A CASE FOR ADVANCING POLITICAL LEADERSHIP FOR DOMESTIC INVESTMENT IN SUSTAINING THE AIDS RESPONSE IN AFRICA

POLICY BRIEF

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Background paper for Champions Meeting on 18-19 September, Pretoria. South Africa
INTRODUCTION

During the first decade of the twenty-first century, the world saw an historically unprecedented scale up of domestic and international programmes that turned around the course of the HIV/AIDS epidemic. Building upon these achievements, countries committed within the Sustainable Development Agenda adopted by the United Nations General Assembly to end the AIDS epidemic as a public health threat by 2030 [1]. Such an achievement was recognized to require an immediate effort to front-load investments in comprehensive HIV/AIDS responses as outlined in the UNAIDS Fast-Track strategy [2].

These goals are now at risk of not being attained:

- The tremendous progress in saving lives has created a false sense of security that the AIDS epidemic is over, and the HIV epidemic is not on track to end by 2030 [3].

- Overall, there is a prevention crisis. In all countries, society’s most vulnerable – the youth and especially adolescent girls and young women, and other key populations – are being left behind [4]. With the population of young people growing rapidly in Africa, just continuing with the current coverage of services could result in a runaway resurgence.

- And, there is a funding crisis. Worldwide, the funding for prevention and treatment has flatlined. About US$21 billion was spent on the AIDS response [4], but US$26 billion are needed annually. UNAIDS estimates that if the gap is not bridged, the funding shortfall will result in an additional 2.1 million infections and one million more deaths.

Africa’s war with HIV/AIDS has now reached a critical juncture that is forcing governments to reappraise their strategies for ending AIDS. Critical to that endeavour is the initiative launched in 2015 with the objective of reaching out to leadership at all levels [5]. Countries can build upon the progress achieved during the last decade, but they need stronger political commitments to overcome changes in priorities and increase their domestic funding to overcome the stagnation of international assistance for HIV/AIDS.

CHANGING LANDSCAPE

Substantial progress in controlling the HIV epidemic has been achieved in sub-Saharan Africa (Annex 1), but on-going demographic trends and shifts in financing priorities are putting the AIDS response at risk.

DEMOGRAPHIC CHANGES AND NEW INFECTIONS

High new rates of infections among young people combined with rapid population growth are resulting in a growing number of people living with HIV. Key trends include:

- In the African region, more than 30% of the population is now made up of adolescents and young people between the ages of 10 to 24 and this figure is projected to increase from 315 million in 2015 to 453 million by 2030 [6].
• Prevention efforts, especially for adolescent girls and young women, remain insufficient. Young women 15-24 years of age accounted for a quarter of all new infections in sub-Saharan Africa in 2017 even though they represent only 10% of the population [4].

• The overall consequence is that the region is not on-track for meeting the 2020 targets for new infections [4].

• Advances in HIV treatment mean that people can now live long and healthy lives. But this comes with the added challenge of an increasing burden of non-communicable diseases and other health issues relating to aging populations [3].

**CHANGING PRIORITIES**

**Globally, external aid for HIV is stagnating.** Growing insecurity, cuts in public service and slow economic growth in much of the western world have reduced political support for HIV funding:

• Donor government funding in low- and middle-income countries amounted to US$ 8.1 billion in 2017, about the same it was 9 years earlier (US$ 7.8 billion) [7]. Almost three quarters of the total donor government funding for HIV comes from the United States and their contribution is likely to decrease in the coming years in line with shifting national priorities [7].

• In Eastern and Southern Africa, available resources reached US$ 10.6 billion in 2017 (with 42% on average being provided by domestic resources) (Annex 2 Figure 1). According to UNAIDS projections, these resources may be sufficient to reach the Fast-Track targets provided efficiency and effectiveness improve further, although some countries that contribute very little will be likely to continue to need support for many years [4].

• In Western and Central Africa, resources are insufficient for reaching the Fast-Track targets. US$ 2.1 billion was available in 2017 (with domestic resources amounting to one-third), and an additional US$ 1.8 billion is needed to reach the Fast-Track targets (Annex 2, Figure 2).

**As countries transition from low-income to low-middle income status, they lose access to official development assistance.** For decades the classification of countries as low- or middle-income countries remained stable and few countries graduated from one category to the next. But during the past two decade developing countries experienced rapid economic growth with the result that between 2005 and 2013, 48 countries changed income categories; 15 moved from low-income to low-middle income status and 22 countries from lower-middle to upper middle-income status.

• In Africa, countries such as Gambia, Kenya, Nigeria, Sudan and Zambia acquired a low-middle income status while Namibia became an upper-middle income country [8].

• The result is a loss in access to official aid. Worldwide, official aid for health declined from 33.6% of health expenditures among low-income countries to 19.4% of health expenditures among lower middle-income countries [9].
A key factor is the eligibility requirements for accessing development assistance.

- The World Bank’s International Development Association (IDA) uses a Gross National Income per capita of US$ 1,165 (in 2018) as its cut-off threshold for accessing concessional assistance from IDA (along with debt distress and credit worthiness) [10].
- To ease the burden for countries heavily affected by the HIV epidemic, the Global Fund and Gavi have issued and implemented specific policies and guidelines to ease the transition from donor funding to domestic resources [11][12].
- Options for easing the transition of countries are also being considered by donor agencies, and in particular, through the Equitable Access Initiative [8].

Worldwide, international aid is shifting towards priority countries (low-income and high HIV prevalence countries):

- In 2011, the Global Fund issues eligibility guidelines that restrict funding based on criteria that include Gross National Income per Capita, the disease burden and the performance. These were periodically revised, and most recently in 2018 [11].
- In 2017, PEPFAR announced that it would focus its support on 13 countries [13], which is likely to result in less funding for other countries. Given the large share of PEPFAR funding in government health expenditures, the announced strategy is likely to significantly affect some African countries (Annex 2, Table 1).

And the rationale for providing external aid has changed:

- The debate has shifted from funding the gap between need and availability of resources to showing that resources are delivering results. And,
- International aid is evolving towards a model where external assistance is seen as a catalytic resource, especially for countries that are graduating from a low-income status to a middle-income status.

The changing priorities affecting international aid have not been ignored by African governments. They have increased their efforts to allocate more resources to HIV/AIDS, but stronger efforts are required to address the financial sustainability of HIV/AIDS programmes. A key component is resource mobilization to assist countries in their endeavour to end AIDS as a public health threat [14].

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1 Acceleration countries include: Botswana, Côte d’Ivoire, Haiti, Kenya, Lesotho, Malawi, Namibia, Rwanda, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. Non-acceleration African countries include: Angola, Burundi, Cameroon, DRC, Ethiopia, Ghana, Mozambique, Nigeria, South Africa, and South Sudan.
OPTIONS FOR INCREASING RESOURCES FOR HIV/AIDS

There are a number of ways in which additional resources for HIV/AIDS can be generated. First and foremost is strong economic growth and better systems for linking economic growth to governments’ ability to provide public services. This will ensure that total amount of funds available for public spending continues to increase year on year. Second, more money for health and HIV/AIDS has to be mobilized from the government budget, supported by other domestic and international resources for health. And third, more health for the money has to be obtained from available resources by improving efficiency.

ECONOMIC GROWTH AND STRONGER SYSTEMS FOR INCREASING GOVERNMENT SPENDING

The past two decades have seen strong growth on the African continent, with an average annual growth rate of 4.6% from 2000 to 2016 (Annex 2, Figure 3) [15]. Countries have benefitted from, inter alia, high commodity prices, diversification of trade partnerships, and improved macroeconomic management. This growth will need to be sustained into the future with a renewed political commitment to reducing inequalities, and translating the general economic growth into higher well-being across the board.

A typical low-income country collects just 15% of GDP in government revenues compared with the 32% collected by European governments. The ability to collect more revenues is central to countries’ capacity to finance health programmes, and especially HIV/AIDS programmes. Considering the expansion needed to bring the HIV/AIDS epidemic fully under control, the low level of tax collection in several countries is putting the objective of ending the AIDS epidemic by 2030 at risk.

Large increases are feasible. A look at successful reforms between 2004 and 2015 in five low-income and emerging market economies show that large gains in government revenues can be achieved. During the reform the tax ratio as a percentage of GDP rose by more than five percentage points of GDP in the five countries. By 2018, Georgia’s tax revenue-to-GDP ratio had doubled to 25% [16].

What made these gains possible are four common characteristics:

- High-level political commitment and buy-in from all stakeholders was secured;
- The tax system was simplified, and exemptions reduced;
- The system of indirect taxation was reformed, including the Value-Added-Tax (VAT);
- A comprehensive reform of tax administration was implemented, including the use of smart information systems.

**Sources:**

- Georgia’s tax revenue-to-GDP ratio had doubled 25% [16].
The gains achieved by the five countries mentioned might seem more difficult to achieve in sub-Saharan African countries. Nevertheless, a feasible objective might be to aim for an increase in tax revenues of about one percentage point of GDP over a four to six-year horizon [17]. As highlighted in the Addis Ababa Action Agenda of the Third International Conference on Financing for Development that was adopted by the United Nations in July 2015 [18], tax collection efforts are critical to support the efforts to mobilize more domestic revenue. Fiscal reforms aimed at increasing the effectiveness of tax collections and taking advantage of the revenue-raising potential of the VAT are likely to be key components.

**Improving the effectiveness of revenue collection efforts**, such as strengthening tax administration institutions, reducing exemptions and broadening the base of value-added taxes and corporate income taxes can substantially increase tax revenues:

- **Ghana** in 2009 introduced measures that included a new integrated tax authority, reducing tax waivers and exemptions for foreign direct investment, and a new communication service tax. As a percentage of the non-oil economy, tax revenues rose from 12% in 2009 to 16% in 2011 [19]. The health sector also benefitted as the share of government health expenditures relative to GDP rose from 2.3% in 2008 to 2.8% in 2011.
- Reform of fiscal regimes for **extractive industries** such as oil and gas could also generate more government revenues.
- **Property taxes** currently do not generate much revenue – at most half a percent of GDP – but it has considerable revenue potential.

**MORE MONEY FOR HEALTH AND HIV/AIDS**

Countries at all income levels struggle to raise funds for health. However, low- and middle-income countries are in a much worse situation as the gap between their needs and current levels of health service coverage is significantly larger. It is therefore perhaps not surprising that health services are at the top of African households’ priorities:

- According to a 2016 Afrobarometer survey of opinions in 36 African countries [20], 31 of the 36 surveyed countries rated health care either as the first or second highest priority (after education) for additional government spending.
- In nine countries (Côte d’Ivoire, Gabon, Mozambique, Senegal, Sierra Leone, Tanzania, Togo, Uganda and Zambia), health was rated as the most important priority.

**Giving greater priority to health is already well recognized.** About half of the sub-Saharan African countries have managed to give greater budgetary priority to health. In 19 countries government health spending amounted to a larger share of government expenditures in 2015 compared to 2005 (Annex 2, Table 2):

- In three countries (Burundi, DRC and Sudan) the share of government health expenditures more than doubled.
- In Congo, Eritrea, Madagascar, Lesotho, Malawi, and Togo the share rose by more than 50%.
Taking advantage of the Value-Added Tax (VAT). In countries with a large informal sector, direct income taxation will not provide sufficient revenues to fund HIV/AIDS programmes in addition to health programs. However, the VAT offers a simpler mechanism for collecting taxes and ensures that a large part of the population contributes. A general concern is that the VAT may be regressive by overburdening the poor, but this need not necessarily be the case as the rates on the goods consumed by poor households can be adjusted.

The potential of the VAT to mobilize revenues depends on the existing level of taxation, but it can be substantial:

- Recent studies by the IMF indicate a revenue potential of about 3% from the VAT in countries such as Cape Verde, Senegal, and Uganda.
- In Uganda for instance, the IMF estimated in its 2014 report that VAT revenues would increase by 2–2.5% of GDP mainly by reducing the compliance gap [21].

Earmarking specific taxes for health. At least 80 countries are using earmarking for health (Box 1) [22]. The most common form of earmarking is an earmarked payroll or income tax to fund social insurance. Over 60 countries worldwide use such a mechanism.

Historically, many countries have relied on payroll tax to fund health insurance, but this tax may not generate enough resources.

- Countries with a large informal sector such as Thailand have also found it difficult to fund the expansion of health coverage through payroll taxes and have resorted to using general revenues for funding health expenditures [23].
- Countries such as France and Japan have reduced their overreliance on payroll taxes as these taxes no longer generate enough revenue in a context where the labour force is not increasing quickly enough to meet the financing needs of the health sector.

Taxes on alcohol, tobacco and sugar-sweetened drinks have received much attention because they not only provide additional resources, but they also reduce harmful consumption and improve health. Worldwide, they are the second most commonly found type of earmarking, found in 54 countries.

Other specific earmarked taxes such as taxes on mobile phones and lotteries have not been widely used. Gabon, for example, levies a 10% tax on mobile phone companies’ turnover and a 1.5% levy on money transfers outside the country that are earmarked for the national health insurance fund, and these funds serve to cover the membership costs of people who cannot afford it [24].
In addition to the Solidarity Airline levies that have been transferred to UNITAID for funding its operation, countries such as Cameroon, Congo, Madagascar, Mali, Mauritius and Niger have also introduced their own airline levies [25].

The concept of earmarking funds for health has generated a vigorous debate [26]. Research has shown that earmarking may have little effect on the expenditures to which they are tied, mainly for the reason that other sources of budgetary funding may be reduced to offset the increase in revenues provided by the earmarked taxes [27]. Earmarking also introduces rigidities in the budgetary process, and for this reason, they are generally opposed by Ministers of Finance. Overall, the general consensus in the literature is that earmarked levies are unlikely to substantially increase tax revenue [28].

**Linking fund raising to health benefits.** New taxes are rarely popular but dedicating a new revenue to a popular health initiative can make a tax increase politically possible.

- In Ghana, for instance, attempts to increase the VAT were politically unpopular until the increase was earmarked for funding the National Health Insurance. Popular support was built on the theme that it would replace existing user fees. A 2.5% tax was added to the VAT, and it funds 70% of the National Health Insurance Scheme.

- In the Philippines support for an increase in the tobacco tax was obtained by earmarking the additional revenues to expanding national health insurance coverage for the poor.

**Mobilizing funds through Social Health Insurance.** Social Health Insurance (SHI) is often viewed as a means of raising additional funds for health, but this may not be the case as the insurance premiums may simply replace out-of-pocket payments.

Several SHI schemes provide coverage for HIV and operate successfully in upper-middle- and high-income countries. In many low- and middle-income countries, however, SHI schemes are often underdeveloped.

In many countries a step towards moving towards universal health coverage (UHC) may require merging existing schemes into a National Health Insurance as was done recently by Zambia (April 2018) (Box 2) [29]. Currently, according to the Ministry of Health, only 4% of the population has health insurance. The total population covered will initially be 22% of the population and reach 35% by 2033.

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**Box 2: Zambia: National Health Insurance (2018)**

The Zambia National Health Insurance became law in April 2018 after a lengthy consultation process that started in 2012 and resulted in building a consensus.

It merges three compulsory schemes: a scheme that covered the formal sector, medical assistance for local populations and mutual health organizations for the informal sector. Enrolment is mandatory.

The insurance will be administered by an independent agency with a single payer payment system. The contracted providers will be paid based on a negotiated reference price list. Coverage will be for contributing member, spouse, all children below 18 years and four other dependents.

The expansion is planned to take place in phases. The initial phase is focused on covering the formal sector employees (public and private), and a second phase would cover the informal sector.

Funding will be derived from general taxes and supplemented by mandatory earmarked payroll-linked contributions set at 2% (1% from employer and 1% from employees).
Mobilizing non-government revenues could be carried out through community-based health insurance schemes. Given the difficulty of raising revenues for health in countries with a large informal sector [30], setting-up voluntary insurance schemes such as community-based health insurance (CBHI) offers a way to reach communities that otherwise would remain without insurance. CBHI operates by pooling resources and risks at the community level. In such schemes, households voluntarily pay a pre-determined amount of money in exchange for a benefit package consisting of a pre-determined set of health services. In many cases, however, the performance of CBHI has been poor. Lack of funds, poor healthcare quality and lack of trust were found to be major reasons for the low CBHI coverage in some countries [31].

In the last few years, CBHI has evolved as an alternative health financing mechanism that is often viewed as a potential step in the transition toward UHC in low-income countries [32]. While CBHI may have a strong potential for enhancing access to health services and increasing resource mobilization for health [33], there is a huge variation in the effects and coverages achieved. In most cases, expanding the coverage of insurance to poor households is likely to require government involvement and subsidies – this kind of support was found to have a positive impact on uptake and in sustaining CBHI [34]. An example is Tanzania.

- **Tanzania’s Community Health Fund** was relaunched in 2014 as the Improved Community Health Fund (iCHF) [35]. It is a district-level voluntary insurance scheme built upon a partnership between the National Health Insurance Fund, the local governments, public and private healthcare facilities and PharmAccess. PharmAccess with the support of the Dutch Ministry of Foreign Affairs provides technical and funding support. The Tanzanian government also provides a subsidy to match the insurance premiums paid by households. Based upon this program which currently reaches 100,000 people, the government is developing a community health fund for a nationwide roll-out as part of its move towards UHC.

Several efforts to include HIV services in health insurance plans were supported by donor funding. For example:

- **In Rwanda**, community-based health insurance schemes experienced steady growth from 1999 onwards. Following the intervention of the Global Fund in 2005, further expansion took place. Financial support was provided to increase access to AIDS, tuberculosis and malaria by subsidizing the health insurance of the poor with results that were deemed positive. A key contribution was strong support from the Health Ministry that led to a dramatic improvement in the coverage of CBHI [36].

- **In Namibia**, the substantial inflow of donor funds for publicly provided HIV/AIDS services led to concerns that the private sector would be “crowded out”. In response to these concerns, the Namibian medical aid industry with donor support set up a special fund in 2006 to subsidize private health insurance, including HIV services. In this context, donor funding was used to allow low-income people to be covered [37].
**User fees.** During the 1980s and 1990s, most countries established user fees as a way of raising revenues for health services. After the turn of the millennium, there was a growing consensus that user fees should be replaced with new financing instruments that were viewed as better tools for avoiding some of the adverse effects of user fees such as impoverishment. Every year, 14.9 million Africans are estimated to fall into poverty due to out-of-pocket payments, and for others, user fees have the perverse effect of keeping the poorest away from health services, leading to poorer health outcomes for those already most vulnerable [38]. In view of the limitations of this type of funding, other possible sources of financing that came to be seen as innovative funding received much attention in the mid-2000s.

**Public-private partnership** is a characteristic of many of the innovative global financing initiatives such as the Advanced Market Commitment, PRODUCT Red, or the Airline Solidarity Levy. In recent years, public-private partnership has taken a new focus aimed at bringing not only additional funding, but new technologies that offer the potential of improving access to health services. Examples include:

- **Improving access to health professionals in Rwanda.** An example is Babylon health, a British start-up, which raised US$60 million to provide health services via a smartphone application called Babyl. Babyl was launched in Rwanda in 2016 and by 2018, it had more than 2 million Rwandan clients. The application allows clients who have a mobile phone to access digital information, prescriptions, and video and telephone communications with health professionals. These services are provided free of charge in partnership with the Rwandan Ministry of Health [39].

- **Improving access to AIDS drugs in South Africa.** Due to South Africa’s widespread HIV epidemic, the demand for treatment has grown rapidly resulting in lengthy wait at pharmacies. Introducing what are called “ATM Pharmacy Dispensing Units” offers a way to cut down on dispensing time. As of July 2018, 16 units have been installed in Johannesburg. These ATM units dispense vital repeat medication for chronic stable patients who have HIV/AIDS, diabetes, or tuberculosis. This initiative was launched by Right to Care, one of South Africa’s biggest NGOs, and Right ePharmacy, which worked with the Department of Health of Gauteng province and the banking sector on the initiative. USAID and GIZ are also supporting the project [40].

Another characteristic of the new public-private partnership is its emphasis on ensuring that private sector funding actually achieves its intended results. An example is provided by **Social/Development Impact Bonds.** These are financing mechanisms that tie payments with results through a contract between private investors and donors or governments. An impact bond is considered a Social Impact Bond (SIB) if a domestic government agency serves as the outcome funder. With a Development Impact Bond (DIB), private investors fund development programmes and get financial returns linked to verified development goals. These bonds have thus far not been widely used for funding HIV programmes but there is optimism that these funding instruments could have a significant positive impact in Africa.
More than 60 SIBs have so far been launched since 2010, mostly in high income countries. But there are several SIBs in the pipeline in developing countries that address water consumption (Costa Rica), child neglect (Chile), and patients with long-term health conditions (Brazil).

DIBs are more recent. The first DIB was launched in 2014 in Peru (for coffee and cocoa production). Subsequent ones are related to social services, for example targeting girls’ education (Rajasthan, India) and maternal and newborn health (Rajasthan, India). Others in Africa include: a cataract bond, a DIB for sleeping sickness in Uganda, a DIB for mother care in Cameroons and a DIB for malaria in Mozambique [41].

Another instrument that can be used for stimulating private sector investment in health is guarantees. In 2014, the World Bank modified its policy and guarantees are now available as a form of financing in investment project financing operations.

Currently, the World Bank’s Guarantee programme has a portfolio of over 38 operations and about US$3 billion in exposure, but have not been used so far for health projects [42].

However, guarantees are also available from the Bill & Melinda Gates Foundation in the form of volume guarantees. These are provided to guarantee suppliers a volume of sales over a specified period for critical products such as vaccines, drugs and contraceptives, helping to make them more available and affordable [43].

Innovative financing at the country level

At the country level, efforts to mobilize resources for HIV/AIDS received a strong impetus from the HIV epidemic as it resulted in growing demands on the budget of African governments. Table 1 includes examples of countries that have levied taxes on specific consumption goods or services, including financial transactions. A key motivation in most cases was to provide a secured source of funding for specific health programmes (such as national health insurance) or HIV/AIDS.

<table>
<thead>
<tr>
<th>Instruments</th>
<th>Possible strategies</th>
<th>Country examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redistributing existing government revenues to health</td>
<td>Creating political will Demonstrating results</td>
<td>About half of the SSA countries managed to increase government health spending as a percentage of GDP between 2005 and 2015</td>
</tr>
<tr>
<td>Increased tax base by reforming taxes</td>
<td>Part of national fiscal reform</td>
<td>Cambodia, Georgia, Guyana, Liberia and Ukraine: tax revenues rose by more than five percentage points of GDP between 2003 and 2009</td>
</tr>
<tr>
<td>Increased taxation of income and profits</td>
<td>Earmarking revenues Setting up AIDS Trust Funds</td>
<td>Zimbabwe: 3% tax on formal sector employees and employers allocated to HIV/AIDS Trust Funds are planned (or in process of implementation) in Kenya, Malawi, Tanzania, Uganda</td>
</tr>
</tbody>
</table>
Innovative financing at the global level

The concept of innovative financing does not have a single widely accepted definition as it covers a wide range of mechanisms, but they all have the common goal of raising funds in a manner that is self-replenishing and increases long-term sustainability. This characteristic of innovative financing is particularly attractive as it holds the promise of offsetting the current stagnation of external aid by raising alternative sources of funding.

Innovative funding mechanisms created great expectations at the global level that led, in particular, to the setting up of the Taskforce on Innovative Financing for Health Systems in 2008 [44]. At that time, new taxes such as on financial transactions were discussed and raised expectations that they could raise billions of dollars. But strong opposition to such tax restrained considerably the scope for raising taxes for HIV/AIDS.

<table>
<thead>
<tr>
<th>Innovative financing instrument</th>
<th>Description</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased Value-Added-Tax</td>
<td>Allocate part of VAT to fund national health insurance</td>
<td>Ghana: a 2.5% tax is added to the VAT, Chile: 1% of the VAT is earmarked for financing a set of guaranteed health services</td>
</tr>
<tr>
<td>Increased taxation of harmful habits and products (e.g. tobacco, alcohol, sugary drinks)</td>
<td>Advocacy on the “win-win” nature of these taxes</td>
<td>Djibouti, Egypt, Guatemala, Mexico, Mongolia, Nepal, Philippines, Thailand, Turkey</td>
</tr>
<tr>
<td>Increased taxation on fuel and cars</td>
<td>Funding earmarked for health fund</td>
<td>Malawi</td>
</tr>
<tr>
<td>Financial transactions</td>
<td>Obtaining support of powerful interest groups</td>
<td>Argentina (tax on current accounts and debits); Brazil (2% levy on stocks and bond transactions from outside the country)</td>
</tr>
<tr>
<td>Airline levies</td>
<td>Earmark for National Health Insurance Fund</td>
<td>Cameroon, Congo, Madagascar, Mali, Mauritius, Niger</td>
</tr>
<tr>
<td>Telephone services</td>
<td></td>
<td>Gabon (10% tax on mobile phones companies’ turnover)</td>
</tr>
<tr>
<td>Compulsory contributions for Social Health Insurance</td>
<td>Earmark</td>
<td>Zambia (introduced in April 2018), Ghana (employer tax of 2.5% and 2.5% earmarked VAT), Tanzania (3% tax on employer and 3% tax on employee)</td>
</tr>
<tr>
<td>Voluntary contributions for health insurance:</td>
<td>Mobilizing private actors behind public health goals, Increase dialogue with private sector actors</td>
<td>Tanzania (ICHF), Namibia, Rwanda</td>
</tr>
<tr>
<td>- Community-Based Health Insurance Fund</td>
<td></td>
<td></td>
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<tr>
<td>- Private health insurance</td>
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</tbody>
</table>

Source: The country examples are based on sources in the text

Box 3: Main innovative financing instruments at global level:

- Advanced Market Commitment Pilot for Pneumococcal Disease (AMC)
- Affordable Medicines Facility for Malaria (AMFm)
- Airline Solidarity Levy (Airline Levy)
- Children’s Investment Fund Foundation (CIFF)
- Debt2Health
- GAVI Matching Fund
- International Finance Facility for Immunisation (IFFIm)
- PRODUCT(RED)
- IDA loan conversion

Source: Atun [45]
• In total, the ten financing mechanisms listed in Box 3 generated an estimated US$ 7.5 billion between 2002 and 2015 – about 2-3% of the Development Assistance for Health [45].

• Most of the disbursements came from the International Finance Facility for Immunisation followed by the Airline Solidarity Levy and the Children’s Investment Fund Foundation. Financing has been primarily channelled to global financing mechanism such as GAVI, the Global Fund and UNITAID (which was the main beneficiary of the Airline Solidarity Levy).

So far, debt conversion has not been successful in increasing resources substantially but recent changes may give more impetus to the Debt-2-Health swap.

• The Debt-2-Health initiative was launched by the Global Fund in 2007 with the purpose of channeling resources of developing countries with high debt and disease burdens away from debt repayments towards health expenditures. This was to be achieved by donors granting debt relief in exchange for a commitment by the beneficiary country to invest an agreed counterpart amount in its health programmes through an approved Global Fund grant. Initially, only Australia and Germany participated in the initiative involving Indonesia, Cote D’Ivoire, Pakistan and Egypt.

• In 2017, the programme got a new boost. The Global Fund announced its first debt swap under which Spain will cancel US$43 million in debt and the corresponding funds will be invested in Cameroon (to fight HIV), DRC (to fight malaria) and Ethiopia (to strengthen health systems). This agreement is viewed by the Global Fund as the beginning of a new phase that will involve new partners [46].

Expanding and protecting the funding available for HIV/AIDS

A critical issue faced by African countries is how to expand and protect the space in their budgets created for additional expenditure on HIV/AIDS. This issue was recognized early on and efforts were mounted to find additional sources of funding. Countries agreed to a variety of measures that included widening the tax base, strengthening the tax administration and combatting tax evasion.

Trust Funds. To ensure that additional resources would be used for HIV/AIDS, several countries have created or are in the process of establishing Trust Funds. They are not a new way of mobilizing revenues, but their innovation is mainly in terms of the pooling of funds. Their attraction also stems from the fact that the revenues can be ring-fenced for HIV/AIDS programmes (as with Zimbabwe’s AIDS levy).

• In Kenya, the creation of an AIDS Trust Fund was proposed in the 2014/15-2018/19 National AIDS Strategic Framework. It is the most far-reaching proposal in terms of the scale of financing as it proposes to finance 75% of domestic financing. To achieve that, it would mobilize resources from air levy, debt swaps, AIDS lottery, corporate social investment, and health bonds, and receive 0.5-1% of government ordinary revenues [47].
• **In Malawi**, the establishment of a Health Fund has been reviewed and finalized. This fund could be financed by a dedicated medical levy on fuel through the existing rural electrification and fuel storage levies, and introduction of a tax on motor vehicle insurance. In total, these taxes would amount to 10% of the 2014/15 government health expenditure or US$0.63 per capita per year. This suggests that earmarked taxes would only make a small contribution to expanding health services [48].

• **Zimbabwe was the first country in Africa to set up a Trust Fund.** The AIDS Trust Fund was established by legislation in 1999, funded by an AIDS levy consisting of a 3% income tax for individuals and a 3% tax on profits of employers. Following dollarization in 2009, annual revenues reached US$39 million in 2014 [49]. But this represents only a small proportion of total needs.

• **In Tanzania**, an AIDS Trust Fund was set up in 2015, but it lacks committed funding. The Government allocated SH5.5 billion to the Trust Fund in the 2016/17 financial year, and it was planning for further fund raising [50]. **In Uganda**, a National AIDS Trust Fund was established in 2014. Funding was expected to come from levies (2% of total revenues) on (beers, spirits, soft drinks, bottled water, cigarettes), direct incomes (including profits and bank interest), and services (phones/internet, air tickets). The Fund was projected to mobilize up to US$100-250 million [51].

In **South Africa**, almost 60% of the government funding for the HIV programme is allocated to the National Department of Health through the Conditional Grant – a funding instrument developed by the National Treasury to ring-fence finances allocated to HIV, and to improve monitoring and accountability of the implementation of programmes [52].

**IMPROVING EFFICIENCY**

Improving efficiency (how resources are being used to produce output) has the potential to save resources, which could be used for generating additional output. This topic is not the focus of this note but it is important to keep it in mind. For instance, the 2010 World Health Report estimated that about 20-40% of resources spent on health were wasted. Ten leading sources of inefficiency were identified (Annex 2, Table 3) [32]. Potential areas that have been identified where efficiency could be improved included improving the supply chain (e.g. increased used of generics, monitoring and publicizing prices), reforming incentive and payment structures, developing clinical guidelines, implementing task-shifting, altering incentives to hospital providers, monitoring hospital performance, and regular evaluation of interventions.

A proliferation of economic analyses and efficiency studies have accompanied many of the Investment Cases that have been developed in recent years to support the development of new national level strategic plans for HIV, and in response to the ambitious targets set out in the UNAIDS Fast Track Strategy [2]. Other studies have also examined efficiency using econometric techniques that provided some indication on possible efficiency gains. In the case of Africa, the average efficiency was found to be 67%, suggesting a potential savings of 33% [53]. However, the aggregate nature of these results does not lead to an immediate identification of what actions should be undertaken to improve efficiency. Finding out more about these potential sources of
savings would require detailed country-specific analyses that are outside the scope of this review, which is focused mainly on the mobilization of additional revenues.

ROLE OF POLITICAL LEADERSHIP IN REPRIORITIZING HIV/AIDS

Despite remarkable progress during the last twenty years, an expanded HIV/AIDS response will be required for years to come. With the success of antiretroviral therapy, AIDS is no longer a death sentence, but growing numbers of people on treatment are creating mounting financial obligations to maintain people on life-long treatment. For all countries, the fiscal consequences of the AIDS response are substantial, but the rewards are clear.

Countries that have achieved high levels of coverage of HIV/AIDS services are bringing the AIDS epidemic under control as shown by the examples of countries such as Botswana, eSwatini [54] (announced in July 2018) and Namibia, that have achieved the Fast-Track targets of 90-90-90. In these countries, 73% of the people living with HIV have an undetectable viral load, which prevents both AIDS-related illness and onward transmission of HIV.

However, there remains a prevention crisis. The success in saving lives has not been matched with equal success in reducing new infections. New infections are not falling fast enough and, as a result, the number of people needing access to antiretroviral treatment continues to grow. Breaking this cycle requires renewed determination at country level as demonstrated by the African leadership since 2000, and most recently by the 2016 African Union Framework to End AIDS, TB, and Eliminate Malaria by 2030 [55].

KEY ARGUMENTS

Depending on the country context, arguments for boosting the AIDS response have rested on the following points:

- Access to HIV/AIDS services is a human right;
- Support for key populations is a state obligation due to previous commitments by governments at global level;
- Government budget will benefit if prevention receives additional support. The choice is between paying more now instead of paying much more over the long-term;
- Reaching the Fast-Track targets generates strong benefits as shown by the example of other countries which have reached these targets (e.g. Botswana, eSwatini, Namibia).

---

2 These targets translate into: 90% of people living with HIV know their HIV status, 90% of people who know their HIV-positive status are on treatment and 90% of people on treatment have suppressed viral loads.

3 Results of the PARTNER2 study confirmed that if people living with HIV take antiretroviral treatment as prescribed and maintain an undetectable viral load, there is effectively no risk of transmitting HIV to their HIV-negative partners [59].
Recent changes in priorities and the funding landscape at the global level now have to be considered and suggest a greater emphasis on:

- **Taking advantage of the Sustainable Development Goals and its objective of reaching Universal Health Coverage (UHC).** At the global level, the adoption of the Sustainable Development Goals is leading to a renewed focus on the importance of UHC. This provides an opportunity to bring out the increase in HIV/AIDS services that is part of UHC. HIV/AIDS is specifically identified in SDG 3.3: “by 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases”, but must find its place among a dramatically expanded set of targets that address health holistically, and specifically to address issues of access, inequality and the quality of health services [1].

- **Highlighting the likely results of the Fast-Track Targets in terms of ending the AIDS epidemic sooner rather than later.** The importance of highlighting results comes from case studies on reprioritization of health. These studies suggest that results-focused reforms – in particular efforts to explicitly expand the breadth and depth of health coverage as opposed to efforts focused only on government budgetary targets are more likely to result in sustained prioritization of health [56]. In Thailand, for example, financial commitment to UHC and increased utilization of services led to sustained increases in government spending on health (76% increase in real terms between 2001 and 2008). This was achieved despite considerable political instability during that period (there were eight different health ministers).

- **By adopting Fast-Track Targets instead of continuing business as usual,** more than 15 million new HIV infections can be averted and more than 5 million lives saved (at the world level). Moreover, it will avert US$ 4.7 billion of financial resources needed for treatment in sub-Saharan Africa in 2017–2030, from which Eastern and Southern Africa accounts for US$ 1.7 billion and Western and Central Africa US$ 3 billion [14].

- **A key result is to include key populations that are left behind.** As mentioned by the UNAIDS in its 2018 report, there is a huge injustice being committed: globally, fewer than half of those under 15 years old living with HIV were being treated last year, and adolescent girls and young women continue to be disproportionately affected [4].

To move forward, countries need to **build a shared understanding** of the changes lying ahead. Within the health field, the HIV response has arguably the best developed mechanisms for governance, and these mechanisms could be used for building a consensus on how additional domestic resources could be raised and where these funds might be invested.

Ultimately, the build-up of the HIV response will be the outcome of a country-level social contract.

- **Coalitions and coordination mechanisms** are therefore key to fostering dialogue and political commitments. Development and implementation of an action plan for reaching the Fast-Track targets requires greater engagement between health and finance authorities to ensure the relevance of increased public funding for health. In addition,
there are targets that are essential to the SDG for health across other SDGs and they can’t be achieved without multisectoral action.

• But countries still need political leaders to provide advocacy, long term planning, and campaigning for the buy-in of wider society.
ANNEX 1: RECENT KEY OUTCOMES

In Eastern and Southern Africa, strong shared responsibility between governments, civil society and international donors is delivering steep declines in new infections and AIDS-related deaths:

- AIDS-related deaths declined by 42% and new HIV infections fell by 30% during the period 2000-2017 [4].

Progress towards the 90-90-90 Fast-Track targets has been steady. Among the 19.6 million people living with HIV in 2017:
  - 81% are aware of their HIV status
  - 66% are on antiretroviral therapy (12.9 million people)
  - 52% have reached viral suppression

However, the scale of the epidemic remains massive:
  - 800,000 people acquired HIV in 2017 and 380,000 died of AIDS-related illness.

In Western and Central Africa, the rate of progress lags behind the rest of sub-Saharan Africa:

- AIDS-related declined by 24% since 2010 and annual infections by 8% (UNAIDS 2018).

Among the 6.1 million people living with HIV in 2017:
  - 48% are aware of their HIV status
  - 40% are on antiretroviral therapy (2.4 million people)
  - 29% have reached viral suppression
ANNEX 2: RESOURCE AVAILABILITY AND EXPENDITURES

Figure 1: Resource availability in Eastern and Southern Africa

![Graph showing resource availability in Eastern and Southern Africa]

*Estimates for low- and middle-income countries per 2015 World Bank income level classification. All figures are expressed in constant 2016 US dollars. Source: UNAIDS 2016 resource availability and needs estimates.

Figure 2: Resource availability and needs in Western and Central Africa

![Graph showing resource availability and needs in Western and Central Africa]

*Estimates for low- and middle-income countries per 2015 World Bank income level classification. All figures are expressed in constant 2016 US dollars. Source: UNAIDS 2016 resource availability and needs estimates.
Figure 3: Growth in Africa and its integration into the global Economy

Growth
Since 2000, Africa’s GDP has tripled

Trade
Africa has diversified its trade partnerships
African triple its trade with China, India and other emerging partners
In 2016, Africa’s trade with emerging partners accounted for:

USD 276 billion

51% of its exports
46% of its imports

Employment

66% Vulnerable

Total

Agenda 2063’s target for vulnerable employment of 41% by 2023 is still far away

Inequality

Africa’s Gini coefficient average

41 points

Asia

African inequality

41 points

35 points

Poverty

Extreme poverty levels decreased, but more people are living on USD 1.90 a day or less

Extreme poverty levels

280 million

Extreme poor

2013

Source: Africa’s Development Dynamics 2018 [15]
Table 1: PEPFAR Acceleration and Non-Acceleration Countries

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Haiti</td>
<td>$87,602,940</td>
<td>136.9%</td>
</tr>
<tr>
<td>Uganda</td>
<td>$283,696,043</td>
<td>106.9%</td>
</tr>
<tr>
<td>Zambia</td>
<td>$239,757,769</td>
<td>57.9%</td>
</tr>
<tr>
<td>Rwanda</td>
<td>$76,610,980</td>
<td>55.0%</td>
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<tr>
<td>Malawi</td>
<td>$90,039,566</td>
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<td>Kenya</td>
<td>$418,843,101</td>
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<td>Tanzania</td>
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<td>Zimbabwe</td>
<td>$108,715,016</td>
<td>31.0%</td>
</tr>
<tr>
<td>Lesotho</td>
<td>$35,847,915</td>
<td>30.1%</td>
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<tr>
<td>Côte d’Ivoire</td>
<td>$101,868,625</td>
<td>25.9%</td>
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<td>Swaziland</td>
<td>$45,143,492</td>
<td>24.6%</td>
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<td>Botswana</td>
<td>$47,312,666</td>
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<tr>
<td>Namibia</td>
<td>$39,690,924</td>
<td>6.1%</td>
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<thead>
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<td>Mozambique</td>
<td>$233,351,503</td>
<td>143.4%</td>
</tr>
<tr>
<td>South Sudan</td>
<td>$11,204,535</td>
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<td>Ethiopia</td>
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<td>DRC</td>
<td>$48,079,955</td>
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<td>Cameroon</td>
<td>$29,519,913</td>
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<tr>
<td>Burundi</td>
<td>$9,424,830</td>
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<tr>
<td>Cambodia</td>
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<td>South Africa</td>
<td>$399,755,835</td>
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<tr>
<td>Myanmar</td>
<td>$6,992,990</td>
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<td>Vietnam</td>
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<td>Ghana</td>
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<td>Papua New Guinea</td>
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<td>Ukraine</td>
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<td>Dominican Republic</td>
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<tr>
<td>Indonesia</td>
<td>$8,744,364</td>
<td>0.1%</td>
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<tr>
<td>India</td>
<td>$15,368,218</td>
<td>0.1%</td>
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Note: GGHE-D: Domestic government health expenditure
### Table 2: Government health expenditures as % of government expenditures

#### Higher percentage 2015 vs 2005: 20 countries

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<tr>
<th>Country</th>
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<th>2010</th>
<th>2015</th>
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<td>4.9</td>
<td>11.8</td>
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<td>5.8</td>
<td>7.2</td>
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<td>Cote d’Ivoire</td>
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<tr>
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<td>1.9</td>
<td>1.8</td>
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<tr>
<td>Gabon</td>
<td>5.1</td>
<td>6.8</td>
<td>7.0</td>
</tr>
<tr>
<td>Gambia, The</td>
<td>10.0</td>
<td>7.8</td>
<td>10.6</td>
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<td>Lesotho</td>
<td>5.9</td>
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<td>Madagascar</td>
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<td>15.6</td>
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<td>Mauritania</td>
<td>3.9</td>
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<td>Mauritius</td>
<td>7.4</td>
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<td>Zimbabwe</td>
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<td>8.1</td>
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#### Lower percentages 2015 vs 2005: 21 countries

<table>
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<td>10.1</td>
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<td>Guinea</td>
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<td>1.9</td>
<td>2.7</td>
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<td>9.5</td>
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<td>1.0</td>
<td>1.3</td>
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<td>7.3</td>
<td>6.3</td>
</tr>
<tr>
<td>Liberia</td>
<td>7.1</td>
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<td>2.7</td>
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<tr>
<td>Mali</td>
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<td>3.2</td>
<td>4.5</td>
</tr>
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<td>Mozambique</td>
<td>15.4</td>
<td>1.4</td>
<td>1.2</td>
</tr>
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<td>Namibia</td>
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<td>Niger</td>
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<td>4.2</td>
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<td>Sierra Leone</td>
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<td>6.3</td>
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<tr>
<td>Tanzania</td>
<td>12.6</td>
<td>7.3</td>
<td>7.4</td>
</tr>
<tr>
<td>Uganda</td>
<td>10.7</td>
<td>7.5</td>
<td>5.6</td>
</tr>
</tbody>
</table>

Table 3: Ten leading causes of inefficiency in health

<table>
<thead>
<tr>
<th>Source of inefficiency</th>
<th>Common reasons for inefficiency</th>
<th>Ways to address inefficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medicines: underuse of generics and higher than necessary prices for medicines</td>
<td>Inadequate controls on supply-chain agents, prescribers and dispensers; lower perceived efficacy/safety of generic medicines; historical prescribing patterns and inefficient procurement/distribution systems; taxes and duties on medicines; excessive mark-ups.</td>
<td>Improve prescribing guidance, information, training and practice. Require, permit or offer Incentives for generic substitution. Develop active purchasing based on assessment of costs and benefits of alternatives. Ensure transparency in purchasing and tenders. Remove taxes and duties. Control excessive mark-ups. Monitor and publicize medicine prices.</td>
</tr>
<tr>
<td>2. Medicines: use of substandard and counterfeit medicines</td>
<td>Inadequate pharmaceutical regulatory structures/mechanisms; weak procurement systems.</td>
<td>Strengthen enforcement of quality standards in the manufacture of medicines; carry out product testing; enhance procurement systems with pre-qualification of suppliers.</td>
</tr>
<tr>
<td>3. Medicines: inappropriate and ineffective use</td>
<td>Inappropriate prescriber incentives and unethical promotion practices; consumer demand/expectations; limited knowledge about therapeutic effects; inadequate regulatory frameworks.</td>
<td>Separate prescribing and dispensing functions; regulate promotional activities; improve prescribing guidance, information, training and practice; disseminate public information.</td>
</tr>
<tr>
<td>4. Health-care products and services: overuse or supply of equipment, investigations and procedures</td>
<td>Supplier-induced demand; fee-for-service payment mechanisms; fear of litigation (defensive medicine).</td>
<td>Reform incentive and payment structures (e.g. capitation or diagnosis-related group); develop and implement clinical guidelines.</td>
</tr>
<tr>
<td>5. Health workers: inappropriate or costly staff mix, unmotivated workers</td>
<td>Conformity with pre-determined human resource policies and procedures; resistance by medical profession; fixed/inflexible contracts; inadequate salaries; recruitment based on favouritism.</td>
<td>Undertake needs-based assessment and training; revise remuneration policies; introduce flexible contracts and/or performance-related pay; implement task-shifting and other ways of matching skills to needs.</td>
</tr>
<tr>
<td>6. Health-care services: inappropriate hospital admissions and length of stay</td>
<td>Lack of alternative care arrangements; insufficient incentives to discharge; limited knowledge of best practice.</td>
<td>Provide alternative care (e.g. day care); alter incentives to hospital providers; raise knowledge about efficient admission practice.</td>
</tr>
<tr>
<td>7. Health-care services: inappropriate hospital size (low use of infrastructure)</td>
<td>Inappropriate level of managerial resources for coordination and control; too many hospitals and inpatient beds in some areas, not enough in others. Often this reflects a lack of planning for health service infrastructure development.</td>
<td>Incorporate inputs and output estimation into hospital planning; match managerial capacity to size; reduce excess capacity to raise occupancy rate to 80–90% (while controlling length of stay).</td>
</tr>
<tr>
<td>8. Health-care services: medical errors and suboptimal quality of care</td>
<td>Insufficient knowledge or application of clinical-care standards and protocols; lack of guidelines; inadequate supervision.</td>
<td>Improve hygiene standards in hospitals; provide more continuity of care; undertake more clinical audits; monitor hospital performance.</td>
</tr>
<tr>
<td>9. Health system leakages: waste, corruption and fraud</td>
<td>Unclear resource allocation guidance; lack of transparency; poor accountability and governance mechanisms; low salaries.</td>
<td>Improve regulation/governance, including strong sanction mechanisms; assess transparency/vulnerability to corruption; undertake public spending tracking surveys; promote codes of conduct.</td>
</tr>
<tr>
<td>10. Health interventions: inefficient mix/inappropriate level of strategies</td>
<td>Funding high-cost, low-effect interventions when low-cost, high-impact options are unfunded. Inappropriate balance between levels of care, and/or between prevention, promotion and treatment.</td>
<td>Regular evaluation and incorporation into policy of evidence on the costs and impact of interventions, technologies, medicines, and policy options.</td>
</tr>
</tbody>
</table>

BIBLIOGRAPHY


