



## Financing Health Systems

April 2006

### Severe Challenges Exist for Low-Income Countries in Setting Health Priorities and Financing Health Systems

About US\$3,059 trillion—nearly 9 percent of global gross domestic product—was spent on health care worldwide in 2001. But only 12 percent of that amount was spent in low- and middle-income countries (LMICs), which account for 84 percent of the world's population and 92 percent of global disease burden.

Now these countries face a growing double burden of disease: increasing rates of noncommunicable diseases such as cancer and heart disease side-by-side with still-potent communicable diseases such as malaria, tuberculosis, and HIV/AIDS as well as new scourges such as SARS and avian flu. The double burden makes this a critical moment for financing capacity in LMIC health systems.

However, resource limitations—especially in low-income countries (LICs)—impose severe challenges for these countries as they try to set health priorities, particularly in raising sufficient funds to provide an essential package of basic services and providing their populations with financial protection against the impoverishing effects of catastrophic illness costs. The donor community and countries urgently need to reform the current system of development assistance for health (DAH), which now funds more than 30 percent of health spending in some LICs. In addition, LMICs must focus on building equitable and efficient health institutional struc-

tures and making the most cost-effective spending choices for health.

#### Low-Income Countries Face Chronic Health Funding Gap

Approximately 2.5 billion people live in countries the World Bank classifies as LICs—that is, with a per capita gross national income in 2002 of less than US\$735 per year. There is a wide gap in these countries concerning the expenditures needed for basic universal health care and actual health expenditures: In 1997, the 48 poorest developing countries spent on average US\$11 per capita (US\$6 per year in public funds) on health—less than one-third the US\$34 per capita needed to ensure delivery of an essential health package for all their citizens. The average per capita health expenditure in all LICs is US\$23 per year, of which between US\$5 and US\$6 comes from public sources (see table).

While LIC governments have recognized the need for greater domestic investments in health, they often have difficulty collecting sufficient domestic revenue—only 18 percent of their GDPs on average, compared with high-income country collections averaging almost 32 percent of GDP. And with projected future economic growth for these countries on the

**Health Expenditures by Country Income Level, Public and Total, 2001**

Country Group	Health expenditure per capita (2001 US\$)	Health expenditure (percentage of GDP)	Public sector expenditures (percentage of total health expenditures)
Low income	23	4.4	26.3
Middle income	118	6.0	51.1
High income	2,841	10.8	62.1
(Countries in the European Monetary Union)	(1,856)	(9.3)	(73.5)
World	500	9.8	59.2

Source: Jamison, D. T. 2006. "Investing in Health." In *Disease Control Priorities in Developing Countries*, 2nd ed., ed. D. T. Jamison, J. G. Breman, A. R. Measham, G. Alleyne, M. Cleason, D. B. Evans, P. Jha, A. Mills, and P. Musgrove, table 1.2. New York: Oxford University Press.

order of 4 percent during 2006-15, LICs will face difficulties mobilizing additional domestic revenues and will in most cases be unlikely to provide the financing base needed to deal with the HIV/AIDS pandemic, achieve the health-related Millennium Development Goals, or even provide a basic package of health services for all. Compounding the problem is the extreme fragmentation of risk-pooling for health insurance in LICs and many middle-income countries (MICs), where between one-half and three-quarters of all health expenditures are out-of-pocket.

Increasing external funds—DAH, either from donor nations, international organizations, or private foundations—is thus critical for LICs to make progress in health. Indeed, DAH has become an increasingly important source of health financing in LICs. Between 1997 and 2002, DAH increased from an average of US\$6.7 billion to US\$9.3 billion. DAH now funds about 20 percent of health spending in LICs and more than 30 percent in 13 extremely poor countries.

But even those levels of DAH still lag far behind the estimated need for health expenditures. The Commission on Macroeconomics and Health estimates that total DAH should rise to US\$27 billion in 2007 and to US\$38 billion by 2015 to scale up coverage to adequate levels. DAH also continues to suffer from a broad range of disappointments: misuse and inefficiency in deployment of funds, gaps in essential areas that require financing support, and weaknesses in institutional and management arrangements. And quick absorption of DAH has proven very difficult in low-income situations where macroeconomic constraints, poor public-sector management, and health-sector specific constraints such as human resources are sorely lacking.

## Middle-Income Countries Are Under Donors' Radar

Middle-income countries (MICs) benefit from higher levels of domestic funding, higher initial levels of risk pooling and prepayment, and stronger health systems than LICs. Many MICs are now focused on ensuring access and financial protection through universal health coverage. However, MICs still face challenges similar to those facing LICs, such as fragmented risk pools for health insurance. Social security

organizations have been opened to the informal-sector employees and the self-employed in some MICs, but in practice still exclude rural workers and the poorest people.

In addition, global health financing policy is currently focused on LICs, leaving most MICs under the radar. The MDG agenda is predominantly an LIC agenda, or at least most MICs perceive it as such—particularly in light of their increased noncommunicable disease and injury burdens, areas that the MDGs do not address.

## Recent Innovations to Improve the Effectiveness of Development Assistance for Health

Evidence is starting to accumulate on the effectiveness of recent innovative approaches to distributing Development Assistance for Health (DAH). These innovations include:

### Providing budget support in strong policy environments.

In LIC settings where policies, governance, and institutions are sound, donors have increasingly sought to provide broad, sector-wide, and flexible budget support to governments to help support a full public expenditure program aimed at raising the level of spending and the effectiveness of resource use for health. This support is typically built on a national poverty reduction strategy that analyzes links between poor health outcomes and income poverty and identifies a policy program that can improve the health of the general population, especially that of poor households. In Mauritania, a transfer of US\$25 million in DAH that backed a public spending plan to double health spending between 2000 and 2004 has shown encouraging early results.

Programmatic sector loans are also showing promise in those MICs where governments have taken key legal, institutional, and spending actions to improve the efficiency of health spending or to target services for poor households. In Argentina, a World Bank US\$750 million loan for health followed government commitments to a maternal and child insurance scheme and other health improvements. The resultant insurance program signed up 100,000 eligible women and children in its first four months.

**Performance-based financing.** Efforts to link the availability of DAH to concrete, measurable results on the ground are now being widely and actively tested at several levels of LIC health care systems—a process pioneered by the Global Alliance for Vaccines and Immunizations, the Asian Development Bank, the U.S. Agency for International Development, and others. Governments of developing countries are paying health care providers in NGOs and the private sector to deliver essential health services to poor households; central governments are determining transfer of funds to local governments based on their performance in strengthening health systems; and donors are releasing funding to recipients in developing countries based on results.

A prime example of such financing is Guatemala's successful large-scale contracting with NGOs to deliver health services. Begun in 1997, that country's Program to Extend Coverage of Basic Health Services had by 2000 a total of 80 NGOs involved in providing health care to about 3.7 million people, with performance measured according to a series of indicators including immunization coverage. Immunization rates rose from 69 percent in 1997 to 87 percent in 2001.

**Stronger engagement with the private sector.** As donors have increasingly become aware of the extent of private-sector involvement in the health sector in LICs—both in the share of health services delivered by private providers and the share of total health spending coming from private sources, including out-of-pocket payments—they have sought to use DAH to engage the private sector in pursuit of basic health goals.

These efforts include both the transfer of development assistance to the private sector through government channels in LICs as well as the provision of direct financial support to private institutions. Prominent examples include subsidies so poor LIC families can buy health-related personal products such as contraceptives, insecticide-treated bednets to prevent malaria, and point-of-use water purification kits; the Global Alliance for Improved Nutrition, which pools funds from donors to expand the fortification of basic foods with micronutrients by private manufacturers; and Avahan, an innovative AIDS prevention program that uses DAH to leverage financial and in-kind support from Indian companies to support a range of HIV prevention programs. Public-private partnerships for new health technologies—including vac-

cines, drugs, and diagnostics—have also raised more than US\$1.5 billion over the past decade and have overseen the development of new drugs for malaria and TB, promising vaccines for malaria and AIDS, and microbicides to protect against HIV infection.

## Recommendations for Donors

While most experts expect that external health funding will continue to grow as developing countries and donors find new ways to boost DAH and use it effectively, substantial room for improvement exists in donor harmonization as well as the amount and effectiveness of DAH.

Recommendations for donors include:

**Make DAH more predictable.** Donor financing is not as reliable or sustained as it needs to be—and in some developing countries such as the Comoros and Eritrea, the fluctuations are so great that they make planning and implementing coherent national health programs nearly impossible. Donors should consider (a) making 10-year guarantees in their DAH grants; and (b) continuing the significant progress already made in forming the International Finance Facility (IFF), which will frontload development assistance by issuing bonds on international markets that would be secured based on legally binding, long-term donor commitments. The IFF could raise an additional US\$50 billion a year in development assistance between now and 2015.

**Increase DAH for health systems.** The recent growth in DAH to combat HIV/AIDS, tuberculosis, and malaria should be matched by similar increases in broad health system improvements. Relatively little DAH is being channeled to address the serious problems of shortages and low productivity in low-income countries' health workforces or to deal with weaknesses in health management information systems, in supply chain logistics for drugs and commodities, and other areas.

**Foster better policy environments.** Even though some carefully targeted disease control activities can confer limited benefits, DAH does not work as effectively in countries where the policy environment is poor. A focus by donors on policy dialogue and technical assistance to improve the environ-

ment for DAH can set the stage for a larger infusion of financial support down the road.

**Support research and development.** The current architecture of DAH does not contain a mechanism to ensure that adequate funds flow to upstream stages of research and development on new health technologies, where the private sector lacks market incentives to invest and where national research bodies have so far not been up to the task. New technologies are emerging with modest external funds from recently established public-private partnerships, but they need to be reinforced with additional funding. One option would be to design a new funding facility within the multilateral banks that would allow them to allocate significant resources to global health research and product development.

**Harmonize pools and donors.** Multiple donors should consider pooling their funds for commonly agreed-upon programs with specific expenditure items and agree to use similar, streamlined procedures for procurement, monitoring and evaluation, and reporting.

**Address DAH absorption.** Effective absorption of DAH will also continue to pose difficulties for countries with weak capacity and raise questions about aid effectiveness, predictability, and stability, and about new investments' financial sustainability at the country and donor levels. In such cases, increased use of NGOs and the private sector in general to complement public-sector action may help.

**Analyze broad versus targeted aid.** The fungibility of external aid—on average, only 29 cents of each additional dollar of aid goes into government development programs, with the rest leaking out into nondevelopment programs such as military spending—has led some analysts to advocate for broad, health-sector DAH conditional to basic government changes in overall patterns of public spending for health. But other analysts argue that broad sector support shortchanges high-impact disease treatments and leads to superficial oversight of bureaucratic processes and a corresponding loss of technical focus and depth. More analysis is needed to determine which circumstances best lend themselves to either sector- or disease-specific aid.

**Cut transaction costs.** Individual procedures for reporting, accounting, and managing DAH funds place heavy and

unreasonable demands on recipient countries. The donor community needs to continue to harmonize and simplify its procedures to reduce these transaction costs.

**Combat leakage.** Central government funds can easily leak as they move through the pipeline from the center to local levels. DAH is more likely to reach communities if they have a decentralized system of fiduciary and technical management in the public sector; strong financial capacity in those NGOs and private-sector firms that serve as providers; a government body appropriately equipped and responsible for regulating quality of providers; and a balanced approach to community-driven development in health to ensure that financing for community health initiatives of the social fund type is sustainable.

**Put MICs on the map.** The donor community needs to put MICs on the global agenda—both in terms of their economic and social development and in terms of their use as good practice examples for LICs as they transition to MIC status. A more concerted effort is needed to analyze what the MDGs mean for MICs and to invest more in the evidence base for MIC-relevant reforms.

## Recommendations for LICs

**Do a few things well.** The implementation capacity of health systems in LICs will often be highly constrained. Capacity is likely to grow most rapidly by building on a base of doing a few things well rather than many things poorly. By focusing limited resources on a few targeted areas, countries with limited capacity can achieve impressive results in terms of disease control efforts and also have such efforts enhance overall system capacity.

**Tax for health.** Healthy fiscal policy—identifying and correcting inappropriate subsidies such as for tobacco production, and taxation policy to change health-related behaviors—is also important.

**Target conditions important to the poor.** Wealthier people are often more likely to benefit from public programs than are the poor. Therefore, making coverage universal for cost-effective interventions for conditions important to the poor

is likely to be an efficient way of both improving health outcomes and enhancing equity.

**Use cost-effectiveness analyses.** The expected volume of DAH is still unlikely to match the large health needs of the developing world and the requirements to attain the MDGs. Countries and donors will therefore face difficult decisions in relation to priority setting and require better tools to make such allocation decisions. Cost-effectiveness analysis such as that offered by the Disease Control and Prevention Project offers one such tool.

## Recommendations for MICs

**Universalize coverage for publicly financed interventions.** Early adoption of universalization of coverage for publicly financed interventions—even if only a few can be financed—sets the stage for expansion in MICs to universal public financing of health care, the overwhelming choice of the democratic process in high-income countries.

**Adopt a virtual single risk pool for health insurance.** For most MICs, the reality is that multiple risk-pooling arrangements for health insurance exist, leading to a fragmented, inefficient, and inequitable health financing situation overall. Given that developing proper regulations and incentive systems for counterbalancing such problems is complicated both institutionally and cost-wise, fostering a virtual single pool (in which medical care would be paid for out of a single publicly administered pool of money rather than by myriad managed-care plans) is likely the most feasible option for these countries.

## Move away from PRSPs as the approach to improving public subsidy management and health system performance.

Poverty Reduction Strategy Papers (PRSPs) are documents jointly prepared by governments, civil society, and development partners that describe a country's macroeconomic, structural, and social policies and programs to promote growth and reduce poverty, as well as associated external financing needs. But few PRSPs consider the role of the health system in ensuring financial protection and reforms of risk-pooling arrangements, which are at the core of most LIC and MIC health-sector financing strategies. A new approach is needed to support MICs' efforts to improve public subsidy management and health system performance to ensure financial protection.

## For More Information

See the following chapters in Jamison, D. T., J. G. Breman, A. R. Measham, G. Alleyne, M. Claeson, D. B. Evans, P. Jha, A. Mills, and P. Musgrove, ed. 2006. *Disease Control Priorities in Developing Countries*, 2nd ed. New York: Oxford University Press.

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