

WITHIN OUR MEANS

Why countries can afford universal health coverage

There is growing agreement that essential health services should be made available to the whole of society, especially its poorest members, through systems of universal health coverage (UHC). One key aspect of UHC is that the funding for health must be sufficient to provide essential health services for everyone. However, many Countdown to 2015 countries do not have enough resources to do this.

Funding for health needs to be raised in ways that are fair, and spent equitably and efficiently. This includes moving away from private and out-of-pocket spending – where the burden falls on the individual to pay for healthcare when they need it – to mandatory, prepaid and pooled funding where the financial risks of ill-health are spread across the population.

This paper makes the case that all developing countries can afford to increase their spending on health by making different policy decisions about how they raise and spend public money. Decisions about tax and spending are vital and within the control of governments, even of the poorest countries. Some countries will continue to need overseas aid, but this needs to complement domestic decisions, and strengthen the capacity of each country to generate additional revenue. In this paper, we calculate how some of the poorest countries with the highest burden of maternal, newborn and child mortality might meet the level of spending needed to end preventable deaths.



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EXECUTIVE SUMMARY

As we discuss the **sustainable development goals** – the targets that will replace the Millennium Development Goals – there is strong support for the ambition to end all preventable maternal, newborn and child deaths. There is also growing agreement that national systems of **universal health coverage** (UHC) are the best way of accomplishing this ambition.

Financing for health – the amount of money raised, and the way it is raised and spent – is critical to the attainment of UHC. It has been estimated recently that countries should spend a minimum of **\$86 per person** in 2015 to provide an essential package of health services. To ensure this healthcare is truly universal, providing access to health services without financial impoverishment, we argue that this **\$86 should be public spending**.

This paper focuses on the world's 75 'Countdown to 2015' countries – those identified as having the highest burden of maternal, newborn and child mortality. We have estimated that, for the Countdown countries to achieve this minimum spending target, they would need to find an extra **\$172 billion** a year.

Much of this funding gap is based on current levels of economic development, and the gap could fall to **\$101bn by 2030** if estimates of growth prove accurate. But we cannot wait for countries to grow: there is a need to act now.

To close the gap, countries need to raise more revenue and place greater priority on health. We estimate that if all Countdown countries that currently do not spend **\$86 per person** raised tax revenue to 20% of gross domestic product (GDP) and spent at least 15% of their budgets on health, the financing gap could fall by almost three-quarters, from \$101bn to just \$28bn.

This paper argues that Countdown countries can and must invest in health and end preventable maternal, newborn and child deaths. Doing so will require them to **expand public revenues, move away from private financing, including out-of-pocket spending**, and make healthcare more of a political priority. Additional revenue should be raised through fairer taxation, so that the financial burden does not fall on the poorest people in society, curbing illicit financial flows and ending tax evasion.

The remaining funding gap can partly be filled through greater efficiencies in health spending – countries could do more with existing resources if they spend them well. But it also indicates that there is a continued need for **donors** to provide increasingly effective development assistance. The post-2015 framework must be seized as an opportunity to make progressive taxation, public investment in health and aligned development assistance global priorities.

THE STORY IN NUMBERS

THE GAP IN PUBLIC FUNDING FOR HEALTH*

\$86 Minimum spending per person, per year required to deliver a basic package of health services

\$172bn Funding gap in public spending in 2012 across all 75 Countdown countries

\$101bn Funding gap in public spending in 2030, if future estimates of economic growth prove correct

CLOSING THE GAP IN COUNTDOWN COUNTRIES

\$71bn Raised through growth

\$84bn Raised through increasing tax revenue, and spending 15% of national budgets on health

\$28bn Gap remaining in 2030, in 26 countries, which can partly be filled through greater efficiencies, but will require a continued role for aid

THE TARGETS FOR INCREASING REVENUE

20% Tax revenue as a share of GDP, the global target for increasing funds for development, and as achieved in middle- and high-income countries

15% Minimum share of the budget to be spent on health – the ‘Abuja target’ signed up to by African governments and used in this report as a benchmark for all Countdown countries

FUNDING FLOWS IN COMPARISON**

\$160bn Cost of tax exemptions to developing country governments

\$268bn Could be raised by improved tax collection in developing countries

* All cost estimates are in \$2012 dollars

** Used here to illustrate the scale of tax funding flows in comparison to health needs. However, these cover different time periods and a different sub-set of countries from the gap we estimate.

I INTRODUCTION

As the world formulates the sustainable development goals that will replace the Millennium Development Goals (MDGs), there is strong support for the ambition to end all preventable maternal, newborn and child deaths. There is also growing agreement that essential health services should be made available to the whole of society, especially its poorest members, through systems of universal health coverage (UHC). Such systems would mean that everyone in a country receives the health services they need, of sufficient quality to be effective, without facing financial hardship.¹

UHC is currently the top priority of both the World Health Organization (WHO) and the World Bank. There are many ways in which governments need to regulate, steward and provide services to make UHC possible. One key aspect is that the funding for health must be sufficient to provide an essential package of services for everyone. Many Countdown to 2015 countries do not have enough resources to do this. Funding for health also needs to be raised in ways that are fair, and spent effectively and efficiently. As we will discuss, this includes moving away from private and out-of-pocket spending – where the burden falls on the individual to pay for healthcare when they need it – to mandatory, prepaid and pooled funding where the financial risks of ill-health are spread across the population.

This briefing makes the case that all developing countries can afford to increase their spending on health by making different policy decisions about how they raise and spend public money. Decisions about tax and spending are vital and within the control of governments, even in the poorest countries. Some countries will continue to need overseas aid, but this needs to complement domestic priorities, and strengthen each country's capacity to generate additional revenue. Ironically, tax has largely been ignored in debates² about how to increase resources

for healthcare and how to improve equity in health financing. Tax can also play a role in changing unhealthy behaviours and making the state more accountable to its people.³

This briefing calculates how some of the poorest countries with the highest burden of maternal, newborn and child mortality might meet the level of spending needed to end preventable deaths. As well as looking at how money can be raised, it is equally important to examine how resources for health should be used to deliver the greatest impact and to benefit the most vulnerable first.

MAKING THE CASE FOR HEALTH – WHY GREATER INVESTMENT IS NEEDED

As Save the Children, our starting point is that health is a human right and governments have an obligation to make sure their people can realise this right to the “maximum extent of their available resources and, where needed, within the framework of international cooperation”.⁴ The reality is that, in far too many countries, quality, effective health services are only available to those who can afford them. Poor people rely on under-resourced public health services or buy care from poor-quality and often unqualified providers.

This paper focuses on how to increase government revenues equitably to meet the minimum amounts needed for health.

Ministries of health and civil society face the challenge of persuading ministries of finance to allocate a greater share of resources to healthcare, even though the Abuja declaration has already committed all governments to spending a minimum of 15% of their budgets on health. During the World Bank/IMF annual meetings in 2014, Ngozi Okonjo-Iweala, Nigeria's Finance Minister, challenged advocates for UHC about why health should be

prioritised over other competing priorities that also affect health outcomes, such as agriculture, infrastructure and education?

When arguing for a greater share of the government budget, the health sector needs to clearly demonstrate how much is needed to deliver health services to the population and improve health outcomes,⁵ and put forward the strong evidence of the high return on investment in health. The Lancet Commission on Investing in Health argues that health spending brings greater value for money than

previously thought. It estimates that between 2015 and 2035 the economic benefits of improvements in health would exceed costs by a factor of approximately nine in low-income countries rising to 20 in lower-middle-income countries.⁶

Now is the opportunity to influence the next set of sustainable development goals and how they will be implemented. Ministries of health and finance must work hand-in-hand to increase and improve health financing. Failing to do so is failing to honour their human rights obligations.

BOX 1: UNIVERSAL HEALTH COVERAGE AND EQUITY⁷

WHO defines UHC as ensuring that “all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.” UHC embodies health and social goals, promoting the realisation of the human right to health, while making sure services aren’t only accessible to those who can pay.

There is growing consensus among many global organisations involved in healthcare, including the World Bank, about the importance of UHC and the elimination of user fees. UHC is likely to feature as a set of targets in the post-2015 agreement on the sustainable development goals for 2016–2030.⁸

UHC has been framed as a direction for countries, rather than a destination.⁹ All countries across the world can continue to make improvements to UHC, for instance, through expanding the benefits package, introducing new technologies, improving the quality of services, or increasing the level of financial risk protection.

Concerns have been raised that some reforms to expand coverage may come at the expense of equity. In this paper, we support the concept of ‘progressive universalism’, which we interpret to mean that reforms should be designed to increase coverage among people with the greatest need. This aims to “ensure that people who are poor or otherwise disadvantaged gain at least as much as those who are better off, every step of the way towards universal coverage.”¹⁰

2 HOW MUCH IS NEEDED FOR HEALTH?

There are various ways to determine the right minimum level of health spending for a country. One is a bottom-up calculation that estimates the cost per person for a package of services. Another establishes a benchmark based on the relationship between spending as a percentage of GDP and progress in the population's health outcomes.

Across the world, the total amount spent on health varies considerably – from \$9,055 per capita in Norway to just \$14 in Eritrea. Government or public spending on health ranges from \$7,704 (again in Norway) to \$4.7 per person in Myanmar.¹¹ Various estimates have been made for the cost of a package of basic services needed to achieve UHC (see Box 2). In this paper we have used the most recent estimate

of \$86 per person per year for 2015, produced by a Chatham House Working Group and based on costings developed by the High Level Task Force on Innovative Financing (HLTF) in 2009.¹²

HOW MUCH DO COUNTRIES SPEND ON HEALTH?

There are 72 'Countdown to 2015' countries for which health expenditure data is available.* The majority of these countries – 42 of them – spend less than the \$86 per capita needed on health. Thirty countries do spend \$86 per capita or more, but this is total spending, and much is out-of-pocket spending (OOPS), the most regressive form of financing health (see Figure 1 overleaf).

BOX 2: ESTIMATING THE COST OF BASIC HEALTH SERVICES

In 2001, the WHO¹³ estimated that total health spending of \$38 per person would be needed by 2015 to achieve coverage rates of 70–80% in basic services, such as the prevention and treatment of HIV/AIDS, TB and malaria, and for maternal and child healthcare. This estimate excludes many of the health system costs needed to expand service coverage.¹⁴

In 2009, the HLTF estimated the cost of a slightly more comprehensive range of services across 49 low-income countries. These included key interventions for HIV, TB, malaria, and maternal and child health; a wide range of health promotion activities; and treatment for some non-communicable diseases, for example, essential drugs for chronic illnesses, some cancers and neglected tropical diseases. For some interventions, near-universal coverage rates of 95–100% were specified.¹⁵ Importantly, these estimates included costs related to strengthening

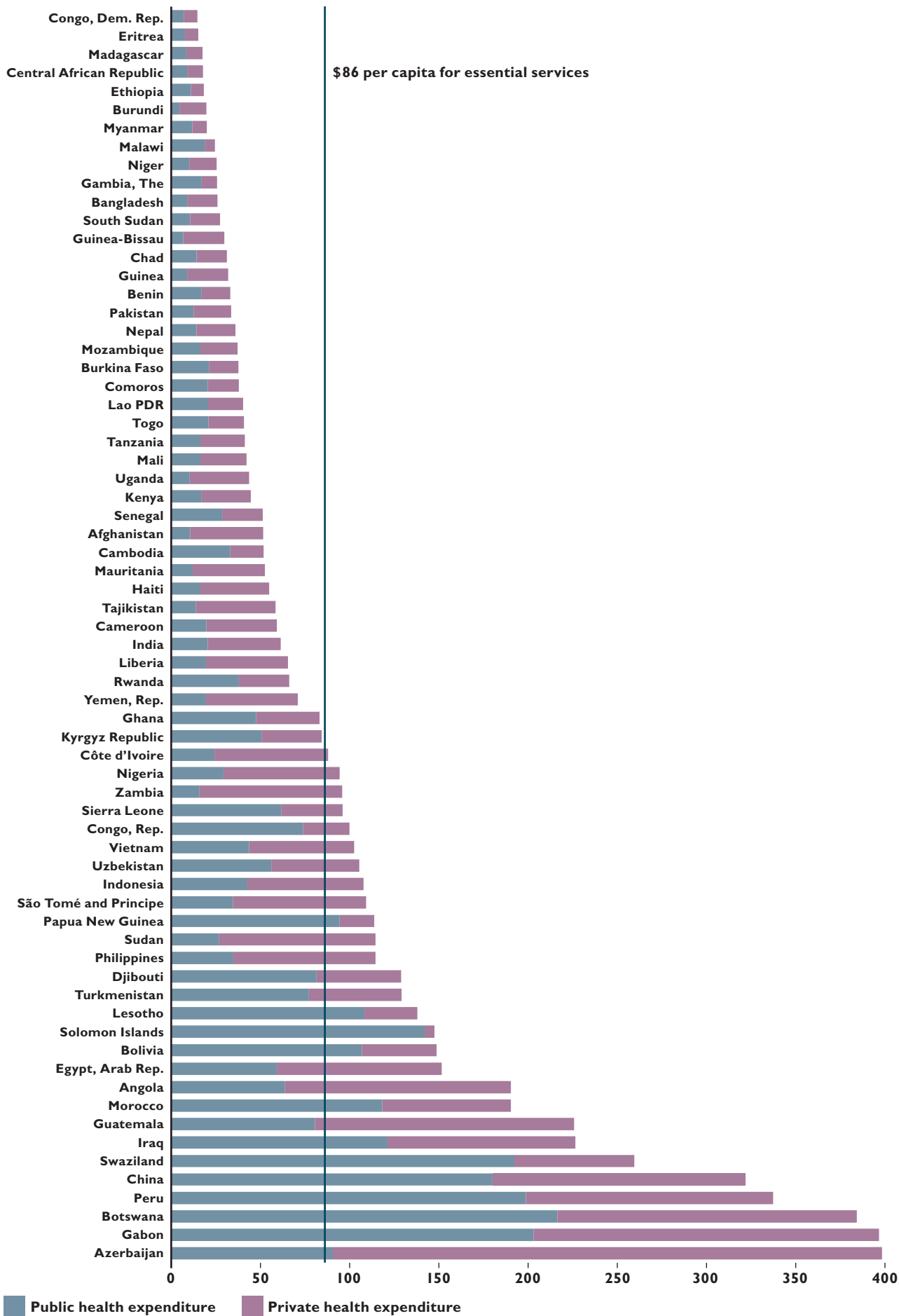
health systems, such as expanding facilities, equipment and staffing.

This minimum package was estimated to cost \$54 per person per year in total health spending (then recalculated in 2010 prices as \$60 per capita). This estimate has recently been updated (by McIntyre and Meheus in 2013) to \$86 per capita of public spending at 2012 prices, taking into account exchange rate fluctuations and the impact of inflation. This is the figure we use as our target in this report.¹⁶

While the HLTF estimate is arguably more comprehensive than other estimates, the rapid rise of non-communicable diseases in low-income countries, as well as the introduction of new technologies and changes to treatment guidelines, may mean the cost of the package requires further calculation. At the same time, there may be a reduction in the costs of some services, such as immunisation, as vaccine prices fall.

* Data not available for three Countdown countries: North Korea, Somalia, Zimbabwe.

FIGURE I: TOTAL SPENDING ON HEALTH PER PERSON, COUNTDOWN COUNTRIES, 2012¹⁷



WHY PUBLIC FINANCING?

There are various ways in which health systems are financed. Most countries rely on a mix of public funding (social insurance, tax) and private funding sources (voluntary insurance, user fees). As has been discussed elsewhere,¹⁸ the way a country finances a health system affects that system's fairness, efficiency and accountability to the people who use it. This, in turn, affects whether UHC can be achieved.

Figure 2 shows four main sources of finance, with the most equitable and efficient sources on the right. To explain why this paper calculates the health financing gap based on public financing, we briefly discuss two of the more regressive methods of funding healthcare. The later section discusses more progressive methods.

USER FEES/OUT-OF-POCKET SPENDING

There is now widespread consensus that countries must move away from relying on out-of-pocket spending (OOPS), as it is the most regressive way to finance healthcare. World Bank President, Jim Kim, stated: "Even tiny out-of-pocket charges can drastically reduce the use of needed services. This is both unjust and unnecessary."²⁰ Evidence gathered over many years shows that user fees charged at facilities, as well as indirect costs of seeking care such as transport or informal payments deter people from

getting the necessary care, disproportionately affect the poor and sick, and cause catastrophic household expenditure.^{21, 22, 23} User fees are not an effective way to contain costs and have limited potential to raise revenues.²⁴ Evidence shows that when user fees are removed, alongside efforts to improve the supply of services, the demand for services increases.²⁵ For instance, the use of emergency maternal care services doubled in Mali after fees were removed.²⁶ One year after free healthcare was introduced in Sierra Leone in 2010, the number of children treated for malaria had tripled.^{27, 28} The introduction of a free basic package of health services in Afghanistan prompted a 400% rise in the use of those services in the first year.²⁹

Nevertheless, OOPS remains a significant way of financing healthcare in most low- and middle-income countries, pushing an estimated 100 million individuals worldwide into poverty each year.³⁰ WHO has recommended that OOPS accounts for no more than 15–20% of total health spending.³¹ But OOPS exceeds this level in the vast majority of Countdown countries – 62. Overreliance on OOPS is related to the level of public investment in health. Where government spending is low, people have little choice but to pay out of their own pockets if they want access to essential health services. Conversely, as public expenditure increases, OOPS tends to decline, and financial risk protection increases.

FIGURE 2: MOVING FROM LEAST TO MOST EQUITABLE SOURCES OF HEALTH FINANCING¹⁹



VOLUNTARY PRIVATE AND COMMUNITY INSURANCE

Voluntary health insurance exists in some form in most health systems across the world, either as private health insurance (PHI), commercial schemes targeting the wealthy and middle classes, or, in low- and middle-income countries, as not-for-profit, community-based health insurance (CBHI) schemes.

While private insurance may increase access to healthcare for people who can purchase an adequate level of cover, its characteristics (voluntary membership, with premiums based on risk and high co-payments) present barriers to access, particularly for elderly, ill and poor people.³² PHI is regressive, particularly where it is a major component of overall healthcare financing. As risk pools tend to be small and made up of the richer/healthy, and in many cases are small, PHI offers limited potential for cross-subsidisation. No country has achieved UHC by relying on private insurance.

There is some, albeit limited, evidence that voluntary insurance in developing countries can provide greater financial protection from OOPS.³³ Some propose CBHI as a policy response for countries faced with low public expenditure on health, limited ability to generate tax revenues and a large informal sector.³⁴ CBHI may be preferable to OOPS, because it is an attempt to introduce the concepts of prepayment and risk pooling. However, as membership is voluntary, it suffers many of the same problems as for-profit PHI. Evidence from existing schemes demonstrates that CBHI is limited in its capacity to provide financial risk protection, with substantial co-payments and small risk pools, and high administration costs.³⁵ CBHI has failed to achieve substantial population coverage: enrolment levels have typically reached less than 10% of the target population.³⁶ Examples of CBHI in West Africa (Benin, Burkina Faso, Mali and Togo) have shown low enrolment (1.5% of the population or less), small pools, and insignificant funding impact on overall health expenditure.³⁷

PUBLIC FINANCING IS KEY TO ACHIEVING UHC

No country has a single source of financing – most rely on a blended system (see Figure 4 on page 8). Even in high-income countries with substantial payroll taxes, there is increased reliance on general revenues. UHC goals of equitable access with financial protection require pooling arrangements that redistribute prepaid resources to individuals with the greatest need for healthcare.³⁸ Two conditions emerge from this:

- compulsion – where contributions are mandatory, ideally based on ability to pay
- subsidisation – where resources and risks are pooled across the population.³⁹

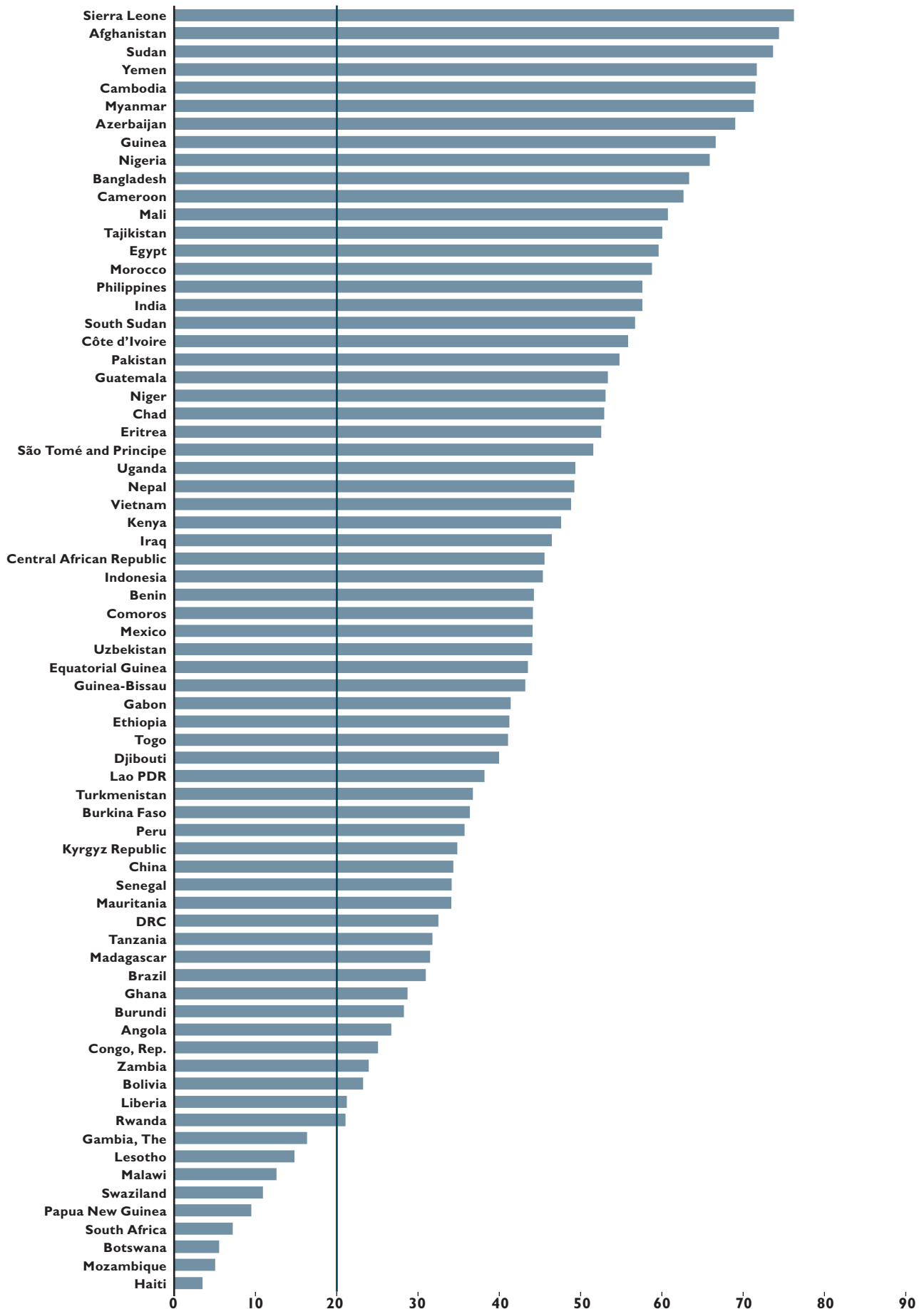
Both theory and evidence demonstrate that private financing – including OOPS and voluntary insurance schemes – fails on both fronts.⁴⁰ This implies either a single pool, or a set of non-competing pools that are linked to enable cross-subsidisation from the rich to the poor and from the healthy to the sick.

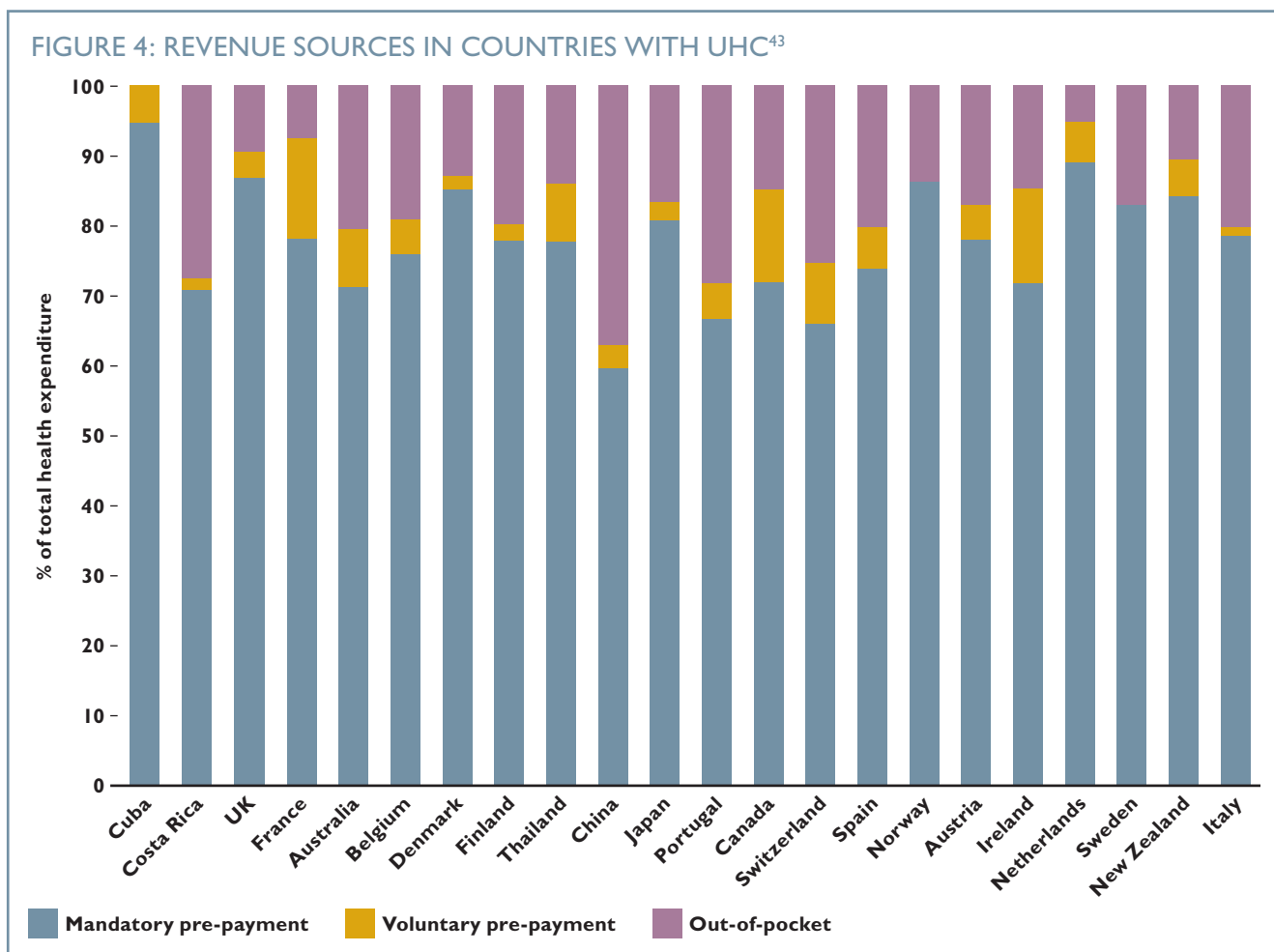
PUBLIC SPENDING ON HEALTH

Looking back at Figure 1, only 16 Countdown countries reach the target of \$86 per capita of **public** spending on healthcare. As the figure shows, most countries remain a long way from this target, with nearly half allocating less than \$20 of public funds per person.

Sierra Leone, a country with some of the worst health indicators in the world even before the current Ebola crisis, has total health spending at \$96 per capita, whereas Rwanda, a country with better health outcomes, has a total health expenditure of \$66 per capita. Crucially, it is the structuring of this funding – where it sits, who controls it and how it is spent – that makes the difference. Rwanda's public, or government spending is \$38 per capita, whereas Sierra Leone's is only \$16 per capita.⁴¹

FIGURE 3: OUT OF POCKET EXPENDITURE AS SHARE OF TOTAL HEALTH SPENDING (%),
COUNTDOWN COUNTRIES, 2012⁴²





HEALTH SPENDING AS PROPORTION OF GDP

The proportion of a country’s GDP spent on health is also an important comparison. There is wide variation in total health spending – with Myanmar spending 1.8% of its GDP on health compared with 17% of GDP in the USA, for example. The USA is way ahead of other high-income countries, which spent on average 9–10% of GDP in 2012. These figures include PHI and OOPS. When considering only public spending on health, South Sudan spends the least (less than 1% of GDP), while the Netherlands and Denmark spent around 10% of GDP.

Various efforts have been made to establish norms for low-income countries’ public spending on health as a share of GDP. These range from 3% to attain a ‘grand convergence’ in health outcomes, as

the Lancet Commission on Investing in Health calculated,⁴⁴ to the 5% of GDP the Chatham House Working Group used.⁴⁵

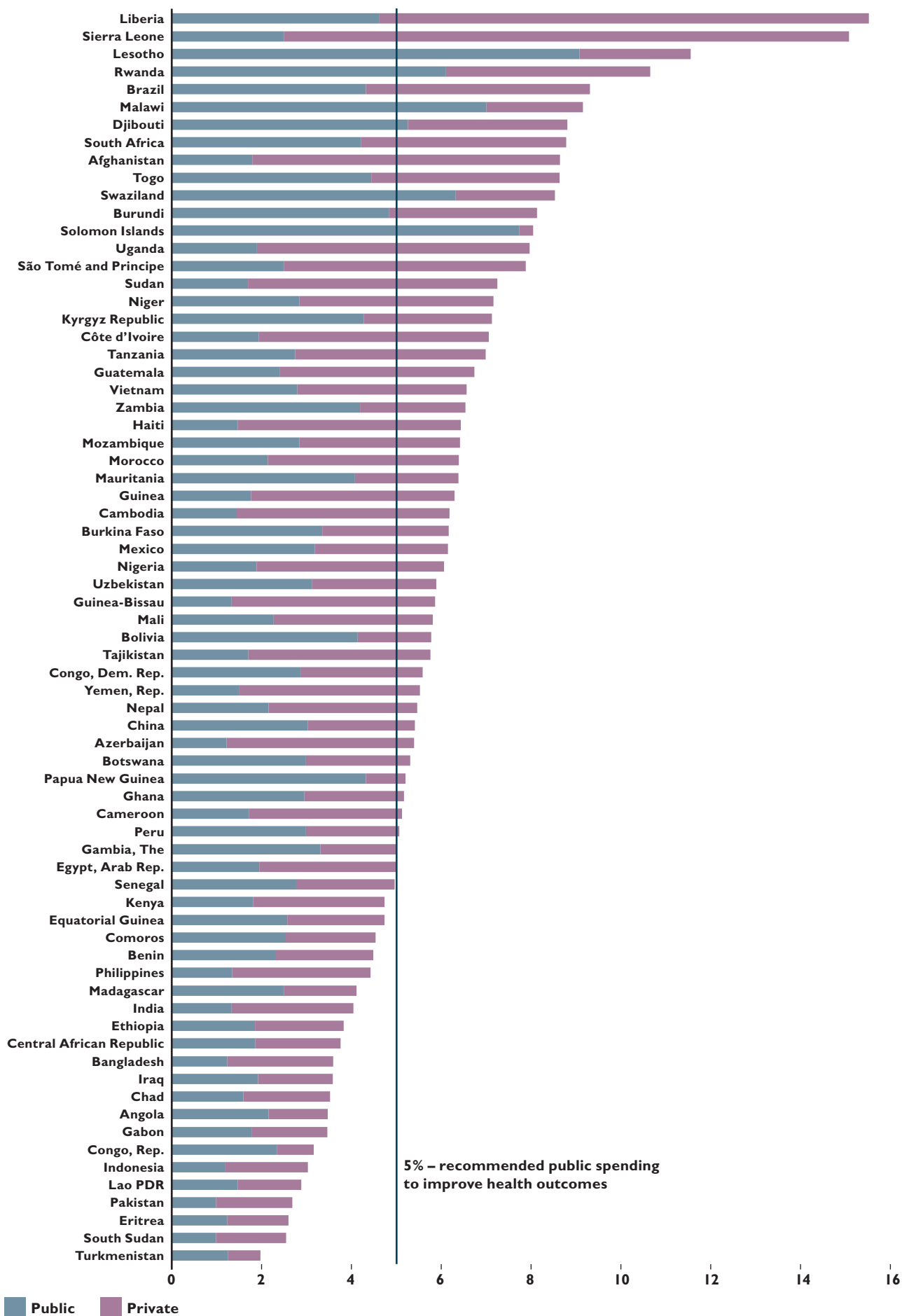
Figure 5 shows health spending as a proportion of GDP in Countdown countries. While many countries spend 5% or more of GDP on health when both public and private spending is considered, only six spend 5% or more of GDP in public funds.* Public spending is highest in Rwanda, which spends 6% of GDP, and lowest in Bangladesh and Afghanistan, which spend 1%. The majority of Countdown countries – 39 – spend 2% or less.

Per capita health spending and health spending as a share of GDP are clearly linked – as each country’s economic development and population size determines the share of GDP that will allow it to meet the per capita target.**

* Solomon Islands, Swaziland, Djibouti, Malawi, Rwanda, Lesotho

** Government health expenditure as a share of GDP * GDP per capita = levels of funding per capita.

FIGURE 5: HEALTH SPENDING AS A SHARE OF GDP (%), COUNTDOWN COUNTRIES, 2012⁴⁶



ESTIMATING THE HEALTH FUNDING GAP

Based on current levels of public spending on health against a minimum target of \$86 per person, we estimate that the annual funding gap across the Countdown countries is \$172bn.*

Many of these countries' economies are growing rapidly and, while populations are also growing, we should see the gap reduce over time. If government revenues as a share of GDP and health spending as a share of total government spending remain constant, projected growth rates will reduce the gap from \$172bn in 2012 to **\$101bn in 2030**. But we cannot simply wait for countries to grow: there is a need to act now.

If a gap is calculated for total health spending (including private as well as public spending) this total gap would be much smaller, and would be \$85bn. However, as shown already, much of this spending is

made out of pocket. Consistent with the Chatham House paper and with an increasing number of international actors,⁴⁷ we call for the \$86 per capita needed for UHC to be met from public sources. We demonstrate how public financing for health can be increased to meet this target.

This hundred billion dollar gap is similar to other global estimates, most recently that of the Lancet's Commission on Investing in Health (which covered more countries with a slightly lower cost for the package of services). Its report noted that the expected economic growth of low- and middle-income countries means that most of the incremental costs of achieving convergence could be covered from domestic sources, although some countries will continue to need external assistance even beyond 2030.⁴⁸ In 2014, UNCTAD noted, "Investment in health is currently about \$70 billion in developing countries. The SDGs would require investment of \$210 billion per year, implying an investment gap of some \$140 billion per year over and above the current level."⁴⁹

* All cost estimates are in 2012 dollars. This gap is based on funding levels in 2012 (calculated from WHO's National Health Accounts data), and is projected forwards to 2030 based on population growth and estimates of government revenue, while maintaining the current share of government expenditure on health constant. Further details of calculations and sources of data are listed in Annex 1: Methodology.

3 EXPANDING PUBLIC FINANCING FOR HEALTH

While there is increasing agreement that countries should spend more on health, and that spending should primarily be publicly funded, there is less of a consensus about how to find the revenues to reduce the gap.

Fiscal space is the ability of a country's government to make budgetary resources available for specific use without undermining the sustainability of that country's financial position.⁵⁰ In the context of health, this means being able to increase spending in the sector without affecting expenditure in different sectors needed to achieve other development objectives, such as the MDGs.⁵¹ While raising revenues is no easy feat, there is wide variation in the levels of revenue and public expenditure across countries, which suggests some countries are not fully using their capacity to increase public investment in health.

As mentioned before, public revenues are the most progressive form of financing for health. That's because, in effect, they pool resources across the population and enable redistribution from the wealthy and healthy to the poor and sick.⁵² They are the dominant form of financing in countries that have made progress on expanding coverage,⁵³ and constitute more than 60% of revenue in countries with universal systems (Figure 3). Public revenues are the most sustainable and predictable. They tend to be more efficient, with lower administrative costs than other approaches.⁵⁴

Beyond generating revenues, public finances have other important functions too. They mean the public has a greater say in how those resources are spent and they make the state more accountable to its people for spending them well. Public finances allow regulation with public oversight and policy levers to adjust the cost of goods, services and various behaviours.⁵⁵

The responsibility for raising revenues generally sits outside ministries of health and with ministries of

finance. Revenues are influenced by factors such as employment levels, natural resource reserves and their use, tax policy choices, the effectiveness of tax systems and the extent of compliance. In turn, expenditure is determined by policy and sectoral spending choices, as well as by macroeconomic conditions such as levels of debt.^{56, 57} Famously, the International Monetary Fund (IMF) has exerted its influence on poor countries to suppress public sector spending and reduce fiscal space. There is compelling evidence that this advice has damaged both the economies and public services of countries that have received IMF loans.⁵⁸

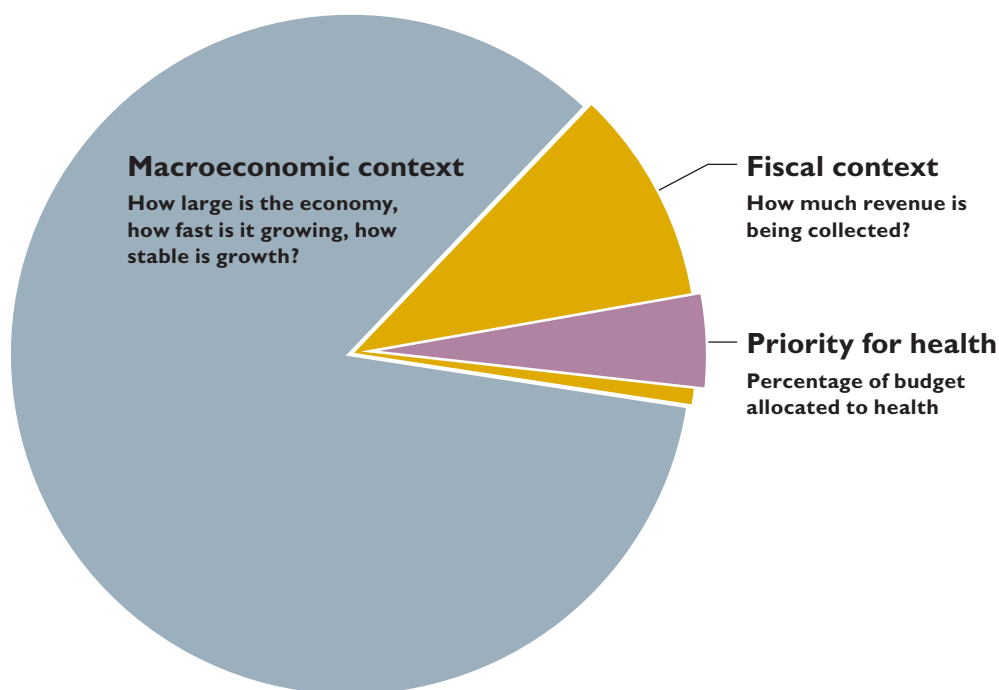
Economic growth in many low- and middle-income countries should allow governments to broaden their tax base and tax revenues.⁵⁹ But many countries have weak and inequitable tax systems and don't prioritise social investment – including health spending. According to IMF estimates, low- and lower-middle-income countries are only reaching 78% and 63% respectively of their fiscal potential.⁶⁰ In Kenya, untapped fiscal capacity is estimated at \$2.86bn, double the country's expenditure on health. Reforms to improve tax collection in Kenya are now under way (see p17).⁶¹ Tax systems are often regressive in low-income countries, as recent reforms have focused on increasing revenues from VAT and other indirect taxes, rather than concentrating on raising more progressive income and enforcing corporate tax collection.⁶²

Expanding fiscal space must be a priority if we are to accelerate progress towards development goals. To this end, governments should pursue two key policy levers:

- Increase government spending as a share of GDP – raising more funds allowing them to spend more, on health, and other sectors.
- Give greater priority to the health sector – thus increasing health spending as a share of total government expenditure (Figure 6).*

* This will involve difficult decisions to shift resources away from other sectors into health, and further work is needed to explore what might be an appropriate share of spending across sectors.

FIGURE 6: FISCAL SPACE FOR HEALTH



Adapted from Cashin, C presentation, Tunis, June 2014

Below, we project what might happen to health spending if countries were to gradually raise revenues and allocate more to health, showing how and when the spending gap could be closed. We draw on two international targets; we suggest these are minimum figures and that countries should spend more than this over time.⁶³

- **20% of GDP to be raised in taxation.** The United Nations Development Programme has recommended that the least developed countries should raise a minimum of 20% of GDP in revenue in order to meet the MDGs.⁶⁴ This target has been interpreted by many to apply to tax revenue specifically.⁶⁵ Many Countdown countries are rich in natural resources and raise considerably more than 20% of GDP in revenue, but much less than that in taxation. We take the 20% target to apply to taxation.
- **15% of government expenditure to be on health.** In the absence of a recommended target across Countdown countries, the African Union’s ‘Abuja’ target provides a useful benchmark for a prioritisation of health spending.

INCREASING GOVERNMENT REVENUES AS A SHARE OF GDP

Governments raise revenues from a range of sources, including taxation, incomes from public corporations, central bank revenues, loans and debts. In 2010, public revenues as a share of GDP averaged 24% in low-income countries, compared to 35% in advanced economies.⁶⁶ Tax revenue ranges from an average in low-income countries of around 13% of GDP, to 35% in rich countries.⁶⁷ Countdown countries should be raising a minimum of 20% of GDP through taxation in order to meet the MDGs. Data on tax is poor, but the latest available information from the OECD shows only 16 Countdown countries meet this target.⁶⁸

If all Countdown countries achieved this 20% target by 2030, and the allocation of revenues to health remained at its current levels, the funding gap would fall from \$101bn to \$76bn.

The following section looks at how this can be achieved in an equitable manner.

DIRECT TAXATION

From an equity perspective, countries should prioritise raising direct taxation over indirect taxation.⁶⁹ By definition, only direct taxes can be designed so that people and businesses contribute according to their ability to pay, whereas indirect taxes are set at flat rates, causing a greater burden on poor households. This involves strengthening tax on income, wealth and property, setting appropriate corporate tax rates, curbing corporate tax evasion, avoidance and exemptions, and improving compliance.

When countries fail to tax wealth and income effectively, the tax burden shifts onto the poor.⁷⁰

This tendency has characterised the tax reform agenda in recent decades. The Tax Justice Network and Christian Aid argue that a ‘tax consensus’, led by the IMF and supported by multilaterals and bilaterals, has been driving the nature of tax reform in developing countries.⁷¹ This consensus has been regressive, promoting a reliance on indirect taxes, reducing attention on compliance, and producing cuts in corporate and personal income tax. It has thwarted efforts to expand fiscal space.⁷²

Empirical analyses demonstrate that increased and progressive domestic tax is a key element of strategies to achieve UHC, particularly in countries with low tax bases. In such countries, it was found that an additional \$100 per capita in tax revenues per year substantially increased skilled birth attendance and health coverage, whereas an additional \$100 per capita in regressive taxes – such as taxes on goods and services – was associated with higher child mortality rates.⁷³

Approaches to financing the sustainable development goals must embrace a new tax consensus: one that is guided by progressivity and ambition to maximise the potential of countries to expand fiscal space.

IMPROVING TAX ON INCOME, WEALTH AND PROPERTY

Although it is not something that is quickly done, experience shows that low-income countries can raise their tax income as a share of GDP by identifying untapped revenue sources.⁷⁴ For example, in the last 10 years, Kenya has increased its tax-to-GDP ratio from 15% to 20%.⁷⁵ In Tanzania, tax as a percentage of GDP increased by more than 4% over the same period,⁷⁶ and in Rwanda by 3%. Burundi and Lesotho have also rapidly increased their tax revenue.⁷⁷

It has been estimated that untaxed assets of wealthy individuals held offshore amount to \$21–32 trillion, with an estimated loss to global revenues of between \$190–289bn per year.⁷⁸ In Kenya, only 100 high-net-worth individuals are currently registered with the tax authority, and an estimated 40,000 wealthy individuals are not paying tax. In South Africa, tax evasion by an estimated 28,000–114,000 high-net-worth individuals has reduced tax revenues by an estimated \$10.9bn – this can be compared to an annual national health budget of roughly \$11bn in 2012.⁷⁹ Undeclared income and assets are perpetuating inequality within countries, limiting the government’s capacity to redistribute resources.

Even for those who do pay tax, the income tax rates are often inadequate. The highest rate of personal income tax in developing countries rarely exceeds 25%, which falls far short of the OECD average of 40%.⁸⁰

Moreover, recent reforms in various countries have actually reduced the tax burden on high-earning individuals. For example, in South Africa tax on the same annual income in real terms fell from 33.8% in 1994/95 to 18.2% in 2010/11. This policy has been estimated to cost the South African government \$17bn in lost revenues.⁸¹ At the same time, tax policies are failing to protect the poor. In Zimbabwe and Malawi, for instance, people are required to pay income tax before they have even earned enough to afford basic food needs.⁸²

Property tax remains underexploited as a potential source of revenue in low- and middle-income countries, especially in Africa. Typically favouring wealthy elites, decisions on property tax tend to be made locally. They are heavily influenced by personal interests and discourage regular revaluations of property.⁸³

CURBING CORPORATE TAX EVASION, AVOIDANCE AND EXEMPTIONS, AND STRENGTHENING COMPLIANCE

Improving corporate tax policies and systems can generate substantial additional revenues. Trade mispricing, undeclared assets and the use of secrecy to avoid existing restrictions are some of the issues that could be addressed, both at domestic and international levels.⁸⁴

The desire to attract foreign direct investment as a source of development finance has led to a ‘race to the bottom’,⁸⁵ where governments offer exemptions

as an incentive for corporate investment.⁸⁶ These can include tax holidays, duty-free import and export, exemptions from environmental safety and labour laws, and the free repatriation of profits.⁸⁷ Such exemptions are estimated to cost developing countries between US\$138.9bn and US\$160bn each year.⁸⁸ This amounts to more than three times the combined total government spending on health (\$57bn) in sub-Saharan Africa in 2012.⁸⁹

These realities are crippling the economies of low- and middle-income countries. For example, undervaluation of assets in five deals between 2010 and 2012 in the Democratic Republic of Congo cost the government more than \$1.3bn in revenues.⁹⁰ UNICEF estimated that illicit capital flight in Nigeria in 2009 amounted to 17% of GDP, over eight times the government's investment in health.⁹¹

Moreover, evidence suggests that these incentives were unnecessary. For example, 93% of investors in East Africa say they would have invested even had the incentives not been available.^{92, 93} In 2012, the African

Department of the IMF issued a report stating that countries in Africa do not need tax incentives to attract foreign investment.⁹⁴

The cost to developing countries of giving incentives to companies for the extraction of natural resources is vast. Almost half of all countries in sub-Saharan Africa are significant exporters of natural resources.⁹⁵ For ten of them, the public revenues raised from these natural resources are greater than all other public revenues combined.⁹⁶ Nevertheless, many low- and middle-income countries are failing to maximise this vast potential revenue source. In Sierra Leone (Box 3) and Zambia, foreign mining companies only contributed 12% of all corporate tax, despite accounting for 70% of export revenues in 2004.⁹⁷ Special concessions to the mining sector and problems enforcing land rental agreements with forestry contracts are undermining efforts to increase tax revenues from natural resources in Liberia.⁹⁸ For resource-rich countries, it is imperative that governments revise corporate incentives and terms of contract without further delay.⁹⁹

BOX 3: UNTAPPED POTENTIAL IN SIERRA LEONE¹⁰⁰

The incentives and exemptions the government of Sierra Leone has granted mining companies are partly to blame for low government spending in social sectors. These include exemptions on customs duties and payments of goods and services taxes, as well as reductions in the rates of corporate income tax.

The Sierra Leone Budget Advocacy Network has estimated the cost to public revenues of mining company incentives in recent years. It found that losses from tax breaks on the import of capital equipment and petroleum products by mining companies in 2011 – a staggering 13.7% of Sierra Leone's GDP – actually exceeded the government's total revenues the following year, at 10.9% of GDP.¹⁰¹ It also estimates that corporate income tax incentives to just five mining companies will cost the government \$131 million between 2014 and 2016.

The economic rationale for these incentives remains unclear. Further, they emerged from opaque deals made at the discretion of individual ministers without parliamentary consultation or public scrutiny. This undermines the constitutional provision that tax waivers should be approved by Parliament. It also hints at potential political patronage and corruption. Other challenges include a disconnect between the National Revenue Authority – mandated to generate revenues – and the Ministry of Mining Resources, which granted the incentives. A Revenue Management Bill has been in the pipeline but it has been delayed and is yet to be enacted. This bill will require the government to publish all exemptions, beneficiaries and revenues foregone each year.

Additional revenues are vital if the government is to implement its poverty reduction plan, the Agenda for Prosperity. Reviewing and reducing the tax incentives granted to mining companies presents a huge opportunity to secure these revenues.

The rise in the power and geographic reach of multinational corporations has seen an increase in transfer mispricing, where companies shift profits from countries with high tax rates to low-tax jurisdictions.¹⁰² This problem is exacerbated by tax havens, which have low or non-existent tax rates and conceal financial flows.¹⁰³

There is a need for company earnings and tax payments to be more transparent, with information available across borders and between tax authorities.¹⁰⁴ It is time for new and binding rules on international finance. This was acknowledged in the High Level Panel's report, which called for "a swift reduction in corruption, illicit financial flows, money-laundering, tax evasion and hidden ownership of assets", and a "transparent and equitable system for collecting corporate tax in a globalised world".¹⁰⁵

Opposition to increased taxation from those who would have to pay it can perpetuate the problem. For example, recent efforts by the Kenyan government to reintroduce capital gains tax on the sale of property and shares were dropped following private sector resistance. Ghana and Zambia have so far failed to introduce their desired windfall taxes on mineral production.¹⁰⁶

SOCIAL HEALTH INSURANCE AND PAYROLL TAX

Social health insurance (SHI) originated in Europe, with healthcare access and contributions initially linked to employment and then expanded to the non-working parts of the population.¹⁰⁷ SHI differs from tax-funded systems in that access to a defined package of benefits is linked to the contribution made by, or on behalf of, individuals, usually employees.¹⁰⁸ SHI is generally a mandatory contribution, usually paid by employers and employees, and collected by government. It has the potential to be an important and progressive source of revenue. It is popular with governments and has the potential to legitimise additional revenue collection by linking it with the visible benefits of receiving healthcare, in a way that general taxation may not show. It might be seen as a hypothecated – or earmarked – tax. SHI schemes for the formal sector are prevalent in many West African Francophone countries, with CBHI in the informal sector – with the latter, however, a private form of health spending.¹⁰⁹

While SHI is popular, the evidence shows there are challenges for proper implementation in low- and middle-income countries.¹¹⁰ Many schemes do not cover the whole population from the start and are initially restricted to formal-sector employees. With as much as half the population in informal employment in some countries, this excludes huge numbers of people, especially the poorest. If schemes are open to all, informal sector workers may be required to pay an annual premium to join.¹¹¹ Even if SHI is in theory mandatory, the very poor are unlikely to be able to afford to join – so in practice schemes become voluntary. Public financing is critical to expand SHI schemes beyond the formal sector, subsidising enrolment for those who cannot afford the premiums and any co-payments. Ghana has spent ten years implementing its National Health Insurance Scheme, but has reached national coverage rates of just 35%, with much lower enrolment rates among people working in the informal sector.^{112, 113}

SHI tends to work better in countries with a growing economy, large formal sector, low levels of poverty/ income levels that can afford contributions.¹¹⁴

To expand coverage, to enrol the poorest households and to offer adequate risk protection, SHI schemes must be integrated into national financing strategies (as in Rwanda, see Box 4). Premiums should be scaled according to ability to pay. Public subsidies should extend entitlements to the informal sector and the poorest people, combining general revenues with SHI contributions in a single risk pool to avoid the fragmentation of risk pools.¹¹⁵ This can be practically and politically challenging. In many countries that have initiated SHI schemes it has been difficult to consolidate risk pools and equalise benefits across different population groups.¹¹⁶

Finally, SHI links access to health with employment as a benefit of work, rather than a universal right for all citizens. These limitations underline the importance of public revenues for effective and equitable health financing.

BOX 4: INTEGRATING INSURANCE INTO NATIONAL FINANCING STRATEGIES: RWANDA¹¹⁷

Rwanda has seen dramatic reductions in under five mortality (182 to 52/1,000 live births) and maternal mortality rates (1,000 to 320/100,000) in the past ten years. The country has also reduced health inequities in mortality rates and coverage of key health interventions.¹¹⁸ While Rwanda's achievements in health outcomes are linked to improvements across a range of sectors, including a national social protection strategy, education, improvements in water and sanitation, and gender equality, specific investments have been made in health.

Rwanda has increased spending on health to 6% of GDP, far beyond others in the Africa region. It currently allocates 23% of its budget to health – one of the seven countries in Africa meeting the Abuja target of 15%.

A national health insurance system means that more than 98% of the population is covered with a package of health services. In 2004 the government enacted a health insurance policy,

unifying the benefit package, enrolment fees, subsidisation mechanisms, organisational structure, and management systems of 30 district-based insurance schemes (*mutuelles*). The compulsory scheme includes national subsidies for the poorest, and has reduced out-of-pocket spending to 20% of total expenditure on health, compared to an average of 56.2% for Africa. Studies have found that this compulsory, nationally subsidised insurance system has improved utilisation and protected households from catastrophic health spending. While the benefit package is differently perceived (a 'limited number of services covered' or 'a comprehensive package offered', presumably depending on the comparator country used), a shortage of health workers, and poor quality of services means that few facilities are fully staffed to deliver the package as it is. Utilisation rates are still lower among the poorest quintiles of enrollees and for certain patients, such as children with acute illnesses. And the poorest people face higher rates of catastrophic health spending.

PURSuing PROGRESSIVE INDIRECT TAX

Low- and middle-income countries tend to depend more on indirect taxation than higher-income countries due to their tendency to have a large informal sector.¹¹⁹ Diversifying revenue sources can help to promote stable and predictable income. Hypothecated – or earmarked – taxes are another popular strategy to increase revenues for health. Levies that are earmarked directly can also be referred to as innovative taxes, and can take various forms, at domestic and international levels. They can be direct or indirect, but many current examples are the latter. For instance, both Brazil and Thailand earmark a proportion of various taxes for health.¹²⁰ Earmarking can help to make tax collection more politically acceptable, especially in countries with high levels of corruption. At the same time, important areas of work that are unpopular, contentious or less visible are unlikely to receive earmarked funds.

Ministries of finance may be reluctant to impose too many earmarked taxes – if funds are unspent it may be more difficult to reallocate them to other areas.

VALUE ADDED TAX

Indirect taxes are typically regressive. This is particularly true of value added tax (VAT) in many low- and middle-income countries, as everyone pays the same rate.¹²¹ VAT can be made less regressive if luxury goods and services – such as cars and electronic items – are taxed, while basic essentials such as food stuffs are exempt.¹²² Ghana's National Health Insurance Levy is an example of a mildly progressive VAT system (Box 5). While in Indonesia, luxury items are subject to a VAT surcharge of 10–200%,¹²³ recent VAT reforms in Malawi and Kenya, for example, have actually increased the burden on the poor.¹²⁴

BOX 5: PROGRESSIVITY OF FINANCING FOR GHANA'S NATIONAL HEALTH INSURANCE SCHEME¹²⁵

Ghana introduced a National Health Insurance Scheme (NHIS) in 2004, which aimed to remove financial barriers to healthcare and provide financial risk protection. One of the key sources of funding for the NHIS is the National Health Insurance Levy – an earmarked 2.5% VAT.¹²⁶

Following popular resistance to the introduction of VAT, a wide range of essential goods and services that were largely consumed by poorer people were exempted. An analysis in 2012¹²⁷ found that the NHIS is broadly progressive. Personal income tax, corporate tax and import tax were all found to be progressive; VAT, thanks to its exemptions, was found to be mildly progressive; while the fuel levy was regressive. Formal sector contributions

were progressive, yet informal sector contributions were regressive. This is largely due to the flat-rate premiums. The regressive OOPS remains the largest source of funding for the NHIS. This somewhat negates the fact that the other funding sources are progressive.

The study also found that the use of healthcare services remains pro-rich. The wealthiest 20% of households received 24% of Ghana's healthcare but only accounted for 16% of the population's healthcare need. In contrast, the poorest 20% of households received 13% of healthcare but accounted for over 23% of need. This indicates the importance of addressing the full range of demand- and supply-side barriers to effective coverage.

OTHER SOURCES OF PUBLIC FINANCE AND SIN TAXES

Aside from traditional forms of tax, there is a wide range of alternative mechanisms (sometimes referred to as 'innovative sources of finance') being proposed in order to raise additional funds for health and other social sectors. The 2010 World Health Report describes many of these, including sin taxes on alcohol or tobacco, financial transaction tax, mobile phone or remittance taxes, airline levies, national lotteries – some of which we explore here.¹²⁸

As discussed earlier, earmarking tax for healthcare can help generate popular support for unpopular tax reforms. The government of Sudan is using resources gained by reducing fuel subsidies – a controversial move, which had prompted popular protest – to fund free medicines for children under five. Iran is also planning to use savings from reduced fuel subsidies to support UHC reforms. For just a third of the investment in fuel subsidies, it is estimated that the government of Indonesia could make substantial progress towards UHC.¹²⁹

Sin taxes are a common earmarked tax on harmful products and behaviours, such as tobacco and alcohol, sometimes allocated directly to the health sector. With the rise in obesity and related illnesses,

many countries are introducing taxes on unhealthy drinks and foods with high sugar and saturated fat content. In Mexico a hypothecated 10% tax on sugar-sweetened drinks was introduced in 2013. It has been estimated that this will prevent up to 630,000 cases of diabetes by 2030. The revenues generated will be used to expand access to drinking water in schools across the country.¹³⁰

Sin taxes are designed to discourage harmful behaviour and can serve an important public health function, particularly when coupled with public health campaigns. But revenues generated from sin taxes are likely to decline if behaviour changes and they are often regressive, placing a greater burden on poor households.¹³¹ As such, sin taxes should be pursued primarily for public health promotion, and not relied on as a revenue source.

Another approach taken in some countries is a tax on **financial transactions**, such as money transfers. Kenya's tax on electronic money transfers is expected to raise an additional 0.1% of GDP.¹³² Other proposals include taxes on tourist entry, exit and hotel rates, and a tax on mobile phone use, due to the unprecedented growth of the telecommunications sector in low- and middle-income countries in recent years.¹³³

At the international level, an **airline levy** has been introduced and earmarked for HIV and AIDS treatment.¹³⁴ And a global surcharge on international financial transactions – the Robin Hood Tax – is being pursued by many large non-governmental organisations, potentially dedicated to international development or climate change.

Taxing **remittances** is another potential source of public revenues, as remittances, at \$404bn, amounted to approximately three times the total official development assistance (\$135bn) in 2013.¹³⁵ The design and implementation of any such tax should be careful to avoid perverse incentives to channel funds informally or reduce remittance flows. Gabon introduced a number of innovative taxes in 2009 to raise funds for health. These included a tax on financial transactions and on mobile phone operators, which raised \$30m for health in 2009¹³⁶ – 10% of the government’s current health budget.¹³⁷

Before any innovative tax is introduced or adapted, its sustainability, stability, progressivity, administrative efficiency, and any potential side-effects, should be analysed.¹³⁸

IMPROVING EFFICIENCIES IN THE TAX SYSTEM

Inefficient and ineffective tax administrations undermine the capacity of countries to generate revenues. For instance, arrears for defaults on

tax payments amounted to half of Kenya’s total public revenues in 2005. Strengthening the tax administration, along with legislative reforms, is crucial to prevent non-compliance. Non-compliance for VAT is estimated to be as high as 50–60% in some developing countries, compared with just 7–13% in high-income countries.¹³⁹ These inefficiencies are exacerbated by corruption and a lack of public accountability – which in itself influences people’s willingness to pay taxes. And these issues pertain throughout the tax system – from central revenue authorities to local government.¹⁴⁰

Making tax administration more efficient can generate huge savings, boosting government revenues. Oxfam estimated that improving tax collection in 52 developing countries could raise an additional 31.3% in tax revenues, amounting to \$268bn.¹⁴¹ Efforts to simplify Indonesia’s tax system led to an increase in tax revenues from 9.9% of GDP to 11.1% in the space of four years.¹⁴² This boosted non-oil tax revenue by 38% in real terms.¹⁴³ In Sierra Leone, a simplified goods and services tax of 15% increased government revenues from 11.7% of GDP to 13.3%.¹⁴⁴ Demonstrating such improved efficiency in tax administration can help to justify tax-rate rises.¹⁴⁵

4 A FAIR SHARE FOR HEALTH

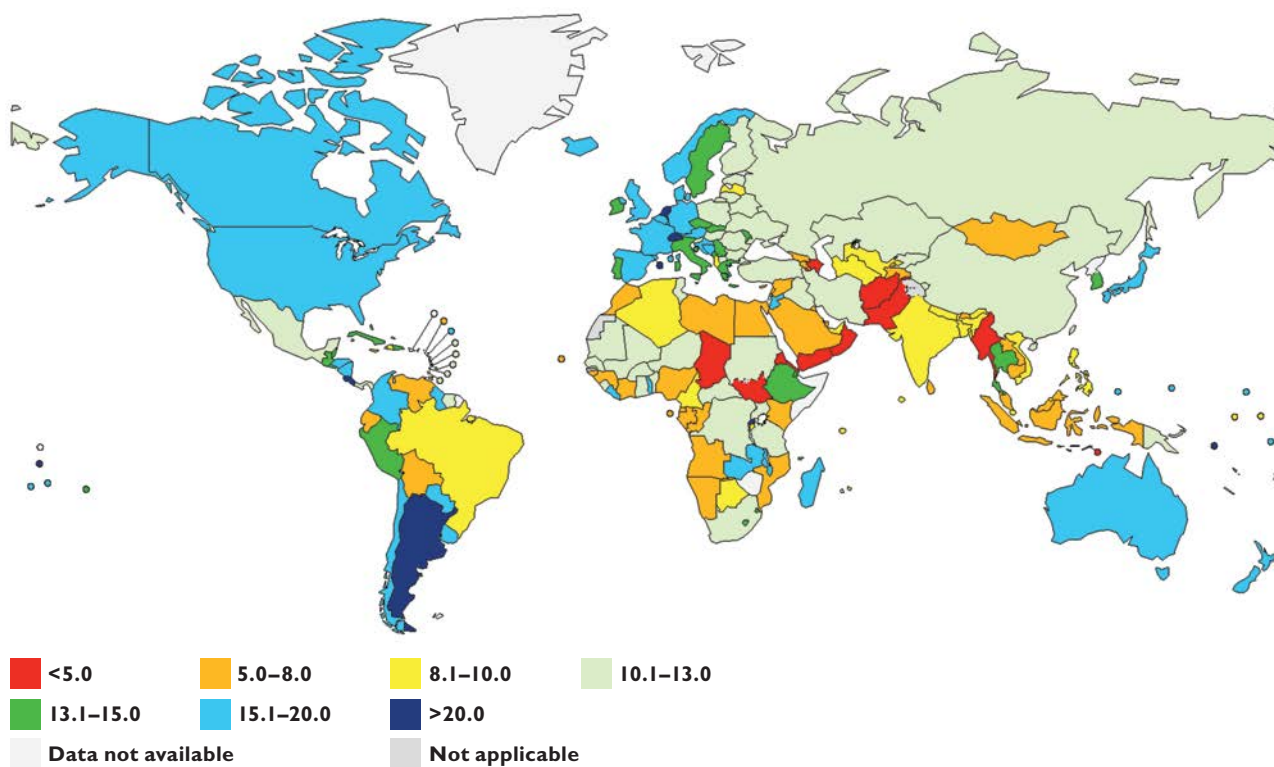
MORE MONEY FOR THE HEALTH SECTOR

There is wide variation in health spending as a proportion of total government expenditure. This ranges from on average 5% in most low-income countries (with Myanmar the lowest, with 2%) to more than 20% in some high-income countries (Argentina, Japan, Netherlands, USA). But this also varies among the low- and middle-income groups – 9% for India and 28% for Costa Rica – reflecting differing priorities across these countries.¹⁴⁶

In the absence of a recommended international target for low- or middle-income countries on

the right amount of the budget to spend on health (which in itself will depend on a country's burden of disease, and the needs of other sectors), the 'Abuja target' provides a useful benchmark. During a meeting in Nigeria's capital city, Abuja, in April 2001, governments from the African Union pledged to increase spending on health to at least 15% of total government expenditure. But in 2012, more than a decade after the declaration, only seven African countries had reached this target: Togo, Liberia, Burundi, Namibia, Rwanda, Swaziland and Malawi. Just four other non-African Countdown countries have met this target (Mexico, Peru, Solomon Islands and Guatemala).

FIGURE 7: GOVERNMENT SPENDING ON HEALTH AS A SHARE OF TOTAL GOVERNMENT EXPENDITURE¹⁴⁷



There are many questions about the appropriateness of the Abuja target, and whether this may need to be reviewed.¹⁴⁸ What is clear is that many low-income countries are currently allocating a very small share of their budgets to health, with the majority (41 countries) allocating less than 10%.

“The returns on investing in health are impressive.” This was declared by the Global Commission on Investing in Health in 2013, which showed that reductions in mortality account for about 11% of recent economic growth in low-income and middle-income countries – and that the returns on investing in health exceed the costs by a factor of between 9 and 20. Spending more on health is not only required to realise every citizen’s right to health, but also has a clear economic benefit.¹⁴⁹

The ministry of health has a key role to play in convincing ministries of finance to increase spending on health. A clear strategy and supporting operational plans for the health sector, alongside the resource needs required to implement them – based on thorough reviews of the cost-effectiveness, for example, of introducing new drugs or technologies can be useful when competing for funds with other sectors. Some countries have also identified specific areas of the budget to reallocate to health – such as fuel subsidies in Indonesia. Government resolutions protecting the share of health in the government budget have been implemented (in Vietnam), or protecting the social sectors from cuts needed in times of economic downturn.¹⁵⁰

The potential for making health a bigger political priority in low- and middle-income countries is substantial. If Countdown countries were to progressively realise the 15% target, the funding gap would halve, falling to \$52bn. When combined with an increase in government tax revenues as a share of GDP, the gap in health spending could fall by over 70% to \$28bn.

At the same time as any increase in budget allocation, it is critical that the health sector has sufficient capacity to absorb these extra funds. This must be carefully factored into health planning. For instance, expanding the health workforce takes time, but appropriate task-shifting with greater use of community health workers may be an effective strategy to accelerate this process.¹⁵¹

MORE EFFICIENT, EQUITABLE AND EFFECTIVE USE OF HEALTH RESOURCES

Even if governments do increase health spending to \$86 per capita, universal access is still far from guaranteed. UHC will depend on which groups of people and types of intervention are allocated resources and how efficiently they are spent. This is just as important as raising sufficient revenues. It is fundamental to improving health outcomes and making them more equitable.

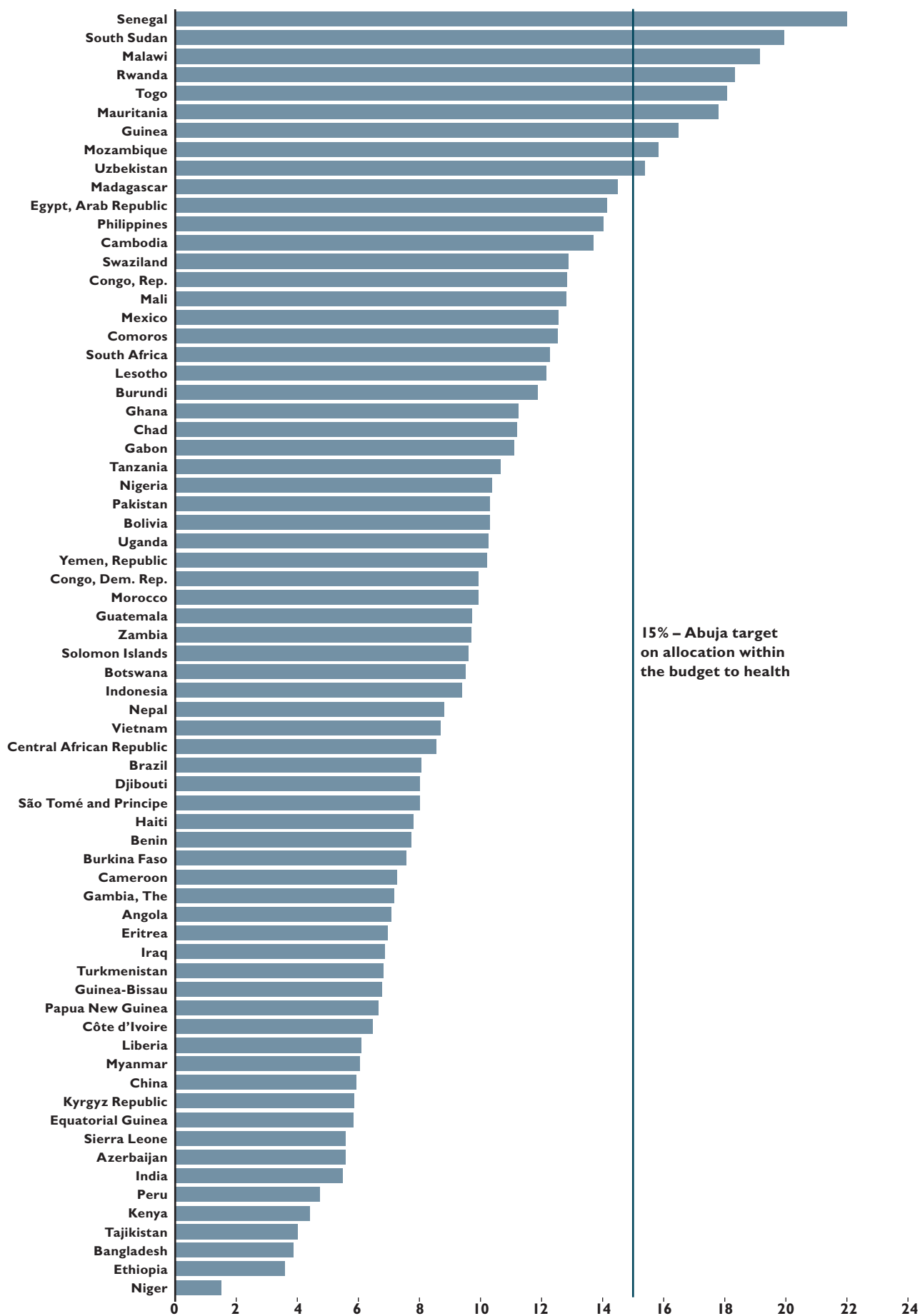
One way to make health spending more equitable is by making certain essential services – particularly primary healthcare – free at the point of use to everyone (regardless of enrolment in any insurance scheme), then expanding the package of services as budgets expand.¹⁵² This helps to ensure that the most vulnerable and disadvantaged people are included from the outset. This approach was set out in our report *A Commitment to Closing the Gap*, co-published with WHO, Unicef and the Rockefeller Foundation.

Equity must also be prioritised in the inter-regional allocation of resources. Transfers from central to devolved governments or targeted support can mitigate against national inequalities. South Africa’s ‘provincial equitable share’ determines budget allocations by a formula that prioritises provinces where a high proportion of the population does not have access to health insurance, or where there is a large number of children out of school, in order to help rectify these imbalances. India uses a ‘fiscal capacity distance formula’, while Tanzania targets specific forms of deprivation by identifying groups, regions or individuals.¹⁵³

Another important message often recognised by proponents of UHC is that ‘you can’t just spend your way to UHC’.¹⁵⁴ The 2010 *World Health Report* (with chapters entitled ‘More money for health’ and ‘More health for the money’) estimated that between 20% and 40% of health spending is wasted, through inefficiencies. These include:

- purchasing over-expensive drugs and the insufficient use of generics
- inappropriate use of medicines, including counterfeits
- the oversupply/overuse of equipment, investigations and procedures
- an inappropriate mix of health workers and unmotivated staff
- unnecessary inpatient admissions
- other leakages, waste, corruption and fraud.¹⁵⁵

FIGURE 8: GOVERNMENT SPENDING ON HEALTH AS A SHARE OF TOTAL SPENDING (%),
COUNTDOWN COUNTRIES, 2012¹⁵⁶



The report notes that up to a quarter of public spending on the procurement of essential medicines and supplies is lost to corrupt practices each year. Inefficiencies in hospitals alone are estimated to account for 15% of government spending on health.¹⁵⁷

More effective provider payment can limit public spending on ineffective and high-cost interventions, reinforce treatment protocols and encourage appropriate use of different levels of the health system, promoting primary healthcare.¹⁵⁸ Governance must be improved if corruption and leakages are to be addressed.¹⁵⁹

Strategic purchasing is a critical strategy for improving efficiencies in health – this links the allocation of resources to providers to information on their performance and/or the health needs of those they serve.¹⁶⁰

Improving efficiency could help Countdown countries reduce their health financing gaps significantly. As an example, cutting wastage by just 10% on their existing health budgets could raise \$15bn across these 75 countries to channel back into their health sectors.

5 THE ROLE OF AID AND INTERNATIONAL ACTORS IN HEALTH

The \$86 per capita target for government expenditure on health used in this paper is somewhat arbitrary, as national needs and costs vary. It is also ambitious. Achieving it will take time, especially in countries with low current levels of economic development. We estimate that, if all Countdown countries were to increase government tax revenues to 20% of GDP and allocate 15% of their budget to health, 26 countries would still fail to reach the \$86 per capita threshold by 2030.

This is broadly in line with WHO estimates that only eight of the 49 low-income countries would be able to finance health spending from domestic resources in 2015, using the lower \$60 per capita target.¹⁶¹

A country's level of economic development is the main driver of spending on health. Public spending of 5% of GDP (double that which is currently spent in Africa) is not enough to reach \$86 per capita in countries with gross national income per capita below \$1,720¹⁶² – this is roughly the mid-point for the lower-middle-income country group (higher than Ghana, for example). Given the updated \$86 target for a basic package of services, it is clear that many Countdown countries will continue to require external assistance for some years to come. As challenges are set for low income governments to raise more resources and devote them to health under the SDGs, donors must assume their human rights obligations and shared responsibilities to help all countries realise these targets.

This paper calculates a residual gap of \$28bn – some of which can be filled through greater efficiencies, as shown above. But this also shows a continuing role for aid. In 2011, official development assistance (ODA) for maternal, newborn and child health in

the Countdown countries was much lower than this, at \$5.6bn.¹⁶³ Since 1970, advanced economies have committed to allocating 0.7% of their GNI to aid. If high-income countries were all to honour this pledge, development assistance in low-income countries would virtually double overnight.¹⁶⁴

WHY AID?

The nature of finance for development is changing. Countries are getting richer, and, as this paper shows, many are able to increase domestic resources and should do so without further delay. But there remains a need for aid for the poorest countries, not simply as a gap filler, but to build capacities, fund long-term investment in health systems, invest in research and development, and leverage private sector finance.¹⁶⁵ Save the Children recommends that donors must ensure that a significant proportion of aid is allocated to the world's least developed countries and conflict-affected states. Three-quarters of the world's absolute poor now live in middle-income countries – countries that are enjoying high rates of economic growth, but where millions of people are excluded from sharing in its benefits. These people must not be forgotten or left behind – aid to MICs should be delivered in smart ways that catalyse change, bolstering government accountability and capacity to deliver for citizens.

Health is a good candidate for aid, given the many direct and spill-over benefits of investing in healthcare – as shown at the start of this paper. The WHO Commission on Macroeconomics and Health proposed that 15% of ODA, and therefore 0.1% of rich-country GNI, should be devoted to health.¹⁶⁶ This target has not been officially endorsed but it has been used widely by advocacy organisations.

WHAT MAKES AID MORE EFFECTIVE?

Donor investment in health has prevented many unnecessary deaths and led to remarkable achievements – for example, on HIV, with 12.9 million people on HIV treatment worldwide,¹⁶⁷ and immunisation, with 112 million children now immunised each year¹⁶⁸ thanks to government investment as well as support of disease-focused organisations. However, given the reliance of many poor countries on aid, the focus of the MDGs on specific diseases and population groups has overlooked the broader needs of health systems, and made health systems fragmented.¹⁶⁹

Health aid also has its inefficiencies, including unpredictable flows and an administrative burden. It is vital that donors improve the quality of the aid they provide, in line with the multiple commitments they have made in Rome, Paris, Accra and Busan. This means adhering to aid effectiveness principles and aligning funding to support national plans.¹⁷⁰

In pursuing sustainable and equitable financing for health, development assistance should be catalytic, helping countries build their own capacity and resources – for example, helping developing-country governments to improve their tax systems and make them more progressive. UK aid to the government of Rwanda funded the development of the national Revenue Authority, which now collects the value of the original aid grant each month.¹⁷¹ Despite donors' rhetoric about the importance of tax revenues, aid to support tax activities has remained marginal (less than 0.1%) of the overall aid provided to African countries.¹⁷² Development partners can help countries to improve efficiency – for instance, by funding electronic systems for reporting taxable income.¹⁷³ Fostering equitable, efficient and accountable tax systems is a wise investment for donors. It will generate lasting returns, promote sustainable domestic finance and reduce dependence on aid.

THE ROLE OF THE IMF IN SHAPING FINANCING FOR HEALTH

The role that the IMF has played in discouraging government spending on public health has received intermittent attention over the years and is identified by many as a barrier to universal health coverage.^{174, 175} By advising the economies of its borrowers in this way, it has reduced the ability of countries to increase public spending – through conditions attached to loans that required recipient governments to adopt policies that have been prioritised short-term economic objectives over investment in health and education, and caps on the public-sector wage bill.¹⁷⁶

As a briefing paper by the Centre for Global Development summarised, the IMF “have often unduly narrowed the policy space by failing to investigate sufficiently more ambitious, but still potentially feasible, options for higher government spending and aid.”¹⁷⁷ Recently, commentators in *The Lancet* have linked IMF policies to the circumstances that enabled the Ebola crisis to arise, saying that “conditions attached to loans that required recipient governments to prioritise short-term economic objectives over investment in health and education” are partly to blame.¹⁷⁸ While the IMF has challenged this,¹⁷⁹ for developing countries to increase their own domestic contributions for health – essential for universal health coverage – the issue of government spending levels will need to be tackled.

Christine Lagarde recently said: “It is good to increase the fiscal deficit when it’s a matter of curing the people, of taking the precautions to actually try to contain the disease. The IMF doesn’t say that very often.”¹⁸⁰ We would argue that investing in building stronger health systems is a precaution – to prevent future disease outbreaks such as the recent Ebola crisis – as well ensuring that all people are able to access essential services.

As developing countries increase their own domestic contributions for health, the IMF should revisit and change these unnecessarily restrictive IMF policies so that developing countries can better generate higher GDP output, employment and tax revenues for increased long-term public investment in rebuilding their health systems.¹⁸¹

6 CONCLUSION AND RECOMMENDATIONS

This paper has sought to demonstrate that low- and middle-income countries have many opportunities to expand domestic resources for health, and should do so progressively, and that this can go a long way towards closing the funding gap. This is largely a matter of national policy choices and political commitment to UHC.

The post-2015 framework is an opportunity to make progressive taxation, public investment in health and aligned development assistance global priorities. As well as facilitating progress towards UHC, raising higher domestic revenues should make governments more accountable to their own people, rather than to donors, and strengthen the social contract between citizens and state.

Our analysis has looked at various ways in which countries can afford to spend \$86 of public money on healthcare for every person in the population. Economic growth is a major determinant: as a country's GDP increases, so can its per capita health spending. But this will take time. More critical will be increasing the revenues available for health (in a way that is not to the detriment of other important sectors) and ensuring that the funds raised are well spent.

The targets we have used are minimums – and we recommend that in the few countries where 5% of GDP exceeds the \$86 per capita minimum threshold, countries should expand the package of services provided and the extent of financial risk protection, and begin to graduate from a reliance on aid for health.¹⁸²

With the final push to accelerate progress on the MDGs, and as the goals shift to end preventable maternal, newborn and child deaths and accelerate progress towards UHC by 2030, we call on:

low- and middle-income governments to:

- commit to end all preventable maternal, newborn and child deaths by 2030

- accelerate progress towards UHC and ensure its inclusion in the sustainable development goals
- develop a health financing strategy for achieving UHC, eliminating OOPS for essential health services and moving towards mandatory prepayment with a national risk pool and universal entitlements
- prioritise expanding fiscal space for health, reviewing opportunities to increase government tax revenues as a share of GDP to reach at least the 20% target and to do that progressively
- increase investment in health, allocating at least 15% of the total government budget to it
- tackle inefficiencies within health spending, ensuring that investments benefit the most vulnerable people first
- increase tax collection capacity and efficiency across different taxes to improve compliance and create a progressive tax system.

development partners to:

- ensure ending all preventable maternal, newborn and child deaths, and achieving UHC are included in the sustainable development goals
- provide technical and financial support to help Countdown countries promote sustainable and progressive domestic revenue sources for health
- help Countdown countries strengthen national health plans, which are fully costed and implemented, filling funding gaps
- deliver on aid commitments and adhere to aid effectiveness principles
- implement domestic and international reforms to curb illicit financial flows.

civil society to:

- engage in tax processes, advocating for progressive tax reforms and increased transparency
- advocate for strong agreements on public and donor country financing for health as part of the sustainable development goals
- monitor domestic budgets to track resource flows, and advocate for increased and more equitable revenue and expenditure.

ANNEX I: PROJECTING COUNTDOWN COUNTRIES' PUBLIC HEALTH FINANCING GAPS: METHODOLOGY

The purpose of the exercise was to project Countdown countries' public per capita health spending to 2030 in order to identify the funding gaps against the \$86 per capita target (at 2012 prices) at both global and national levels. The analysis covers 72 Countdown countries for which the relevant data was available.

SOURCES OF DATA AND TARGETS

We used the WHO Global Health Expenditure Database for all health expenditure statistics – in 2012 dollar exchange rate terms rather than purchasing power parity (PPP) (due to methodological challenges with using PPP for long-term forecasts). We recognise this may underestimate the funding available for health, as much of the spending on health is made in local currencies. We use the World Bank for population data. Tax data is compiled from OECD papers and databases for Asia, Latin America and Africa, as this is the most reliable available source (see reference 72). We use the IMF's Government Finance Statistics as the source of data for economic growth.

MODEL SCENARIOS AND ASSUMPTIONS

We draw on two often-cited international targets:

- 20% of GDP to be raised in taxation. UNDP has recommended in the past that the least-developed countries should be raising a minimum of 20% of GDP in revenue in order to meet the MDGs. This target has been interpreted in many cases

to apply to tax revenue specifically. Given that many Countdown countries are rich in natural resources and so raise considerably more than 20% in revenue, but much less than that in taxation, we take this target to apply to taxation.

- 15% of government expenditure to be spent on health. In the absence of a recommended target across Countdown countries, the Abuja target for countries in Africa provides a useful benchmark for prioritisation of health spending.

AN EQUATION FOR GOVERNMENT HEALTH SPENDING¹⁸³

$$\frac{\text{Government health spending}}{\text{GDP}} = \frac{\text{Total government spending}}{\text{GDP}} \times \frac{\text{Government health spending}}{\text{Total government spending}}$$

Per capita spending on health is linked to a country's current economic development context:

= government health expenditure as share of GDP * GDP per capita.

Per capita public health spending is determined by four parameters:

- GDP
- public spending as a share of GDP
- health spending as a share of public spending
- size of population.

In the exercise, we considered different scenarios involving changes in governments' fiscal policies, but we treated GDP as a given. Projections were based on the following assumptions:

Basic scenario: Countdown countries make no changes to planned public spending as a share of GDP, maintain public health spending as a share of public spending at 2012 level, and GDP grows as projected by the IMF.

Scenario 1: Countdown countries increase their tax revenues as % of GDP by 1% a year until it reaches 20% of GDP and use all of the extra revenues to increase public spending. The share of public health spending in public spending is constant. GDP grows as projected by the IMF.

Scenario 2: Countdown countries make no changes to planned public spending as a share of GDP, but they increase health spending as a share of public spending by 1 percentage point a year until it reaches 15%. GDP grows as projected by the IMF.

Scenario 3: Countdown countries increase their tax revenues by 1% of GDP a year until it reaches 20% of GDP and use all of the extra revenues to increase public spending. At the same time, they increase health spending as a share of public spending by 1 percentage point a year until it reaches 15%. GDP grows as projected by the IMF.

We also examine the levels of per capita expenditure if countries spend 5% of their GDP (public spending) on health and, conversely, the level of GDP required for countries to spend \$86 per capita on health.

TABLE I: VARIABLES USED IN PROJECTIONS

Inputs	Source, years, formulas
National GDP (\$bn)	IMF, 2012–2019, own calculations for 2020–2030 based on the annual change rate between 2016–2019
Public spending as a share of GDP (%)	IMF, 2012–2019, own calculations for 2020–2030 based on the annual change rate
Tax revenues as a share of GDP (%)	OECD databases for Asia, Africa and Latin America
Population	UN, 2012-2030 (also used by World Bank)
Public health spending as a share of GDP (%)	World Health Organization Global Health Expenditure Database, 2012
Per capita health spending in 2012	World Health Organization Global Health Expenditure Database, 2012
<i>Derived variables</i>	
Public health spending (\$bn)	$GDP * \text{public spending as a share of GDP} * \text{health spending as a share of public spending}$
Per capita public health spending – future (%)	$\text{Public health spending} / \text{population}$
Per capita gap (\$)	$86 - \text{per capita public health spending}$
Total gap (\$bn)	$\text{Per capita gap} * \text{population}$
Public health spending as a share of GDP (%)	$\text{Public health spending} / GDP$

LIMITATIONS OF THE MODEL

Similar to other models that involve long-term projections for a large number of cases using multiple variables and uniform assumptions, our model is subject to certain limitations and caution is required when interpreting the results.

First, in all our projections we rely on IMF and World Bank projections of macroeconomic indicators, which have their own drawbacks. For example, the IMF's GDP estimates have often been criticised for overly optimistic economic growth projections that do not take into account possible shocks, macro-level deficits and debt levels. Second, the IMF's projections are available only up to 2019 and we had to use the average change in 2016–2019 as a yardstick for projecting changes beyond this period.

We use World Bank estimates of population growth, which may not take account of demographic changes

that result from higher health spending. It is clear that improved health will affect morbidity, the labour force and productivity – this would be very uncertain across 75 countries with different epidemiological and labour market profiles, and as growth estimates beyond 2019 are already very rough. We also do not include the impact of tax on growth (either drawing on evidence of limits to growth or counter evidence on inclusive growth) as this is beyond the scope of the model. We do not feel our targets of 20% are above recommended levels, as those already reached in many middle- and high-income countries are higher than this.

Despite these limitations, when treated as indicative rather than assertive, our projections provide a useful broad picture about the overall scope of the problem, and about how effective different fiscal approaches for tackling it can be.

ANNEX 2: DATA TABLE

Countdown countries	HLTF country?	Income group	GNI/CAPITA	Total health expenditure (THE) as % Gross Domestic Product (GDP)	General government expenditure on health as % of GDP	General government expenditure on health (GGHE) as % of THE	GGHE as % of general government expenditure	External resources on health as % of THE	Private expenditure on health (PvtHE) as % of THE	Out of pocket expenditure as % of THE	Total expenditure on health / capita at exchange rate	General government expenditure on health / cap x-rate
Afghanistan	Yes	Low income	700	8.6	1.8	20.8	7.1	21.7	79.2	74.4	51.5	10.7
Angola	No	Upper middle income	5,010	3.5	2.2	62.2	5.6	1.7	37.8	26.7	190.5	118.4
Azerbaijan	No	Upper middle income	7,350	5.4	1.2	22.8	3.9	1.0	77.2	69.0	398.2	90.6
Bangladesh	Yes	Low income	900	3.6	1.2	34.4	7.7	7.2	65.6	63.3	26.0	9.0
Benin	Yes	Low income	790	4.5	2.3	51.5	10.3	32.0	48.5	44.3	33.1	17.0
Bolivia	No	Lower middle income	2,550	5.8	4.1	71.8	9.5	3.8	28.2	23.2	148.7	106.7
Botswana	No	Upper middle income	7,730	5.3	3.0	56.4	8.0	15.6	43.6	5.5	384.1	216.5
Brazil	No	Upper middle income	11,690	9.3	4.3	46.4	7.6	<	53.6	31.0	1,056.5	490.4
Burkina Faso	Yes	Low income	670	6.2	3.4	54.3	11.9	31.4	45.7	36.4	37.8	20.5
Burundi	Yes	Low income	280	8.1	4.8	59.5	13.7	46.3	40.5	28.3	20.0	11.9
Cambodia	Yes	Low income	950	6.2	1.4	23.4	7.3	19.1	76.6	71.5	58.5	13.7
Cameroon	No	Lower middle income	1,270	5.1	1.7	33.5	8.5	9.3	66.5	62.6	59.1	19.8
Central African Republic	Yes	Low income	320	3.8	1.9	49.7	11.2	28.6	50.3	45.6	17.8	8.8
Chad	Yes	Low income	1,020	3.5	1.6	45.3	5.9	11.7	54.7	52.9	31.2	14.1
China	No	Upper middle income	6,560	5.4	3.0	56.0	12.5	<	44.0	34.3	321.7	180.0
Comoros	Yes	Low income	880	4.5	2.5	55.9	9.9	26.9	44.1	44.1	37.7	21.1
Congo, Dem. Rep.	Yes	Low income	400	5.6	2.9	51.4	12.8	50.4	48.6	32.5	15.2	7.8
Congo, Rep.	No	Lower middle income	2,660	3.2	2.3	73.9	6.5	7.7	26.1	25.1	99.8	73.7
Côte d'Ivoire	Yes	Lower middle income	1,380	7.1	1.9	27.5	8.0	8.7	72.5	55.8	87.9	24.2
Djibouti	No	Lower middle income	0	8.8	5.3	59.7	14.1	12.7	40.3	40.0	129.2	77.1
Egypt, Arab Rep.	No	Lower middle income	3,160	5.0	2.0	39.0	5.8	<	61.0	59.6	151.6	59.2
Equatorial Guinea	No	High income: non-OECD	14,320	4.7	2.6	54.3	7.0	1.1	45.7	43.5	1,138.2	617.8
Eritrea	Yes	Low income	490	2.6	1.2	47.5	3.6	24.7	52.5	52.5	14.7	7.0
Ethiopia	Yes	Low income	470	3.8	1.9	48.4	11.1	50.3	51.6	41.2	17.6	8.5

Source WHO National Health Accounts Data, Global Health Expenditure Database, accessed 13 October 2014⁸⁴

continued overleaf

ANNEX 2: DATA TABLE continued

Countdown countries	HLTF country?	Income group	GNI/CAPITA	Total health expenditure (THE) as % Gross Domestic Product (GDP)	General government expenditure on health as % of GDP	General government expenditure on health (GGHE) as % of THE	GGHE as % of general government expenditure	External resources on health as % of THE	Private expenditure on health (PvtHE) as % of THE	Out of pocket expenditure as % of THE	Total expenditure on health / capita at exchange rate	General government expenditure on health / cap x-rate
Gabon	No	Upper middle income	10,650	3.5	1.8	51.2	7.2	1.3	48.8	41.4	396.7	203.1
Gambia, The	Yes	Low income	510	5.0	3.3	66.0	11.2	49.2	34.0	16.3	25.7	16.9
Ghana	Yes	Lower middle income	1,760	5.2	3.0	57.1	9.7	10.9	42.9	28.7	83.0	47.4
Guatemala	No	Lower middle income	3,340	6.7	2.4	35.6	16.5	2.6	64.4	53.3	225.8	80.4
Guinea	Yes	Low income	460	6.3	1.8	28.1	6.8	10.3	71.9	66.6	32.0	9.0
Guinea-Bissau	Yes	Low income	520	5.9	1.3	22.7	7.8	34.5	77.3	43.2	29.8	6.8
Haiti	Yes	Low income	810	6.4	1.5	22.8	5.5	66.9	77.2	3.5	52.5	12.0
India	No	Lower middle income	1,570	4.0	1.3	33.1	9.4	1.2	66.9	57.6	61.4	20.3
Indonesia	No	Lower middle income	3,580	3.0	1.2	39.6	6.9	1.1	60.4	45.3	107.7	42.7
Iraq	No	Upper middle income	6,710	3.6	1.9	53.6	4.4	<	46.4	46.4	226.4	121.2
Kenya	Yes	Low income	930	4.7	1.8	38.1	5.9	42.3	61.9	47.6	44.6	17.0
Kyrgyz Republic	Yes	Lower middle income	1,200	7.1	4.3	60.1	12.2	12.2	39.9	34.8	84.3	50.6
Lao PDR	Yes	Lower middle income	1,460	2.9	1.5	51.2	6.1	22.1	48.8	38.2	40.2	20.6
Lesotho	No	Lower middle income	1,550	11.6	9.1	78.6	14.5	30.1	21.4	14.8	137.8	108.3
Liberia	Yes	Low income	410	15.5	4.6	29.8	19.1	34.6	70.2	21.2	65.5	19.5
Madagascar	Yes	Low income	440	4.1	2.5	60.8	12.8	20.9	39.2	31.5	18.2	11.1
Malawi	Yes	Low income	270	9.2	7.0	76.5	17.8	53.6	23.5	12.6	24.5	18.8
Mali	Yes	Low income	670	5.8	2.3	39.0	12.5	31.5	61.0	60.7	42.1	16.4
Mauritania	Yes	Lower middle income	1,060	6.4	4.1	63.9	9.9	8.2	36.1	34.1	51.7	33.1
Mexico	No	Upper middle income	9,940	6.1	3.2	51.8	15.8	0.6	48.2	44.1	618.3	320.3
Morocco	No	Lower middle income	3,030	6.4	2.1	33.5	6.0	:	66.5	58.8	190.3	63.7
Mozambique	Yes	Low income	590	6.4	2.8	44.3	8.8	55.7	55.7	5.0	37.2	16.5
Myanmar	Yes	Low income	0	1.8	<	23.9	1.5	8.1	76.1	71.3	19.8	4.7
Nepal	Yes	Low income	730	5.5	2.2	39.5	10.4	18.5	60.5	49.2	35.9	14.2
Niger	Yes	Low income	410	7.2	2.8	39.7	10.3	20.1	60.3	53.1	25.5	10.1
Nigeria	Yes	Lower middle income	2,760	6.1	1.9	31.1	6.7	5.3	68.9	65.9	94.3	29.4
Pakistan	Yes	Lower middle income	1,380	2.7	1.0	36.9	4.7	4.7	63.1	54.8	33.6	12.4

Countdown countries	HLTF country?	Income group	GNI/CAPITA	Total health expenditure (THE) as % Gross Domestic Product (GDP)	General government expenditure on health as % of GDP	General government expenditure on health (GGHE) as % of THE	GGHE as % of general government expenditure	External resources on health as % of THE	Private expenditure on health (PvtHE) as % of THE	Out of pocket expenditure as % of THE	Total expenditure on health / capita at exchange rate	General government expenditure on health / cap x-rate
Papua New Guinea	Yes	Lower middle income	2,010	5.2	4.3	83.1	14.0	21.6	16.9	9.5	113.6	94.4
Peru	No	Upper middle income	6,390	5.1	3.0	58.9	18.3	0.5	41.1	35.7	337.3	198.7
Philippines	No	Lower middle income	3,270	4.4	1.3	30.4	8.0	0.9	69.6	57.6	114.5	34.8
Rwanda	Yes	Low income	620	10.7	6.1	57.3	22.1	46.6	42.7	21.1	66.1	37.9
São Tomé and Príncipe	Yes	Lower middle income	1,470	7.9	2.5	31.7	5.6	43.0	68.3	51.5	109.2	34.6
Senegal	Yes	Lower middle income	1,070	5.0	2.8	55.9	9.6	19.1	44.1	34.1	51.2	28.6
Sierra Leone	Yes	Low income	680	15.1	2.5	16.6	12.3	13.2	83.4	76.2	95.7	15.9
Solomon Islands	Yes	Lower middle income	1,610	8.0	7.7	96.2	19.9	52.3	3.8	2.2	147.6	142.0
South Africa	No	Upper middle income	7,190	8.8	4.2	47.9	12.9	1.7	52.1	7.2	644.6	308.7
South Sudan	No	Lower middle income	1,120	2.6	1.0	38.7	4.0	30.1	61.3	56.7	27.4	10.6
Sudan	No	Lower middle income	1,130	7.2	1.7	23.4	10.6	2.1	76.6	73.7	114.5	26.8
Swaziland	No	Lower middle income	3,080	8.5	6.3	74.1	18.1	22.0	25.9	10.9	259.5	192.3
Tajikistan	Yes	Low income	990	5.8	1.7	29.6	6.8	9.0	70.4	60.0	54.9	16.3
Tanzania	Yes	Low income	630	7.0	2.8	39.3	10.2	37.7	60.7	31.8	41.3	16.3
Togo	Yes	Low income	530	8.6	4.4	51.4	15.4	18.1	48.6	41.1	40.8	21.0
Turkmenistan	No	Upper middle income	6,880	2.0	1.3	63.2	8.7	1.1	36.8	36.8	128.8	81.5
Uganda	Yes	Low income	510	8.0	1.9	23.9	10.2	28.6	76.1	49.3	43.6	10.4
Uzbekistan	Yes	Lower middle income	1,900	5.9	3.1	53.1	9.7	1.5	46.9	44.1	105.5	56.0
Vietnam	Yes	Lower middle income	1,730	6.6	2.8	42.6	9.5	2.4	57.4	48.8	102.5	43.6
Yemen, Rep.	Yes	Lower middle income	1,330	5.5	1.5	27.3	4.0	3.7	72.7	71.7	71.0	19.4
Zambia	Yes	Lower middle income	1,480	6.5	4.2	64.1	16.4	32.3	35.9	23.9	96.1	61.6

ENDNOTES

I INTRODUCTION

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2 HOW MUCH IS NEEDED FOR HEALTH?

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6 CONCLUSION AND RECOMMENDATIONS

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ANNEX 1: PROJECTING COUNTDOWN COUNTRIES' PUBLIC HEALTH FINANCING GAP: METHODOLOGY

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ANNEX 2: DATA TABLE

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