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Editorial

Global health financing towards 2030 and beyond

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Universal health coverage and healthy lives for all are now widely shared goals and central to the 2030 Agenda for Sustainable Development. Despite significant progress over the last decades, the world is still far from reaching these goals. Billions of people lack basic coverage of health services, live with unnecessary pain and disability, or have their lives cut short by avoidable or treatable conditions (Jamison *et al.*, 2013; Murray *et al.*, 2015; World Health Organization, World Bank, 2015). At the same time, millions are pushed into poverty simply because they need to use health services and must pay for them out-of-pocket. Fundamental to this situation is the way health interventions and the health system are financed. Numerous countries spend less than is required to ensure even the most essential health services, scarce funds are wasted, out-of-pocket payments remain high and disadvantaged groups get the least public resources despite having the greatest needs.

It is clear that today's global and national arrangements for health financing need to change, and this is a multifaceted endeavour. It is about domestic

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financing of health systems, joint financing of global public goods and external financing of health systems. It is about resource mobilisation, pooling and effective use. And it is about economics, politics, public health, human rights, law and ethics. To get health financing right, these areas, functions and perspectives must all be integrated and aligned.

Chatham House Working Group

The need for a broad and fresh look at global health financing was the starting premise for the Chatham House Centre on Global Health Security Working Group on Health Financing. The Group was established in 2011, following a conference at the Centre marking the 10th anniversary of the Commission on Macroeconomics and Health (Commission on Macroeconomics and Health, 2001). The mandate was to revisit the central themes addressed by the Commission and develop updated recommendations in light of new knowledge and developments since 2001. The Working Group would also build on the insights of three other landmark reports: the World Development Report 1993 *Investing in Health* (World Bank, 1993), the 2009 final report of the Taskforce on Innovative International Financing for Health Systems (HLTF, 2009), and the 2010 World Health Report *Health Systems Financing: The Path to Universal Coverage* (World Health Organization, 2010).

To facilitate a broad view on health financing, the Working Group brought together members with diverse backgrounds and perspectives from 15 countries. This included policy makers, researchers in multiple fields, representatives of civil society, and representatives of national and international institutions. The group met three times, and multiple working papers were prepared to form the basis for the final report, entitled *Shared Responsibilities for Health: A Coherent Global Framework for Health Financing* (Røttingen *et al.*, 2014), which was launched during the World Health Assembly in 2014.

The report characterises key economic, epidemiological and institutional transitions and describe how these come with both challenges and opportunities for health financing. Against that background, a set of policy responses is offered, encapsulated in 20 recommendations for making progress towards a coherent global framework for health financing. These recommendations pertain to domestic financing of health systems, joint financing of global public goods for health, external financing of health systems and the cross-cutting issues of accountability and agreement on a new framework.

This issue

This special issue addresses all these questions and does so more broadly and more in depth than the Working Group's Report could do. *Health Economics, Policy and Law* serves as an ideal platform for such a wide-ranging health policy issue, where economics, politics and legal considerations need to converge. While most

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contributions are in the form of academic articles, the close link to practical policy has been sought maintained throughout. The link between the analyses and policy making is further underscored in two editorials by leading decision makers – one domestic and one global. Sujatha Rao, former Secretary of Health and Family Welfare in India, comments on the past, present and future of health financing in India, including the interactions with external actors. Correspondingly, Mark Dybul, the CEO of the Global Fund to Fight AIDS, Tuberculosis and Malaria, comments on the challenges and opportunities for global health financing as seen from the Fund. Following this, Joe Dieleman and Annie Haakenstad highlight in their editorial a critical issue for all areas of health financing. They argue that a data *revolution* is needed and recommend focussing on data on expenditures across health focus area, type of care, payer and subnational units.

While this issue covers a wide range of the major topics in health financing, some topics are treated in less depth than others. For example, the articles do not go thoroughly into private financing for health, the effectiveness and cost-effectiveness of different targets and forms of spending, priority setting across specific services, or strategies to reduce waste. These too are all important topics for the future of health financing.

Domestic financing

National within-country financing for health in low- and middle-income countries is examined in the first four articles. Domestic sources of financing can be private, which include private insurance and out-of-pocket payments, or public, which include taxes and other mandatory, prepaid, pooled mechanisms organised by the government. In the first article, Diane McIntyre, Filip Meheus and John-Arne Røttingen explore potential targets for government spending on health in the pursuit of universal health coverage. They propose two complementary targets – government health expenditure of >5% of Gross domestic product (GDP) and government health expenditure per capita of >$86 – offer rationales for these levels, and argue for the usefulness of these targets in policy making.

A large majority of low- and middle-income countries currently fall short of one or both of these targets. In the second article, Riku Elovainio and David Evans examine the potential for raising more domestic money for health in many of these and other countries. They find that economic growth alone will be insufficient to ensure access to even basic health services in most of the countries studied. They lay out a range of complementary options to increase domestic funds for health, but conclude that universal health coverage will not be reached without also increasing external financing in many of the least developed countries.

Diane McIntyre and Filip Meheus look further into government revenue generation in the third article and show that the level of revenue is not predetermined by the country's level of economic development. Instead, it is very much a question of fiscal policy and political choice. They describe

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how governments can increase revenue through both tax-related and other strategies, and they offer arguments for choosing the most progressive strategies available.

The complex relationship between tax and health is followed up by David McCoy, Simukai Chigudu and Taavi Tillmann, who see this as a neglected area of concern. In the fourth article, they describe how taxes can help address pressing global health priorities not only through revenue generation, but also through four other 'Rs': representation, redistribution, re-pricing and regulation. They argue that the global community, including high-income countries, have a responsibility to help realise this potential by help curbing tax avoidance and evasion and by promoting an enabling environment for taxation more generally.

Global public goods

A conducive environment for domestic resource mobilisation can be seen as a global public good, i.e., a good that is non-excludable (once it is provided, no country can be prevented from enjoying it) and non-rival (one country's enjoyment of the good cannot impinge on the consumption opportunities of other countries). The provision and financing of such goods is itself a key area of global health financing, as discussed by Suerie Moon, John-Arne Røttingen and Julio Frenk in the fifth article. They consider a broad range of global public goods – including standards and guidelines, research on the causes and treatment of disease, and comparative evidence and analysis – and argue that institutions to provide global public goods for health are in particular short supply. They suggest to strengthen the financing and provision of these goods through better data on today's financing, through robust processes for prioritising among global public goods and estimating resource needs, and through channelling more funds through institutions fit for purpose. Looking into the future, they suggest that that some development assistance for health (DAH) might need to shift away from financing health programmes in recipient countries towards financing global public goods for health.

External financing

Such a shift does not imply, however, that traditional DAH will become irrelevant in the near future. This kind of financing comprises grants and concessional loans from one country to another. With the new, ambitious Sustainable Development Goals, the need for DAH may increase rather than decrease especially for low-income countries. Whatever the exact funding needs are, it is clear that the landscape for DAH has changed radically over the least two decades. In the sixth article, Suerie Moon and Oluwatosin Omole describe several important transitions and provide, against that background, a systematic overview of problems with the current system for DAH and related proposals for change. Top challenges

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pertain to the total level of funds; volatility and uncertainty; additionality; the share of DAH actually reaching recipient countries; priority setting; coordination; accountability; and the rationale for DAH.

The challenge of priority setting is particularly complex and an issue where values and evidence are highly intertwined. In the seventh article, Trygve Ottersen, Aparna Kamath, Suerie Moon, Lene Martinsen and John-Arne Røttingen review and discuss the allocation criteria currently used by 14 major funders of DAH. These criteria guide which countries are eligible for assistance and how much each country will be offered. The authors found that several funders had only limited information about concrete criteria publicly available, that many did not have different criteria for DAH and other forms of development assistance, and that no funder had criteria directly related to inequality. They also found that national income per capita was emphasised by many funders, but that the associated thresholds varied considerably.

These findings suggest that stakeholders should critically examine the allocation criteria they use or otherwise support. In the eighth article, Trygve Ottersen, Suerie Moon and John-Arne Røttingen seek to inform such an inquiry by presenting a simulation of the distributional implications of 11 criteria. Specifically, they examined for each criterion how the current global envelope of DAH would be allocated across countries and country categories, and they found profound variation among the criteria. For example, the group of low-income countries received most DAH from needs-based criteria linked to domestic capacity, while the group of upper-middle-income countries was most favoured by an income-inequality criterion.

This speaks to one of the great challenges to the entire system of DAH: to find the proper role of middle-income countries in this system. In the ninth article, Trygve Ottersen, Suerie Moon and John-Arne Røttingen address this challenge head on. They discuss the trade-off between concerns for a country's capacity to meet domestic needs and the magnitude of unmet health needs in the country. Against this background, they illustrate a capacity-based approach to setting the level of an eligibility threshold and outline options for the future role of MICs.

Bringing it all together

The issues examined in the nine articles are all brought together in the final article. It presents the 20 recommendations offered by the Chatham House Working Group. These recommendations make concrete a vision of shared responsibilities for health financing and link these responsibilities to quantifiable targets. With regard to domestic financing of health systems, the Working Group asserted that every government should meet its primary responsibility for securing the health of its own people, should commit to spend at least 5% of GDP on health and move progressively towards this target, should ensure government health expenditures per capita of at least $86 whenever possible, and should commit to out-of-pocket

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payments representing <20% of total health expenditures. With regard to global public goods, the Working Group asserted that every government should meet its key responsibility for the co-financing of global public goods for health and that the public funding for research and development for new technologies that specifically meet the needs of the poor should be at least doubled compared with the current level. Finally, regarding external financing of health systems, the Working Group asserted that every country with sufficient capacity should contribute with such financing and that high-income countries should commit to a contribution of at least 0.15% of GDP, while most upper-middle-income countries should commit to progress towards the same contribution rate. Together with the recommendations for promoting accountability and agreement, this is offered as the basis for achieving a coherent global framework for health financing.

The final article further discusses the Working Group's recommendations in light of key events over the last two years. The authors conclude that recent events have underscored the Group's recommendations and the need to revise the today's approach to health financing, but that these developments have also come with new opportunities to make real progress.

We hope this issue can help stakeholders exploit these opportunities. We hope the comprehensive assessment of the current state of global health financing provides a useful basis for stakeholders to explore new approaches. We hope that other analysts and researchers will debate and critique the work, and extend the debate through new empirical work and theoretical analyses. We hope the concrete policy recommendations provide direction for anyone who agrees that the *status quo* is not an option. Most importantly, we hope this can help actors converge on a more coherent global framework.

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