

INNOVATIVE AND
DOMESTIC FINANCING
FOR HEALTH IN AFRICA

Documenting good practices and lessons learnt

June 2016



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ACKNOWLEDGEMENTS

The African Union Commission extends its appreciation to various resource persons who gave substantial input to **these** case studies on innovative and domestic financing for health in Africa. Special thanks to Paul Booth, independent consultant, and Professor Alan Whiteside, CIGI Chair in Global Health Policy Professor at Balsillies School of International Affairs for doing the groundwork on these case studies.

Member States Experts, Regional Economic Communities and development partners who reviewed these case studies during the AWA Consultative Experts Meeting in June 2016 deserve special recognition.

The support from the Global Fund to Fight AIDS, TB and Malaria and the United Nations Foundation facilitated the development of these case studies contained in this report. Special thanks to Amina Egal and Shu-Shu Tekle-Haimanot.

The staff from the Department of Social Affairs of the African Union Commission namely Ambassador Olawale Maiyegun, Dr. Marie-Goretti Harakeye, Sabelo Mbokazi, Tawanda Chisango, Dr. Adiel Kundaseny Mushi and Dr. Sheila Tamara Shawa closely worked with the consultants to finalise the case studies.

FOREWORD

Significant strides have been achieved in strengthening health systems and in addressing AIDS, TB and Malaria in African countries. While some targets have not been reached there is a critical need to address the remaining challenges. The African Union set bold and ambitious targets to end the three biggest diseases on the continent in the Catalytic Framework to end AIDS, TB and Eliminate Malaria in Africa by 2030. Reaching these targets will require Member States to expand their fiscal space for health in line with the strong political will that has continued to keep health high on the continent's development agenda.

Innovative financing mechanisms provide interesting examples of leveraging on domestic resources for health. However they are not the sole panacea for Africa's health financing resource challenges. While the revenue raised is small by comparison to domestic funding requirements, innovative financing can provide a steady, sustainable and equitable way of generating additional resources for health. These mechanisms should be used to complement traditional government revenue generation in the short term while governments work to expand their revenue base. It is expected that African countries can learn from these case studies and consider adoption their depending on their context.

The case studies presented in this report contain selected country specific examples on expanding the fiscal space for health in Africa. The compilation complements a study on Innovative and Domestic Financing for Health that was commissioned by the African Union to provide practical models, challenges, lessons learnt and their applicability.

Examples presented include an AIDS levy, airline levies, alcohol levies, Debt2Health Debt Swap Agreements and concessional borrowing.

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INTRODUCTION

Africa's long term development framework, *Agenda 2063* provides clear priorities for Africa's structural transformation. However the achievement of the set aspirations will to a greater extent be predicated on domestic resource mobilisation as a key source of financing for the continent's development agenda. This collection of case studies selected from the five African Union regions explores how selected countries are evolving innovative and domestic financing models that seek to expand the fiscal space for health. However it should be highlighted at the outset that **these mechanisms are not a panacea for domestic health financing in the long term but rather as short term mechanisms to complement traditional government revenue generation while the tax base is being expanded.**

These selected initiatives from the continent are representative of continental efforts to fast track universal health coverage aspirations set out in continental policies and frameworks. While many of the 54 AU Member States have not met the bold and ambitious health targets set by its leaders since 2001 political commitment has remained high. The failure to meet these targets often obfuscates the fact that by far domestic resources contribute to Africa's health much more than external support.

Health thus continues to be prioritised by African leaders in the context of many legitimate competing priorities. *Agenda 2063* places the objective of realising "healthy and well-nourished citizens" among the first of the seven aspirations towards the attainment of 'the Africa we want.' Africa's health frameworks for the next fifteen years that include the overarching *Africa Health Strategy* and the *Catalytic Framework, to end AIDS, TB and Malaria in Africa by 2030* translate this objective into

concrete actions plans and business models. However meeting these targets will require significant investment in health, yet this comes during a period of plateauing development partner support. It is in this context that the African Union Member States are in the short to medium term looking at innovative mechanisms to expand the fiscal space for health.

While domestic health financing focuses on increasing the revenue base in a bid to increase resources allocated to health, it is critical to ensure that income collection and spending is progressive rather than regressive. Furthermore, financially prudent economic management requires that sources for the fiscal space be implemented in combination and the degrees of implementation be determined in accordance with the local economic environment. Creating a balance between the primary domestic sources of increase in fiscal space for health includes prioritising health within the existing allocation of government expenditure, generating additional government revenue through innovative sources of funding and efficiency spending and investments within the health sector. The case studies in this collection illustrate effective ways of increasing domestic financing for health through improved allocation and innovative financing.

Case Studies

CASE STUDY ONE:

HEALTH TRUSTS OR ENDOWMENT FUNDS

THE ZIMBABWE AIDS LEVY AND ZIMBABWE NATIONAL AIDS 'TRUST FUND'

What is the health financing mechanism?

- An AIDS Levy – a 3% tax on the income of individuals, companies and trusts that is paid into the *Zimbabwe National AIDS Trust Fund* (ZNATF) to finance activities of the national AIDS response.

Describe the mechanism?

- A financial endowment fund (or trust fund) is a donation of money or property to an institution that is tasked to manage the financial asset in an investment fund. The initial endowment is invested so that it grows financially. This enables the donation to have an impact over a longer period of time.
- Once the fund reaches a certain level of capitalisation a percentage of the investment can be accessed to fund the operational costs or activities specific to the programme. The remaining funds are invested to augment the endowment and to compensate for inflation.
- In a stricter sense the Zimbabwe AIDS Levy is technically not a trust fund or endowment as the revenue it generates is spent as it is collected.

Introduced by Who, When and Where?

- The *Zimbabwe National AIDS Trust Fund* (ZNATF) – commonly known as the AIDS Levy – was established in 2000 through an Act of Parliament, the National AIDS Council of Zimbabwe Act.
- It is a local resource mobilisation initiative for Zimbabwe's HIV response. The fund is one of the pathfinders in domestic financing for health and its existence set an example for the recommendations (Article 50) of the AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria (2012) that urges countries to implement strategic investment approaches to health.
- The statutory levy is a 3% deduction from Pay as You Earn (PAYE) for individuals as well as 3% of income tax levied on corporates.
- The *levy* is collected monthly by the *Zimbabwe Revenue Authority* (ZIMRA) and deposited into an account of the National AIDS Council (NAC) for independent administration by ZNATF.

What is the rationale behind the tax levy?

- The burden of the AIDS epidemic had become severe and the resources available from government and other players to address the challenges were limited.
- The Government of Zimbabwe faced with a worsening HIV & AIDS situation conceived the idea for AIDS levy in the late 1990s.
- The AIDS Levy was established to finance the operations of key HIV and AIDS interventions *through the National AIDS Council* (NAC).
- The fund was established as a "seed fund" into which donors were expected to contribute and augment available national resources.
- The fund was founded partly due to the advocacy efforts of people living with HIV who lobbied for the establishment of a dedicated AIDS-fund to meet their treatment and care needs.

How is it administered?

- In line with sound corporate governance principles the Fund is administered by the NAC board with clear stipulations regarding its use to ensure that it is spent in a manner intended to achieve stated objectives.
- The board produces an annual work plan and budget which is then submitted to the Ministry of Health and Child Care for approval. The Fund Administration also takes place under the guidelines and policies approved by the Minister.
- The Fund has been decentralised through NAC structures at provincial, district and ward levels, where AIDS action committees have been established. District AIDS Action Committees (DAACs) are the active components of the decentralised structures where action plans have become the basis for disbursements of funds to ensure that the response is tailor made to meet district needs.

AIDS Levy Collections 2009-2013

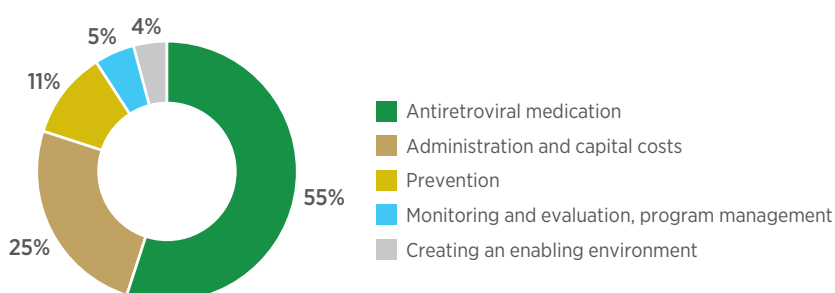
The table below shows the AIDS levy collection for the period 2000 to 2014. However due to hyper-inflation experienced between 2007 and 2008, the annual revenue collected was distorted.

Year	Annual revenue (million USD / ZIM \$)	As % of NAC expenditure	As % of GDP
2000	\$793,903 (Zim \$)	12.3%	0.3%
2001	\$1,525,922 (Zim \$)	11.4%	0.2%
2002	\$2,835,887 (Zim \$)	10.5%	0.2%
2003	\$11,247,338 (Zim \$)	12.6%	0.3%
2004	\$92,622,847 (Zim \$)	10.6%	0.4%
2005	\$262,537,228 (Zim \$)	8.5%	0.3%
2006	\$5,648,585,976 (Zim \$)	8.9%	0.3%
2007	\$1,118,870,698,065 (Zim \$)	15.2%	2.4%
2008	\$347,482,953,678,240 (Zim \$)		
2009	\$5,710,820 (USD \$)	7.5%	0.1%
2010	\$20,522,121 (USD \$)	9.6% (estimate)	0.3% (est.)
2011	\$26,459,054 (USD \$)		
2012	\$32,640,678 (USD \$)		
2013	\$34,236,005 (USD \$)		
2014	\$35,5 million (USD \$)		

Funded activities

The pie chart below shows the allocation of the AIDS Levy between 2009 and 2012 to the following strategic activities: antiretroviral medication (55%), prevention (11%), monitoring and evaluation and programme management (5%), creating an enabling environment (4%), and administration and capital costs (25%). By law, 55% of the *AIDS Levy* is allocated to the purchase of ARVs.

AIDS Levy budget allocations: 2009 – 2012



Analysis

- As of August 2015 about 815,000 of the country's estimated 1,207,175 people living with HIV were enrolled on ART.
 - 29% of these are domestically financed (195,000);
 - Domestic funding for ART is pooled as follows: AIDS Levy (11%), Out-of-Pocket expenditure (13%), local NGOs (4%) and for-profit companies (1%). The remaining 71% is donor funded [2012 *National AIDS Spending Assessment (NASA)*];
 - Although 55% of the AIDS Levy budget is allocated to ART, this is only sufficient to purchase drugs for 11% of the 815,000 people on ART.
 - The AIDS Levy generates only 15% of the country's annual HIV funding needs.

Challenges

- The cabinet directive that 55% of funds be allocated to the purchase of ART is a strategic move in ensuring access to medicines. This has however resulted in very limited resources being allocated to prevention and other interventions. In 2014 the Levy collected \$35.5 million and only \$5.68 million (16%) was spent on prevention.
- While the AIDS levy has provided an alternative source of domestic financing for health it generates a small proportion of the country's funding requirements. The amount is very minimal in light of the huge financial investment required for HIV interventions and other health responses.
- In spite of this the AIDS levy accounted for 11.38% (\$311,9 million in 2015) of the total budget of the Ministry of Health and Child Care. The AIDS Levy amounted to 0.82% of the total government budget (\$4,340 million). However due to the insufficient amount of funds raised from the AIDS levy, the country still remains donor dependant for its response.
- Funds may be affected by prevailing circumstances such as hyperinflation as experienced during the 2006 – 2008. Furthermore in difficult times, authorities may place demands on the Fund for services from other ministries and sectors.
- The AIDS Levy is seen as everyone's fund, as such this leads to increased demands on the fund.
- The tax is only levied on individuals in formal employment (70% of Zimbabwe's productive population are employed in the informal sector) and companies. This means that wages and profits from the informal sector which account for a huge proportion of the productive population is not levied.
- By financing the response, the NAC role of *Coordination vs. Implementation* becomes complex.

Conclusions

- The Zimbabwe AIDS Levy is considered as a regional best practice by SADC and UNAIDS for increased domestic financing for health. It is a resourceful approach to ensuring self-sustainability and reducing aid dependency in the HIV response.
- The AIDS levy sustained NAC activities through Zimbabwe's 2007 to 2008 economic crisis, an indication that it can be sustainable regardless of the prevailing circumstances. In spite of hyper-inflation and decreasing external funding, Zimbabwe continued to accelerate enrolment onto ART, which reached 59% of those eligible by the end of 2010.
- The sustainability of the AIDS levy is demonstrated by its endurance over fourteen years.

Lessons Learnt

- Self-financing of the HIV response allows government to have greater autonomy in determining its priorities and areas of focus.
- The AIDS Levy is a visible commitment on the part of government and its citizens to address national challenges.
- Transparency in managing the AIDS levy serves as a basis for attracting donor funds for other interventions. Transparency on the utilisation of the fund is also essential for the policy makers, implementers and the populace.
- Periodic media updates on the utilisation of the Fund's helps to promote accountability.
- Political commitment is important for mobilisation of resources to the Fund and implementation of desired interventions.
- Whenever an additional tax burden is placed on workers, careful planning is required, including to solicit acceptance, support and participation.

CASE STUDY TWO:

SOCIAL HEALTH INSURANCE

THE CAISSE NATIONALE DE L'ASSURANCE MALADIE (CNAM) IN TUNISIA

What is the health financing mechanism?

- The Tunisian National Health Insurance Fund is a mandatory payroll contribution rate of 6.75% of earnings.
- Health care in Tunisia is financed through a combination of social health insurance, general government revenue, private insurance and out-of-pocket payments.
- The CNAM contributory system has enabled the expansion of health insurance to 71% of the population.
- By law, the government guarantees free or subsidised health care services to low-income groups through two public medical aid schemes- the free health care scheme and a reduced-fee plan.

What is the role of Social Health Insurance (SHI)

- Social Health Insurance (SHI) is one of several social protection mechanisms that address the equity of the financial burden of health care. SHI increases access to health services for the underprivileged. SHI pools health risks across all those who are insured and finances this through a combination of contributions from members, employers and government.
- SHI ensures that access to health care is available to all, regardless of wealth, employment status, health condition or geographic location.
- The primary objectives of social health insurance are:
 - To provide health care that avoids large out-of-pocket expenditure;
 - To increase appropriate utilisation of health services;
 - To improve the health status of individuals.

Introduced by Who, When and Where?

- Social Health Insurance is primarily provided by the state, although several NGOs provide SHI at community level in developing countries.
- SHI began in Germany in 1883 as a means to displace private financing for health in Western Europe during the late 19th century. It was adopted extensively in the Americas in the 20th century.
- The introduction of SHI is in line with the recommendations (Article 50) of the AU *Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria* (2012) on strategic investments to health approaches.

The re-emergence of Social Health Insurance

- The low total health expenditure in many countries makes it difficult for governments to provide a minimum package of health services to its population.
- Private expenditure, particularly out-of-pocket expenditure, fills the gap. But experience of critical illness results in catastrophic outcomes for poor households.
- A heavy dependence on out-of-pocket expenditure also makes the financial cost a major barrier to accessing health care. As a result, health service utilisation tends to be higher among the rich compared to the poor.
- Many countries are finding it increasingly difficult to adequately finance health care where the main source of funding for health services is general tax revenue. This has led international policy makers to recommend SHI as an alternative health financing mechanism.
- In 2005, the *World Health Assembly* passed a resolution in support of the strategy of mobilising more resources for health through risk pooling to increase access to health care for the poor and deliver quality health care in all its member states, particularly low income countries.

What is the problem that Social Health Insurance seeks to address?

- The question at the heart of healthcare financing is how national health financing systems can provide sufficient financial risk protection against the costs of healthcare for the whole population.
- SHI falls within the concept of risk-pooling where all individuals and households in a society share the financing of total healthcare costs. In such cases, the larger the degree of risk-pooling in a health financing system, the less people will have to bear the financial consequences of their own health risks, and the more they are likely to have access to the care they need.

Social Health Insurance in Tunisia

In 2004, Tunisia reformed the health sector by creating Caisse Nationale d'Assurance Maladie (CNAM) through a merger of health insurance and health benefits provided through the *National Social Security Fund (CNSS)* and *National Pension and Welfare (CNRPS)*. The reforms also enabled health services to be accessed through the private sector.

- CNAM is responsible for managing public health insurance plans, occupational disease pay-outs, injury compensation and granting of sickness benefits.
- CNAM purchases health services from public and private providers, in one of the following three ways:
 - **Public sector:** Outpatient care in public health facilities (including polyclinics outside of urban areas). About 75% of CNAM beneficiaries chose to receive treatment in the public sector.
 - **Private sector:** Outpatient care in private health facilities, following referral by a General Practitioner. Payment is via CNAM, topped up with user co-payments.
 - **The reimbursement system:** Inpatient and outpatient services accessed through a network of contracted care providers, with payment reimbursed by CNAM (at set rates).

Introduced by Who, When?

- CNAM was created through legislation in 2004.
- The entity is administered by a board of directors and is subject to supervision by the Minister of Social Security.

Genesis of CNAM Social Health Insurance

- Tunisia introduced insurance coverage by first providing medical health insurance for civil servants and formal sector employees and gradually extending this to additional groups.
- At the same time, the country placed strong emphasis on prevention programmes.
- The health system was decentralised from hospital-centred tertiary health services mainly in large urban areas to extending coverage in geographically accessible primary health facilities that were physically and financially accessible for the entire population.
- Finally, private providers were gradually incorporated into the health care delivery system.

What is the problem that this mechanism seeks to address?

Health financing reform in Tunisia was aimed at overcoming the following three key challenges:

1. High Household Out-of-Pocket (OOP) expenditure on health (including catastrophic health expenditure) for the underprivileged:
 - Despite success efforts in expanding the coverage of social health insurance (the free, subsidised and CNAM health insurance schemes) the Tunisian healthcare system is still largely funded through direct out-of-pocket payments;
 - Still, 41% of health expenditure is borne directly by households as OOP expenditure;
 - It estimated that the poorest households spend an average of 10% percent of their total OOP expenditure on health services. This rises to 68% of OOP for the poorest 10% of the population.
2. The declining quality of the health care system (services, outcomes and infrastructure).
3. Significant investment required in order to address inequalities between urban and rural areas in health outcomes, spending and in the distribution of health services.

Delivery System

Health care in Tunisia is delivered through public, parastatal, and private facilities. The public health system predominates in service provision with 87% of all beds and over 55% of medical personnel found in public hospitals. However 40% of CNAM expenditure (1138 million Tunisian Dinars) was spent in the private sector in 2009. This shows that the private sector still plays a significant role in health service delivery.

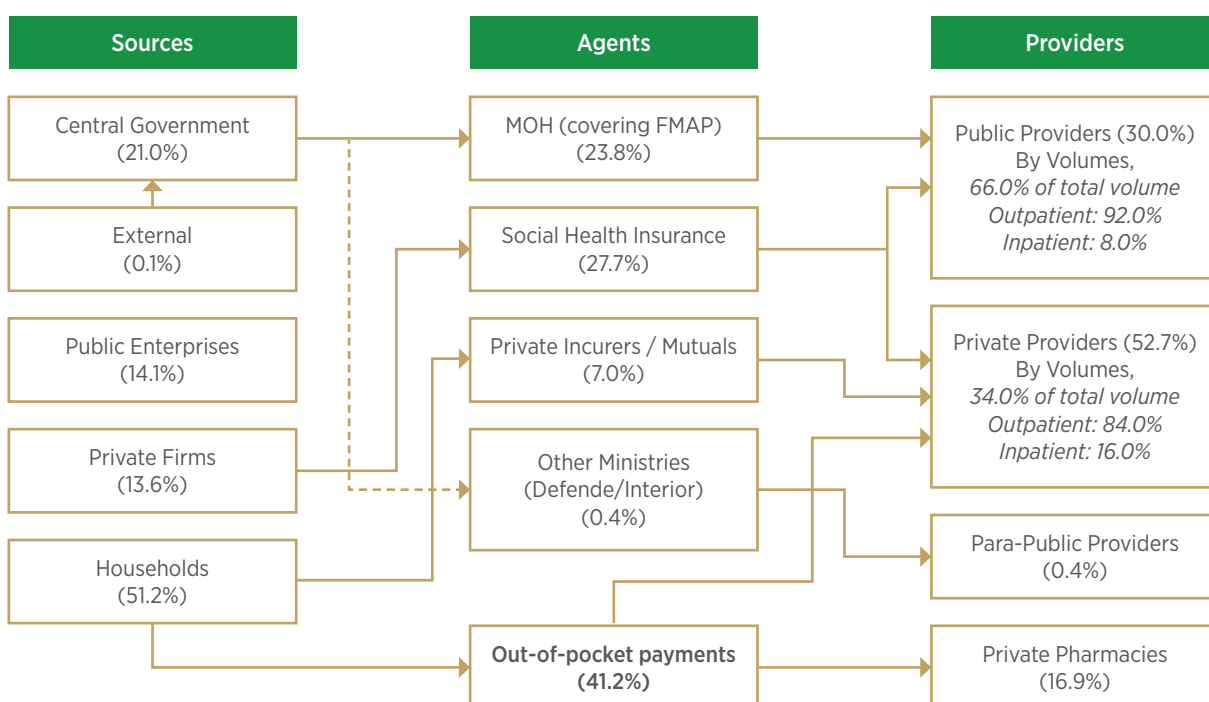
Coverage

About 99% of the Tunisian population has health care coverage, provided through various means that include the following:

- Approximately 71% through mandatory social security schemes (including CNAM). Some patients who can afford, top up their social health schemes with private insurance;
- Approximately 7% is provided through free medical services;
- An estimated 21% is financed through reduced charges.

Financing Agents and Flows of Funds (2010)

Health care in Tunisia is financed through a combination of social health insurance, general government revenue and private sector insurance as shown in the table below.



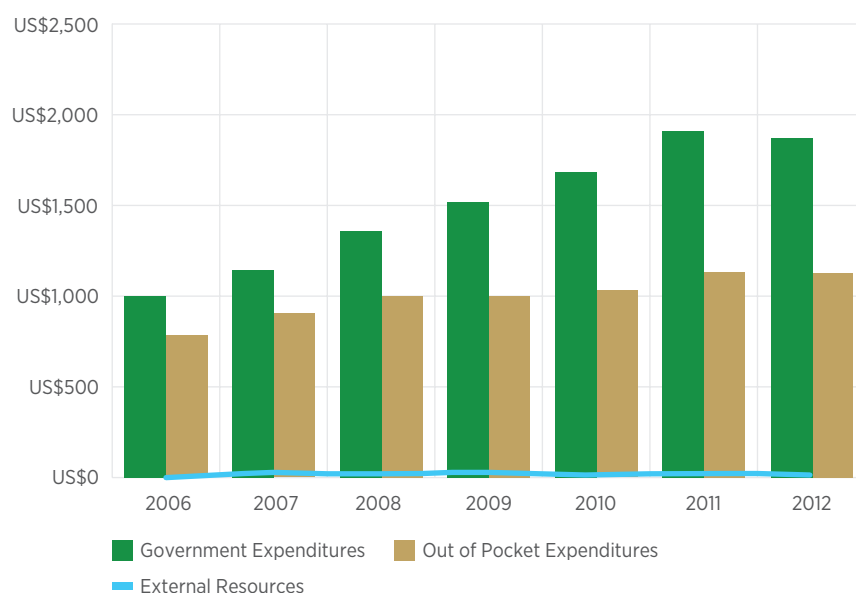
- Social Health Insurance (CNAM) rose from 27.7% in 2010 to approximately 30% in 2015. Government continues its efforts to increase this share and CNAM accounts for an increasingly greater year-on-year share.
- The State through general government revenue accounts for 23.8% of the financial contribution.
- Out of pocket expenditure spending by households accounts for 41.2%, which is a larger proportion compared to the other two financing agents.
- However, the past 5 years have seen a 4% reduction in OOP since 2010, down to 37% in 2015. Other forms of private insurance accounts for 7%.

Spending on health care (2006 to 2012)

External resources (donor) account for less than 1% of the total health expenditure in Tunisia. Government spending on health constitutes 7.3% of total governmental expenditure, an increase on the 6.3% spent in 2010.

Total Health Expenditure (THE) – public and private – as a percentage of GDP has grown from 3.2 % in 1980 to 7% in 2010. Total Health Expenditure has increased by an average of 12% annually between 1980 and 2008. The graph below shows trends in health spending in Tunisia between 2008 and 2012.

Tunisia: Trends in Health Spending



Analysis

- Despite the mandatory payroll contribution rate of 6.75%, Social Health Insurance (including CNAM) provides only 30% of Tunisia's Total Health Expenditure (THE). Since 2011 the government of Tunisia has demonstrated commitment to increase the contribution of SHI to Total Health Expenditure.
- In 2010, the Ministry of Public Health contributed an additional 23.8% towards Total Health Expenditure. This amount was used to finance free and subsidised social health insurance (FMAP) provided to those not able to pay CNAM contributions.
- In 2015 these two contributions combined contributed only 54% of total health expenditure (2015). This places great pressure on households and exposes them to the risk of catastrophic health expenditure.
- At 37%, household out-of-pocket expenditure makes up the largest share of total health expenditure.
- However social health insurance reform since 2011 has seen OOP expenditure reduce from 42.5% in 2011 to 37% in 2015. Yet it remains a significant burden on households.

Challenges

- Health expenditure is considered to be 'catastrophic' if it constitutes more than 10% of household expenditure. Catastrophic health expenditure (CHE) affects all socio-economic groups, but tends to be more concentrated among the lower-income groups and those who are supposed to benefit from free or subsidised care.
- This case study has thus shown that the Tunisian social health insurance covers (CNAM and FMAP) do not provide protection from CHE for all. Thus extending coverage of social health insurance will not necessarily lead to better financial protection in health.
- To ensure protection from CHE, there is need to reinforce effective, rather than the nominal, coverage of social protection mechanisms – particularly among lower-income groups.

OOP expenditure results from accessing care in the private sector due to overcrowding or drug shortages in the public sector. This calls for the strengthening of the public health systems to prevent the population from having to seek private care.

- While private healthcare providers help to overcome challenges in service delivery of the public health sector, 40% of CNAM expenditure which is quite a significant portion of the social health insurance budget is spent in the private healthcare sector.
- Notably, the majority of CNAM beneficiaries (75%) seek care in the public healthcare system. While the private health care delivery system constitutes only 13% of beds and 45% of medical personnel it received approximately 40% of CNAM expenditure in 2009.

Lessons Learnt

- Domestic financing for health requires political commitment and leadership. If a country is committed to substantively expand its finance health coverage, this can be achieved. However, without political will and leadership this can be a very daunting task.
- Strengthening of primary health delivery system and expanding PHC access to communities has contributed to the Tunisian achievements.
- The success in Tunisia shows that it is possible to move quickly towards the goal of universal health coverage by establishing an appropriate financing mechanism and changing consumer behaviour.
- The transparency of CNAM has been critical to its public acceptance and success.
- The dimensions of large-scale mandatory health insurance reform should not be underestimated when initially implemented. Coverage expansion is complex and entails extensive, long-term financial commitments.
- The paradigm shift from focusing on 'social security' to 'health insurance' has enabled various agents in the country to have a dialogue on the appropriate funding mix regarding primary health funding.
- The extensive growth of the private sector and the manner of its integration into the national healthcare delivery system contributed to the significant growth in household OOP health expenditure. This growth and integration could have been managed better.
- Regulatory and administrative capacity is critical to the successful expansion of health care coverage and must be backed up by a commitment to provide access to quality health care services. The development of management capacity within public hospitals and the promotion of participatory management will drive hospital performance improvements.
- The development of Health Management Information Systems (HMIS) is essential. Tunisia has invested heavily in information technology but continues to face extensive HMIS demands.
- The Tunisian experience has shown that it is not easy to increase the payroll contribution rate. The aim to reach the ideal contribution rate should be gradual in order to avoid mistakes and mitigate negative repercussions of any increases.

Conclusions

- SHI offers an important component of health financing as demonstrated by CNAM, however it faces formidable challenges in providing coverage to populations with unreliable or limited incomes. These includes those working in the informal sector and subsistence agriculture. Enrolling these populations requires substantial government subsidies, which in turn are subject to fiscal constraints. Increasing health funding levels through the creation of compulsory insurance contributions (SHI) faces the same macroeconomic constraints as do increasing general tax revenues (Kutzin, 2001).
- While often viewed as a means to inject new resources into the health sector, the introduction of SHI typically leads to the creation of new organisations for pooling funds, paying providers, and in some cases, even for providing services. While this results in new revenues it also results in new costs, administrative and regulatory challenges (Kutzin, 2001 and Carrin and James, 2004). The costs of collecting revenues can also be substantial both in the informal and formal sector where non-enrolment and evasion are commonplace (Carrin and James, 2004).
- SHI can also have negative labour market effects, including formal sector workers moving into the informal sector (Wagstaff, 2007). Due to all these challenges, there need to increase public funding for health and to reduce OOP health expenditure.

CASE STUDY THREE:

AIRLINE LEVIES

AIRLINE LEVIES IN SELECTED AFRICAN COUNTRIES

Introduction

The 2008 *High Level Taskforce on Innovative International Financing for Health Systems* recommended that among possible new sources of financing for health, countries should “extend the mandatory solidarity levy on airline tickets to more countries.” Airline levy entails a small tax (commonly \$1-2 for economy class passengers and \$10 for business class passengers) that is added to the price of outbound airplane tickets. In 2006 France became the first country to implement an airline levy. The tax is intended to generate a stable and predictable source of revenue for supporting developing countries in their efforts to achieve their development goals. In African countries that implement the tax, the revenue generated is commonly used to fund domestic HIV responses. Since 2006, more than 30 countries have introduced an airline levy. Many of the advanced economies who apply the airline levy use *part* of the revenue to finance national contributions to international development. Between 2008 and 2013 approximately 50% of UNITAID funding was derived from airline levies.

Implementation modalities

- The implementation of the ‘airline levy’ is coordinated by UNITAID – an International Drug Purchase Facility – hosted at the WHO in Geneva.
- However, the decision to implement, the management of implementation and revenue collection is done at country level.

What is the problem that this mechanism seeks to address?

- At the international level the airline levy provides sustainable funding to UNITAID to tackle inefficiencies in markets for medicines and diagnostics. This includes bringing new drugs to the market, ensuring the lowest possible prices for drugs and diagnostics and preventing drug stock-outs.
- The fund is used to fund programmes for AIDS, Tuberculosis and Malaria in developing countries. In principle, all levies represent a small fraction of the cost of travel and are not expected to negatively impact on passenger traffic volumes.

Where is the airline levy implemented?

- In Africa the following countries have implemented airline levies: Benin; Burkina Faso; Cameroon; Central African Republic; Democratic Republic of the Congo; Cote d'Ivoire; Gabon; Guinea; Liberia; Madagascar; Mali; Mauritius; Morocco; Namibia; Niger; Sao Tome and Principe; Senegal; South Africa and Togo. Other African countries considering a similar mechanism include Chad, Kenya, Mozambique and Nigeria.
- Outside of Africa, Brazil, Chile, Cyprus, France, Luxembourg, Norway, Republic of South Korea, Spain and United Kingdom also implement the levy.

How is it administered/implemented?

- Following the adoption of the levy through domestic legislation, airlines are instructed to collect and declare funds generated from the tax.
- Generated revenue is then transferred to the national treasury, usually through the Ministry of Transport or the Civil Aviation Authority.
- The tax is not applied to the airline but to passengers when they purchase their tickets (as a component of all applicable airport taxes). It is levied on all passenger flights originating from countries that impose it.

What are the advantages of airline levy as a source of innovative financing?

- Economically neutral, equitable and transparent.
- Research has shown that it has no negative effect on air traffic, airline jobs or profitability.
- Administratively simple and cost effective.
- Positive reception among passengers and tax payers – the levy is relatively a small amount and therefore it is not felt by the clients.

How much does it generate globally?

Over 70% of UNITAID's long-term financing, approximately \$250 million annually, comes from the airline levy in the participating countries. The table below shows the contribution of participating countries between 2006 and 2012.

Members – Africa	Domestic flights	International flights	Contributions: 2006 – 2012	Contributions: 2012
Cameroon	€1	€4	\$1,430,000	\$412,000
Congo	€40 (business class only)		\$1,090,000	
Guinea			\$49,000	
Madagascar	€1 (business and 1st class)		\$30,000	\$3,000
Mali	✓	✓	\$928,000	
Mauritius			\$8,741,000	\$1,790
Niger	✓	✓	\$281,000	

CASE STUDY FOUR:

CONSUMPTION TAXES / LEVIES

THE ALCOHOL LEVY IN BOTSWANA

- Alcohol Levy also known as a “sin tax” is charged on the sale of alcoholic beverages.
- Funds collected finance programmes that seek to minimise the effects of alcohol abuse, public education, rehabilitation and law enforcement measures.

What is the problem that the mechanism seeks to address?

- Alcohol abuse causes 2.5 million deaths worldwide (2010). Many of these could be prevented by reducing alcohol consumption.
- Alcohol (and tobacco) are under-taxed in low- and middle-income countries while their consumption is growing. The evidence shows strongly that increasing tax on alcohol and tobacco improves public health.

Evolution of the alcohol levy as a health financing mechanism

- The alcohol levy was introduced in November 2008 at a rate of 30% through the Levy on Alcoholic Beverages Fund Order.
- During World AIDS Day 2008, a month after the alcohol levy was introduced, Botswana’s President Ian Khama stated that “The continued abuse of alcohol is one of the greatest obstacles to Botswana’s Vision 2016 ideal of an HIV free nation by 2016.”
- The levy was subsequently raised in 2010 to 40%, then 45% in 2013 and 55% in January 2015.
- The levy on alcoholic beverages is one component of a multi-faceted approach that, together, seeks to regulate the availability, price, and marketing of alcohol in order to reduce consumption, especially heavy drinking.
- The policies and activities of the levy are managed by the Alcohol Levy Implementation Committee housed in the Ministry of Health.
- Funds collected from this tax are used to support, among other things, public education and rehabilitation programmes as well as law enforcement measures to combat alcohol abuse.

Why an alcohol levy- What is the situation in Botswana?

- Despite key successes, Botswana still has one of the world’s highest HIV burden.
- Donor funds peaked in 2008 but have been in decline since then.
- 70% of the national AIDS programme is funded by the Government.
- The ART programme has more than 90% coverage. This has resulted in a significant reduction in AIDS-related deaths but with a huge financial investment.
- Only 10% of total expenditure in the AIDS response is allocated to prevention efforts resulting in interventions lagging behind.
- Responding to the AIDS epidemic requires a predictable commitment of resources over the long term. At the same time, there are many diverse health and development needs that compete for the same resources.
- Lifelong ART treatment requires long term sustainable financing mechanisms. The alcohol levy is part of efforts to identify alternative sources of financing that contribute to the financial sustainability of the AIDS programme.
- The Government of Botswana considered a range of alternative financing options, and concluded that a levy on alcohol was the least regressive, least distortionary and a measure linked at least in part to causation.

What results can the alcohol levy achieve?

- Since the introduction of the alcohol levy, US\$79 million has been collected.
- Resources from the alcohol levy are distributed as follows, 45% to Ministry of Youth, Sport and Culture, 10% to the Ministry of Health and 45% to the Government Consolidated Fund.

How was it implemented?

- High-level political commitment and visionary leadership was key in successful implementation.
- Extensive research prior to implementation including a report on the impact of the alcohol levy, comparison to other interventions as well as consistent reviews to monitor its impact were undertaken.
- Legislative revision such as amendment of the Road Traffic Act, separating the Trade and the Liquor Act in to two Acts and drafting of the Traditional Beer Regulations provided a legal framework for the implementation of the new measures.

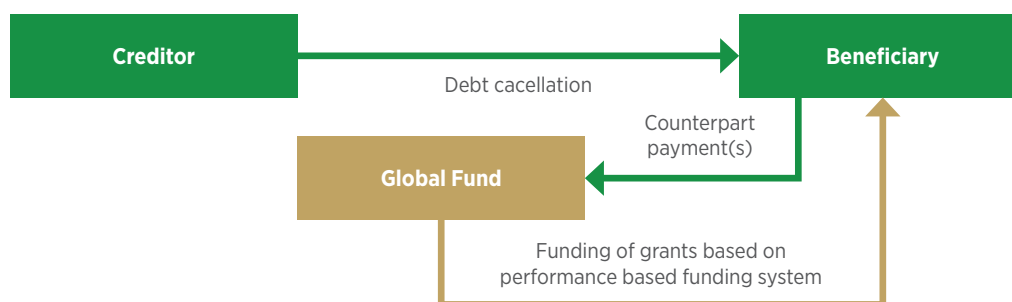
CASE STUDY FIVE: DEBT SWAP AGREEMENTS THE COTE D'IVOIRE'S DEBT2HEALTH DEBT SWAP AGREEMENT

What is the health financing mechanism or innovation?

- Debt2Health is an arrangement that enables developing countries to redirect debt repayments to domestic investments in health.
- 'Debt swap' / 'debt conversion' was introduced to the health sector in 2007 by the Global Fund. Under individually negotiated agreements, creditors relinquish a part of their rights to repayment of loans from a beneficiary country, on the condition that the beneficiary country invests the freed-up resources into programmes approved by (and performance managed by) the Global Fund.
- The Global Fund facilitates the negotiation of the 'debt swap' agreement. Since funds are disbursed through the existing Global Fund performance-based system no new governance structure or administration is required for Debt2Health reallocations.
- Debt2Health is an attempt to overcome weakened donor financing following the financial recession by bringing together donors who might be struggling to meet their ODA promises and poorer countries who have considerable outstanding debt so as to generate domestic funding for health. The diagram below illustrates the modalities for the implementation of the Debt2Health Debt Swap Agreement.

The Debt2Health Mechanism in Action

Under Debt2Health, a creditor government (the "Creditor") writes off a certain amount of debt owed by a developing country with high debt and high disease burden (the "beneficiary"). The Beneficiary subsequently makes the counterpart payment to the Global Fund. The Global Fund then disburses these funds to prevention, treatment and care services for those in most need.



Debt2Health debt swaps were piloted in Indonesia, Kenya, Pakistan and Peru.

- Germany has pioneered Debt2Health, with arrangements amounting to almost €120 million across Indonesia (€50 million), Pakistan (€40 million), Côte d'Ivoire (€19 million) and Egypt (€6.6 million).
- Anything entitled to funding from the Global Fund can be financed through Debt2Health.

Côte d'Ivoire's Debt2Health Debt Swap Agreement.

- The Global Fund facilitated negotiations between Côte d'Ivoire and Germany in 2010, making it the first African country to benefit from Debt2Health. Under the agreement, Germany cancelled Côte d'Ivoire's debt obligations worth €19 million (\$27 million). Côte d'Ivoire in turn invested half of this amount (€9.5 million) in national programmes to combat HIV/AIDS.
- Côte d'Ivoire was required to transfer this €9.5 million amount to the Global Fund (in the form of cash or as a promissory note).

The criteria for a country to qualify for Debt2Health are as follows:

- High disease burden
- Liquidity to invest in the counterpart fund
- An adequate mix of potentially convertible debt
- Good past performance of Global Fund grants
- Demonstrated need
- Potential and capacity for scale-up
- Potential for involvement of civil society

CASE STUDY SIX:

CONCESSIONAL BORROWING

CONCESSIONAL BORROWING TO FINANCE THE HEALTH SECTOR IN BOTSWANA

The innovative financing mechanism in action

- The HIV/AIDS response in Botswana had, prior to 2008, been heavily focussed on providing HIV treatment and as a result less focus was accorded to prevention.
- To address the gap in prevention the country sought technical and financial assistance from the World Bank to help the country transition from an emergency response to a broader, more strategic and sustainable response.
- As an upper middle-income country, however, Botswana is excluded from access to the World Bank's highly concessional IDA lending programme.
- The government of Botswana negotiated a loan of US\$50 million from the IBRD to finance the strengthening of HIV prevention efforts as part of the Botswana National HIV/AIDS Prevention Support Project (BNAPS).
- In an attempt to improve the terms of a proposed IBRD loan the government of Botswana requested that part of the loan involve a "buy-down" using donor funds.
- The IBRD loan "buy-down" mechanism was developed to increase the flexibility and concessionality of funding for projects where it is justified by global public good or cross-border externalities.
- A "buy-down" combines a loan to a developing country with a donor commitment to pay ("buy down") part or all of the loan, with the "buy-down" component performance managed and debt "bought" only if predetermined objectives are achieved
- In essence, the IBRD loan can become a grant if the loan is used to achieve negotiated results but will remain a repayable loan where satisfactory results are not achieved.

What is the health financing mechanism?

- A concessional loan is a credit extended on terms substantially more generous than market loans. The concessionality is achieved either through low interest rates below those available on the market (typically 1% to 7%). This can also be provided through generous lending terms such as grace periods, repayment terms and up-front fees, or through a combination of the two.
- The loans are typically provided over long repayment periods of between 10 and 40 years and are commonly provided by multilateral financial institutions. They are provided directly to national governments and usually for the purpose of financing large-scale programmes in a particular sector such as health, infrastructure and education.
- The 'concession' component of the loan also commonly includes providing a proportion of the 'loan' in the form of a grant. Under new terms recently negotiated by OECD member states (October 2015), concessional loans may only be considered as Official Development Assistance (ODA) if at least 45% of the loan is provided in the form of a grant.
- The official OECD definition of concessional lending in fact classifies giving by any of the major regional development banks (African Development Bank, Asian Development Bank, and the Inter-American Development Bank) and from the IMF and World Bank as concessional lending – with concessionality defined on the basis of each institution's own classification of concessional lending. [International Monetary Fund: External Debt Statistics: Guide for Compilers and Users, June 2003 (2013 edition)].
- The World Bank provides concessional loans through different lending mechanisms depending on a recipient country's creditworthiness and income level. Loans to low-income countries are provided through the International Development Association (IDA) – which is vested with the authority to provide financing at lower interest rates and at more generous payment terms. Loans to middle-income countries are managed by the International Bank for Reconstruction and Development (IBRD).
- During the most recent fiscal year (which ended June 30, 2015), IDA commitments totalled \$19 billion (including IDA guarantees), of which 13 percent was provided on grant terms. IDA has averaged \$19 billion annually over the three previous financial years. Since 1960, IDA has provided \$312 billion to 112 countries.
- The IMF as well as Regional Development Banks have similar lending policies and mechanisms.
- The IMF provides concessional loans to low-income country member governments through the Poverty Reduction and Growth Facility (PRGF). In 2012 the IMF adopted a strategy to establish an annual concessional lending capacity of SDR 1¼ billion (\$2 billion).

What are the advantages of concessional borrowing?

- Predictable and stable funding (a set amount is disbursed over a set number of years).
- Allows countries to gradually assume financial responsibility over a long period of time.
- Low transaction costs (low interest rates and up-front fees).
- Quick implementation (from application to approval can take between six months to two years).

What are the disadvantages of concessional borrowing?

- Must compete with other funding priorities at a national and multilateral level.
- The World Bank and ADB has funded infrastructure, energy, and public sector/ governance programmes more than health.

Results of the IBRD loan “buy-down” in Botswana

- The IBRD loan for BNAPS leveraged a US\$20 million contribution from the European Union Commission (EC) to achieve a performance-based “buy-down” of part of the loan.
- The EC approved an additional \$20 million in its next four-year Economic Development Framework (EDF-10, 2010-2014) to finance the buy-down of this IBRD loan. The financial impact of this amount effectively enabled Botswana to access a zero-interest project loan to finance BNAPS and to receive roughly \$3million toward the principle repayment.
- The release of the additional \$20 million from the EU was triggered by meeting performance objectives within the project time frame. The performance objectives agreed upon were a subset of the project’s performance indicators derived from the M&E framework, with funds scheduled for release based on the results of IBRD mid-term and end-term reviews.
- The recently released BAIS IV sero-survey indicates positive progress with respect to improvements in access to HIV testing services, knowledge levels, among other key areas.
- Botswana provided pathfinder learning on the innovative performance-based buy-down mechanism for other IBRD countries in the region – including for the governments of Swaziland and Lesotho who thereafter adopted similar loan “buy-downs” for their HIV/AIDS response.

CASE STUDY SEVEN:

ESTIMATE OF REVENUE FROM INNOVATIVE FINANCING

INNOVATIVE FINANCING OPTIONS FOR HEALTH IN TANZANIA

Introduction to health financing in Tanzania

- The United Republic of Tanzania is a low-income economy (a GNI per capita of \$1,045 or less).
- 60% of Tanzania’s response to AIDS, TB and Malaria is sustained through external funding.
- Canada and Denmark are two of the largest bilateral donors of the country’s HIV & AIDS response, but have both announced the withdrawal of funding by the year 2015.
- Tanzania is also the second largest recipient of the Global Fund grants.
 - There is no GFATM commitment to health financing beyond the 2015 deadline.
 - This led the Global Fund in 2013 to urge Tanzania “to fast-track efforts to establish a multimillion-dollar health trust fund aimed at sustaining the country’s campaign to fight HIV & AIDS, tuberculosis and malaria.”
- Analysis by the Tanzania Commission for AIDS (TACAIDS) show that foreign assistance for HIV has declined by nearly 50%, and is projected to decline further.

Tanzania’s ability to increase domestic financing for health through Innovative Financing?

- As part of its effort to implement Universal Health Coverage the Government of Tanzania commissioned Oxford Policy Management to prepare an analysis of how the country could finance the introduction of UHC.
- The report – *Fiscal Space and Innovative Financing for the Tanzania Health Sector*¹ – includes an analysis of the potential contribution of five innovative sources of financing to meet the financing gap that would make a minimum package of UHC possible.
 - Two financing gaps were considered: a ‘minimum funding gap’ and a ‘wider financing gap’
- The table below summarises the resources that could be available from each of these alternative funding mechanisms each year on average for the next ten years.
 - Were the Government of Tanzania to implement a combination of a Remittances Levy, Airtime Levy, Alcohol Levy and Airline Levy as well as to implement private sector mainstreaming the total funding that this would generate would amount to only 4% of the ‘minimum funding gap’ and 2.9% of the ‘wider financing gap’ – an amount of USD \$246 million per year.
 - The combination of these levies “would be insufficient to fill any of the financing gap”.
 - This is prior to consideration of whether it is politically or technically feasible to institute these types of taxes on the Tanzanian economy.

Potential Revenues from innovative financing for Health (10-year average)

	\$ Millions	As a % of the ‘Wider Financing Gap’	As a % of the ‘Minimum Financing Gap’
Alternative Funding Sources (USD)	\$ 246 million	-4.0%	-2.9%
Alternative Funding Sources (TzSh)	\$ 461,173 million	-4.0%	-2.9%
Earmarked Taxation (million TzSh)	385,092	-3.3%	-2.4%
Remittances Levy	2,084	-0.02%	-0.01%
Airtime Levy	68,785	-0.6%	-0.4%
Alcohol Levy	256,381	-2.2%	-1.6%
Airline Levy	57,842	-0.5%	-0.4%
Mainstreaming	76,080	-0.7%	-0.5%
Private sector mainstreaming	76,080	-0.7%	-0.5%

- The report identifies that efficiency improvements alone could generate at least twice as much (‘minimum funding gap’) and possibly three times as much (‘wider financing gap’) ‘fiscal space’
 - Tanzania can move from operating at 70% efficiency to 82% efficiency by 2024/25.
 - Doing so would close the health financing gap by 10%.
- Thus the priority for Tanzania should be on strengthening general government taxation and to pursue efficiency improvements, although some innovative financing interventions can prove complementary.

¹ Oxford Policy Management: Fiscal Space and Innovative Financing for the Tanzania Health Sector. December 2014. Available at: http://apps.who.int/health_financing/events/2_opm_fiscal_space_tanzanian_health_sector.pdf

