



## World Bank – Health Systems Development — June 2006

### Economic Viewpoint



“Health Financing in Developing Countries” by **George Schieber**, Consultant, Former Health Policy Advisor in the HNP Hub and Former Sector Manager Health and Social Protection for the Middle East and North Africa Region in the World Bank.

### Editorial

**More Money Spent Wisely**

### Featured Reading



[Health Financing Revisited: A Practitioner's Guide](#), by Pablo Gottret and George Schieber, eds., The World Bank, March 2006.

### Related Event



[American Society of Health Economics: Inaugural Conference](#), Madison, Wisconsin, **June 4-7, 2006**. Read [announcement from ASHE Executive Director Richard Arnould](#) (pdf)

### Bulletin Board

- [International Health Economics Association \(iHEA\)](#)
- [American Society of Health Economists \(ASHE\)](#)
- [Asia Pacific Health Economics Network \(APHEN\)](#)
- [ECHE](#)
- [Collège des Economistes de la Santé \(CES\)](#)
- [Global Links](#)

### Archives

- [Leadership Forum](#)
- [Economic Viewpoints](#)
- [Editorials](#)
- [Featured Events](#)
- [Featured Readings](#)
- [HSD Newsletter](#)

### Newsletter Subscription

You are subscribed to the **HSD Newsletter**

The purpose of this list is to provide policymakers, health professionals, practitioners, and development experts an open forum for the posting and discussion of news and information relating to Health Systems Development (HSD). We are looking forward to a dynamic and informative discussion. Please share your knowledge and views.

- Join HSD News List: [join-hsdnews@lists.worldbank.org](mailto:join-hsdnews@lists.worldbank.org)
- Posting to the List: [hsdnews@lists.worldbank.org](mailto:hsdnews@lists.worldbank.org)
- Unsubscribe: [leave-hsdnews@lists.worldbank.org](mailto:leave-hsdnews@lists.worldbank.org)
- List Manager: [listmanager@lists.worldbank.org](mailto:listmanager@lists.worldbank.org)

**Contact:** Editor: Alexander S. Preker (Lead Economist) [apreker@worldbank.org](mailto:apreker@worldbank.org)



[Search](#) | [Index](#) | [Feedback](#) | [WB Home](#)

## Health Financing in Developing Countries



Author **George Schieber**  
Consultant, Former Health Policy Advisor  
in the HNP Hub  
Former Sector Manager Health and  
Social Protection for the Middle East and  
North Africa Region  
The World Bank

Major changes in global health policy,  
financing modalities, and financing  
instruments have occurred over the past

ten years resulting from the global focus on poverty reduction, new global health threats from HIV/AIDS, SARS, and avian influenza, and the international community's commitment to the Millennium Development Goals (MDGs). As a result of these factors global health policy has now become a foreign policy, national security, and humanitarian issue for all countries, and significant amounts of increased resources for development assistance, much of it targeted to health, have been committed. International health is on the global agenda as it never has been before, and it is incumbent on the global community and governments to effectively deal with this enormous humanitarian, social, and economic challenge.

In a new book just published by the World Bank, entitled [Health Financing Revisited: A Practitioner's Guide](#) (Pablo Gottret and George Schieber, Principal Authors), we focus on the formidable challenges of health financing faced by developing countries. We assess health financing policies from the perspectives of the basic financing functions of collecting revenues, pooling resources, and purchasing services. We evaluate these functions for their ability 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 purchase by consumers.

More important than the models, however, are three basic principles of public finance:

- Principle 1. Raise enough revenues to provide individuals with basic packages of essential services and financial protection against catastrophic medical expenses caused by illness and injury in an equitable, efficient, and financially 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 in *Health Financing Revisited* 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.

Any assessment of health financing policies needs to start with an evaluation of a country's underlying demographic, epidemiological, economic, social and political situations. Current spending levels and revenue mobilization efforts need to be assessed in terms of the above stated principles and in terms of whether they (public and private) are sufficient to provide a basic package of essential services and assure financial protection in an efficient, equitable and sustainable manner. Current spending levels and 'needs' must be collated with available revenues both domestic and external. Issues of domestic resource mobilization potential, external assistance and country absorptive capacity are paramount. Revenue raising potential must also be considered in the context of the current global emphasis to scale up to meet the MDGs and the new instruments (e.g., Poverty Reduction Strategy Papers, Public Expenditure Tracking Surveys, Medium Term Expenditure Frameworks) and available sources of funding (e.g., Global Fund, Bill and Melinda Gates Foundation, IFFim, French airline tax) that have evolved over the past decade.

Countries, particularly low-income countries, face difficult trade-offs in terms of being able to afford a basic package of essential services and providing their populations, particularly the poor, with financial protection against catastrophic illness costs. Countries then need to focus on the most appropriate risk pooling mechanism to assure financial protection in an equitable, efficient and sustainable manner. They also need to purchase services in the most allocatively and technically efficient manner. Donors need to do a better job harmonizing and aligning their procedures behind country-led reform efforts.

The global evidence based on the underlying principles of public finance, the underlying literature on fiscal policy and on aid effectiveness, and evidence from the financing experiences of developed and developing countries suggests the following:

1. Underlying demographic, epidemiological, economic, and political constraints establish both the needs base and the present and future economic circumstances to meet these needs. The health transition—with its attendant changes in population size, structure, and epidemiology—will have significant consequences for health needs, labor forces, and economies. There is an enormous mismatch between the global disease burden and global 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 56 percent of the global disease burden, but account for only 2 percent of all health spending.
2. Current health spending patterns indicate the low level of spending relative to needs in low-income countries, the importance of private financing and out-of-pocket payments in low-income countries and many middle-income countries, the limited financial protection that is currently provided through risk pooling, and the differential importance of external assistance by region and income. Indeed, high-income countries spend about a hundred times more on health per capita (population-weighted) than low-income countries (30 times if one adjusts for cost of

living differences). The public share of total health spending increases as countries move up the income spectrum, being only 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. Social health insurance institutions are a very limited source of health care spending in low-income countries accounting for only some 2 percent of total spending, 15 percent in lower-middle-income countries, and 30 percent in upper-middle-income and high-income countries. For the private share of spending, the poorer the country the larger the amount that is out-of-pocket: 93 percent of private spending in low-income countries (more than 60 percent of the total), more than 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, as out-of-pocket payments are the most inequitable type of financing because they hit the poor hardest and deny all individuals the type of financial protection from the costs of catastrophic illness provided by public and private insurance mechanisms. External sources account for 8 percent of spending in low-income countries and less than 1 percent in middle-income countries (using population-weighted expenditure information). But on a country-weighted basis, external sources account for 20 percent of total low-income country spending.

3. Basic health financing functions of revenue collection, pooling, and purchasing can be carried out in a variety of ways, each very much dependent on country-specific circumstances. Coverage decisions about an essential services package, the universality of such a package, the modalities for risk pooling, and the arrangements for prepayment are critical elements in the design and implementation of financing policies. The success of countries in carrying out these functions has important implications for:

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

4. Domestic resource mobilization expands as economies grow. Revenue collection in developing countries is the art of the possible, not the optimal. While 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. Low-income countries collect some 18 percent of their GDP as government revenues, severely limiting their ability to finance essential public services, while middle-income countries raise some 23 percent. Given current revenue-raising abilities in low-income countries, it is highly unlikely that expanded domestic revenue-raising efforts will provide sufficient financing to reach the Millennium

Development Goals for health. However, an essential element of scaling up government health spending in low-income and some middle-income countries is to ensure that the expansions take place under macroeconomic conditions which provide adequate “fiscal space” for such increases.

5. The prominent risk pooling mechanisms are: national health service systems, social health insurance, voluntary health insurance, and community-based health insurance. While the features of each financing mechanism differ significantly, no one method is inherently more desirable than another. Policy-makers must examine the context and determine which method(s) 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 to ensure that the system's development is aligned with country-specific economic, institutional, and cultural characteristics. However, international experience provides important evidence on the enabling conditions. Health Financing Revisited provides detailed assessments of the enabling conditions for successful implementation of these various methods based on international experience.

6. External financial flows are growing in importance, as are their impacts on economies and health sector financing. 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. Most of the recent increases have been focused on Africa for specific diseases and interventions. Given the renewed efforts for 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, donor harmonization and alignment, absorption, use, and sustainability of this external assistance have been receiving a great deal of attention.

7. Government policy levers, institutions, and funding instruments are keys to absorbing the \$25–\$70 billion needed annually for scaling up to meet the Millennium Development Goals for health. It is clear that developing countries, particularly low-income countries, will not be able to finance such costs within their domestic resource envelopes. They will need substantial increases in external assistance. However, they will also need to enhance their domestic resource mobilization efforts, improve the efficiency of current public spending through improvements in public sector management and governance reforms, and reduce the transaction costs of dealing with multiple donors.

8. Low-income countries are severely challenged in providing basic health services and financial protection, and therefore face difficult policy choices. Most regions will not reach the Millennium Development Goals for health, because of slow progress in the 1990s. Neither increased health spending nor growth alone will do the job. Reaching the goals requires growth, a multi-sectoral effort, enhanced domestic resource mobilization, increased donor assistance, enhanced efficiency of public spending, and

improved risk pooling. 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. 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 by the poor and non-poor 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 more able and ready to mobilize greater funding for health care. Donor funding will be critical in closing the gap most countries face in scaling up to meet the Millennium Development Goals. Donors need to reduce the volatility, improve the predictability, and improve the longevity of aid as well as align their administrative procedures with country systems. They also need to ensure that aid goes to countries as general budget support and to resolve the issue of aid becoming increasingly siloed. 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. To improve financial protection, low-income countries must improve risk pooling.

9. Middle-income countries are focusing more on improving risk pooling and ensuring universal coverage for their populations. More effective purchasing is a critical part of such reforms. In addition, these countries still face challenges of poverty and income inequality, as well as challenges in literacy, education, employment, and social security. The main policy recommendations for middle-income countries include:

- View efficient and equitable revenue mobilization as a top priority for health, since it is critical that funding be sustainable and commensurate with long-term needs resulting from the health transition.
- 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 a first step, integrate informal workers by providing the right incentives.
- Provide maximum financial protection and universal coverage by consolidating multiple risk pools.
- Focus on designing appropriate benefit packages for covered populations because they affect the efficiency

of risk pooling, the level of financial protection, and allocative efficiency.

- While there is no “best” strategy, policy-makers in middle-income countries should be parsimonious with health spending in order to expand coverage to more people, particularly focusing immediate attention on improving health services and health coverage for the very poor and vulnerable.

10. 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 health insurance or national health insurance–based financing systems. Political will has proven 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. While high-income countries operate in very different contexts from low- and middle-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 pilots 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 much toward effective and equitable financing of health coverage.

Health Financing Revisited is intended to equip policy-makers at global and country levels with the tools for navigating this extremely complex domain. It provides an overview of health financing policy in developing countries and is a primer on major health financing and fiscal issues. Health is an extremely complex sector, and reformers must be prepared to deal with its complexities when designing and implementing health policy reforms. Slogans, flavors of the day, and magic bullets will not provide the basis for effective policy-making.

## References

- Davidson R. Gwatkin, Adam Wagstaff, and Abdo S. Yazbeck (eds), *Reaching the Poor with Health, Nutrition, and Population Services*, Washington, D.C., World Bank, 2005.
- Alexander S. Preker and John Langenbrunner (eds.), *Spending Wisely: Buying Health Services for the Poor*, Washington, D.C., 2005.
- Francisco Sagasti, Keith Bezanson, and Fernando Prada, *The Future of Development Financing: Challenges and Strategic Choices*, PALGRAVE and MACMILLAN, London and New York, 2005.
- Adam Wagstaff and Mariam Claeson, *Rising to the Challenges*, World Bank, Washington, D.C., 2004.

## Editorial

---

### More Money Spent Wisely

The health challenges faced by the developing world are formidable. Africa, with 10 percent of the world's population, accounts for 25 percent of the global disease burden, 60 percent of people living with HIV/AIDS, and the highest morbidity and mortality from TB and malaria. Yet, spending on health care in Africa accounts for less than 1 percent of global health expenditure.

Addressing this imbalance will cost a lot, much more than is currently spent by countries in the Africa region and donors. It will require better spending. And it will involve improved management of financial risk.

In 2001 Heads of State of the Africa Union passed a resolution which set a target of 15 percent of public spending on health by member countries (the Abuja Declaration on health care financing). These are good intentions. But have they been translated into action on the ground?

A review of health spending in the Africa region since 2001 tells a troublesome story:

- Since 2001 only a few countries have made progress towards the Abuja health financing target and only two have actually reached the goal
- Many governments are spending less today than they were in 2001
- Some countries have a very low execution rate with a little as 20 percent of the planned budget actually reaching the Ministries of health
- In most countries, even if the Abuja target was reached this would yield less resources than the US\$34 per capita spending needed to reach the MDG goals
- To reach the internationally agreed spending level of US\$34 some many countries would have to spend more than 50 percent of their public budget on the health sector, sometimes as much as 80 percent.

Something is clearly wrong. Governments are not spending what they say they will. And the spending targets set by the international donor community are not realistic. In addition, many donors and NGOs are prescribing the wrong medicine.

Low spenders are being rewarded by more donor money. Countries that are trying to supplement their health budgets with other sources of income are being pressured to abolish user fees and not introduce mandatory or voluntary insurance mechanisms.

On May 2-4, 2006 the Africa Union convened a special Summit on Aids, TB and Malaria. At the time of this meeting, a special resolution was once again tabled and passed by the Heads of State. It reaffirmed earlier commitments by member countries to a 15 percent spending target. It also called on countries to become less reliant on donor money. And it called for increased insurance coverage to deal with the financial risk of illness.

Time will show if this time countries and donors alike will take the health financing agenda seriously. This requires matching lofty proclamations with action on the ground which includes more attention and financial resources devoted to health care financing.

