



DISEASE CONTROL
PRIORITIES PROJECT



Financing Health

ECSCA Health Community, DJCC
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INVESTING IN GLOBAL HEALTH "BEST BUYS" AND PRIORITIES FOR ACTION IN DEVELOPING COUNTRIES

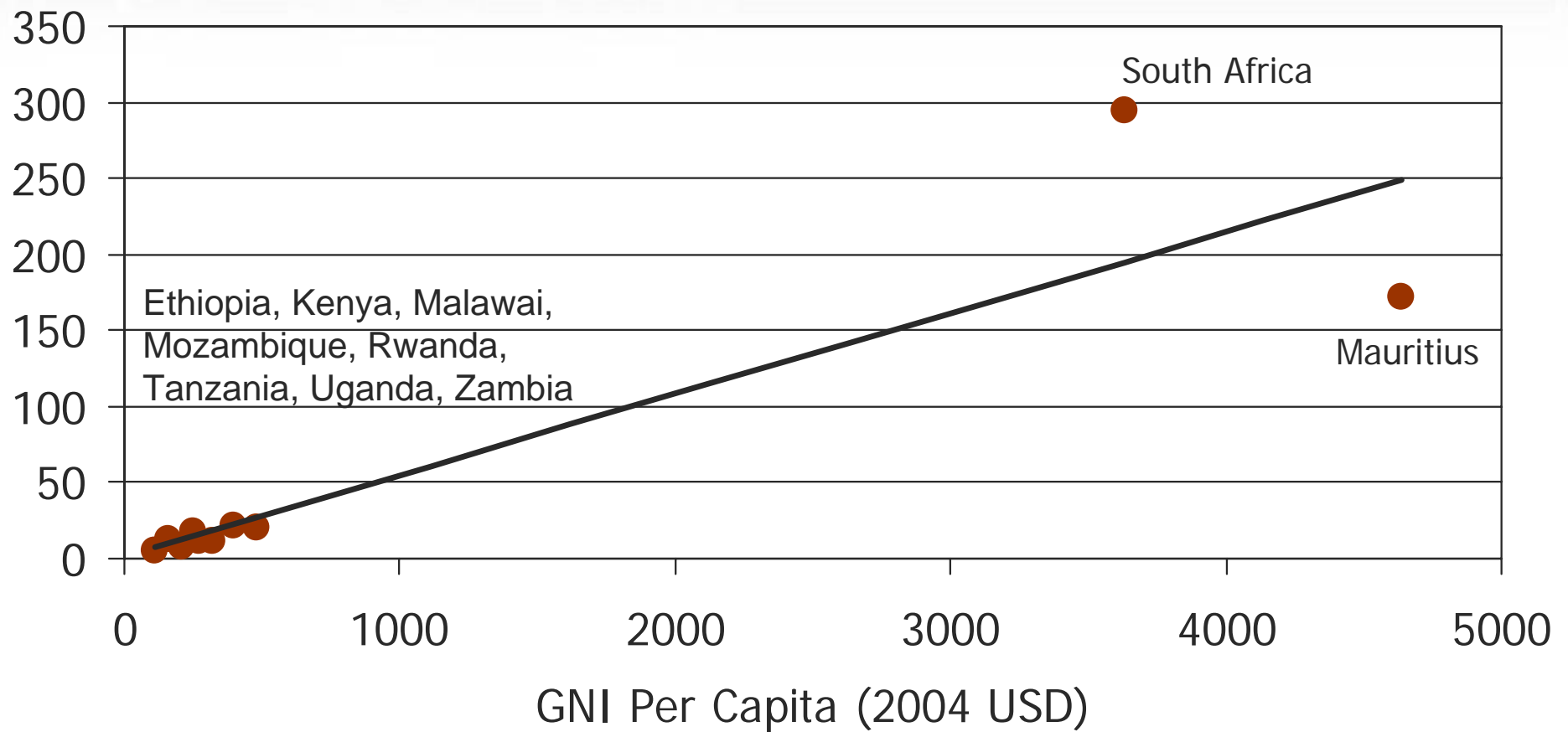
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Outline of Presentation

- ❖ Health expenditures in context
- ❖ Impact of demographic transition on future population health needs
- ❖ Health financing objectives
- ❖ Health financing models
- ❖ Fiscal considerations
 - Sustainability and efficiency of public spending
 - Sustainability of development assistance
 - Absorptive capacity constraints
- ❖ Financing Challenges

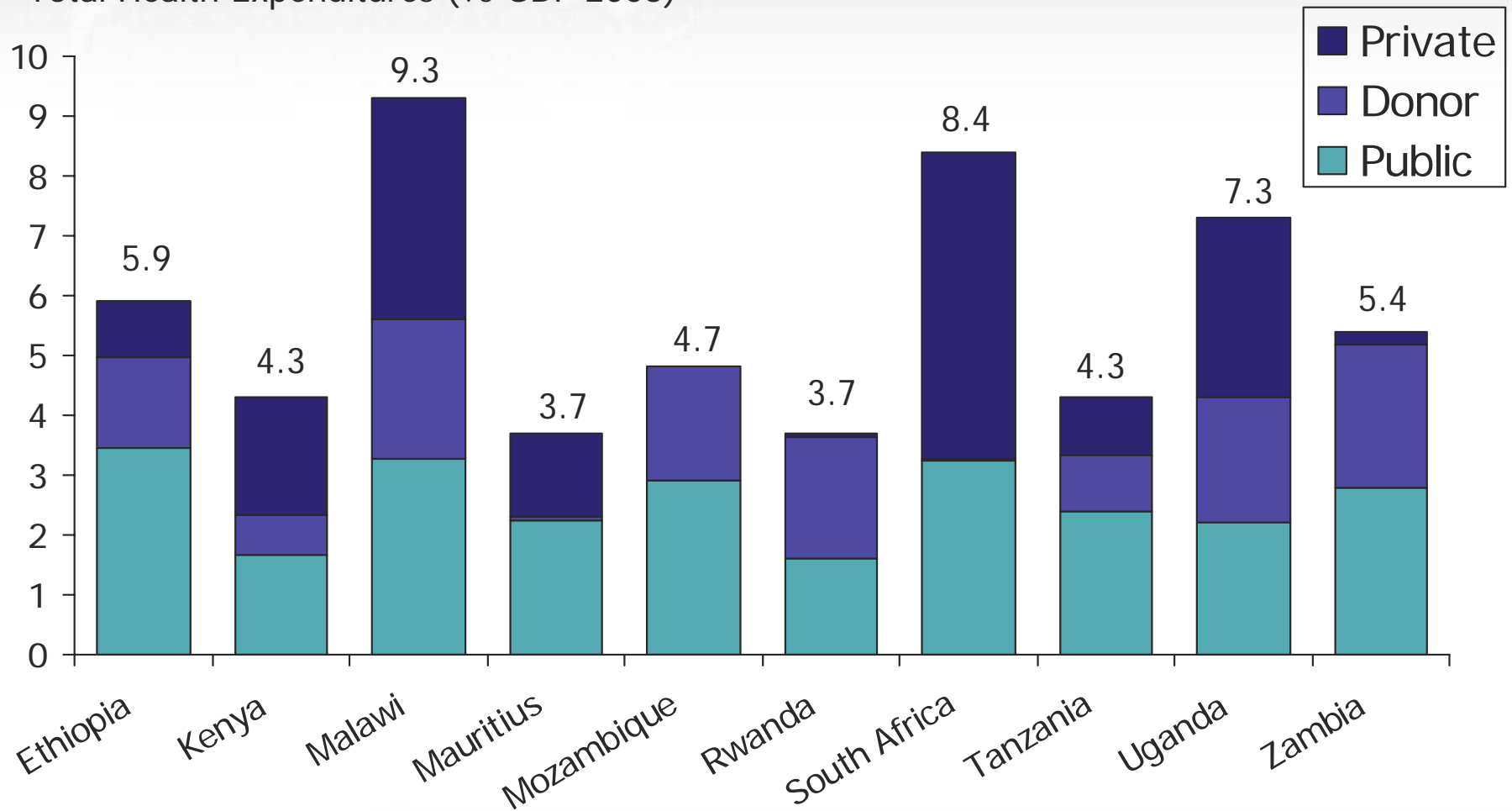
Health Expenditures in ECSCA Countries

Per Capita Health Expenditures (2003 USD)

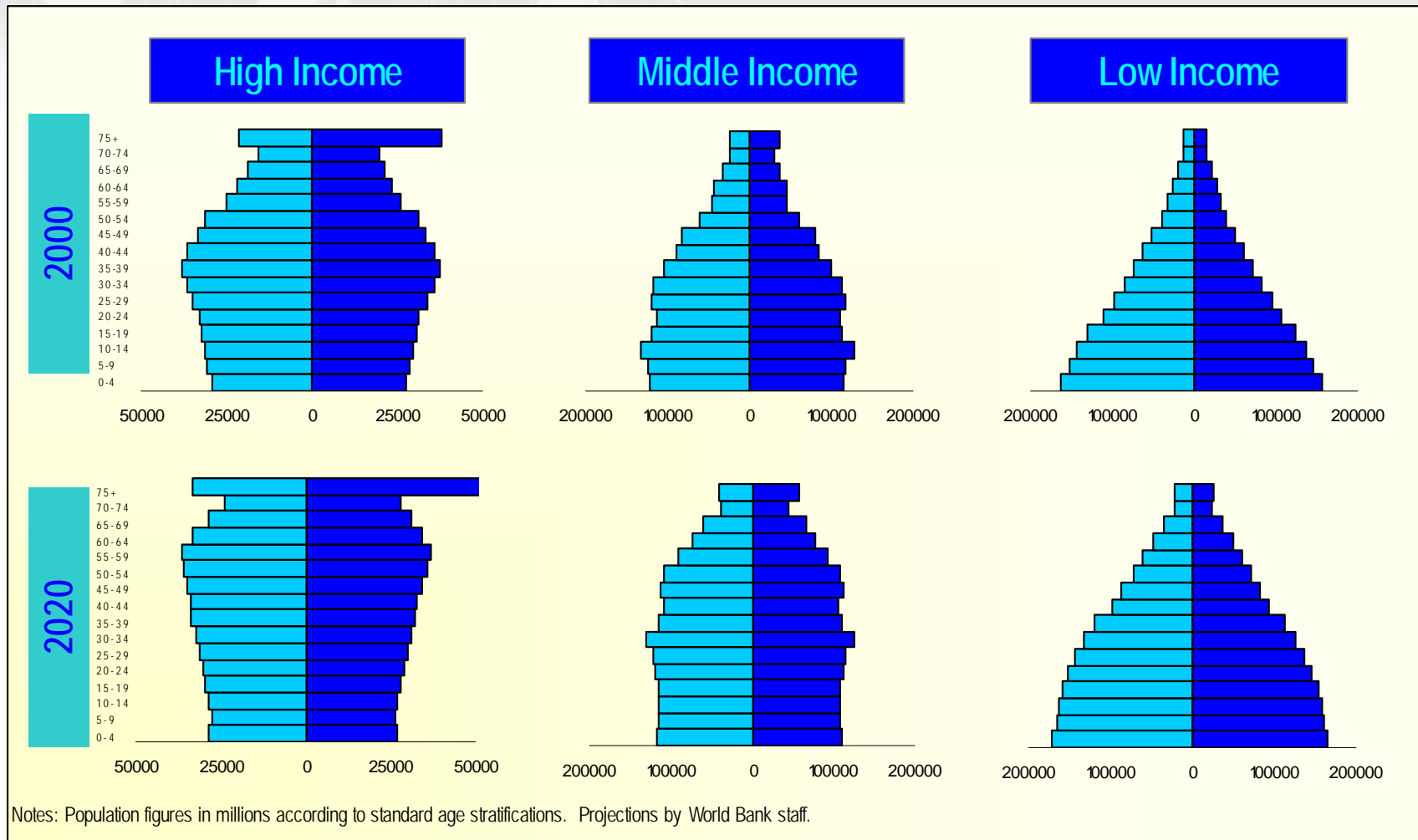


Who Pays?

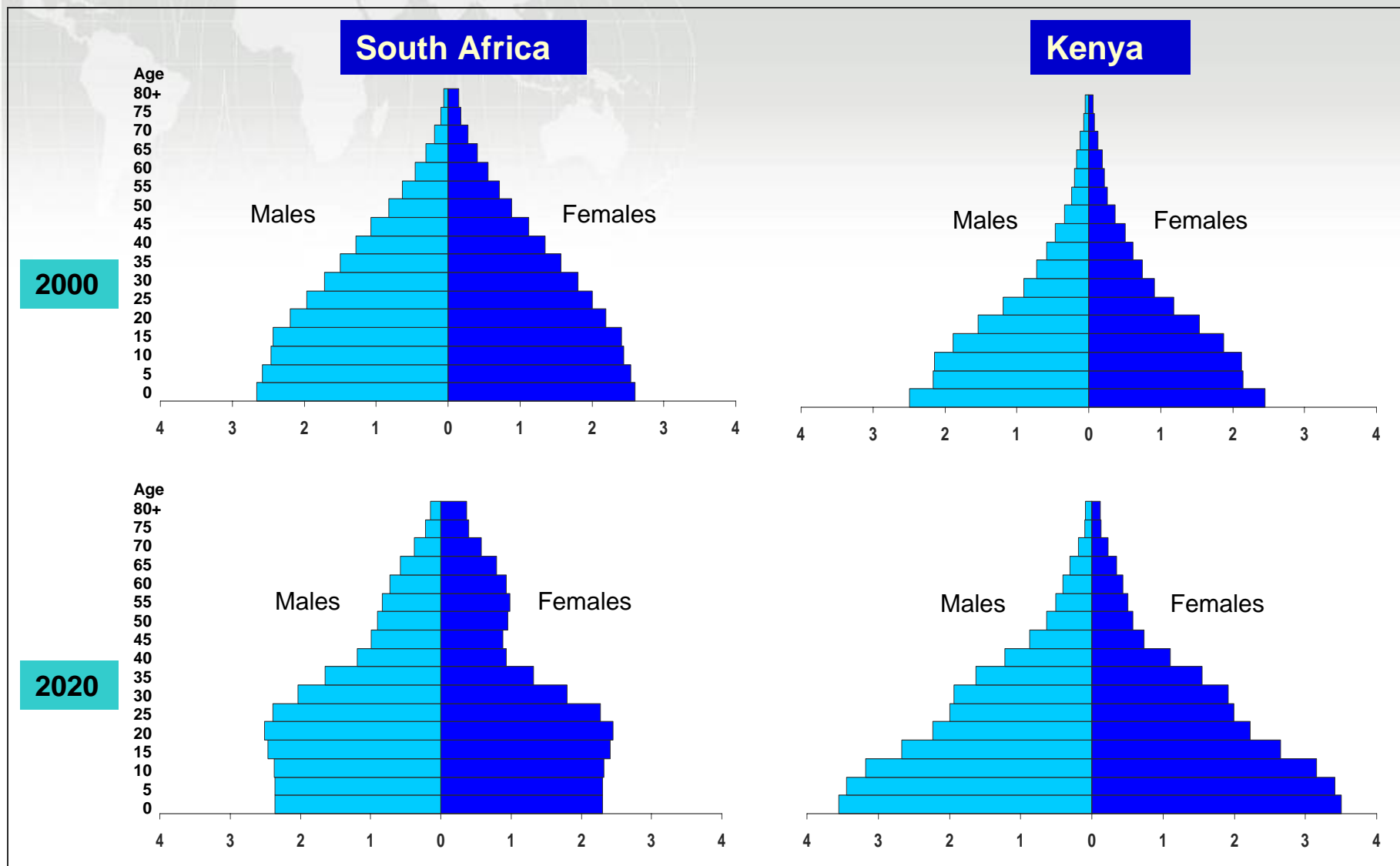
Total Health Expenditures (% GDP 2003)



Underlying Demographics Will Drive Needs/Demands & Affect Economies



Population Structure in SSA



Note: In millions. **Source:** United Nations, *World Population Prospects: The 2004 Revision (medium scenario)*, 2005.

Health Financing Functions & Objectives

Functions

Objectives

Revenue Collection



raise *sufficient* and *sustainable* revenues in an *efficient* and *equitable* manner to provide individuals with both a *basic package of essential services* and *financial protection against* unpredictable catastrophic financial losses caused by illness and injury

Pooling



equitably and *efficiently* pool health risks

Purchasing



purchase health services in an *allocatively* and *technically efficient* manner

Criteria for Effective Tax/Revenue Systems

- ❖ Revenue adequacy and stability
- ❖ Efficiency
- ❖ Equity
- ❖ Ease of collection
- ❖ Political acceptability

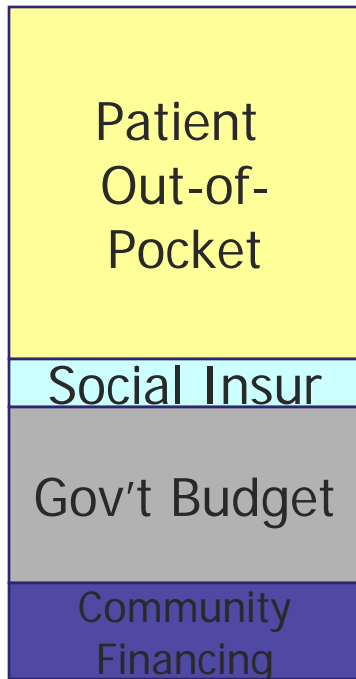
Domestic Resource Mobilization is Limited in MICs & LICs

Regions	Total Revenue as % of GDP	Tax Revenue as % of GDP	Social Security Taxes as % of GDP
Early 2000s			
Americas	20.0	16.3	2.3
Sub-Saharan Africa	19.7	15.9	0.3
Central Europe, Baltics, Russia & Other Former Soviet Republics	26.7	23.4	8.1
Middle East & North Africa	26.2	17.1	0.8
Asia & Pacific	16.6	13.2	0.5
Small Islands (Pop. < 1 million)	32.0	24.5	2.8
Low-income countries	17.7	14.5	0.7
Low middle-income countries	21.4	16.3	1.4
Upper middle-income countries	26.9	21.9	4.3
High income Countries	31.9	26.5	7.2

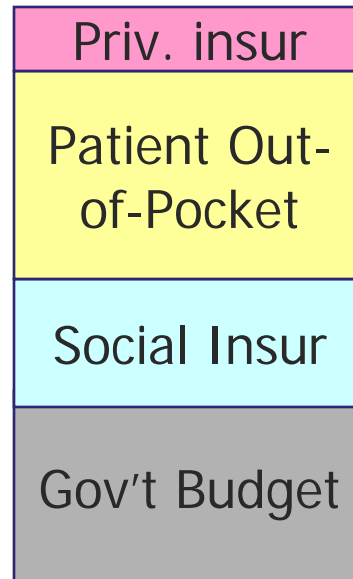
Source: IMF, Government Finance Statistics 2004

Evolution of Health Financing Systems

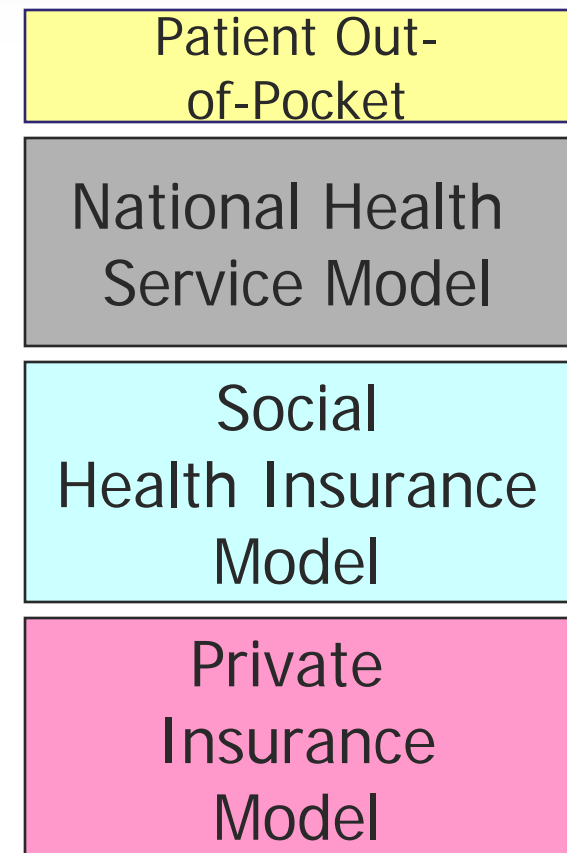
Low Income Countries



Middle Income Countries



High Income Countries



Source: Modified from A. Maeda

Major Health Financing Models

Model	Revenue Source	Groups Covered	Pooling Organization	Care Provision
Out-of-Pocket Payments (including public user fees)	Individual payments to providers		None	Public and private facilities (public facilities)
Social Health Insurance	Payroll taxes	Specific groups	Semi-autonomous organizations	Own, public, or private facilities
Community-based Health Insurance	Private voluntary contributions	Contributing members	Non-profit plans	NGOs or private facilities
National Health Service	General revenues	Entire population	Central government	Public providers
Voluntary Health Insurance	Private voluntary contributions	Contributing members	For- and non-profit insurance organizations	Private and public facilities

Evidence on User Fees is Mixed

Strengths

- Generate additional revenue with which to improve health care quality
- Increase demand for services owing to the improvement in quality
- May reduce out-of-pocket and other costs, even for the poor, by substituting public services sold at relatively modest fees for higher-priced and less accessible private services
- Promote more efficient consumption patterns by reducing spurious demand and encouraging the use of cost-effective health services
- Encourage patients to exert their right to obtain good quality services and make health workers more accountable to patients
- When combined with a system of waivers and exemptions, serve as an instrument to target public subsidies to the poor and to reduce the leakage of subsidies to the non-poor

Weaknesses

- Are rarely used to achieve significant improvements in quality of care, either because their revenue generating potential is marginal or because fee revenue is not used to finance quality gains
- Do not curtail spurious demand because in poor countries there is a lack, not an excess, of demand
- Fail to promote cost-effective demand patterns because the government health system fails to make cost-effective services available to users
- Hurt access by the poor, and thus harm equity, because appropriate waivers and exemption systems are seldom implemented; where they are, the poor get discriminated against with lower quality treatment

Social Health Insurance

(Systems with publicly mandated coverage for designated groups, financed through payroll contributions, semi-autonomous administration, care provided through own, public, or private facilities)

Strengths

- ❖ Health revenue source
- ❖ May be more 'willingness to pay'
- ❖ Removes financing from annual general government appropriations process
- ❖ Generally provides covered population with access to a broad package of services
- ❖ Often has strong support from population
- ❖ Can effectively redistribute between high and low risk and high and low income groups in the covered population
- ❖ Often serves as the basis for the expansion to universal coverage

Weaknesses

- ❖ Poor are often excluded unless subsidized by government
- ❖ Payroll contributions can reduce competitiveness and lead to higher unemployment
- ❖ Can be complex and expensive to manage
- ❖ Governance and accountability can be problematic
- ❖ Can lead to cost escalation unless effective contracting mechanisms are in place
- ❖ Often provides poor coverage for preventive services and chronic conditions
- ❖ Often needs to be subsidized from general revenues

Enabling Conditions for Social Health Insurance

- ❖ High income to support contributions
- ❖ A large payroll contribution base
- ❖ Concentrated beneficiary population
- ❖ Economy able to absorb labor costs
- ❖ Administrative capacity
- ❖ Supervisory capacity
- ❖ Political consensus and will

Community Based Health Insurance

(Not-for-profit prepayment plans for health care, with community control and voluntary membership, care generally provided through NGO or private facilities)

Strengths

- ❖ Community-run and not-for-profit
- ❖ Membership is voluntary
- ❖ Promotes pre-payment
- ❖ Mobilizes financial resources
- ❖ Risk sharing from the well to the sick
- ❖ If premiums are based on income, also risk sharing from the better off to the poor

Weaknesses

- ❖ Access and financial protection limited due to the small size of most schemes
- ❖ Questionable financial sustainability
- ❖ CBHI schemes generally do not reach the very poor
- ❖ Impacts on care delivery are quite limited
- ❖ Should be encouraged only where more comprehensive health financing arrangements cannot be implemented on a large scale

NHS Systems

(Systems Financed Through General Revenues, Covering Whole Population, Care Provided Through Public Providers)

Strengths

- Pools risks for whole population
- Relies on many different revenue sources
- Single centralized governance system gives administrative efficiency and cost control

Weaknesses

- Unstable funding
- Often disproportionately benefits the rich
- Potentially inefficient due to lack of incentives and effective public sector management

Voluntary Health Insurance

(Financed through private voluntary contributions to for- and non-profit insurance organizations, care provided in private and public facilities)

Strengths

- ❖ Prepayment and risk pooling makes it preferable to out of pocket expenditure
- ❖ May increase financial protection and access to health services for those able to pay
- ❖ When an “active purchasing” function is present it may also encourage better quality and cost-efficiency of health care providers

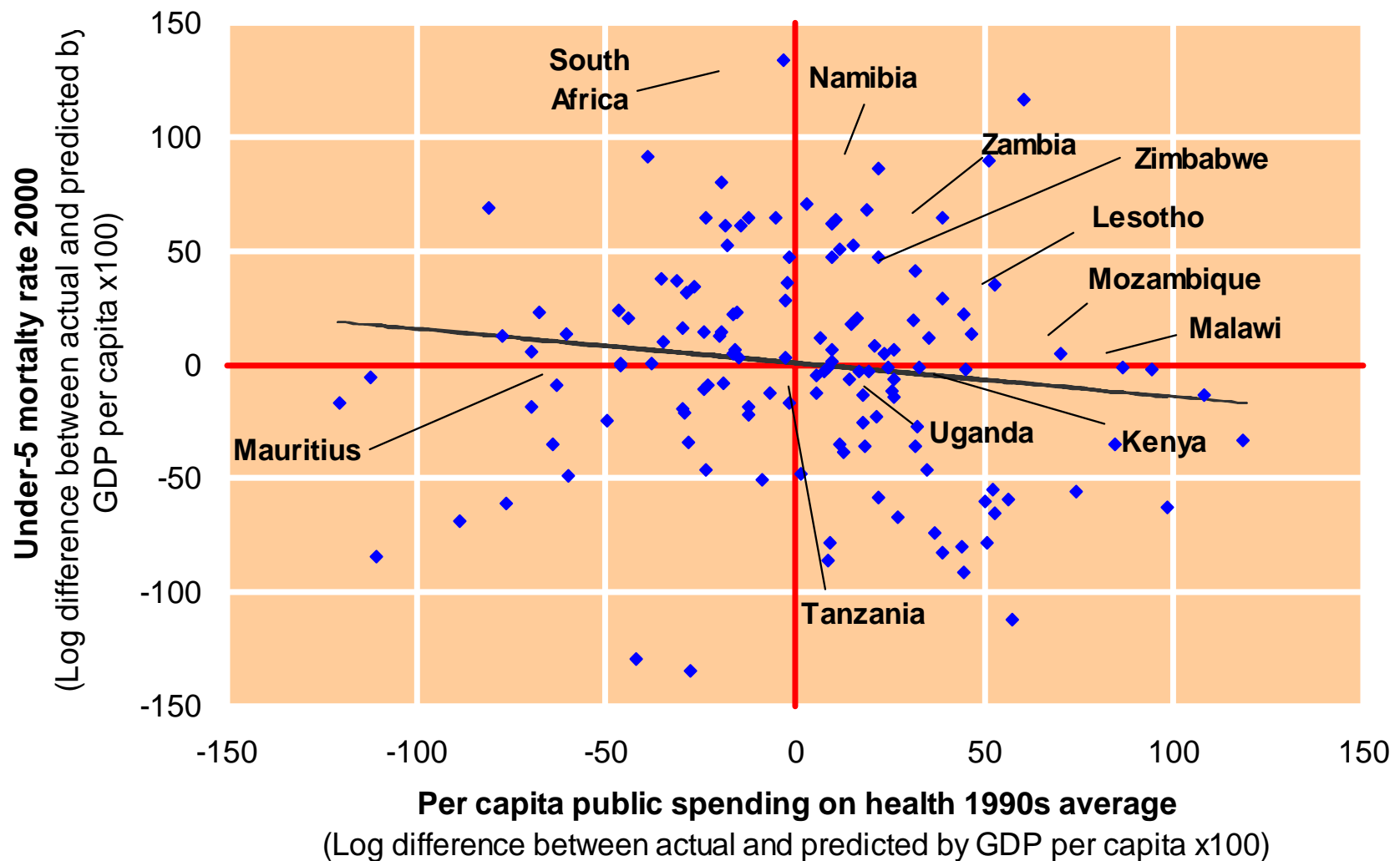
Weaknesses

- ❖ High administrative costs
- ❖ Not effective in reducing cost pressures on public health financing systems
- ❖ May need public intervention to subsidize premiums or regulate insurance content and price
- ❖ Can divert resources and support from mandated health financing mechanisms
- ❖ Requires well developed financial markets and strong regulatory capacity

Sustainable Health Financing

- ❖ Self-sufficiency -- generate sufficient resources to fund the full costs of a particular program, sector, or economy, including the incremental service costs associated with new investments and the servicing and repayment of external debt.
- ❖ Replace donor funds with funds from domestic sources.
- ❖ Sustainability -- defined as the ability to fund recurrent program costs, or a stable and fixed share of costs

Public Spending Efficiency Could be Improved

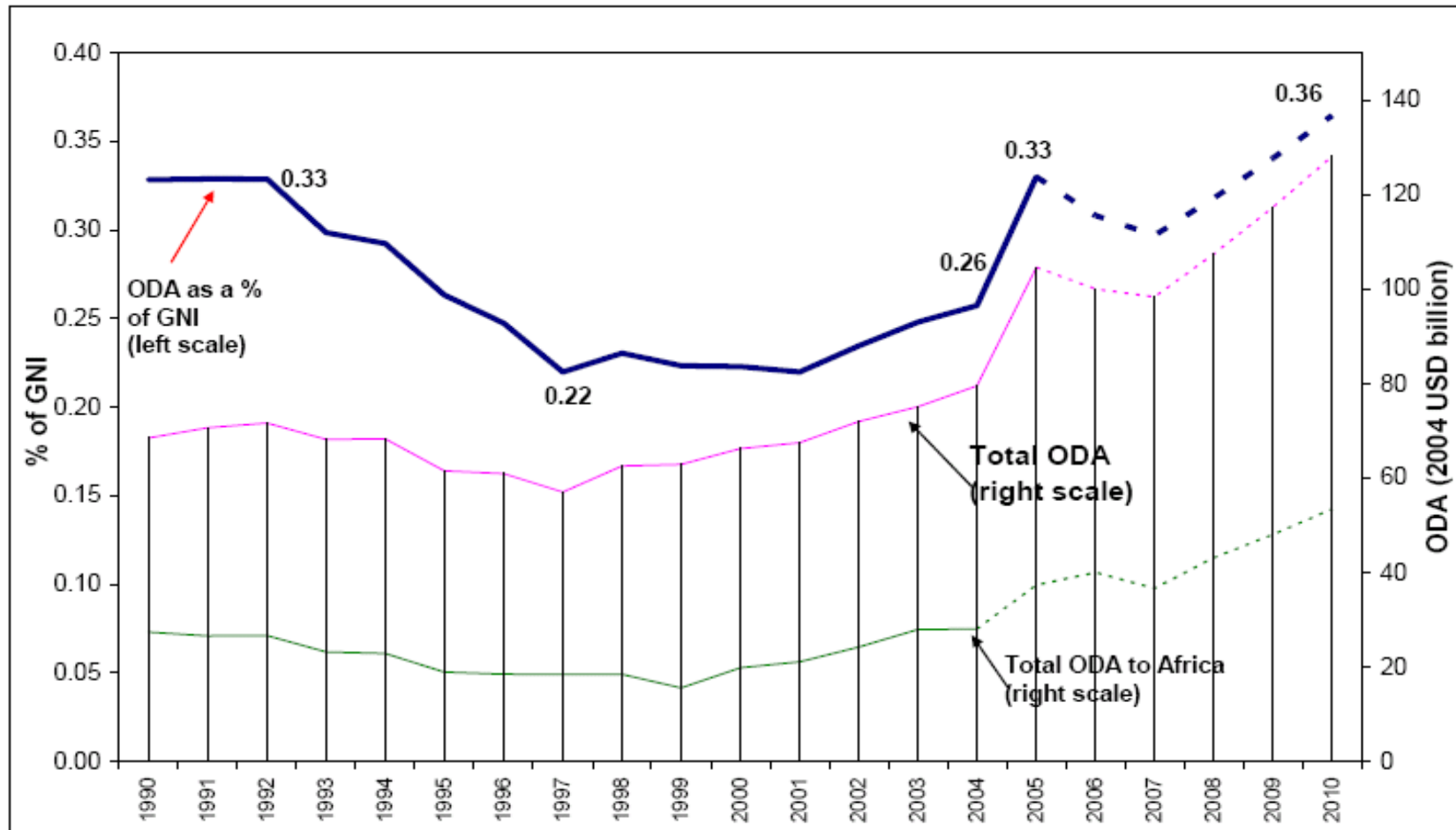


* Public spending and child mortality rate are shown as the percent deviation from rate predicted by GDP per capita
 Source: Spending and GDP from World Development Indicators database. Under-5 mortality from UNICEF 2002, WDR 2004



ODA is Rising But is Well Short of What is Needed

(0.54 percent of GNI to Meet the MDGs and 0.70 to Fulfill the Monterrey Commitments)



Basic Problems in Current ODA System

- ❖ Unpredictable funding, short-term, large differences between donor commitments and disbursements, and lack of harmonization of donor procedures and processes generate problems of macroeconomic management and planning at the country level.
- ❖ Growing concern about the 'verticalization' of aid and the need to focus holistically on health systems as opposed to specific diseases or interventions.
- ❖ Large numbers of new actors and donors and the plethora of 'new' aid instruments (e.g., SWAps, PRSPs, PRSCs, PRGFs, MTEFs, etc.) create problems of management and coordination at both the global and country levels and generate transactions costs and absorptive capacity constraints.

Basic Problems in Current ODA System (cont.)

- ❖ Lack of responsiveness and flexibility of aid to sudden problems and crises.
- ❖ Little accountability of donors and countries for missing M&E systems.
- ❖ A significant portion of aid is off-budget and doesn't enter into the balance of payments or the government's budget.
- ❖ Countries need to create 'fiscal space' to absorb these large increases in external assistance, a potentially problematic situation given IMF fiscal ceilings.

Absorptive Capacity Constraints are Multi-Dimensional

	Macro	Institutional	Physical & Human	Social/Cultural/Political
National Government	<ul style="list-style-type: none"> •Debt sustainability •Competitive -ness 	<ul style="list-style-type: none"> •Monetary & fiscal policy instruments •Exchange rate management 	<ul style="list-style-type: none"> •Administrative, management, & planning skills •Trained technicians •Sector specialists 	<ul style="list-style-type: none"> •Stable national political institutions •Power-sharing mechanisms •Social stability
Fiscal Instruments/ Allocative Mechanisms		<ul style="list-style-type: none"> •Budget systems & procedures •Administrative capacity •Legal framework 	<ul style="list-style-type: none"> •Sector management skills •Connectivity & communications networks 	<ul style="list-style-type: none"> •Cultural norms •Weak institutions •Power-sharing mechanisms
Service Delivery/ Local Government		<ul style="list-style-type: none"> •Local government institutions •Private sector capacity 	<ul style="list-style-type: none"> •Road accessibility, water control, geography •Local government skills & capacity 	<ul style="list-style-type: none"> •Cultural norms, ethnic, caste, & class relations •Local power structure

Financing Challenges

- ❖ No 'right' financing model
- ❖ System financing must be sustainable
- ❖ Tradeoffs between financing essential services and providing financial risk protection
- ❖ Absorptive capacity may be low among countries reliant on donor funding

Financing Challenges

- ❖ Challenging to provide universal coverage, reduce fragmentation among risk pools, and improve purchasing efficiency.
- Risk pooling is essential.
- Evolution to universal coverage depends on level of income and rate of growth. Ability to administrate is a key enabling factor for success.
- ❖ Models need to be tailored to individual country circumstances.