Author's response to reviews

Title: Obligations of low income countries in ensuring equity in global health financing

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Corrections and Responses to the Reviewer’s comments

“Major Compulsory Revisions”

1. We agree with the reviewer that the WHO estimate of the cost of basic life-saving services (US$44) per person is a global average and any average of this kind will buy different amounts of health goods and services in, for example, Uganda and Kenya as he puts it. We also took seriously the reviewer’s concern about the need to justify US$60 as our hypothetical cost for covering the minimum health opportunities. We have attempted to justify the $60 by clarifying that since the cost of providing basic life-saving services is different in different countries, it means that this cost can be either below or above the WHO estimate of $44. We have put our hypothetical cost for covering the minimum at this higher figure ($60) in order to account for these variabilities, and we have also emphasized that this is a hypothetical figure and the correct figure should be determined by country-specific health needs studies and the local costs of those needs. Our mechanism implies, as the reviewer suggests, that it is the total of these costs per person in each country that will dictate the amount of money required for each country to cover its minimum. These explanations are found on the following pages and lines: p. 11, lines 18 – 24 continuing to p.12 lines 1 &2.

2. Regarding the reviewer’s concerns about the Abuja Declaration, we have provided a very brief background for the benefit of the readers who are not familiar with it. This is on p. 6 lines 10 – 13. Other controversial issues raised by the reviewer regarding the Abuja Declaration have been clarified on page 13, last line to page 14, lines 1 – 7. Mainly, we have indicated that the Abuja declaration did not justify the 15% it recommended from the point view of the resource capacity of countries and this might explain why most of the members have not fulfilled their commitment – it could be too high. We have cautioned that the identification of the actual percentage should be evidence-based (taking into account resource capacities), participatory and democratic. We have also indicated that our decision to use a hypothetical percentage of 15 is primarily for the purpose of illustrating the effective of the obligation we are proposing and the mechanism we have proposed. This has been emphasized on p.16 last line to p. 17 lines 1 – 5; also see endnote “c”.

3. We realized that the reviewer’s comments in the third paragraph of the “compulsory revisions” arose from lack of clarity on our part in some of the points we made in the manuscript. This is especially so the concern he raises in the first example relating to Uganda’s capacity. Our argument is not that LICs should be obligations to cover the
whole cost of their minimum health services. The total cost is to be proportionately
divided between HIC and LIC governments taking into account the resource
capacities of each – so that faltering on these obligations will not attributed to lack of
resources but unwillingness. So, since we are treating the minimum as a right which
must be guaranteed to all individuals, then our view is that it will be an injustice
against individuals whose minimum health opportunities are not guaranteed. These
clarifications have been made and emphasized on the following pages and lines:
p. 5, lines 17 – 25; P. 8, lines 8 -13; and p.10, lines 19 -27.

The term “unjust” claims (on p. 13, line 17 of the old manuscript) now on page 16
line 14, has been qualified on page 15 in line 14 -18.

“Minor essential Revisions”
1. The specification regarding US$44 (originally on p. 1 lines 12 -13) has been made
   and is now on page 8, lines 11- 12.
2. We tried to proof-read and correct spelling errors.

“Discretionary revisions”
We have tried to remain consistent with the concept of fair opportunity for good
health which we have termed as a certain minimum level of health opportunities
which ought to be guaranteed to all individuals as a matter of right. Since we are
primarily concerned with health financing, we sometimes we express this minimum
as global minimum health expenditure per capita (which can be different for
countries but based on the concept of the globally accepted minimum level of health
opportunities).