

Can earmarking mobilize and sustain resources to the health sector?

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Introduction

The way a health system is organized and financed is one of the key determinants of whether it provides equitable access to essential health care and improves population health. Financing is important as it determines access to and availability of health care, and the level of protection against catastrophic costs of illness. In low- and middle-income countries, financing becomes a central issue of health reform, especially in the light of fiscal constraints that result in a large proportion of out-of-pocket payments for health, leading to financial catastrophe and impoverishment for some households.¹

In the 58th session of the World Health Assembly in May 2005, WHO Member States endorsed Resolution WHA58.33 urging countries to strive towards sustainable health financing and achieving universal coverage, through applying a mix of prepayment health financing systems such as social health insurance and tax-financed national health services based on their specific context and institutional capacity.

Social health insurance has a limited role in developing countries due to the small size of the formal employment sector. When commitment towards the Millennium Development Goals is at stake, what are effective mechanisms in securing and sustaining resources to the health sector in the light of limited fiscal space and multiple players at international and national levels? This question challenges policy-makers in low-income countries. We review and discuss the contributions of specific diseases funding from global health initiatives (GHIs) and from earmarked taxes on specific goods and services to assess their strengths and weaknesses and provide appropriate policy recommendations.

Global health initiatives

A significant increase in global funding for HIV/AIDS has occurred in the past 5 years, as a response to the UN General Assembly Special Session on HIV/AIDS in June 2001. Three global HIV/AIDS initiatives are contributing most of the direct external funding for scaling-up HIV/AIDS prevention, treatment and care: The World Bank Global HIV/AIDS Program, which includes the Multi-country AIDS Program (MAP); the Global Fund to Fight AIDS, Tuberculosis and Malaria; and the United States of America's President's Emergency Plan for AIDS Relief (PEPFAR).

Evaluation of the first 5 years of PEPFAR operation² proved that scaling-up HIV interventions is feasible in resource-poor settings. By 2006 it had achieved the following results: > 800 000 adults and children on antiretroviral therapy; preventing mother-to-child transmission services for > 6 million women; and care and support for 4.5 million people. However, it did not achieve its commitment towards harmonization, fostering country ownership or the "three ones" principles of UNAIDS (i.e. one national HIV/AIDS plan, one coordinating mechanism and one monitoring and evaluation framework).

The nature of its policies on abstinence, faithfulness and consistent correct use of condoms, limits the harmonization of PEPFAR programmes with governments and other donor's programmes. Its requirement for approval of antiretrovirals by the Food and Drug Administration (FDA) prevents long-term financial sustainability by the government when support ends. PEPFAR uses rigid congressional budget allocations that do not observe country-led programme and ownership. For example, 33% must be spent on treatment; 20% on prevention of which

33% must be spent on abstinence-until-marriage programmes. In 2006, the Zambian Ministry of Health's total budget was US\$ 136 million while PEPFAR provided an HIV-targeted budget of US\$ 150 million.³

Huge resources from the Global Fund flow to AIDS programmes in Mozambique, Uganda, the United Republic of Tanzania and Zambia, but empirical evidence shows that early Global Fund programmes did not promote coordination, harmonization and monitoring at the country level.⁴ The main challenge for successful implementation of Global Fund and other GHI programmes is human resources; many countries are facing low staff morale and motivation and retention.

The World Bank's MAP did better in observing country ownership and focussed not only on disease-specific intervention, but investment in health systems strengthening⁵ (Fig. 1). MAP helped build political leadership and an institutional environment at the national and subnational levels in which the national HIV response can thrive, set the foundation for significant resource mobilization and provided financial support to other sectors involved in the response to HIV.

Specific tax on goods and services

Tobacco

Another form of earmarking advocated by the WHO Framework Convention for Tobacco Control are levies on health damaging products that are earmarked directly for health. A global increase in cigarette taxes of 10% would raise cigarette tax revenues by nearly 7%, with relatively larger revenue increases in high-income countries and smaller revenue increases in low- and middle-income countries.⁶

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