

INNOVATIVE AND
DOMESTIC FINANCING
FOR HEALTH

Expanding the fiscal space for health in Africa

June 2016

 The Global Fund





TABLE OF CONTENTS

Abbreviations	4
Acknowledgements	4
Foreword	5
1. Introduction: The Challenge	6
2. Situating innovative domestic financing for health within Africa's health financing debate	8
3. Africa's priorities: Agenda 2063 and the <i>Catalytic Framework</i>	13
4. African Domestic Investment in Health: How has Africa adjusted to the squeeze?	16
4.1. How much should countries spend on health?	18
5. How much will it cost to end AIDS and TB and to eliminate Malaria from Africa by 2030?	20
5.1. Estimated costs of ending TB in Africa by 2030	21
5.2. Estimated costs of Malaria elimination in Africa by 2030	21
5.3. Estimated costs of ending AIDS in Africa by 2030	21
6. Increasing the Fiscal Space for health	22
6.1. Theoretical perspectives on how governments can increase the fiscal space for health?	23
6.1.1. Conducive macroeconomic conditions and greater domestic revenue mobilisation	24
6.1.2. Prioritising health within the government budget	25
6.1.3. Taxes earmarked for health and other health sector-specific resources	25
6.1.4. Official Development Assistance (ODA)	25
6.1.5. Efficiency improvements in the health sector	25
6.2. How practically can governments increase the fiscal space for health?	26
6.3. Raising government revenue – to what level?	26
7. Fiscal Space for Health through Innovative Financing	28
7.1. Sources of Innovative Financing for Health	29
7.1.1. Health / AIDS Trust Funds	30
7.1.2. Alcohol levy	30
7.1.3. Airline levy	30
7.1.4. Remittances levy	31
7.1.5. Currency Transaction Levy (CTL) or Financial Transaction Tax	32
7.1.6. Mobile phone 'airtime' levy	32
7.1.7. Concessional borrowing to finance the health sector	32
7.2. Revenue generating potential of Innovative Financing for Health	32
8. Can Africa meet the domestic financing targets of the <i>Catalytic Framework</i> through innovative financing?	33
9. Conclusion	35
Reference List	38
Annex 1: How much should countries spend on health	41
Annex 3: Currency Fluctuations	42

ABBREVIATIONS

AfDB	African Development Bank	ODA	Overseas Development Assistance
AIDS	Acquired Immune Deficiency Syndrome	OECD	Organisation for Economic Cooperation and Development
ART	Antiretroviral Therapy	ODA	Official Development Assistance
AU	African Union	OOP	Out of Pocket
CHGA	Commission on HIV/AIDS and Governance in Africa	PEFA	Public Expenditure and Financial Accountability
CSO	Civil Society Organisation	PEPFAR	United States President's Emergency Plan for AIDS Relief
DAC	Development Assistance Committee	PHC	Primary Health Care
DAH	Development Assistance for Health	PHI	Private Health Insurance
DIPI	Domestic Investment Priority Index	PLHIV	People living with HIV
EAC	East African Community	PMTCT	Prevention of Mother to Child Transmission
ECA	Economic Commission for Africa	ROI	Return on Investment
ECOWAS	Economic Community for Western African States	SADC	Southern African Development Community
GDP	Gross Domestic Product	SDG's	Sustainable Development Goals
GFATM	Global Fund to Fight AIDS, TB and Malaria	SHIB	Social Health Insurance Benefits
GGEH	General Government Expenditure on Health	STI	Sexually Transmitted Infection
GHE-S	Government Health Expenditure as Source (IHME classification for GGHE)	TB	Tuberculosis
GHI	Global Health Initiatives	THE	Total Health Expenditure
GNI	Gross National Income	TOR	Terms of Reference
GNP	Gross National Product	UHC	Universal Health Coverage
HDI	Human Development Index	UNAIDS	The Joint United Nations Programme on HIV & AIDS
HIV	Human Immunodeficiency Virus	UNDP	United Nations Development Programme
IAPAL	International Air Passenger Adaptation Levy	UNECA	United Nations Economic Commission for Africa
IHME	Institute for Health Metrics and Evaluation	UNGASS	United Nations General Assembly Special Session
IMF	International Monetary Fund	USAID	United States Agency for International Development
M & E	Monitoring and Evaluation	USD	United States Dollars
MDG's	Millennium Development Goals	VAT	Value-Added Tax
MoF	Ministry of Finance	WEO	World Economic Outlook
MoH	Ministry of Health	WHA	World Health Assembly
MTEF	Medium Term Expenditure Framework	WHO	World Health Organisation
MTR	Mid-Term Review		
NASA	National AIDS Spending Assessment		
NGO	Non-governmental Organisation		
NHA	National Health Accounts		

ACKNOWLEDGEMENTS

The African Union Commission wishes to thank various resource persons who provided critical input to this compilation of this report on innovative and domestic financing for health in Africa. This report was written by Paul Booth, independent consultant, and Professor Alan Whiteside, CIGI Chair in Global Health Policy Professor at Balsillies School of International Affairs.

This report would not have been possible without the valuable support from Member States Experts, Regional Economic Communities and development partners who reviewed the study during the AWA Consultative Experts Meeting in June 2016.

This study was made possible through the support of the Global Fund to Fight AIDS, TB and Malaria and the United Nations Foundation. Special thanks to Shu-Shu Tekle-Haimanot and Amina Egal.

Special recognition to the Department of Social Affairs team that worked with the consultants in undertaking and finalising this study, Ambassador Olawale Maiyegun, Dr. Marie-Goretti Harakeye, Tawanda Chisango, Sabelo Mbokazi, Dr. Adiel Kundaseny Mushi and Dr. Sheila Tamara Shawa. The facts presented herein will guide the African Union Member States and various players as policies to expand the fiscal space for health on the African continent evolve.

FOREWORD

Current continental policy frameworks that provide the future direction for Africa's structural transformation and inclusive economic growth have prioritised health as a key tenet for sustainable development. The first of the seven aspirations of Africa's long term development framework, Agenda 2063 accords first priority to 'healthy and well-nourished citizens'. Therefore the achievement of the seven bold aspirations of Agenda 2063 and getting to 'the Africa we want' is predicated on meeting the health related targets.

It is in this context that the African Union in 2016 adopted continental health related frameworks that include the Africa Health Strategy (2015-2016) and the Catalytic Framework to end AIDS, TB and Eliminate Malaria in Africa by 2030. The successful implementation of these strategic frameworks will highly rely on increased domestic financing to achieve universal health coverage. Many African countries are already implementing promising health financing reforms which can enable the African continent to achieve its set goals.

Domestic resource mobilisation facilitates greater domestic policy ownership, coherence with domestic needs and higher development impact. It is in this context that the African Union commissioned this study to look at the fiscal space for domestic health financing. Africa's remarkable economic growth, resilient over the previous two decades, provides the hope that we can gradually mobilise the resources required domestically.

While external support is necessary in the short to medium term, Africa will need innovative financing to complement existing domestic revenue for health. Lessons from this study suggest that health financing is not simply about 'raising more money domestically' to 'fill a funding gap' but also about ensuring that spending of the generated resources is progressive rather than regressive.

There is no doubt that while significant progress has been made in health financing, Africa's health sector is underinvested. Therefore, there is a need for AU Member States to increase investments in health to achieve their commitments on universal health coverage.

In return the increased allocation of resources to Ministries of Health will continue to improve the efficiency of health systems. If Africa is to achieve the objectives of the Catalytic Framework to end AIDS and TB and eliminate Malaria by 2030 in line with the aspirations of Agenda 2063 then AU Member States need to give themselves the means to achieve them, guided by this document.

Dr. Mustapha Sidiki Kaloko
Commissioner for Social Affairs

1

Introduction: The Challenge

The 54 African Union (AU) Member States have been resolute in their efforts to achieve ambitious health targets for the continent. Strong political leadership has ensured that health remains high on the continent's list of development priorities. While some targets have not been achieved Africa has made great strides in improving health outcomes across a range of performance metrics.

Africa's long term development framework, *Agenda 2063*,¹ places the objective of realising "healthy and well-nourished citizens" within the first of the seven ambitious aspirations to realise 'the Africa we want'. Achieving this objective will require Africa to meet the bold targets of the *Catalytic Framework*,² which include ending AIDS and TB and eliminating malaria by 2030.

Meeting these targets will require significant investment in health, yet this comes during a period of plateauing development partner support. If Africa is to achieve its set targets in the context of stagnating and declining development partner support significant new revenue will need to be generated from domestic sources. Health financing, however, is not simply about raising more money. It is also about ensuring that revenue collection and spending is progressive (richer citizens subsidising the poorer) rather than regressive. There is need to ensure that resources for health are appropriately pooled.

The primary domestic sources of fiscal space for health include:

1. Prioritising health within the existing allocation of general government expenditure;
2. Generating additional government revenue, including through innovative sources of funding; and
3. Efficiency savings in health.

Fiscally prudent economic management requires that the three elements of primary domestic sources be implemented in combination. The degree to which each is implemented should be determined by the local economic context.

This study explores innovative financing as a source for raising additional revenue for health. It concludes that while innovative financing can provide a steady, sustainable and equitable way of generating small amounts of additional resources for health, it should not be looked upon as the solution to Africa's health financing resource challenges. Where innovative mechanisms are able to create room in the budget for additional spending while not jeopardising the fiscal stability of the economy they should be implemented. However, innovative financing is not a panacea for domestic health financing. The mechanisms should be used only to complement traditional government revenue generation and as short term solutions to funding needs while governments work to expand the tax base.

The mechanisms should be used only to complement traditional government revenue generation. Innovative financing provides short term solutions to funding needs while governments work to expand the tax base.

General government taxation must therefore remain the priority and Ministries of Finance and tax revenue authorities should be strengthened in order to collect and fund government activities from the more progressive, equitable and efficient general taxation.

1 African Union: *Agenda 2063, The Africa We Want*. Second Edition, August 2014.

2 African Union: *Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030*.

A large, stylized number '2' in a dark green color, positioned on the left side of the page, partially overlapping the text.

Situating innovative domestic financing for health within Africa's health financing debate

Africa's response to AIDS, TB and Malaria is an incredible success story

The scale-up of the response to HIV and AIDS and malaria on the African continent is remarkable, since 2000, facilitated by the African leadership's strong and sustained political commitment to ending these three major public health threats. AIDS-related deaths in Africa declined by 48% between 2005 and 2014 while new HIV infections declined by 39% between 2000 and 2014. More than 10.7 million people are enrolled on antiretroviral therapy in 2016, a 100-fold increase since 2002. AU Member States collectively reduced the rate for contracting malaria by 42% between 2000 and 2013. The incidence of malaria in children aged 2 to 10 years declined by 48%. The mortality due to malaria (all ages) declined by 66%. The TB response has been accelerated and the TB treatment success rate reached 86% in 2013.³

Africa's health sector is weak, performs poorly and remains heavily underfunded

While HIV incidence and AIDS mortality have declined, AIDS remains among the leading causes of death in Africa. AIDS was responsible for almost 800,000 deaths in 2014, a year which saw a further 1.4 million people newly infected with HIV.⁴ The malaria burden remains high, particularly for children under-five years. Approximately 90% of malaria infections worldwide in 2012 occurred in Africa⁵ while more than 500,000 African children die from malaria each year.⁶ The TB response needs to reach about 1.3 million people in Africa.⁷

Looking beyond these three diseases, many African countries missed the set targets in spite of the significant effort that went into achieving the health-related Millennium Development Goals (MDGs).⁸ The African continent accounts for 25% of the global burden of disease but has only 12% of the global population. About 50% of under-five deaths and 70% of those living with HIV are in Africa. The infectious diseases that have declined elsewhere continue to account for the greatest portion of mortality and morbidity on the African continent.⁹

Thus, despite the progress made, Africa confronts the world's most acute public health threats with weak health systems and complex bottlenecks which the AU Member States need to "weather in the face of" seriously underfunded global commitments.¹⁰

Health system performance is constrained by insufficient resources

Building health system resilience requires an increase in investment. Furthermore this increased level of resources allocated to health needs to be sustained over a long period of time. The 2001 Abuja Declaration 15% target galvanised all AU Member States to a common target and spurred a progressive increase in domestic funding for health on the continent. However Africa's health systems have had decades of underinvestment. The level of investment in health in the Africa region is best expressed by considering that **the regions of South Asia and Africa South of the Sahara together account for over 50% of the global disease burden – and 37% of the world's population – but only 2% of global health spending.**¹¹ So far, few African countries south of the Sahara have COME close to MEETING the Abuja target of ALLOCATING 15% of the government budget to the health sector.¹²

3 All figures from African Union: *Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa By 2030: Stride towards sustainable health in Africa*. Pg.3 and Pg.4.

4 African Union: *Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030*. Pg.4.

5 African Union: *Agenda2063: The Africa We Want Strategic Framework*. March 2015. Pg.39

6 African Union: *Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030*. Pg.4.

7 African Union: *Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030*. Pg.4.

8 African Union: *Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030*. Pg.4.

9 African Union: *Agenda2063: The Africa We Want Strategic Framework*. March 2015. Pg.38

10 African Union: *Agenda2063: The Africa We Want Strategic Framework*. March 2015. Pg.38

11 Tandon, A and Cashin, C: *Assessing Public Expenditure on Health from a Fiscal Space Perspective*. 2010

12 Tandon, A and Cashin, C: *Assessing Public Expenditure on Health from a Fiscal Space Perspective*. 2010

Development assistance for health

“The dwindling and unpredictability of development assistance compels Africa to look inwards for domestic resources for the care of her people. Africa will need to mobilize internal resources for the promotion of her health”

-Agenda 2063: Strategic Framework.

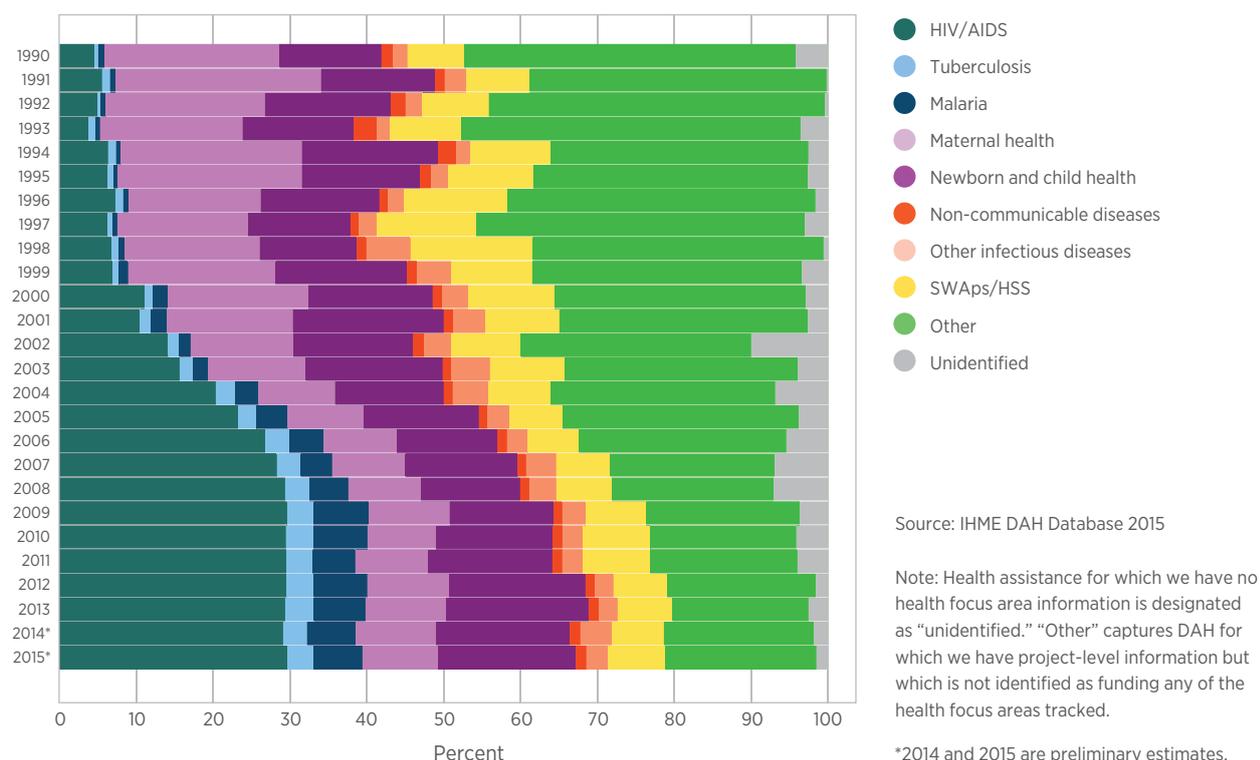
Development Assistance for Health (DAH) has been a significant factor underpinning the scaling up of health responses across the African continent. Globally domestic financing provides the greatest source of health financing.¹³ However in Africa health programmes have substantially been dependent on Official Development Assistance (ODA), which threatens sustainability.

In absolute (non-inflation adjusted) terms DAH grew dramatically from \$5.7 billion in 1990¹⁴ to US\$36.4 billion in 2015, peaking in 2013 at \$38 billion.¹⁵ DAH increased at a rate of 4.9% annually from 1990 to 2000¹⁶ and then at

a rate of 11.3% per year between 2000 and 2009.¹⁷ Since 2010, however, DAH has grown at just 1.2% annually, remaining more or less static at \$36 billion.¹⁸ Indeed, so dramatic has been the transformation since 2010 that the *Institute for Health Metrics and Evaluation (IHME)* believes that the quantity of DAH is forever altered¹⁹ and that this pattern will persist into at least the medium term.²⁰

IHME further expects a continuation of the shift “among the major health focus areas, with relatively little growth for HIV/AIDS, malaria, and tuberculosis.” Figure 1 below shows that the proportion of DAH allocated to HIV/AIDS and TB has remained relatively constant since 2006, and for Malaria since 2009. The plateauing of development assistance for health has potentially critical effects on health services in recipient countries. This elevates the importance of both domestic financing and innovative funding.

FIGURE 1:
SHARE OF DAH ALLOCATED BY HEALTH FOCUS AREA, 1990–2015²¹



13 Van Rooijen, P. Where is the Money? Challenges and opportunities in mobilizing increased domestic financing. The role of domestic resource mobilization. *Presentation delivered to a Satellite Session at the 20th International AIDS Conference in Melbourne, Australia.* July 2014. Slide #2

14 Institute for Health Metrics and Evaluation. *Financing Global Health 2012.*

15 Institute for Health Metrics and Evaluation (IHME). *Financing Global Health 2015.* The 2015 total, at \$36.4 billion, is a 4.3% drop from 2013 DAH levels, but a slight increase (0.3%) relative to 2014.

16 Institute for Health Metrics and Evaluation (IHME). *Financing Global Health 2015.* Pg.19

17 Dieleman JL, et al. “Development assistance for health: past trends, associations, and the future of international financial flows for health” in *The Lancet.* 2016 April 13.

18 Institute for Health Metrics and Evaluation (IHME). *Financing Global Health 2015.* Pg.19

19 Institute for Health Metrics and Evaluation. *Financing Global Health 2013: Transition in an Age of Austerity.*

20 Dieleman JL, et al. *Ibid.*

21 Institute for Health Metrics and Evaluation (IHME). *Financing Global Health 2015.* Figure 15, Pg.29

Africa South of the Sahara receives the largest share of DAH and this portion continued to grow, at least until 2013. In 2013, these countries received 34.3% of all DAH – an amount totalling \$13 billion.²² The bulk of this funding was directed to HIV/AIDS (47.9%), with maternal health receiving \$2 billion (15.4%) and child health \$964 million (7.4%).²³

Table 1 below presents the percentage of Gross National Income (GNI)²⁴ - note, not GNP - for the 23 countries that report their ODA contributions to the Organisation for Economic Cooperation and Development (OECD) Development Assistance Committee (DAC), for the period 2000 to 2014. These countries account for the bulk of development aid globally.

Can we rely on Development partners to meet their 0.7% GNP commitment to ODA?

In 1970 developed country governments committed in a UN General Assembly Resolution to devote 0.7% of their Gross National Product (GNP) to ODA. Developed country governments have repeatedly affirmed their commitment to this target. This includes during the Monterrey Consensus emerging out of the 2002 UN International Conference on Financing for Development, the 2002 World Summit on Sustainable Development and the 2005 G8 Gleneagles Summit.

TABLE 1:
NET ODA AS A % OF GNI, 2000-2014

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
AUSTRALIA	0.27	0.25	0.26	0.25	0.25	0.25	0.30	0.32	0.32	0.29	0.32	0.34	0.36	0.33	0.31
AUSTRIA	0.23	0.34	0.26	0.20	0.23	0.52	0.47	0.50	0.43	0.30	0.32	0.27	0.28	0.27	0.28
BELGIUM	0.36	0.37	0.43	0.60	0.41	0.53	0.50	0.43	0.48	0.55	0.64	0.54	0.48	0.45	0.46
CANADA	0.26	0.22	0.28	0.24	0.27	0.34	0.29	0.29	0.33	0.30	0.34	0.32	0.32	0.28	0.24
DENMARK	1.06	1.03	0.96	0.84	0.85	0.81	0.80	0.81	0.82	0.88	0.91	0.85	0.83	0.85	0.86
FINLAND	0.31	0.32	0.35	0.35	0.37	0.46	0.40	0.39	0.44	0.54	0.55	0.53	0.53	0.54	0.60
FRANCE	0.31	0.31	0.38	0.4	0.41	0.47	0.47	0.38	0.39	0.47	0.50	0.46	0.45	0.41	0.37
GERMANY	0.27	0.27	0.27	0.28	0.28	0.36	0.36	0.37	0.38	0.36	0.39	0.39	0.37	0.38	0.42
GREECE	0.20	0.17	0.21	0.21	0.16	0.17	0.17	0.16	0.21	0.19	0.17	0.15	0.13	0.10	0.11
IRELAND	0.30	0.33	0.40	0.40	0.39	0.42	0.54	0.55	0.59	0.55	0.52	0.51	0.47	0.46	0.38
ITALY	0.13	0.15	0.20	0.17	0.15	0.29	0.20	0.19	0.22	0.16	0.15	0.20	0.14	0.17	0.19
JAPAN	0.28	0.23	0.23	0.20	0.19	0.28	0.25	0.17	0.19	0.18	0.20	0.18	0.17	0.23	0.19
KOREA	0.04	0.06	0.05	0.06	0.06	0.10	0.05	0.07	0.09	0.10	0.12	0.12	0.14	0.13	0.13
NETHERLANDS	0.84	0.82	0.81	0.80	0.73	0.82	0.81	0.81	0.81	0.82	0.82	0.75	0.71	0.67	0.64
POLAND	0.02	0.02	0.00	0.01	0.05	0.07	0.09	0.10	0.08	0.09	0.08	0.08	0.09	0.10	0.09
PORTUGAL	0.26	0.25	0.27	0.22	0.63	0.21	0.21	0.22	0.27	0.23	0.29	0.31	0.28	0.23	0.19
RUSSIA	/	/	/	/	/	/	/	/	/	/	0.03	0.03	0.02	0.03	0.05
SAUDI ARABIA	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
SPAIN	0.22	0.30	0.26	0.23	0.24	0.27	0.32	0.37	0.45	0.46	0.43	0.29	0.16	0.17	0.13
SWEDEN	0.80	0.77	0.84	0.80	0.78	0.94	1.02	0.94	0.98	1.12	0.97	1.02	0.97	1.01	1.09
TURKEY	0.04	0.04	0.04	0.04	0.11	0.17	0.18	0.09	0.11	0.12	0.13	0.17	0.32	0.40	0.45
UNITED KINGDOM	0.32	0.32	0.31	0.34	0.36	0.47	0.51	0.36	0.43	0.51	0.57	0.56	0.56	0.71	0.70
UNITED STATES	0.10	0.11	0.13	0.15	0.17	0.23	0.18	0.16	0.18	0.21	0.20	0.20	0.19	0.18	0.19
AVERAGE (%)	0.30	0.30	0.32	0.31	0.32	0.37	0.37	0.35	0.37	0.38	0.39	0.38	0.36	0.37	0.37

● 0.70% and above ● 0.50% to 0.69% ● Below 0.50%

22 Institute for Health Metrics and Evaluation (IHME). Financing Global Health 2015. Figure 15, Pg.40

23 Institute for Health Metrics and Evaluation (IHME). Financing Global Health 2015. Figure 15, Pg.40

24 The OECD collects and measures data on Gross National Income (GNI) as opposed to Gross National Product (GNP).

Denmark, the Netherlands and Sweden are the only 3 out of the 23 countries that have consistently met their ODA commitments. In 2014 ODA commitments represented an average of 0.35% of the combined Gross National Income (GNI) of DAC countries which is half of the pledged 0.7% commitment.²⁵ ODA from traditional European donor countries is likely to remain static due to many competing challenges that include mass migration. It is thus unrealistic for AU Member States to expect additional ODA commitments as a source of funding for health programmes that are already heavily dependent on ODA.

If not from ODA, where will the money come from?

In order for countries to continue to aggressively scale-up investments in health in the post-2015 development agenda era, AU Member States have to answer the question of how to finance their concurrent policy agendas in the context of plateauing and decreasing ODA.

New resources need to be generated domestically. This can be in part achieved through using existing resources more efficiently and more effectively, but health in Africa has been chronically underfunded for generations and will not be improved through efficiency gains alone (although efficiency improvements are required to generate the credibility to convince finance ministries that additional resource allocations will be well spent).

Economic growth offers a further area for new revenue collection, both through general taxation and through a variety of innovative financing mechanisms. Total health expenditure as well as the government's share of total health expenditures generally increase with national income across countries. The responsiveness, or elasticity, of government health expenditure with respect to GDP gives an indication of whether favourable macroeconomic conditions can be expected to translate into more public expenditure on health. The elasticity of government spending to GDP is estimated to be about 1.16 across all low-income countries. This implies that a 1% rise in income on average leads to a 1.16% rise in government health spending, on average. However, the overall fiscal health and discipline of a country can significantly affect the degree to which economic growth can be translated into increased resources for health.²⁶ Chapter 6 on Increasing the *Fiscal Space* for health will explore how African countries can raise the additional resources from domestic sources required to achieve set targets.

This highlights the potential of innovative financing mechanisms for health to complement existing domestic funding to bridge the resource gap and enable Africa to realise the Agenda 2063 vision.

²⁵ Whiteside, A. et al, *Responding to Health Challenges: The Role of Domestic Resource Mobilisation*. 2013, Pg.17
²⁶ Tandon, A. and Cashin, C. *Assessing Public Expenditure on Health from a Fiscal Space Perspective*. 2010

3 Africa's priorities: Agenda 2063 and the *Catalytic Framework*

AU Member States in 2012 adopted the Roadmap for Shared Responsibility and *Global Solidarity for AIDS, TB and Malaria Response in Africa*.²⁷ The Roadmap sought to deal with the reality of plateauing development partner support and the rising costs associated with the scaling-up or even maintaining existing health responses. The following year African Heads of State and Government committed in the *Abuja+12 Declaration* to key actions intended to lead to the end of AIDS and TB and the elimination of Malaria in Africa by 2030.²⁸ In 2016 the objectives of the *AU Roadmap*, the *Abuja+12 Declaration* and the SDG targets were consolidated into the recently endorsed *Catalytic Framework to end AIDS, TB and to Eliminate Malaria in Africa by 2030*.²⁹ The framework provides a business case to end the three diseases as a public health threat by 2030. Together with the *Maputo Plan of Action and the Africa Health Strategy*³⁰ these frameworks sets the policy architecture to catalyse the realisation of the health related goals of Africa's *Agenda 2063*.³¹

Agenda 2063

In 2014 Member States adopted³² a new vision for Africa. Agenda 2063³³ provides a common development framework for Africa for the next 50 years, setting seven aspirations which are:

1. A prosperous Africa based on inclusive growth and sustainable development;
2. An integrated continent, politically united, based on the ideals of Pan Africanism and the vision of Africa's Renaissance;
3. An Africa of good governance, respect for human rights, justice and the rule of law;
4. A peaceful and secure Africa;
5. An Africa with a strong cultural identity, common heritage, values and ethics;
6. An Africa whose development is people-driven, relying on the potential of African people, especially its women and youth, and caring for children; and
7. Africa as a strong, united, resilient and influential global player and partner.

The objective of ensuring Africa is home to “healthy and well-nourished citizens” falls within the first aspiration.³⁴

The Agenda 2063 development framework emphasises the need for a ‘paradigm shift’ towards African led initiatives for funding responses to diseases. There is an emphasis both on how development partner financing has plateaued and on how Africa is funding its own development through “export earnings, trade and remittances among others.”³⁵ GDP growth is considered crucial for generating additional resources.

Building on the *Common African Position*,³⁶ *Agenda 2063* prioritises domestic resource mobilisation and trade as the main sources of financing for the continent's structural transformation. Indeed, Article 69.b of *Agenda 2063* emphasises self-reliance as a pre-condition for Africa's success. It recognises the centrality of mobilisation of Africa's domestic resources to finance its development as a critical enabler of continental transformation.³⁷ For this reason, Article 67.n commits the continent to strengthening domestic resource mobilisation by 2025, through “reducing aid dependency by 50%” and by “building effective, transparent and harmonised tax and revenue collection systems and public expenditure.”³⁸

However *both Agenda 2063* and the *Catalytic Framework* recognise the need for external sources of finance, advocating for collaboration between Africa and its strategic partners. A recent joint discussion paper argues the case both for aggressively increasing domestic resource mobilisation and for pressuring development partners to meet their ODA commitments.³⁹ It argued that domestic resource mobilisation is of critical importance for the following reasons:

1. reliance on domestic resources reinforces a country's ownership of public policy and strengthens accountability;
2. domestic resources can spur a more effective use of development financing;
3. external resources are not only unpredictable and erratic, but would not be sufficient to meet Africa's development financing needs;
4. most donor countries have failed to live up to their long-standing commitments.

27 The Roadmap was extended to 2020 by the Decision on the Report of the AIDS Watch Africa (AWA) Doc. Assembly/AU/14(XXV) to ensure its full implementation.

28 AU: Declaration of the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria. 2013.

29 African Union: *Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030*.

30 Maputo Plan of Action (2016-2030) for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights and the Africa Health Strategy (2016-2030).

31 African Union: *Agenda2063 Framework Document, The Africa We Want*. 2015

32 The Agenda2063 framework was adopted by the African Union at the AU Assembly in 2015.

33 African Union: *Agenda2063, The Africa We Want*. Second Edition, August 2014.

34 The health targets under this goal cover: access to quality basic health care and services; maternal, neo-natal and child mortality rates; HIV/AIDS, malaria and TB; child stunting and malnutrition; Africa Centres for Disease Control; African Medicines Regulatory Harmonisation and Domestic Financing for Health.

35 African Union: *Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030*. Pg.28

36 African Union: *Common African Position on the Post-2015 Development Agenda*.

37 African Union: *Agenda2063, The Africa We Want*. Second Edition, August 2014. Article 69.b. Pg.19

38 African Union: *Agenda2063, The Africa We Want*. Second Edition, August 2014. Article 67.n. Pg.18

39 AU Commission and ECA: *Joint African Union Commission-Economic Commission for Africa elements paper for the regional consultation on financing for development*. March 2015.

The paper provides a cogent analysis of the place of Official Development Assistance in Africa's structural transformation:

"International resources are generally found to be less stable and predictable than domestic resources as a source of development finance, they play a vital and complementary role in shaping Africa's development prospects. The various challenges associated with international resources make it vitally important for African countries to effectively harness them in the service of the continent's overarching goal of achieving inclusive and sustainable growth and structural transformation."⁴⁰

Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030⁴¹

The *Catalytic Framework* also calls on the international community "to honour commitments to strengthen health systems and finance the three diseases in Africa." Development partners are also requested, "In line with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action" to "align their financial and technical assistance and cooperation plans with national priorities for the implementation of the Catalytic Framework."

The *Catalytic Framework* argues that African leadership and ownership of development strategies and Africa's accountability are the critical success factors underpinning the achievement of Africa's health aspirations. Finally, the *Catalytic Framework* emphasises the importance of domestic financing for health:

"Various commitments by African governments including the Abuja Declarations have recognized the need to invest in health for sustainable development. In order to achieve the Agenda 2063 and SDGs health outcomes, Member States should fully implement their costed National Strategic Plans for the three diseases to ensure efficient utilisation of the allocated resources. African countries should continue to champion true transformation and a paradigm shift towards optimal domestic financing for health and diversifying sources of financing."⁴²

40 AU Commission and ECA: IBID.

41 All references in this section: AU: *Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030*.

42 *Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030* Pg.13.

4 Situating innovative domestic financing for health within Africa's health financing debate

“There is no doubt in my mind that those of us in the developing world have to do more and better to take charge of our destiny... I know that this is easier said than implemented all the more so because much of the external assistance we get has in practice been predicated on us towing the line of the donor community... The fact remains, however, there is no possibility of us keeping our promise to our people unless we do more and better to take charge of our destiny and depend on our own resources as the primary means of achieving the MDGs.”⁴³

Meles Zenawi

Late former Prime Minister of Ethiopia

Africa South of the Sahara was home to 926.9 million people in 2015, thus constituting 12.8% of the total global population. In 2013 these countries spent \$35.8 billion on health, representing 4.7% of global government health expenditure (GHE-S⁴⁴). This amounts to an average of \$37.1 per capita, with the highest rates in Southern Africa and the lowest in parts of East Africa. Between 2000 and 2013, GHE-S in *Africa South of the Sahara* rose by 5.9% annually. This annual rate of increase, however, is lower than the percentage gains observed in other regions. It was also insufficient to raise the level of domestic spending on health above the 15% Abuja Declaration target for the overwhelming majority of AU Member States.⁴⁵

Despite generating “more than \$520 billion annually through domestic resource mobilisation... more than 8.5 times the amount the continent receives in ODA⁴⁶... most African governments have not been able to consistently meet their 2001 Abuja commitment to spend 15% or more of their domestic budgets on health programmes.”

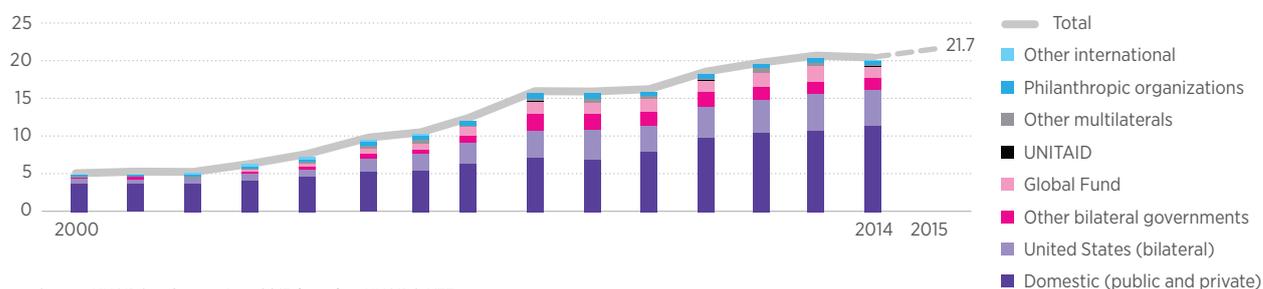
“In 2013, only 6 of the 46 countries in Africa South of the Sahara for which comparable data exist met this target. These were Rwanda, Swaziland, Ethiopia, Malawi, the Central African Republic and Togo. Between 2012 and 2013, 10 countries saw an increase in the proportion of their budgets going to health, while 26 countries saw no change and 10 countries saw a decrease.”⁴⁷

Comparison against the *Abuja 15% target*, however, hides the fact that domestic financing for health always was and remains the primary source of funding of health. Implementing countries spend on average 20 times more from their own resources than they receive from ODA. Over the previous decade, domestic investment in health grew almost 50% faster than ODA.⁴⁸

When examining the three diseases – AIDS, TB and malaria – global domestic spending doubled between 2006 and 2011.⁴⁹ At the global level, domestic financing “already accounts for more than half of funding for HIV, more than three-quarters for TB and around a quarter for malaria.”⁵⁰

The acceleration in domestic investment in health can be seen through the increase in domestic investment in the HIV and AIDS response in low- and middle-income countries over the period 2000 to 2014. This is represented globally in Figure 2 below. In Africa, domestic investment in the AIDS response accounted for 35% of the total amount invested.⁵¹

FIGURE 2:
GLOBAL RESOURCES FOR HIV & AIDS IN LOW- AND MIDDLE-INCOME COUNTRIES, 2000-2014 (IN US\$ BILLION)⁵²



Source: UNAIDS estimates June 2015, based on UNAIDS-KFF reports on financing the response to AIDS in low- and middle-income countries until 2014; OECD CRS last accessed June 2015; GARPR/UNGASS reports; FCAA Report on Philanthropic funding Dec 2014.

43 UNAIDS Issues Brief: AIDS dependency crisis: sourcing African solutions.2013.

44 GHE-S: “Government Health Expenditure as Source.” This is an IHME classification for GGHE.

45 Drawing strongly on Institute for Health Metrics and Evaluation (IHME). Financing Global Health 2015. Pg.76

46 Runde, D.F. and Savoy, C.M.: Paying for Development: Domestic Resource Mobilization. 2014.

47 ONE Campaign: AIDS Report 2015: Unfinished Business. 2015.

48 Van Rooijen, P. Where is the Money? July 2014. Slide #2

49 Whiteside, et. al. Responding to Health Challenges: The Role of Domestic Resource Mobilisation. 2013.

50 Global Fund: Global Fund Investment Case (December 2015). Pg.2

51 ONE Campaign: AIDS Report 2015: Unfinished Business. 2015. Pg.45

52 UNAIDS: How AIDS Changed Everything. June 2015. Pg.193

4.1. How much should countries spend on health?

The amount of resources that a government should invest in health has been studied extensively. While the Abuja Declaration commitment to allocate 15% of the government budget to health has received global attention, meeting this target (indeed measuring performance against it) has proven to be a significant challenge. Indeed, since the Abuja 15% target was agreed by AU Member States in 2001, the World Health Organization reports that only 27 out of 54 Member States have increased (at all) the proportion of total government expenditure allocated to health.⁵³

Measuring a government's per capita spending on health provides an additional performance measure. Three large costing studies have attempted to provide benchmark health financing targets for this measure. (See Annex 2: How much should countries spend on health). The *first* of these was the WHO-led *Commission on Macroeconomics and Health* (CMH) in 2001. The *second* was conducted by the *High Level Taskforce on Innovative International Financing for Health Systems* (HLTF) in 2005 and revisited in 2009. The *third* was conducted in 2014 by Di McIntyre and Filip Meheus, academics at the University of Cape Town (McIntyre & Meheus).

Per Capita investment in health for the three health financing targets are as follows (inflated to 2012 US\$ for uniformity):

1. The CMH per capita target of \$71 per capita.
2. The HLTF per capita target of \$86 per capita.
3. The McIntyre & Meheus target of the greater of 5% of GDP or \$86 per capita.

The \$86 per capita target provides only for a very basic set of Primary Health Care (PHC) services (see Footnotes 121 and 122 for an overview of the PHC services covered). Yet only 12 of the 46 *Africa South of the Sahara* countries spent at least \$86 per capita in 2013 (see Figure 3 below).⁵⁴ Of the five Member States who met the Abuja 15% target in 2013, “three (Ethiopia, Malawi and the Central African Republic) had some of the lowest nominal per capita spending levels on health.” This suggests that “achieving the Abuja spending target alone will not necessarily provide sufficient resources to tackle their complex health needs.”⁵⁵

Figure 3 below shows the degree of domestic under-investment in the health sector. It also demonstrates that ending AIDS and TB and eliminating malaria will be impossible without continued international assistance.⁵⁶ This chapter posits that “in order to realise its major objective of structural transformation... Africa has stepped up its policy initiatives aimed at addressing the financing gap by relying more on public and private domestic resources.”⁵⁷ Nevertheless, while AU Member States have begun to scale up their domestic investments in health, the level of these investments remains significantly below the Abuja 15% target in 40 of the 46 Africa South of the Sahara countries (2013).

Against the per capita government expenditure on health targets, 34 of the 46 Africa South of the Africa south of the Sahara countries do not meet the HLTF target required to provide a very minimal set of PHC services. Even fewer meet the McIntyre & Meheus target of ‘the greater of 5% of GDP or \$86 per capita’. African countries’ expenditure is not commensurate with disease burden and ability to pay.⁵⁸

53 World Health Organisation: *The Abuja Declaration: 10 Years On*. 2012.

54 ONE Campaign: *AIDS Report 2015: Unfinished Business*. 2015. Pg.31

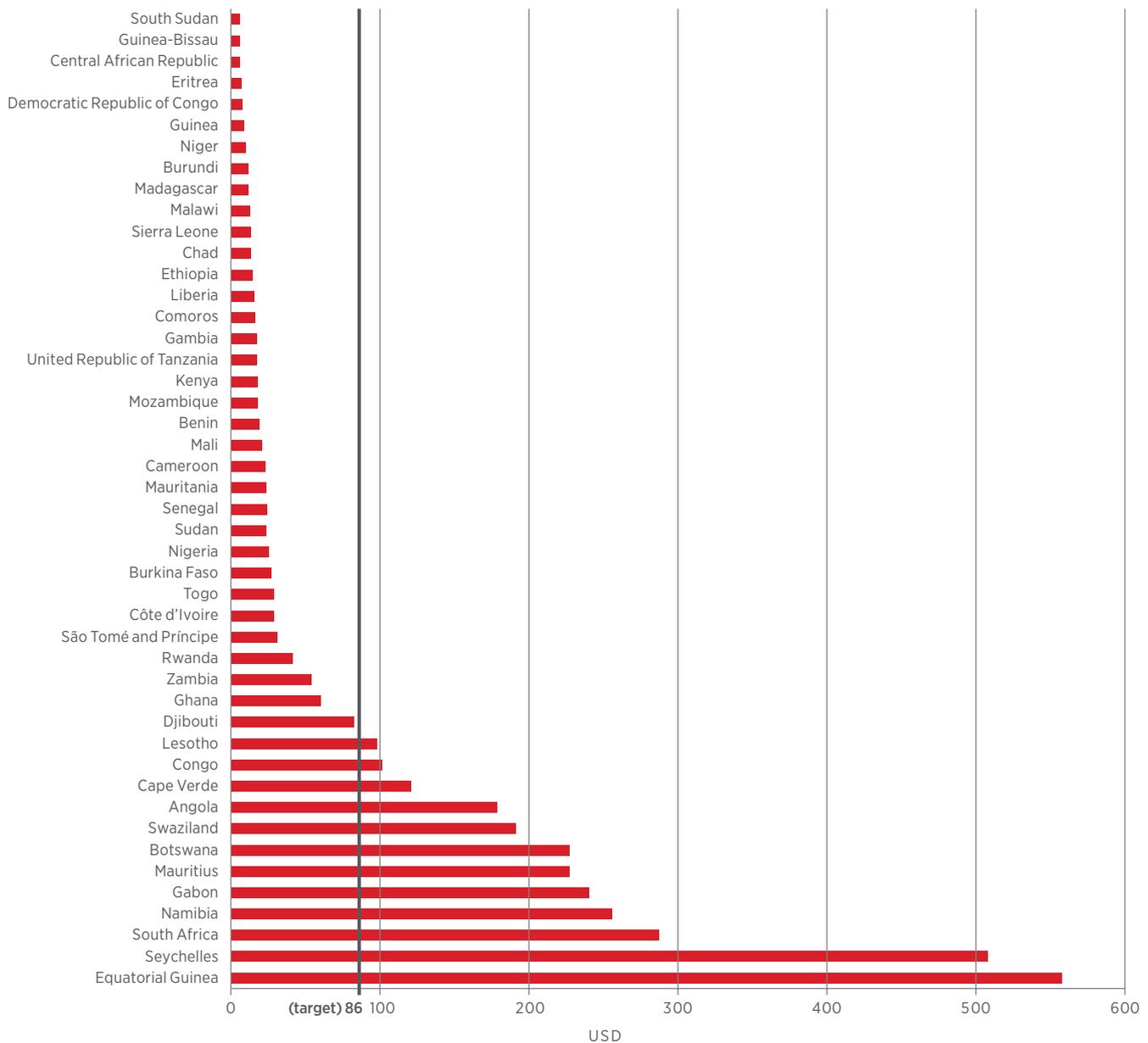
55 ONE Campaign: *AIDS Report 2015: Unfinished Business*. 2015. Pg.31

56 UNAIDS: *How AIDS Changed Everything*. June 2015. Pg.205

57 AU Commission and ECA: *Joint AU Commission-ECA elements paper*. 2015. March 2015.

58 Whiteside, et. al. *Responding to Health Challenges: The Role of Domestic Resource Mobilisation*. 2013.

FIGURE 3:
GENERAL GOVERNMENT HEALTH EXPENDITURE PER CAPITA (2013)⁵⁹



Projecting global health spending into the future, a recent study in April 2016⁶⁰ estimates that “by 2040, only one (3%) of 34 low-income countries and 36 (37%) of 98 middle-income countries will reach the *McIntyre & Meheus* goal of having 5% of gross domestic product consisting of government health spending.” Domestic investment in health follows clear trends. Using “a series of ensemble models and observed empirical norms” the same study projects government investment in health to 2040. Across 184 countries globally the study expects “per-capita health spending to increase annually by 3.4% (2.4–4.2%) in upper-middle-income countries, 3.0%

(2.3–3.6%) in lower-middle-income countries, and 2.4% (1.6–3.1%) in low-income countries.”⁶¹ Dieleman JL et al further contend that:

“Despite remarkable health gains, past health financing trends and relationships suggest that many low-income and lower-middle-income countries will not meet internationally set health spending targets...unless substantive policy interventions occur. ...current trends suggest that meaningful increases in health system resources will require concerted action.”⁶²

59 ONE Campaign: *AIDS Report 2015: Unfinished Business*. 2015. Pg.32

60 Dieleman JL, et al: “National spending on health by source for 184 countries between 2013 and 2040” in *The Lancet*. 13 April 2016.

61 Ibid.

62 Dieleman JL, et al: “Ibid. 13 April 2016.

A large, stylized number '5' in a dark green color, positioned on the left side of the page. The number is composed of thick, rounded lines and is partially obscured by the text to its right.

How much will it
cost to end AIDS and
TB and to eliminate
Malaria from Africa by
2030?

This brief chapter presents what it would cost to end AIDS and TB and to eliminate Malaria in Africa by 2030.

5.1. Estimated costs of ending TB in Africa by 2030⁶³

There is no existing data on the estimated cost to control TB in Africa. However, according to the Global TB Report 2015 the funding required for a full response to the global TB epidemic in low- and middle-income countries was estimated at about US\$ 8 billion per year in 2015. This excludes research and development for new TB diagnostics, drugs and vaccines. The Stop TB Partnership estimates that between 2016 and 2020, US \$58 billion is required to implement TB programmes and US \$9 Billion for research and development of new tools. Logically, most of these resources will be required in Africa where most cases are known to occur.

5.2. Estimated costs of Malaria elimination in Africa by 2030⁶⁴

The WHO *Global Technical Strategy for Malaria as adapted in Africa Malaria Strategy and Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030* estimates that between 2016 and 2030 the effort to eliminate malaria from Africa by 2030 will cost USD \$66 billion.⁶⁵ The per capita investment required each year will rise from USD \$3 per capita in 2016 (\$2.4 billion) to USD \$7 in 2030 (\$5.6 billion).

5.3. Estimated costs of ending AIDS in Africa by 2030⁶⁶

Based on the UNAIDS Fast Track estimates, ending AIDS in Africa will cost an estimated USD \$295 billion between 2015 and 2030. The requirement of USD \$14 billion in 2015 will rise to USD \$20 billion by 2020, before decreasing gradually to USD \$18 billion by 2030.⁶⁷

A recent study calculated that the costs of meeting the demand for ART alone would “**account for as high as 47% of GDP in high prevalence Africa south of the Sahara countries such as Malawi.**”⁶⁸ Thus, these financing needs “create long-term financing obligations” that “pose fiscal and debt sustainability challenges for the Africa south of the Sahara countries that lack the domestic financial resources, fiscal flexibility and economic strength.”⁶⁹

63 African Union: *Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030*, Pg.14.

64 African Union: *Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030*, Pg.14.

65 This cost-projection assumes a fixed population of 800 million being at risk of malaria each year (the 2013 figure).

66 African Union: *Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030*, Pg.14.

67 African Union: *Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030*, Pg.14.

68 Atun R, Chang AY, et al: Long-term financing needs for HIV control in sub-Saharan Africa in 2015–2050: a modelling study in *BMJ*. June 2016. Referencing Atun R, Chang AY, et al. Long term financing needs for HIV control in sub-Saharan Africa in 2015–2050: modelling study. *BMJ*. June 2016.

69 Atun R, Chang AY, et al: Long-term financing needs for HIV control in sub-Saharan Africa in 2015–2050: a modelling study in *BMJ*. June 2016



Increasing the *Fiscal Space* for health

This chapter will explore increasing fiscal space for health in a manner that brings domestic expenditure in line with ability to pay and disease burden, but without jeopardising fiscal sustainability.

The implementation of the *Catalytic Framework* takes place within an environment of growing demand for health services, increasing costs for service provision and ever-growing health needs. This environment is made all the more difficult by competing interests for funding⁷⁰ and the plateauing of development partner support.⁷¹ All of these factors combined make it more difficult for AU Member States to aggressively increase domestic investments in health. This is both in terms of the share of health expenditure within general government expenditure and in terms of per capita government expenditure on health.

The most recent flagship World Bank report '*Global Economic Prospects*' uses the term 'fiscal space'. In its broadest sense the term 'refers to "the capacity of government to provide additional budgetary resources for a desired purpose without any prejudice to the sustainability of its financial position."⁷² It therefore refers to the effort to create room within the budget for additional spending while at the same time not jeopardising the fiscal stability of the economy.

For Roy et al 'fiscal space' is defined less in terms of the emphasis on the 'gap' or 'room' in the budget for 'additional' spending and more in terms of political economy factors. They define fiscal space as "the financing that is available to government as a result of concrete policy actions for enhancing resource mobilisation, and the reforms necessary to secure the enabling governance, institutional and economic environment for these policy actions to be effective, for a specified set of development objectives."⁷⁴

This study employs the term 'fiscal space' in preference to talking about the 'health financing gap' or the 'funding shortfall'. This is because, for AU Member States to have the resources necessary to end AIDS and TB and eliminate Malaria, they will require more than simply trying to find the money to fill a large gap. What is required is to ensure that the generation of additional resources does not jeopardise the fiscal stability of the economy. The term 'fiscal space' is used to capture this.

6.1. Theoretical perspectives on how governments can increase the fiscal space for health?⁷⁵

There are five primary sources through which a government can expand the fiscal space (overall – not just for health). Governments must ensure that in creating fiscal space, it has the short term and longer term capacity to finance its desired expenditure programmes while at the same time being able to service its debt. Ultimately the decision regarding how to increase the 'fiscal space' is a policy decision dependent upon how that source is consistent with the country's macroeconomic fundamentals. The choice is thus inherently country specific and there is a lot of variation in the ways in which this is implemented.

Various criteria are considered when choosing the best combination of sources for increasing the fiscal space for health. These include progressivity or equity of the measures, the revenue raising potential and its stability and efficiency of the measure that is for example does it not introduce major imbalances in the economy. Other key factors include political acceptability, technical feasibility, the nature of incentive effects, the ease and costs of collection and potential fungibility. Making the decision requires "detailed assessments of a government's initial fiscal position, its revenue and expenditure structure, the characteristics of its outstanding debt obligations, the underlying structure of its economy, the prospects for enhanced external resource inflows and a perspective on the underlying external conditions facing an economy."⁷⁶

The five sources for expanding fiscal space are:

- 1) Conducive macroeconomic conditions (GDP growth) combined with greater domestic revenue mobilisation (improved tax administration, tax policy reforms);
- 2) Prioritising health within the government budget;
- 3) Taxes earmarked for health and other health sector-specific resources;
- 4) Official Development Assistance (ODA) (including aid and debt relief);
- 5) Efficiency improvements in health, which decrease the resources required.

Borrowing (from both domestic and foreign lenders) and the printing of money to finance public programmes (monetary expansion) can be included in this framework but will not be explored in this study.

70 Powell-Jackson, et al: *Fiscal Space for Health: A Review of the Literature*. December 2012.

71 Whiteside, et. al. *Responding to Health Challenges: The Role of Domestic Resource Mobilisation*. 2013.

72 World Bank: *Global Economic Prospects: Having Fiscal Space and Using It*. January 2015.

73 Heller, P.: *The prospects of creating 'fiscal space' for the health sector*, Health Policy Plan. March 2006.

74 Roy, R., et al.: "Fiscal Space for What? Analytical Issues from a Human Development Perspective." 2007

75 This section draws heavily on the following articles: Heller (2006), McIntyre & Meheus (2014), Tandon & Cashin (2010) and Powell-Jackson, et al (2012).

76 Drawing from Heller, P.: *The prospects of creating 'fiscal space' for the health sector*, Health Policy Plan. March 2006. and McIntyre, D. and Meheus, F. 2014. Pg.31

This section will briefly explore each of the five options in turn:

6.1.1. Conducive macroeconomic conditions and greater domestic revenue mobilisation

This refers to expanding the fiscal space through additional national income generated by improved economic growth (GDP growth), additional revenues raised by increasing taxes, improving tax collection, or reduced levels of fiscal deficits and debt. Sustained high levels of economic growth is a significant factor because, although health might for example remain unchanged at a certain share of GDP (e.g. 5%) year on year the actual financial allocation increases. For example GDP growth (of, for example, 7.5%) means that even if government spending on health remain at the same proportion of the budget (e.g. 5%), the financial allocation towards health will increase by 7.5%. Equally, slow growth will hamper health expenditure.

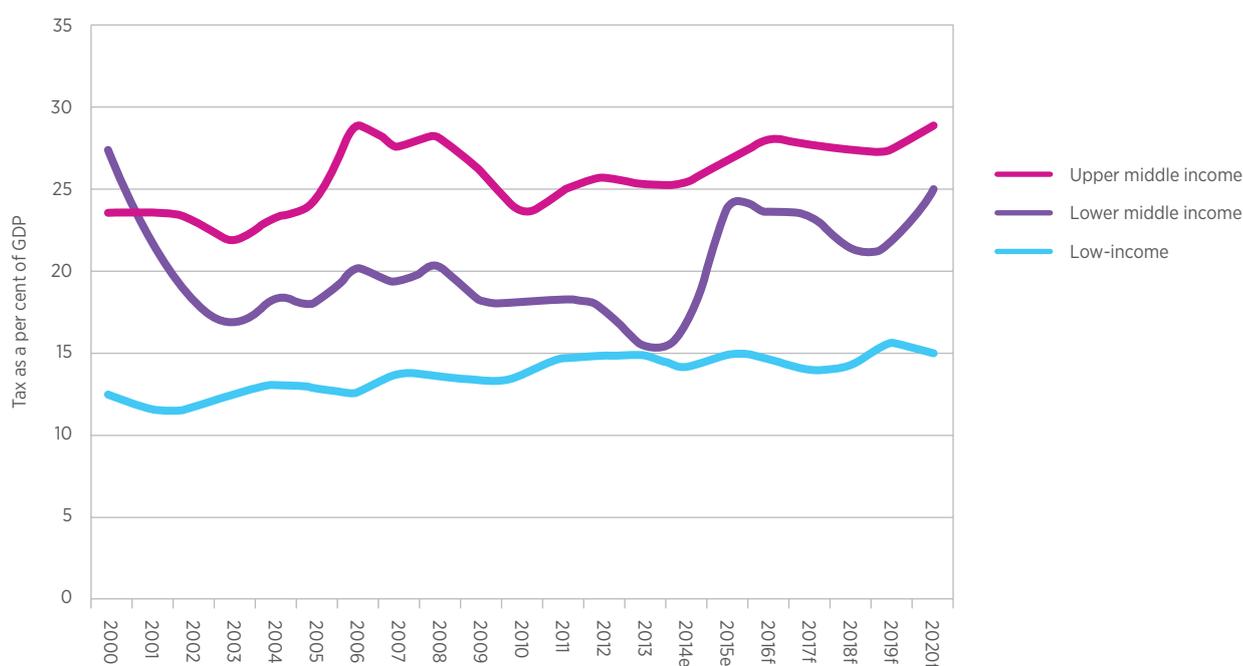
For countries with low ratios of government revenue (tax) to GDP, broadening the tax base and improving tax administration in order to raise the revenue share in GDP are likely to be important objectives. Economic projections anticipate global tax-to-GDP ratios to increase from 19.2% in 2015 to 21% in 2020 and to 28% in 2030.⁷⁷ This will boost government resources for funding different social sectors.

In middle income African countries the tax-to-GDP ratio increased during the period 2000 to 2013, and is projected to keep rising until 2020. However, for low-income countries on the continent the tax-to-GDP ratio remains below 15% and is anticipated to remain so beyond 2020.⁷⁸ This is however considered a reasonable target taking into consideration their level of development.⁷⁹ Total tax revenue on the continent increased from \$331 billion in 2009 to \$527.3 billion in 2012. In fact tax revenue now ranks second only to export earnings as a source of the continent's revenue generation. McIntyre, D. and Meheus, F (2014) argue further that:

“Ultimately, tax reforms are part of the formalization process, and at the same time the formalization process will determine the impact of the tax reforms, so the end result in terms of government revenue will depend on the combined effect of these two (interlinked) processes.”⁸⁰

Finally, the evidence shows that countries with reduced levels of fiscal deficits and debt are better able to increase spending levels for any purpose, including for health.

FIGURE 4:
TAX-TO-GDP RATIO BY LEVEL OF DEVELOPMENT, 2000-2020⁸¹



77 UNAIDS: *How AIDS Changed Everything*, June 2015, Pg.208
 78 AU Commission and ECA: *Joint AU Commission-ECA elements paper*, 2015.
 79 Heller P.: "Back to Basics - Fiscal Space: What It Is and How to Get It." June 2005.
 80 McIntyre, D. and Meheus, F, 2014, Pg.23
 81 AU Commission and ECA: *Joint AU Commission-ECA elements paper*, 2015, Figure 1, Pg.28

6.1.2. Prioritising health within the government budget

A second source of fiscal space is for the health sector to receive greater prioritisation within the overall government budget by receiving a larger share of government spending. In general, cross-country comparisons show a wide variation in government spending on health, even among countries with similar income. In other words, the priority attached to health by governments varies enormously. This is despite the fact that the proportion of the budget allocated to the health sector is an area that is directly under the control of government decision makers.⁸² Arguing for a reallocation of a larger share of the budget to health is typically not an easily attained source of fiscal space in most countries. Furthermore, the allocation of the budget is a highly politicised process and all countries have many competing needs for which compelling cases are also being put forward.⁸³

6.1.3. Taxes earmarked for health and other health sector-specific resources

Earmarking taxes for health is another method to create the fiscal space for health and involves dedicating an entire tax to fund a particular programme. An example is when governments dedicate payroll tax to fund social health insurance. Additionally a fixed portion of a particular tax to fund a programme can be set aside (e.g. a fixed proportion of general tax revenues allocated to the health budget). Earmarking can also entail specific user charges in public health facilities. The purpose of these various mechanisms is to increase the resource base for public spending on health.

Additional fiscal space for health can be created through levying 'sin taxes' on goods that have adverse health effects such as tobacco and alcohol. These are considered justified due to the impact of these products to health and society. Social Health Insurance (SHI) can provide another source of health-sector-specific fiscal space. SHI collects mandatory financial contributions from designated segments of the population, typically through payroll taxes. These contributions are pooled into independent funds to pay for services on behalf of the insured, help to finance public health care and improve financial risk protection.⁸⁴

Earmarked taxes, however, create significant economic rigidities and may in fact 'crowd out' other expenditures.⁸⁵ Furthermore, earmarking is often viewed as imposing an unnecessary constraint on fiscal policy-making, one

that reduces flexibility and allocative efficiency.⁸⁶ Thus, while it is not unusual that calls be made to introduce earmarked taxes as a way to insulate health spending from other competing publicly funded activities, these calls are generally supported by political rather than economic arguments.⁸⁷

6.1.4. Official Development Assistance (ODA)

ODA provides an additional source for expanding the fiscal space for health. This source was explored in great detail in the section on *Development Assistance for Health*.

6.1.5. Efficiency improvements in the health sector

A common criticism by the treasury is that Ministries of Health are not sufficiently well armed with evidence of performance efficiency to defend their budget requests or to advocate for greater resources for health. Additionally the Ministries of Health have not adequately countered the perception that 'the available funds are not being used efficiently'.⁸⁸ Efforts to improve efficiency are rarely simply about 'cutting costs'. They are about making better use of existing resources – of increasing the impact of spending as well as improving the efficiency with which funds are spent – so as to expand coverage and access.

Fiscal space created through efficiency improvements can take a variety of forms. This includes increasing the efficiency with which services are delivered, introducing policies that reduce corruption and improve governance and achieving greater alignment and harmonisation of donor resources. The World Health Report (2010) identified 10 common sources of inefficiency and argued that between 20 to 40% of total health spending – or between \$1.3 and \$2.6 trillion annually – is lost through waste, corruption and other forms of inefficiency.⁸⁹

In conclusion, the five sources for generating the fiscal space for health should not be regarded as independent of each other. If Member States are to generate the fiscal space for health needed to reach the \$86/capita (2012 US \$ target) then these sources should be employed in tandem.

82 Powell-Jackson, et al: *Fiscal Space for Health: A Review of the Literature*. December 2012.

83 Tandon, A. and Cashin, C.: *Assessing Public Expenditure on Health From a Fiscal Space Perspective*. 2010.

84 Tandon, A. and Cashin, C.: *Assessing Public Expenditure on Health From a Fiscal Space Perspective*. 2010.

85 Heller, P.: *The prospects of creating 'fiscal space' for the health sector*. Health Policy Plan. March 2006.

86 Tandon, A. and Cashin, C.: *Assessing Public Expenditure on Health From a Fiscal Space Perspective*. 2010.

87 Tandon, A. and Cashin, C.: *Assessing Public Expenditure on Health From a Fiscal Space Perspective*. 2010.

88 Blecher, M: "A view from Finance." 8 December 2014 & Powell-Jackson, et al. *Fiscal Space for Health*. 2012.

89 McIntyre, D. and Meheus, F. 2014. Pg.36

6.2. How practically can governments increase the fiscal space for health?

How can governments generate the fiscal space for health? The first thing to note is that ‘Official Development Assistance’ (ODA) (section 7.2.4) and ‘Efficiency improvements in the health sector’ (section 7.2.5) are the only sources within the sole control of the Ministry of Health. However it is important to note that ODA (7.2.4) is also controlled primarily by development partners. All other potential remaining sources for generating fiscal space - ‘conducive macroeconomic conditions and greater domestic revenue mobilisation’ (7.2.1), ‘prioritising health within the government budget’ (7.2.2) and ‘taxes earmarked for health’ (7.2.3) – fall within the remit of the Ministry of Finance. This suggests two things:

1. the attention of the Health Ministry should be devoted to generating fiscal space for health from within those two sources under its control; and
2. the Health Ministry must become adept at lobbying the Ministry of Finance with a strong case for increased spending on health. To achieve this will require an understanding of how the Ministry of Finance both considers fiscal space and of how it understands each of the three sources under its direct remit.

With this in mind, it is not encouraging that Ministries of Health often do not present a very convincing case to Finance Ministries as to why the health sector needs more government resources.⁹⁰ This will need to be addressed if Health Ministries are to become adept at successfully lobbying for increased resources for health. The literature also argues that Ministries of Health need to generate the credibility that comes with a record of good governance, good past and present performance in public expenditure management and high absorptive capacity during implementation.⁹¹

6.3. Raising government revenue – to what level?

“The IMF has studied the ratio between countries’ fiscal potential and actual government revenues, finding that low-income countries are on average reaching only 78% of their [revenue raising] potential, while lower-middle-income countries reach 63% of their potential for mobilizing government revenue.”⁹²

As we have seen in section 6.1 the list of options for increasing domestic revenues for health is long. Table 2 below summarises the range of options and attempts to estimate the possible revenue generation capacity of selected approaches.

⁹⁰ Blecher, M: “A view from Finance.” 8 December 2014 & Powell-Jackson, et al. *Fiscal Space for Health*. 2012.

⁹¹ Powell-Jackson, et al: *Fiscal Space for Health: A Review of the Literature*. 2013.

⁹² *Revenue Mobilization in Developing Countries*. International Monetary Fund, Washington, DC, 2011. Referenced in McIntyre, D. and Meheus, F. 2014. Pg.15

TABLE 2:
OPTIONS FOR INCREASING DOMESTIC REVENUE FOR HEALTH⁹³

Revenue mobilization approaches	Possible actions and strategies	Possible revenues generated (in general and for health)	Remarks
Formalization of economies	Improving governance; enforcing existing regulations; simplifying some administrative procedures	Depends on country contexts, but formalization could potentially increase GGE/GDP ratios by several percentage points	Needs an overarching, longterm politico-administrative approach, so obtaining results may take time
Redistributing existing government revenues to health	Advocacy; creating political will; demonstrating results; demonstrating efficiencies	If AU countries would meet 15% GGHE/GGE target they would increase health expenditure by \$29 billion	Prioritization of health not always evident; need to take into account spending through other sectors for improving health outcomes
Increased government revenue mobilization – structural approaches	Structural reforms in the tax regime (e.g. introducing VAT); strengthening enforcement mechanisms	Context-dependent; could potentially increase GGE/GDP ratios by several percentage points	Needs political will and technical knowledge; need to focus on equity aspects (e.g. seeking to exempt necessity products from VAT)
Increased taxation relying on natural resource exports	Good governance to avoid the ‘resource curse’; specific taxation measures on ‘super-profits’	Context-specific; Botswana has shown that significant amounts of revenue can be raised with sound policies and transparency	Not an option for countries with no or few natural resources; potentially an unpredictable source of revenues
Increased taxation of large industries	Obtaining support of powerful interest groups; advocacy directed at corporations that it is in their interest that government can invest in public goods	1% tax on turnover of companies that would represent 5% of GDP would yield 0.05% of GDP in revenue	Every country needs to balance the possible gains in revenue collection and possible negative effect on economic activity
Increased taxation of harmful habits and products	Advocacy on the ‘win-win’ nature of these taxes; creating evidence on implications on revenue and health outcomes	Possibilities for increases, especially for countries with existing rates below regional averages; e.g. Philippines, increased alcohol and tobacco taxes to raise additional \$3.4 billion = 1.3 times current GGHE	Opposition from business interests; need for parallel actions on illegal production and trade; equity – are the poorest more affected by these taxes?; also a ‘win’ from public health perspective
Taxing specific goods and services (luxury items, mobile phone use)	Linking this approach to overall policy for increasing redistributive effect of taxation; focusing on countering possible tax avoidance strategies	Probably best suited in middleincome country contexts; revenue depends on the type of goods or services taxed and the rate used	Can work with high-value but infrequent transactions, and with low-value and frequent transactions; need to be careful about equity; is mobile phone a luxury?
Increased direct funding for health (earmarked taxation)	Convincing finance ministry and other budget deciders on the need to earmark	Depends on the case – needs additional revenue collection to be fully effective (e.g. earmarking an increase of VAT, not a part of existing VAT)	False hopes – e.g. increased earmarking in the form of statutory health insurance contributions can lead to similar cuts in the regular health budget
Voluntary sources of revenue (e.g. from businesses)	Mobilizing private-sector actors behind public health goals; increase dialogue with private-sector actors	Can provide catalytic resources and can be used as leverage to raise other funds	Need to be aware of the supplementary and possibly unpredictable nature of this type of funding

93 Elovainio, R. and Evans, D. "Raising and Spending Domestic Money for Health". May 2013. Pg.34



Fiscal Space for Health through Innovative Financing

The *Catalytic Framework* emphasises “increasing domestic financing for health including innovative mechanisms in line with African Union and global commitments.”⁹⁴ The *Taskforce on Innovative International Financing for Health Systems* (2009) provides an overview of the full spectrum of innovative financing mechanisms on offer that can provide the African Union Member States with a menu of options to choose from. The Taskforce identified that the number of innovative financing mechanisms on offer exceeds 100.⁹⁵

This chapter conducts a rapid appraisal of a selection of innovative financing mechanisms and will examine ‘good practices’ in implementing these innovative financing mechanisms. This will draw from the experiences of AU Member States. Additionally it will evaluate the revenue generating potential of innovative financing mechanisms broadly.

7.1. Sources of Innovative Financing for Health

There are a wide variety of innovative financing mechanisms. Figure 5 below provides an overview of a small selection of the available ‘innovative financing mechanisms’, divided into four categories.

FIGURE 5:
OVERVIEW OF SOME OF THE AVAILABLE INNOVATIVE FINANCING MECHANISMS⁹⁶

Taxes	Voluntary Solidarity Contribution	Debt Instruments	Public-Private Incentives
Air ticket tax	PRODUCT (RED)	Sustainable Investing Bonds	Advance Market Commitments
Global Solidarity Tobacco Contribution	MassiveGood	Pay-for-Performance	Affordable Medicines Facility for Malaria (AMFm)
Financial Transaction Tax	National Lotteries	Diaspora Bonds	Health Micro Insurance
Remittance tax	Matching fund	Debt2Health	

It should be mentioned that the use of the term ‘innovative’ financing mechanisms is contested due to the fact that a number of the ‘innovations’ are not new and, moreover, constitute regressive (rather than progressive) forms of taxation.⁹⁷ However, for the purposes of this study we consider all non-traditional sources of financing for

health to fall within the category of an ‘innovative’ source of financing. This particularly applies to those sources of financing that are implemented as shorter term solutions to funding needs while governments work to expand the tax base. We briefly assess seven innovative financing mechanisms:

94 African Union: *Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030*. Pg.14.

95 Taskforce on Innovative International Financing for Health Systems: *More Money for Health, and More Health for the Money*. 2009.

96 Drawn from Global Fund: “Innovative Solutions for Funding Health: Past, Present, & Future”. *Presentation delivered to Meeting of Ministers of Health and Finance*. Addis Ababa, Ethiopia; 12 November 2013.

97 Atun R, Knaul FM, Akachi Y, and Frenk J: “Innovative financing for health: what is truly innovative?” *Lancet* 2012.

7.1.1. Health / AIDS Trust Funds

A trust fund can operate in either a funded or an unfunded scheme. A funded scheme requires a substantial upfront injection of resources that will accumulate quickly, thereby enabling the scheme to begin paying dividends rapidly. An unfunded scheme receives resources (usually from many sources) over a longer period of time. The unfunded scheme then determines whether (or what proportion) of its resources to invest and what proportion to use on trust fund recurrent expenditure. The fund becomes an operation mechanism for managing and allocating these resources.

Trust Funds have their drawbacks from a health financing and public finance management point of view. They create yet another pool for a specific disease, taking away some flexibility of both the Ministry of Finance and Health to allocate resources according to relative priority. A Trust Fund brings new implementation modalities which must be integrated in the policy, planning and budgeting cycle of the Ministry of Health. This can overstretch the already high levels of planning complexity, in often capacity-poor contexts. In its motivation to set up a Trust Fund, Kenya was therefore explicit that this was a temporary measure, to overcome a temporary shortfall of funding for its AIDS response as long as the National Hospital Insurance Fund is extending its benefit and population coverage.

7.1.2. Alcohol levy

This taxation measure is simply a rise in the taxation on alcohol sales which is earmarked for health. It penalises drinkers and is not paid by non-drinkers. Alcohol levy may actually result in some improvements in health as a result of its imposition. The assumption is that if alcohol is more expensive, demand will decrease and so less damage is done to the health of the drinking population. Sustainability of this tax should be long term as there would be little pressure to reduce taxation of alcohol from a social standpoint.

The 55% tax levied on the sale of alcoholic beverages in Botswana is used to support, among other things, public education and rehabilitation programmes as well as law enforcement measures to combat alcohol abuse. It has raised a total of US\$79 million since it was introduced in 2008. However the Ministry of Health does not benefit exclusively from this Alcohol Levy. In fact, 45% of the funds generated by the levy is allocated to the Ministry of Youth, Sports and Culture while another 45% is earmarked for the Government Consolidated Fund. Thus, only 10% of the levy is channelled to the Ministry of Health. Approximately \$1million has been raised per year from the levy. Cape Verde and Comoros also charge alcohol excise taxes, with funds earmarked specifically for HIV programmes.”

‘Sin taxes’ – taxes on unhealthy products, such as tobacco – could also be used to fund global health programmes and help mitigate the risk of non-communicable diseases in the long term. It is estimated that governments already collect nearly \$270 billion in tobacco excise tax revenues today.⁹⁸ However WHO consider earmarked taxes as less equitable since the poor pay a larger premium relative to their income.

7.1.3. Airline levy

One of the innovative funding mechanisms implemented by UNITAID in a number of countries in Europe and a few in Africa is a ‘solidarity levy’ on airline tickets. An aviation solidarity levy has been used to help mitigate the negative impacts of globalisation and also provide funds to finance AIDS, TB and Malaria programmes. UNITAID member countries agree to donate a portion of the revenues generated by a tax added to airline tickets to existing national and international development institutions. A levy on airline tickets provides both long-term and predictable revenue, as air travel is growing and is expected to continue to grow in years to come.

The main advantage of the airline solidarity levy is that it can be implemented in participating countries even if other countries do not wish to participate in the initiative. Over 70% of UNITAID’s long-term financing, approximately USD \$250 million annually, comes from the ‘airline levy’ applied in participating countries. It is estimated that close to USD \$1 billion has been generated from the UNITAID airline levy to respond to AIDS, tuberculosis and malaria.⁹⁹

⁹⁸ The Center for Global Health and Diplomacy: Partnerships and Solutions. 2015. Referenced in One Campaign: *AIDS Report 2015*.
⁹⁹ UNITAID: *Innovative Financing: The Air Ticket Levy*. 2015. Referenced in One Campaign: *AIDS Report 2015*.

7.1.4. Remittances levy

Imposing a levy on international remittances has been identified as a potential revenue source for funding health by charging a small fee on all money transfers from abroad. Remittances can be made through formal and informal channels.

Formal channels include domestic and international banks and service providers such as Western Union and Money Gram. Factors affecting their use include:

- High transaction costs which are believed to dampen the scope of money transfers;
- Banking requirements often excluding potential users from accessing banking services;
- Stringent exchange controls;
- Clearance times for money transfers are long.

Informal channels include money carried by migrants themselves, remittances carried by friends and family, or sent through taxis and buses. These have advantages and disadvantages:

- Costs are typically lower;
- They provide an opportunity to avoid government taxes;
- They do not require documentation and facilitate transfers from illegal immigrants;
- But they are less reliable and are extremely difficult to monitor.

The policy option to impose a levy would only impact on the formal sector transactions. This additional cost to transferring money may lead to a move from formal to informal channels, with consequent externalities associated with this. It is possible that, if the diaspora are aware that the extra charges are channelled to health programmes, they will be sympathetic and this could mitigate the shift towards informal remittances. However, the importance of fully researching this policy option cannot be underestimated, as remittances are a key flow of funds to developing countries:

“Remittances are the second biggest source of external financing after foreign direct investments for developing countries... Remittances represent almost 2.5 times the volume of ODA. Due to lack of data, this amount is considered by the [World] Bank as grossly underestimated, since it only reflects transfers through official channels.”¹⁰⁰

However any policy change to remittances should be handled with caution as they act as a safety net in times of hardship. Remittances are used to support families in the face of unexpected health care expenditure and they protect poor families from slipping into extreme poverty.¹⁰¹ It is clear that remittances provide a crucial source of income for the population. They can be spent on health services and in doing so will contribute to the financing of health. They are also likely to be called on in the case of catastrophic health expenditures.

100 Lamontagne, E. and Greener, R.: Long term sustainable financing opportunities for HIV in Africa. 2008. Pg.9
101 Lamontagne, E. and Greener, R.: Long term sustainable financing opportunities for HIV in Africa. 2008.

7.1.5. Currency Transaction Levy (CTL)¹⁰² or Financial Transaction Tax

A currency transaction levy is a tax on currency transactions implemented nationally. Countries can opt to apply the levy on a mandatory basis to all trades using that currency worldwide. The levy can be collected by the large-scale foreign-exchange settlement systems, such as the Continuous Linked Settlement (CLS) Bank and the Society for Worldwide Interbank Financial Telecommunication (SWIFT). If every currency in the world levies a transaction tax of 0.05% of the value of every transaction in the four major global currencies (US\$, Euro, JPY, GBP) one estimate is that this could generate US\$ 3.3 billion in annual revenues.

7.1.6. Mobile phone 'airtime' levy

A levy sufficiently small not to distort demand could in principle be imposed on mobile phone calls. However, the mobile phone industry affects a large and diverse population. The mobile phone market is also young and it is therefore uncertain how suppliers will react and consumer demand will change in response to a tariff on calls.

The mobile phone market covers more than just phone calls. Bank transactions can be done through mobile devices in many countries even in remote rural areas. A new financial services industry including agricultural insurance is developing in East Africa on the back of mobile phone penetration. The introduction of an additional cost to using these services may therefore have a detrimental impact on these services and more widely on the economic development of these countries. A 2012 report¹⁰³ claims that such taxes are regressive in nature as they penalise the poorer sections of society. It also claims that by lowering taxes on mobile phones, governments will in fact increase receipts as millions of people will be able to afford to use mobile phones.

Some countries such as Gabon and Burkina Faso are contemplating the introduction of an additional mobile phone levy. However, this has been faced with criticism primarily due to its impact on the mobile phone industry. Furthermore, the tax places a disproportionate burden on the poor. As a result of these complex factors, this option needs to be explored further before a decision is made.

7.1.7. Concessional borrowing to finance the health sector

The Global Fund's Debt2Health project is an innovative financing mechanism in which creditor governments relinquish a part of their rights to the repayment of loans, on condition that the beneficiary country invests the freed-up resources in programmes approved by the Fund.¹⁰⁴ In the first Debt2Health swap in 2007, Germany cancelled €50 million in debts from Indonesia, enabling the government and the Global Fund to jointly contribute €25 million to HIV and AIDS programmes.¹⁰⁵ For the 2008 to 2016 period, an additional \$106 million has been pledged to Debt2Health. Australia provided AUD 9.5 million in 2014 and Germany €2 million in 2015 to support HIV and AIDS programmes in Indonesia, Egypt, Pakistan and Côte d'Ivoire. France also implements debt swaps to support the fight against AIDS, contributing €62 million in 2013 and €7 million in 2014.¹⁰⁶ The *Debt2Health initiative* has generated a total of US\$300 million.¹⁰⁷

7.2. Revenue generating potential of Innovative Financing for Health

Early research estimates of the revenue generating potential of innovative financing mechanism in the health sector suggested that, if fully implemented by all AU Member States, innovative financing could raise nearly \$15.5 billion annually.¹⁰⁸ **These estimates have since been revised substantially downwards.**¹⁰⁹

In the next chapter we will review whether AU member states can meet their domestic financing commitments through innovative financing.

102 Drawing on The Taskforce on Innovative International Financing for Health Systems: *Taskforce Fact Sheet: Currency Transaction Levy (CTL)*. 2009.

103 GSMA: *Taxation and the Growth of Mobile Services in Sub-Saharan Africa*. 2012

104 Brookings Institution, *Debt2Health: Debt Conversion for the Global Fund to Fight AIDS, Tuberculosis, and Malaria*. Referenced in *One Campaign: AIDS Report 2015*.

105 World Bank: *Working Document: Debt-based, Right Timing Instruments*. Referenced in *One Campaign*. 2015.

106 French Ministry of Foreign Affairs and International Development: *Document de politique transversale projet de loi de finances pour 2016: Politique française en faveur du Développement*. 2015. Referenced in *One Campaign: AIDS Report 2015*.

107 UNAIDS: *How AIDS Changed Everything*. June 2015. Pg.213

108 Global Fund. *Innovation for Greater Impact: Exploring Resources for Domestic Health Funding in Africa*. 2014.

109 UNAIDS and its partners are seeking to generate just \$3billion from innovative financing mechanisms (time period unclear, but not annual).
UNAIDS: *How AIDS Changed Everything*. 2015. Pg.213

A large, light green number '8' is positioned on the left side of the page, partially overlapping the text.

Can Africa meet the
domestic financing
targets of the *Catalytic
Framework* through
innovative financing?

Innovative financing mechanisms hold the potential to raise additional sources of revenue for health. However revenue raising capacity is limited in Africa. This study has shown that “innovative financing instruments have contributed a very modest share of funding toward domestic HIV/ AIDS programmes.”¹¹⁰

Firstly, taxes levied on mobile phone ‘airtime’ or “sin-taxes” levied on tobacco, alcohol or even sugar are regressive in that they impose a disproportionate financial burden on the poor. The same is the case with raising the rate of Value Added Tax (VAT). These **types of taxes should therefore be implemented with caution, and with a comprehensive understanding of their impact on the economy. Health financing is not simply about raising more money but about ensuring that revenue collection and spending is progressive.**

Di McIntyre and Filip Meheus challenge this view. They argue that general wage-based taxation offers the greatest potential for progressive taxation but argue that “where informal sectors are large, it is difficult to rely on wage deductions to raise government revenue.” They posit that “forms of indirect taxation are simpler to collect and serve as a means to ensure that everyone contributes pending the growth of the formal sector.”¹¹¹ This view is countered by a 2015 study¹¹² which argues forcefully that expediently implementing consumption taxes is associated with increased rates of post-neonatal-, infant- and under-5 mortality. These incidences were not detected in the effects of the more progressive taxes on income, profits and capital gains. There is no doubt that increasing domestic tax revenues is integral to achieving Universal Health Coverage. However, **efforts to increase the fiscal space for health through domestic sources should focus on expanding pro-poor taxes on profits and capital gains particularly in countries with low tax base.**

Secondly, Africa faces many competing challenges that have suggested these self-same innovative interventions as sources of financing. These include addressing Africa’s massive infrastructure deficit (at an annual cost of \$93 billion), mitigating climate change on the continent (\$34 billion per annum),¹¹³ migration and the refugee crises, financing African peace-keeping operations, or even core funding of the United Nations system. There is an implicit assumption that Finance Ministers will commit the revenues raised through any of the proposed innovative financing mechanisms entirely (or even partly) to health, as opposed to any of these other legitimate needs. In reality, global health would have to get into a long queue.¹¹⁴ That only 10% of the revenue generated through the 55% levy on alcoholic beverages in Botswana goes to the Ministry of Health provides a case in point.

Thirdly, the revenue generating potential of innovative financing mechanisms has consistently been revised downwards. The funding generated through innovative financing is merely complementary and a valuable addition to each domestic economy. However it is insufficient to finance the continued scale-up of AIDS, TB and malaria responses or the effort to achieve Universal Health Coverage.

Therefore, **Can Africa meet the domestic financing targets of the Catalytic Framework through innovative financing? No, FAR FROM IT.** We will elaborate on this in the concluding chapter that follows.

110 Atun R, Silva S, Ncube M, and Vassal A: “Innovative financing for HIV response in sub-Saharan Africa” 2016

111 McIntyre, D. and Meheus, F. 2014, Pg.31

112 Reeves A, et. al: “Financing universal health coverage - effects of alternative tax structures on public health systems: cross-national modelling in 89 low-income and middle-income countries” in *The Lancet* 2015.

113 World Bank, United Nations, IMF, AFDB, WHO, International Food Policy Research Institute, Bill and Melinda Gates Foundation estimates. Referenced in Garrett, L. *Existential Challenges to Global Health*. Figure 12, Pg.13.

114 See, for example, the UNDP Discussion Paper: Innovative Financing for Development: A New Model for Development Finance? 2012

9 Conclusion

In 2014 the 54 Member States of the African Union adopted Agenda 2063, a new vision that provides a common 50-year development framework for the continent. The framework places the objective of realising “healthy and well-nourished citizens” within the first of the seven aspirations for ‘the Africa we want’. The path to meeting this objective has been set out in the *Catalytic Framework*, which requires ending AIDS and TB and eliminating malaria by 2030.

Meeting the targets of the *Catalytic Framework* will require significant investment in health. Yet this comes during a period of plateauing development partner support. If Africa is to raise the additional resources required to achieve its ambitions, then significant new revenue will need to be generated from domestic sources. *Agenda 2063* commits Member States to overcome “the dwindling and unpredictability of development assistance” by ‘looking inwards’ and ‘mobilising internal resources for the promotion of her health’. Africa’s remarkable economic growth, resilient over the previous two decades, provides the hope that at least some of the required resources can be funded domestically.

Innovative financing has been identified as a way to complement existing domestic revenue collection in order for Africa to meet its funding requirements. Through the concept of fiscal space this study has argued that health financing is not simply about ‘raising more money’ to ‘fill a funding gap’. Ensuring that domestic revenue collection and spending is progressive (that richer citizens are subsidising the poorer) rather than regressive and that resources for health are pooled is critical. This study has highlighted that the primary sources of fiscal space for health are:

1. Prioritising health within the existing allocation of general government expenditure;
2. Generating additional government revenue, including through innovative sources of funding; and
3. Efficiency savings in health.

We have argued that fiscally prudent economic management requires that the three be implemented in combination, with the degrees to which each is implemented determined by the local economic context.

Against the *first* this study has shown that in spite of the *Abuja Declaration* commitment to increase domestic investment in health, only 27 out of the 54 AU Member States have increased the proportion of total government expenditures allocated to health since the adoption of the Abuja agreement in 2001.¹¹⁵

Against the *second*, we have shown that 34 of the 46 Africa South of the Sahara countries fail to meet the HLTF target required to provide a very minimal set of PHC services (defined as US\$86 per capita in 2012). Even fewer member states meet the *McIntyre & Meheus* target of ‘the greater of 5% of GDP or \$86 per capita’. The investments by African governments in health have not yet matched disease burden and ability to pay.¹¹⁶ Even projecting domestic health spending into the future we find that ‘by 2040, only 3% of low-income and 37% of middle-income countries will reach the *McIntyre & Meheus* goal of 5% of GDP on health’. Thus, many low- and lower-middle-income AU Member States are unlikely to meet the ambitious Agenda 2063 domestic health spending objectives without concerted action to increase investments in health.

This study has further demonstrated that **although innovative financing mechanisms provide interesting examples of leveraging and mobilisation of domestic resources, the revenue raised is small by comparison to domestic funding requirements. We therefore contend that innovative financing can only generate small amounts of additional resources for health. Thus these interventions should not be looked upon as the solution to Africa’s health financing resource challenges. The mechanisms should be used only to complement traditional government revenue generation and only as short term solutions to funding needs while governments work to expand the tax base.**

115 World Health Organisation: The Abuja Declaration: 10 Years On. 2012. Pg.

116 Whiteside, et. al. Responding to Health Challenges: The Role of Domestic Resource Mobilisation. 2013.

General government taxation must therefore remain the priority. Yet in many countries taxation is inefficient. This includes individual, corporate tax and consumption taxes such as general sales tax or value added tax. Indeed, we showed that the ratio between a countries' revenue-raising potential and actual government revenues was 78% in low-income countries and 63% in lower-middle-income countries. **Thus, Ministries of Finance and tax revenue authorities should be strengthened in order to collect and fund government activities from the more progressive, equitable and efficient general taxation.**

Moreover, in return for increased allocation of resources, Ministries of Health should commit to improving the efficiency of their health systems. International comparison shows that significant efficiency savings (upwards of 20% of total health spending) can be made. It is important to mention that some of these efficiency improvements require greater spending. Ministries of Health should engage on a programme to identify, quantify, prioritise and implement efficiency savings measures. This is important in order to generate the credibility that comes with a record of good governance, good past and present performance in public expenditure management and high absorptive capacity during implementation.

There is no doubt that health in Africa continues to be beset by heavy underinvestment and that AU Member States themselves are not investing enough. Current levels of health financing need to be stepped up if Africa is to achieve the objectives of the *Catalytic Framework* and *Agenda 2063*.

REFERENCE LIST

- African Development Bank. *African Development Bank: The Bank's Human Capital Strategy for Africa, 2014-2018*. Tunis: African Development Bank. May 2014. Available at: <http://www.afdb.org/en/news-and-events/article/one-billion-people-one-billion-opportunities-afdb-approves-its-first-human-capital-strategy-13254/>
- African Development Bank, OECD, et al. "Special Theme: Structural Transformation and Natural Resources" in *African Economic Outlook 2013*. 2013. Available at: <http://www.africaneconomicoutlook.org/fileadmin/uploads/aeo/PDF/>
- Africa Progress Panel. *Africa Progress Report 2014: Grain, Fish, Money: Financing Africa's Green and Blue Revolutions*. Africa Progress Panel, Geneva. 2014. Available at: http://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/Africa_Progress_Report_2014.PDF
- African Union: *Agenda2063, The Africa We Want*. Second Edition, August 2014.
- African Union: *Agenda 2063: The Africa We Want Strategic Framework*. March 2015.
- African Union: *Agenda 2063 - First Ten Years Implementation Plan*. October 2015.
- African Union: *Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa By 2030: Stride towards sustainable health in Africa* (Final Draft_Version_01032016). [Not yet publicly available]
- African Union: *Common African position on the 2015 development agenda*. March 2014. Available at: http://www.uneca.org/sites/default/files/uploaded-documents/Macroeconomy/post2015/cap-post2015_en.pdf
- African Union: *Declaration of the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria - Abuja Actions Toward the Elimination of HIV and AIDS, Tuberculosis and Malaria in Africa by 2030*. 2013
- African Union. 2012. *The Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria in Africa* (2012).
- Atun R, Knaul FM, Akachi Y, and Frenk J.: "Innovative financing for health: what is truly innovative?" in *Lancet* 2012; 380: 2044-49. Published Online 24 October 2012. Available at: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(12\)61460-3.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(12)61460-3.pdf)
- Atun R, Chang AY, Ogbuoji O, Silva S, Resch S, Hontelez J and Bärnighausen T: "Long-term financing needs for HIV control in sub-Saharan Africa in 2015-2050: a modelling study" in *British Medical Journal (BMJ)* June 2016. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4785296/pdf/bmjopen-2015-009656.pdf>
- Atun R, Silva S, Ncube M, and Vassal A: "Innovative financing for HIV response in sub-Saharan Africa" in *Journal of Global Health (JOGH)*. Vol. 6 No. 1. June 2016. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4871060/pdf/jogh-06-010407.pdf>
- AU Commission and ECA: *Joint African Union Commission-Economic Commission for Africa elements paper for the regional consultation on financing for development*. March 2015. Available at: <http://www.regionalcommissions.org/aucffd.pdf>
- Avila, C., Connor, C. and Amico, P.: *Universal Coverage of Essential Health Services in Sub-Saharan Africa: Projections of Domestic Resources*; The USAID Health Finance and Governance Project. August 2013. Available at: <http://hfgproject.org/wp-content/uploads/2013/09/Universal-Coverage-of-Essential-Health-Services-in-Sub-Saharan-Africa-Pr.pdf>
- Blecher, M: "A view from Finance." *Presentation delivered to the WHO meeting on fiscal space, financial management and health financing. Montreaux, Switzerland*. 8 December 2014. Available at: http://www.who.int/entity/health_financing/events/3_blecher_a_view_from_finance.pdf?ua=1
- Bloom, D. and Fink, G.: "The economic case for devoting public resources to health." *PGDA Working Paper No 104 :30*." PGDA Working Paper No 104. 2013.
- Borghi, J., Mtei, G., and Ally, M.: "Modelling the implications of moving towards universal coverage in Tanzania"; *Health Policy and Planning* 2012; 27:i88-i100; doi:10.1093/heapol/czs009. 2012
- Chatham House: *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*. United Kingdom. May 2014. Available at: www.chathamhouse.org/sites/files/chathamhouse/field/field_document/20140521HealthFinancing.pdf
- Chisholm, D. & Evans, D. B. *Improving health system efficiency as a means of moving towards universal coverage*. World Health Organisation, Geneva. 2010.
- Dieleman JL, Schneider MT, Haakenstad A, Singh L, Sadat N, Birger M, Reynolds A, Templin T, Hamavid H, Chapin A, Murray CJL. "Development assistance for health: past trends, associations, and the future of international financial flows for health" in *The Lancet*. Published Online: 13 April 2016. Available at: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(16\)30168-4.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)30168-4.pdf)
- Dieleman JL, Templin T, Sadat N, Reidy P, Chapin A, Foreman K, Haakenstad A, Evans T, Murray CJL, and Kurowski, C.: "National spending on health by source for 184 countries between 2013 and 2040" in *The Lancet*. Published Online: 13 April 2016. Available at: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(16\)30167-2.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)30167-2.pdf)
- V. Durairaj and D. Evans: "Fiscal space for health in resource-poor countries," *World Health Report: Background Paper 41*; 2010.
- Elovainio, R. and Evans, D. "Raising and Spending Domestic Money for Health." *Centre on Global Health Security Working Group Papers - Finance Working Group*. May 2013. Available at: https://www.chathamhouse.org/sites/files/chathamhouse/public/Research/Global%20Health/0513_healthfinance.pdf
- Farag, M., Nandakumar, A., Wallack, S., Gaumer, G., and Hodgkin, D.: "Does funding from donors displace government spending for health in developing countries?" in *Health Affairs* 28(4): Pg.1045-1055 (2009).
- Friends of the Global Fund: *Innovation for Greater Impact: Exploring Resources for Domestic Health Funding in Africa*. 2014. Available at: http://theglobalfight.org/wp-content/uploads/Innovation_for_Greater_Impact.pdf
- Garrett, L. *Existential Challenges to Global Health*. Centre on International Cooperation. 2013.
- Global Fund: *Global Fund Investment Case*. Geneva. December 2015. Available at: http://www.theglobalfund.org/documents/publications/other/Publication_InvestmentCase_Report_en/
- Global Fund. *Innovation for Greater Impact: Exploring Resources for Domestic Health Funding in Africa*. 2014. Available at: http://theglobalfight.org/wp-content/uploads/Innovation_for_Greater_Impact.pdf
- Global Fund: "Innovative Solutions for Funding Health: Past, Present, & Future." *Presentation delivered to Meeting of Ministers of Health and Finance*. Addis Ababa, Ethiopia; 12 November 2013.

- Heller P: "Back to Basics - Fiscal Space: What It Is and How to Get It?" in *Finance and Development*, a quarterly magazine of the IMF; Volume 42, Number 2. (June 2005). Available at: <http://www.imf.org/external/pubs/ft/fandd/2005/06/basics.htm>
- Heller, P.: *The prospects of creating 'fiscal space' for the health sector*; Health Policy Plan, 21 (2): 75-79. (March 2006). Available at: <http://heapol.oxfordjournals.org/content/21/2/75.long>
- Hussain F, Kimuli C. *Determinants of Foreign Direct Investment Flows to Developing Countries*. 2012.
- Institute for Health Metrics and Evaluation. *Financing Global Health 2012: The End of the Golden Age?* Seattle, WA: IHME, 2012.
- Institute for Health Metrics and Evaluation. *Financing Global Health 2013: Transition in an Age of Austerity*. Seattle, WA: IHME, 2014.
- Institute for Health Metrics and Evaluation. *Press Release: "Global health funding reaches new high as funding priorities shift."* 8 April 2014. Available at: <http://www.healthdata.org/news-release/global-health-funding-reaches-new-high-funding-priorities-shift>.
- Institute for Health Metrics and Evaluation (IHME). *Financing Global Health 2015: Development assistance steady on the path to new Global Goals*. Seattle, WA: IHME, 2016.
- IMF: "Sub-Saharan Africa: Keeping the Pace" in *Regional Economic Outlook*. 2013. Available at: <http://www.imf.org/external/pubs/ft/reo/2013/afr/eng/sreo1013.pdf>
- Jamison, D., Summers, L., Alleyne, G., Arrow, K., et al. "Lancet Commission: Global health 2035: A world converging within a generation" in *The Lancet*, Volume 382: 7 December 2013. Available at: <http://www.globalhealth2035.org/sites/default/files/report/global-health-2035.pdf>
- Kutzin, J. Cashin, C and Yip, W: "Alternative Financing Strategies for Universal Health Coverage" in *World Scientific Handbook of Global Health Economics and Public Policy*. 2016. Volume 1, pp. 267-309.
- Lamontagne, E. and Greener, R.: Long term sustainable financing opportunities for HIV in Africa. Concept Paper, Geneva, UNAIDS. 2008.
- Lievens T., Humphrey, E. and Sekidde S. *Assessment of the Potential of Innovative Financing Mechanisms for HIV, Health and Development. A focus on Africa*. UNAIDS. 2012.
- McIntyre, D. and Meheus, F.: *Fiscal Space for Domestic Funding of Health and Other Social Services*, Centre on Global Health Security Working Group Papers - Finance Working Group; (March 2014). Available at: http://www.chathamhouse.org/sites/files/chathamhouse/home/chatham/public_html/sites/default/files/20140300DomesticFundingHealthMcIntyreMeheus.pdf
- McKinsey Global Institute. *Lions on the Move: The Progress and Potential of African Economies*. June 2010.
- Moon, S. and Omole, O.: *Development Assistance for Health: Critiques and Proposals for Change*, Centre on Global Health Security Working Group Papers - Finance Working Group (April 2013). Available at https://www.chathamhouse.org/sites/files/chathamhouse/public/Research/Global%20Health/0413_devassistancehealth.pdf
- Musango L, Elovainio R, Nabyonga J, Toure B: *The state of health financing in the African Region*. 2013. <http://www.who.int/sites/default/files/ahm/reports/556/ahm1603.pdf>
- Ncube, M.: *The Emerging Middle Class in Africa*. Johannesburg: Routledge. 2014
- Oxford Policy Management. *Development of a Framework of Action for Sustainable financing for health and HIV and AIDS responses in the SADC region*. 2014.
- Oberth, J. and Whiteside, A.: "What Does Sustainability Mean in the HIV and AIDS Response" in *African Journal of AIDS Research*: Volume 15, Issue 1, 2016. 20 January 2016. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/26785676>
- One Campaign: *AIDS Report 2015: Unfinished Business*. 2015. Available at: <https://www.one.org/us/aids-report/>
- Powell-Jackson, T., Hanson, K. and McIntyre, D: *Fiscal Space for Health: A Review of the Literature*, Working Paper #1; (December 2012). Available at: <http://r4d.dfid.gov.uk/PDF/Outputs/ReSyst/Resyst-WP1.pdf>
- Reeves A, Gourtsoyannis Y, Basu S, McCoy D, McKee M, and Stuckler D.: "Financing universal health coverage - effects of alternative tax structures on public health systems: cross-national modelling in 89 low-income and middle-income countries" in *The Lancet* 2015; 386: 274-80. Published Online: 15 May 2015. Available at: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(15\)60574-8.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(15)60574-8.pdf)
- Results for Development Institute. *Financing National AIDS Responses for Impact, Fairness, and Sustainability: A Review of 12 PEPFAR Countries in Africa*. October 2013.
- Roy, R., Heuty A., and Letouze E.: "Fiscal Space for What? Analytical Issues from a Human Development Perspective," *Paper for the G-20 Workshop on Fiscal Policy, Istanbul*, 30 June -2 July, 2007
- Runde, D.F. and Savoy, C.M.: *Paying for Development: Domestic Resource Mobilization*. Center for Strategic and International Studies (CSIS). May 2014. Available at: <http://csis.org/publication/paying-development-domestic-resource-mobilization>
- Sidibé M. *Speech delivered by Michel Sidibé, Executive Director of UNAIDS, on the occasion of the AU Conference of Ministers of Economy and Finance and ECA Conference of African Ministers of Finance, Planning and Economic Development*. 28 March 2011. Addis Ababa, Ethiopia. Available at: http://www.unaids.org/sites/default/files/media_asset/20110328_SP_EXD_addisfinanceministers_en_0.pdf
- Tandon, A. and Cashin, C.: *Assessing Public Expenditure on Health From a Fiscal Space Perspective*, World Bank HNP Discussion Paper; (February 2010). Available at: <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/AssesingPublicExpenditureFiscalSpace.pdf>
- Taskforce on Innovative International Financing for Health Systems: *More Money for Health, and More Health for the Money*. 2009.
- UNDP: *Human Development Report, 2013: The Rise of the South. Human Progress in a Diverse World*; 2013. Available at: <http://hdr.undp.org/en/2013-report>
- UNAIDS: *Abuja +12: Shaping the future of health in Africa*. 2013. Available at http://www.unaids.org/sites/default/files/media_asset/JC2524_Abuja_report_en_0.pdf
- UNAIDS: *AIDS Dependency Crisis: Sourcing African Solutions*. January 2012. Available at: http://www.unaids.org/sites/default/files/media_asset/JC2286_Sourcing-African-Solutions_en_1.pdf

UNAIDS: Executive Director Michel Sidibé, PCB Board Meeting (UNAIDS EX Dir PCB-35 (20141209). December 2014

UNAIDS. *Fast-Track: Ending the AIDS epidemic by 2030*. Geneva: UNAIDS. 2014.

UNAIDS: *How AIDS Changed Everything – MDG 6: 15 years, 15 Lessons of Hope from the AIDS Response*. Joint United Nations Programme on HIV/AIDS, Geneva. June 2015. Available at: http://www.unaids.org/sites/default/files/media_asset/MDG6Report_en.pdf.

UNAIDS. *Press release*: “Countries adopt UNAIDS Fast-Track Strategy to double number of people on life-saving HIV treatment by 2020.” 24 November 2015. Available at: http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2015/november/20151124_LocationPopulation

UNAIDS. *Press release*: “UNAIDS announces that the goal of 15 million people on life-saving HIV treatment by 2015 has been met nine months ahead of schedule.” July 2015. Available: http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2015/july/20150714_PR_MDG6report

UNAIDS: *Strategy for 2016-2021: On the Fast-Track to end AIDS*. Joint United Nations Programme on HIV/AIDS, Geneva. 3 August 2015. Available at: http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf

UNAIDS: *UNAIDS Programme Coordinating Board*, UNAIDS/PCB (37)/15.25. 2015

UNDP: Discussion Paper: Innovative Financing for Development: A New Model for Development Finance? January 2012. Available at: http://www.undp.org/content/dam/undp/library/Poverty%20Reduction/Development%20Cooperation%20and%20Finance/InnovativeFinancing_Web%20ver.pdf

UN General Assembly: *Transforming our World: the 2030 Agenda for Sustainable Development: Resolution adopted by the General Assembly on 25 September 2015 A/RES/70/1*.

Van Rooijen, P. Where is the Money? Challenges and opportunities in mobilizing increased domestic financing. The role of domestic resource mobilization. *Presentation delivered to a Satellite Session at the 20th International AIDS Conference in Melbourne, Australia*. July 2014

Whiteside, A.: “Domestic Funding for Health in Africa: The Road of Sustainability and Ownership.” *Presentation delivered to, The Global Fund Satellite Meeting. Cape Town, South Africa*. 7 December 2013

Whiteside, A., Greener, R., Bradshaw, S., Muccheuki, C., and Surgey, G. *Responding to Health Challenges: The Role of Domestic Resource Mobilisation*. HEARD. December 2013. Available at: <https://alanwhiteside.files.wordpress.com/2016/01/03122013-responding-to-health-challenges-final-1330.pdf>

Williams, G. and Hay, R: “Fiscal Space and Sustainability from the Perspective of the Health Sector – Background Paper on the High Level Forum on the Health MDGs”; *Policy Practice*, London. 2005.

World Bank. Africa’s Pulse, No. 7. April 2013. Available at: http://www.worldbank.org/content/dam/Worldbank/document/Africa/Report/Africas-Pulse-brochure_Vol7.pdf

World Bank. Africa’s Pulse, No. 9. April 2014. Available at: http://www.worldbank.org/content/dam/Worldbank/document/Africa/Report/Africas-Pulse-brochure_Vol9.pdf

World Bank. Africa’s Pulse, No. 12. October 2015. Available at: <http://documents.worldbank.org/curated/en/2015/10/25116683/africas-pulse-october-2015>

World Bank. Africa’s Pulse, No. 13. April 2016. Available at: <http://documents.worldbank.org/curated/en/2016/04/26197314/africas-pulse-april-2016>

World Health Organisation: *World Health Report 2010 – Health Systems Financing: The path to universal coverage*; 2010. Available at: <http://www.who.int/whr/2010/en/>

World Bank: *Global Economic Prospects: Having Fiscal Space and Using It*. January 2015. Available at: https://www.worldbank.org/content/dam/Worldbank/GEP/GEP2015a/pdfs/GEP15a_web_full.pdf

World Bank. *World Development Report 1993: Investing in Health*. World Bank and Oxford University Press. 1993.

World Health Organisation: *Kampala Declaration on Fair and Sustainable Health Financing: Report from the Regional and Evidence based Workshop*. Kampala, Uganda. 23-25 November 2005. 2006. Available at: http://www.who.int/health_financing/documents/kampala.pdf

World Health Organisation: *Report of the Commission on Macroeconomics and Health: Macroeconomics and Health: Investing in Health for Economic Development*. 2001. Available at: <http://www1.worldbank.org/publicsector/pe/PEAMMarch2005/CMHReport.pdf>

World Health Organisation: The Abuja Declaration: 10 Years On. Available at: <http://www.who.int/healthsystems/publications/Abuja10.pdf>

World Health Organisation: World Health Assembly resolution 58.33; Available at: http://apps.who.int/iris/bitstream/10665/20383/1/WHA58_33-en.pdf?ua=1

World Health Organisation: *World Health Report 2010: Health Systems Financing: The Path to Universal Coverage*; (2010). Available at: <http://www.who.int/whr/2010/en/>

World Health Organisation: *Global Health Expenditures Database*. Available at: www.who.int/health-accounts/ghed/en/

ANNEX 1: HOW MUCH SHOULD COUNTRIES SPEND ON HEALTH

The Commission on Macroeconomics and Health (2001)

The 2001 *Commission on Macroeconomics and Health* (CMH) estimated the cost¹¹⁷ of scaling up coverage of 49 priority health interventions to address the MDGs for low-income countries.¹¹⁸ The CMH target was intended to provide an absolute minimum level¹¹⁹ of per capita health expenditure required for **low-income countries** to provide a highly limited set of services. This estimate was \$38 in 2002. Expressed in 2012 \$ terms, the CMH estimate is equivalent to **\$71 per capita**.

The package of interventions proposed was based on local population health needs, coverage levels and the cost of expansion. Further adjustments were also made to account for the process of scaling up coverage levels – for example increased management and salary costs.¹²⁰ Finally, the analysis included estimates of the cost of addressing various constraints. These included shortage and poor distribution of appropriately qualified staff; weak technical guidance, programme management and supervision; inadequate drug and medical supplies; lack of equipment and infrastructure and poor accessibility to health services.

The High Level Task Force (2005 and 2009)

The *High Level Taskforce on Innovative International Financing for Health Systems* (HLTF), 2005 and 2009, was an effort to cost the health benefits that were guaranteed by UN conventions. The HLTF estimates were based on the health burden of 49 low-income countries (including 33 in Africa south of the Sahara). The focus was on the cost of scaling up interventions and health system support required to accelerate achievement of the health-related MDGs. The benefit package therefore focussed on HIV, TB, malaria, child health, immunisation and maternal and new-born health interventions.¹²¹ It further included the cost of providing the necessary health system support – the inputs required to scale-up the systems and the services.¹²²

For the interventions included in the benefit package¹²³ the HLTF estimated that an average of \$54 per capita was required to provide this basic but slightly more comprehensive set of primary health care services. Expressed in 2012 \$ terms, the HLTF estimate is equivalent to **\$86 per capita**.

Di McIntyre and Filip Meheus (2014)

A 2014 study¹²⁴ by two academics based at the University of Cape Town examined the funding requirement to offer a basic package of services to the entire population in a way that protected the population from the risk of financial impoverishment. The authors, McIntyre and Meheus, show that:

- Countries in which the government spends around 5.5% of GDP on health (including mandatory health insurance payments) tend to have infant mortality rates lower than 10 per 1,000 live births;
- Countries in which the government spends around 6% of GDP on health tend to have out of pocket expenditures that account for less than 20% of total health expenditure;
- Countries in which the government spends more than 5% of GDP on health tend to achieve the current global average of 44 health workers per 10,000 population;

Based on this, they argue that 5% of GDP is enough to fund a sector that provides UHC up to basic quality standards (in terms of provision of care (adequate HR), outcomes (adequate infant mortality) and financial protection (adequately low OOP).

Recognising, however, that where GDP is low a target of 5% of GDP may not cover basic health needs the authors argue that a GDP dependent target should also be complemented with a GDP-independent target. Thus the study suggests a dual target: a minimum acceptable public health funding level of **whichever is greater between 5% of GDP and \$86 (2012 dollars) per capita**.

117 This analysis was performed for 83 countries – including all the countries of sub-Saharan Africa and all other countries exhibiting a per capita GDP less than \$1,200 in 1999 prices (US \$)

118 The services selected for the analysis were those related to improving health services that are regarded as priorities for achieving the MDG targets: reducing maternal and child health mortality (immunisations, acute respiratory infections, diarrhoeal diseases, maternal and perinatal conditions and malnutrition) and addressing AIDS, TB and Malaria. See Report 1: Diagnosis for details for an outline of these health services.

119 The *Commission on Macroeconomics and Health* define this as “very roughly...the minimum per capita sum needed to introduce the essential health interventions”. The Commission goes on to “stress, however, that not a lot of quality health services can be purchased at \$30 to \$45 per person, certainly not the kind of comprehensive care found in the high-income countries, where outlays are currently \$2,000 or more per year!” *The Commission on Macroeconomics and Health*, Pg.56.

120 Cost estimates were developed for the provision of these interventions, particularly at the close-to-client level (e.g., health centre and outreach services) but also included other levels of service delivery where needed for the interventions. Costs included capital components and requirements for complementary management and institutional support as well as investments in new facilities and the recruitment and training of new personnel.

121 The HLTF provides for a more comprehensive range of PHC services than the CMH. The specific interventions covered by HLTF are focussed on MDG1 (undernutrition), MDG4 (maternal health), MDG5 (child health) and MDG6 (AIDS, TB and malaria). Moreover, it includes the cost of health promotion for MDGs 4-6 as well as two interventions 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 as well as the medicines needed for the above-mentioned areas (MDG8e). The HLTF also includes the cost of providing the necessary health system support – the inputs required to scale-up the systems and the services.

122 These elements include: 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. They also included payments to pregnant women (to encourage the use of safe delivery services) and improved remuneration of health workers.

123 Each ‘Activity’ includes HR costs, Drugs and Commodities, Infrastructure, equipment and vehicles and ‘other’.

NOTE: HR costs (salaries) do not refer to service delivery but rather to the management of the programme (i.e., staff costs incurred at national, regional and district level for employing staff for administration, data management and monitoring). The costs of the front-line health workers are included in the health system component for human resources because most would service multiple disease interventions.

NOTE: The category ‘Other’ include those resources not included in the above three categories, such as: per diems and other costs for conducting meetings, workshops and training courses; costs for disease-specific surveys; information campaigns; and advocacy events.

124 McIntyre, D. and Meheus, F.: *Fiscal Space for Domestic Funding of Health and Other Social Services*. 2014.

ANNEX 2: CURRENCY FLUCTUATIONS

Southern Africa continues to have the highest HIV prevalence in the world. It ranges from a high of 27.7% in Swaziland in adults aged 15 – 49 to 10.6 percent in Mozambique. One of the success stories of the past 10 years has been rolling out treatment, and in many countries in the region significant numbers of people are on life saving medication. There is however a new threat to the AIDS programmes across the region that includes slow growth and declining currencies.

All these countries experience the effects of global economic volatility and this has been particularly marked over the past year. Of great significance has been the decline in the value of regional currencies as is shown below for the Rand/Dollar exchange rate. At the peak in the last two years one Rand would buy 9.075 US cents, at the lowest level in January 2016 the Rand bought less than 6 US cents.

TABLE 3:
USD PER ZAR, 2013-2016



Lesotho, Namibia, South Africa and Swaziland are in a common monetary union and their currencies are pegged. This means a change in the value of the Rand leads to a similar change in the value of the Lesotho Maloti, Namibian Dollar and Swazi Lilangeni. What does this decline in value of the currency mean for the HIV and AIDS response? On the one hand donor dollars go further. However the need and pressure to increase domestic funding and the fact that the drugs and equipment have mostly to be sourced from international markets means the cost of the response is increased.

An additional issue shown in Table 4 is how country World Bank classification rankings will change as a result of currency fluctuations. The table shows that a number of countries will fall into a lower World Bank classification.

TABLE 4:
WORLD BANK RANKINGS BASED ON GNI PER CAPITA

