The WHO Council on the Economics of Health for All

Financing Health for All:
Increase, transform and redirect

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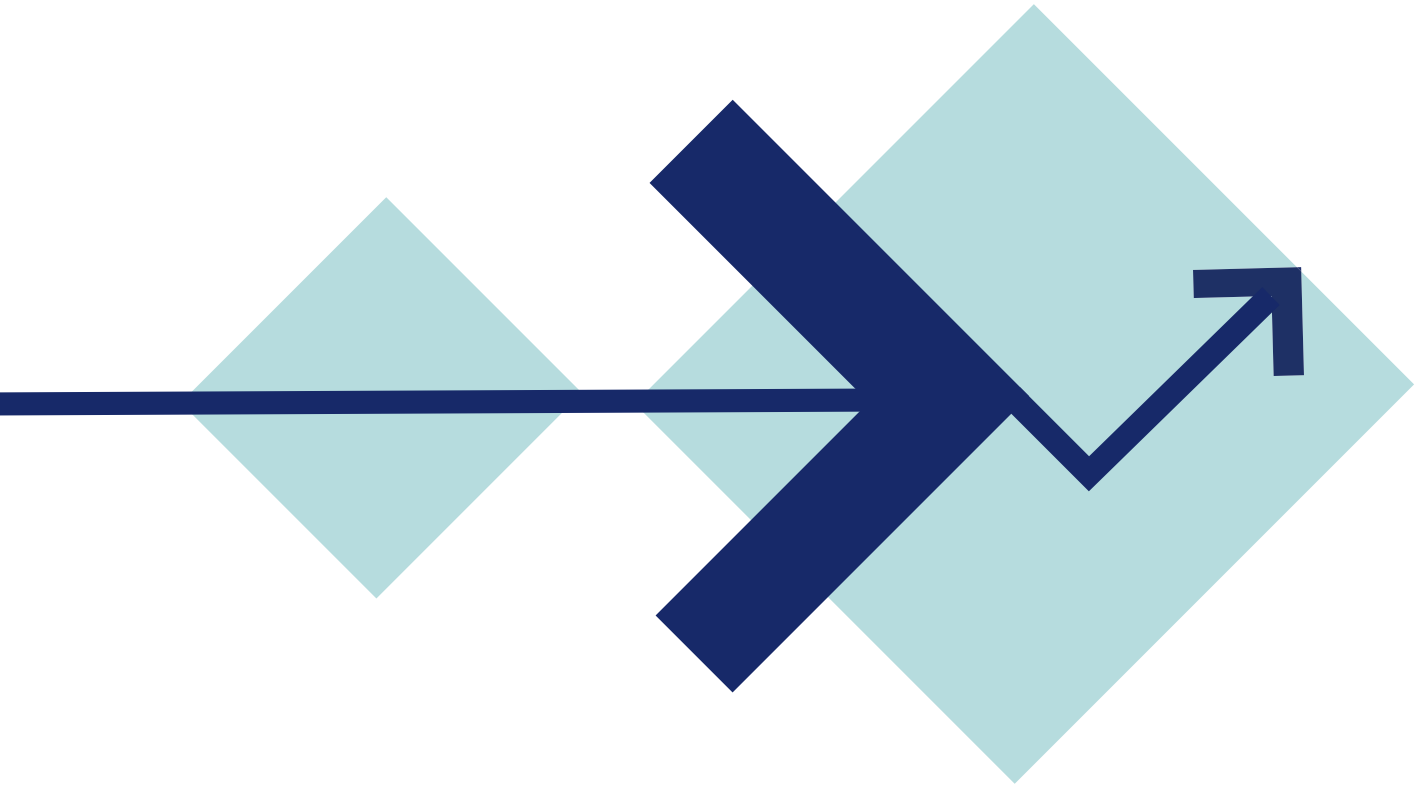

World Health Organization

The WHO Council on the Economics of Health for All

The world has been turned on its head by the coronavirus disease 2019 (COVID-19) pandemic. This has provided a stark wake-up call on the severe under-financing of health systems around the world. It has laid bare the inequalities and limitations in the capacities of countries at all levels of development to prevent major health crises or respond to them. But it doesn't have to be this way.

The new WHO Council on the Economics of Health for All recognizes that health and economies are deeply intertwined. Indeed, economic development could improve health and well-being. Leveraging its platform, the Council demands now, more than ever, the need for clear, ambitious goals to catalyze and focus investments and action, and to put priority on financing health as a long-term investment and not a short-term cost.

The Council has written this brief to focus on how to finance Health for All. There are two key dimensions: more finance and better finance. By moving to a new paradigm where health is an investment, governments can overcome internal fiscal limits and transform the relationship between public and private sectors, towards common goals. In other words, increasing financing is not enough: the quality of finance is crucial to delivering Health for All. This mission can be achieved by designing policies to reach Health for All now by realigning finance from all sectors and sources through conditionalities that fuel symbiotic gains in the public interest.

The Council stresses three pathways for action

1) Creation of fiscal space
2) Direction of investment
3) Governance of public and private finance.

For each, this brief proposes specific actions for governments and multilateral organizations. These actions should strengthen health systems to ensure access to life-saving and life-improving products and services; and to improve robust socioeconomic conditions across sectors that recognize the co-benefits of Health for All from a whole-of-government approach.

The COVID-19 crisis has opened a window for a radical redirection. The Council believes that it is vital to pursue a new paradigm that eliminates macroeconomic policies and assumptions that move us away from Health for All, and instead, find finance that achieves the mission of Health for All. To realize such aims, we must reverse – and expand – our perspective on health and economic development: from pursuing health for the economy, to redesigning the economy for health.

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SUMMARY OF KEY PRINCIPLES

MORE FINANCE

We need to increase the quantity of total finance to fund Health for All. Health is an investment not a cost, and therefore needs to be protected from budget cuts. The cost of inaction far outweighs that of action.

Creating fiscal space for Health for All

National governments should:

- reverse the harmful effects of an austerity approach to public administration and public finance reforms;
- harness the power of monetary policy to channel a larger volume of bank credit towards investment in Health for All;
- leverage procurement to expand budgets available for health.

Multilateral organizations should:

- negotiate debt relief for low- and middle-income countries;
- redirect the IMF's new special drawing rights towards investments that enable low- and lower-middle income countries to invest in health system transformation and purchase COVID-19 vaccines;
- push for and help to coordinate minimum corporate tax rates building on the newly negotiated rate of 15% or higher;
- advance the G20 reform of sovereign credit ratings by credit rating agencies at the global level.

BETTER FINANCE

The quality of finance matters: we need to improve the governance, design and delivery of public, private and donor finance to align with the goal of Health for All. Long-termism, mission setting and conditionalities are key to engendering symbiotic partnerships rather than wasteful fragmentation.

Directing investment towards Health for All

National governments should:

- forge symbiotic public-private partnerships through a combination of investment conditionalities, regulations and incentives;
- align public budgets and procurement contracts to channel funds towards public health goals and integrate departmental silos into a whole-of-government approach;
- create a newly unified taxonomy for financial market investments in the health sector with preferential tax and regulatory treatment linked to clear outcome measurements that focus on contributions to Health for All.

Multilateral organizations should:

- shift focus on loan conditionalities and grant co-financing requirements away from narrow disease-oriented spending obligations towards strategic cross-cutting system investments in borrower countries.

Governing public and private finance

- regulate the functioning and financing of private health markets;
- steer private health investment through explicit and implicit subsidies, particularly in health innovation and the extension of health services to underserved populations, and away from investments based on market segmentation that create inequity and inefficiency;
- strengthen and invest in existing mechanisms for global vaccine distribution (through COVAX) and technology transfer (through the COVID-19 Technology Access Pool).

1. Finance is not neutral: the need for more *and* better finance

Health is a fundamental human right, so the goal must be Health for All. In 1981, the then WHO Director-General, Dr Halfdan Mahler, defined Health for All as health and wellbeing within the reach of every citizen of every country globally. Health for All, he suggested, "implies the removal of the obstacles to health – that is to say, the elimination of malnutrition, ignorance, contaminated drinking water and unhygienic housing – quite as much as it does the solution of purely medical problems such as a lack of doctors, hospital beds, drugs and vaccines."[1] Crucially, Mahler argued that Health for All should be a primary objective of economic development and not merely one of the secondary means for economic development.

Forty years later, the experience of COVID-19 has demonstrated what happens when we ignore such wisdom. When we focus on the minimum health spending required for economic functioning rather than on the strategic investments needed to improve health outcomes over the long-term, we fail to foster healthy populations and resilient economies – as the Economic Resilience Panel of the Group of Seven (G7) has recently pointed out.[2] The consequences for lives, and for individual, community and economic well-being, are immense.

» The comparison with climate change is acute: the cost of inaction is greater than the cost of action now. «

The COVID-19 pandemic has proven to be a stark wake-up call to the limitations of current approaches. The cumulative financial costs of the COVID-19 pandemic in terms of lost output alone – not accounting for the value of lives lost – over the decade following 2020 are estimated to be around 54.7% of total global gross domestic product (GDP) in 2019, or $47.7 trillion.[3] An International Monetary Fund (IMF) report calling for a set of urgent actions to tackle the pandemic states that the "benefits of such measures at about $9 trillion far outweigh the costs which are estimated to be around $50 billion".[4] The comparison with climate change is acute: the cost of inaction is greater than the cost of action now. This requires a view of health as an investment not a cost, and one that requires long-term thinking not self-defeating short-term cost cutting.

» More money is not enough. «

In response to COVID-19, a number of leading international organizations and panels – including the IMF, the High-Level Independent Panel of the Group of 20 (G20), and the WHO Independent Panel for Pandemic Preparedness and Response – have made major calls for substantial additional investments in global health infrastructure, in tens of billions of dollars per annum.

This is clearly a necessary first step. However, more money is not enough. This is because finance is not neutral; the type of finance available can affect the directionality, and eventually the outcomes of the investments.[5] The structural problems above require not only adding finance into the system, but also addressing the shortcomings in existing structures and transforming them. Therefore, just as important as the amount of investment is the way in which the investment is designed and delivered to align with the goal of Health for All. Indeed, many of the dysfunctions in the current system stem from the ways in which finance has been structured and how priorities have been set. Thus, increasing funding must come with reforming funding mechanisms.

In the run-up to the G20 Rome Summit, we must recognize the critical challenge is both to increase the proportion of the finance available for health, and to govern it in a more directed and effective manner. Health for All can only be achieved through a realignment of public, private and donor finance (whether multilateral, bilateral or philanthropic). What is needed, therefore, is to:

a. increase the quantity of total finance to fund Health for All;
b. improve the governance, design and delivery – the quality – of public, private and donor finance to align with the goal of Health for All.

Thus, rather than invest in healthcare industries and regulate the market to realize important but marginal and often unequal gains for health, we must first set ourselves ambitious goals to achieve Health for All and then work towards the goals by designing financial architecture and an economic system that can deliver on this mission.[6] Without this radical redirection, we will never achieve Health for All.

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Achieving the goal of Health for All requires a public sector that is empowered to expand the fiscal space for health, direct financing from across sectors, and govern the financing in line with the goal. This Council brief explains why Health for All requires both more finance and a very different form of financing, with strong conditionalities between stakeholders; and renewed urgency and innovation in the policy tools used to govern it. Specifically, it focuses on the critical role of public finance, and its relationship with other sources of finance.

2. Beyond the usual myths

Standing in the way are two basic economic assumptions. The first relates to the quantity of finance. It concerns the notion of government expenditure as being constrained in the same way as household spending, and therefore beholden to the same rules of financial management and prudence. The second assumption relates to the quality of finance, that increased private investment in health would necessarily lead to better health outcomes.

Below, we argue that such assumptions are wrong, and dispelling these myths is indispensable to enhancing the quantity and quality of finance and creating the fiscal space to realize Health for All.

Myth 1

Government budgets are like household budgets

The assumption that no significant increase in government financing is possible without substantially raising taxes or risking bankruptcy or adverse macroeconomic consequences has conventionally constrained public spending on health. However, unlike households, governments can create money and they cannot go bankrupt. We see this during military build-ups and wars, when there seems to be no limit to the supply of finance. We also see this in the COVID-19 pandemic when sizable fiscal stimulus is generated and injected into the economy, but only after the pandemic has become too widespread to control.

Governments, especially those with monetary sovereignty, do not face any real fiscal limits on investments in health – or any other domain – owing to the unique way in which government debt effectively finances money creation.[7] In such contexts, the rules of the game for delivering Health for All already exist. However, political conditions often prevent governments from playing ball.

Many countries around the world do not enjoy monetary sovereignty in any substantive sense. Most governments, especially in the Global South, are constrained from increasing deficit spending on health for four main reasons:

a. There are internally imposed legal limits on the levels of budget deficits, national debt, or government expenditure, which is a constraint to long-term expenditure and policy goals.

b. There are externally imposed fiscal rules, in the form of austerity recommended or required by supranational groups, such as the European Union, or by international financial institutions such as the IMF, which have historically required governments to limit the size of their budgets or meet debt reduction targets in exchange for financial assistance in the event of an economic, financial or social crisis.

c. There is concern about the impact on credit rating and ability to access capital. Capital market players tend to have exaggerated concerns with sovereign debt viability, to the extent that even modest increases in fiscal deficits or national debt can lead to sell-offs of government bonds and national currencies.

d. It is difficult to raise tax revenues consistently in proportion to economic activity, owing to low corporate tax rates and corporate tax incentives[8], reliance on regressive value added taxes, tax avoidance by multinational corporations and high net-worth individuals[9], and trade and investment treaties that compromise public capacities to raise tax revenue[10].

None of these obstacles are insurmountable. They are the product of nationally and internationally designed rules rather than inherent economic laws. Changing the rules of the game is a fundamental priority of any strategy to deliver Health for All, and policymakers with the will have the ability to do this now. But even within existing rules, there is still room for manoeuvre. Governments in countries with less than absolute monetary sovereignty, for example Costa Rica and Cuba, have nonetheless created the fiscal space for consistent investments in health despite hard fiscal and balance of payments constraints.[11] [12] Such innovation could become more widespread were fiscal and policy environments made more hospitable.

» Changing the rules of the game is a fundamental priority of any strategy to deliver Health for All. «

Substantially increased and redirected public investment is fiscally and economically possible. It is an urgent political imperative if we are to ensure that basic conditions are met for humans to flourish, prepare for future risks and provide a firm financial footing for long-term leaps in medical innovation.

The challenge is to change mindsets within countries that impose internal constraints on spending. It is also to transform externally imposed conditionalities that hinder spending into positive conditionalities that support and promote Health for All.

Myth 2

Increased private investment in health would necessarily lead to better health outcomes

The private sector (both for-profit and not-for-profit) plays an important role in most of the world's health systems, and nearly all countries have "mixed health systems" – relying on a mix of public and private revenue sources and providers to fund and deliver health-related goods and services. Yet the short-term profit maximization that tends to characterize private finance runs counter to the long-term investments needed to foster Health for All.

» The current rules governing private finance are not delivering Health for All. Therefore we need new forms of governance. «

Capital investment for health is a deeply long-term and holistic endeavour that runs against the short-term profit maximization imperative. Investments in health are characterized by strong positive externalities. In other words, the gains to society extend beyond the direct return to investors because there are more than just monetizable benefits, which are reaped over a longer time horizon than financial markets have the patience for. Long-term financing is thus fundamental to securing Health for All that covers services and essential functions, including pandemic preparedness and response. Health for All and equitable access to products and services can put in practice the core principles of the WHO Constitution, a foundational legal document for global health governance. The Constitution calls for government action as well as broad-based social and economic measures to achieve the highest possible attainment of health for people. Ratified by countries around the world, it has stood the test of time more than 70 years since it came into force.[13,14]

However, the misalignment between the goals of private finance and those of public health has only widened as the global economy has become increasingly financialized and highly focused on maximizing shareholder value. Between 2007 and 2016, 19 of the largest pharmaceutical companies included in the Standard & Poor's 500 Index spent US$297 billion repurchasing their own shares, equivalent to 61% of their combined research and development (R&D) expenditures over this period.[15] This high level of share buyback has increased share prices and executive pay. The stupendous amount of finance spent on this represents a sizable opportunity cost for investing in innovative and productive activities instead.

Another problem is that large biopharmaceutical firms have increasingly disinvested from riskier early upstream research, focusing instead on acquiring products already in later clinical trial stages from biotech companies.[16] Biotech start-ups seek to project high profitability and boost market valuation, which exacerbates high drug pricing, further hampering access to innovative drugs.[17,18,19]

Owing to these global economic trends, private finance has not adequately provided funding that serves our collective health needs. Our failure to translate impressive technological progress into an effective global health response to the pandemic and protect the most vulnerable everywhere[20] is not only a moral failure[21], as WHO Director-General Dr Tedros Adhanom Ghebreyesus points out, but also a colossal failure of how we direct finance around health goals.

Private finance has a key role to play in advancing innovative products and services that will improve health outcomes, but the current rules governing private finance are not delivering Health for All. Therefore, we need new forms of governance. Public and private finance must be directed both in terms of what is being financed and how, by improving the design of symbiotic public-private partnerships for the public interest.

From status quo to the new paradigm

		Status quo	New paradigm
QUANTITY of finance	Assumption	Government expenditure is beholden to the same rules of financial management and prudence. While medium-term revenue and expenditure frameworks exist, they are not always operationalized into annual budget processes.	Government budgets function within an operationalized medium- or long-term framework that enables counter-cyclical spending to cushion societies where external shocks create needs for greater social spending. Health as an investment and not just an expenditure leads to long-term thinking.
	Implication	It is not possible to significantly increase government financing for health without substantially raising taxes or risking bankruptcy or adverse macroeconomic consequences.	Governments can overcome internal fiscal limits on investments for health; multilateral organizations and supranational groups can also help transform externally imposed limits.
QUALITY of finance	Assumption	Governments need to get out of the way to enable private investment to drive better health outcomes.	Existing finance – public, private and donor– needs reorienting around the mission of achieving Health for All.