Health Financing Alternatives in Low and Middle Income Countries

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The Millennium Development Goals (MDGs)

In the 1990s

The Global Community Made a Pledge to Help Developing Countries Achieve the MDGs

Millennium Development Goals (MDG)

Extreme Poverty:

- Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day.
- Halve, between 1990 and 2015, the proportion of people who suffer from hunger.

Safe Water & Sanitation:

- Halve by 2015 the proportion of people without sustainable access to safe drinking water.
- By 2020, achieve significant improvement in the proportion of people with access to sanitation.

Child & Maternal Health:

- Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.
- Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.

Primary & Girls' Education:

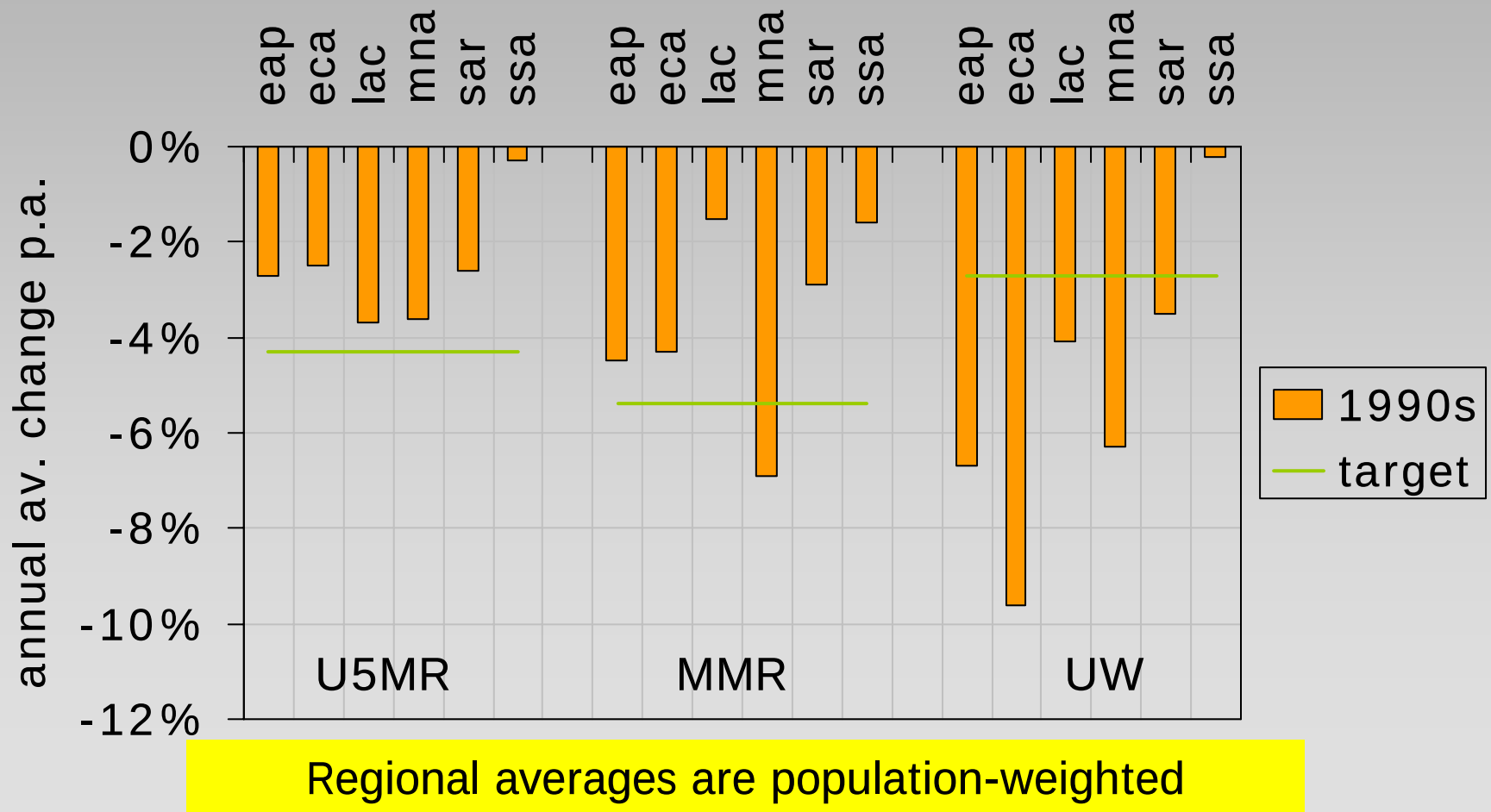
- By 2015, boys and girls everywhere complete a full course of primary schooling.
- Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015.

Communicable Diseases

By 2015, halt and begin to reverse the spread of:

- HIV/AIDS
- Malaria &
- Other major diseases.

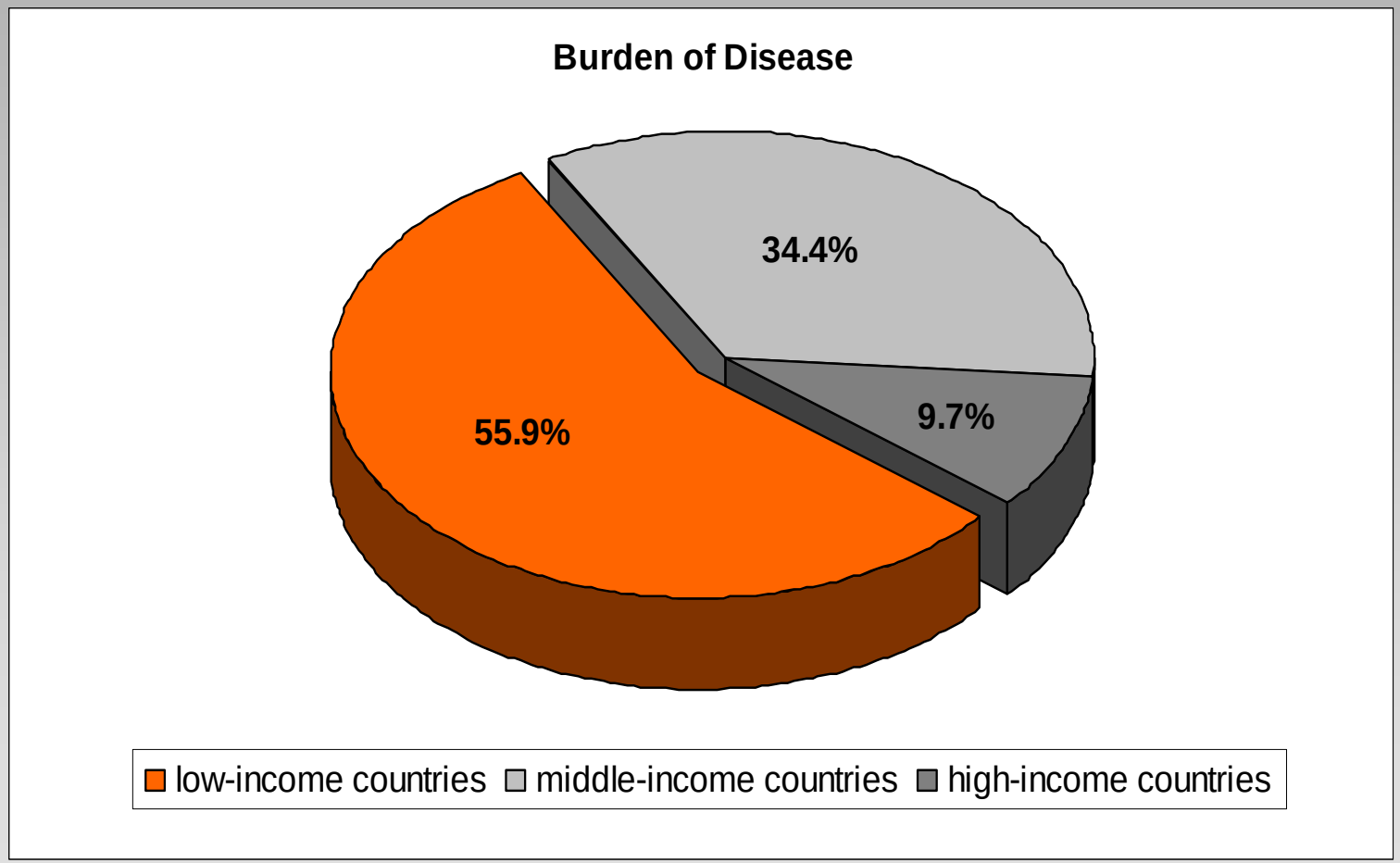
MDG progress to date… the good news, & the bad



Regional averages are population-weighted

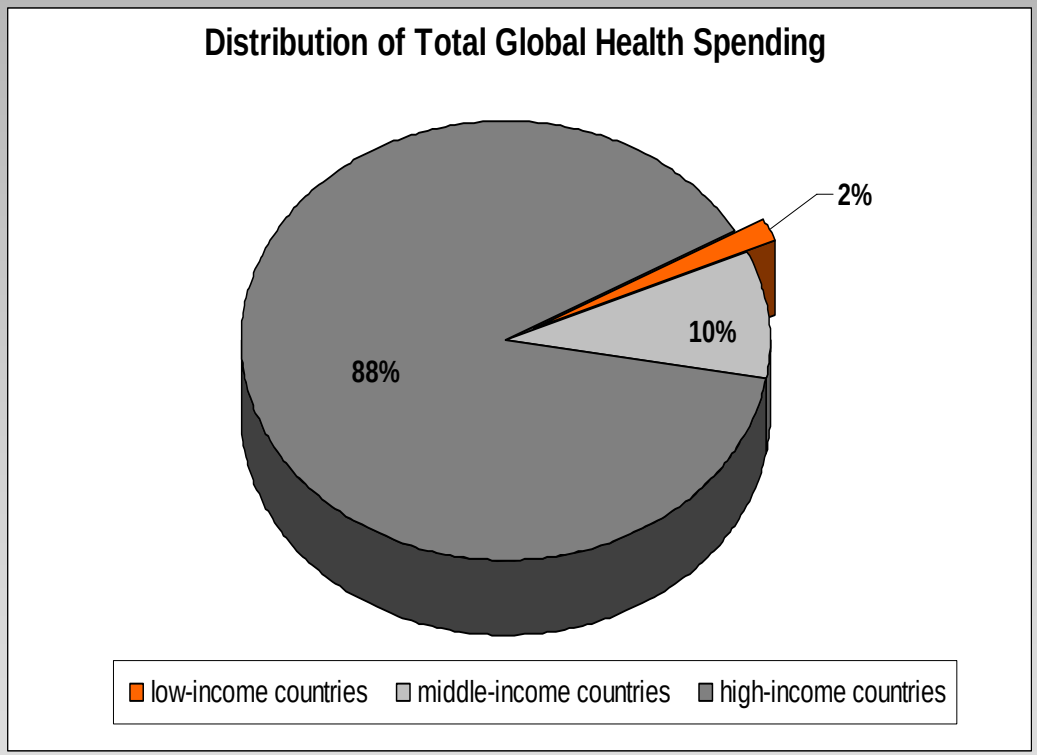
Global inequities are rampant…

Developing countries account for 90% of the global disease burden



Source: WDI 2005 and Lopez, Mathers, and Murray 2006.

…but only 12% of global health spending

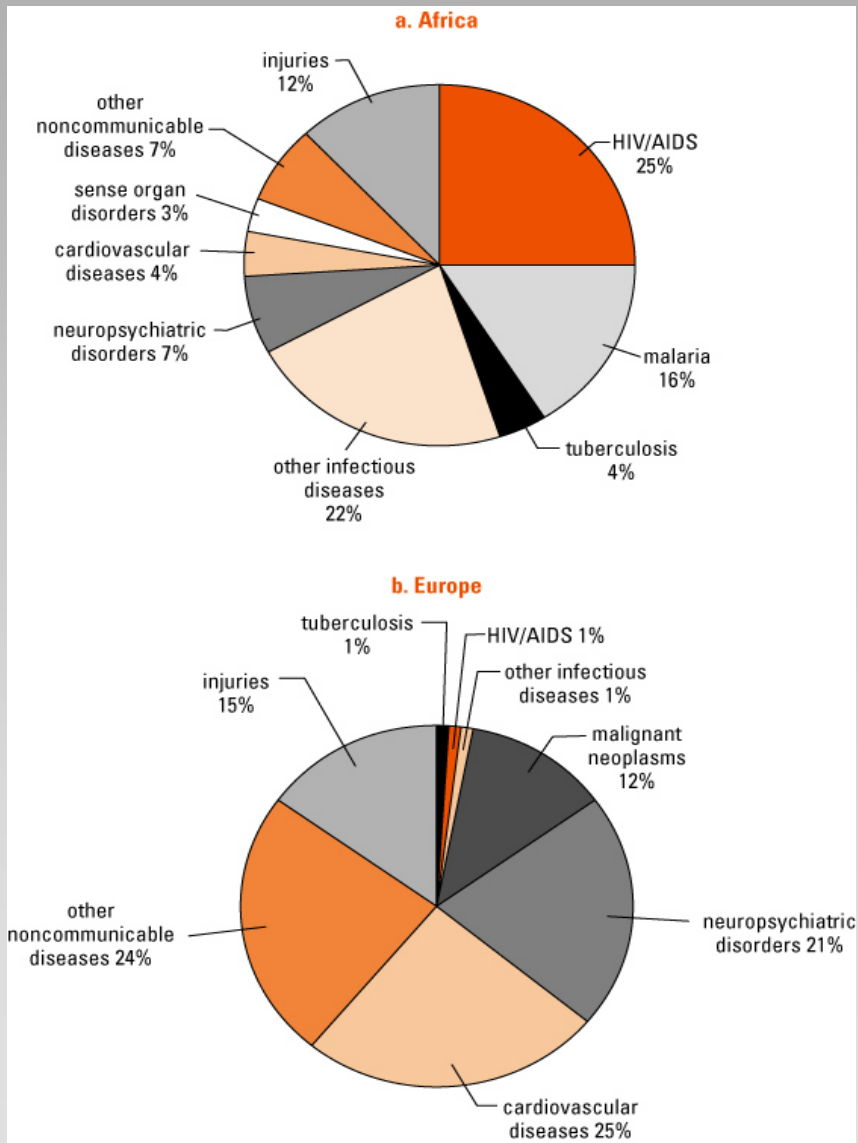


Annual Per Capita Health Spending

Low-income countries:	**$30**
Low-middle income countries:	**$82**
Upper-middle income countries:	**$310**
High-income countries:	**$3,000**

Source: WDI 2005 and Lopez, Mathers, and Murray 2006.

Cost-effective interventions do exist



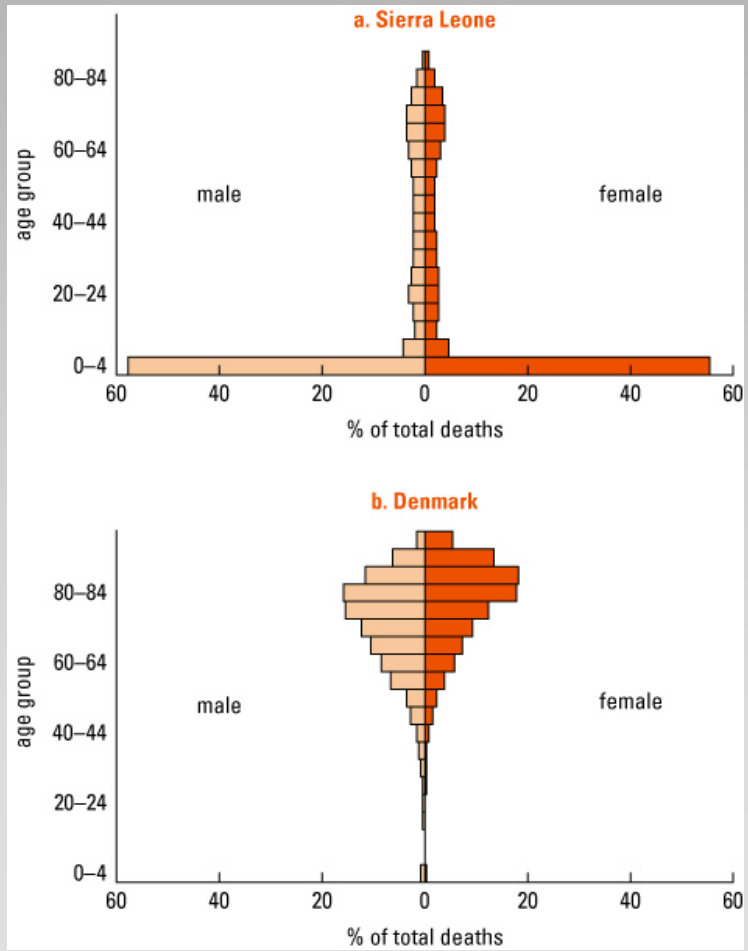
Source: WHO 2004.

Then why can’t we find the silver bullet for financing

- Universal access to a package of essential health services
- Financial protection of the population from the catastrophic spending due to illness

Mortality patterns are unique

“One-size-fits-all” solutions will not work



Source: United Nations 2005.

Health Policy Baselines, 2004

(population-weighted)

Regions & Income Levels	Per capita GDP ($US)	Per capita health expenditures ($US)	Per capita health expenditures ($USPPP)	Total health expenditures (% GDP)	Public (% total health expenditures)	Out-of-pocket (% total health expenditures)	External (% total health expenditures)	Life Expectancy at birth (years)	Under-5 mortality rate (per 1,000 live births)
East Asia & Pacific	1,457	64	239	4.4	39.8	51.0	0.5	70	37
Eastern Europe & Central Asia	3,801	249	552	6.6	67.6	26.5	1.1	69	34
Latin America & the Caribbean	3,777	271	608	7.3	51.0	36.3	0.7	72	31
Middle East & North Africa	1,833	103	270	5.6	48.8	46.3	1.1	69	55
South Asia	611	27	131	4.6	18.8	76.1	1.6	63	92
Sub-Saharan Africa	732	45	119	6.3	42.1	46.3	6.8	46	168
Low-income countries	533	24	105	4.7	23.9	70.0	5.5	59	122
Lower middle-income countries	1,681	91	298	5.4	47.3	42.9	0.7	70	42
Upper middle-income countries	5,193	339	689	6.7	57.6	30.3	0.7	69	28
High-income countries	33,929	3,812	3,606	11.2	60.3	14.9	0.0	79	7
World	6,523	658	771	10.1	59.0	17.9	0.2	67	79

Source: World Development Indicators, IMF Government Finance Statistics

Notes: Per capita indicators weighted by population, ratio indicators by ratio denominator

Revenue and GDP data reflect averages between 2000 and 2004.

Out-of-pocket health spending in Sub-Saharan Africa excludes South Africa, which, if included, changes the estimate to 26 percent of total health spending.

Health Financing

Sources and Gaps

Health Financing Functions and Objectives

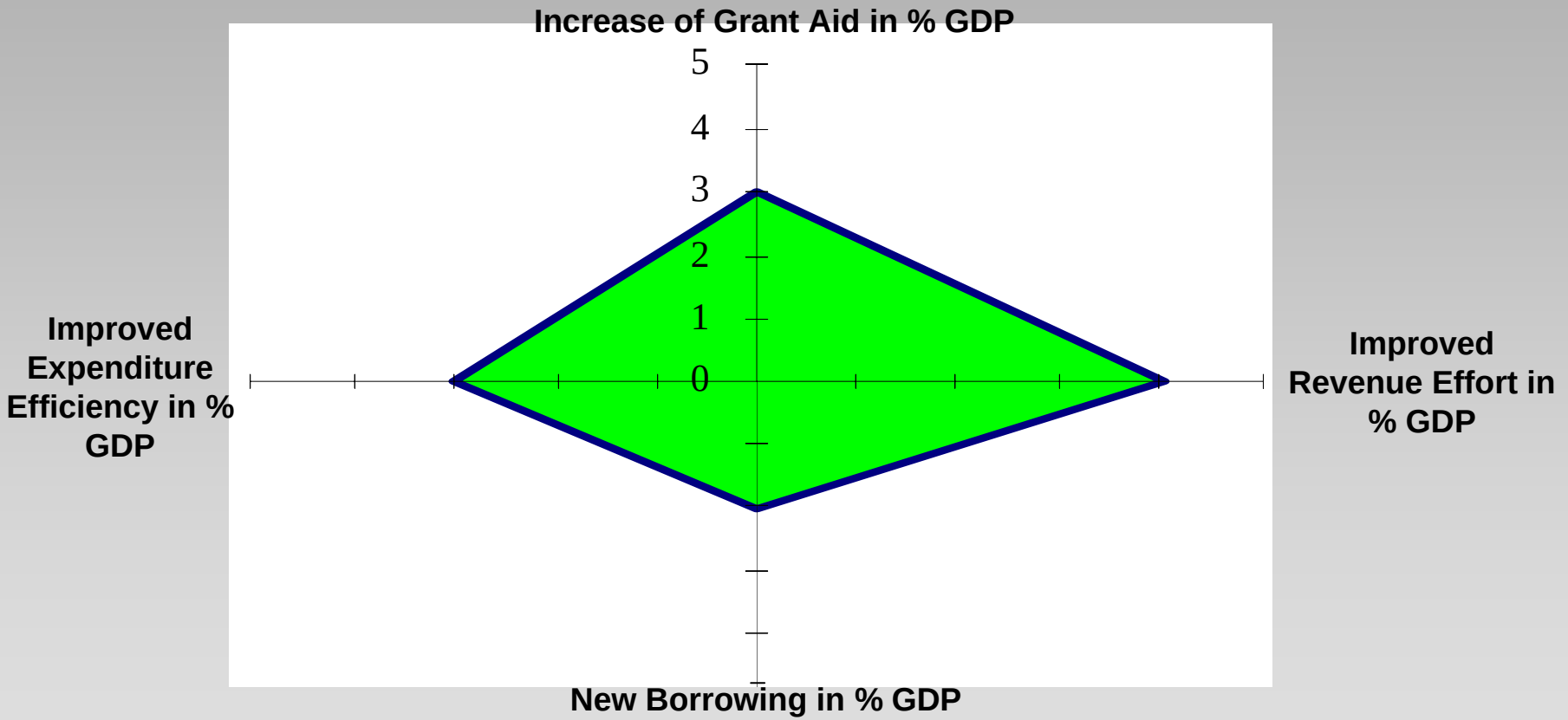
Functions	Objectives
Revenue Collection	raise *sufficient* and *sustainable* revenues in an *efficient* and *equitable* manner to provide individuals with both a *basic package of essential services* and *financial protection against* unpredictable catastrophic financial losses caused by illness and injury
Pooling	manage these revenues to *equitably* and *efficiently* pool health risks
Purchasing	assure the purchase of health services in an *allocatively* and *technically efficient* manner

Major Health Financing Models

Model	Revenue Source	Groups Covered	Pooling Organization	Care Provision
National Health Service	**General revenues**	**Entire population**	**Central government**	**Public providers**
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
Voluntary Health Insurance	Private voluntary contributions	Contributing members	For- and non-profit insurance organizations	Private and public facilities
Out-of-Pocket Payments (including public user fees)	Individual payments to providers		None	Public and private facilities (public facilities)

Fiscal Space* is Needed

***Budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of its financial position**



- Estimates of revenue effort may suggest that an additional 4 percent of GDP could be raised through domestic revenue measures.
- Negotiations with development partners may elicit indications of an additional 3 percent of GDP in grant aid.
- A PER may have identified areas for rationalization that would release 3 percent of GDP in resources for reallocation.
- Macroeconomic and debt management may suggest that new borrowing over the period should be limited to 2 percent of GDP.
- Seignorage (govt prints money which it loans to itself) is yet another, but generally limited, mechanism for creating fiscal space.

Source: PREM: FISCAL POLICY FOR GROWTH AND DEVELOPMENT: AN INTERIM REPORT, 2006

Domestic Resource Mobilization is Limited in MICs and 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

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 has the potential for administrative efficiency and cost control

Weaknesses

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

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

- Additional health revenue source
- As a 'benefit' tax, there 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, which is particularly problematic for LICs and some MICs
- 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

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
- Plays a role in mobilizing additional resources, providing access and financial protection in LICs
- Risk sharing is usually from the well to the sick
- If premiums are based on income, there can also be risk sharing from the better off to the poor
- CBHI can be a helpful complement but is not a substitute for NHS or SHI systems

Weaknesses

- Heterogeneous in terms of populations covered, regulation, and benefits provided
- Providing access and financial protection are limited due to the small size of most schemes
- The financial sustainability of most schemes is questionable
- CBHI schemes generally do not reach the very poor
- Their impacts on care delivery are quite limited
- Should be encouraged only where more comprehensive health financing arrangements cannot be implemented on a large scale

Voluntary Health Insurance

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

Strengths

- As a prepayment and risk pooling mechanism is generally 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

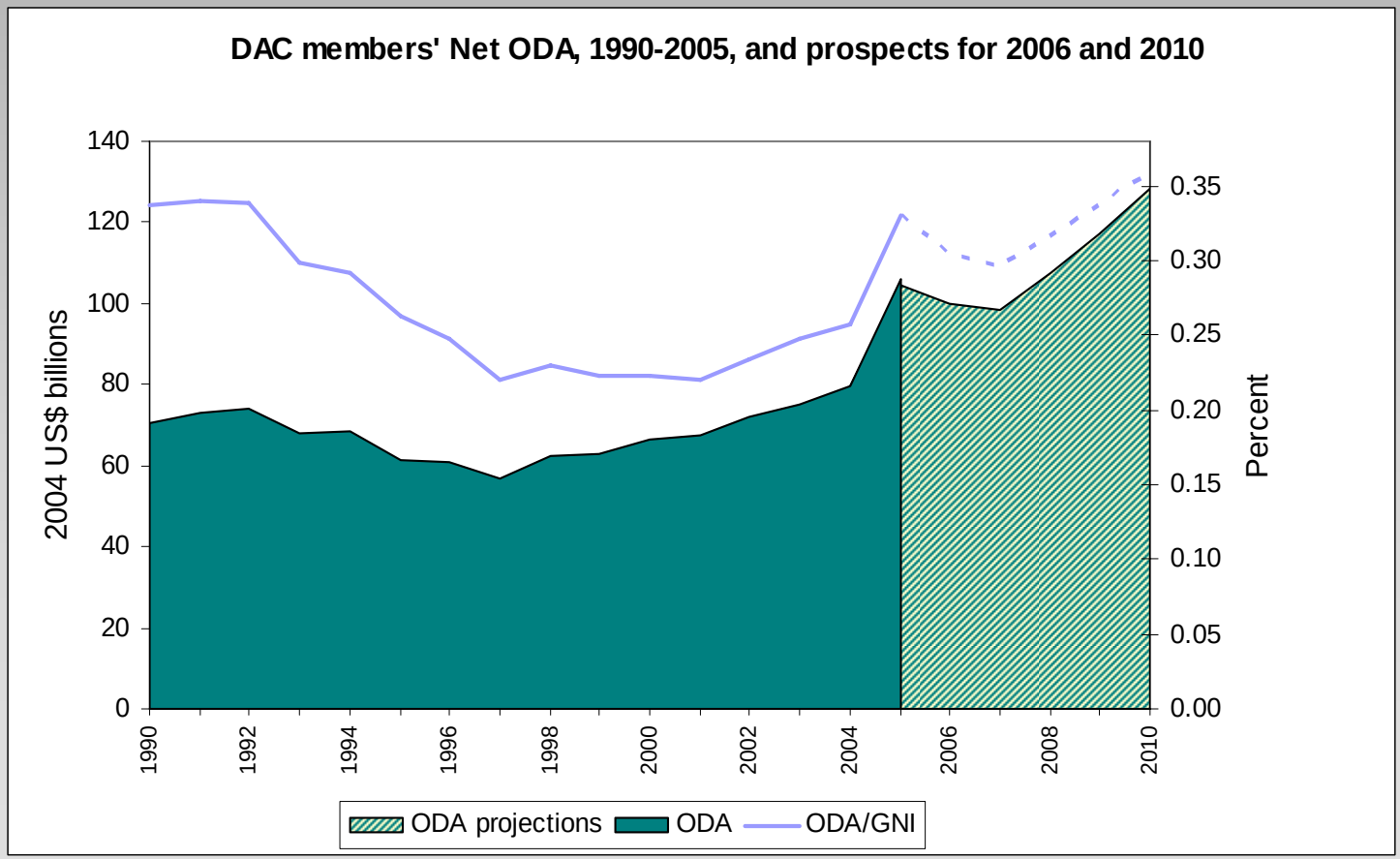
Weaknesses

- Associated with high administrative costs
- Not effective in reducing cost pressures on public health financing systems
- May be inequitable without public intervention either to subsidize premiums or regulate insurance content and price
- Has the potential to divert resources and support from mandated health financing mechanisms
- Applicability in LICs and MICs requires well developed financial markets and strong regulatory capacity

Development aid is increasing but falls far short of what is needed and what has been promised

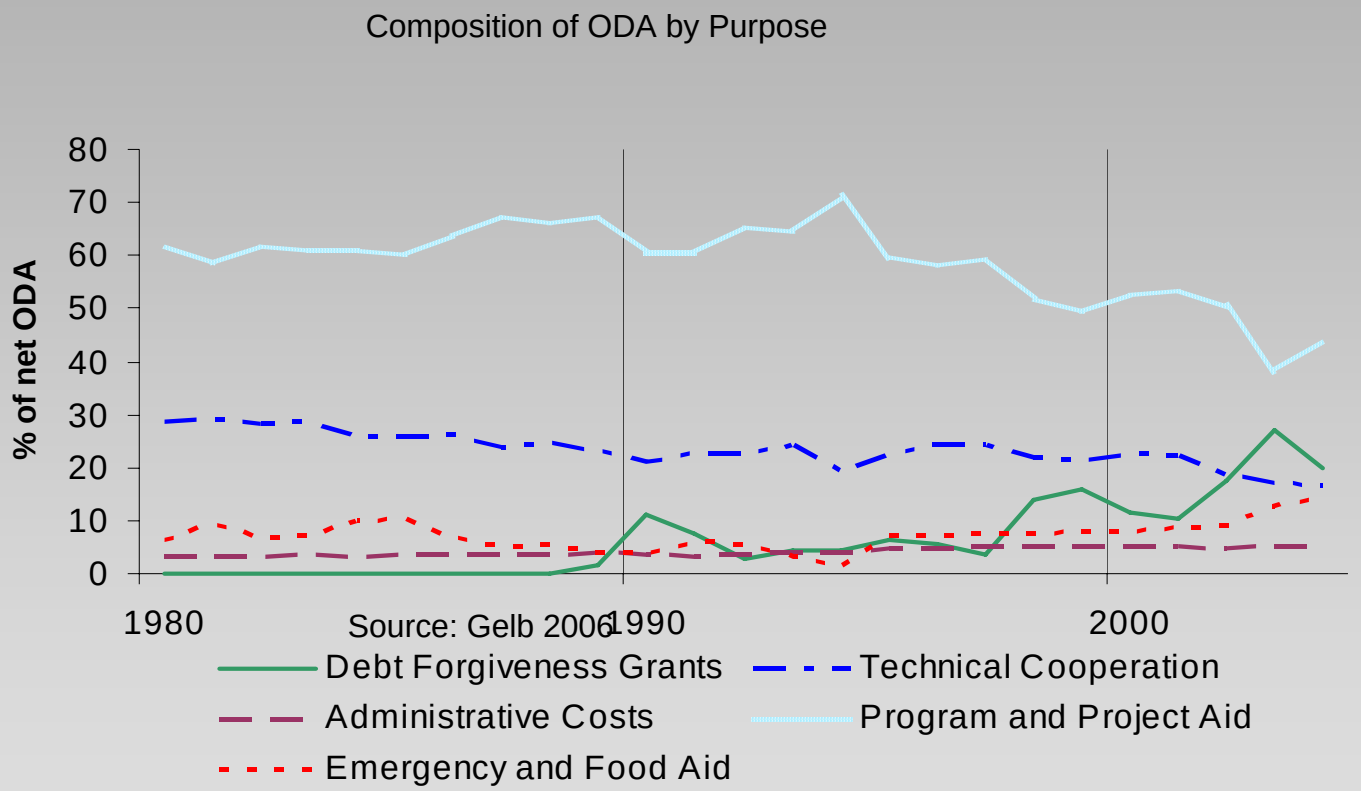
0.7% of Gross National Income promised by developed countries

0.54% of Gross National Income to meet MDGs



Source: GMR 2006

Where does the aid go



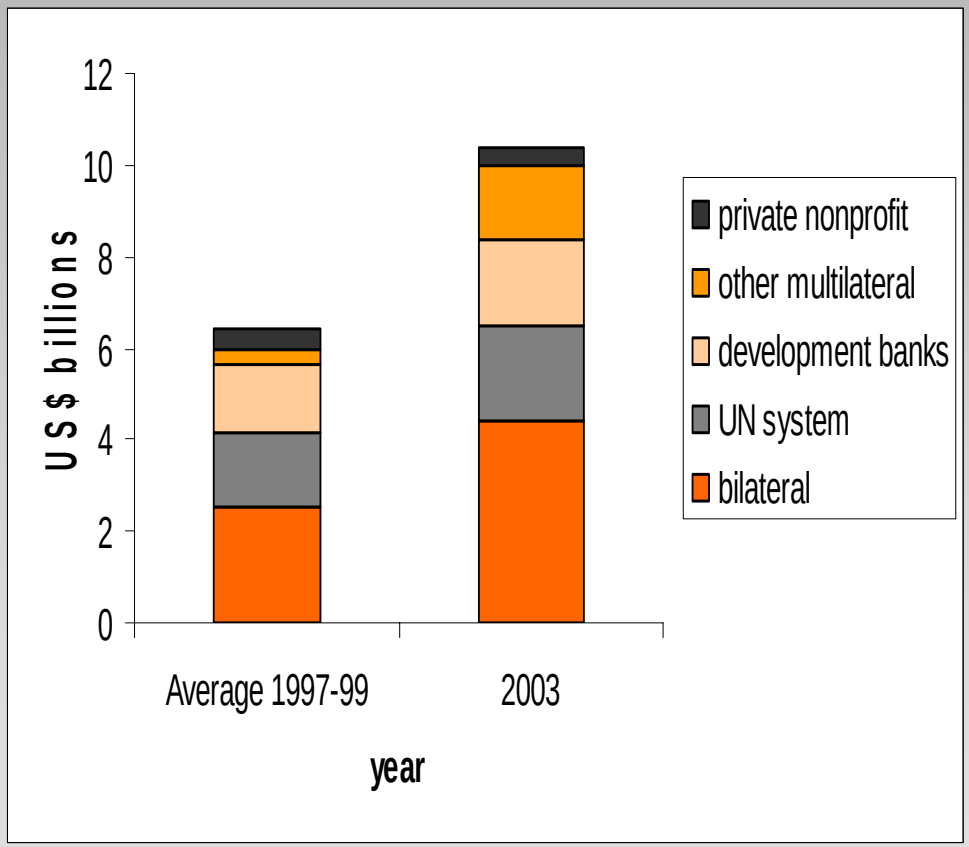
Where Does All the Aid Go?

On average, for every $1 disbursed by donors to our 14 case study countries, we estimate:

- Not recorded in balance of payment $0.30
- Recorded in BOP but not in Govt spending $0.20
- Aid earmarked to specific projects $0.30
- Budget support $0.20

- 1990s structural adjustment provided a larger share of aid as general budget resources.

Donor aid for health has increased significantly

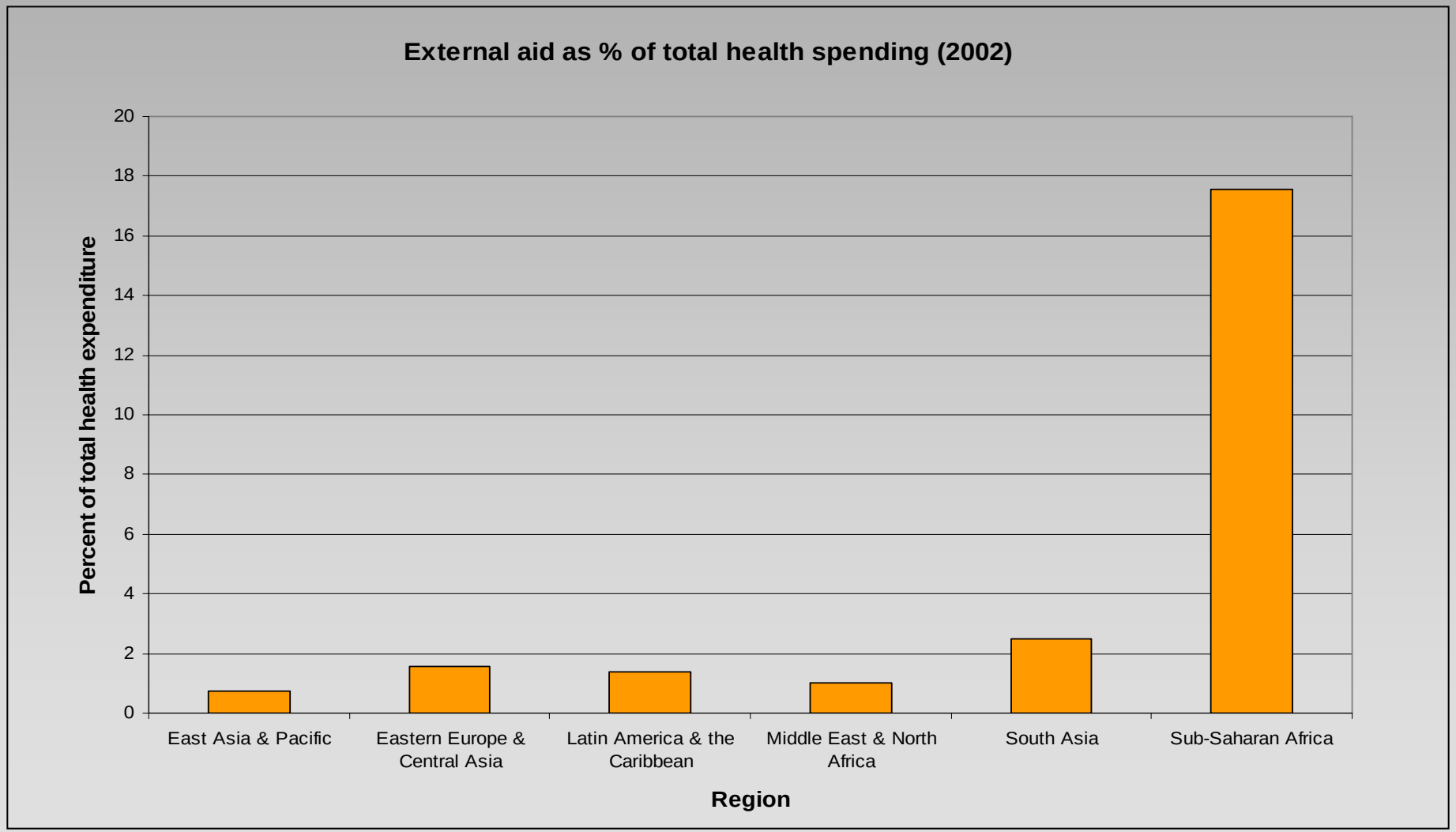


Most of the recent increases:

- **Focus on Africa**
- **Focus on specific diseases**
- **Come from bilaterals and multilaterals (GAVI, Global Fund)**

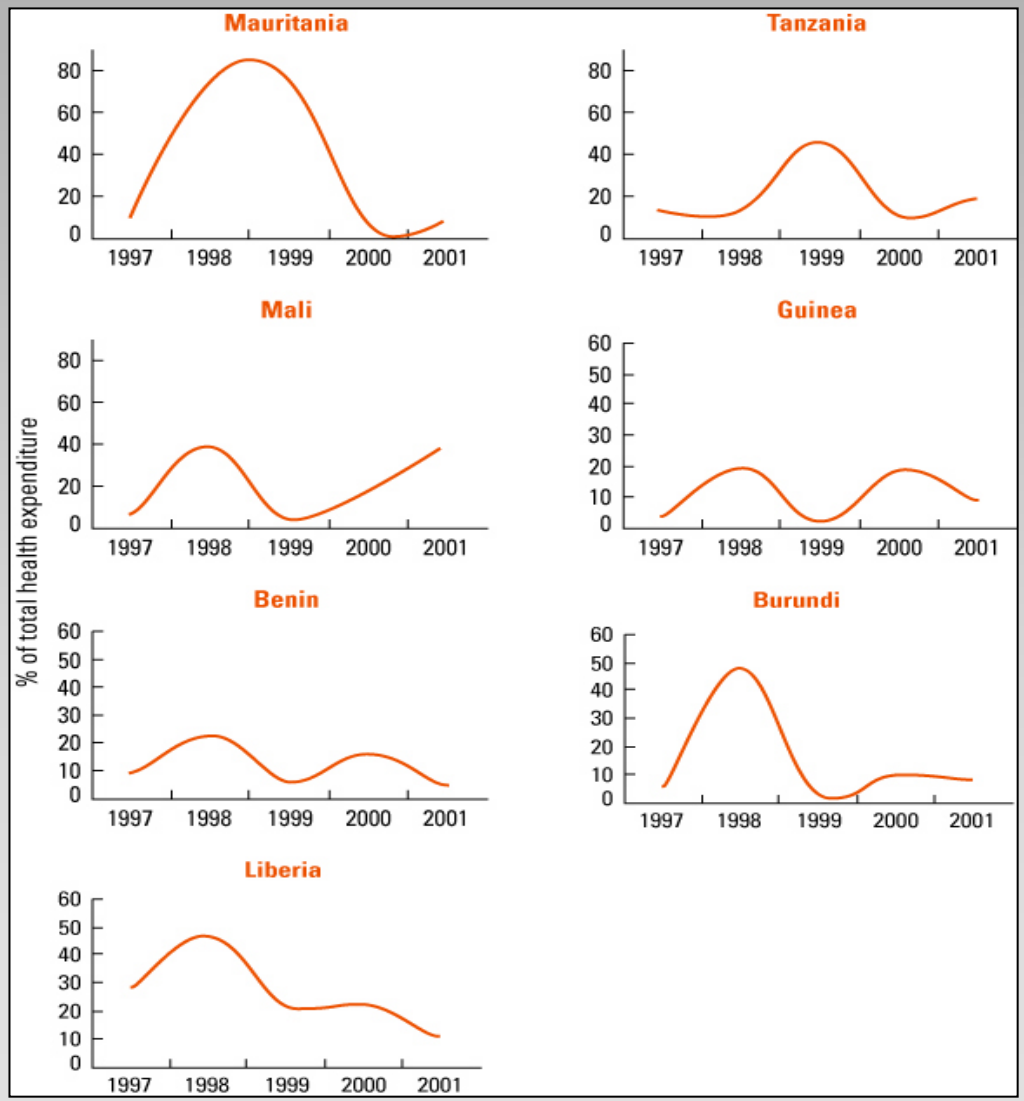
Source: Michaud 2006

External aid is an important source of health spending

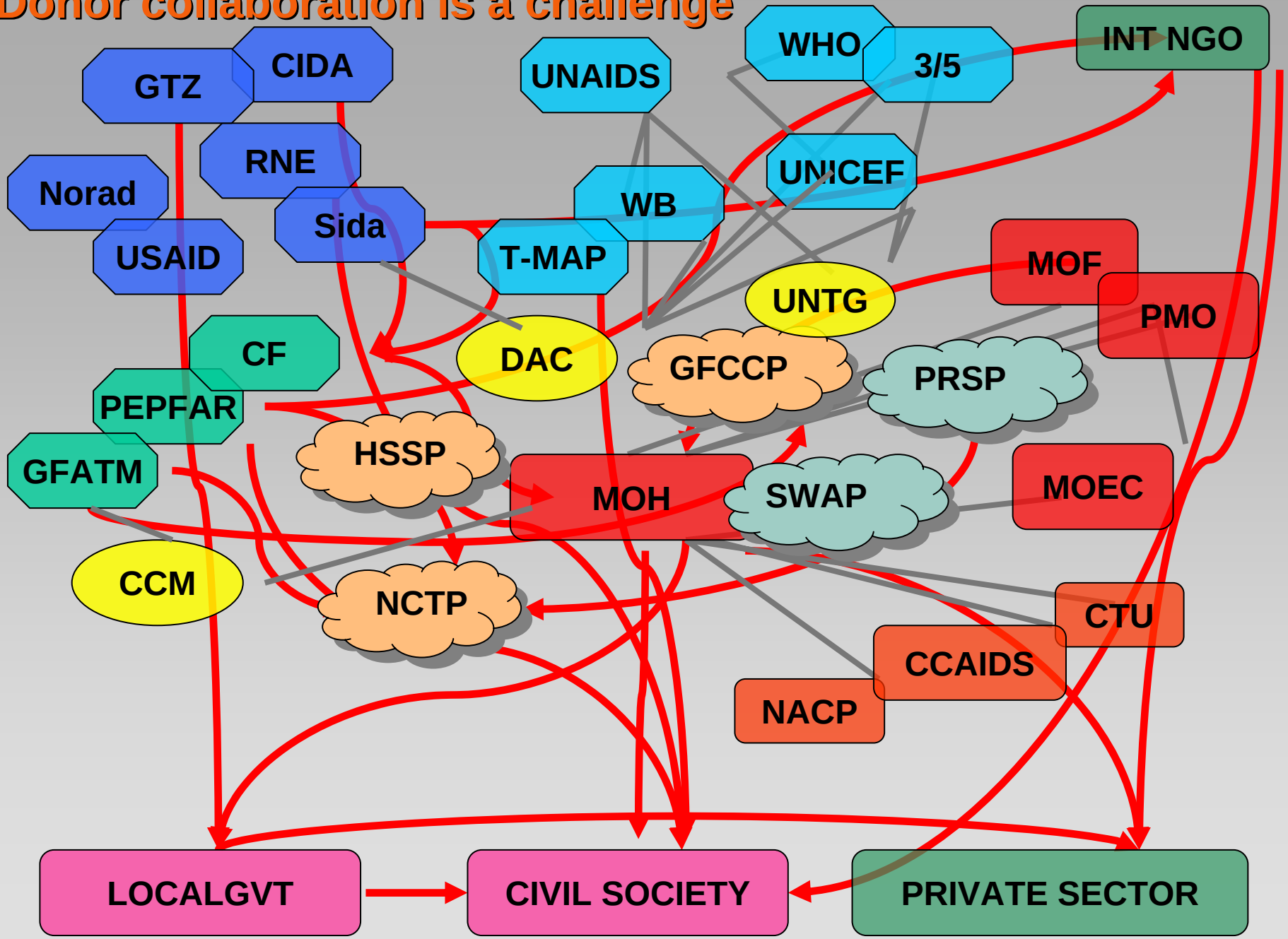


However, donor commitments for health are volatile and unpredictable

Try managing this…

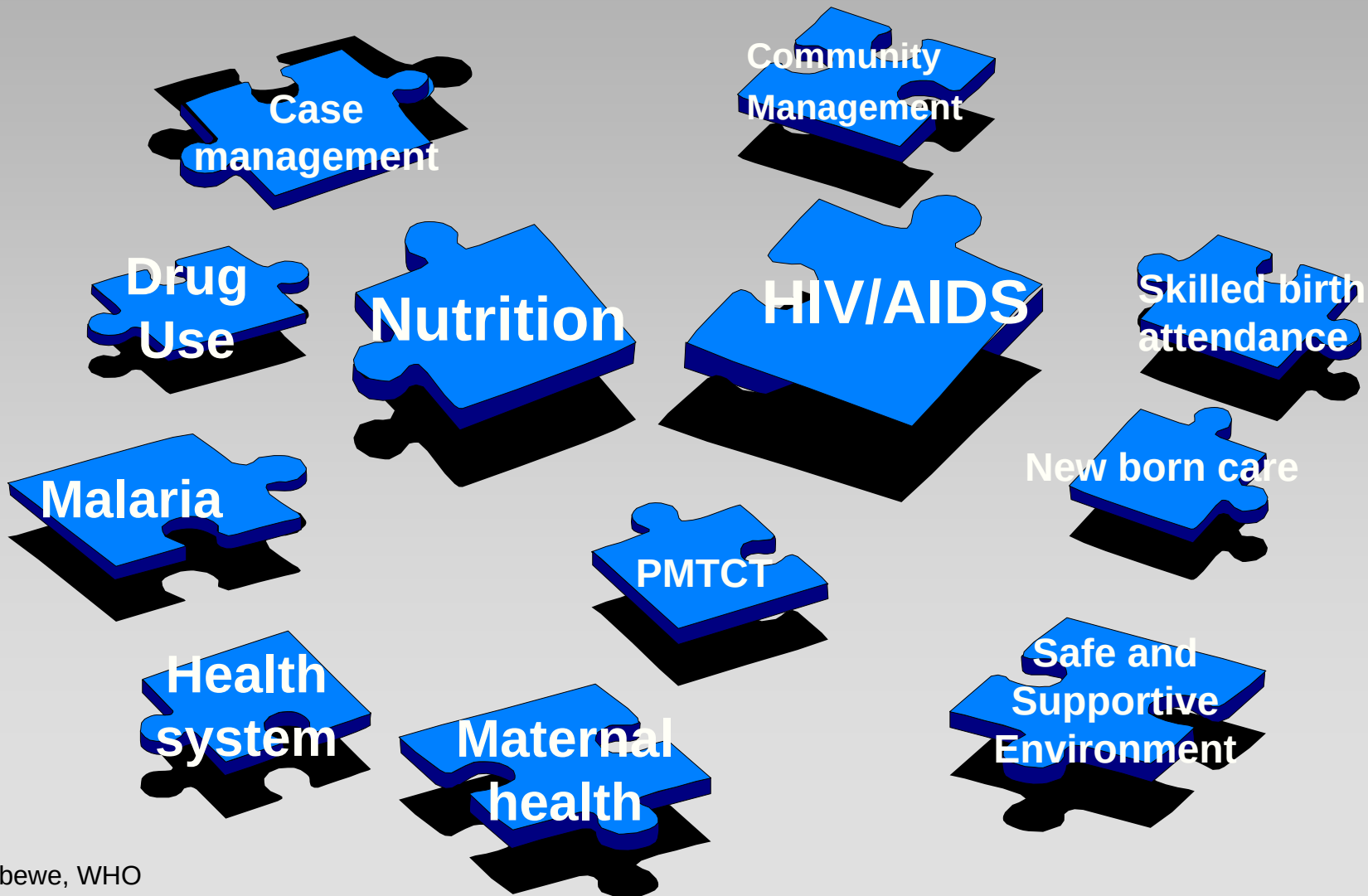


Donor collaboration is a challenge



Source: Mbewe, WHO

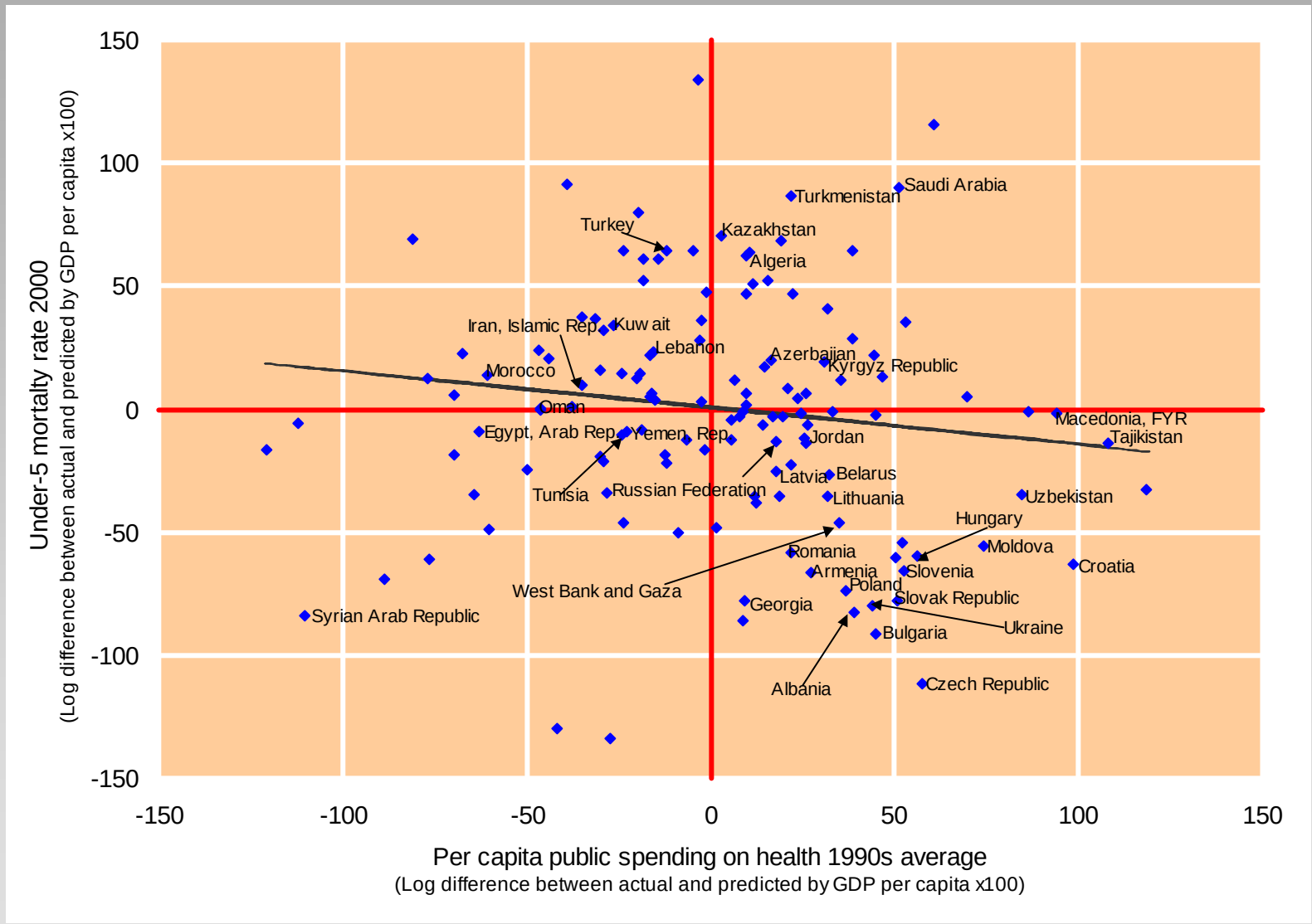
Vertical aid distorts priorities



Source: Mbewe, WHO

Efficiency Gains are Another Source of 'Financing'

(Higher Public Spending Does Not Necessarily Result in Better Outcomes)

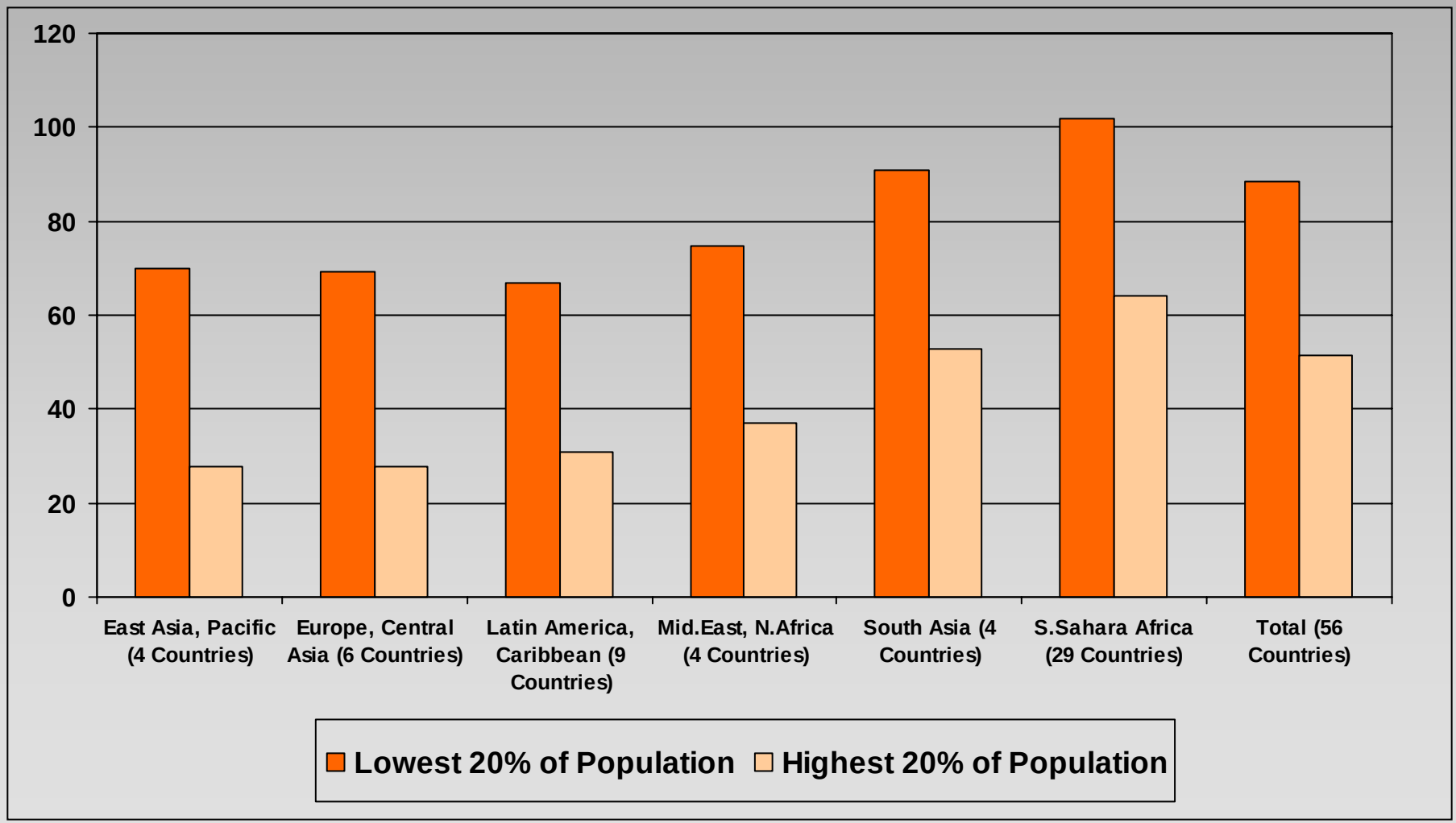


* Public spending and child mortality rate are shown as the percent deviation from rate predicted by GDP per capita

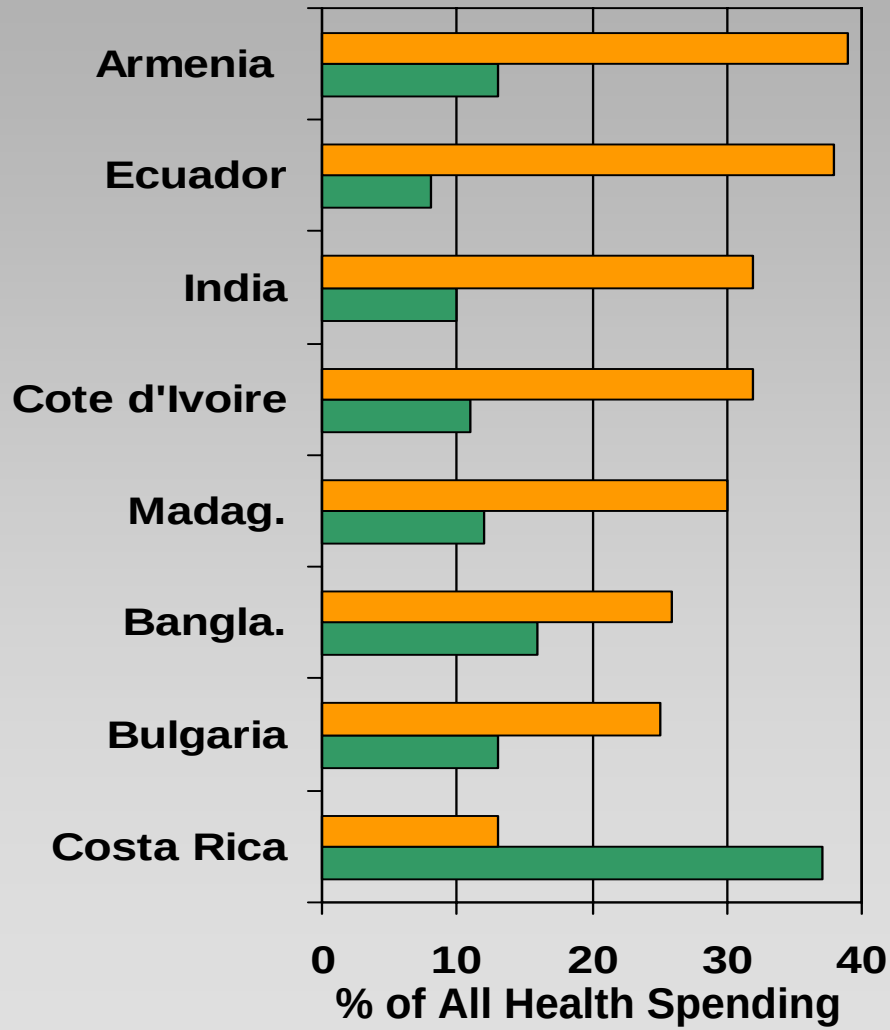
Source: Spending and GDP from World Development Indicators database. Under-5 mortality from Unicef 2002`, WDR 2004

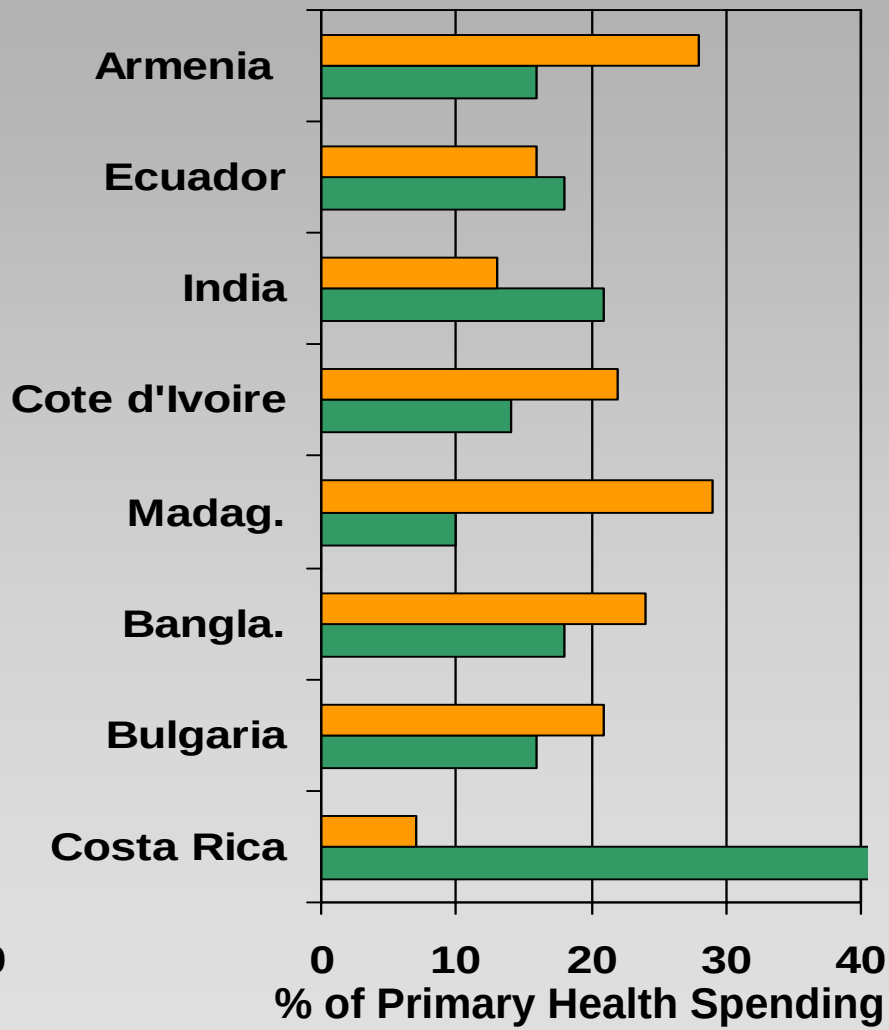
Recipient countries have serious management issues as well: there are large inequities within individual countries

Infant mortality rates among poorest and richest 20%: 56 low- and middle-income countries



The richest also benefit from government health spending





Poorest 20 % Green

Richest 20% ORANGE

Source: World Development Report 2004

More money alone will not achieve results unless countries deal with their major constraints including:

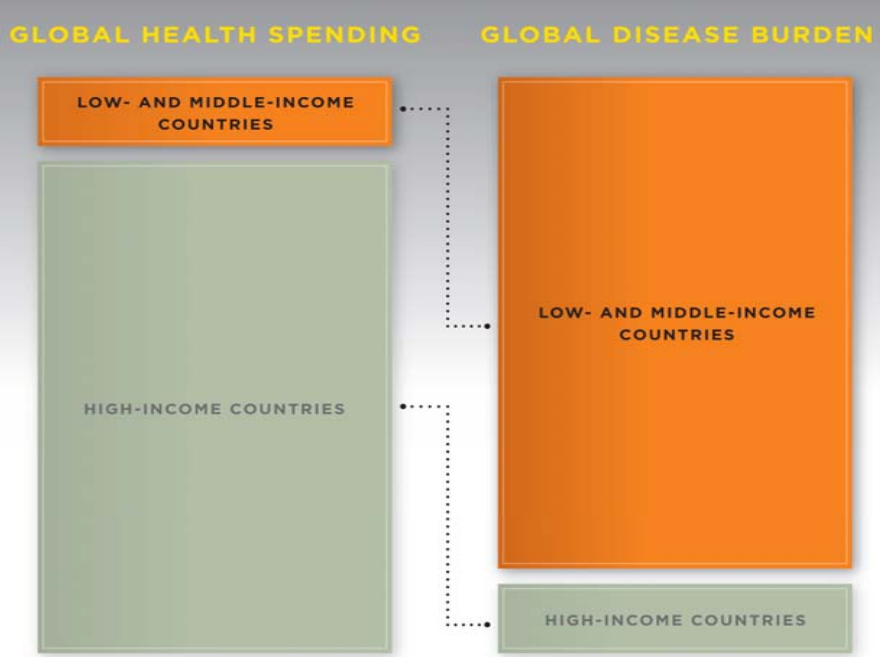
- Macroeconomic issues (e.g. capacity to raise more money domestically)
- Institutional issues (e.g. administrative capacity, level of corruption)
- Health staffing issues (e.g. skills and number of administrative, managerial & medical staff)
- Social/cultural/political issues (e.g. political and social stability, cultural norms, etc)

Global health reforms will fail unless

- The global community lives up to its aid commitments and improves donor harmonization
- Countries base decisions on sound policy and global evidence bases tailored to individual country circumstances
- Countries improve their capacity to absorb more aid and to spend it effectively and wisely
- Donors and countries better align their preferences, political expectations, and processes
- Monitoring and evaluation efforts are given higher priority in development

A PRACTITIONER'S GUIDE

HEALTH FINANCING REVISITED



THE WORLD BANK