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RESPONDING TO HEALTH CHALLENGES: THE ROLE OF DOMESTIC RESOURCE MOBILIZATION

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KEY POINTS

- At least US$87 billion is needed to support the prevention, care and treatment of HIV/AIDS, tuberculosis (TB) and malaria in low- and middle-income countries between 2014 and 2016.
- Much of the financing for these diseases previously came from international sources. However, implementing countries are progressively graduating from international support as their economies grow.
- In order to reach the US$87 billion target, national governments need to mobilize more domestic resources and increase spending on health.
- Health ministers in Africa should work with international donors, development partners and their own respective national governments to mobilize domestic resources and develop stronger accounting frameworks that are tailored to the individual and specific needs of the domestic state.

INTRODUCTION

Over the last decade, tremendous progress has been made in the prevention, care and treatment of HIV/AIDS, TB and malaria globally. The international community has played a key role in this progress and remains committed to the fight,[1] but as implementing countries' economies grow, they are progressively graduating from international support. This could leave national governments,

1 Dieleman et al. (2014) estimated in April 2014 that development assistance for health (DAH) reached US$31.3 billion in 2013, its highest level to date. The Organisation for Economic Co-operation and Development (OECD) also reported that "development aid rose by 6.1 percent in real terms in 2013 to reach the highest level ever recorded, despite continued pressure on budgets in OECD countries since the global economic crisis" (OECD 2014).

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AUTHORS' NOTE

This brief is based, in part, on research carried out over the past year for the Global Fund, UNAIDS and the Department for International Development. The opinions expressed are, however, our own.

especially health ministers, uncertain about the future of financing available for their national health programs. Without sufficient resources from both domestic and international resources, there is a risk of resurgence of these diseases. If these trends continue, there may not be a "grand convergence"[2] in health by 2035, resulting in enormous economic and social costs.

The Global Fund to Fight AIDS, Tuberculosis and Malaria collaborated with partners — the Joint United Nations Programme on HIV/AIDS, the World Health Organization (WHO), the Stop TB Partnership and the Roll Back Malaria Partnership — to estimate the total resources required to finance these health challenges over the 2014–2016 period. They predicted that a total of US$87 billion will be required to provide all vulnerable populations in Global Fund-eligible low- and middle-income countries with essential services. Of this amount, it was hoped that the Global Fund would raise US$15 billion and that US$24 billion would come from international funding. In December 2013, the Global Fund received pledges of US$12 billion in new funding — a 30 percent increase over 2010 (Aidspan 2013). By the summer of 2014, this amount had risen to approximately US$12.4 billion. Currently, domestic funding for health is approximately US$23 billion for the three diseases. If national governments can apply realistic but aggressive strategies to increase domestic financing, the Global Fund estimates that these increases could cover up to US$37 billion, amounting to a total of US$73 billion (Global Fund 2013). This will cover approximately 84 percent of the resources needed.

2 According to Jamison et al. (2013), as low- and middle-income economies continue to grow, international development assistance (IDA) investments in health and health-related research rise, and technology continues to improve, the world could see a historical breakthrough in the prevention and treatment of infectious, child and maternal mortality rates.

For the past decade, the international community has taken a large responsibility in financing the battle against these diseases through IDA and specifically DAH. Given the growth of their economies and the need for sustainable long-term action, national governments in implementing countries need to take the lead on mobilization of domestic resources for health.

It is recommended that African health ministers take the lead by working with the international community to develop stronger accounting frameworks that help track how funds for health are being raised and allocated. Once a clearer assessment of domestic health spending can be made, health ministers should work with their respective national governments to adopt benchmarks for resource mobilization. These benchmarks should reflect a commitment to both shared responsibility and the needs of each country.

PROGRESS AND CHALLENGES: HIV/AIDS, TB AND MALARIA

Over the last decade, progress has been made in preventing HIV, there has been a massive rollout in antiretroviral treatment for AIDS, the number of TB cases has declined and the global malaria mortality rate was reduced by 26 percent between 2000 and 2010 (Global Fund 2013). Because of dedicated programs within countries and increased funding for them, HIV prevalence appears to have stabilized and the number of new infections (although still significant) has steadily declined since the late 1990s. TB incidence rates have been falling since 2000, and improvements have been made in the detection and treatment of the disease; malaria incidence and mortality have both fallen since 2000 with most progress since 2005 (ibid.).

Despite this significant progress, HIV/AIDS, TB and malaria continue to pose challenges that have devastating human tolls. According to the Global Fund, there were "some 2.7 million deaths from AIDS and TB related causes in 2011, and 660,000 malaria-related deaths in 2010" (ibid.).

There is currently an opportunity to significantly reduce the economic and human toll of HIV/AIDS, TB and malaria. The global community has the financial and ever-improving technical capacity to universally reduce infectious disease mortality rates. Jamison et al. (2013) suggest that the expected economic growth of low- and middle-income countries means that some of the "incremental costs of a achieving a convergence could be covered by domestic sources." Coupled with international investment in health and health technologies, the world could "prevent about 10 million deaths in 2035, across low-income and lower-middle-income countries relative to a scenario of stagnant investment and no improvements in technology" (ibid.).

IDA AND DAH

IDA has been the largest source of funding for AIDS, TB and malaria. In 2010, approximately US$123.5 billion was transferred to low-income countries for development assistance. Of this US$123.5 billion, about 19 percent or approximately US$23.3 billion was DAH. About 70 percent of DAH comes from governments. In 2010, the United States was the largest governmental DAH donor, followed by the United Kingdom, France, Germany, Canada, Japan, Norway, Spain, the Netherlands and Australia (Moon and Omole 2013).

The rationale for IDA has largely been driven by the assumption that low-income countries have difficulty raising domestic resources. However, this

has the potential to take the responsibility away from governments to spend domestic funds on health, a concern noted in a recent review of 12 countries that qualify for the United States President's Emergency Plan For AIDS Relief. The review remarks on the "deeply ingrained perceptions by finance and other senior government officials that 'donors will take care of the AIDS program,' as indeed donors have done over the past decade" (Results for Development Institute 2013).

These perceptions can affect how funds are allocated to health, as public officials may be more inclined to reallocate, divert or displace funds into other sectors of the economy. Studies have shown that health- and agricultural-related projects exhibit the most reallocation, compared to other sectors such as education, energy, transportation and communication (Devarajan, Rajkumar and Swaroop 1999). Studies have also shown that displacement can even occur within the health sector. For example, donor funding for HIV/AIDS can significantly displace efforts for malaria and other health-sector funding (Lordan, Tang and Carmignani 2011).

It is important that governments recognize negative long-term consequences associated with under-spending and reallocating health funds into other sectors. If implementing countries graduate from international support, it will become extremely difficult for governments to shift resources back, especially if funds have been committed to other sectors. While IDA and DAH play an important catalytic function for countries to push toward universal coverage and better health policies, domestic resources for health must increase in order to ensure sustainable health financing in the long run.

DOMESTIC RESOURCE MOBILIZATION AND INCREASING DOMESTIC SPENDING ON HEALTH

Domestic resource mobilization (DRM) is "the generation of savings from domestic resources and their allocation to socially productive investments" (Osoro 2009). It involves mobilizing human and financial resources for investment, and both the public and private sectors have an important role to play in DRM. The public sector mobilizes domestic resources through taxation and public revenue.

Strengthening DRM strategies reduces a government's dependency on external flows of financing. Thus, DRM plays a critical role in the long-term growth and sustainability of development efforts, especially in health. Increasing DRM also increases policy space by strengthening a state's capacity and giving it ownership over the development process.

THE COSTS OF HEALTH

In 2001, heads of states of the African Union made the Abuja Declaration — a commitment to allocate at least 15 percent of their annual budgets to the health sector by 2015. Since then, none of those countries has achieved this target, yet significant progress has been made within domestic financing efforts. Between 2006 and 2011, domestic spending on AIDS, TB and malaria has doubled, bringing some African countries closer to reaching the Abuja target. However, not enough is being done currently to mobilize domestic resources. Many countries, especially those with the heaviest disease burden, are unable to fund their responses to AIDS, TB and malaria without international support (see Table 1 for examples of countries involved in the Abuja Declaration).

TABLE 1: GOVERNMENT EXPENDITURE ON HEALTH AND HIV PREVALENCE IN 2011

Country	HIV prevalence (in %)	Actual per capita government expenditure (in US$)	External funding as % of total health expenditure
Botswana	23.4	263	9.2
Kenya	6.2	14	38.8
Lesotho	23.1	105	25.2
Malawi	11.0	23	52.4
Mozambique	11.2	15	69.8
South Africa	17.8	329	2.1
Swaziland	26.5	184	19.4
Uganda	7.2	11	27.0
Zambia	13.0	52	27.2

Data sources: McIntyre and Meheus (2014) and World Bank (2014).

THE CHALLENGES WITH MEASURING SPENDING

The ability to measure health expenditure from both international and domestic sources is problematic. First, the definition of health expenditure differs among African countries, with some including a proportion of welfare or disability in the expenditure. Health expenditure may also go toward the development of infrastructure, such as building public hospitals, and in some countries this expense may be defined as public works or infrastructure expenditure.

Second, governments may not disaggregate between national and international resources, general health expenditure and expenditure on the three diseases, or whether or not the funds are being spent on prevention or treatment.

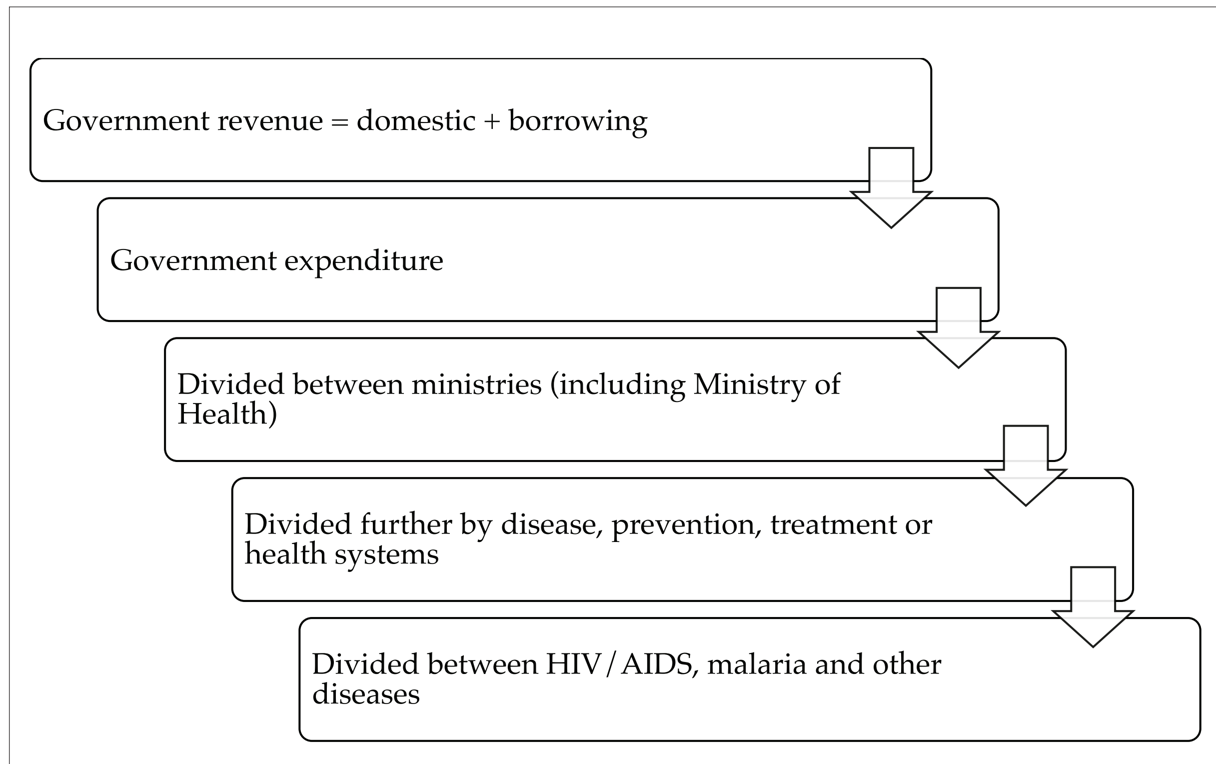
GOVERNMENT BUDGETING AND DOMESTIC RESOURCE ALLOCATION

When determining how much to spend on health, governments must make a number of hierarchical decisions that start with a country's income. As governments move down the decision chain, each allocation is constrained by the decision above (see Figure 1).

One of the basic rules of public economics is that the resources can be used only once; there is a pool of money that gets divided between ministries. Each point in Figure 1 shows choices that have to be made, making the issues about more than economic decisions. Considerations must be given to politics, human rights, morality and policy. This may result in resources being poorly allocated for a number of reasons.

First, one explanation of poor resource allocation is that high-disease-burden African countries do not have access to the full information required to make informed decisions regarding health expenditure. It is important to note that HIV/AIDS is a privileged disease in the sense that people on treatment receive more than the per capita public health allocation in most countries. Science has created treatment, and advances in technology and medicines mean costs continue to fall; however, the disease is still expensive to treat and economic tools become especially important in making decisions about resource allocation, especially considering low-income and vulnerable populations that cannot afford out-of-pocket expenditures to pay for

FIGURE 1: DETERMINANTS OF FUNDING AND DECISION POINTS



Source: Authors.

care. Most countries do not have access to information about the cost effectiveness of different interventions, especially non-biomedical prevention efforts.

Second, and relatedly, poor resource allocation may occur because policy makers are unclear as to the best practice. The studies on different cost-effective interventions can be inadequate, often not including all costs, and policy makers might view studies conducted in one region as inapplicable to others. Finally the science is changing. For example, five years ago, medical male circumcision seemed the most effective prevention intervention, while in 2014, putting everyone who is HIV infected on treatment as early as possible is being proposed by some scientists. Policy makers do not always read scientific papers or necessarily understand the debates, which can leave them unable to determine how to effectively budget for different health initiatives.

Third, poor resource allocation can also result from a lack of control over resources. This is due to the fact that some international donors have their own agendas to fulfill. In many of these cases, recipient countries are "likely to be hesitant to turn down resources, even if those resources will skew the national response towards intervention which planners do not believe will be successful" (Forsyth, Stover and Bollinger 2009). Countries may adjust their spending based on the desires of the donor.

Fourth, a lack of political will, leadership and/or transparency may lead to poor resource allocation for health. One necessary condition for strengthening the health system in Africa resides in its national leadership's willingness to advocate spending on health over other national challenges.

Fifth, some health intervention strategies are more palatable to some societies than others. Men who have sex with men are disproportionality affected by HIV/AIDS. There is evidence that targeted prevention interventions for this group can reduce the risk of HIV infections.[3] However, in societies where it is illegal to be a homosexual or there are societal norms that find this practice "unnatural," prevention efforts are difficult. Countries are left with no other option than to treat these marginalized populations once they have contracted the disease. Because HIV prevention may be more cost-effective than AIDS treatment, some countries are unable to effectively and efficiently finance their responses to contracted HIV.

FAIR SHARE FOR DOMESTIC SPENDING ON HEALTH

Health is the responsibility of governments; however, domestic funding for health will account for less than half the resources required to meet the US$87 billion target. This imbalance raises the issue of what kinds of funding distribution could be constituted as "fair share." Policy makers must ask: What contributions can or should be expected from low- and middle-income countries, given their economic and fiscal situations and their disease burdens? And what contributions can or should be forthcoming from high-income countries?

While it is important to maximize the potential of domestic sources to finance strategies to address these three diseases, it is equally imperative to understand their limitations. A productive debate requires acknowledgement that both domestic and international sources will need to be sustained and increased if global targets are to be met. Because of these challenges, there is not a one-size-fits-all solution to how much money should be spent on health in any particular country. Therefore, it is not only vital to discuss this situation in the context of shared responsibility, but also in the context of an approach that is tailored to the individual and specific needs of the domestic state.

RECOMMENDATIONS

Health ministers should work with the international community to create stronger international accounting frameworks to manage funds. Helping countries track funds will improve accountability for domestic finances raised and spent. It will also provide a stronger assessment of domestic health spending and a disaggregation of where funds are allocated. A stronger accounting framework will allow countries to see where resources are being poorly or properly allocated. This would improve the quality and efficiency of spending by governments.

Health ministers should work with their national governments and development partners to encourage political leadership on issues of health, and craft advocacy messages that are tailored to specific country needs. Countries need to support their own programs and strategies for mobilizing domestic resources, and take responsibility for their own needs. Health ministers are often the most aware of the challenges the health sector faces in regards to ineffective or insufficient spending. Thus, they can play an important role in creating advocacy messages that put health at the top of the government's agenda. Access to health care and services has been improved in some countries because of the leadership of health ministers. However, continued

3 AIDSTAR-One (2014) studies suggest that community-level interventions have been shown to lead to a 43 percent decrease in unprotected anal sex, and group-level interventions have been shown to increase the odds of condom use to as high as 81 percent.

improvements rest on the responsibility of leaders to make change happen.

Health ministers should act as intermediaries to create partnerships between international donors and domestic governments and develop benchmarks for resource mobilization and allocation that reflect a commitment to shared responsibility. An appropriate mix of domestic and international investment in the health sector will vary depending on a variety of factors, including a country's ability to pay, its wealth and the amount of funding given to other development areas. Often, international donors lack country-specific knowledge on how their funds could be most efficiently spent. Setting country-specific benchmarks that consider a variety of developmental factors will help countries allocate IDA more effectively and efficiently. When it comes to the health sector, health ministers are often aware of the gaps in spending in their own particular countries. Their expertise and position present a unique opportunity to act as an intermediary that strengthens the relations between donors and governments, and to develop informed and appropriate benchmarks for resource mobilization that reflects a commitment to shared responsibility.

CONCLUSION

There is a need to finance the prevention, care and treatment of HIV/AIDS, TB and malaria between 2014 and 2016 and beyond. Without sufficient resources to continue to finance these efforts, there is a risk of losing ground in this fight. As countries graduate from international support, African health ministers will need to step up to the plate. They must work with international donors, development partners and their own respective national governments to develop stronger accounting frameworks, mobilize domestic resources and advocate health spending in the context of shared responsibility and individualized needs.

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Le CIGI a été fondé en 2001 par Jim Balsillie, qui était alors co-chef de la direction de Research In Motion (BlackBerry). Il collabore avec de nombreux partenaires stratégiques et exprime sa reconnaissance du soutien reçu de ceux-ci, notamment de l'appui reçu du gouvernement du Canada et de celui du gouvernement de l'Ontario.

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