DRM efforts. Table 2 outlines experience in countries that have attempted to put targeted DRM efforts in place for health. It describes at a high level what the effort was, the impact that additional revenue had on the target program or population, whether there was a sustained impact on public spending for health, and additional references that can be sought for more detail.

Table 2. Overview of DRM efforts by country

Country	DRM effort	Impacts of revenue on target	Impacts on public spending for health	References
Armenia	Focus on increasing health's share of public expenditure and implementation of efficiency enhancing reforms such as quality adjusted capitation payments	Unclear	Unclear	JLN Narrative Summary, 2020
Bangladesh	Health development surcharge of 1% on all imported and domestically produced tobacco products for tobacco control and prevention of tobacco related NCDs (*2015)*	Approx. US $26m/ per capita $.15 collected per year, but not fully injected into health budget	Unclear	JLN Narrative Summary, 2020
Ghana	Funding to establish NHIL: 2.5% points from 17.5% VAT. Also 2.5% points from SSNIT and small contribution from road traffic fund *(2003)*	Provides 91% revenue for NHIS; however, lack of controls creates overruns	No sustained reprioritization: Initial increase, total allocation to health decreased over time	WHO Earmarking for Health, 2017 JLN blog post: Coming Soon!
	Cap on all earmarked revenue (*2017)* Decoupled NHIL/VAT; kept constant rate (*2018)*	Possible under allocation to NHIA due to cap, gains of reform not yet seen	Unclear	JLN blog post: Coming Soon!
India	Health and education cess of 4% is levied on individual income tax Goods and Service Tax (GST) on caffeinated beverages was increased from 18% to 25% + 12% cess in the 37th GST Council meeting in 2019 Tobacco products: 28% + up to 290% cess depending on the product Alcohol: not brought under GST, but VAT and excise duty is applicable Sugary drinks: 28%	Health and education cess collection in 2018-19 was ~ US $ 6200 m	Until 2016-17- 3% education cess was levied to which 1% cess was added for mobilizing additional resources for health and the ambit was widened to include health. Unclear on the allocation of GST revenue from SSB, alcohol and tobacco	https://www.gst.gov.in/

Indonesia	Earmarked central government budgetary allocations at 5% of total central government budget; district government budget allocations at minimum of 10% each districts total government budget (both excluding salaries, *2009).*	Central government spending on health has seen an eight-fold increase over 2000-2017, and an average annual increase of 12.3% (Adjusted)	Sustained reprioritization: per capita spending on health increased five-fold from 2000-2017	WHO Earmarking for Health, 2017 JLN Narrative Summary, 2020
	Other forms of earmarking include: Mandatory contributions from the formal sector and non-poor informal sector for JKN (*2014);* Earmarked local tobacco tax for health (*2018)*	Unclear. For non-payroll, difficult to track funds throughout the system especially at subnational level. For payroll, hard to raise revenue because rate cannot be adjusted.	Unclear	
Mexico	Special Consumption Tax earmarked for central government health spending imposed on beverages, tobacco (2010) and SSB (2014)	Increase in revenue collection for the government	Currently, revenue collected from these taxes is not set aside for any particular type of expenditure.	World Bank Discussion Paper 2016
Philippines	Sin Tax Law, 100% incremental alcohol tax revenue and 85% incremental tobacco tax revenue *(2012)* RA 10963 or The Tax Reform for Acceleration and Inclusion (TRAIN law) (passed 2018)	80% of incremental revenues goes to premium for poor and 20% to DOH. Increased DOH budget fourfold from 2012-2018 Under the new TRAIN law not more than seventy percent (70%) to fund infrastructure projects and part of the remaining thirty percent (30%) may fund social mitigating measures and investments in health, targeted nutrition, and anti-hunger programs for mothers, infants, and young children, among others.	Sustained reprioritization: Public spending per capita increased from US$20 per 2012 to US$41 in 2016	WHO Earmarking for Health, 2017 JLN blog post: Coming Soon!

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