



HEALTH FINANCING REVISITED: AN OVERVIEW

Pablo Gottret and George Schieber

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Abstract

Health is now widely recognized as a basic human right, and the urgency of some global issues has pushed global health policy to the top of the international agenda. This paper provides an overview of health financing policy in developing countries in order to assist policy makers and other stakeholders in the design, implementation, and evaluation of effective health financing reforms. The paper also highlights some policy recommendations for middle-income countries, such as viewing efficient and equitable revenue mobilization as a top priority for health; promoting increased risk pooling; focusing on designing appropriate benefit packages for populations; and to be parsimonious with health spending to expand coverage to more people. Finally, the paper offers some lessons for lower-income countries in light of the experiences of high-income countries.

ملخص

تعد الرعاية الصحية من الحقوق الأساسية للإنسان، كما أصبحت سياسات الرعاية الصحية تحتل صدارة أجندة التنمية العالمية بفعل القضايا الملحة التي ظهرت مؤخرا على الصعيد العالمي. وفي هذا الإطار، تقدم الورقة نظرة عامة على سياسات تمويل الرعاية الصحية في البلدان النامية وذلك بهدف مساعدة صانعي السياسات والجهات المعنية الأخرى في تصميم وتنفيذ وتقييم الإصلاحات المتعلقة بتمويل خدمات الرعاية الصحية. كما تطرح بعض التوصيات للبلدان متوسطة الدخل، منها الاهتمام بتعبئة الإيرادات في هذا المجال بما يتسق مع اعتبارات العدالة والكفاءة، وتشجيع التضامن في توزيع المخاطر، والتركيز على تصميم برامج رعاية صحية تتلاءم مع احتياجات السكان، بالإضافة إلى ترشيد الإنفاق على الخدمات الصحية بغية تغطية أعداد أكبر من السكان. وفي النهاية، تقدم الورقة بعض الدروس المستفادة للبلدان منخفضة الدخل وذلك في ضوء التجارب الناجحة للبلدان ذات الدخل المرتفع.

INTRODUCTION

Health is now widely recognized as a basic human right, and the urgency of some global health issues has pushed global health policy to the top of the international agenda. With globalization comes the flow of ideas, capital, and people across borders, which has profound implications for the spread and treatment of disease. The epidemics of HIV/AIDS and SARS, the potential impact of avian flu, and the international public goods dimensions of public health make global health policy both a national security issue and a foreign policy issue. Furthermore, it has become clear that the Millennium Development Goals cannot be achieved without massive infusions of new overseas development assistance, much of it targeted to health.

These issues have produced new global health policy developments among multilateral and bilateral donors, the new financiers (such as the Bill and Melinda Gates Foundation), the new global programs (such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria), and recipient countries. Multilateral and bilateral institutions and foundations, nongovernmental organizations (NGOs), and joint donor initiatives are helping countries to finance, rationalize, and operationalize health reforms.

The international community must live up to its promise to scale up development assistance and make it predictable and sustainable. Nevertheless, it is ultimately the developing countries that must face the challenges of organizing their institutions and health financing systems to provide sufficient financial resources, ensure equitable access to effective health interventions, and protect their people against health and income shocks. These reforms must be based on social and macroeconomic realities and especially on good governance.

This paper provides an overview of health financing policy in developing countries. It is a primer on major health financing and fiscal issues, intended to assist policy makers and all other stakeholders in the design, implementation, and evaluation of effective health financing reforms. The health sector is an extremely complex one, and reformers must be prepared to deal with its complexities when designing and implementing health policy reforms.

The paper assesses health financing policies from the perspectives of the basic financing functions of collecting revenues, pooling resources, and purchasing services. It evaluates

these functions for their capacity to improve health outcomes, provide financial protection, and ensure consumer satisfaction—in an equitable, efficient, and financially sustainable manner.

There are various well-known models for implementing these basic functions—national health service systems, social health insurance funds, private voluntary health insurance, community-based health insurance, and direct purchases by consumers. More important than the models, however, are three basic principles of public finance:

- *Principle 1.* Raise enough revenues to provide individuals with a basic package of essential services and financial protection against catastrophic medical expenses caused by illness and injury in an equitable, efficient, and sustainable manner.
- *Principle 2.* Manage these revenues to pool health risks equitably and efficiently.
- *Principle 3.* Ensure the purchase of health services in ways that are allocatively and technically efficient.

All health financing systems try to follow these principles, but the evidence reviewed here shows that there is no single road. Countries operate within highly different economic, cultural, demographic, and epidemiological contexts, and the development of their health provision and financing systems—and the optimal solutions to the challenges they face—will continue to be heavily influenced by these and other historical factors as well as political economy considerations. Even so, countries can learn from both the successes and the failures of each other's health financing efforts.

THE NUMBERS

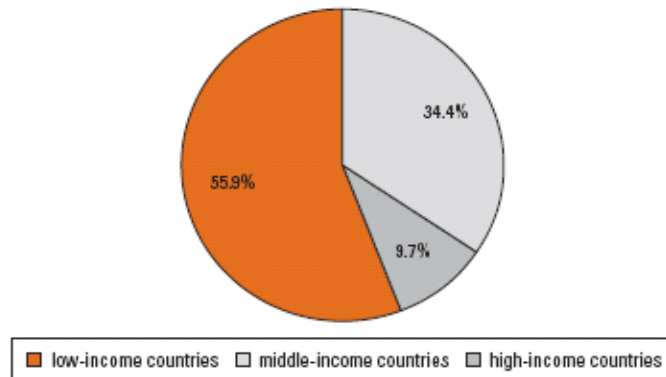
Globally there exists an enormous mismatch between countries' health financing needs and their current health spending. Developing countries account for 84 percent of global population and 90 percent of the global disease burden, but only 12 percent of global health spending. The poorest countries bear an even higher share of the burden of disease and injury, yet they have the fewest resources for financing health services (figure 1).

The underlying population and epidemiological dynamics will have profound effects on the economies and future health needs of all countries. The world's population will grow to a projected 7.5 billion by 2020 and to 9 billion by 2050. Most of this growth is expected to

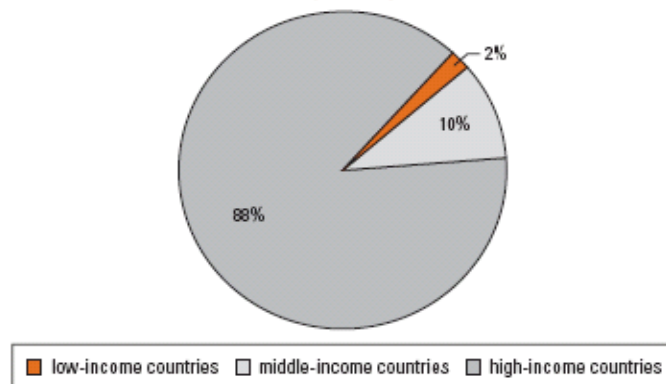
occur in developing countries. Low-income countries face the highest rates of growth; the populations in 50 of the poorest countries will double by 2050.

FIGURE 1 The mismatch between health needs and health spending

a. Burden of disease in disability-adjusted life years



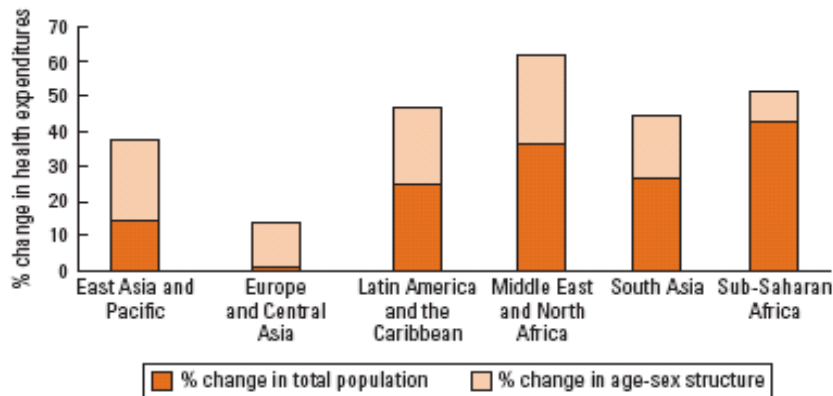
b. Distribution of total global expenditures on health



Source: World Development Indicators 2005 and Mathers, Lopez, and Murray, forthcoming.

The shift in demographics (high but declining rates of population growth and increased life expectancies) as well as the trend toward non-communicable diseases and injuries will dictate the needs and service delivery systems in low- and middle-income countries. Over the next 20 years, changes in population size and structure alone will increase total health care spending needs by 14 percent in Europe and Central Asia; 37 percent in East Asia and the Pacific; 45 percent in South Asia; 47 percent in Latin America and the Caribbean; 52 percent in Sub-Saharan Africa; and 62 percent in the Middle East and North Africa. Excluding Europe and Central Asia, developing countries will face 2–3 percent annual increases in health care expenditure needs (or pressures) from demographics alone (figure 2).

FIGURE 2 Demographics and health care spending, 2005–25



Source: 2000 National Medical Expenditures Survey and HNPStats.

High but declining rates of population growth coupled with longer life expectancy means that developing countries will face significant increases in population in all age ranges, particularly the elderly range. As a result of population momentum, larger numbers of individuals will enter the workforce. Whether this will be a “demographic gift” of faster economic growth or a “demographic curse” of greater unemployment and social unrest will depend on government policies that foster economic and labor force growth. Industrial structures need to be in place and employment patterns established for domestic resource mobilization and specific health financing efforts.

PATTERNS AND EFFECTIVENESS OF CURRENT HEALTH SPENDING

Global health spending in 2002 was \$3.2 trillion, about 10 percent of global gross domestic product (GDP). Only some 12 percent of that, \$350 billion, was spent in low- and middle-income countries. High-income countries spend about 100 times more on health per capita (population-weighted) than low-income countries—30 times if one adjusts for cost of living differences. Worse still, more than half of the meager spending in low-income countries is from out-of-pocket payments by consumers of care—the most inequitable type of financing because it hits the poor hardest and denies all individuals financial protection from catastrophic illness that public and private insurance mechanisms provide.

The public share of total health expenditures changes with income category: the public share is 29 percent in low-income countries, 42 percent in lower-middle-income countries, 56

percent in upper-middle-income countries, and 65 percent in high-income countries. (In 2003, the World Bank defined countries as low-income when their GNI was less than \$766; countries with a GNI per capita between \$766 and \$9,385 were considered middle-income; and \$3,035 was the dividing line between lower-middle-income and upper-middle-income countries).

Social health insurance institutions are a very limited source of health care spending in low-income countries. They accounted for only some 2 percent of total spending on health in low-income countries, 15 percent in lower-middle income countries, and 30 percent in upper-middle-income and high-income countries. In Sub-Saharan Africa only 2 percent of all public spending on health (less than 1 percent of total health spending) is through social insurance institutions and in South Asia 8 percent (less than 2 percent of total health spending).

For the private share of spending, the poorer the country the larger the amount that is out of pocket: 93 percent in low-income countries (more than 60 percent of the total); some 85 percent in middle-income countries (40 percent of the total); and only 56 percent in high-income countries (20 percent of the total). Such figures in the low- and middle-income countries are troublesome because it implies that out-of-pocket expenditures, the most inequitable source of health financing, predominates in these countries.

External sources account for 8 percent of health spending in low-income countries and less than 1 percent in middle-income countries (according to population-weighted expenditure information). But on a country-weighted basis, external sources account for 20 percent of total low-income country health spending. In 12 countries in Sub-Saharan Africa, external sources finance more than 30 percent of total health expenditures.

How effective is this spending for health outcomes? Various studies document a range of effects—from no impacts, to limited impacts, to impacts for only specific interventions. Greater improvements in health outcomes are associated with stronger institutions and higher investments in other health-related sectors, such as education and infrastructure.

A new econometric analysis performed for this study finds strong impacts of government health spending on maternal mortality and child mortality; direct health spending effects are larger than those found for public investments in infrastructure, education, and

sanitation. The analysis also shows that parallel investments in infrastructure and education further reduce infant and child mortality, supporting the need for a cross-sectoral approach to reach the Millennium Development Goals for health. Economic growth also has a large impact on health outcomes—both by directly improving outcomes and by generating increased resources that can be mobilized by governments for increased public spending.

Another important finding is that external donor assistance has a limited direct impact on health outcomes. Development assistance for health has a direct impact on under-five mortality, after controlling for volatility. But it does not affect maternal mortality directly—it does so only indirectly, through its effect on government health spending. This outcome is not surprising given the fungibility of aid, the off-budget nature of a significant amount of aid, the exclusion of much aid from the balance of payments, and the fact that much aid has gone to debt forgiveness and technical assistance.

HEALTH FINANCING FUNCTIONS AND SOURCES OF REVENUES

There are myriad ways for countries to design and implement policies to collect revenues, pool risks, and purchase services. *Risk pooling* is the collection and management of financial resources so that large unpredictable individual financial risks become predictable and are distributed among all members of the pool.

Purchasing refers to the many arrangements for buyers of health care services to pay health care providers and suppliers.

The success of countries in carrying out these functions has important implications for funds available (now and in the future) and the concomitant levels of essential services and financial protection, fairness (equity) of the revenue collection mechanisms to finance the system (basing financial access on need rather than ability to pay), economic efficiency of revenue-raising in not creating distortions or economic losses in the economy, levels of pooling and prepayment (and the implications for risk and equity subsidization), numbers and types of services purchased and consumed and their effects on health outcomes and costs (allocative efficiency), technical efficiency of service production (producing each service at its minimum average cost), financial and physical access to services (including equity in access).

Collecting Revenue

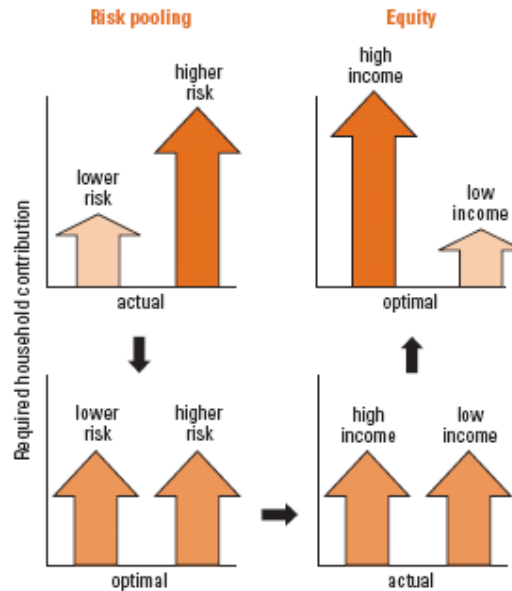
Revenue collection in developing countries is the art of the possible, not the optimal. Although there are numerous public and private sources for raising revenues, the institutional realities of developing countries often preclude the use of the most equitable and efficient revenue-raising mechanisms. Revenue-raising capacities increase as country incomes increase (as a result of greater formalization of the economy, greater ability of individuals and businesses to pay, and better tax administration). Low-income countries collect some 18 percent of their GDP as government revenues, severely limiting their ability to finance essential public services. For example, a country with a per capita GDP of \$300 can collect \$54 per capita (18 percent of GDP) for all public expenditure needs—defense, roads, airports, electricity, sewage systems, pensions, education, health, and water. Middle-income countries raise some 23 percent of their GDP from government revenues and high-income countries, 32 percent.

Pooling Risk

Risk pooling and prepayment are critical for providing financial protection. Pooling health risks enables the establishment of insurance and improves citizens' welfare by allowing individuals to pay a predetermined amount to protect themselves against large unpredictable medical expenses (figure 3).

There are various ways for governments to finance public health insurance programs, and each should be assessed on the basis of equity, efficiency, sustainability, administrative feasibility, and administrative cost. Most low- and middle income countries have multiple public and private pooling arrangements, and governments should strive to reduce fragmentation (and thereby improve equity and efficiency), lower administrative costs, and provide the basis for more effective risk pooling and purchasing.

FIGURE 3 Models of cross-subsidization for pooling risk or increasing equity of household contributions for health services



Source: International Labour Organization/Strategies and Tools against Social Exclusion and Poverty 2002.

Resource Allocation and Purchasing

Resource allocation and purchasing mechanisms determine for whom to buy, what to buy, from whom, how to pay, and at what price. Purchasing includes the many arrangements used by purchasers of health care services to pay medical care providers. A variety of arrangements exists: some national health services and social security organizations provide services in publicly owned facilities where staff members are salaried public employees; sometimes individuals or organizations purchase services through direct payments or through contracting arrangements from public and private providers. Other arrangements combine these approaches.

Resource allocation and purchasing procedures have important implications for cost, access, quality, and consumer satisfaction. Efficiency gains (both technical and allocative) from purchasing arrangements provide better value for money and thus are a means of obtaining additional “financing” for the health system.

Purchasing has taken on increased importance because donors want to be assured that new funding to scale up services is being used efficiently. Moreover, the efficiency of a

system has important financial implications for long-term fiscal sustainability and for governments to find the “fiscal space” in highly constrained budget settings for large increases in public spending. Indeed, health financing policies (collection, pooling, and purchasing) must be developed in the context of a government’s available fiscal space.

Fiscal Space

Large proposed increases in public health spending must be considered in the context of the available *fiscal space*—the budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of its financial position. (Fiscal space is at the center of the current debate over the purported negative impacts of International Monetary Fund (IMF) programs that preclude countries from using the increased grant funding for health investments and recurrent health expenditures, such as hiring additional health workers).

In principle, a government can create fiscal space in the following ways:

- through tax measures or by strengthening tax administration;
- cutting lower-priority expenditures to make room for more desirable ones;
- borrowing resources, either from domestic or from external sources;
- getting the central bank to print money to be lent to the government; or
- receiving grants from outside sources.

Fiscal space requires a judgment that the higher short-term expenditure, and any associated future expenditures, can be financed from current and future revenues. If financed by debt, the expenditure should be assessed for its impact on the underlying growth rate or its impact on a country’s capacity to generate the revenue to service that debt.

RISK POOLING MECHANISMS

Policy makers must assess the most appropriate mechanisms to pool health risks and provide financial protection to their populations. The challenge for low- and middle-income countries is to somehow direct the high levels of out-of-pocket spending into either public or private pooling arrangements, so that individuals will have real financial protection. Four main health insurance mechanisms are used to pool health risks, promote prepayment, raise revenues, and

purchase services:

- State-funded systems through ministries of health or national health services
- Social health insurance
- Voluntary or private health insurance
- Community-based health insurance

While the features of each financing mechanism differ significantly, no one method is inherently better than another. So, policy makers must examine the context and determine which method constitutes the best means for developing a strong health financing system in terms of equity, efficiency, and sustainability. It is important to be pragmatic and ensure that the mechanisms chosen are aligned with country-specific economic, institutional, and cultural characteristics.

Ministry of Health/National Health Service Systems

Ministry of health or national health service–style systems generally have three main features. First, their primary funding comes from general revenues. Second, they provide medical coverage to the country’s entire population. Third, their services are delivered through a network of public providers. (In most low- and middle-income countries, ministries of health function as national health services and generally exist alongside other risk pooling arrangements, so they are not the sole source of coverage for the entire population).

The features of national health services give them the potential to be equitable and efficient. Their broad coverage means that risks are pooled broadly, without the dangers of risk selection inherent in more fragmented systems. And unlike other systems, they rely on a broad revenue base. National health service–style systems also have the potential for efficient operation. Most are integrated and under government control, and they have less potential for the high transaction costs that arise from multiple players. But when power is decentralized or shared with local authorities, and when the decision-making authority is unclear, coordination problems can ensue.

Provision under the pure national health service model is through public facilities and personnel, but in practice there is much variability—many governments contract services from nongovernmental organizations, faith-based organizations, and other private providers.

Whether public provision is more efficient, equitable, and sustainable than private provision is a question not of ownership but of the underlying delivery structures and incentives facing providers and consumers.

Although national health service systems have the theoretical benefit of providing health care to the entire population free of charge (except for any applicable user fees), the reality is less encouraging. Reliance on general government budgets is vulnerable to the vicissitudes of annual budget discussions and changes in political priorities. And in most low-income developing countries, public health spending as a share of the budget is low.

Health services in many low- and middle-income countries are primarily used by middle- and high-income households in urban areas because of access problems for the rural poor. In addition, the poor tend to use less expensive local primary care facilities, whereas the rich disproportionately use more expensive hospital services. Public provision of health services may also face problems of corruption and inefficiencies caused by budgets that do not generate the appropriate incentives and accountability—which has led many governments to split financing from provision.

To exploit the potential strengths of national health service-style systems, it is important for developing countries to improve the capacity to raise revenue, the quality of governance and institutions, and the ability to maintain the universal coverage and reach of the system. It is also important to take specific measures to target spending to the poor, such as increasing the budget allocations for primary care. But the system must not neglect the needs of the middle- and high-income populations—that way, they can maintain political support and deter the middle- and high-income populations from opting for privately financed providers at the expense of supporting the public system.

Social Health Insurance Systems

Social health insurance systems are generally characterized by independent or quasi-independent insurance funds, a reliance on mandatory earmarked payroll contributions (usually from individuals and employers), and a clear link between these contributions and the right to a defined package of health benefits. In many countries, coverage has been progressively extended to subpopulations and then to the whole population.

The state generally defines the main attributes of the system, although funds are generally nonprofit and supervised by the government. The number of funds varies by country. Where there are multiple funds, mechanisms are often used to compensate for different risk profiles across funds, and administrative costs are generally higher. Some countries are reducing the number of funds to maximize risk pooling and to benefit from economies of scale.

The payroll base of much of the funding of social health insurance systems insulates them from budgetary negotiations that may subject national health service systems to more variable funding. Yet social health insurance contributions alone may not be adequate to fully fund health care costs, especially if the system is intended to cover a broader population than those who contribute. Social health insurance systems may thus require an infusion of resources from general tax revenues. Additional subsidies may come from external aid or other earmarked taxes.

The equity of social contribution financing depends on the presence or absence of contribution ceilings and other features, but some studies have concluded that such financing is less progressive than general revenue financing, or at best as progressive. Social contributions may also have a deleterious effect on employment and economic growth if they increase labor costs (as might happen if employers are unable to offset the added cost by reducing wages).

Social health insurance systems often cover only a limited population (for example, those in large formal sector enterprises), at least at their inception, and it is difficult to add informal sector workers to the covered population. When successfully implemented, they often have strong support from the population, which perceives them as private and stable in their management and finances.

Social health insurance systems sometimes are more difficult to manage, because they involve more complex interactions among players. They can also confront cost escalation and difficulties in paring back benefits. And their less integrated nature does not lend itself to efficient treatment of chronic diseases and preventive care.

What preconditions might lead to the successful development of social health insurance

systems in developing countries?

- *Level of income and economic growth.* The systems often begin in lower-middle income countries, and expansions to universal coverage generally occur during periods of strong economic growth.
- *Dominance of formal sector versus informal sector.* The systems are easier to administer in countries with a high proportion of industrial or formal sector workers, because employers will likely have a formal payroll system for contributions.
- *Population distribution.* The systems are successful in countries with growing urban populations and increased population density but face slower implementation in countries with a large rural population.
- *Room to increase labor costs.* Countries where the economies can tolerate increased payroll contributions without negative effects on employment and growth are better candidates for such systems.
- *Strong administrative capacity.* The ability to implement a social health insurance system without excess administrative costs—and in a transparent, well-governed fashion—is critical for population support and for financial and political sustainability.
- *Quality health care infrastructure.* The systems can be successful only if the services they fund are available and of good quality, which will support membership in the scheme and avoid a system in which the wealthier populations opt for a separate, privately financed system; such a system would also encourage them to provide political support.
- *Stakeholder consensus in favor of social health insurance, together with political stability and rights.* Societies that place a high value on equity and solidarity are likely to support the redistributive aspects of such systems. But significant differentials in contributions may not be tolerated in systems where solidarity plays a less prominent role.
- *Ability to extend the system.* Governments seeking to expand their social health insurance systems must design realistic and progressive goals that reflect the operating context. These goals include the ability to encourage the affiliation of informal sector workers and the means to collect regular contributions from them. Transparent and participatory schemes are more likely to garner population support. And governments may need to subsidize the extension of social health insurance to the poor.

Countries aiming to implement social health insurance systems face formidable challenges but also have the potential to reap significant rewards. It is important to examine the specific socioeconomic, cultural, and political contexts and determine whether the setting and the timing are right for implementing such a system.

Community-Based Health Insurance

Community-based health insurance schemes have existed for centuries. They were the precursors to many of the current social health insurance systems, such as those in Germany, Japan, and the Republic of Korea, and they are currently prevalent in Sub-Saharan Africa. The schemes can be broadly defined as not-for-profit prepayment plans for health care that are controlled by a community that has voluntary membership. Most community-based health insurance schemes operate according to core social values and cover beneficiaries excluded from other health coverage.

There is evidence that such schemes reduce out-of-pocket spending, and one study found that they contributed to greater use of health resources. They may also fill gaps in existing schemes (as for informal workers in Tanzania) and form part of a transition to a more universal health care coverage system.

But the protection and sustainability of most community-based health insurance schemes are questionable. They are often unable to raise significant resources because of the limited income of the community, and the pool is often small, making it difficult to serve a broad risk-spreading and financial protection function. The schemes' size and resource levels make them vulnerable to failure. They are also placed at risk by the limited management skills available in the community, and they have limited impact on the delivery of health care, because few negotiate with providers on quality or price. They also cannot cover the poorer parts of the population—even small premiums may be out of reach for the poor.

Government intervention could improve the efficiency and sustainability of such schemes through subsidies, technical assistance, and links to more formal financing arrangements. But community-based health insurance is not likely to be the “magic bullet” for solving the bulk of health financing problems in low-income countries. It should be regarded more as a complement to, rather than a substitute for, other forms of strong government

involvement in health care financing.

Private or Voluntary Health Insurance

Private or voluntary health insurance often supplements publicly funded coverage, especially in high-income countries. Private health insurance is paid for by non-income-based premiums (not tax or social security contributions). Voluntary health insurance is defined as any health insurance paid for by voluntary contributions. Although the two types of coverage are distinct, most private health insurance markets are also voluntary—except in a few countries, such as Switzerland and Uruguay, where the purchase of private coverage is mandatory for all or a part of the population.

There are several roles that private/voluntary health insurance can play in a country's public or social coverage:

- Primary—as the main source of coverage for a population or subpopulation
- Duplicate—covering the same services or benefits as public coverage, but differing in providers, time of access, quality, and amenities
- Complementary—covering cost-sharing under the public program
- Supplementary—for services not covered by the public program

Private/voluntary health insurance markets have been somewhat controversial, partly because they often reach wealthier populations and have been the subject of market failures, such as adverse selection by covered individuals and “cream skimming” of better health risks by insurers. Nonetheless, at least in countries of the Organisation for Economic Co-operation and Development (OECD), such markets have been found to promote risk pooling of resources that are often otherwise paid out of pocket, to enhance access to services when public or mandatory financing is incomplete, and in some cases to increase service capacity and promote innovation.

Yet private/voluntary health insurance has limits. A study of OECD countries found financial barriers to access because of affordability and premium volatility. Such insurance can contribute to differential access to health care services in some countries. It has done little to reduce cost pressures on public systems. Nor has it made significant contributions to quality improvements, except in a few countries.

The complexity of private/voluntary health insurance markets raises questions about their relevance and feasibility in low-income countries. They may be more plausible options in middle-income countries with large literate and mobile urban populations. Some of the challenges and market failures associated with these markets can be addressed through regulations that mandate certain insurer actions (on acceptance of applicants and premium calculations) and minimize or rectify market failures. Yet these regulations can be difficult to implement and enforce. And they presuppose regulatory resources, political backing, and well-functioning financial and insurance markets. It can also be challenging to strike the most appropriate balance between access and equity concerns and desires to promote an efficient and competitive marketplace.

In sum, each of the pooling mechanisms discussed here raises challenges and must be considered in the country context. While national health services and social health insurance have different institutional eligibility and financing criteria, they both face the same issues of ensuring adequate and sustainable financing in an equitable and efficient manner. Future contingent liabilities are a concern for both systems even if national health services in theory have a wider revenue base than payroll contributions. Policy makers need to focus on underlying principles—maximizing risk pooling and assuring equitable, efficient, and sustainable financing—not on labels or generic models.

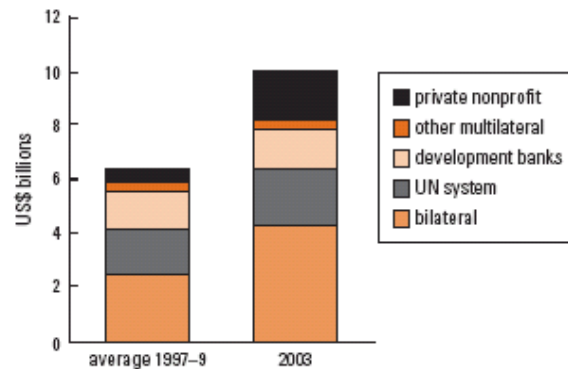
DEVELOPMENT ASSISTANCE FOR HEALTH

Large increases in official development assistance and development assistance for health will be needed to assist poor countries in providing essential services to their populations and scaling up to meet the Millennium Development Goals. After almost a 25 percent decline in the 1990s, official development assistance has once again started to increase. In 2003 it was 0.25 percent of gross national income (some \$70 billion), still well short of the Monterrey target of 0.7 percent and the Millennium Project's estimated need of 0.54 percent. Much of the increase has been devoted to debt relief and technical assistance.

Development assistance for health has increased significantly over the past few years, to more than \$10 billion in 2003 (figure 4). Most of the recent increases have been focused on Africa and on specific diseases and interventions. Given the renewed efforts of countries to meet their Monterrey commitments from the European Union and Group of Eight as well as

the large amounts of assistance pledged to meet the Millennium Development Goals, issues concerning the impact, absorption, use, and sustainability of this external assistance have been receiving attention.

FIGURE 4 Development assistance for health by source, 1997–2003



Source: Catherine M. Michaud, Harvard Initiative for Global Health.
 Note: The category of other multilateral includes the European Commission and the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

Increased assistance on the order of \$25–70 billion a year will be needed to achieve the Millennium Development Goals for health. Although official development assistance is of critical importance, accounting for 55 percent of all external flows to Africa, it accounts for only 9 percent of such flows to other developing regions. In those regions foreign direct investment, workers’ remittances, and other private flows account for 91 percent of external flows. It is essential for policy makers to focus on these critically important external sources of funding as well as official development assistance.

Global programs, generally focused on specific diseases or interventions, have been responsible for the bulk of the recent increases in external health assistance, representing 15–20 percent of development assistance for health. Global partnerships and private funding are becoming a more important part of the picture, whereas the United Nations’ organizations and development bank roles are relatively constant.

Aid Effectiveness and Absorption

Large increases in donor funding for health, much of it for recurrent spending, raise important questions about the ability of countries to absorb these funds, the predictability and maturity

of these funds, and the ability of countries to sustain services once donor funding stops.

With most of the recent increases in development assistance for health directed to specific diseases and interventions, there is growing concern about the disease-and intervention-specific focus of aid. Such a focus can be very effective in resource-scarce environments. But as health systems develop, waste and inefficiency can result from separate delivery silos for different diseases. And given the severe human resources constraints in many African countries, aid programs compete with each other to hire away the few skilled professionals needed to run the public health system. It is important for the ongoing work on health systems to address this issue; evidence-based policy recommendations as opposed to conventional wisdom and conceptual arguments should drive much of this debate.

A recent study of 14 poverty reduction strategy papers (PRSPs) found that 30 percent of external aid did not enter into the balance of payments, and another 20 percent was entered into the balance of payments but not the government budget. Of the remaining 50 percent, only 20 percent was for general budget support. For governments to effectively implement their “country-owned” programs, they need the flexibility to manage these funds. Donors and countries need to seek ways to funnel this increased external funding through general budget support and to finance gaps in the recipient countries’ programs as much as possible.

Aid’s fungibility implies that governments may divert domestic resources to other uses given the presence of donor funding in priority areas (such as primary care). Once donor funding stops, governments may face difficulties in reallocating resources to these priority areas, which could lead to their underfunding. Donors must exercise care in analyzing the impact of their own resources, which may not actually attain the intended outcomes. They must also give serious consideration to supporting government budgets directly, through budget support for an agreed program, rather than to directly financing projects that may crowd out the government’s own resources. Budget support for existing government programs must be predictable, committed over longer maturities to ensure continuity, and facilitate planning.

Large increases in development assistance for health to low-income countries (promised and actual) raise questions about whether countries can make effective use of new aid flows. Absorptive capacity has macroeconomic, budgetary, management, and service delivery

dimensions. It also rests on critical macro conditions: good governance, lack of corruption, and sound financial institutions. Also critical are human resources for public sector management and for service delivery. Both donors and recipient countries need to develop a better understanding of these constraints and provide an evidence-based system for dealing with them.

REALITIES OF GOVERNMENT SPENDING AND POLICY LEVERS

One of the most significant challenges to improving health system performance in developing countries is weak public sector management, particularly at the district or municipal level. Empirical analyses support direct correlations among the quality of policies and institutions, absorptive capacity, and the country's ability to improve certain health outcomes through increased government health spending. Several tools have been developed to improve public sector management.

Poverty Reduction Strategy Papers, Poverty Reduction Support Credits, and Medium-Term Expenditure Frameworks

To receive concessionary funding assistance from the World Bank and IMF, all low-income countries are required to base their macroeconomic and sectoral reforms on a poverty reduction strategy, embodied in a PRSP. In theory PRSPs are designed to strengthen country ownership, provide a poverty focus for country programs; establish a coordinated framework for the World Bank and IMF and other development partners; and improve governance, accountability, and priority-setting.

Evidence to date has been mixed. PRSPs have encouraged a results-oriented approach but have fallen short as a roadmap for integrating sectoral strategies into the macroeconomic framework, understanding micro-macro linkages, and linking medium- and long-term operational targets. The process could be more inclusive, and the focus could be sharper for capacity building and for monitoring and evaluation. PRSPs become meaningful only if priorities feed into the annual budget process. Ownership by countries and their external partners remains problematic. And external partners have not adapted their procedures to the PRSP process in a coordinated manner.

Poverty reduction support credits (PRSCs), one of the World Bank's major general

budget support vehicles for implementing PRSPs, are intended to provide medium-term support, encourage donor harmonization, improve resource predictability, and reinforce country ownership. They have been found to facilitate coordination between central and line ministries, as well as among donors. In addition, they have limited conditionalities. Further progress could be made in streamlining policy matrices and improving monitoring and evaluation.

Medium-term expenditure frameworks (MTEFs) combine macroeconomic models projecting revenues and expenditures in the medium term with “bottom-up” reviews of sector policies—a tool to optimize intrasectoral allocations in the context of annual budget processes. To date, these frameworks have not improved macroeconomic balances or increased budgetary predictability for line ministries. But there is some limited evidence that they have led to reallocations to priority sectors.

An analysis of countries implementing PRSPs, PRSCs, and MTEFs produced several examples of good practices. These practices include (1) establishing clear priorities and criteria within the PRSP through an iterative process that involves line ministries and the central government; (2) conducting annual reviews of progress by sector; and (3) having a credible process for budget preparation by the ministry of finance and the cabinet, along with medium-term assurances of budget levels for each sector. Even so, PRSPs remain a work in progress.

Public Expenditure Reviews and Public Expenditure Tracking Surveys

Public expenditure reviews (PERs) and public expenditure tracking surveys (PETS) assist countries in developing public expenditure strategies and tracking expenditures.

PERs seek to provide objective analysis of public spending issues. They analyze and project tax revenues, the level and composition of public spending, and intersectoral and intrasectoral allocations, as well as review financial and nonfinancial public enterprises and the governance structure and functioning of public institutions. In the health sector, PERs have revealed important information about budget execution and have shown disparities between disbursements and amounts budgeted through the MTEF.

PETS track the flow of government resources to determine the amount that actually

reaches the service delivery level. They have uncovered significant leakages (as high as 90 percent) in the education and health sectors, leading governments to improve public sector management. A review of PETS in African countries found nonwage funds to be more susceptible to leakage than salaries, and it showed leakage occurring at specific levels of governments. This information can help in creating and targeting more efficient interventions.

HEALTH FINANCING CHALLENGES IN LOW-INCOME COUNTRIES

Most low-income countries are being severely challenged to provide essential services to their populations and to provide financial protection. Without substantial increases in external assistance, meeting the Millennium Development Goals is highly unlikely.

Most regions will not reach the Millennium Development Goals for health because of slow progress in the 1990s. In Africa the declines in child mortality of some 0.5 percent a year since 1990 will have to accelerate to declines of 8 percent a year to reach the target of halving childhood mortality by 2015. Similarly, East Asia and the Pacific will need to improve previous annual reductions of 2.7 percent to 5 percent. Neither increased health spending nor growth alone will do the job. Reaching the goals requires growth and a multisectoral effort. For example, India would need a 15 percent annual economic growth rate from 2000 to 2015 to reach the goals on the basis of growth alone. Rwanda would need a twentyfold increase in public spending on health to achieve the Millennium Development Goals on the basis of public health spending alone.

Mobilizing Domestic Resources and Deciding on User Fees

Some countries can improve their domestic resource mobilization efforts, particularly as there appear to be such wide ranges for countries at the same income levels. Various estimates suggest that countries can possibly generate an additional 1–4 percent of their GDPs in government revenues. This is an important area of focus, given the poor revenue performance of many low-income countries in the past decade.

User fees have been a contentious source of financing in low-income country settings. In most cases they have occurred spontaneously as a result of the scarcity of public financing, the prominence of the public system in the supply of essential health care, the government's inability to allocate adequate financing to its health system, the readiness of the poor and

nonpoor to pay fees as a way of reducing the travel and time costs of alternative sources of care, the low salaries of health workers, the limited public control over pricing practices by public providers, and the lack of key medical supplies such as drugs. User fees are likely to remain in place until governments are ready and more able to mobilize greater funding for health care.

A blanket policy to remove user fees could do more harm than good by removing a small but important source of revenue at the health care facility level. Until low-income country governments can mobilize alternative (and more equitable) financing mechanisms, the global community should focus on helping countries design policies that can foster access by the poor to health-enhancing services and protect the poor and near-poor from catastrophic health spending. User fees can be harmonized to achieve these objectives if they reduce financial barriers to the poor by improving the quality of public services, reducing waiting time, reducing the need for costly self-medication, or substituting lower-priced quality public services for more expensive private care.

Conditional cash transfers provide direct cash payments to poor households, contingent on behaviors such as completing a full set of prenatal visits or attending health education classes. They thus represent a negative user fee. The evidence, largely from middle-income countries, suggests that well-designed conditional cash transfers have the potential to improve health outcomes and reduce poverty with relatively modest administrative costs. But additional research is needed to determine whether such programs can be effective in low-income settings.

Securing More External Funding

Donor funding will be critical for most countries to meet the Millennium Development Goals. Donors need to reduce the volatility, improve the predictability, and improve the longevity of aid. They also need to ensure that a larger proportion of aid goes to countries as general budget support and to resolve the health systems, fragmentation, coordination, and sustainability issues raised by disease- and intervention-specific aid. And they need to deal with capacity constraints. Increased debt relief will provide countries with additional fiscal space and resources to fund programs. There are, however, important questions about how this debt relief will be financed by donors and used by countries.

Improving Risk Pooling

To improve financial protection, low-income countries must improve risk pooling. Because private out-of-pocket payments are such a large share of total spending, governments should improve risk pooling through the most viable and effective methods. These methods can include more effective risk pooling through the ministries of health financed by the general budget—and the use of social health insurance, voluntary health insurance, or community-based health insurance—with caveats and enabling conditions kept in mind.

The most globally prominent and straightforward way to increase risk pooling in most low-income countries is through ministries of health acting as national health services. General government revenue-based systems represent the main source of health care funding in 106 of 191 members of the World Health Organization. However, the problems with national health service systems overall, and particularly in low-income countries, have been well documented. Issues of management, accountability, corruption, incentives, underfunding, and misallocation of expenditures are common. The results are limited access to and poor quality of health services as well as limited financial protection against catastrophic health expenditures, particularly for the poor in rural areas. Thus whether a country can take advantage of the substantial strengths of this approach depends heavily on the country's general revenue base, the public sector's management capacities, the public's views about the availability and quality of government services, and the public's willingness to use general government revenues for this purpose.

Social health insurance has the potential not only to improve risk pooling but also to bring additional funding into the health sector. It exists in some 60 countries, mostly high- and middle-income countries. The question is whether social health insurance is the best mechanism in a low-income country setting. Payroll taxes are not the most efficient source for funding a health system, particularly when formal sector employment may be only 10–15 percent of the total. And ministries of health may offer more financial protection than social health insurance.

Proponents of social health insurance argue that giving contributors a clear stake in the system, earmarking funds to protect health expenditures, and improving efficiency through competition on the purchasing side are sufficient justifications to pursue it. At issue are the

preconditions for social health insurance: a growing economy and level of income capable of absorbing new contributions, a large payroll contribution base and thus a small informal sector, a concentrated beneficiary population, and good administrative and supervisory capacity.

Voluntary health insurance can also increase risk pooling using private funding. But it accounts for less than 5 percent of private health spending in low-income countries, and it clearly fares poorly on equity grounds. In most middle- and high-income countries, it generally supplements other types of public insurance. Its scope for promoting significant amounts of financial protection in low-income country settings is likely to be quite limited for several reasons: individuals lack purchasing power, financial markets are generally not well developed, and the ability of low-income countries to set up the complex regulatory structures needed for an effective voluntary health insurance market is questionable.

Community-based health insurance may provide some marginal benefits in increased risk pooling and resources, but alone is unlikely to significantly improve financial protection in low-income settings.

Increasing the Efficiency and Equity of Public Spending

Low-income countries need to increase the efficiency and equity of all public spending, including health spending. Given budget constraints and difficulties in generating additional fiscal space, low-income countries are likely to have a larger and more equitable impact on health outcomes if they select a very basic universal package of public and merit goods, including some treatment services that have been proven effective in advancing toward the Millennium Development Goals. The financing of other interventions should be targeted. Studies of equity show large imbalances in the benefit incidence of public spending on health. So low-income countries must improve their targeting of expenditures to those interventions that have the greatest marginal impact on the poor. Low-income country governments also need to do a better job in purchasing. Whether this job involves decentralization, contracting out, or developing efficiency-based provider payment incentives and systems, countries need to get better value for money spent.

HEALTH FINANCING CHALLENGES IN MIDDLE-INCOME COUNTRIES

The focus of middle-income countries is now on universal coverage, financial protection, and health system efficiency. But these countries still have poverty and income inequality, as well as challenges in literacy, education, employment, and social security. Their health spending, while not insignificant (6 percent of GDP), is substantially below the average for high-income countries (10 percent). They also rely heavily on out-of-pocket expenditures, which account for some 40 percent of all health spending. High out-of-pocket payments, higher but still limited revenue-raising capacities, generally fragmented financing systems, and inefficient purchasing arrangements pose significant constraints to universal coverage and better risk pooling.

Middle-income countries are attempting to increase risk pooling and reduce fragmentation in their multiple pooling arrangements by

- subsidizing the premiums of the poor and sometimes informal sector workers through general revenues,
- expanding pools through mandatory inclusion of other groups and integration of private health insurance funds,
- creating single actual or virtual pools.

Purchasing reforms are a critical part of most middle-income country reform efforts. Most reforms follow the general principles of separating finance from provision, having money following patients, and using incentive-based provider payment systems. Although there is a wealth of experimentation with purchasing reforms, few have been rigorously evaluated, and in many cases results have not lived up to expectations because of the lack of reforms in public sector management and civil service laws.

The main policy recommendations for middle-income countries are to

- View efficient and equitable revenue mobilization as a top priority for health, because it is critical that funding be sustainable and commensurate with long-term needs resulting from the health transition. Count on domestic revenues for the bulk of financing because most development assistance for health is focused on low-income countries.
- Promote increased risk pooling on grounds of equity, financial protection, and allocative

and technical efficiency. Start by pooling the almost 40 percent of total health spending that is out of pocket. As the first step, integrate informal workers by providing the right incentives.

- Provide maximum financial protection and universal coverage by consolidating multiple risk pools. The associated benefits are greater purchasing power and greater efficiency through reduced transaction costs.
- Focus on designing appropriate benefit packages for covered populations because these packages affect the efficiency of risk pooling, the level of financial protection, and allocative efficiency. Standard benefit packages should have the right mix between the breadth and depth of coverage, so that tradeoffs among universal coverage, financial protection, costs, and health outcomes are well balanced.
- Be parsimonious with health spending to expand coverage to more people. Consider increasing overall system efficiency by reforming service purchasing functions and by instituting incentive-based payment mechanisms. Furthermore, payment policies should be in line with overall cost containment and cost-effectiveness objectives.

The specific form of insurance schemes is of less importance than a focus on improving the specific financing functions of revenue collection, risk pooling, and service purchasing. Depending on the context, a combination of insurance schemes may be necessary to accomplish the dual goals of universal coverage and financial protection.

Although there is no “best” strategy to achieve universal coverage, improve financial protection for all, and increase efficiency and quality through more effective purchasing arrangements, policy makers in middle-income countries should focus their immediate attention on improving health services and health coverage for the very poor and vulnerable. Learning what mechanisms have worked well in other countries is necessary for informing reform efforts. Success can occur only when proven financing strategies are adapted to a country’s socioeconomic and political context.

LEARNING FROM HIGH-INCOME COUNTRIES

High-income countries have a rich history of health financing reforms as their systems have evolved from community-based voluntary insurance arrangements to formal public insurance funds to social or national health insurance–based financing systems. Nearly all high-income

countries, with the exception of the United States, have achieved universal or near universal health coverage. The tax-financed systems have been in place for some time, the social insurance systems more recently. Political will was critical to achieving universal coverage, along with economic growth. As most high-income countries have achieved universal coverage, recent reform activities have tended to focus on efficiency gains through purchasing arrangements, rather than on revenue collection and pooling.

Although high-income countries operate in very different contexts from low-income countries, their experiences furnish some lessons for lower-income countries:

- Economic growth is the most important factor in the move toward universal coverage.
- Improved management and administrative capacity is critical in expanding coverage, as is strong political commitment.
- For low- and middle-income countries transitioning to universal coverage, general revenues and social health insurance contributions are the two principal sources of public funding. Both accumulate public revenues into one or several pools. Because the critical issue is pooling, whether a social health insurance or national health service system is ultimately chosen is of secondary importance.
- Voluntary and community-based financing schemes can serve as tests for countries as they seek to expand the role of prepaid health coverage schemes.
- Broader risk pooling mechanisms, instead of fragmented, smaller risk pools, can contribute significantly to effective and equitable financing of health coverage.

Products and services must be evaluated for their effectiveness and cost-effectiveness within the context of particular countries' coverage systems. To facilitate the affordability of such efforts, cooperation among similar countries should be encouraged, possibly led by one or more international organizations.

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