

## Funding

### Overall scope of funding targets

Main elements of targets: Should the FCGH financing framework comprehensively cover the effective health systems and underlying determinants of health/public health services (water, sanitation, etc.) to which everyone is entitled, and that are guaranteed under the FCGH? Should these targets include any funding for social determinants of health, or would these be outside the funding framework?

Costs of underlying determinants of health: What would be the cost of ensuring everyone each of the underlying determinants of health (see section on Ensuring For All Universal Conditions of Good Health, including footnotes 3 and 4, and questions addressing which underlying determinants [and public health measures] the FCGH would include)?

Social determinants of health: If the social determinants of health are outside the FCGH financing framework, should the FCGH address their financing at all? If so, how? If they are included in the FCGH financing framework, then which should be included, and how? Given their expanse and in some cases, their expense, what impact would this have on the political feasibility of the FCGH?

Collective or disaggregated targets: Should the FCGH have a collective funding target across all relevant sectors (health, water/sanitation, etc.), and if so, which sectors? Or should the FCGH have specific targets for each sector? What are the advantages and disadvantages of each approach?

Evolving funding goal: How can the funding goal be designed to reflect changing disease-burdens, priorities, and costs? Should the FCGH include processes to review and update funding targets if the overall health investments that they must cover changes? Should there be a regular review of funding targets? If so, by whom? What would the process be?

Country differences and common funding target: Would standards in the FCGH be sufficiently precise to serve as the basis for an overall financing target from which the international portion could be derived, even if adapted at national level to meet community expectations and respond to country circumstances? If not, how to account for variations across countries? To the extent that needs are determined nationally – and thus investment needs will be the aggregate of country needs – a bottom-up process – can (or how can) there be an overall funding target determined before each country undertakes a process (which the FCGH might require) from which the cost emerges? If FCGH funding requirements to not take account these national processes, would any additional financing required based on higher country-determined standards be funded through domestic resources, or possibly be supported by additional innovative financing strategies or assistance outside the financing framework?

Country differences and domestic financing targets: Given varying country circumstances and community expectations, how should the FCGH set domestic funding targets? Might some areas (e.g., health care) have a common funding target across all countries, while certain underlying

determinants of health have a range, and possibly criteria for which countries would fall within the range (e.g., high spending requirements to achieve adequate sanitation for the entire population for countries with low levels of sanitation coverage)? Might the FCGH include default (indicative) budget targets, along with stipulations on inclusive national processes for adapting these targets domestically? Are there areas where country spending needs vary too much for the FCGH to include any domestic targets?

Regional funding targets: Should the FCGH have different funding targets for different regional groupings, and if so, based on what justifications, and using which groupings? Should they be regional (e.g., African Union) or sub-regional (e.g., West Africa)?

Global to national goal-setting: Might a process be developed whereby after a certain period of time, an initial goal is replaced by a bottom-up approach that is based on funding gaps in national health and development strategies that are designed to universal health coverage for health and the underlying determinants of health?

Economic policy constraints: How (and how much) do macroeconomic (or other economic, e.g., trade regime) policies constrain national health spending, or otherwise impede health, in developing countries? In practice, what control do developing countries (and other countries seeking support from international financing institutions) themselves (as opposed to international financial institutions) have over these policies? Are there specific changes needed in international financial institution practices that would enable countries to increase health and health-enhancing spending? If so, what, and should the FCGH respond to the need for these changes? Similarly, outside of international financial institutions, such as in the area of trade, are there rules or policies that impede on health and health-enhancing government spending? How should these be changed, and what is the role of the FCGH in these changes? [NOTE: Question also in the Global Governance for Health section.]

Health funding efficiency: Are there measures (besides those addressing transparency and accountability, discussed elsewhere) that the FCGH could include to increase the efficiency of health spending (to achieve improved health services and outcomes for equivalent amounts of health funding)?

Eligibility for international funding: What domestic requirements (if any?) should the FCGH attach to receiving funds through the FCGH financing framework (i.e., requirements related to countries receiving this funding)?

Legitimately missing the target: What are legitimate reasons for which countries might not meet funding targets?

### National

Health system costs: Many states will provide services (perhaps certain specialty care, or teaching hospitals) that may extend beyond estimated costs of well-functioning health systems to which everyone is entitled. How should these be factored into funding targets? What about the likelihood, that even if well-meaning efforts, spending is not likely to be wholly efficient, further driving up costs beyond any estimate – particularly developed global, but possibly also at the

national level.

Basis of national funding targets: How should domestic health funding targets be defined (e.g., percentage health sector spending, funding levels need to achieve specific health outcomes or provide certain goods and services, or achieve certain standards for health systems and underlying determinants of health)? How should overall economic strength (e.g., GNI) and capacity for generating additional revenue (such as through domestic financing mechanisms; see below) be incorporated into determining these targets and resource availability? What other factors, if any, should factor into domestic health funding targets?

Existing national funding targets: What are the rationales behind existing national targets for health, agricultural development, etc. (e.g., Abuja Declaration, Maputo declaration on agriculture and food security in Africa)? How sound are these rationales as possible rationales for FCGH targets? Should any existing targets be incorporated into the FCGH?

Substitution effect in health spending: What factors account for developing countries reducing domestic spending in response to increasing international health assistance (the substitution effect)? To what sectors and purposes are these domestic resources diverted? Are these other sectors and purposes promoting health? Human development more broadly What are possible implications for the FCGH? Particularly to the extent funds are diverted to non-health-promoting activities, should the FCGH include strategies or incentives that will help reduce this substitution effect, or are clearly defined national and international funding targets (or processes for developing national targets) sufficient?

Increasing tax collection: Should the FCGH promote strengthened national tax systems and innovative domestic financing mechanisms and (e.g., taxes on tobacco and unhealthy foods, dedicated taxes for health financing, methods to capture capital flight, improved tax collection)? If so, what mechanisms and how should the FCGH support them? To what degree is it possible for global health treaty to reach into overall revenue collection?

Sources of revenue: Should the FCGH include various categories of potential revenue (e.g., taxes, royalties) that countries should utilize in advancing the right to health? What sources? Or simply all sources?

### International

Range of countries with international funding responsibilities: Beyond OECD countries (traditional “donors”), what countries should have international funding responsibilities under the FCGH? Those with a certain income threshold, and if so, what threshold? Should all countries have international funding responsibilities, where the level of responsibility for poorer countries is miniscule compared to the funding that they would receive under the treaty, meaning that poorer countries would participate in this system as an act of solidarity (without materially affecting their finances)? How would (if at all) their own rights to international funding under the treaty be affected, if at all, by the level of their international funding?

International financing target connection to overall health financing goal: How should

international funding responsibilities relate to an overall health financing goal? Would it simply be the overall health financing goal less the domestic responsibility? Or would there be another way for determining the international financing target?

International health assistance target: Should the FCGH have a specific international health assistance funding target? If so, what should it be? What sectors should it cover? Should it be a portion of GNI? How would it relate (if at all) to the long-standing 0.7% GNI commitment of “economically advanced countries” and any other existing commitments? What other commitments?

Evolving international health assistance target: Would a given country’s international health assistance obligation, rather than being a set level, vary based on the total international financing target? Might other factors then affect international funding obligations (e.g., number of countries participating in the FCGH financing framework)?

Allocating international responsibility: Should the FCGH have uniform international funding targets (e.g., X% of GNI) or take another approach to dividing health funding responsibilities among members of the international community, such as specifically agreed figures that vary by country income or other (what?) issues related to country capacity (and potentially their own needs), and which might be included in an annex or protocol to the treaty? Should the FCGH have different responsibilities for OECD member (i.e., traditional “donors”) and other countries with international financing responsibilities under the treaty (e.g., emerging economic powers)? If so, how would the responsibilities differ? Should the FCGH have different levels of funding targets, with the proportion of GNI (or other measure of economic strength) increasing as the country becomes richer, with countries therefore having higher funding obligation as their wealth increases (e.g., 0.01% for lower-middle income countries, 0.05% for upper-middle income countries, 0.2% for high-income countries)? If so, what would these targets be?

Other possibilities for international funding targets and allocating responsibility: Are there other possible approaches to funding targets that an FCGH could incorporate that are not proposed above? What are they, and what are their advantages and disadvantages?

Financing framework and incomplete participation: How should the international funding obligations and the FCGH financing framework be structured to account for the high probability that not all countries, including possibly significant funders of global health (e.g., the United States) will ratify the FCGH, at least not initially? For example, if the international financing need is \$100 billion but countries that under financing formulas would be responsible for only \$60 billion ratify the FCGH, how to respond to the \$40 billion gap? Would the \$60 billion be allocated to all countries in need of funding, but at lower levels? Or would certain countries or needs be prioritized? What lessons might come from the Global Fund to Fight AIDS, Tuberculosis and Malaria and debates within and around the Fund about allocating insufficient resources?

Financing framework and non-FCGH parties: Might one way to respond to incomplete FCGH ratification be through side agreements with non-ratifying countries that stipulate their anticipated global health funding (or failing this, estimated like likely health financing), with the

remainder to be apportioned among FCGH ratifying countries? Might then a formula for international funding responsibilities be adjusted annually based on the number and capacity of FCGH parties and estimated funding of non-parties?

Financing framework shortfalls and innovative financing: What role might innovative financing have in covering the difference between identified need and international resources available through the FCGH financing framework in light of incomplete ratification?

Financing framework and growing participation: Would international funding obligations under an FCGH be affected in any way by the number of countries contributing to this financing (e.g., reducing obligations as more countries join? If a critical mass of countries join the FCGH financing framework, such international funding obligations be targeted to the full international health-related funding needs, but with international funding obligations for each FCGH party falling as additional countries ratify the treaty, reducing the health assistance required from current parties to meet the overall funding need?

Ensuring reliability of international health financing: What structures and safeguards can be developed or strengthened to ensure the long-term reliability of international health financing? Should the FCGH establish a global health trust fund (or other such mechanism), to be used to compensate for unmet commitments? How would this be structured, and could it be designed and financed in a way that does not reduce the availability of funds for current health needs? Should the FCGH include a strategy to collectively compensate for funding shortfalls from other parties to the FCGH, and if so, how might such a compensatory mechanism be designed?

Global Fund for Health: Should an FCGH establish a Global Fund for Health? Would this cover all aspects of health that the FCGH financial framework encompasses? What would the Global Fund for health contribute to enhanced sustainability and predictability of health funding?

Global Fund for Health governance: If there is a Global Fund for Health, what governance structures should it have? What is and is not working for the Global Fund to Fight AIDS, Tuberculosis and Malaria (and other global funding organizations) that could inform a Global Fund for Health?

International funding and national strategies: What measures can countries take to ensure that global health funding is aligned with their own strategies and priorities, and how can the FCGH support these measures? To what extent should the FCGH require that international funds be provided through national strategies and structures, rather than any separate bilateral programs? All funds? A certain proportion? Should the FCGH set a standard in this area?

Human rights and other responsibilities through international health funding: What responsibilities attach to global health funding (e.g., participation, equity, accountability),<sup>1</sup> and how could the FCGH help operationalize these responsibilities? What additional principles

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<sup>1</sup> See Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights, adopted in Maastricht, Netherlands, September 28, 2011, at para. 32, <http://www.maastrichtuniversity.nl/humanrights>.

(besides participation, equity, and accountability) might come into play vis-à-vis global health funding (e.g., harmonization and alignment), and how prescriptive should the FCGH be in operationalizing them? Or if all funding is through national structures and strategies, does this question become largely irrelevant?

International health funding and community involvement: What approaches to channeling global health resources to countries would be the most effective, equitable, and efficient for involving communities and civil society and achieving accountability? For example, a Global Fund for Health, or direct support to countries through sector wide approaches (SWAps), or a combination of approaches? What criteria can be used to measure and compare these (and other?) approaches?

International funding and equitable coverage: How can international health financing best complement national health financing schemes to maximize coverage and equity? How should the FCGH address this?

Vertical funding: What should be the role, if any, of disease-focused (vertical) funding streams in a revised global governance for health?

Accountability and international health funding: What are the best ways to ensure the effective, efficient, and accountable use of international health funding (e.g., anti-corruption policies, reporting requirements)? How should these requirements be designed (e.g., to have effective reporting without overburdening countries with reporting requirements, and developing processes to ensure that where problems are identified, countries and other partners take necessary steps to address them)?

Innovative financing mechanisms: What existing or proposed innovative financing mechanisms for health can the FCGH advance or institute? What level of funding would these mechanisms likely raise, and how might and should they impact traditional government assistance (from national foreign assistance budgets)? How can these mechanisms be designed to ensure that they do not compete with other international funding needs related to global social justice (e.g., climate change mitigation and adaptation measures)? Would funding raised through non-traditional sources be within or outside the scope of the FCGH financing framework?

Private health financing: What role should private financing (including from individual charitable giving, corporate charitable giving, foundations, and investors) have in meeting global health funding needs, and how might an FCGH address this? Are there any innovative financing approaches for health that would give a financial return on investments, thus encouraging health investments? Would these raise ethical and human rights, or other, concerns? Would such private financing be within or outside the scope of the FCGH financing framework?

Private health financing and state responsibilities: Should private health financing have any role in determining whether a country is meeting its international funding responsibility? If so, what sort of private health funding would count? Would it depend on the source and destination (use) of that funding? How would this work? Or would only public health funding count towards a state's own international funding responsibilities?

Direct budget support: What role, if any, should direct budget support have in revised global health structures? Would this be one way to address the question of how FCGH should set targets for health-related spending across sectors? Might direct budget support be available to countries if they have a national strategy and standards to health-related standards under the FCGH?

Tied aid: Should an FCGH address present conditions that development partners may place on international health assistance (e.g., requiring that countries receiving this assistance purchase technical assistance, equipment, or other requirements from the country providing the assistance)? If so, what conditions, and how should the FCGH address them? Should it prohibit any of these practices entirely?

International funding and national accountability: What structures will ensure that an FCGH that enables countries to receive more international health financing nevertheless enhances, and does not risk undermining, the accountability of governments to their own people?

Funding for global health organizations: Should the FCGH have a role in ensuring funding for health-related international actors (e.g., WHO, UNICEF [Global Fund])? Should their funding needs be incorporated into the FCGH's health funding targets? If so, how?

Beyond universal conditions for good health: Should an FCGH financing framework address in any way funding beyond the universal conditions for good health (or particularly effective health systems and underlying determinants of health)? The international assistance human rights obligations may extend beyond ensuring the core obligations are met for each right (see right to health questions, above). If the universal conditions of good health to which everyone is entitled is equated to these core obligations, does their need to be a corollary to the additional obligations in the FCGH financing framework? Or for FCGH purposes, would sufficient financing to ensure for everyone the conditions of good health be sufficient?