Financing for health: where there's a will...

On Aug 23, WHO quietly released a report that should be essential reading for all. Coming 15 years after the Abuja Declaration by African governments to commit to spending 15% of annual domestic budgets on health, *Public Financing for Health in Africa* concludes with a stark analysis: "For every US$100 that goes into state coffers in Africa, on average US$16 is allocated to health, only US$10 is in effect spent, and less than US$4 goes to the right health services."

The analysis is a timely reminder that the issue of domestic health financing is not simply a function of economic development. Indeed, the report shows clearly that increased gross domestic product (GDP) in Africa over the past 15 years has rarely led to increased government spending on health, and current figures show that the average proportion of public expenditure on health of 10% applies to countries across all levels of the income spectrum. In fact DR Congo, at a GDP of $476, allocates 11% of public expenditure to health, whereas Botswana, with its 13 times greater GDP of $6041 allocates only 9%.

The 2016 Africa Data Report released by the advocacy organisation ONE on the same day presents complementary findings, including an analysis of the amount spent on health per capita. The High-level Taskforce on Innovative International Financing for Health Systems calculated that the amount of spending necessary to provide a package of key basic health services in low-income countries is $54 (in 2005 prices). The ONE report illustrates the vast range of current per-capita health spending across sub-Saharan Africa, with eight countries spending at least double this figure, but 29 countries spending less than half of it.

In many cases, health has actually been shifted further down the agenda as a country's financial prosperity has increased. The WHO report's authors put this down to several factors, including poor coordination between ministries of health and finance; unstable funding flows (both domestic and donor) that hamper health sector planning, contribute to poor performance, and thus compound health's lower priority; and continued low revenue generation through taxation even as GDP rises, leaving little "fiscal space" for allocation to health.

Beyond health sector allocation, however, the WHO report highlights an all-too-commonplace failure to actually spend the money set aside for health. The authors estimate that, across Africa, 10–30% of budgets authorised to be devoted to health remain unspent, particularly funds destined for infrastructure. These failures seem to come down to a fundamental deficiency in public expenditure management, and are an obvious yet under-recognised target for analysis and reform.

Finally, the report drills down into the question of spending prioritisation within the health sector itself. Evidence shows that recent increases in health expenditure in Africa have not tended to favour expansion of primary care services nor those most accessible to poorer people. Indeed, less than 40% of public expenditure is estimated to be spent on primary care in most African countries. Furthermore, even when coverage has expanded, subsidisation has not necessarily followed, resulting in a continued skewing of catastrophic expenditure towards the lowest income sectors. The quality of the services provided is another crucial issue, the report finds, since bellwether indicators such as maternal mortality ratio can vary from less than 250 to almost 1500 per 100 000 livebirths for the same level of health expenditure (in this case $200 per capita).

What are the recommendations, then? Revenue (ie, tax) collection is a key target for strengthening, and, as outlined in a recent blog by José Luis Castro, tobacco taxation is a prime candidate. Castro points to the Philippines' "sin tax" reform as a model: not only does it simplify the country's previously complex tax structure and enshrine it in law, it directs the proceeds towards a defined health benefit—ie, the country's universal health-care programme. Such identification of defined benefits and alignment with appropriate payment mechanisms is another key recommendation of the WHO report, and feeds into the need for better engagement between ministries of health and finance and cultivation of long-term, sustainable sources of health financing. Castro praises the Philippines' then Undersecretary of Finance, Jeremias Paul, for bridging the gap, and calls for more such role models to come forward. President Xi Jinping of China's recent public statement that health authorities alone cannot ensure a healthy populace was a landmark step: which African leader will follow?

■ *The Lancet Global Health*

For the **WHO Public Financing for Health in Africa report** see http://apps.who.int/iris/bitstream/10665/249527/1/WHO-HIS-HGF-Tech.Report-16.2-eng.pdf?ua=1

For the **2016 Africa Data Report: Health Financing, Outcomes, and Inequality in Sub-Saharan Africa** see https://s3.amazonaws.com/one.org/pdfs/ONE_Africa_DATA_Report_2016_EN.pdf

For the **blog by José Luis Castro** see http://globalhealth.thelancet.com/2016/08/30/we-wont-achieve-sustainable-development-goals-ncds-or-other-targets-without-tobacco-taxes

For **Xi Jinping's statement on health in all policies** see http://www.china.com.cn/cppcc/2016-08/22/content_39138640.htm