UNDERSTANDING FISCAL SPACE FOR UNIVERSAL HEALTH COVERAGE

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GLOBAL FLAGSHIP COURSE

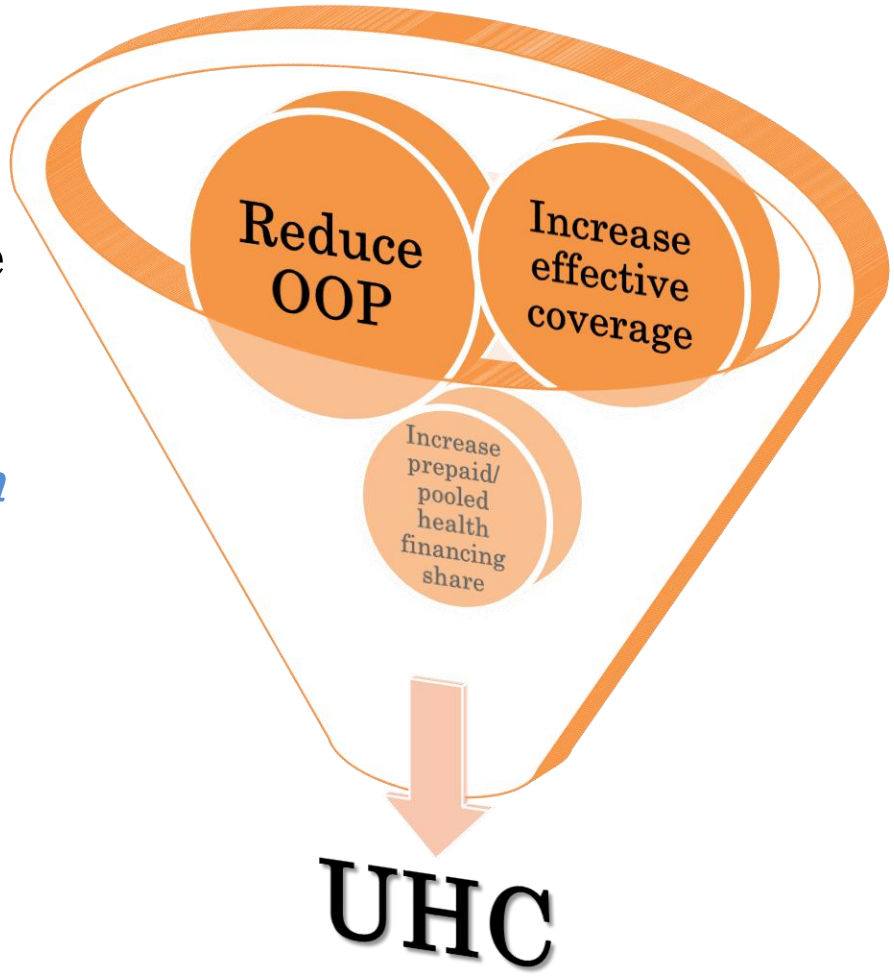
I. Review of UHC

What is UHC?

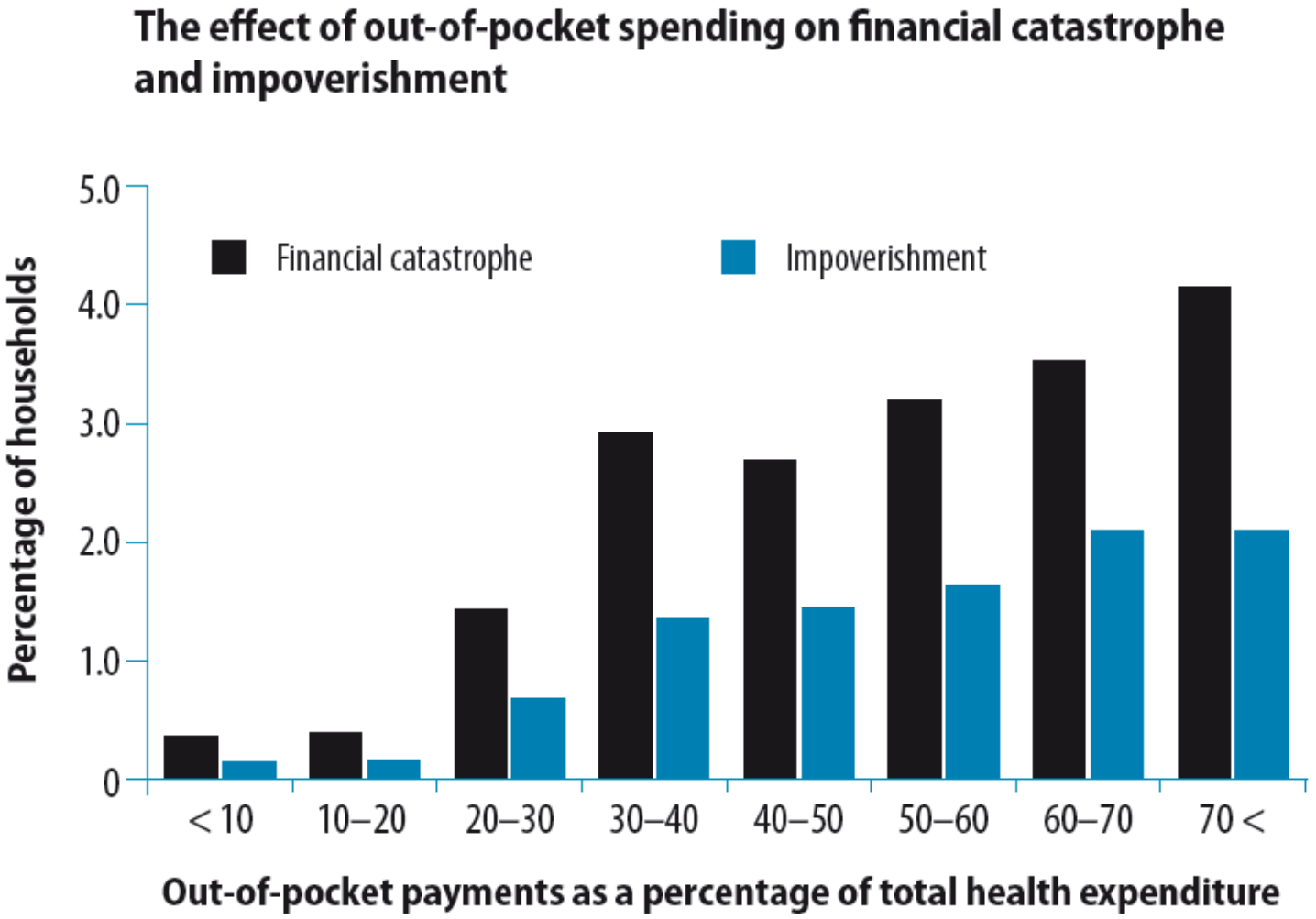
Defining UHC: UHC is about "… ensuring that all people can use the ***promotive***, ***preventive***, ***curative***, ***rehabilitative***, and ***palliative health services they need***, of sufficient quality to be ***effective***, while also ensuring the use of these services does not expose the user to ***financial hardship***."

- UHC is about progressively reducing both the *ill-health burden* and part of the *economic burden of disease*.

- Increasing *effective coverage* of health interventions and reducing dependence on *OOP payments* as well as increasing financing from *prepaid/pooled* sources are key to making progress towards UHC.

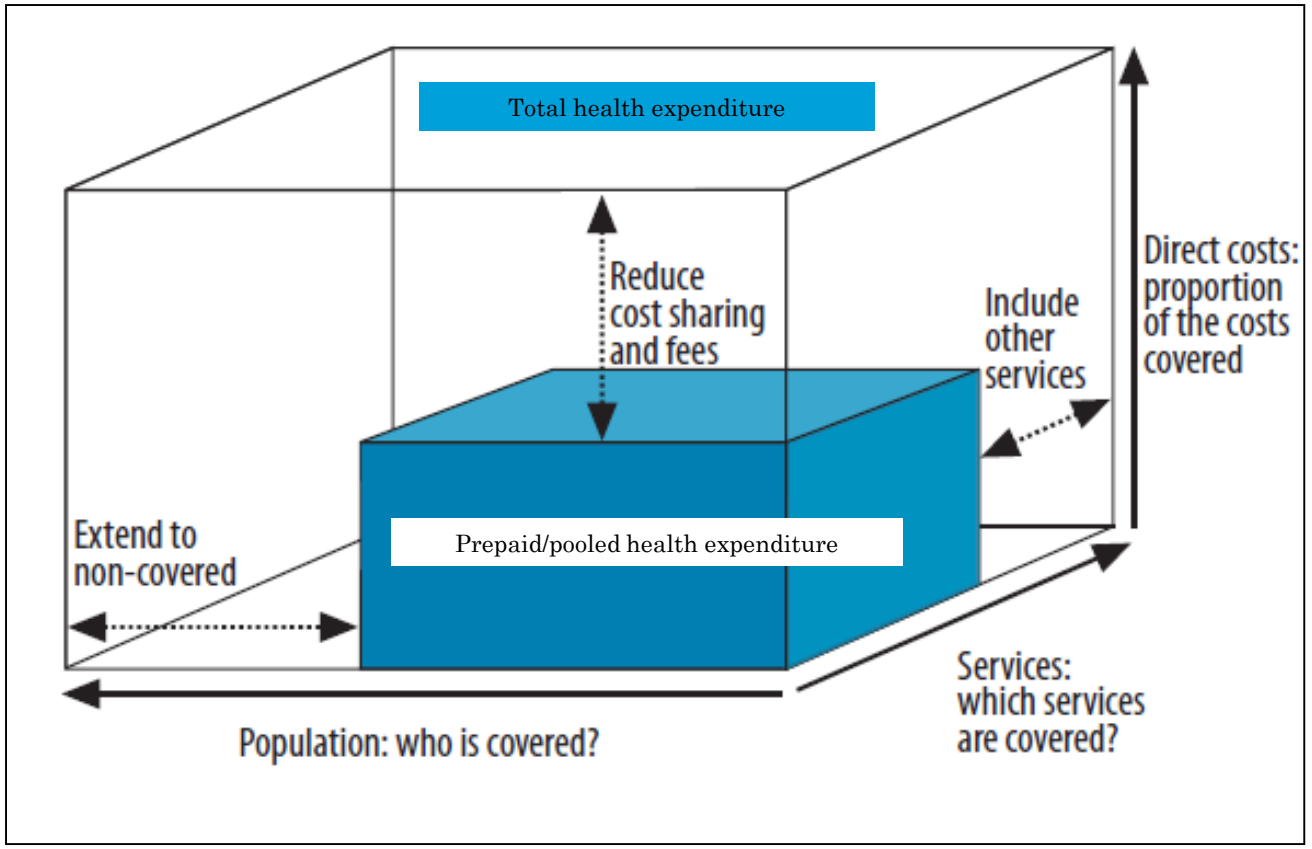


High OOP Payments are a Risk Factor for Impoverishment



Source: WHO

Conceptualizing UHC



1. **Population coverage** ("breadth").
2. **Service coverage** ("scope").
3. **Financial coverage** ("depth").

UHC is a Sustainable Development Goal (SDG)

SDG 3: "ensure ***healthy lives*** and promote well-being for all ages"

Target 3.8:
Achieve universal health coverage

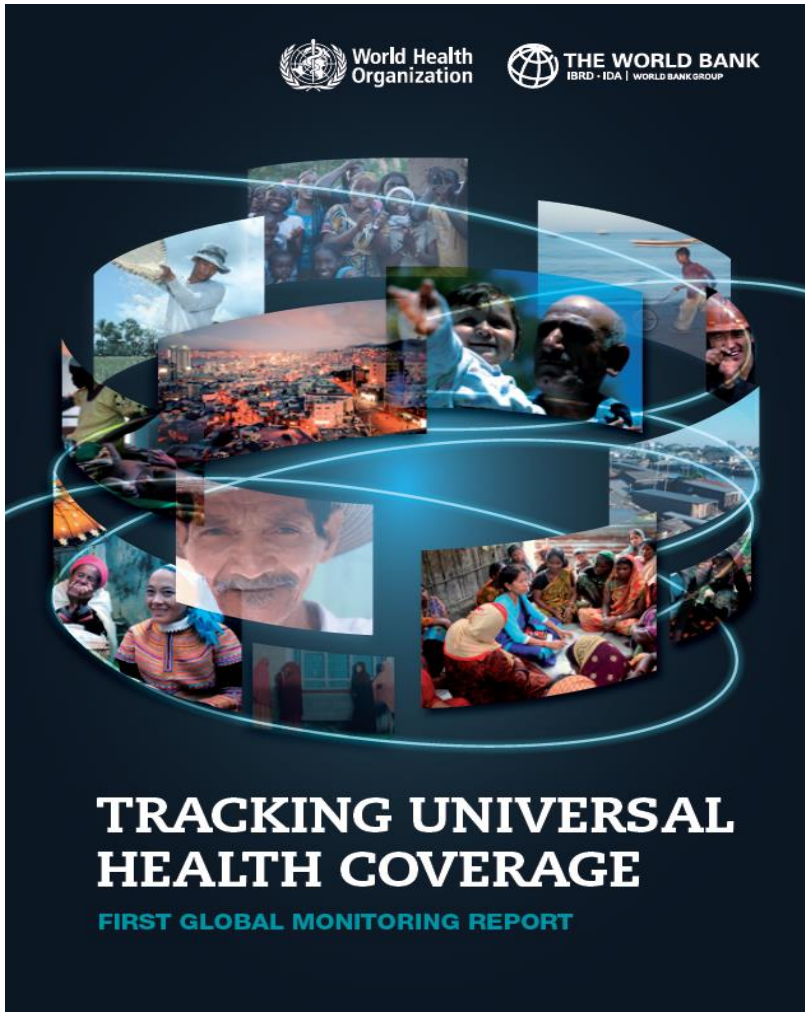
Indicator 3.8.1:
Coverage of essential health services

Indicator 3.8.2:
Financial protection for all

Many Countries Have Attained or Have Committed to Attaining UHC

	Japan 1961	Korea 1989	Malaysia 1990s
Thailand 2002	Philippines 2016*	Indonesia 2019	Vietnam 2020*
India 2022	Lao PDR 2025	Myanmar 2030	Bangladesh 2032

WHO-WB UHC Monitoring Indicators



Preventive/Promotive:

- Access to modern contraceptives
- Antenatal care (ANC) coverage
- Skilled birth attendance
- Full immunization
- Non-smoking rates
- Access to improved water sources
- Access to improved sanitation

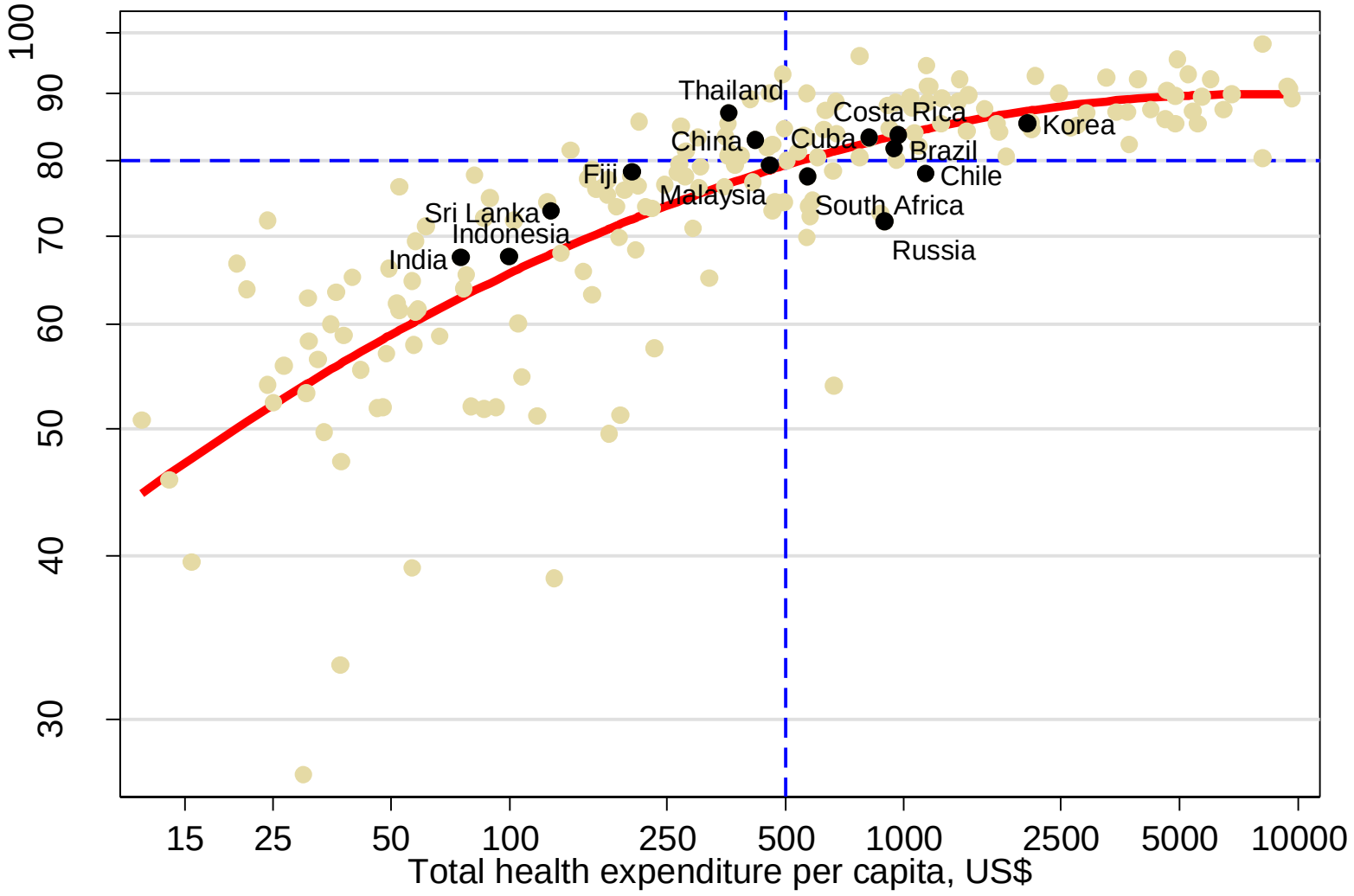
Treatment:

- ARV coverage
- Hypertension treatment
- TB treatment coverage
- Diabetes treatment coverage

Financial Protection:

- OOP spending as share of household consumption
- Household impoverishment due to OOP expenditure

UHC Attainment Index



Source: UHC attainment index is the average of service coverage and financial protection

For the 31 developing countries that have UHC attainment index>=80%:

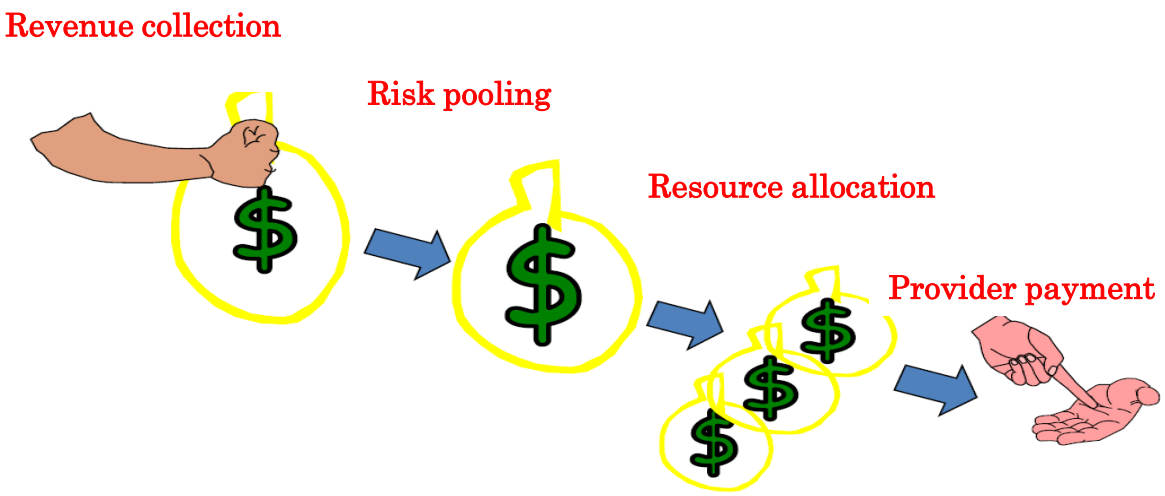
- Median total health expenditure per capita: **US$464** (mean US$541).
- Median total health expenditure share of GDP: **6.7%**.
- Median public share of total health expenditure: **70%**.
- Median OOP share of total health expenditure: **23%**.

Session Objectives

II. Review Basics of Health Financing and Global Trends

Health Financing Objectives and Functions

Health financing is concerned with the mobilization, accumulation, allocation, and utilization of resources in order to help countries make progress towards objectives such as UHC; The amount of money spent on health matters, but where money comes from and how financing is structured is also important

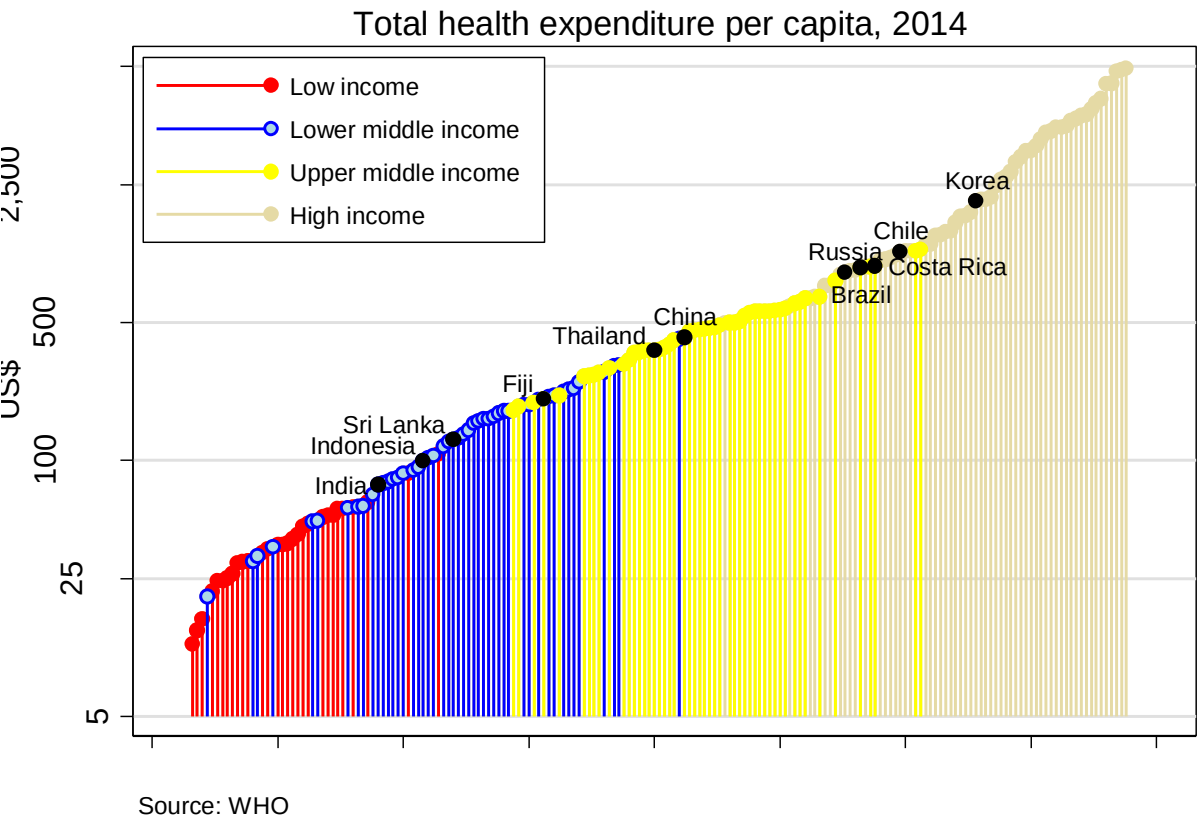


IDEALLY

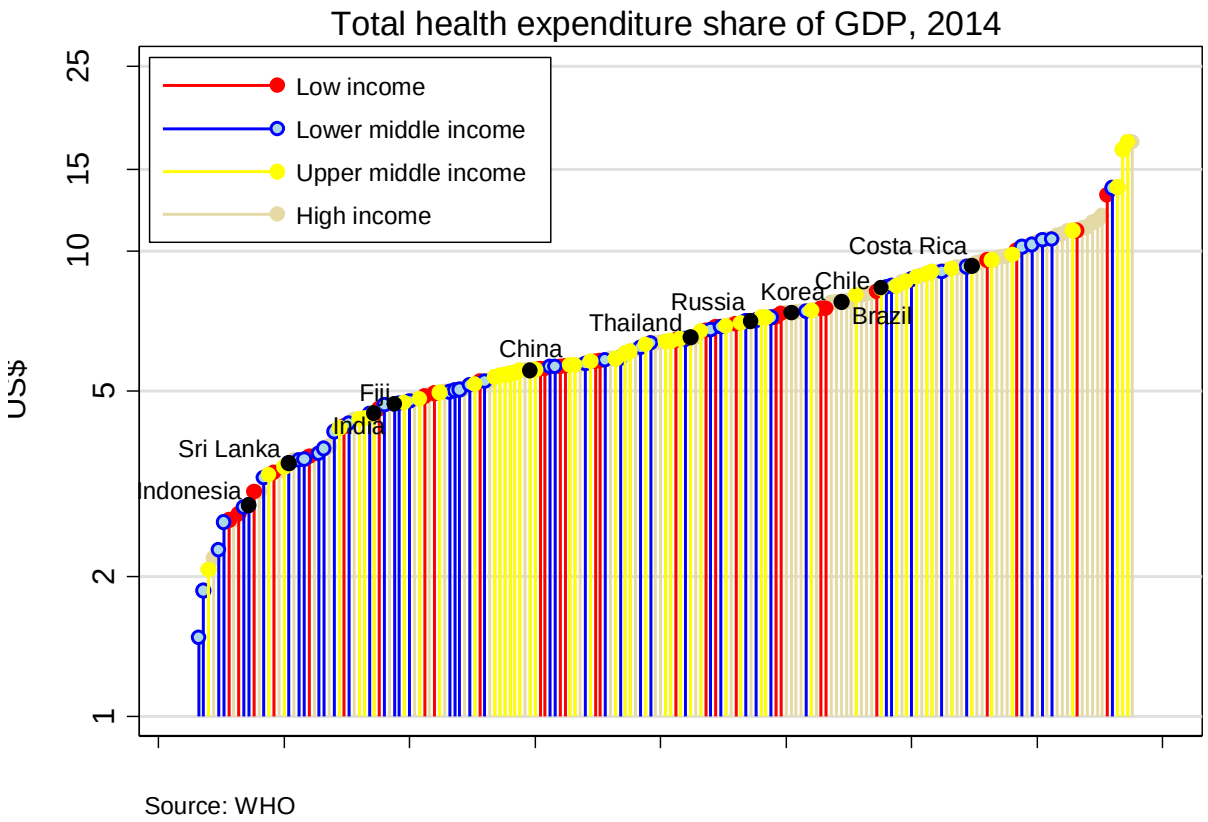
- Raise *sufficient* and *sustainable* revenues in an *efficient* and *equitable* manner
- Manage revenues to pool health risks *efficiently* and *equitably*
- Define *explicit benefits package* commensurate with revenues/service delivery capacity
- Assure allocation of resources and purchasing of health services in an *equitable* as well as in a *technical* and *allocative efficient* manner

Global Health Financing Landscape

Large variations in total health expenditures: from ~US$15 in Madagascar, Central African Republic, and Democratic Republic of Congo (DRC) to almost ~US$10,000 in Norway, Switzerland, USA.



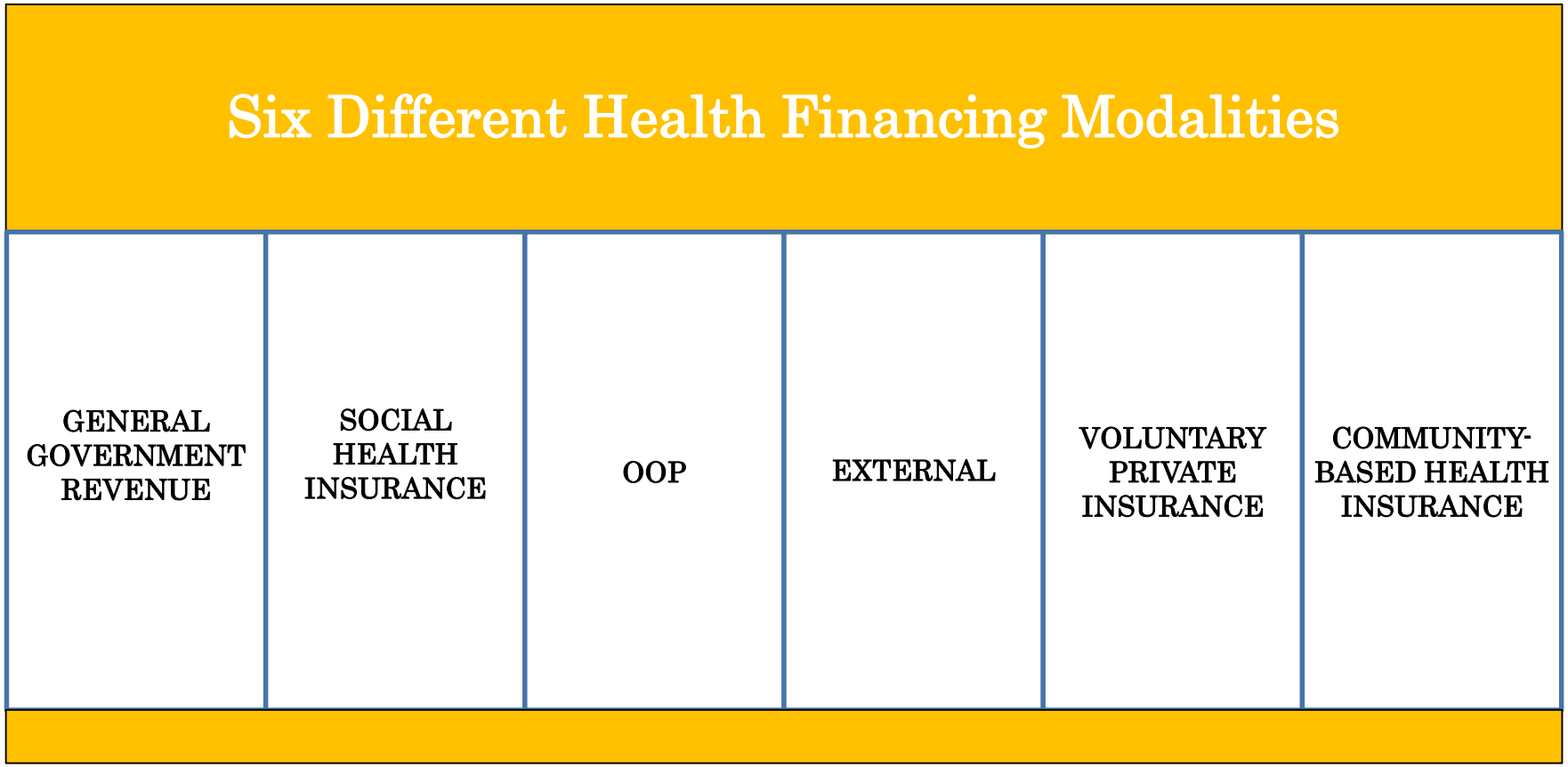
Source: WHO



Source: WHO

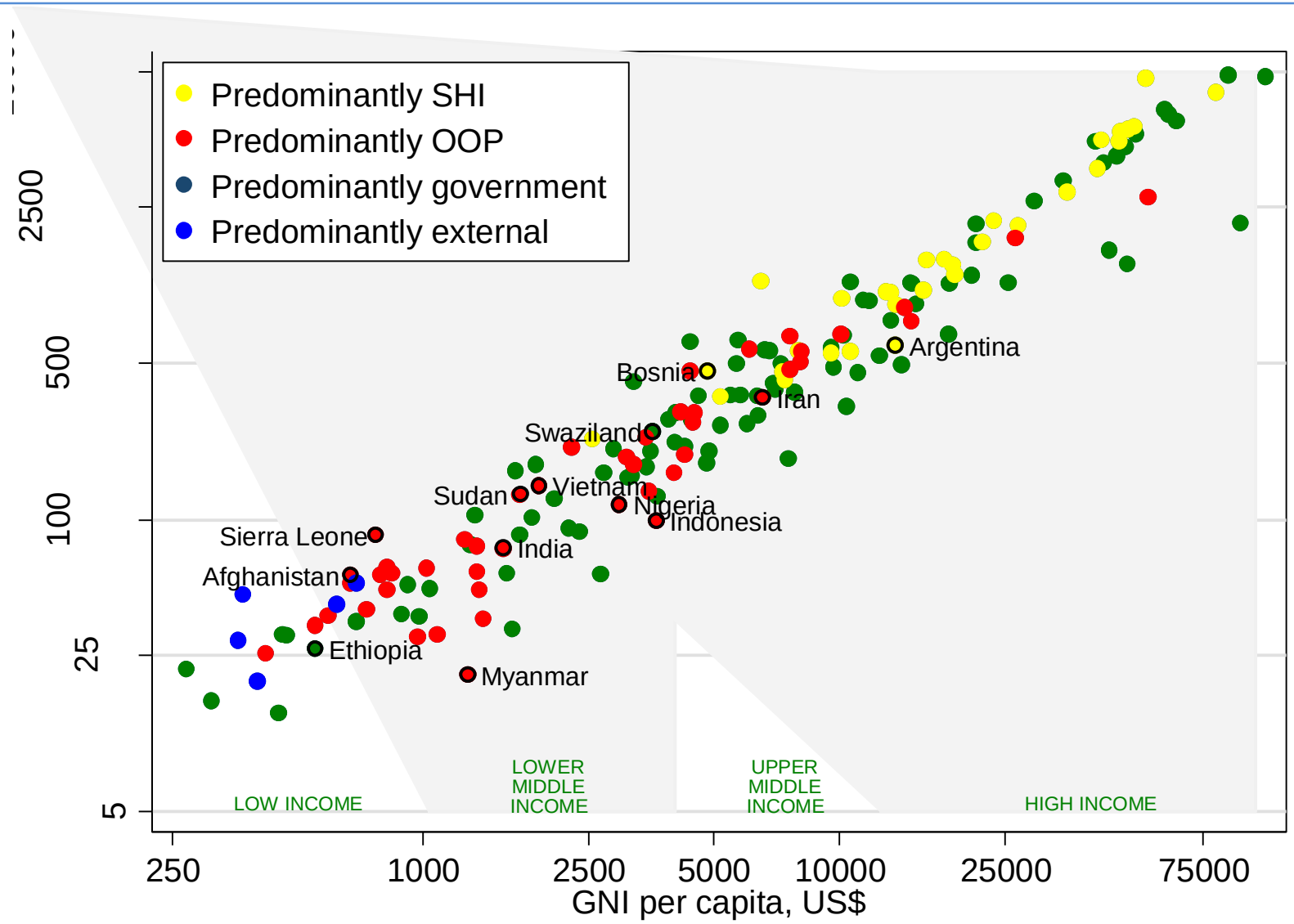
Range: ~1.5% of GDP (Timor-Leste) to ~17.1% of GDP (USA).

Large Variations Not Only in *Levels* But Also in *Composition* of Health Expenditures

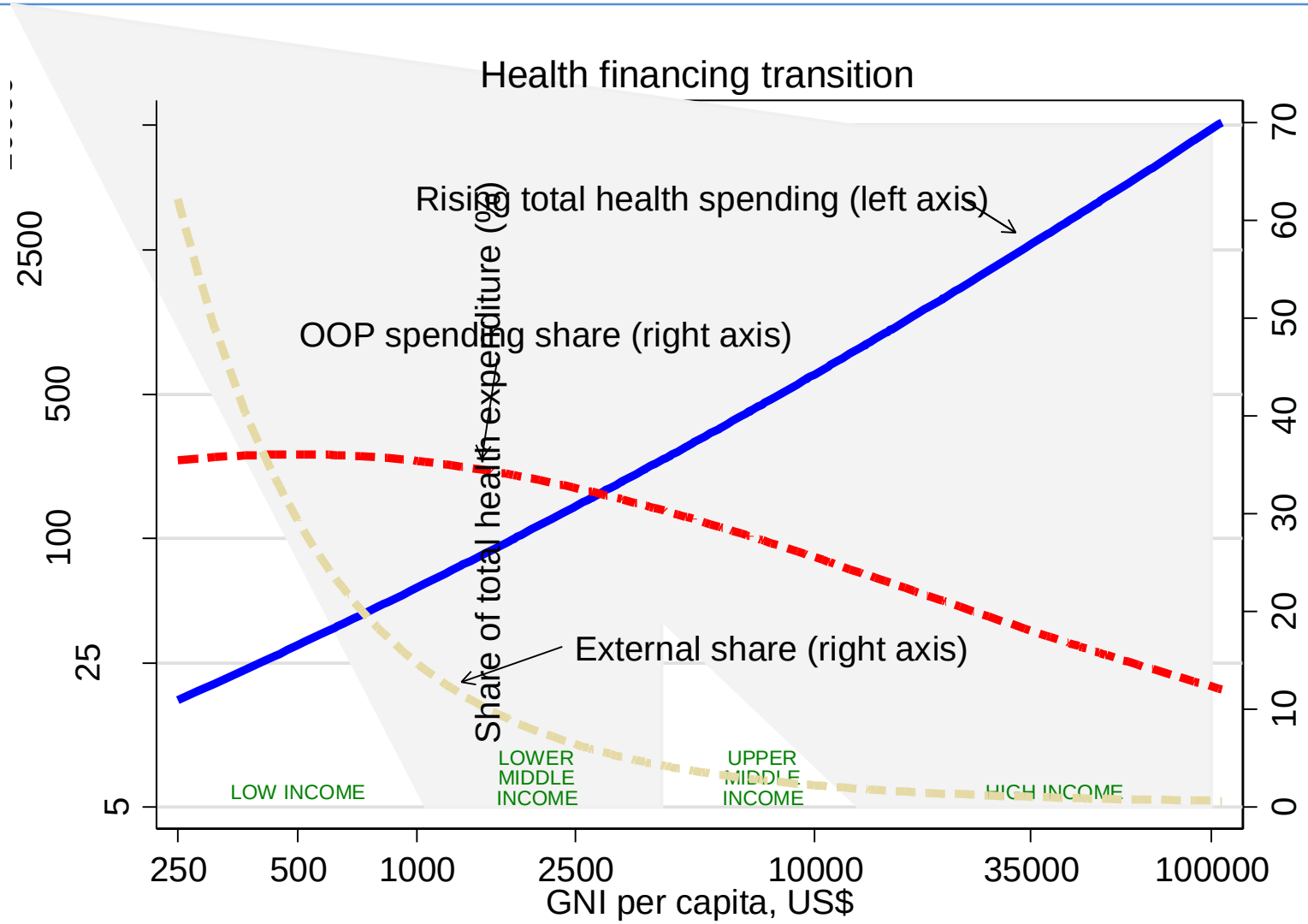


Each option is associated with different modalities of how revenues are generated, pooled, and how health services are purchased, with associated pros and cons; Rarely do we see a "pure" form exist in a country and almost all countries are hybrids; Often different sources in same country and sometimes different populations covered by different methods of health financing.

Health Financing Modalities Change with Income



The “Health Financing” Transition



Source: World Development Indicators database

Session Objectives

III. Outline Framework for Assessing Fiscal Space for UHC

Assessing Fiscal Space for Health

Systematic assessment of the willingness and ability of countries to increase public financing for health in a financially sustainable, efficient, and equitable manner

- Assessments often conducted as a complement to **needs/costing** assessments and follow-up of health financing systems assessments that might show that the health sector is **under-financed** and/or **inefficiently/inequitably** financed.

- Forward-looking assessment; Purpose is to identify possible **sources of** and **constraints to** increasing public financing for health, analyze the pros and cons of the different options, and highlight "good practice" examples from other countries.

- Situates public financing for health within **broader macroeconomic** and **country context** and often is an important aspect of the overall health financing systems assessment; Underscores the fact that the health sector often may have to **"compete"** with other sectors and priorities for scarce public resources.

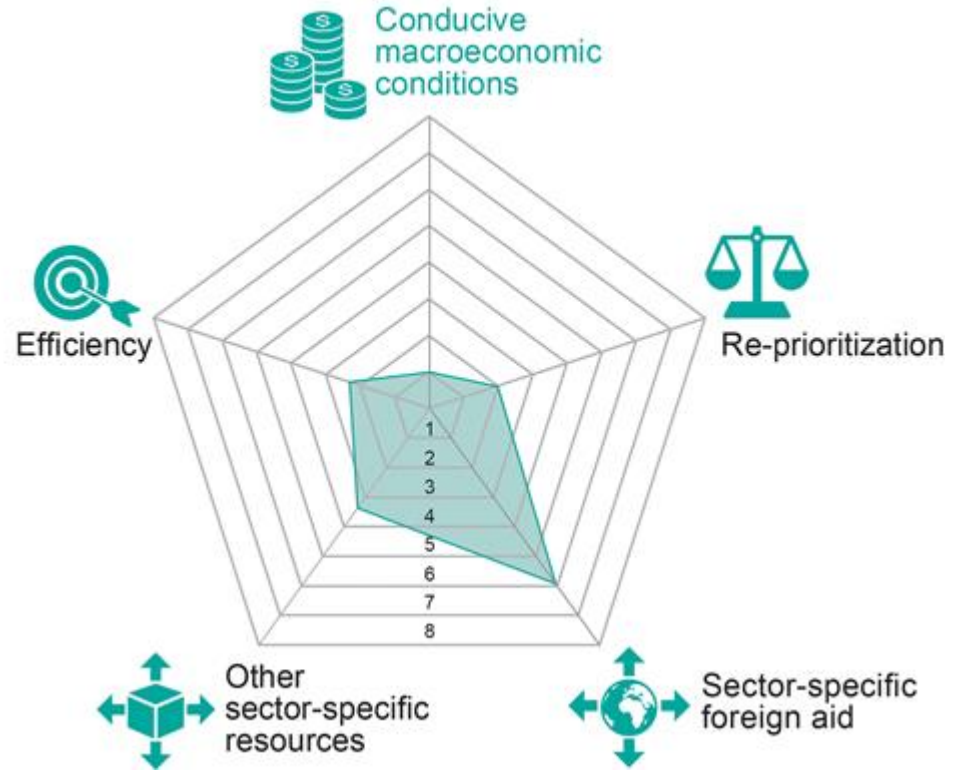
Five Pillars of Fiscal Space for Health

- Can be assessed by (typically) focusing on five different pillars:

I. Deriving implications for health sector from overall fiscal space framework, e.g., as a result of **conducive macroeconomic conditions**.
II. Focusing on the extent to which health might be **reprioritized** within the government budget.
III. Improving the **efficiency** of existing and/or new health sector outlays.
IV. Examining pros and cons of **sector-specific means to raising additional revenues**, e.g., by use of earmarked "sin" taxes, social health insurance, etc.
V. Evaluating the use of additional sector-specific resources from **development assistance for health** from agencies such as GAVI and Global Fund.

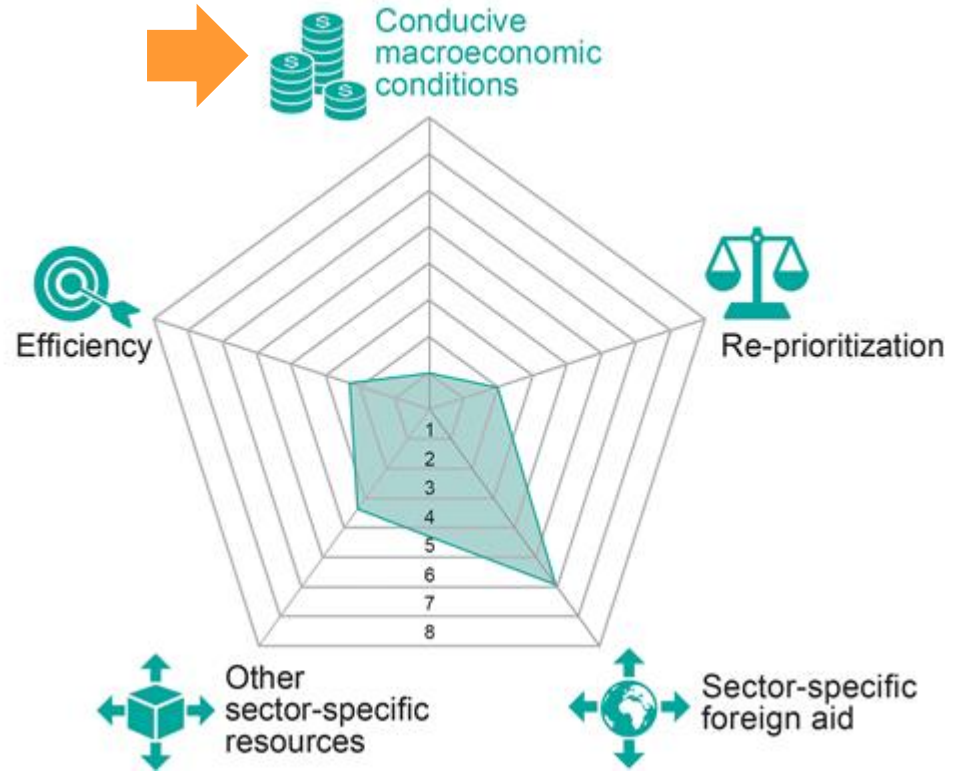
- Some options (e.g., pillar I) outside domain of health sector; nevertheless important to understand implications for health sector.

Fiscal Space Can Be Visualized as "Spider Plot"



Percentage increase in public financing for health

Fiscal Space for Health



Percentage increase in public financing for health

I. Conducive Macroeconomic Conditions

- Assessment of macro-fiscal context of health financing:
  - Interplay between **broader macroeconomic environment** and potential **impact on public financing for health**.
  - Is necessary to "situate" health financing within macroeconomic context; can be used as a first step in fiscal space assessment to derive **business-as-usual** scenarios.
- Focus is generally on impact of economic growth and increases in general government expenditures (due to an increase in general government revenues and/or borrowing) on public financing for health.
  - Impact of other factors such as deficit, debt, inflation/medical inflation, unemployment, informality trends, etc., can also be assessed.

Macro-Fiscal Context Matters for Public Financing of Health

GDP ↑
General government expenditure share of GDP **unchanged**
Health share of general government expenditure **unchanged**

General government expenditure share of GDP

GDP

Scenario I

Scenario II

GDP

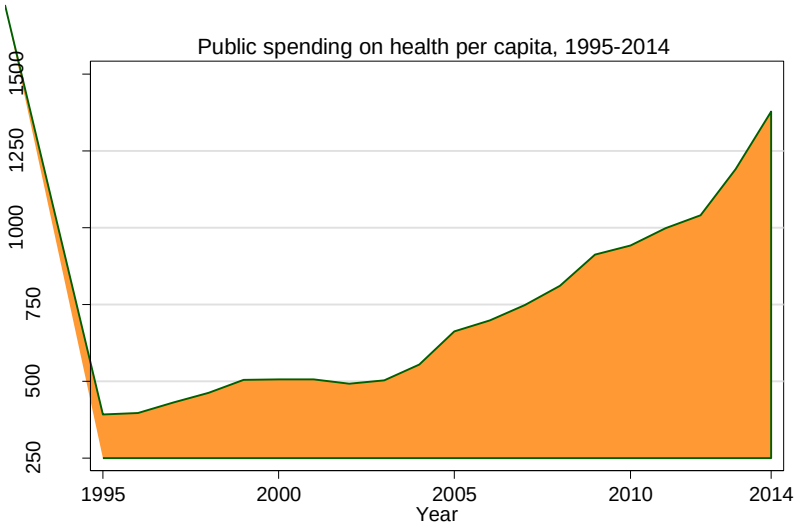
Public expenditure on health ↑

GDP **unchanged**
General government expenditure share of GDP ↑
Health share of general government expenditure **unchanged**

GDP

INDIA

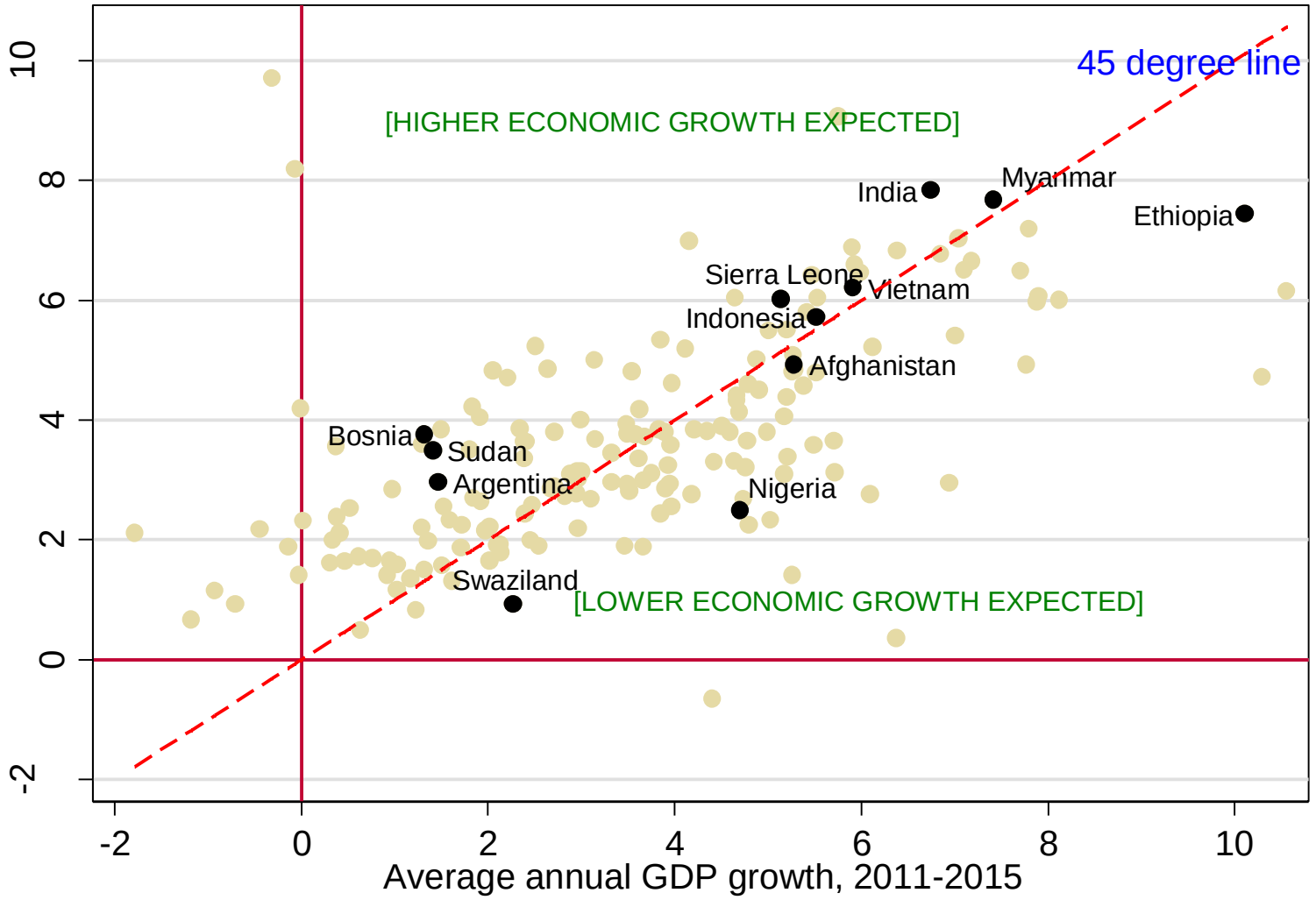
Source: WHO



Source: WDI & WHO
Note: Data are in constant 2014 LCU

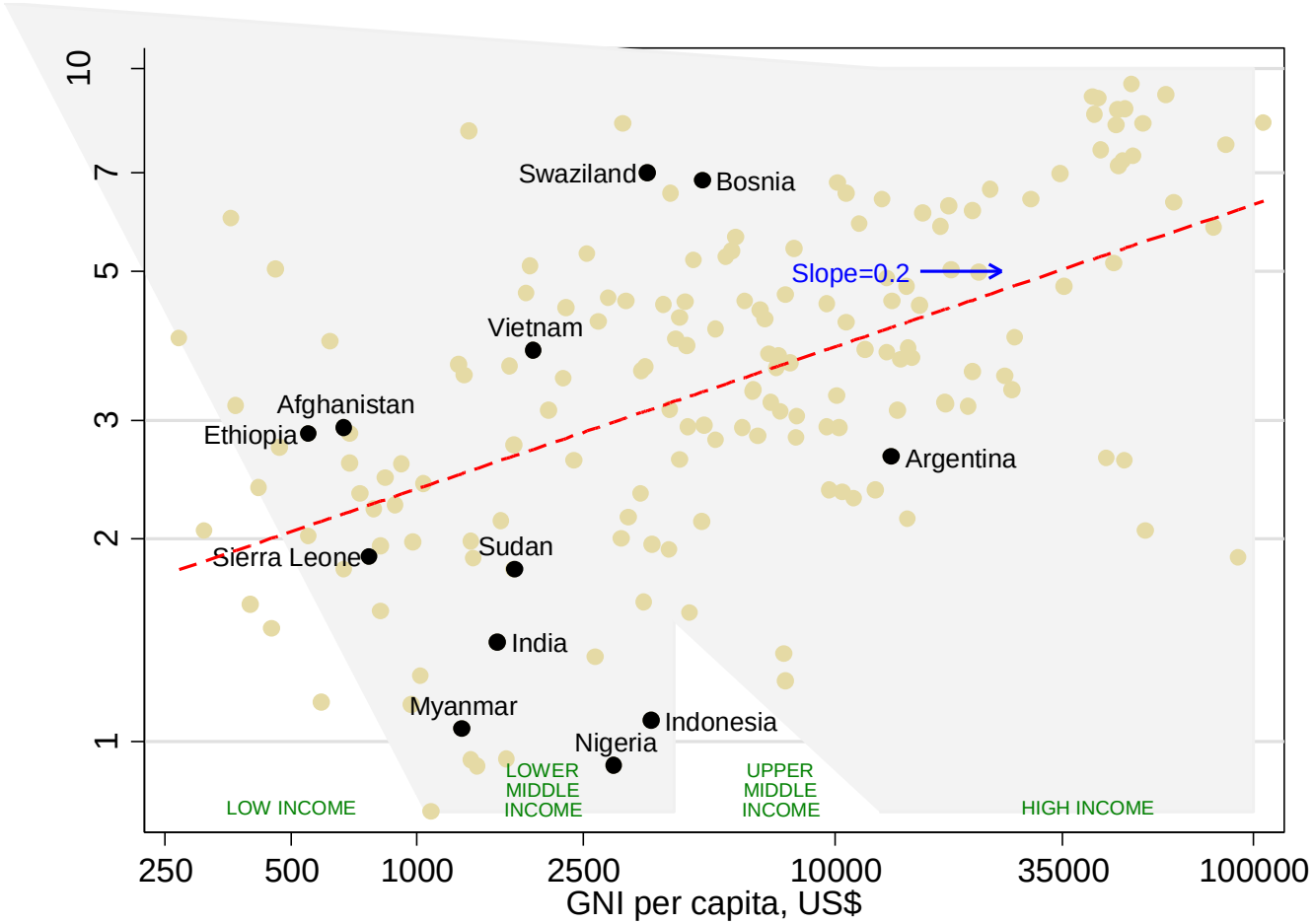
- Public spending on health share of GDP fluctuated around **~1% of GDP** over 1995-2010.
- However, public spending on health **tripled** in real per capita terms over the same period.
- This is because **GDP** grew at an average annual rate of **over 7%** over 1995-2010 (**GDP per capita** grew at **over 5%**). India example underscores the importance of strong economic growth for fiscal space for health, even if nothing else changes.
- Additionality of public resources for health underpinned expansion of the massive National Rural Health Mission (NRHM) program in India, a large infusion of financing for improvements of primary care.

Actual and Projected Economic Growth, 2011-2021



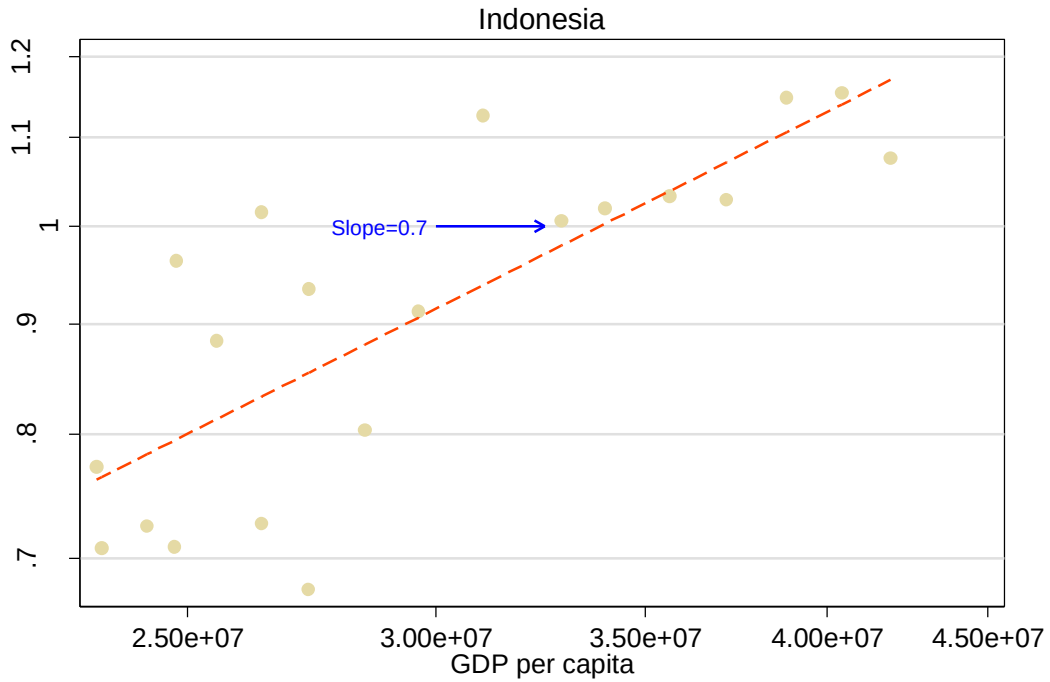
Source: IMF

Public Spending on Health Share of GDP Generally Rises with Income (Cross-Section Data)

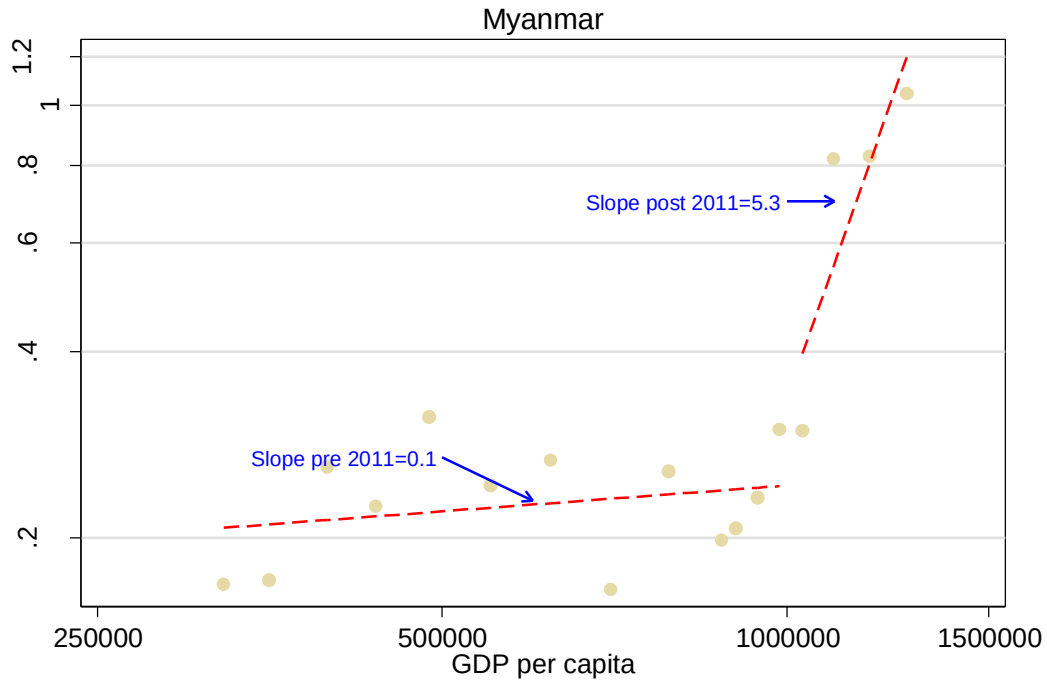


One way to use macro-fiscal information is to assess how public spending on health responds to changes in key variables such as national income: can derive this "elasticity" from cross-section data.

Public Spending on Health Share of GDP Generally Rises with Income (Time-Series Data)



Note: data in 2014 real LCU



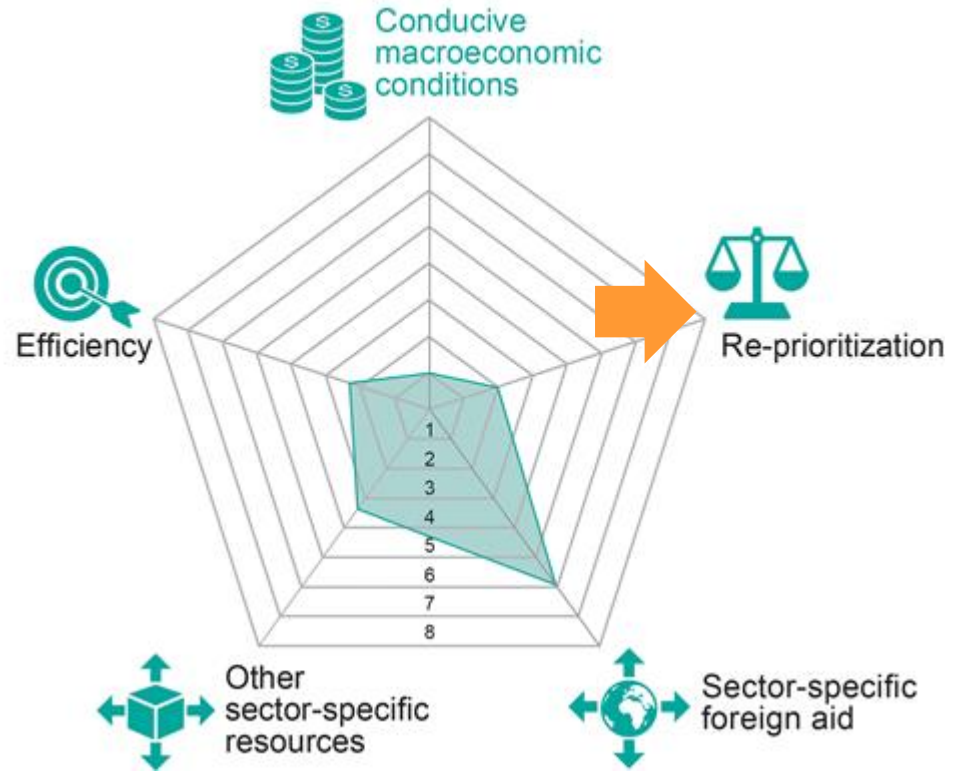
Note: data in 2014 real LCU

One way to use macro-fiscal information is to assess how public spending on health responds to changes in key variables such as national income: can derive this "elasticity" from time-series data (generally preferable).

Improving General Government Revenue Collection Can Be Important Source of Fiscal Space for Health

- Improvements in **resource mobilization** are an SDG target.
- WB/IMF research shows that if that if developing countries could simply increase their revenues collection by **2-4% of GDP**, the amount they raised would **eclipse the amount of development assistance** they are receiving.
- WB/IMF **Tax Administration Diagnostic Assessment Tool (TADAT)** can help identify areas of weaknesses and to make tax systems more efficient and fair.

Fiscal Space for Health



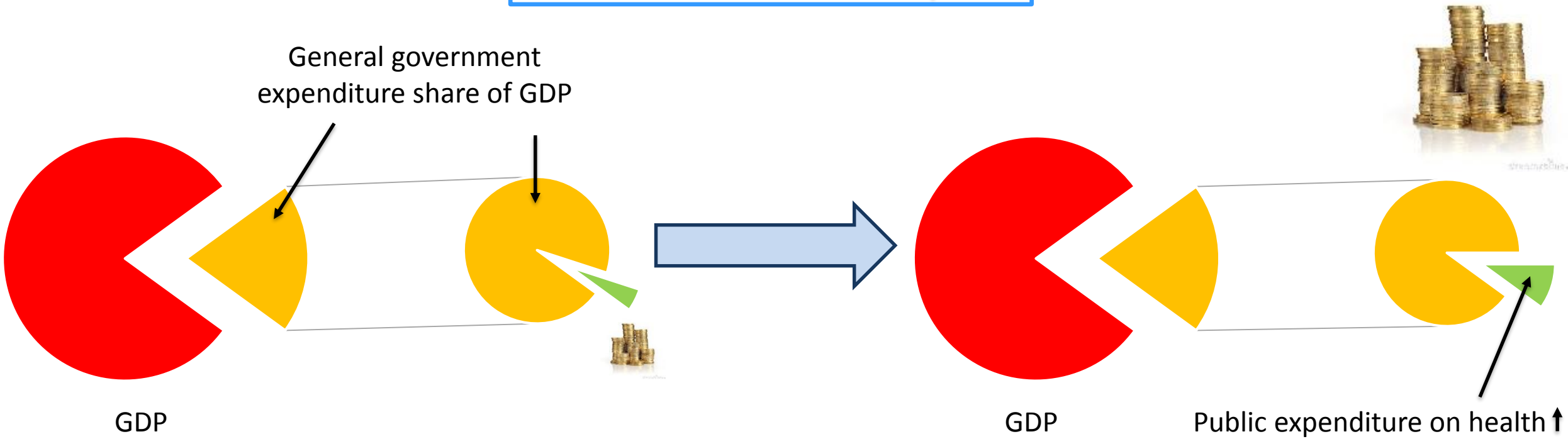
Percentage increase in public financing for health

II. Re-Prioritizing Health

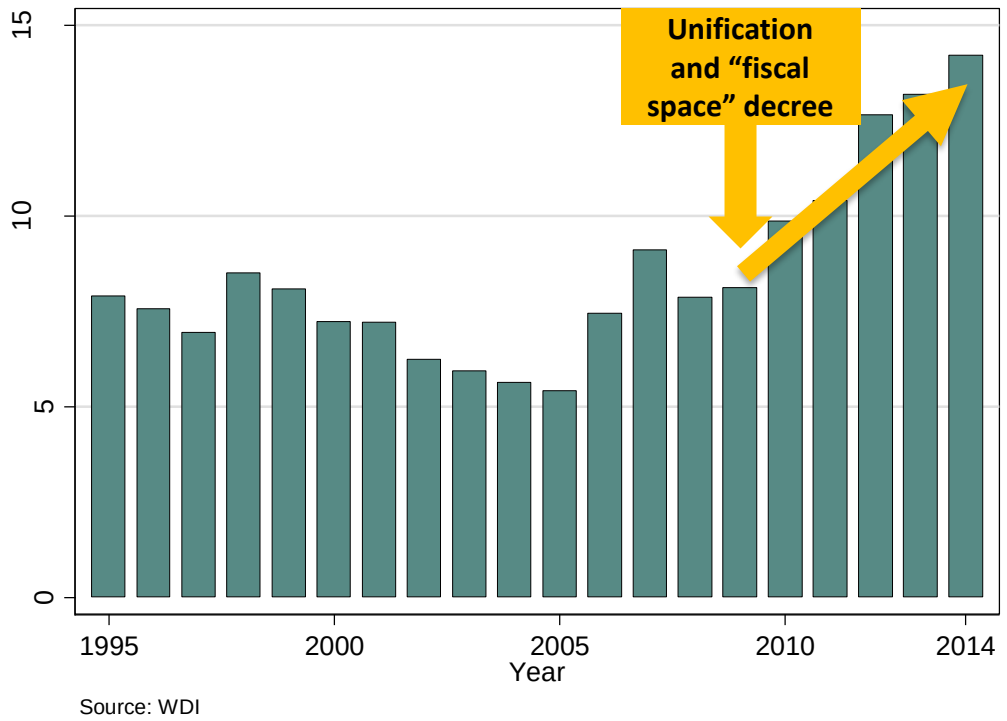
- Share of government expenditures on health often a key signal of **overall government commitment to health**.
- Key **intermediating factor** in translating the extent to which changes in overall macro-fiscal environment have an impact on public financing for health.
- Pits health against **competing priorities** in other sectors such as education, infrastructure, agriculture, etc.
- Key challenge being that health is often perceived by ministries of finance and planning as being an **inefficient** and a **non-productive** sector.

Re-Prioritization Is Often Key for Fiscal Space

GDP **unchanged**
General government expenditure share of GDP **unchanged**
Health share of general government expenditure ↑



VIETNAM



Source: WDI

- 2009: unification of all existing contributory and non-contributory social health insurance schemes; Currently ~70% of population has coverage under social health insurance program; Government plans to attain UHC by 2020.

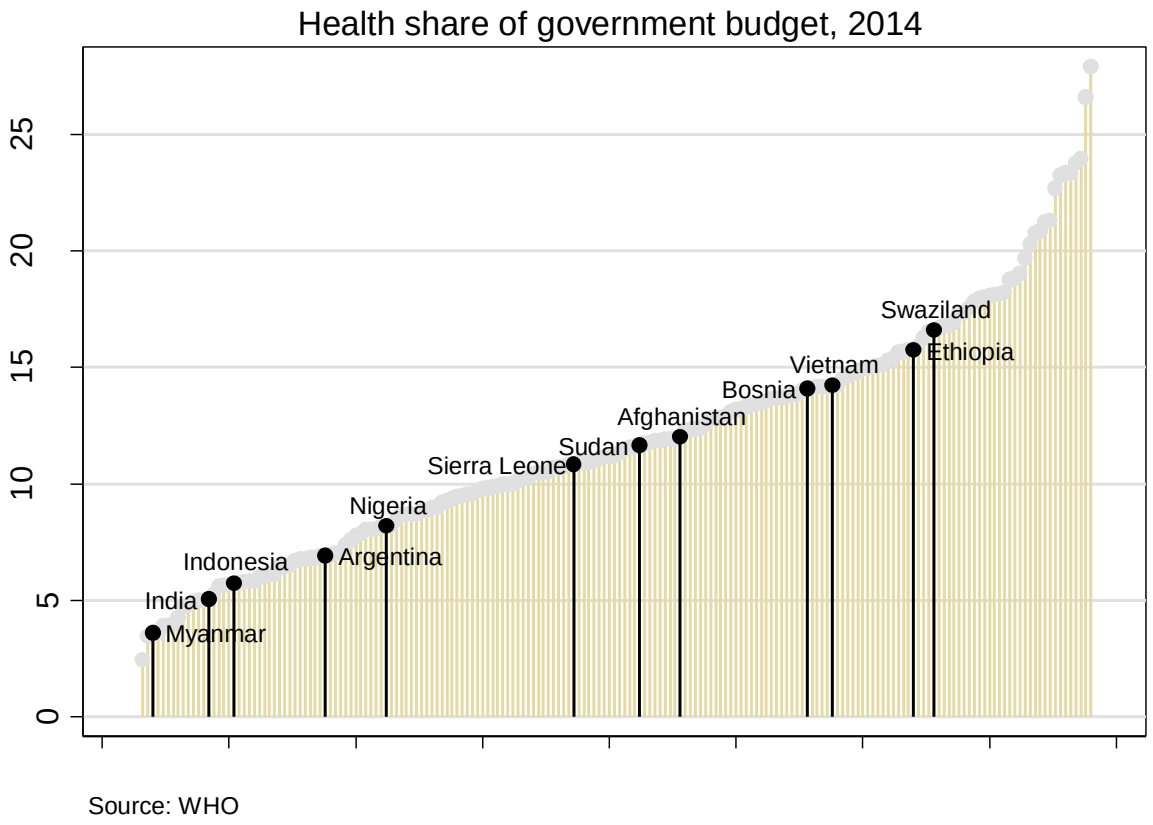
- Despite expansion of social health insurance, government budgetary financing for health remains important (for payment of premiums for the poor; supply-side budgetary spending for public health facilities).

- National Assembly passed Resolution No. 18/2008/NQ-QH12: "...to increase the share of annual state budget allocations for health, and to ensure that the growth rate of spending on health is greater than the growth rate of overall spending through the state budget".

Health Generally Accorded Lower Priority Relative to Education

Region	*Share of government expenditure (%)*			
	Health	***Education***	***Military***	***Debt Service***
Latin America & Caribbean	12%	15%	7%	10%
East Asia & Pacific	12%	17%	8%	5%
Sub-Saharan Africa	10%	18%	9%	8%
Europe & Central Asia	10%	15%	10%	3%
Middle East & North Africa	8%	18%	12%	5%
South Asia	7%	14%	15%	11%
Global	***11%***	***15%***	***9%***	***5%***

Health's Share of Government Budget



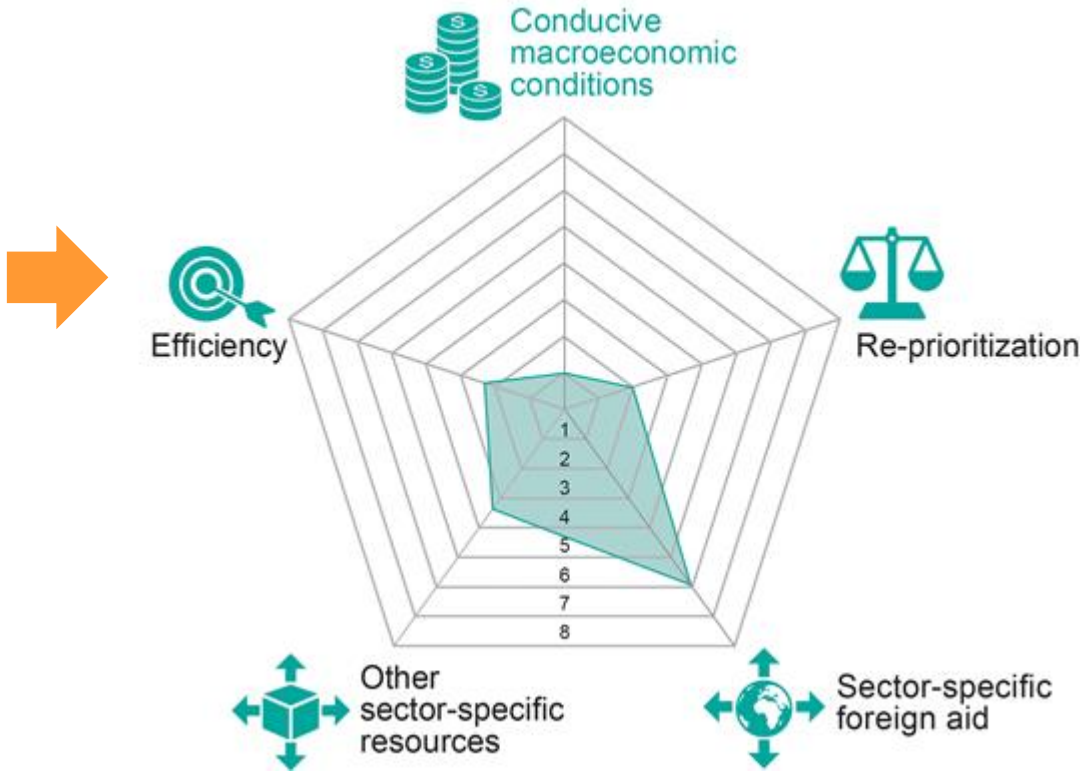
Source: WHO

- Large variations in prioritization to health across countries **even after controlling for income**; Literature suggests factors such as level of **democratization, income inequality, ethno-linguistic fractionalization, role of women in politics,** etc., are important determinants of the degree to which health is prioritized by governments; however, these findings are not robust and are sensitive to model specification.

- Evidence from case studies suggests that country-specific **political economy considerations are key**, and that **results-focused reform efforts** – in particular efforts to explicitly expand the breadth and depth of health coverage as opposed to efforts focused only on government budgetary targets – are more likely to result in sustained and politically-feasible prioritization of health.

- **Efficiency considerations are important**: efficiency is in itself a source of effective fiscal space; but can also be important for attracting additional public resources for health.

Fiscal Space for Health



Percentage increase in public financing for health

III. Efficiency

- Efficiency, broadly defined for any generic production system, typically implies getting the most out of limited resources ("more health for the money"; "bigger bang for your buck").

  - *Allocative efficiency* implies producing the right set of outputs to achieve health system objectives ("doing the right things"; focus on *what* things are produced).
  - *Technical efficiency* implies attaining outputs at minimum (unit) cost ("doing things right"; focus on *how* things are produced).

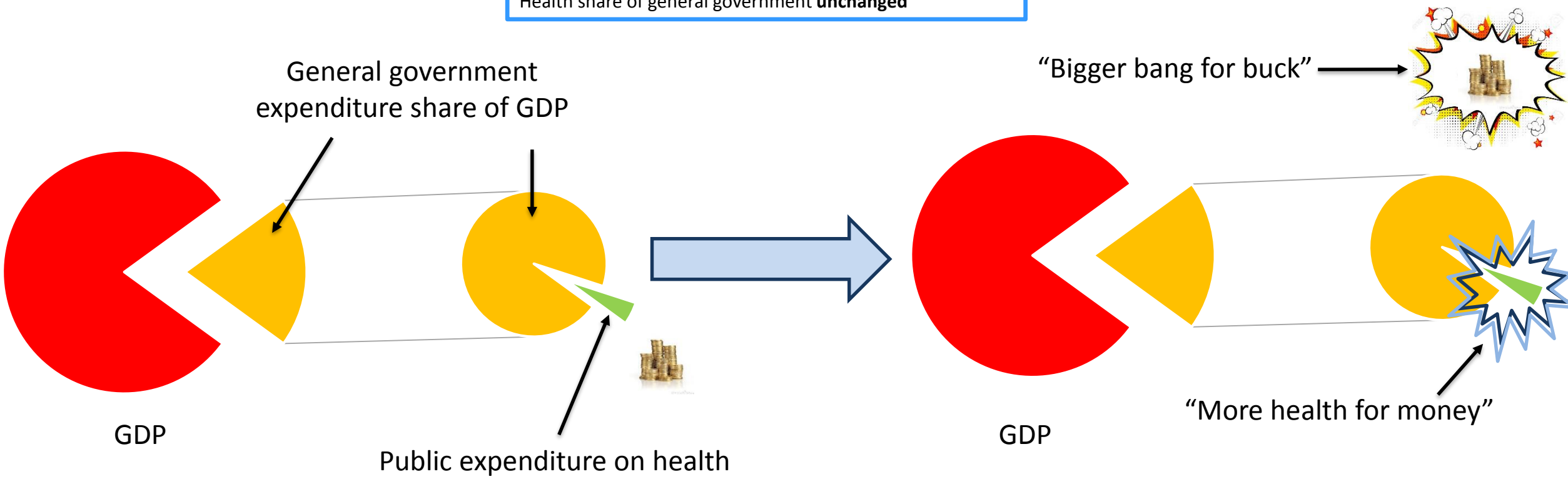
- Low levels of financing for health can itself be a source of inefficiency! Other common sources of inefficiency:

  - Paying too much for medicines and medical technology and using them inefficiently.
  - Leakages and waste; not enough invested in primary care and poor referrals.
  - De-motivated health workers with poor skills and misallocations of resources.
  - Payment systems that don't incentivize efficiency.

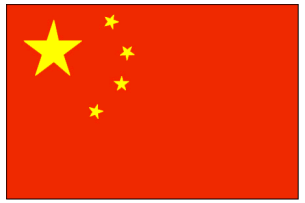
- Improvements in efficiency can increase effective fiscal space and also attract additional resources from ministries of financing and planning.

Efficiency is Critical for Fiscal Space

GDP **unchanged**
General government expenditure share of GDP **unchanged**
Health share of general government **unchanged**

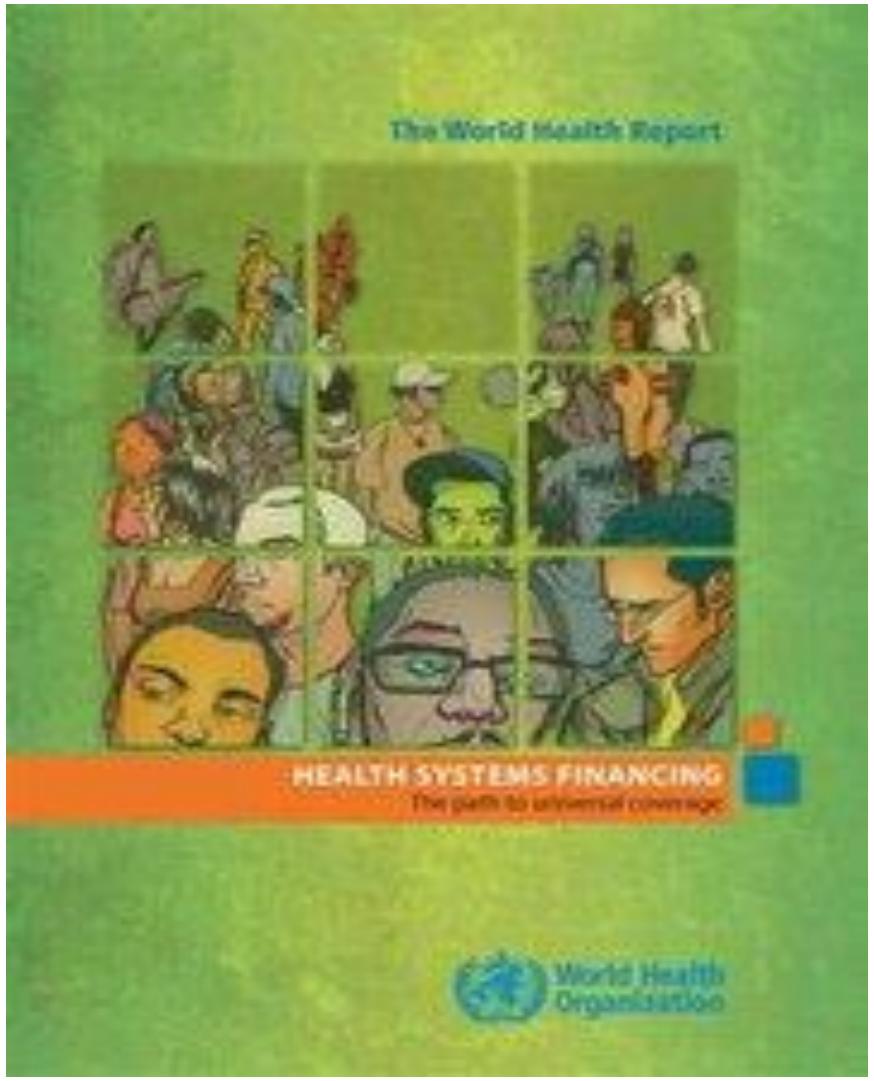


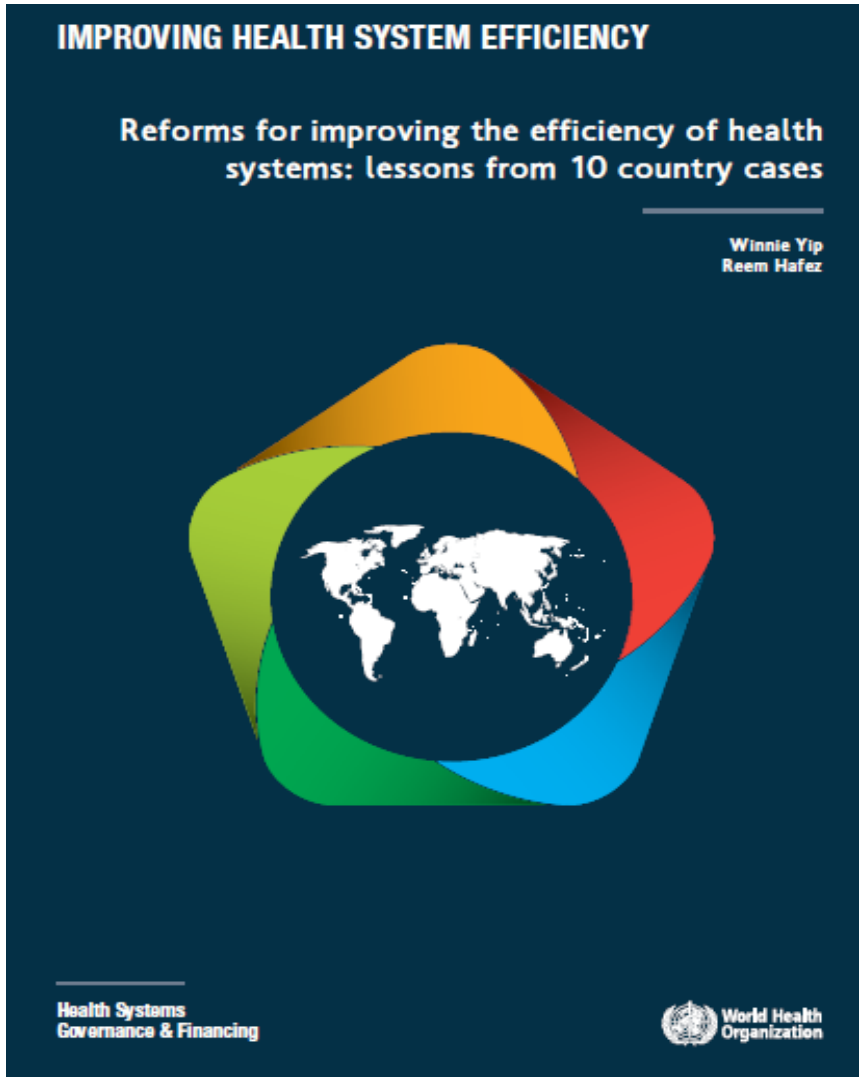
CHINA



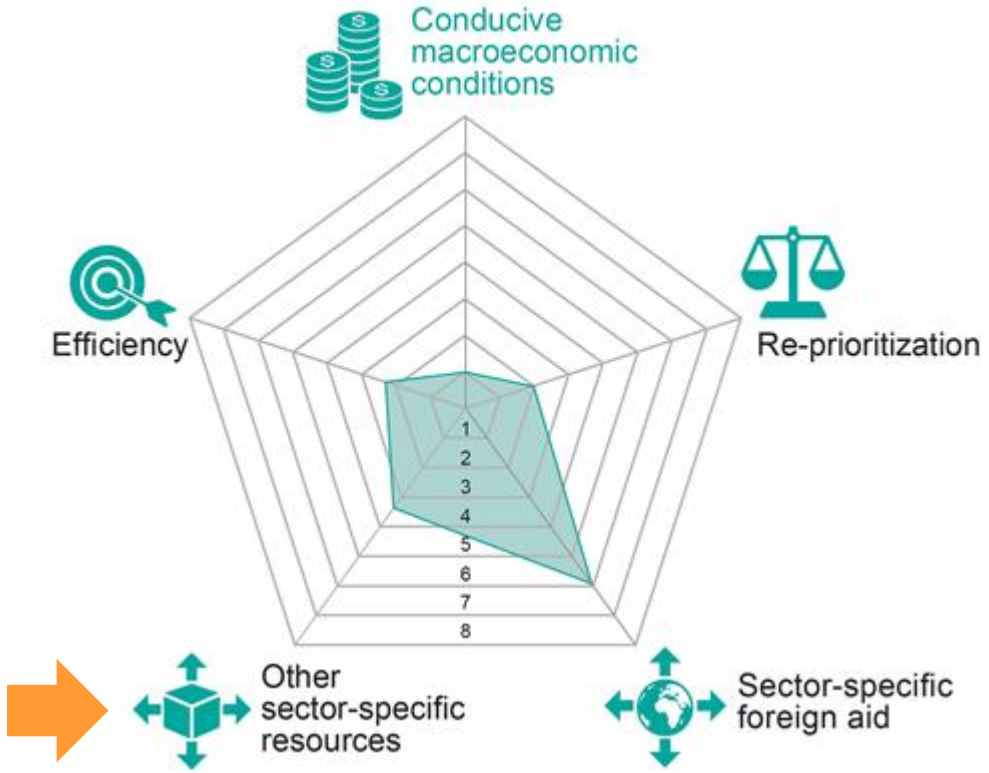
- Provider payment mechanisms incentivized over-prescription of drugs, tests, and infusions.
  - 23-61% of medical encounters resulted in injections; over half the prescriptions for antibiotics deemed unnecessary.
- Provider incentives for higher-profit, branded products also indirectly reduced the availability of essential drugs.
- Resulted in very high levels of and increases in drug expenditures.
- In 2009, essential medicines program introduced along with zero-profit drug policy, bulk procurement, and provision of subsidies to providers to compensate for potential loss in revenues.
- Public primary care facilities were authorized to stock and prescribe only drugs on essential list.
- Resulted in reductions in medicine prices and improved availability of essential drugs; nevertheless, loss in revenue led to an increase in doctor charges.

On Efficiency





Fiscal Space for Health



Percentage increase in public financing for health

IV. Sector-Specific Revenue Sources

- Social health insurance and other forms of earmarked revenues (e.g., from "sin" taxes, earmarking of VAT, etc.) are examples of sector-specific revenue sources.

  - Social health insurance often introduced as a way to collect additional revenues for health, especially from employers; Introducing and/or increasing contribution rates from formal sector often a key fiscal space question; Challenge in implementing mandates and collecting contributions in economies with large levels of informality.

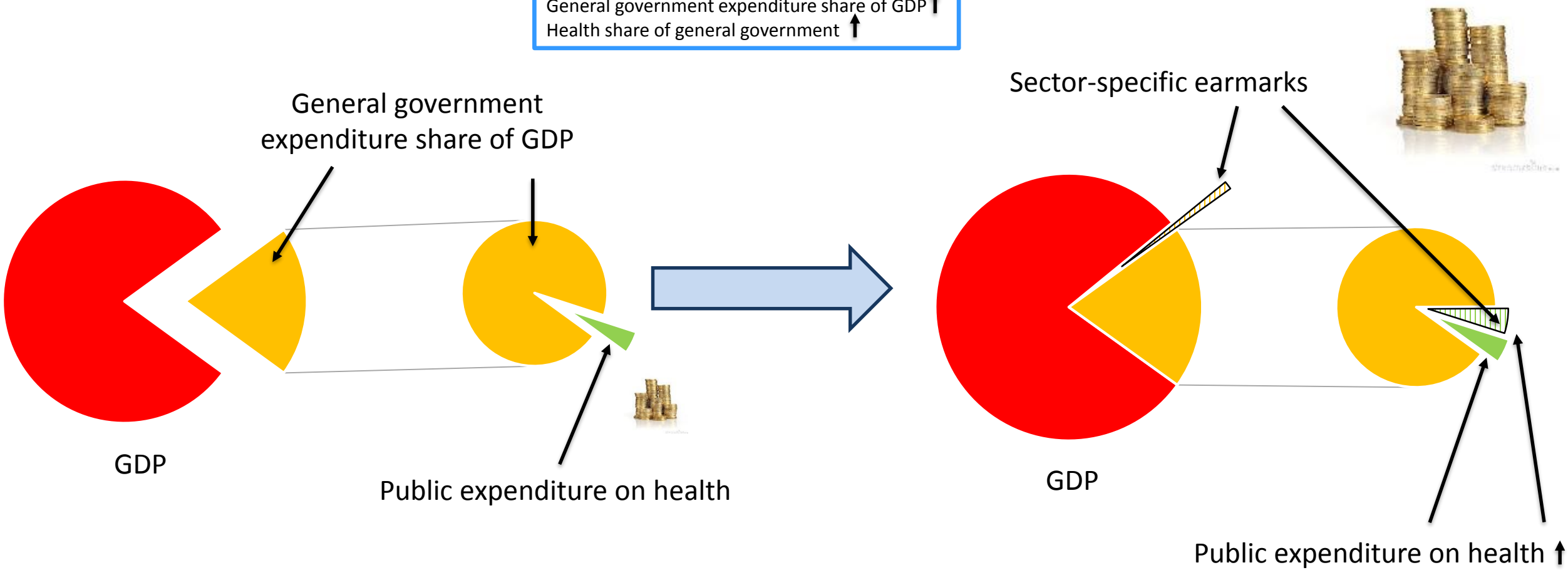
- Use of "sin taxes" on tobacco and alcohol increasingly prevalent for financing health and are often justified from health as well as fiscal perspective, despite sometimes being regressive; Impact on revenues can vary, dependent on elasticity of response including impact on smuggling/evasion;

  - Earmarking often unpopular with ministries of finance: introduces rigidities in allocations across sectors, often viewed as second-best option.

- Key questions: why earmark, and are earmarked resources for health truly additional?

Sector-Specific Revenue Sources for Fiscal Space

GDP **unchanged**
General government expenditure share of GDP ↑
Health share of general government ↑



PHILIPPINES

- In 1995, government-sponsored health insurance was expanded, replacing Medicare with the National Health Insurance Program. However by 2010 only 21% of poor households, and less than 75% of the total population were enrolled.

- The 2012 Philippines Sin Tax Law reformed tobacco and alcohol taxation:
  - Simplified and increased excise taxes, especially on cigarettes.
  - Law was framed primarily as a health measure and not a tax measure.
  - Reforms led to an increase in government revenues, despite early reports of declines in smoking prevalence.

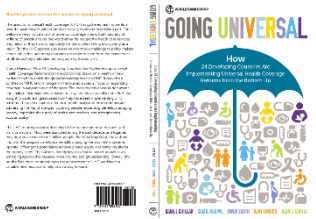
- Share of tobacco and alcohol excise collections to GDP increased from 0.5% in 2012 to 0.9% in 2013 (highest since 2000) and Department of Health budget increased by 57%.

- Revenues from reform were used to finance expansion of fully-subsidized social health insurance, especially for the bottom 40% of the population.

- Resulted in dramatic increase in social health insurance coverage: from 65 million (70%) of the entire population in 2013 to 86.2 million (87%) in 2014.

- Coverage for the poor increased from 5.2 million families in 2013 to 14.7 million families (43 million individuals) in 2014.

Earmarking Examples from *Going Universal* Book



Earmarked Taxes as a Source of Government Health Revenue

Type of earmarking	Country	Description
Specific taxes earmarked for financing UHC programs	Colombia	Earmarked payroll tax from parallel formal sector insurance program
	Costa Rica	Taxes on luxury goods, liquor, beer, soda, and other imported goods to finance noncontributory regime
	India	Earmarked taxes on alcohol for RA
	Jamaica	Earmarked taxes on tobacco, alcohol, petroleum, and motor vehicles; earmarked payroll tax in parallel formal sector insurance program
	Tunisia	Earmarked transfers from parallel formal sector insurance program
Specific taxes earmarked for financing general government health spending (or for financing other non-UHC program health programs)	Chile	Tobacco taxes, customs revenues, and sales of shares in public health enterprises earmarked for financing SHI reform (AUGE)
	Colombia	Earmarked state-level taxes on tobacco and alcohol for financing general government health spending
	Guatemala	Earmarked alcohol and tobacco taxes for financing general government health spending
	Mexico	Earmarked alcohol and tobacco taxes for financing general government health spending
	Thailand	Earmarked alcohol and tobacco taxes to support the Thailand Health Promotion Fund
General taxes earmarked for financing UHC programs, other non-UHC program health programs, or general government health spending	Chile	Earmarked 1% VAT for AUGE
	Ghana	Earmarked 2.5% VAT
	Brazil	Federal health spending equal to health spending in previous year adjusted for changes in nominal GDP; minimum 12% of state expenditure and 15% of municipal expenditure earmarked for health
	Vietnam	Increase in government spending on health has to be higher than increase in overall government spending by law (Resolution No. 18/2008/NQ-QH12 in 2008)

Sources: UNICO studies; for Vietnam general taxes: Grover 2011.
Note: The taxes are other than mandatory SHI premiums.

Social Health Insurance

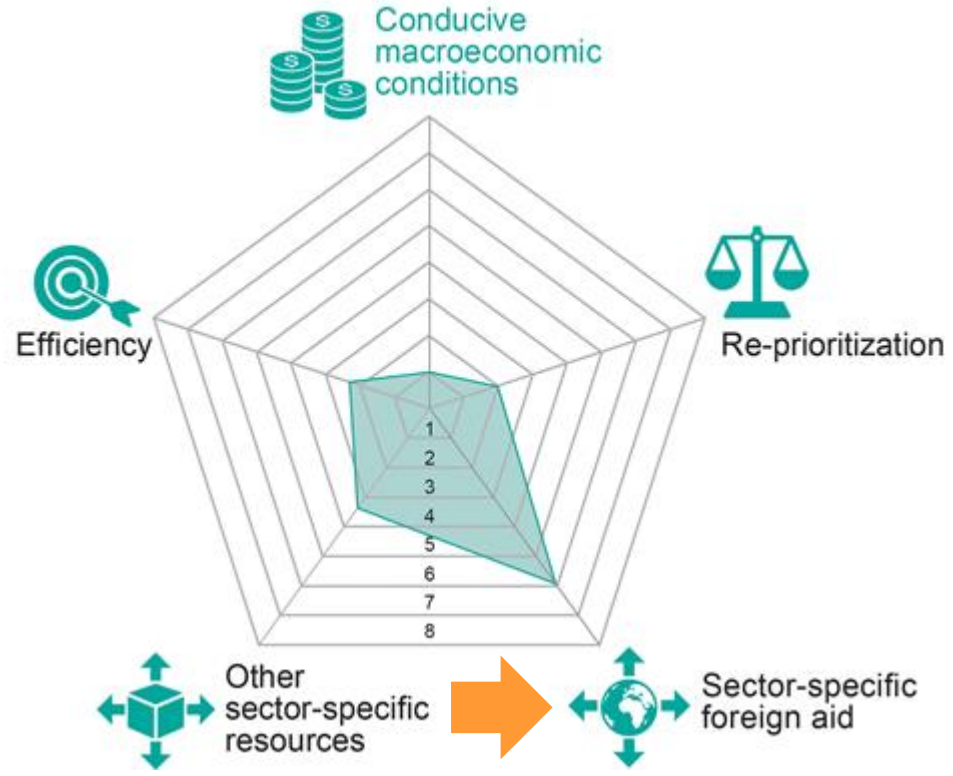
Top Ten Countries with the Largest Social Health Insurance Shares of Total Health Expenditure
Netherlands (81%)
Czech Republic (77%)
Croatia (77%)
France (74%)
Japan (73%)
Luxembourg (70%)
Bosnia (69%)
Germany (69%)
Belgium (66%)
Slovak Republic (66%)

- **Vietnam:** Insured: 1.5% of gross earnings, with maximum monthly earnings used to calculate contributions are US$ 20,000 (20 times the minimum wage for civil servants). Self-employed: flat rates. Employer: 3% of payroll;

- ***Philippines:*** Insured: 1.25% of gross earnings, with maximum monthly earnings used to calculate contributions are 1,000 USD (50,000 pesos). Self-employed: two-tier flat rate premium. Employer: 1.25% of the employee's basic monthly salary;

- ***Indonesia:*** Civil servants pay 2%, employer 3%; Private formal sector: employer 4%, insured 0.5%; three-tiered flat-rate premium for non-poor informal sector.

Fiscal Space for Health



Percentage increase in public financing for health

V. Development Assistance for Health

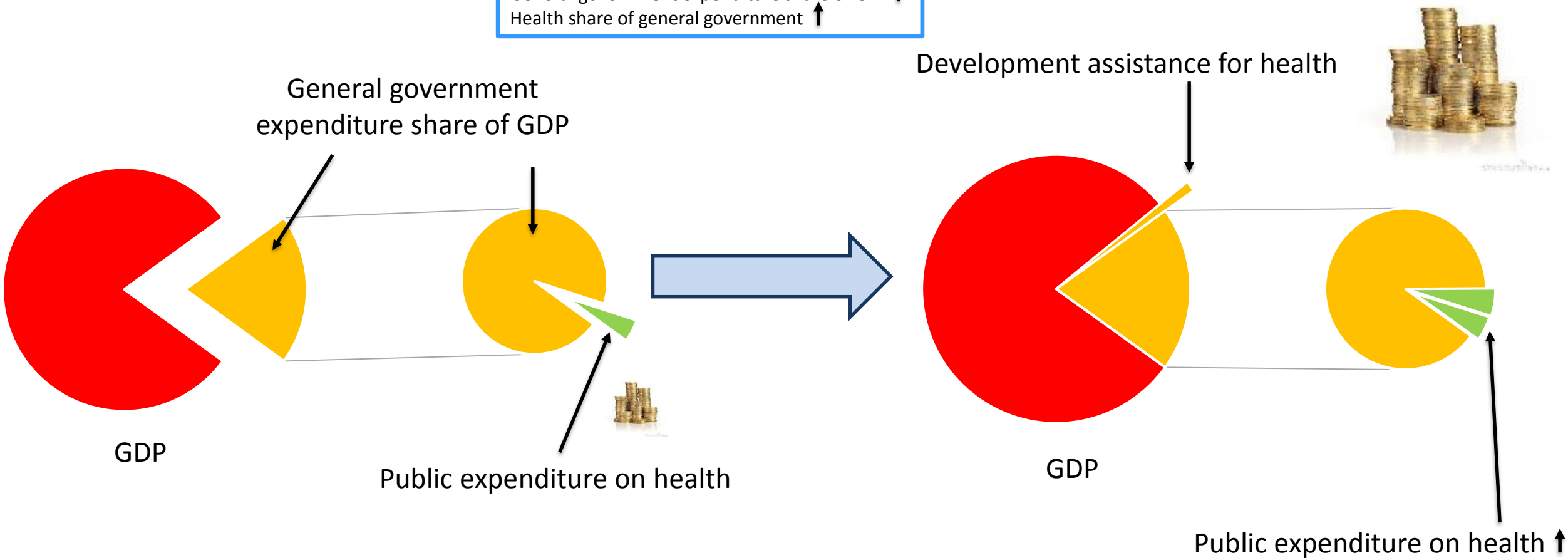
- Large increase in development assistance for health, especially following the 2000 adoption of MDGs, with entry of several new players including **GAVI**, **GF**, and **BMGF**.

- Critical for financing interventions related to **HIV/AIDS**, **TB**, **malaria**, **immunization**, and **MCH**, in many low and lower middle income countries; in many cases, resources are channeled outside of government systems.

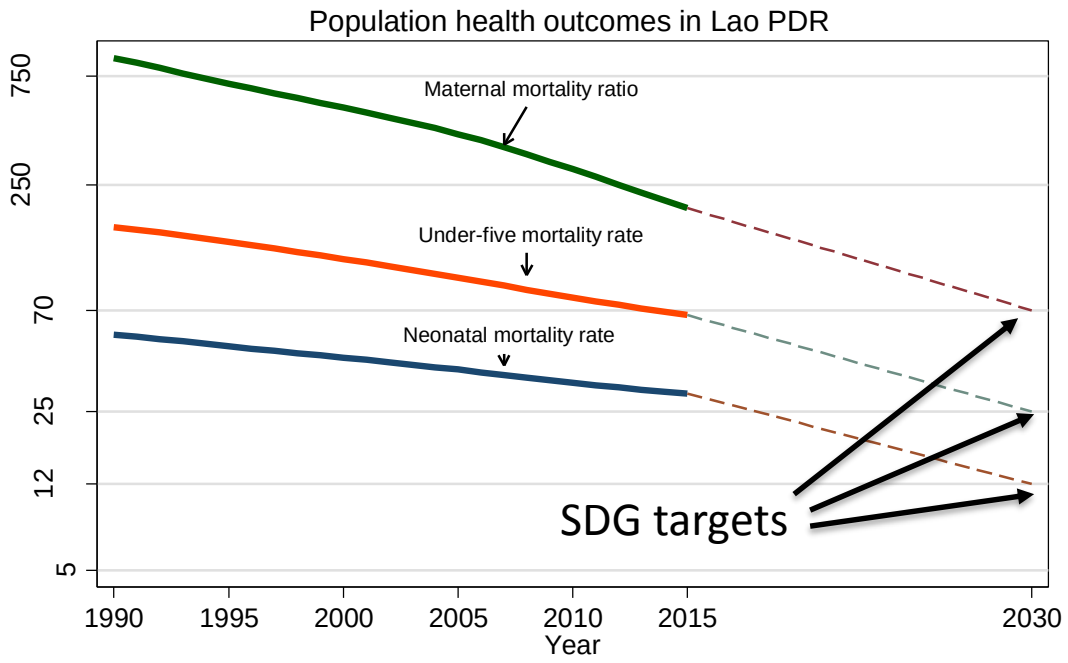
- Key challenges with regard to additionality, harmonization, and alignment with national priorities.

Development Assistance Can Be Key for Fiscal Space

GDP **unchanged**
General government expenditure share of GDP ↑
Health share of general government ↑



LAO PDR



Source: WDI
Note: maternal mortality per 100,000; under-five/neonatal mortality per 1,000 live births

- Significant progress made over past few decades; Lao PDR one of the few countries that attained both the maternal mortality and under-five mortality MDGs; faster progress will be needed to attain some of the key health-related SDGs by 2030.

- Government has committed to attaining UHC by 2025; Health sector remains under-financed: total health expenditure: US$32 per capita; External share ~30%; OOP share ~40%.

- In 2004, health equity funds (HEF) introduced and implemented in 125/143 districts, predominantly externally financed and with hydroelectric power (NT2) revenues, providing coverage to 35% of the poor; payments made on behalf of the poor for preventive, curative care in public facilities, as well as for transport/food; Plans underway to merge coverage mechanisms including HEFs, formal public/private social health insurance.

Some Key "Take-Away" Messages

Increasing the share of prepaid sources of financing for health is key for making progress towards UHC

Collection of social health insurance contributions from informal sector is nearly impossible in developing countries

OOP is a generally inequitable and inefficient source of core financing for the health sector

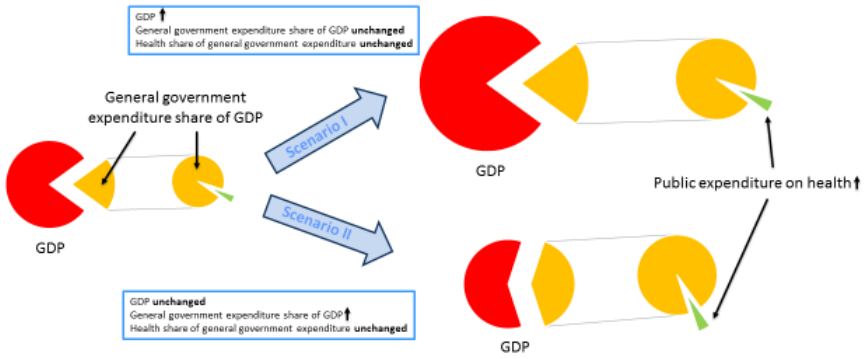
Important to situation health financing within broader macroeconomic context for identifying opportunities and constraints to fiscal space

Efficiency in how revenues are both raised and spent is one of the most important factors for helping realize fiscal space

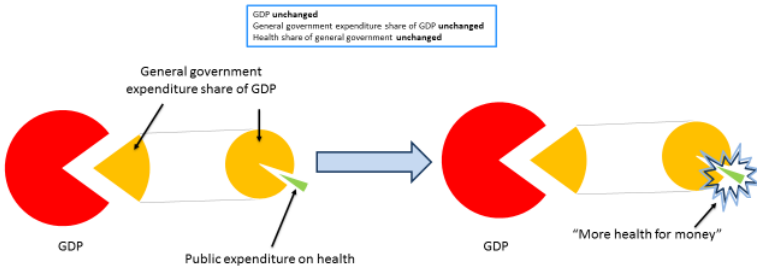
Benefits packages should align with revenue collection and service delivery capacity

In Summary: Fiscal Space "Cheat Sheet"

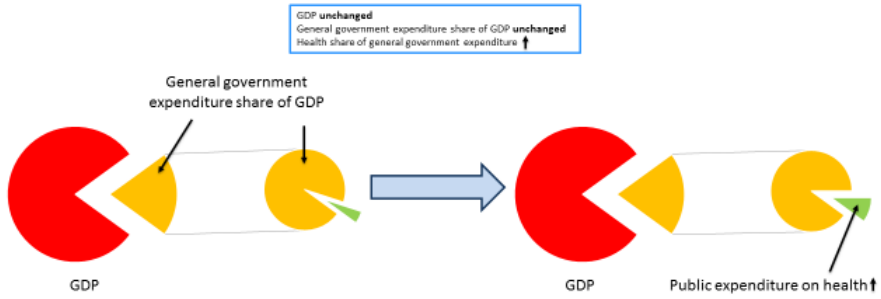
Macro-Fiscal Context Matters for Public Financing of Health



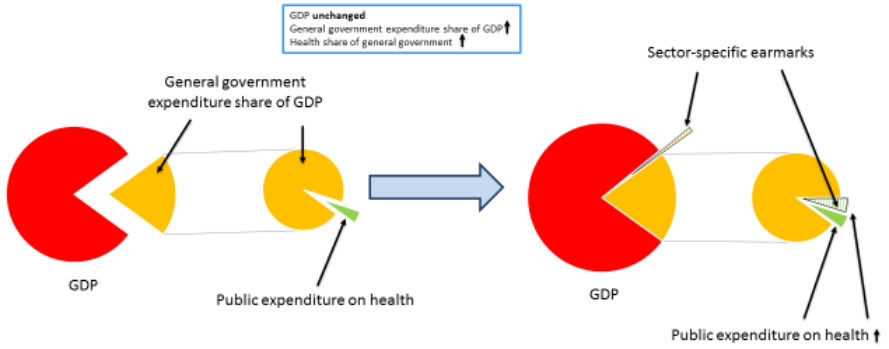
Efficiency is Critical for Fiscal Space



Re-Prioritization Is Often Key for Fiscal Space



Sector-Specific Revenue Sources for Fiscal Space



Development Assistance Can Be Key for Fiscal Space