through the Global Fund.** Investing domestic resources in health sends a very strong message to traditional donors about shared responsibility and the drive for increasing independence in funding, which could be a catalyst for increased funding from existing and other emerging donors. A small investment in the Global Fund is a promise of large dividends on every level.

**Leverage innovation by private sector and new partnerships.** Governments alone cannot do everything. Existing financing mechanisms should be enriched with new actors, complementary resources and innovative models as governments alone cannot do everything in the health sector. There is a clear potential for private sector and civil society organisations to pursue a more integrated/complementary role in health and in the
financing of health domestically, which has traditionally been viewed as a public sector concern. Countries should aim to build mutually beneficial partnerships with the private sector and leverage on their core competencies to devise sustainable solutions at the national and global level.

5. Overview of the Global Fund’s new funding model and the built-in mechanisms to unlock additional domestic resources and enhance value for money

Achieving the ambitious goals and targets set out in the Global Fund Strategy for 2012-2016 requires increased efforts to mobilise additional resources. While the Global Fund continues to mobilise external financing and other innovative partnerships and schemes to support the global fight against the three diseases, the Global Fund’s ability to allocate funding from donor governments and the private sectors is far from sufficient to address the full cost of fighting the three diseases and to strengthen health systems in low and middle-income countries. More than ever, the Global Fund must actively work with implementing countries to ensure increased domestic resources for AIDS, tuberculosis and malaria programmes and for health in general.

In March 2014, the Global Fund Board approved the final elements of the new funding model and full implementation of the model is now underway. With an overall goal of enhancing strategic investment in order to achieve greater impact, the Global Fund’s new funding model has built-in mechanisms that are designed to encourage increased domestic investments in health, and in particular, in the AIDS, tuberculosis and malaria programmes supported by the Global Fund. These include:

**Counterpart financing and willingness-to-pay:** In the new funding model, all programmes supported by the Global Fund must continue to comply with the counterpart financing requirements by: (a) meeting the minimum threshold contribution; (b) increasing government contributions to the national disease programmes and the health sector; and (c) ensuring reliable data is available to measure government spending. In addition, 15 percent of a country’s allocated funding can be accessed only once a government has made a willingness-to-pay commitment beyond minimum counterpart financing requirements. Willingness-to-pay commitment amount is determined during country dialogue and may be adjusted based on the percentage of the allocation that is comprised of existing funding and on a critical analysis of past spending trends, country income, and fiscal space.

The grant agreement in the new funding model formalises both counterpart financing commitments for the duration of the grant as well as the additional willingness-to-pay commitments. It specifies the annual government investments, outputs of government investments, mechanism and time-frame for reporting annual government spending. If commitments are not met, the Global Fund can proportionally reduce its resources for the next year through its annual disbursement decision.

**More flexible timing of applications and predictability on the level of funding available:** By offering more frequent application windows throughout the allocation period, the new funding model allows countries to access their allocated funding when needed and according to their fiscal/budget cycles. In addition, the fact that countries are informed of their total allocation for the period allows for better planning and resource
allocation within the country. This also means that countries can more easily identify funding gaps, if any, and search for alternative sources of funding, including from their national health budgets, to address the gaps.

**More active engagement with implementing countries and increased donor/partner coordination:** The Global Fund, through its Country Teams, engages more actively in the ongoing discussions that occur at country level to prioritize how to fight the three diseases and strengthen health and community systems. This should result not only in stronger and more strategically focused funding requests to the Global Fund, but also to overall better coordination with technical agencies and bilateral partners on the ground, complementing efforts to enhance collaboration with partners at headquarters level. Better coordination with countries and partners should mean enhanced clarity around the funding landscape for the three diseases at the national and international levels, leading to easier identification of critical funding and programme gaps and shortfalls, and a faster and more coordinated response to addressing the gaps.

**Offering incentives for countries to present a full expression of demand:** The new funding model incentivises countries to indicate the full cost of a technically appropriate response against the three diseases by making available, on a competitive basis, a separate reserve of funding to reward high impact, well-performing programs, and encourage ambitious requests. The advantages of presenting a National Strategy-based ‘full expression of demand’ to the Global Fund are three-fold. First, this can be done with little additional effort if the country already has a strong and robust costed National Strategy. Second, by showing the overall financing need for a disease programme, it should help the country and its partners, including the Global Fund, to mobilise external resources to address funding gaps. Lastly, it should help health officials to position themselves in internal budget discussions.

**Greater emphasis on strategic focus and value for money of interventions:** The new funding model places greater emphasis on smart spending which means the Global Fund will not only allocate money where it is most needed (through the allocation formula), it will also apply a rigorous review to ensure that the programmes it supports focus on the right areas and populations. This will help optimize the return on investment not only of donor resources but also domestic finances invested in AIDS, tuberculosis and malaria programmes.

### 6. GF strategy to mobilising domestic resources

Complementary to the mechanisms build into the new funding model, a critical part of the Global Fund resource mobilisation strategy 2013-2016 has been to involve implementing countries in the replenishment efforts and also to advocate and demonstrate increased domestic resources for health. Based on the needs assessment exercise undertaken with its partners, existing domestic funding for the period of 2013-16 is at the level of $24 billion. With a further $14 billion raised domestically, the Fund and its partners estimate that

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1. This is only available to applicants in Country Bands 1, 2 and 3. Disease components that are considered significantly “over-allocated”, Band 4 applicants, and regional applicants are not eligible to be awarded incentive funding.
approximately 87% of the global need will be covered and that this will be sufficient to reach a tipping point in the fight against the three diseases.

With partners such as the African Union (AU), African Development Bank, United Nations Economic Commission for Africa and other development partners, the Global Fund has been involved in helping countries to identify and implement innovative domestic financing mechanisms to help raise resources domestically in a number of priority countries in Africa. The GF is currently working on a number of initiatives, including:

**Supporting countries in putting in place and highlighting the importance of innovative mechanisms to raise domestic resources for health:** This consists of supporting five priority countries, namely, Kenya, Tanzania through the establishment of AIDS Trust Funds and also Ethiopia, Senegal and Malawi through exploring viable options/mechanisms.

In addition, in collaboration with AU and Friends organizations, the Global Fund also actively supports documenting of country case studies on innovative domestic financing schemes in four countries, namely Kenya, Tanzania, Zambia and Zimbabwe.

**Strengthening political and civil society advocacy at domestic and international levels:** In partnership with the AU and others, national campaigns are coordinated on the importance of domestic financing for health in the 5 priority countries. As in the previous replenishment, the Global Fund also continues to mobilize selected Heads of States and First ladies as Champions, ministers of finance and health as Co-Champions as well as parliamentarians, private sector and civil society actors to support and to advocate for increased domestic financing at national levels, and to highlight important achievements in domestic financing at international level to demonstrate shared responsibility and mutual accountability.

### 7. Conclusion

There is not a single blueprint for a country’s domestic funding. Countries need to take responsibility to share the burden of financing health. Health expenditure should keep pace with economic growth. This will result in a real increase in resource availability. Each country should decide on realistic goals for health provision which should include a minimum package. These should be costed and a formula to calculate disease burden, domestic resources and need should be developed and the international community should only intervene where there is a gap that cannot be filled. This will certainly be the case in some AIDS affected countries with a high burden of disease and low income as the cost of treating a person with ARVs is significant and a long term commitment.

In 2005, all WHO Member States made the commitment to achieve universal health coverage (UHC). This is high on the global health agenda at present and ties in with the belief that people should have access to the health services they need without risking financial ruin or impoverishment. The concept of universal health coverage should be considered further in planning domestic health care.
References:


Annexes:


Source: CCM Reported Spending (Phase-2 request, TFM/NFM Proposals), gaps supplemented with WHO/UNAIDS reporting

*Government spending includes only earmarked programmatic contribution. Excludes service delivery costs


Source: Global Health Expenditure Database, WHO