United Nations A/67/302

General Assembly

Distr.: General
13 August 2012

Original: English

Sixty-seventh session
Item 70 (b) of the provisional agenda*
Promotion and protection of human rights: human rights questions, including alternative approaches for improving the effective enjoyment of human rights and fundamental freedoms

Right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretary-General

The Secretary-General has the honour to transmit to the members of the General Assembly the interim report prepared by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

* A/67/150.

12-46101 (E) 070912

Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Summary

The present report considers health financing in the context of the right to health. Full realization of the right to health is contingent upon the availability of adequate, equitable and sustainable financing for health, at both the domestic and international levels. The present report thus discusses the obligation of States to ensure adequate, equitable and sustainable domestic funding for health. The report addresses three critical areas in health financing: how States ensure adequate funds are available for health and the sources from which they raise these funds; how these funds are pooled; and how funds and resources are allocated within health systems towards ensuring universal access to good quality health facilities, goods and services. The Special Rapporteur also explores a number of substantive issues in this regard, including taxation and international funding for health; pooling mechanisms, including social health insurance; and allocative concerns, such as allocation of health funds and resources between primary, secondary, and tertiary health care and the resource divide between rural, remote and urban areas. The Special Rapporteur concludes his report with a set of recommendations on ensuring availability of adequate resources for health, pooling funds and allocating health funds equitably.

Contents

I. Introduction

1. Full realization of the right of everyone to the highest attainable standard of physical and mental health is contingent upon the availability of adequate, equitable and sustainable financing for health, at the domestic and international levels. The present report thus considers health financing in the context of the right to health. It discusses the obligation of States to ensure adequate, equitable and sustainable domestic funding for health and provides a conceptual framework for a right to health approach to health financing. In particular, it examines States' obligations to: ensure that adequate funds are available for health and to prioritize funding for health in national budgets; ensure equitable allocation of health funds and resources; and cooperate internationally to ensure the availability of sustainable international funding for health. The report also explores a number of substantive issues in this regard, including taxation and international funding for health; pooling mechanisms, including social health insurance; and allocative concerns, such as allocation of health funds and resources among primary, secondary, and tertiary health care and the resource divide between rural, remote and urban areas.

2. The contemporary landscape of health financing is characterized by persistent deficits and recurring challenges in financing health systems throughout the world. Public spending on health is too low in many States because of low budget prioritization for health and, in some cases, the unavailability of adequate public funds in absolute terms. Deficits in governance are also central to many States' failure to finance health adequately. Widespread corruption, tax loopholes and weak tax administration, characterized by high rates of tax evasion, often diminish States' capacity to raise revenues and allocate adequate public funds towards health. Many States are overly dependent on out-of-pocket payments from users and international funding to finance their health systems. International funding for health, however, is unpredictable and unsustainable, as the recent financial crisis has demonstrated, and out-of-pocket payments for health goods and services disproportionately impact on the poor, who must pay considerably larger proportions of their income on health care than wealthy patients. As a result, poor households often experience financial catastrophe and impoverishment due to out-of-pocket payments, resulting in a chilling effect that discourages many from seeking health care in the first place.

3. The right to health approach to health financing recognizes that an appropriate balance must be achieved between public and private financing for health, as well as between public and private administration of health facilities, goods and services. However, the global trend towards privatization in health systems poses significant risks to the equitable availability and accessibility of health facilities, goods and services, especially for the poor and other vulnerable or marginalized groups. In many cases, privatization has led to increased out-of-pocket payments for health goods and services, disproportionate investment in secondary and tertiary care sectors at the expense of primary health care, and increased disparity in the availability of health facilities, goods and services among rural, remote and urban areas.

4. The right to heath approach to health financing is especially critical in the light of these global trends and challenges in financing for health. It provides a framework to ensure the prioritization of health in State budgets, strengthened by the active and informed participation of affected individuals and communities in the formulation, implementation, monitoring and evaluation of health budgets. The

approach requires the equitable allocation of health funds and resources and recognizes the essential role international assistance plays in ensuring that adequate funds and technical resources are available for health globally, particularly for low-income States. The approach emphasizes the importance of prioritizing funding for primary health care in striking a balance among financing the primary, secondary and tertiary care sectors. Finally, the right to health approach recognizes the resource divide among rural, remote and urban areas and requires States to equitably allocate health funds and resources to rural and remote areas to ensure the availability and accessibility of good quality health facilities, goods and services in those areas based on the principle of non-discrimination.

II. Conceptual framework

5. Health financing is a central component of the right to health and instrumental to full realization of the right to health as articulated in article 12 of the International Covenant on Economic, Social and Cultural Rights, elaborated by General Comment No. 14 of the Committee on Economic, Social and Cultural Rights. Numerous other international and regional instruments, such as the Declaration of Alma-Ata adopted at the International Conference on Primary Health Care in 1978 and the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, adopted by the African Union in 2001, have also recognized the centrality of health financing to the stability and effectiveness of health systems and meeting international development goals. States therefore have an obligation to ensure adequate, equitable and sustainable funding for health. The primary concerns of health financing are: how States ensure that adequate funds are available for health and the sources from which they raise those funds; how the funds are pooled; and how funds and resources are allocated within health systems to ensure universal access to good quality health facilities, goods and services. The right to health approach provides a conceptual framework through which each of these key concerns may be addressed.

A. Ensuring adequate funds and prioritizing health financing

6. States have an obligation under the right to health to ensure that adequate funds are available for health and to prioritize financing for health in their budgets. That obligation is a necessary prerequisite to the realization of nearly every aspect of the right to health and required under States' obligation to make use of maximum available resources to ensure full realization of the right (General Comment No. 14, para. 33). As elaborated in General Comment No. 14, the right to health includes numerous entitlements, such as the availability of good quality health facilities and access to essential medicines, which require positive outlays by the State. Adequate public funding is necessary in order to realize these positive entitlements. Insufficient expenditure or misallocation of public resources may result in the lack of enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized, and amount to a violation of the State's obligation to fulfil the right to health (General Comment No. 14, para. 52).

7. In order to make use of maximum available resources, States must therefore take all necessary steps to raise adequate revenue and mobilize resources for health

and ensure that health financing is correspondingly prioritized in national and subnational budgets. Budget prioritization requires States to set aside a significant portion of general government expenditures towards spending on health and prioritize health alongside other core funding commitments, such as spending on education, social security and defence. States have a positive obligation in this regard to facilitate the active and informed participation of affected individuals and communities in the formulation, implementation, monitoring and evaluation of health budgets. States should also ensure transparency in the formulation, implementation, monitoring and evaluation of budgets for health. In order to ensure accountability for the implementation of national and subnational health budgets and related laws and policies, States should also develop and implement mechanisms that allow or provide for independent auditing and oversight of those instruments.

8. The obligation to prioritize funding or health in State budgets is closely linked to the principle of progressive realization, which establishes a specific and continuing obligation for States to move as expeditiously and effectively as possible towards the full realization of the right to health of all persons, without discrimination and taking into account constraints due to the limits of available resources (General Comment No. 14, paras. 30 and 31, and General Comment No. 3, para. 9). In order to facilitate progressive realization of the right to health for all persons, States should make use of the maximum available funds and resources to realize the right to health, which requires successfully raising funds and ensuring that they are allocated to health through budget prioritization. States unwilling to utilize the maximum of their available resources towards realization of the right to health are in violation of their obligations under the right (General Comment No. 14, para. 47).

9. The obligation to ensure that adequate funds are available for health and to prioritize financing for health should be informed by the core obligations of the right to health (General Comment No. 14, paras. 43-45). Core obligations are non-derogable and represent the minimum essential levels which States are required to meet in order to be in compliance with the right to health. Core obligations include positive and negative entitlements and address distributional and equity concerns. Positive entitlements, such as the obligation to ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water, often require States to utilize significant funds and resources towards their realization. Core obligations that establish negative entitlements and address distributional concerns, such as the obligation to ensure equitable allocation of, and non-discriminatory access to, good quality health facilities, goods and services assume the existence of such facilities, goods and services, and thus also require significant financial outlays from States. States should therefore ensure that adequate funds are available for health and prioritize financing for health in order to meet at least these core obligations of the right to health. In this sense, core obligations establish a funding baseline below which States would be considered in violation of their obligations under the right to health.

B. Pooling and allocation of health funds and resources

10. The obligation to ensure the equitable allocation of health facilities, goods and services for all persons without discrimination is a core obligation under the right to

health. The right to access good quality health facilities, goods and services on a non-discriminatory basis, particularly for vulnerable or marginalized groups, including, among others, ethnic, racial, religious and sexual minority groups, women, children and the poor, constitutes an additional core obligation for States. In order to meet these core obligations under the right to health, States must ensure the equitable allocation of health funds and resources towards achieving universal access to good quality health facilities, goods and services, in accordance with the principle of non-discrimination and with special attention to the needs of vulnerable or marginalized populations. Inequitable allocation of health funds and resources may lead to indirect discrimination within health systems, particularly with respect to vulnerable or marginalized groups who often lack the social and political means to challenge the inequitable allocation of public resources (General Comment No. 14, para. 19).

11. Equitable allocation of funds and resources for health may be achieved through the pooling of health funds collected through prepayment schemes. Pooling allows for the cross-subsidization of financial risks associated with health care among different groups across large populations and the transfer of health funds from the rich to the poor and the healthy to the sick. Cross-subsidization of financial risks thus protects vulnerable or marginalized groups, such as the poor, from catastrophic health expenditures and ensures access to good quality health facilities, goods and services that may otherwise be financially inaccessible. Pooling of funds for health in order to facilitate the cross-subsidization of health and financial risks is thus an essential method by which States may ensure the equitable allocation of health funds and resources as required under the right to health.

12. General Comment No. 14 of the Committee on Economic, Social and Cultural Rights recognizes that investments in health should not disproportionately favour expensive curative care services, which are often accessible only to a small fraction of the population, over primary and preventive health care, which benefit a far larger part of the population. Primary health-care services are generally less costly than secondary and tertiary care, which by definition require health-care workers with specialized training, sophisticated diagnostic equipment and significant physical health infrastructure. Investment in primary health care is thus more cost-efficient in the long run because it prevents illness and promotes general health, which reduces the need for more costly secondary and tertiary care.[1] The resulting savings may be reinvested in the health system, possibly in the form of additional health-care subsidies for the poor. The right to health thus requires an efficient allocation of health funds and resources between primary, secondary and tertiary care sectors, with an emphasis on primary health care.

13. States should allocate health funds and resources towards ensuring good quality health facilities, goods and services are available and easily accessible for rural and remote populations. The significant disparity in health outcomes among rural and remote populations and their urban counterparts in many States is well documented.[2] This is due to a number of factors, including inadequate investment in

[1] Rifat Atun, *What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services?* (Copenhagen, WHO, 2004), pp. 6-8.

[2] Juan Antonio Casas et al., “Health Disparities in Latin America and the Caribbean: The Role of Social and Economic Determinants”, *Equity and Health*, Occasional Paper No. 8 (Pan American Health Organization, 2008), pp. 37 and 42.

health infrastructure and the lack of qualified health workers in rural and remote areas. This problem is compounded by the fact that rural and remote populations often comprise vulnerable or marginalized groups, such as the poor, ethnic and racial minorities, and indigenous populations, who tend to be poorer than those in urban areas.[3] In accordance with the right to health approach, States must therefore ensure health funds and resources are equitably allocated among rural, remote and urban areas.

C. International assistance

14. The right to health approach recognizes the essential role that international assistance plays in ensuring that adequate funds and resources are available for health globally, particularly in developing States. In the spirit of Article 56 of the Charter of the United Nations, articles 2 (1), 12, 22 and 23 of the International Covenant on Economic, Social and Cultural Rights, and the Declaration of Alma-Ata, States should recognize the essential role of international cooperation and comply with their commitments to take joint and separate action to achieve full realization of the right to health globally. In this regard, the Declaration of Alma-Ata proclaims that gross inequalities in health among various groups, particularly between developed and developing countries, but within countries as well, is politically, socially and economically unacceptable and must be of common concern to all States. The right to health approach requires States to cooperate internationally in order to ensure the availability of sustainable international funding for health. This includes a responsibility to pool funds internationally from compulsory contributions by States, based upon their ability to pay, and allocate funds to States, based upon their need, in order to achieve cross-subsidization of resources for health globally.

III. Substantive issues in health financing

A. Ensuring adequate funds for health

1. Taxation

15. Taxation is a common method through which States raise public funds for health by prepayments, as opposed to out-of-pocket payments at the point of service delivery. Several States have achieved universal (or near universal) access to health facilities, goods and services through the utilization of tax revenue to finance health.[4] Taxation provides States access to a variety of sources from which to fund health care, including taxes on personal income, property, wages, manufacturing, sales, trade, capital gains and financial transactions. Taxation allows States to pool funds and spread financial risks associated with health care across the entire population. Taxation is thus an instrument with which States may ensure adequate funds are available for health through progressive financing, as required under the right to health.

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[3] World Health Organization, *World Health Statistics 2008*, Inequities in health care and health outcome, pp. 92-95.

[4] WHO, *World Health Report Health Systems Financing: The path to universal coverage* (Geneva, 2010), p. 6.

16. The right to health approach to health financing requires that taxation to fund health be levied progressively in order to ensure equitable revenue generation. Progressive taxation requires taxpayers to contribute according to their ability to pay. For example, progressive income taxation requires wealthy taxpayers to contribute a higher percentage of their income than poorer taxpayers. In contrast, regressive taxation involves greater proportional contributions from those with less financial resources than from wealthier taxpayers. Regressive taxation is thus an inequitable financing mechanism for health and not in accordance with the right to health.

17. Many States utilize consumption taxes, such as excise and valued-added taxes (VAT), to raise general revenue and provide funds for health. VAT has been adopted in close to 140 States and now accounts for substantial proportions of revenue collection in many States, particularly in the developing world.[5] Some States have experienced success in setting aside specific portions of revenue raised from VAT for spending on health.[6] The so-called sin taxes — excise taxes levied on socially harmful goods such as alcohol, junk foods or tobacco — are also used to raise funds for health, and may be specifically earmarked for health spending. Sin taxes may serve a secondary purpose of discouraging unhealthy behaviours by raising the cost of consumption, which may promote overall public health in some circumstances.[7]

18. Under the right to health, consumption taxes must not disproportionately burden the poor. However, VAT may operate regressively, with the poor spending larger portions of their income on VAT than the wealthy.[8] Raising the threshold for profits below which enterprises are not subject to VAT and distinguishing between luxury and necessity goods has been shown to increase the progressivity of VAT.[9] Sin taxes may also be regressive[10] and should be applied proportionately so that less expensive products used by the poor are taxed less than more expensive products used by the wealthy. Attention must also be paid to the financial impact sin taxes have on poor communities, who may purchase taxed products with greater frequency. VAT, sin taxes and other forms of consumption taxes that are primarily regressive are not in accordance with the obligation of States to respect the right to health.

19. International tax competition has proliferated as a result of globalization and the increasing mobility of capital and its corresponding elasticity in response to taxation. Tax competition triggers a race to the bottom, wherein States attempt to

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[5] Michael Keen, "What Do (and Don't) We Know about the Value Added Tax? A Review of Richard M. Bird and Pierre-Pascal Gendron's *The VAT in Developing and Transitional Countries*", *Journal of Economic Literature*, vol. 47, issue 1, 2009, p. 159.

[6] Ghana and Chile have set aside 2.5 and 1 per cent, respectively, of revenues from value-added taxes to fund health: WHO, *Health Systems Financing: The path to universal coverage* (Geneva, 2010), p. 27.

[7] See WHO, Regional Office for South-East Asia, *Tobacco Taxation and Innovative Health-care Financing* (New Delhi, 2012).

[8] Nahida Faridy and Tapan Sarker, "Who really pays Value Added Tax (VAT) in developing countries? Empirical evidence from Bangladesh", *International Journal of Modeling and Optimization*, vol. 11 (2011); L. Sekwati and Brothers W. Malema, "Potential Impact of the Increase in VAT on Poor Households in Botswana", *International Journal of Economics and Research*, vol. 2, issue 1 (2011).

[9] Nahida Faridy and Tapan Sarker, p. 194.

[10] Christopher Snowdon, "The Wages of Sin Taxes", Adam Smith Institute (London, 2012), pp. 51-54.

attract foreign direct investment through tax incentives and other tax abatements for foreign investors and low or non-existent trade and capital gains taxes.[11] Tax competition reduces tax revenue in developing States and weakens their ability to raise sufficient funds to finance health.[12] In some developing countries, revenue lost from tax incentives amounted to nearly twice the budget for health.[13] High-income States have also experienced diminished tax revenue from taxation of capital income as a result of tax liberalization in developing States.[14] Multinational corporations have shifted their assets offshore to take advantage of tax havens and engaged in transfer pricing in order to claim profits in low-tax jurisdictions and avoid paying higher taxes in the States in which they are domiciled.[15]

20. States should ensure that tax liberalization policies resulting from international tax competition do not result in reduced public funding for health. However, lower tax revenue and diminished tax bases resulting from tax abatements for foreign investors and low or non-existent trade and capital gains taxes are likely to weaken States' ability to raise adequate funds for health, as required by the right to health. States and international financial institutions should therefore avoid promoting tax competition through free-trade agreements, investment treaties and conditional lending if such instruments and policies threaten to reduce the availability of tax-based funding for health in developing States.

21. International tax competition has placed the burden of taxation in many States on consumption and income or wage-based taxes rather than taxes on business profits and capital income.[16] Income and wage-based taxes, however, are difficult to collect in States with large informal sectors, including most of the developing world. These States incur significant administrative costs associated with tax collection from the informal sector, experience high levels of tax evasion and face difficulties in maximizing income tax bases.[17] It is estimated, however, that taxing the informal sector could increase tax revenue by 35 to 55 per cent in some States.[18] Innovative approaches to tax collection from the informal sector, including through State cooperation with informal workers' associations, have been successful in some instances and hold promise for increasing tax bases in States with large informal sectors.[18] In order to ensure the availability of adequate, equitable and sustainable funding for health, as required by the right to health, States should not be left, as a result of tax liberalization policies, to rely primarily on tax revenue from sectors that are difficult to regulate. However, in order to promote equity in health funding through taxation, and given the size of potential revenue, States should make efforts

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[11] International Confederation of Free Trade Unions, *Having Their Cake and Eating It Too: The Big Corporate Tax Break* (Brussels, 2006), pp. 16-17.

[12] Marta Ruiz, Rachel Sharpe and María José Romero, *Approaches and Impacts IFI tax policy in developing countries*, available from: http://eurodad.org/?p=4564.

[13] Tax Justice Network and ActionAid International, *Tax competition in East Africa: a race to the bottom?* (April 2012), p. 12.

[14] See Howard Wachtel, "Tax Distortion in the Global Economy", Paper presented at the Global Crisis Seminar, Transnational Institute (Amsterdam, February 2002).

[15] Ibid.

[16] Allison Christians, "Fair Taxation as a Basic Human Right", *International Review of Constitutionalism*, University of Wisconsin Legal Studies Research Paper No. 1066 (November 2009), p. 20.

[17] International Tax Compact, *Addressing tax evasion and tax avoidance in developing countries* (Eschborn, Germany, December 2010).

[18] Ibid.

to collect taxes from businesses in the informal sector, contingent upon the provision of State services and other benefits associated with being a taxable entity.

2. International funding

22. Under the right to health, States have an obligation to cooperate internationally towards ensuring the availability of sustainable international funding for health. International assistance is among the main sources of funding for health in many developing States. Many of these States lack sufficient health funds and resources to meet domestic health needs and thus depend heavily upon international assistance. Moreover, given the level and rate of development in some low-income States, they will be unable to raise adequate funds domestically to meet domestic health needs in the near future. Realization of the right to health in the developing world is thus also dependent upon the availability of sustainable international funding for health, which should ultimately be realized through an obligatory, treaty-based regime founded upon the principle of global solidarity.

23. Existing international funding practices present a number of problems. Donor States, multilateral donor institutions, international financial institutions and other funders continue to engage in practices that undermine full realization of the right to health. In many instances, funders fail to focus their activities on the health needs of recipient States and direct assistance towards health systems development, inadequately incorporate the inputs of affected communities in their activities, and attach conditionalities to the receipt of funding for health.

24. International funders should ensure that their activities respect the right to health. The activities of funders should therefore be directed towards meeting domestic health needs and promoting the development of self-sustaining interventions and health systems. Towards that end, donors should incorporate the participation of civil society and affected communities in their activities in order to ensure health interventions are responsive and sustainable and in accordance with the right to health. Donors should also abstain from attaching pernicious conditionalities to the receipt of international assistance.

25. International donors tend to focus on short-term interventions addressing specific health issues without adequate focus on strengthening health systems.[19] In some States, this has resulted in an overdependence on international funding and the underdevelopment of domestic health systems, many of which are incapable of meeting even basic health needs in the absence of international assistance. Moreover, States that have become overdependent on international funding for health may be less likely to prioritize health in their budgets, which is critical to the long-term sustainability of domestic health systems.

26. Many low-income States lack adequate funds and resources for health in absolute terms. Other States may at times face severe resource shortfalls that require international funding to resolve. However, in many cases, even low-income States may mobilize funds beyond those currently allocated for health through budget prioritization. Moreover, some States possess sufficient resources but have simply failed to mobilize and allocate adequate funds for health equitably. While the right to health approach requires States to cooperate internationally towards ensuring the

[19] P. Prakongsai et al., “Can earmarking mobilize and sustain resources to the health sector?”, *Bulletin of the World Health Organization*, vol. 86, No. 11 (Geneva, November 2008), p. 898.

availability of sustainable international funding for health, recipient States should also take all possible steps to ensure domestic resource self-sufficiency in order to avoid overdependence on international funding.

27. International assistance is often conditioned on recipient States adopting policies in line with the social, political or economic interests and ideologies of donors. Conditional aid may require recipient States to implement specific health strategies preferred by donors in order to obtain funds. Donor-driven strategies, however, may not be aligned with the health needs of recipient States and may instead distort domestic health priorities.[20] For example, donor funds earmarked for abstinence-only programmes in AIDS-affected countries promote the benefits of abstaining from sexual activity until marriage, but are required to withhold valuable information about the health benefits of condoms and contraception on the premise that such information contradicts the message of abstinence.[21] Studies have found abstinence-only programmes to be ineffective in preventing HIV and that withholding information about contraceptives places young people at increased risk of pregnancy and sexually transmitted infections.[22]

28. Another bilateral assistance fund directed towards combating HIV/AIDS, does not grant funds to organizations that do not have a policy explicitly opposing sex work.[23] However, sex workers are among the most high-risk groups for HIV and have played a critical role in combating HIV transmission. They must therefore be fully integrated into all HIV prevention efforts in order to ensure that interventions are responsive, sustainable and in line with the right to health. Donor States should therefore not be driven by social, political or economic ideologies when designing and implementing health interventions. In accordance with the right to health, donors should instead ensure that they implement the most effective health strategies available given the needs of the recipient State as articulated by local stakeholders.

29. In many instances, as a result of macroeconomic conditions attached to loans from international financial institutions, international assistance for health does not result in increased public spending on health, but is instead used by States to build up reserves.[24] Studies indicate that each additional $1 of aid for health adds only approximately $0.37 to health budgets in recipient States, and less than $0.01 in States under the advice of the International Monetary Fund.[25] For example, in order to meet health-related Millennium Development Goals, one State would have needed to increase its total revenue by 20 per cent and allocate 15 per cent of the increased amount towards health.[26] However, conditions attached to macroeconomic loans required the Ministry of Health to freeze health budgets moving forward.[26] Restrictions on State health spending of this nature infringe upon the right to health

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[20] Gorik Ooms et al., “Financing the Millennium Development Goals for health and beyond: sustaining the ‘Big Push’”, *Globalization and Health*, vol. 6, issue 17 (October 2010), p. 3.

[21] Elaine Murphy et al., “Was the ‘ABC’ Approach (Abstinence, Being Faithful, Using Condoms) Responsible for Uganda’s Decline in HIV?”, *PLoS Medicine*, vol. 3, No. 9 (September 2006), p. 1445.

[22] Heather Boonstra, “Advancing Sexuality Education in Developing Countries: Evidence and Implications”, *Guttmacher Policy Review*, Summer 2011, vol. 14, No. 3, p. 19.

[23] See footnote 21.

[24] See footnote 20.

[25] David Stuckler et al., “International Monetary Fund and Aid Displacement”, *International Journal of Health Services*, vol. 41, No. 1 (2011), p. 67, 70.

[26] Gorik Ooms et al., p. 4.

because they disproportionately impact the poor, who rely more heavily on the availability of public health facilities, goods, and services than other groups.

Pooling international funds for health

30. International funding for health is inconsistent and insecure. Donor interventions are often fragmented and poorly coordinated. The insecurity of international funding has been highlighted by the recent global financial crisis, which led, in part, to the cancellation of Round 11 of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Inconsistent international funding for health places States that rely heavily on international assistance at risk of severe funding shortfalls during global economic downturns. Fragmentation of donor interventions is illustrated by the situation in one State, where 50 donors operate, 19 of which directly provide assistance to the Government through budget support and 31 of which provide aid through isolated individual mechanisms or agreements[27]. Poorly coordinated donor interventions lead to redundant spending, inefficient allocation of health funds and resources, and the failure of initiatives to address domestic health needs effectively.

31. In order to cooperate towards ensuring the availability of sustainable international funding for health as required by the right to health, States should pool funds for health internationally. International cooperation in the form of a single global pool or multiple coordinated pools would facilitate the cross-subsidization of health systems in developing States and allow for the coordination of donor activities in recipient States. International cooperation in the form of global pooling of funds for health is critically needed at this time in order to meet the global disease burden and promote the development of sustainable domestic health systems.

32. The Global Fund and the International Drug Purchase Facility (UNITAID) represent two successful examples of global pooling that have had significant positive impacts in the fight against HIV/AIDS, tuberculosis and malaria globally. Both the Global Fund and UNITAID have collected and pooled significant resources from donor States and through innovative financing mechanisms and allocated funds and resources based on need.[28] Under programmes funded by the Global Fund, 3.3 million people living with HIV received antiretroviral treatments in 2011 alone[29] and 9.3 million smear-positive cases of tuberculosis were detected and treated between 2010 and 2012.[30] UNITAID has provided child-friendly treatment to 400,000 children living with HIV and delivered 46 million artemisinin-based combination therapies to first-line purchasers of malaria medications.[31] Moreover, in contrast to bilateral aid and assistance from international financial institutions, the Global Fund and UNITAID have removed conditionalities and increased levels of transparency and

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[27] Karen McColl, “Europe Told to Deliver More Aid for Health”, *The Lancet*, vol. 371, No. 9630 (2008), p. 2073.

[28] See United Nations, *Innovative Financing for Development*, The I-8 Group Leading Innovative Financing for Equity (New York, 2009).

[29] The Global Fund to Fight AIDS, Tuberculosis and Malaria, Global Fund Results Fact Sheet End-2011 (2011), p. 1.

[30] The Global Fund to Fight AIDS, Tuberculosis and Malaria, News Release: Global Fund Results Show Broad Gains against HIV, 23 July 2012, available from: www.theglobalfund.org/en/mediacenter/newsreleases.

[31] UNITAID, *Annual Report 2011* (WHO, December 2011), available from: www.unitaid.eu/images/Annual_Report_2011/UNITAID_AR2011_EN.pdf.

stakeholder participation in funding processes and programmatic activities in accordance with the right to health approach to health financing.[32]

33. In order to shift the global paradigm of international assistance for health from a donor-based charity regime towards an obligatory system based on the principle of solidarity, global pooling mechanisms should be founded upon international or regional treaties under which States incur legal obligations to contribute to the pool according to their ability to pay and through which funds are allocated based upon need. Such a shift is necessary in order to ensure the availability of sustainable international funding as required by the right to health. In order to promote ownership and accountability within the regime, each State would contribute to the fund regardless of its income level and all funding and programmatic processes must be transparent and include the active and informed participation of civil society and affected communities. In order to realize the right to health globally, States should therefore take all necessary steps towards the development of treaty-based global pooling mechanisms, comprising compulsory progressive contributions allocated based upon need and driven by transparent, participatory processes.

B. Pooling of domestic funds for health

34. The right to health requires States to ensure that good quality health facilities, goods and services are accessible to all without discrimination. To respect and fulfil the right to health, States should remove financial barriers that restrict access to health care. Accordingly, the right to health requires States to ensure that the ability to pay does not affect an individual's decision whether to access necessary health goods and services. Health systems funded by prepayments, such as tax- and compulsory insurance-based systems, reduce financial barriers through the pooling of funds collected prior to the point of service delivery. Pooling is a method by which funds for health are accumulated and managed in order to spread the financial risk of illness across all members of a pool, over a period of time.[33] Pooling promotes equitable financing for health by facilitating cross-subsidies from healthy to unhealthy and from wealthy to poor members of the pool and across the life cycles of individual members. Pooling also increases efficiency by promoting more equitable improvements in health across populations[34] and hedging against risks associated with uncertainties related to future health and financial capacity.[35]

35. The primary financial barrier to accessing health care in most States is out-of-pocket payments. Out-of-pocket payments are payments for health goods and services made by the user at the point of service delivery. In 2007, in 33 mostly low-income countries, out-of-pocket payments represented more than 50 per cent of total

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[32] Gian Luca Burci, "Public/Private Partnerships in the Public Health Sector", *International Organizations Law Review*, vol. 6 (2009), pp. 359-382.

[33] WHO, *World Health Report 2000*, "Health Systems: Improving Performance" (Geneva, 2000), p. 99.

[34] Peter Smith and Sophie Witter, "Risk Pooling in Health Care Financing: The Implications for Health System Performance", Health, Nutrition and Population Discussion Paper (Washington, D.C., World Bank, 2004), p. 4.

[35] Chris James and William Savedoff, "Risk pooling and redistribution in health care: an empirical analysis of attitudes toward solidarity", *World Health Report* (2010), Background Paper No. 5, available from: www.who.int/healthsystems/topics/financing/healthreport.

health expenditures.[36] Out-of-pocket payments may also lead to catastrophic health expenditures.[37] Every year approximately 100 million people, in mostly low-income countries, are pushed into poverty owing to excessive or catastrophic spending on health care.[38] At a minimum, the right to health requires States to reduce out-of-pocket payments for health and eliminate those payments that disproportionately impact on the poor. The pooling of prepayments for health goods and services reduces out-of-pocket payments for all users and may eliminate these payments for the poor.[39] Pooling thus insulates users against catastrophic health expenditures through the cross-subsidization of financial risks associated with expenditures on health.

36. Single payer systems with a single risk pool or multiple payer systems with multiple risk pools reduce financial barriers to accessing health facilities, goods and services, as required under the right to health approach. In single payer systems, one organization collects and pools funds and purchases services for the entire population. In most cases, all pool members within the system are provided access to the same health goods and services.[40] Owing to its ability to generate and raise funds, through mechanisms such as taxation, and compulsorily enrol large numbers of people, the Government, in most cases, administers the pool and purchases health goods and services in a single payer system. Single risk pools promote equitable access to health facilities, goods and services in accordance with the right to health approach by allowing for greater cross-subsidization than systems with smaller, fragmented pools. Single payer systems are thus effective in promoting universal access to health facilities, goods and services, reducing out-of-pocket payments, and insulating users from catastrophic health expenditures.

37. Private health-care providers may also operate alongside single payer systems. Private hospitals and doctors may be allowed to opt out of the publicly funded system and collect private fees from patients. As a result, the public system may be left underfunded, if users are exempt from contributions upon exit from the system, and understaffed, if large numbers of health workers exit the public system for higher pay in the private sector. This, in turn, may reduce the overall quality of public health facilities, goods and services. The poor and other groups who are unable to exit the public system because they cannot afford private care are the most negatively affected under those circumstances. A parallel private health system may thus result in infringements of the right to health because it may reduce overall access to and quality of health facilities, goods and services in the public sector.

38. In contrast to single payer systems, multiple payer systems typically comprise multiple insurance pools operated by competing private insurers, but do not rule out the possibility of government-run insurance programmes. The existence of multiple pools allows for packages of health goods and services offered by insurers to be more specifically tailored to the needs of different groups. Insurers in multiple payer systems raise funds through contributory mechanisms such as insurance premiums.

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[36] WHO, *World Health Report*, "Health Systems Financing: The path to universal coverage" (Geneva, 2010), p. 12.

[37] Ke Xu et al., "Household catastrophic health expenditure: a multicountry analysis", *The Lancet*, vol. 362, Issue 9378 (July 2003), pp. 111-117.

[38] WHO, *World Health Report*, "Health Systems Financing: The path to universal coverage", p. 8.

[39] Margaret Kruk et al., "Borrowing And Selling To Pay For Health Care In Low- And Middle-Income Countries", *Health Affairs*, vol. 28, No. 4 (2009), pp. 1056, 1063.

[40] Gerald F. Anderson and Peter Hussey, *Special Issues with Single-Payer Health Insurance Systems*, Health, Nutrition and Population (HNP) Discussion Paper (World Bank, 2004), p. 28.

However, premiums may be regressive, and thus inequitable, if they are not based on an individual's ability to pay, but rather linked solely to individual health risks. Risk-rating premiums in this way also results in adverse selection, wherein insurers screen applicants in order to exclude high-risk individuals from coverage.[41] Adverse selection leads to the exclusion of the poor and individuals with pre-existing illnesses from insurance pools, including the poor, and results in smaller, less diverse pools, which weakens the effects of cross-subsidization.[42] Regressive premiums and practices leading to adverse selection infringe upon the right to health to the extent that they discriminate against vulnerable or marginalized groups and reduce overall access to good quality health facilities, goods and services.

39. In order to reduce the negative effects of regressive premiums and adverse selection within a multiple payer system, participation in a health insurance pool should be compulsory. Compulsory participation ensures universal insurance coverage and allows for the use of equalization mechanisms, or risk adjusters, to facilitate cross-subsidization between different pools. For instance, a percentage of the funds of low-risk pools may be required by law to be transferred to high-risk pools under particular circumstances.[43] States may also directly regulate private insurers by, among other measures, limiting the information they are permitted to collect about potential pool members, restricting the manner in which premiums are calculated, and prohibiting the exclusion of individuals with pre-existing health conditions from insurance pools. Government insurance programmes should also provide coverage for the poor or other vulnerable or marginalized groups who are excluded from private pools owing to their inability to pay, because of pre-existing health conditions or because they are high-risk of poor health. For example, individuals employed in dangerous work may be denied health insurance because of increased health risks and workers in low-paying jobs may be unable to afford high premiums charged by private insurers. Under the right to health, States have an obligation to ensure that these individuals have access to health services through health insurance. This obligation may be met through appropriate regulation of private health insurers, the subsidization of private insurance premiums or the availability of government-run insurance programmes.

40. At a more targeted level, community-based health insurance pools funds collected from members of small communities and includes a variety of financing mechanisms, such as community health funds, mutual health organizations and rural health insurance. Community-based health insurance programmes may operate in complement or supplement to single or multiple payer systems. These programmes generally exist in poor and other vulnerable or marginalized communities and may increase access to health facilities, goods and services for vulnerable or marginalized groups and facilitate the participation of communities in decision-making processes affecting their health.[44]

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[41] Elias Mossialos and Sarah Thomson, *Voluntary health insurance in the European Union*, European Observatory on Health Systems and Policies (Belgium, WHO, 2004), pp. 107, 108.

[42] Robert Carroll and Phillip Swagel, "The Intersection of Tax and Health Care Policy", *National Tax Journal*, vol. LXII, No. 3 (Washington, D.C., 2009), p. 568.

[43] Naoki Ikegami and John Campbell, "Medical Care in Japan", *The New England Journal of Medicine*, vol. 333, No. 19 (1995), pp. 1295-1299.

[44] See Werner Soors et al., "Community Health Insurance and Universal Coverage: Multiple paths many rivers to cross", *World Health Report* (2010), Background Paper No. 48 (Geneva, 2010).

41. However, community-based health insurance programmes may be unable to achieve effective cross-subsidization owing to the size and constitution of community pools. In most cases, community-based pools are very small in size and comprise poor individuals at high risk for illness; financial and health risks therefore may not be effectively subsidized across pool members. Contributions to community-based health insurance have also been shown to be regressive in some instances, as contributions are made as flat amounts and income-rated contributions and exemptions for the poor have been difficult to implement owing to challenges in determining household incomes.[45] Moreover, the costs associated with collecting contributions from populations in rural areas and informal urban areas are high relative to the revenue generated from contributions. Thus, while in some cases community-based insurance programmes may be used to increase access to health facilities, goods and services for vulnerable or marginalized groups and facilitate the participation of communities in health-related decision-making processes, they are not a substitute for larger, more centralized pooling mechanisms.

Social health insurance

42. Social health insurance is a pooling mechanism funded by compulsory prepayments collected through individual and organizational contributions supplemented by taxation. Social health insurance programmes are generally administered by the State, which uses funds raised through compulsory contributions and tax revenues to purchase health goods and services for the insured. In contrast to pooling mechanisms that comprise smaller, fragmented pools, social health insurance programmes establish sufficiently large pools, through compulsory contributions, to facilitate effective cross-subsidization of financial and health risks across large populations.[46] Social health insurance thus increases utilization of and promotes equity in access to health facilities, goods and services and affords higher levels of financial protection for the poor.[47] Social health insurance programmes may take the form of single payer systems, which tend to encourage efficient health spending and lower administrative costs, or multiple payer systems, which encourage competition and allow other entities to purchase health services. Social health insurance programmes are therefore one example of a pooling mechanism that promotes the realization of the right to health.

43. Social health insurance programmes must be funded through compulsory contributions in the form of prepayments in order to achieve universal access to good quality health facilities, goods and services and robust cross-subsidization of financial and health risks. Voluntary contribution schemes may help raise funds in the absence of widespread payment and pooling, familiarize individuals with the benefits of insurance, and serve as an intermediate funding mechanism that eases the transition towards a more inclusive compulsory contribution scheme, but they do not necessarily increase rates of insurance coverage because enrolment is not compulsory. In contrast to a system of voluntary contributions, compulsory

[45] See Anne Mills et al., “Equity in financing and use of health care in Ghana, South Africa, and Tanzania: implications for paths to universal coverage”, *The Lancet*, vol. 380, Issue 9837 (2012), pp. 126-133.

[46] Pablo Gottret and George Schieber, “Health financing revisited: a practitioner’s guide” (World Bank, Washington, D.C., 2006), pp. 58-59.

[47] Regional Committee for the Eastern Mediterranean, “Technical Paper: The impact of health expenditure on households and options for alternative financing” (WHO, 2004), p. 9.

contribution schemes prevent wealthy and healthy members from opting out of the programme and diluting the size of the pool at the expense of poorer and sick members. Compulsory schemes also prohibit individuals from buying into the programme only during times of medical need.[48] While voluntary contributions may help raise funds in the absence of widespread payment and pooling, familiarize individuals with the benefits of insurance, and serve as an intermediate funding mechanism that eases the transition towards a more inclusive compulsory contribution scheme,[48] they do not necessarily increase rates of insurance coverage because enrolment is not compulsory. Voluntary schemes are thus ineffective in increasing access to health facilities, goods and services for the poor because they do not generate large enough pools to facilitate robust cross-subsidization.

44. According to the right to health approach, the design and scope of social health insurance programmes should be informed by the health needs, financial capacity and employment status of target populations. Social health insurance programmes should therefore ensure that a minimum set of health goods and services are available and universally accessible based on need. Benefits packages must be responsive to the disease burden and health needs of the population, comprise effective and community-centred primary health-care services that address the particular needs of each community, and include essential medicines and generic drugs in order to ensure access to safe, effective and affordable medicines, as required under the right to health. Contribution schemes must be designed to ensure universal access to good quality health facilities, goods and services. Mechanisms meant to contain programme costs that limit enrolments, such as caps on the percentage of individuals allowed to receive absolute exemptions, must be consistent with realities of poverty and ability to pay.[49] The right to health approach thus requires, at a minimum, that contributions be structured progressively, based on individuals' ability to pay, and that programmes may provide absolute exemptions for the poor.

45. Social health insurance programmes often rely on compulsory wage-based contributions, which may fail to identify and include those whose incomes are not formally reported or easily assessed, such as informal workers, self-employed persons and workers in rural and remote areas. For example, informal workers who may qualify for absolute exemptions or reduced contributions are difficult or impossible to identify through compulsory wage-based social health insurance programmes and thus may not be enrolled in these programmes. Such individuals may be unable to access good quality health facilities, goods and services owing to unaffordable out-of-pocket payments. Under the right to health approach, States should use innovative strategies to include the informal sector in social health insurance programmes. For example, associational taxes, in which an association representing a particular group of workers collects funds and pays into the tax system, have been shown to increase the participation of informal sector employees in formal benefits programmes.[50]

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[48] WHO, *World Health Report* (2010), "Health Systems Financing: The path to universal coverage", pp. 88-89.

[49] See Patrick Apoya and Anna Marriot, "Achieving a Shared Goal: Free Universal Health Care in Ghana" (Oxfam International, March 2011).

[50] Anuradha Joshi and Joseph Ayee, "Associational taxation: a pathway into the informal sector?", *Taxation and State-Building in Developing Countries: Capacity and Consent*, eds. Deborah Brautigam, Odd-Helge Fjeldstad and Mick Moore (Cambridge University Press, 2008), p. 186.

C. Allocation of health funds and resources

46. The right to health approach requires the equitable allocation of health funds and resources towards achieving universal access to good quality health facilities, goods and services, in accordance with the principle of non-discrimination. In all allocative decisions, special attention must be paid to the needs of vulnerable or marginalized groups, including, among others, ethnic, racial, religious and sexual minority groups, women, children and the poor. Better overall health outcomes and more effective health systems result from eliminating inequalities in access to health facilities, goods and services.[51] States should therefore allocate health funds and resources to ensure that good quality health facilities, goods and services are financially accessible for the poor, physically accessible for rural and remote populations, and responsive to primary health-care needs for all, rather than specialized care for the few.

Primary, secondary and tertiary care sectors

47. Under the right to health approach, in order to provide health goods, services and facilities to all persons in a non-discriminatory manner, States should ensure equitable and efficient allocation of health funds and resources between primary, secondary and tertiary health care, with particular emphasis on primary care. Primary health care is defined as essential and preventative health care universally accessible in the community at a cost the community can afford.[52] In contrast to primary health care, secondary and tertiary health-care services typically address illnesses that cannot be managed at the community level and are usually provided by specialized doctors and health workers in facilities such as hospitals at comparatively higher costs, using special equipment and sometimes in-patient care.

48. Primary health-care goods and services include routine health check-ups, preventive screenings, immunizations and vaccinations, services for the management of chronic illnesses, family planning services, nutrition services, maternal care and childbirth services and mental health counselling, all of which serve basic health needs at low cost and reduce the need for secondary and tertiary health care. Primary health care also includes health awareness-raising and educational services, such as sanitation and public hygiene campaigns, which have both preventative and promotional effects and empower community members to improve and maintain their health on their own.

49. Primary health-care goods and services do not require specialized training for health-care workers, sophisticated diagnostic equipment or significant physical infrastructure. Primary health care is provided in the community setting in small clinics or in homes by doctors, nurses and other health-care workers and may therefore be administered in a more socially and culturally acceptable manner. Primary health care is thus more geographically adaptable and less costly to administer and make use of, which increases the availability of health goods and services for rural and remote communities and the poor.

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[51] WHO, “Primary health care as a strategy for achieving equitable care: a literature review commissioned by the Health Systems Knowledge Network” (Geneva, 2007), p. 21.

[52] See Declaration of Alma-Ata adopted at the International Conference on Primary Health Care in 1978.

50. In addition to achieving more equitable health outcomes, allocating health funds and resources with a focus on primary health care also promotes efficiency within health systems.[53] Primary health care has been demonstrated to be more cost-efficient over the long term because it prevents illness and promotes general health, reducing the need for advanced levels of curative care, which tend to be more costly.[54] Savings resulting from investment in primary health care may be reinvested in the health system and utilized to increase access to health care for the poor, which in a virtuous cycle should further improve health outcomes. While a comprehensive and balanced health system must include available and accessible secondary and tertiary care services, States should prioritize primary health care in the allocation of health funds and resources.

Rural, remote and urban areas

51. In order to achieve equitable health outcomes and full realization of the right to health, States must allocate health funds and resources towards ensuring that good quality health facilities, goods and services are available and easily accessible for rural and remote populations. Populations in rural and remote areas have poorer health than their urban counterparts globally.[55] Many otherwise preventable and treatable illnesses are prevalent in rural and remote areas, infant and maternal mortality rates are higher than in urban areas, and children experience higher levels of malnutrition.[56] Moreover, people in rural and remote areas often have to travel significant and difficult distances and spend large sums of money in order to access health care, which is often not available in their communities owing to a lack of investment in physical health infrastructure in rural and remote areas.[57]

52. For example, the right to health requires that States take steps towards improving maternal health and reducing maternal mortality. However, owing to inadequate allocation of health funds and resources to rural and remote areas, maternal health-care services, trained maternal health-care workers and good quality health facilities are often unavailable in those areas.[58] Women are thus unable to access maternal health-care services in their communities, and instead must travel considerable distances at significant costs to obtain care. As a result, women in rural and remote areas experience lower rates of live births attended by skilled health workers[58] and significantly higher levels of maternal mortality and maternal morbidity than women in urban areas.[59]

53. The right to health also requires that States ensure that good quality health facilities, goods and services are available and accessible on a non-discriminatory basis. In many States, rural and remote populations largely comprise vulnerable or marginalized groups, such as the poor, ethnic and racial minorities, and indigenous

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[53] WHO, “Primary health care as a strategy for achieving equitable care”, p. 32.

[54] WHO, *World Health Report* (2008), *Primary Health Care: Now More Than Ever* (Geneva, 2008), pp. xvii, 42-51.

[55] WHO, “Inequities in health care and health outcome (2008)”, pp. 92-95.

[56] Pan American Health Organization, *Health in the Americas*, vol. 1 (Washington, D.C., 2007), pp. 58, 60, 62.

[57] Mandy Leveratt, “Rural and remote Australia — Equity of access to health care services”, *The Australian Health Consumer*, No. Two (2006-2007), pp. 16-17.

[58] WHO, *Maternal Health: Investing in the Lifeline of Healthy Societies & Economies* (September 2010), p. 10.

[59] WHO, “Making Pregnancy Safer”, Maternal Mortality Factsheet (Geneva 2008).

populations.[60] These groups often already face difficulties in accessing health care because they lack the social and political means to challenge the inequitable allocation of public resources.[61] Inequitable allocation of health funds and resources between rural, remote and urban areas may thus lead to structural discrimination of vulnerable or marginalized groups within the health system who, unlike their urban counterparts, lack access to good quality health facilities, goods and services in their communities.

54. The situation of indigenous populations around the world demonstrates this problem. In many States, indigenous communities are vulnerable as a group owing to persistent poverty, historical marginalization and political disempowerment.[62] These challenges are exacerbated by the fact that indigenous populations traditionally live in rural and remote areas that often lack public infrastructure, including health facilities.[63] Indigenous populations in all parts of the world experience worse health outcomes than non-indigenous populations as a result.[64] For example, indigenous populations in three different countries faced infant mortality rates 3 times higher, suicide rates 11 times higher and the prevalence of poor sanitation 7 times higher than non-indigenous populations.[65] The right to health approach requires States to allocate health funds and resources between rural, remote and urban areas equitably in order to respect and fulfil the right to health of vulnerable and marginalized groups living in these areas.

IV. Conclusion and recommendations

55. **The right to health approach to health financing provides a framework with which to ensure adequate, equitable and sustainable health financing. The approach addresses three critical areas in health financing: how States ensure adequate funds are available for health and the sources from which they raise these funds; how these funds are pooled; and how funds and resources are allocated within health systems towards ensuring universal access to good quality health facilities, goods and services.**

56. **The Special Rapporteur urges States to take the following steps in order to ensure adequate funds are available for health:**

(a) **Implement a progressively structured system of general taxation to fund health or improve upon the progressivity of such systems where they already exist;**

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[60] Human Rights Council, “Final study of the Human Rights Council Advisory Committee on the advancement of the rights of peasants and other people working in rural areas” (A/HRC/19/75, sect. IV).

[61] WHO/European Commission, *How health systems can address health inequities through improved use of Structural Funds* (Copenhagen, 2010), pp. 9-10.

[62] Robyn Eversole et al. (eds.), *Indigenous Peoples & Poverty: An International Perspective* (Bergen, Comparative Research Programme on Poverty, 2005), pp. 69, 128.

[63] World Bank, *Indigenous Peoples: Still among the Poorest of the Poor* (2010), p. 5.

[64] WHO, *The Health and Human Rights of Indigenous Peoples*, Health and Human Rights Team, (2011).

[65] WHO, *Health of indigenous peoples*, Fact sheet No. 326 (2007), available from: www.who.int/mediacentre/factsheets/fs326/en/index.html.

(b) **Ensure that consumption taxes, such as excise taxes and VAT, are not regressive. This may include setting appropriate thresholds below which small enterprises are not subject to taxation and reducing or removing consumption taxes on necessity goods;**

(c) **Consider earmarking portions of revenue from specific taxes, such as sin taxes and VAT, for spending on health;**

(d) **Ensure tax liberalization policies resulting from international tax competition, including tax abatements for foreign investors and low or non-existent trade and capital gains taxes, do not result in reduced public funding for health;**

(e) **Find ways to collect taxes from businesses in the informal sector, contingent upon the provision of State services and other benefits associated with being a taxable entity to such businesses.**

57. **The Special Rapporteur urges States to take the following steps in order to cooperate internationally towards ensuring the availability of sustainable international funding for health:**

(a) **Coordinate all donor activities in recipient States, incorporating the participation of civil society and affected communities, towards meeting domestic health needs and promoting the development of self-sustaining health systems;**

(b) **Develop a treaty-based global pooling mechanism, comprising compulsory progressive contributions from States allocated based upon need and driven by transparent, participatory processes, in order to shift from a donor-based system towards an obligatory system of international funding.**

58. **The Special Rapporteur urges States to prioritize funding for national and subnational health budgets in order to reduce overdependence on international funding and ensure domestic resource self-sufficiency for health.**

59. **The Special Rapporteur urges States to take the following steps in order to pool funds for health:**

(a) **Implement a pooling system comprising compulsory, progressive prepayments, such as taxes and insurance contributions, in order to reduce or eliminate out-of-pocket payments for health and ensure access to good quality health facilities, goods and services for the poor;**

(b) **Develop social health insurance programmes funded through compulsory, progressive contributions, supplemented by general tax revenue, comprising a pool of contributors large enough to promote effective cross-subsidization, with absolute exemptions for the poor;**

(c) **Ensure that enrolment in social health insurance programmes captures all necessary parts of the populations, particularly vulnerable or marginalized populations, with special attention to informal workers;**

(d) **Ensure that benefits under social health insurance programmes include a minimum set of health goods and services and are available and universally accessible based on need. Benefits packages must:**

(i) **Be responsive to the disease burden and health needs of the population;**

(ii) **Include effective and community-centred primary health-care services;**

(iii) **Include essential medicines and generic drugs in order to ensure access to safe, effective and affordable medicines.**

60. **The Special Rapporteur urges States to take the following steps in order to equitably allocate funds for health:**

(a) **Ensure equitable and efficient allocation of health funds and resources between primary, secondary and tertiary health care, with particular emphasis on primary care;**

(b) **Ensure that good quality health facilities, goods and services are available and accessible on a non-discriminatory basis for rural and remote populations. This will require:**

(i) **Increased investment in physical health infrastructure in rural and remote communities;**

(ii) **Creation of incentives for health workers, such as competitive salaries, tax abatements, rotational postings and accelerated career advancements to work in rural and remote areas.**