

## Chapter 12

# Financing Health Systems in the 21st Century



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This chapter assesses health financing policy in low- and middle-income countries (LMICs). It discusses the basic functions of health financing systems and the various mechanisms for effective revenue collection, pooling of resources, and purchase of interventions (WHO 2000). It analyzes the basic financing challenges facing LMICs as a result of revenue generation and collection constraints, increasing flows of development assistance for health (DAH) coupled with donors' concerns about aid effectiveness, and the difficult economic situation facing many LMICs as a result of globalization and poor economic management.

In 2001, about US\$3.059 trillion—approximately 9 percent of global gross domestic product (GDP)—was spent on health care worldwide (WHO 2004b; World Bank 2004e); however, only 12 percent of this amount was spent in LMICs, which account for 84 percent of the global population and 92 percent of the global disease burden (Mathers and others 2002). Ongoing epidemiological, demographic, and nutrition transitions will pose significant challenges for health financing systems in LMICs in the near future as the communicable disease burden lessens and the noncommunicable disease and injury burdens expand. At the same time, the current communicable disease burden in low-income countries (LICs) and in many middle-income countries (MICs), especially that caused by malaria, tuberculosis, and HIV/AIDS, poses a serious threat to public health, health systems, and economic growth.

As a result of the international focus on poverty reduction, the HIV/AIDS pandemic, and the Millennium Development Goals (MDGs), international health financing policy has evolved over the past decade from defining a basic package of

cost-effective health services to figuring out how to finance and deliver those services equitably and efficiently, to recognizing the need to scale up health systems to meet basic service needs and achieve the MDGs, which will require large amounts of DAH for poor countries (see, for example, WHO 2000, 2001; World Bank 1993, 2004b).

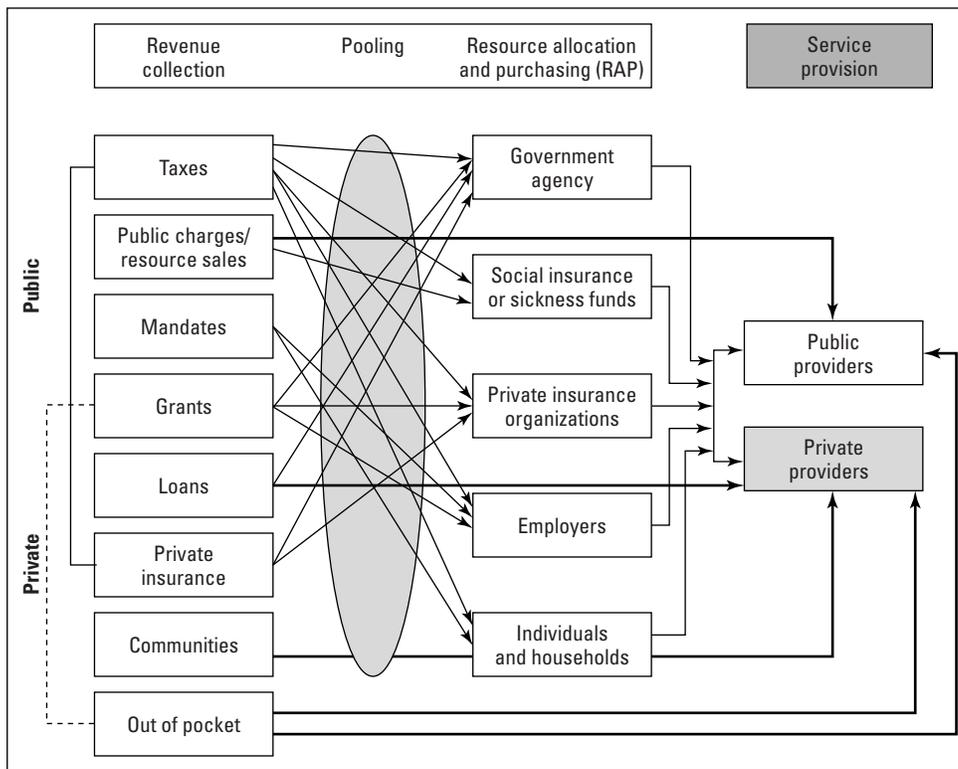
This chapter updates and reviews the global evidence on health spending, health needs, revenue-raising capacity, organization of health financing, and trends in DAH. It discusses the key challenges that country policy makers face in ensuring access to services and financial protection while dealing with a new health policy world defined by new instruments such as sectorwide approaches (SWAs) and Poverty Reduction Strategy Papers (PRSPs). The chapter also discusses the scope and potential effects of new and relatively large global funding sources, such as the Bill & Melinda Gates Foundation; the Global Fund to Fight AIDS, Tuberculosis, and Malaria; and the Global Alliance for Vaccines and Immunization (GAVI) Vaccine Fund.

## HEALTH FINANCING SYSTEMS

Health financing provides the resources and economic incentives for the operation of health systems and is a key determinant of health system performance in terms of equity, efficiency, and health outcomes.

### Health Financing Functions

Health financing involves the basic functions of revenue collection, pooling of resources, and purchase of interventions.



Source: Authors.

**Figure 12.1** Interactions among Revenue Raising, Risk Pooling, Resource Allocation, and Service Provision

- *Revenue collection* is how health systems raise money from households, businesses, and external sources.
- *Pooling* deals with the accumulation and management of revenues so that members of the pool share collective health risks, thereby protecting individual pool members from large, unpredictable health expenditures. Prepayment allows pool members to pay for average expected costs in advance, relieves them of uncertainty, and ensures compensation should a loss occur. Pooling coupled with prepayment enables the establishment of insurance and the redistribution of health spending between high- and low-risk individuals and high- and low-income individuals.
- *Purchasing* refers to the mechanisms used to purchase services from public and private providers. Figure 12.1 illustrates these functions and their interactions.

In terms of health policy at the country level, these three financing functions translate into the following:

- raising 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 or injury.

- managing these revenues to equitably and efficiently pool health risks; and,
- ensuring the purchase of health services in an allocatively and technically efficient manner.

These financing functions are generally embodied in the following three stylized health financing models:

- *national health service (NHS)*: compulsory universal coverage, national general revenue financing, and national ownership of health sector inputs
- *social insurance*: compulsory universal coverage under a social security (publicly mandated) system financed by employee and employer contributions to nonprofit insurance funds with public and private ownership of sector inputs
- *private insurance*: employer-based or individual purchase of private health insurance and private ownership of health sector inputs.

Although these models provide a general framework for classifying health systems and financing functions, they are not useful from a micropolicy perspective because all health systems embody features of the different models. The key health policy issues are not whether a government uses general

revenues or payroll taxes, but the amounts of revenues raised and the extent to which they are raised in an efficient, equitable, and sustainable manner. Similarly, nothing is intrinsically good or bad about public versus private ownership and provision. The important issue is whether the systems in place ensure access, equity, and efficiency.

### Revenue Collection

Governments use a variety of financial and nonfinancial mechanisms to carry out their functions, including directly providing services; financing, regulating, and mandating service provision; and providing information (Musgrove 1996). A substantial literature is devoted to the various sources for financing health services and the economic and institutional effects of using these sources in terms of efficiency, equity, revenue-raising potential, revenue administration, and sustainability (Schieber 1997; Tait 2001; Tanzi and Zee 2000; WHO 2004b; World Bank 1993). An additional source of revenue receiving increasing attention is efficiency gains (Hensher 2001). LICs rarely use tax credits as a financing source (Tanzi and Zee 2000).

The key fiscal issue for LMICs is for their financing systems, both public and private, to mobilize enough resources to finance expenditures for basic public and personal health services without resorting to excessive public sector borrowing (and creation of excessive external debt); to raise revenues equitably and efficiently; and to conform with international standards (Tanzi and Zee 2000). Institutional constraints are particularly important, including a country's economic structure—for example, large rural populations and limited formal sector employment; ineffective tax administration; and lack of data, all of which tend to preclude LMICs from using the most efficient and equitable revenue-raising instruments (Schieber and Maeda 1997; Tait 2001). The high level of inequality in most LMICs means that governments face the difficult situation of needing to tax the politically powerful and wealthy elites to raise significant revenues in an equitable manner but of being unable to do so easily. As Tanzi and Zee (2000, 4) point out, “tax policy is often the art of the possible rather than the pursuit of the optimal.”

Another area of health financing that continues to generate heated debate is user fees (that is, charges to individuals for publicly provided services). The need to significantly scale up resources to meet the MDGs in LICs has pushed the user fee issue to the forefront of this debate. Arhin-Tenkorang (2000) and Palmer and others (2004) suggest that the overall effect is negative: use decreases, particularly among the poor, and frequently, administrative costs of collecting the fees are higher than the revenue generated. Further, Kivumbi and Kintu (2002) suggest that granting waivers and exemptions for the poor is difficult, if not impossible. Given those findings, many have called for the abolition of user fees, including the United

Nations Millennium Project (2005) and the Commission for Africa (2005).

Others have argued, however, that absent resources to fund drug purchases, provide facilities with some discretionary funding, and motivate providers, use of primary health care by the poor will remain low because of both poor quality and lack of drugs, and the poor will purchase these essential services on the private market. The Bamako Initiative shows that user fees may be an important revenue source where institutions are weak, resources are limited, and the choice is between having drugs or not having them (World Bank 2003, 76–77). Furthermore, studies indicate that user fees can improve benefit incidence if user fee and waiver policies have been well designed and implemented and if providers are compensated for forgone revenues. Indeed, proponents of user fees argue that as long as the fees are set below private market levels, this “savings” may result in a net reduction in overall out-of-pocket spending for the poor (Bitrán and Giedion 2003). These diverse experiences demonstrate the difficulty involved in making blanket statements regarding user fees. As the World Bank (2003, 71) points out, “user fees, as with other public policy decisions, must balance protection of the poor, efficiency in allocation, and the ability to guarantee that services can be implemented and sustained.”

### Risk Pooling and Financial Protection

Preventing individuals from falling into poverty because of catastrophic medical expenses and protecting and improving the health status of individuals and populations by ensuring financial access to essential public and personal health services provide a strong basis for public intervention in financing health systems. Public intervention may be needed because of market failures in private financing and provision (for instance, information asymmetries) and instabilities in insurance markets (such as favorable risk selection by insurers and moral hazard). Indeed, in virtually all Organisation for Economic Co-operation and Development (OECD) countries except the United States, governments have decided to publicly finance or require private financing of the bulk of health services. However, given both low income levels and limits on possibilities for domestic resource mobilization in LICs and some MICs, these countries face severe challenges in publicly financing essential public and personal health services. They also often confront difficult tradeoffs with respect to financing these basic essential services and providing financial protection against the costs of catastrophic illness.

**Ensuring Financial Protection.** Ensuring financial protection means that no household spends so much on health that it falls into and cannot overcome poverty (ILO and STEP 2002b). Achieving adequate levels of financial protection requires maximizing prepayment for insurable health risks; achieving the

largest possible pooling of health risks within a population, thereby facilitating redistribution among high- and low-risk individuals; ensuring equity through prepayment mechanisms that redistribute costs from low- to high-income individuals; and developing purchasing arrangements that promote efficient delivery of good-quality services.

Meeting those requirements depends on how health systems arrange the three key health financing functions of revenue collection, risk pooling, and purchasing. Although all health financing functions play an important role in ensuring financial protection, risk pooling and prepayment—whether through taxes or individual premiums—play the central and often the most poorly understood roles.

*Risk pooling* refers to the collection and management of financial resources so that large individual and unpredictable financial risks become predictable and are distributed among all members of the pool. The pooling of financial risks is at the core of traditional insurance mechanisms. Whereas pooling ensures predictability and the potential for redistribution across individual health risk categories, *prepayment* provides various options for financing those risks equitably and efficiently across high- and low-income pool members. The health financing models described earlier embody different means for creating risk pools and financing such pools through prepaid contributions.

In most LMICs, multiple public and limited private arrangements coexist, making system fragmentation the norm rather than the exception. This situation increases administrative costs; creates potential equity and risk selection problems, for example, when the wealthy are all in one pool; and limits pool sizes. Moreover, health care risks change over the life cycle of an individual or household, but because generally little correlation exists between life cycle needs and capacity to pay, subsidies are often necessary and are facilitated by risk pooling.

Risk pooling and prepayment functions are central to the creation of cross-subsidies between high-risk and low-risk (that is, a *risk subsidy*) and rich and poor (that is, an *equity subsidy*) individuals. The larger the pool, the greater the potential for spreading risks and the greater the accuracy in predicting average and total pool costs. Placing all participants in a single pool and requiring contributions according to capacity to pay rather than individual or average pool risk facilitates cross-subsidization and, depending on the level of pooled resources, can significantly increase financial protection.

However, spreading risks through insurance schemes is not enough to ensure financial protection, because it can result in low-risk, low-income individuals subsidizing high-income, high-risk individuals. Furthermore, significant portions of the population may not be able to afford insurance. For this reason, most health care systems aim not only at spreading risk, but also at ensuring equity in financing of health care services through subsidies from high- to low-income individuals. Equity subsidies are the result of such redistribution policies.

At least four alternative organizational arrangements exist for risk pooling and prepayment: ministries of health (MOHs) or NHSs, social security organizations (SSOs), voluntary private health insurance, and community-based health insurance (CBHI). Each of these is linked to distinctive instruments for revenue collection (for example, general revenues, payroll taxes, risk-rated premiums, and voluntary contributions) and for purchase of health services.

Within these organizational structures, three alternatives often coexist for generating revenues and financing equity subsidies: subsidies within a risk pool, subsidies across different risk pools, and direct public subsidies through transfers from the government. Although medical savings accounts (with or without public subsidization) are also sometimes referred to as a risk pooling mechanism, they do not pool risks over groups and, therefore, are far more limited in terms of predictability and equity subsidization. They are simply intertemporal mechanisms for smoothing health risks over an individual's or household's life cycle.

Subsidies within a risk pool, whether financed through general revenues or payroll taxes, are prerequisites for pooling risks in traditional NHSs and SSOs. The goal of collecting revenues through an income-related or general revenue-based contribution (in contrast to a risk-related contribution, as is generally the case with private insurance) is to generate subsidies from high- to low-income individuals. These systems are effective when payroll contributions are feasible, when the general revenue base is sufficient and a large proportion of the population participates in the same risk pool, or when both conditions exist. Moreover, in a system with multiple, competing, public and private insurers and a fragmented risk pool, payroll contributions may increase incentives for risk selection. In the case of a NHS or SSO, financial resources might be insufficient or inappropriate for spreading the financial risks or for creating an equity subsidy, particularly if the general revenue or payroll contribution base is regressive.

Subsidies across different risk pools involve the creation of funds, often called *solidarity* or *equalization funds*, financed by a portion of contributions to each risk pool. This mechanism is found in systems with multiple insurers in, for example, Argentina, Colombia, Germany, and the Netherlands. A key element of this mechanism's success is the implementation of adequate systems of compensation among different risk and income groups.

Finally, in many OECD countries, direct public transfers funded through general taxation are made to insurers for subsidizing health care for certain groups or for the entire population. They are also used in some LMICs, although at a limited level because of low revenue collection capacity.

In most LMICs, risk pool fragmentation significantly impedes effective risk pooling, while limited revenue-raising capacity precludes the use of broad public subsidies as the main

source of finance. Therefore, targeting scarce public subsidies across different risk pooling schemes is probably the most feasible way to finance equity subsidies for the poor and those outside formal pooling arrangements. However, this method has important transaction costs. Because a significant portion of the population is excluded from the formal sector, using this mechanism for ensuring universal financial protection is limited, particularly in LICs. Even if significant subsidies are available from general taxation, the lack of insurance portability restricts its usefulness as a subsidization mechanism among risk pools because individuals may lose their coverage when they change jobs. LICs and certain MICs will be challenged both to publicly finance essential public and personal health services and to ensure financial protection through equity subsidies. Thus, LMICs should strive to achieve the best value for publicly financed health services in terms of health outcomes and equity and should try to facilitate effective risk pooling for privately financed services. Providing public financing for cost-effective interventions is one critical aspect of determining which services to finance publicly.

**Distributing and Sourcing Health Expenditures.** As table 12.1 shows, health spending is derived from three broad sources: public sector (expenditures financed out of general revenues and social insurance contributions), private sector (expenditures financed out of pocket and by private insurance), and external sources (grants or loans from international funding agencies). In 2001, high-income countries spent an average of 7.7 percent of their GDP on health (country weighted), MICs spent 5.8 percent, and LICs spent 4.7 percent.

Even though a clear upward trend between a country's income level and the level of public and total health spending is apparent in terms of both absolute spending and share of GDP, spending for any given income level varies a great deal, particularly at lower income levels (Musgrove, Zeramini, and Carrin 2002). The composition of health spending also exhibits major differences. As incomes increase, both private and out-of-pocket shares of total health spending decrease. In LICs, private and out-of-pocket spending and external assistance account for the bulk of all health spending. As countries move up the income scale, public spending predominates and both out-of-pocket spending and external assistance decrease drastically.

LMICs with high levels of out-of-pocket spending have limited opportunities for risk pooling, which hinders allocative efficiency and financial protection efforts.<sup>1</sup> Moreover, low overall spending levels in many LICs and some MICs result in limited access to essential services and limited financial protection, particularly for the poor. As Musgrove (personal communication with G. Schieber, April 2004) indicates, if GDP is adjusted for basic subsistence needs, poor households in LICs appear to be spending a substantial share of their postsubsistence income on health, reinforcing much of the discussion

that follows on the need for additional funds from external financing sources.

As also discussed by Hecht and Shah in this book (chapter 13), external funds—development assistance for health—have become an increasingly important source of health financing in LICs, supporting some 20 percent of LIC spending. Specifically, DAH from governments, multilateral and bilateral agencies, and private foundations increased from an average of US\$6.7 billion between 1997 and 1999 to US\$9.3 billion in 2002. Sub-Saharan Africa received 36 percent of DAH funds in 2002, and in 13 extremely poor countries, DAH accounted for more than 30 percent of health spending (WHO 2004b).

The relationship between health expenditures and health outcomes is not always clear. Higher spending does not necessarily translate to better health outcomes. Although the evidence tenuously demonstrates a positive relationship between public spending on health and selected health indicators, it falls far short of a definitive statement (Bidani and Ravallion 1997; Filmer and Pritchett 1999; Gupta, Verhoeven, and Tiongson 2001; World Bank 1993, 2003). Health outcomes also vary across income groups, with the poor generally receiving fewer services and having worse health outcomes. As in the case of health services and health outcomes, health spending is often not pro-poor (Gwatkin and others 2003). The quality of a country's institutions also plays a key role in determining the effectiveness of health spending (Devarajan, Swaroop, and Heng-Fu 1996; Rajkumar and Swaroop 2002; Wagstaff and Claeson 2004; World Bank 1993).

**Mobilizing Government Revenues.** Governments of LICs have recognized the need for greater domestic investments in health. In the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases, African leaders pledged to increase health spending to 15 percent of their government's budgets (Haines and Cassels 2004; UNECA 2001). Yet LICs' ability to raise enough revenue to meet needs and demands for publicly financed health services is highly constrained (Gupta and others 2004; Schieber and Maeda 1997). Even though revenue mobilization is directly correlated with income, wide cross-country variation in revenue mobilization within income groups is apparent. For example, Myanmar's tax revenues amounted to only 4 percent of its GDP, whereas Lesotho's were 36 percent (WHO 2002).

As table 12.2 shows, during the early 2000s, LICs collected the equivalent of about 18 percent of their GDP as revenues, whereas high-income countries collected almost 32 percent. Given projected future economic growth on the order of 4 percent for LMICs during 2006–15, they will face difficulties in mobilizing additional domestic revenues (World Bank 2004b). In other words, even though economic growth is a necessary condition for progress, it is unlikely to provide the financing

**Table 12.1** Composition of Health Financing by Region and Country Income Level, 2001  
(Averages)

Region and country income level	Per capita GDP (US\$)	Per capita health expenditures (US\$) <sup>a</sup>	Total health expenditures as a percentage of GDP	Public expenditures on health as a percentage of total health expenditures	Social security expenditures on health as a percentage of total public health expenditures	Private expenditures on health as a percentage of total health expenditures	Out-of-pocket expenditures on health as a percentage of total private health expenditures	Private prepaid plans as a percentage of private health expenditures	External provision for health as a percentage of total health expenditures
East Asia and the Pacific	1,387	84 (46)	5.6	59.3	11.1	40.7	83.4	3.5	11.9
Eastern Europe and Central Asia	2,053	132 (131)	5.5	67.1	42.1	32.9	94.9	3.5	2.6
Latin America and the Caribbean	3,705	237 (264)	6.4	56.2	28.5	43.8	81.5	13.7	4.0
Middle East and North Africa	2,834	102 (82)	5.6	52.7	15.6	47.3	79.1	8.1	3.1
South Asia	737	38 (21)	4.6	49.0	6.2	51.0	97.7	0.2	9.9
Sub-Saharan Africa	868	42 (29)	4.5	54.0	1.0	46.0	83.3	6.9	21.7
High-income countries	21,198	1,527 (2,860)	7.7	70.1	33.1	29.9	74.0	16.2	0.1
MICs	3,026	176 (106)	5.8	61.7	28.5	38.3	86.4	8.9	3.4
LICs	576	25 (19)	4.7	51.7	2.2	48.3	84.4	4.0	20.0

Sources: WHO 2004b; World Bank 2004e.

Note: All figures are weighted by country.

a. Per capita health expenditures include population-weighted averages (in parentheses).

**Table 12.2** Average Central Government Revenues, Early 2000s

Region and country income level	Total revenue as a percentage of GDP	Tax revenue as a percentage of GDP	Social security taxes as a percentage of GDP
Americas	20.0	16.3	2.3
Asia and the Pacific	16.6	13.2	0.5
Central Europe, Baltic states, Russian Fed., and other former Soviet republics	26.7	23.4	8.1
Middle East and North Africa	26.2	17.1	0.8
Sub-Saharan Africa	19.7	15.9	0.3
Small islands (population less than 1 million)	32.0	24.5	2.8
LICs	17.7	14.5	0.7
Lower-middle-income countries	21.4	16.3	1.4
Upper-middle-income countries	26.9	21.9	4.3
High-income countries	31.9	26.5	7.2

Source: IMF 2004b.

base needed to deal with the HIV/AIDS pandemic or to achieve the health MDGs.

### Trends in Health System Financing

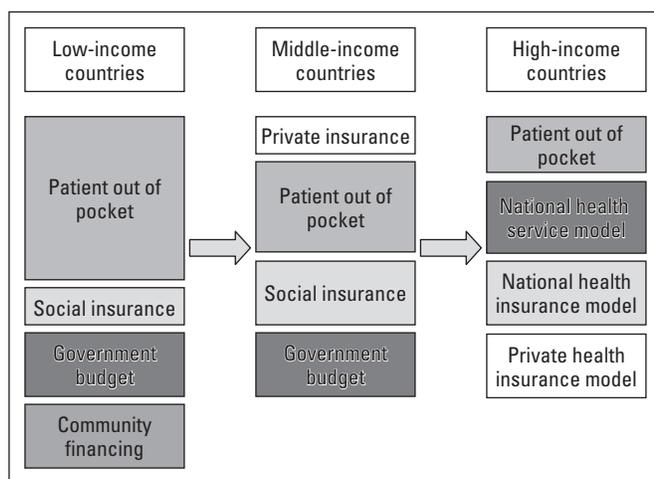
As countries move to different stages of the income spectrum, their health financing profiles transition as well. The following discussion compares countries at different stages of the income spectrum. Given health systems' variability across time periods, countries, and income levels, the analysis provides only a snapshot. Figure 12.2 illustrates transitions in general health systems as countries move from low- to middle- to high-income status.

In LICs, almost half of health spending is private, virtually all out of pocket, and usually in the form of payments for

privately provided health services and pharmaceuticals. The government, through the MOH, generally operates like a NHS. It provides basic public health and other services, including some tertiary-level hospital care, generally in major urban areas, to the entire population within an extremely limited budget. In general, because of the small size of formal sector employment, social insurance is limited, except perhaps for government employees. Community-based health insurance may be available to varying degrees but is unlikely to play a major role. Private health insurance, if any, is extremely limited because of people's inability to pay and institutional constraints to the industry's development, including the lack of well-developed financial markets and regulatory environments.

As countries' economies improve, government revenues tend to increase because of the expansion of the more readily taxable formal sector. Other institutions, such as financial markets, legal systems, and regulatory capabilities, are able to develop. Although private spending still accounts for some 40 percent of all health spending in MICs, the out-of-pocket share declines as private health insurance markets develop. The MOH generally continues to provide basic public health services and to serve as the insurer of last resort for the poor or for the entire population for specific chronic conditions as social health insurance mechanisms develop.

Countries move into the high-income group with improved institutions, more efficient governments, and greater revenue-raising capacity and spend a relatively small share on basic public health. With few exceptions, publicly financed universal coverage—or, in some cases, publicly mandated private coverage—becomes the goal. MOHs maintain responsibility for public health and surveillance and for the general regulatory environment but generally do not directly provide services. Risks are pooled either through a NHS, as in Italy and the



Source: Maeda 1998.

**Figure 12.2** Health Care Financing System Trends by Country Income Level

United Kingdom, or through single or multiple insurance mechanisms, as in France and Germany. The Netherlands requires wealthier individuals to be insured through a private system. Private spending declines to 30 percent, and out-of-pocket spending represents about 20 percent of total health spending. Although health financing systems are highly country specific, available information on sources of health spending and government revenues supports these stylized models.

## ABSORPTION, EFFECTIVENESS, AND SUSTAINABILITY OF DONOR FUNDS

In recent years, several new dimensions have emerged in the debate on international health financing, namely the effectiveness of large increases in DAH and the enormous costs of scaling up health and other social systems to meet the MDGs. Both the donor community and recipient countries have raised concerns pertaining to countries' absorptive capacity, aid effectiveness, and sustainability.

### Countries' Absorptive Capacity

Large increases in DAH channeled to LICs have raised questions about whether countries can make effective use of these new aid flows. As table 12.3 shows, absorptive capacity has macroeconomic, budgetary management, and service delivery dimensions.

Increased aid has important macroeconomic implications given its potential effect on exchange rates, inflation, balance of trade, overall competitiveness, aid dependency, domestic

revenue mobilization efforts, and future recurrent costs. Most studies indicate that the macroeconomic saturation point for aid lies somewhere between 15 and 45 percent of GDP, depending on the country's policy environment (Clemens, Radelet, and Bhavnani 2004; Collier and Dollar 1999; Collier and Hoeffler 2002; Foster 2003).

Aid can have a number of negative effects. If aid flows are not included in the recipient country's budget, they can result in corruption. Aid may substitute donors' priorities for countries' priorities. A country may have insufficient human resources, physical infrastructure, or managerial capacity to use funds effectively. Resources that may already be in short supply and that are critical for effective service delivery may be diverted from other important activities. New resources may overwhelm the system, and the donors' reporting and administrative requirements may impose additional burdens on countries.

Absorptive capacity problems may also result from demand-side constraints at the individual, household, or community levels, including lack of education, limited information, travel costs, and income loss (Ensor and Cooper 2004). Conditional cash transfers are among the demand-side innovations developed to improve the use of essential public health services by the poor that have been receiving increased attention. Such programs were initially developed in Latin America as part of social safety-net programs and provide direct cash payments to poor households contingent on certain behavior, such as completing a full set of prenatal visits or attending health education classes (Rawlings 2004). Conditional cash transfers are in effect negative user fees. Even though investigators have found that such programs are quite successful in

**Table 12.3** Major Constraints to Countries' Absorption of Additional External Resources

	<b>Macroeconomic</b>	<b>Institutional</b>	<b>Physical and human</b>	<b>Social, cultural, and political</b>
National government	Debt sustainability Competitiveness Dutch disease	Monetary and fiscal policy instruments Exchange rate management	Administrative, management, and planning skills Training technicians and sector specialists	Stable national political institutions Power-sharing mechanisms Social stability
Fiscal instruments and allocative mechanisms	n.a.	Public expenditure management: Budget preparation and execution Accounting and auditing	Sector management skills Connectivity and communications networks	Cultural norms Weak institutions Power-sharing mechanisms
Service delivery and local governments	n.a.	Local government institutions Private sector capacity	Accessibility Sanitation and water Roads Geography Local government skills and capacity	Cultural norms Ethnic, caste, and class relations

Source: World Bank 2004a.  
n.a. = not applicable.

MICs and have the potential to improve human capital and health outcomes and reduce poverty with relatively modest administrative costs, their applicability in LICs is still unresolved.

Health sector supply and demand constraints can also hinder countries' effective employment of large increases in health resources. As Mills, Rasheed, and Tollman point out in this book (chapter 3) and elsewhere, these constraints can occur at all levels of service delivery and governance (Oliviera-Cruz, Hanson, and Mills 2003). Additional funding alone does not create sufficient conditions for overcoming structural weaknesses, particularly in the short run. If aid is targeted to specific diseases or interventions, effective use of such aid may "consume" different amounts of a country's administrative capacity. Increased public funds may supplant private spending not only by the poor, but also by the nonpoor, resulting in limited marginal effects on the poor (Filmer and Pritchett 1999).

### Aid Effectiveness

Given calls for increases in aid of anywhere between US\$25 billion and US\$75 billion a year, the question of aid effectiveness has taken on increased importance.<sup>2</sup> A protracted debate has generated the following findings concerning aid (Burnside and Dollar 1997; Clemens and Radelet 2003; Clemens, Radelet, and Bhavnani 2004; Collier and Dollar 1999; Collier and Hoeffler 2002; Foster 2003; United Nations Millennium Project 2005; WHO 2001; World Bank 2004a):

- Aid has diminishing returns.
- Countries' absorptive capacity is limited.
- Aid is fungible overall and among sectors.
- Aid achieves better results in good policy environments.<sup>3</sup>
- Aid requires ownership by countries; for example, donor-imposed conditions rarely work.
- Aid is related to increased investment and growth.
- Debt repayments have a negative effect on economic growth.
- Aid has high transaction costs for countries.
- Aid makes governments accountable to donors as opposed to their citizens.

Serious overall and health sector-specific questions pertain to the levels, predictability, variability, fungibility, and sustainability of aid flows, and debate continues between those arguing for vertical disease-specific program assistance and those supporting broader health system reform changes (WHO 2001). As Mills, Rasheed, and Tollman show in this book (chapter 3), evidence on the effectiveness of both approaches is mixed. Aid unpredictability and uncertainty need to be addressed by aligning donors' disbursement and commitment cycles with those of recipient countries, strengthening

countries' budgetary and financial management capacity, and fostering a more transparent and predictable implementation structure (World Bank 2004a).

The effect of the composition of aid on countries' efforts to mobilize domestic resources is also critical given the strong push by heavily indebted countries, several Group of Seven (G-7) countries, and the United Nations Millennium Project for grant assistance. Gupta and others (2004) find that increases in overall aid (net loans plus grants) result in a decline in total domestic revenues; however, the effects of loans were quite different from those of grants. Each 10.0 percent increase in loans was associated with a 2.3 percent increase in domestic revenues, whereas a 10.0 percent increase in grants was associated with a 2.8 percent decrease in domestic revenues. The same study also finds higher levels of corruption result in reduced domestic revenue-raising efforts.

### Fiscal Sustainability

*Fiscal sustainability* is an often used but rarely defined term, though it has generally been defined in terms of self-sufficiency. In its broadest context, achieving sustainability means that, over a specific period, the managing entity will generate sufficient resources to fund the full costs of a particular program, sector, or economy, including the incremental service costs associated with new investments and the servicing and repayment of external debt.

Knowles, Leighton, and Stinson (1997, 39) define *health system sustainability* as the "capacity of the health system to replace withdrawn donor funds with funds from other, usually domestic, sources" and *sustainability of an individual program* as the "capacity of the grantee to mobilize the resources to fund the recurrent costs of a project once it has terminated." However, given the enormous unmet needs in the poorest countries, coupled with stagnant economic performance, some donors are now defining sustainability on the basis of the managing entity's commitment of a stable and fixed share of program costs (Brenzel and Rajkotia 2004; Kaddar, Lydon, and Levine 2003).

In light of criticisms leveled at the International Monetary Fund (IMF) regarding its structural adjustment programs and fiscal ceilings, IMF has recently paid increased attention to fiscal sustainability. However, evaluating a country's fiscal situation and defining sustainability are not easy matters (Croce and Juan-Ramon 2003; Dunaway and N'Diaye 2004; Hemming, Kell, and Schimmelpfennig 2003; Tanzi and Zee 2000). Work is under way to develop operational indicators of debt and fiscal sustainability and to define the concept of fiscal space (Dunaway and N'Diaye 2004; Heller 2005). Understanding the details of IMF fiscal programs and ensuring stable and predictable long-term DAH are important conditions for avoiding the macroeconomic distortions discussed earlier.

## HEALTH FINANCING ISSUES IN LICs

This section discusses the severe challenges LICs face in mobilizing sufficient revenues, both domestically and externally, to meet even the basic health needs of their populations.

### The Needs Gap

Since the release of the 1993 World Bank *World Development Report: Investing in Health*, researchers have undertaken numerous efforts to estimate the costs of a basic package of essential health services. The Commission on Macroeconomics and Health (WHO 2001) estimated that, in 1997, the 48 poorest developing countries were spending on average US\$11 per capita (US\$6 per year in public funds) and that the level of spending would have to rise to US\$34 per capita to ensure delivery of an essential package.<sup>4</sup> On the basis of these data, the Commission on Macroeconomics and Health estimated that total DAH should rise to US\$27 billion in 2007 and to US\$38 billion by 2015 to scale up coverage (WHO 2001).

Within the framework of the MDGs, a number of other studies have been undertaken to determine the financial resources needed to meet the goals. In this book, Wagstaff and others (chapter 9) review the estimates and methodologies from these various studies, finding that the annual cost of scaling up to meet the MDGs is between US\$25 billion and US\$75 billion. The United Nations Millennium Project (2005) estimates that the additional overall development assistance needed for scaling up to meet all the MDGs will be US\$74 billion by 2015. All the studies indicate that most LICs will face enormous constraints in raising additional resources through domestic resource-mobilization efforts and that the international community must essentially finance most of the gap.

### New Global Alliances and Funds

Recent years have witnessed a marked increase in the number of global alliances and institutions aimed at alleviating specific health sector deficiencies, a number of which owe their existence to resources made available by philanthropic organizations.<sup>5</sup> The GAVI Vaccine Fund and the Global Fund to Fight AIDS, Tuberculosis, and Malaria are perhaps the largest and most well known. While the GAVI Vaccine Fund is both a funder and an implementer, Roll Back Malaria is an example of an alliance that is a global partnership without a funding mechanism. Some entities like the Global Fund are purely financial vehicles with little alliance structure. The effect of these new alliances and funds is significant. Since its inception in 2000, the GAVI Vaccine Fund has raised and spent more than US\$1 billion for immunization, and the Global Fund has commitments of more than US\$5 billion and has signed grant agreements with more than 70 countries worth in excess of US\$3 billion.

Although assessments of global initiatives and alliances are generally positive, some observers have concerns about their effects on health systems and prioritization (Travis and others 2004). Increasing concerns are being expressed about the “verticalization” of DAH and the development of separate health system “silos,” each dedicated to specific diseases and activities. This strategy is especially problematic in light of the scarce human resources available for health in many LICs (Global Health Trust 2004; Joint Learning Initiative 2004).

As a result of these concerns, the G-7 countries are currently discussing a number of new, broad-based, global financing mechanisms to mobilize and facilitate the transfer of resources from developed countries to LICs, and significant progress has been made in relation to the International Finance Facility (IFF), a proposal advanced by the U.K. government. The IFF will frontload development assistance by issuing bonds on international markets that would be secured based on legally binding, long-term donor commitments. The IFF would repay bondholders using future donor payments. Depending on the number of donors involved, the IFF could raise an additional US\$50 billion a year in development assistance between now and 2015. One of the many advantages of this kind of mechanism is that a portion of funding for international development is effectively taken out of the annual budgetary process in participating countries. In this way, the hope is that the revenue streams available to fund development can be rationalized, both in terms of the total volume of assistance and in terms of the stability of annual flows.

These global funds have added a major new dynamic to global health policy and a new level of influence over LICs. Large grants are approaching the World Bank’s financing levels for the health sector. Moreover, such funding is often targeted to specific diseases or interventions, frequently outside the basic broadly based financing instruments required by the World Bank and the IMF. This factor raises important issues of donor coordination and harmonization of procedures and has implications for IMF fiscal ceilings.

### Financing Instruments

During the past decade, a new reform instrument known as the SWAp has heavily influenced health financing, particularly for LICs. Concomitantly, the World Bank and the IMF have imposed a series of requirements and instruments to ensure that external assistance is targeted to the poor through PRSPs. These new policy blueprints and requirements are radically different from previous DAH mechanisms, which were largely funded on a bilateral basis through projects.

**SWAps.** Starting in the mid-1990s, donors and recipient countries established the SWAp to address the limitations of project-based forms of donor assistance, to ensure that overall health

reform goals were met, to reduce large transaction costs for countries, and to establish genuine partnerships between donors and countries in which both had rights and responsibilities. The core elements of a SWAp follow (McLaughlin 2003, 2004):

- The government is “in the driver’s seat.”
- The partnership results in a shared vision and agreed-upon priorities for the sector.
- A comprehensive sector development strategy that reflects all development activities to identify gaps, overlaps, or inconsistencies.
- An expenditure framework that clarifies sectoral priorities and guides all sectoral financing and investment.
- A partnership across development assistance agencies that reduces governments’ transaction costs.

SWAps explicitly recognize the need to tie health sector changes to new aid instruments, to macroeconomic and public sector management, to poverty reduction, and to achievement of the MDGs (Cassels 1997). A key aspect of this approach is to improve countries’ policy-making processes, including budget and public expenditure management, by capturing all funding sources and expenditures and by putting resource allocation decisions into a medium-term budget and expenditure framework that is based on national priorities (Foster 1999). To date, SWAps are in various stages of development and implementation, and few conform fully to the specifications listed above (Institute for Health Sector Development 2003). At this point in their evolution, SWAps should be viewed as a way of coordinating development assistance and creating country ownership. They should be judged on how well they do these things compared with the previous environment characterized by multiple, stand-alone projects.

**PRSPs.** Starting in the mid 1990s, the World Bank and the IMF began to radically change both the focus and the tools for providing development assistance to poor countries. In response to criticisms about the ineffectiveness of previous development assistance efforts and the high level of indebtedness in some of the world’s poorest countries, the two organizations focused on debt forgiveness for heavily indebted poor countries, poverty reduction, and improved economic growth. Debt forgiveness required countries to reprogram the bulk of the savings from forgiven debt into social sectors such as health and education.

In 1999, the World Bank and the IMF stipulated that all of their concessionary assistance to 81 eligible poor countries would need to be based on a Poverty Reduction Strategy Paper (IMF and World Bank 2002, 2003). This new approach was intended to the following:

- strengthen country ownership
- enhance the poverty focus of country programs

- provide a comprehensive coordination framework for the World Bank, the IMF, and other development partners
- improve public governance and accountability
- improve priority setting.

The PRSP process is country driven, involves broadly based participation, is results oriented and focused on outcomes that benefit the poor, is comprehensive in recognizing the multidimensional nature of poverty, is partnership oriented, and is based on a long-term perspective (IMF 2004a; World Bank 2004d).

The PRSP process has made poverty reduction the priority issue for development (SHC Development Consulting 2001). Because macroeconomic and sectoral strategies need to be formulated around the PRSP, health reform strategies must be included and focus on the poor. As of September 2004, about 42 LICs had developed PRSPs that are serving as the basis for World Bank and IMF financing in those countries. Extensive evaluations of PRSPs by the World Bank and the IMF, by bilateral donors, and by other development partners have painted the following mixed picture of their success (IMF 2004a; IMF and World Bank 2002, 2003; World Bank 2004d):

- PRSPs have the potential to encourage the development of country-owned, long-term strategies for poverty reduction and growth, but tensions concerning ownership among countries, the World Bank and the IMF, and other donors remain. External partners have not adapted their assistance programs to PRSP processes in a coordinated manner, and better frameworks for accountability of both countries and partners are needed.
- Country participation has improved; however, greater inclusiveness is still needed. Moreover, the process has not strengthened domestic institutional policy-making processes or accountability.
- PRSPs are an improvement over previous processes in terms of results orientation, poverty reduction focus, and long-term perspective. They have fallen short in terms of being a strategic reform road map, especially in relation to undertaking structural reforms, boosting economic growth, linking with medium-term expenditure frameworks and budgets, integrating sectoral strategies into the macroeconomic framework, assessing the social effects of macroeconomic strategies, understanding links between macroeconomics and microeconomics, integrating strategy components, and linking medium- and long-term operational targets.
- Capacity constraints have been serious impediments to effective implementation, but little attention has focused on capacity building.
- Monitoring and evaluation is still a significant weakness.

Evaluations of the health sector components of PRSPs raise many of these issues (DFID Health Systems Resource Centre 2003; WHO 2004a). As more and more partners buy into this

process and as increased amounts of development assistance are funneled through PRSPs, their effectiveness will ultimately depend on country commitment, capacity, and processes; partner flexibility; and funding availability. At this stage, PRSPs still seem to be a work in progress.

### **Community-Based Health Insurance**

As noted earlier, private and out-of-pocket spending accounts for almost half of total health spending in LICs. Given LIC governments' limited abilities to mobilize revenues, country and donor attention has turned to informal sector insurance mechanisms as a way to improve financial protection, mobilize revenues, and improve the efficiency of out-of-pocket spending. *Community-based health insurance* is an umbrella term for the various types of community financing arrangements that have emerged because of high out-of-pocket spending, uncertainty surrounding anticipated financial flows from donors, and large and unregulated private sectors. Here, CBHI refers to prepayment plans that attempt to pool risks to reduce the financial risk an individual faces because of illness (Atim and others 1998; Bennett, Creese, and Monash 1998; Bennett, Kelley, and Silvers 2004).

CBHI is found throughout the world but is particularly prevalent in Sub-Saharan Africa (Bennett, Kelley, and Silvers 2004). CBHI plans are relatively heterogeneous in terms of populations covered, services offered, regulation, management function, and objectives. The Commission on Macroeconomics and Health found that CBHI plans provided significant financial protection and extended access to a large number of rural and low-income populations (WHO 2001), but that affordability impeded access for the very poor. As a result, the commission called for increased support for CBHI and for the establishment of a cofinancing scheme that would match dollar for dollar the premiums individuals paid toward their health insurance with a government or donor dollar (WHO 2001).

One recent review of the CBHI experience found less positive results, noting "no evidence from the documents reviewed that [CBHI schemes] positively impact health status or at least the utilization of services and financial protection for their members and/or for society at large, particularly the poor" (ILO and STEP 2002a, 54). The review finds that most CBHI schemes "tend to be small organizations (70 percent covering less than 200 members) with community participation in key decisions at one point or another in their history but with limited legal or de facto ownership by the community and with significant dependence from other health subsystems or subsidies as reflected by their low market exposure" (ILO and STEP 2002a, 54).

In his assessment of CBHI, Ekman (2004, 249) notes the following:

Overall, the evidence base is limited in scope and questionable in quality. There is strong evidence that

community-based health insurance provides some financial protection by reducing out-of-pocket spending. There is evidence of moderate strength that such schemes improve cost-recovery. There is weak or no evidence that schemes have an effect on the quality of care or the efficiency with which care is produced. In absolute terms, the effects are small and schemes serve only a limited section of the population. The main policy implication of this review is that these types of community financing arrangements are, at best, complementary to other more effective systems of health financing.

The evidence from these reviews suggests that, even though CBHI provides financial protection for those enrolled and some degree of resource mobilization, the overall effect is relatively small and schemes are less effective in reaching the very poor. Thus, CBHI is unlikely to be a panacea for substantially improving risk pooling and mobilizing resources in LICs, and for MICs, CBHI is less relevant given higher incomes and levels of formal sector employment. This finding does not suggest that CBHI should not be part of an overall solution to financing health care, but it indicates that CBHI is unlikely to play a major role.

The most critical challenge facing LICs is raising sufficient revenues to meet their basic health needs and the health MDGs. Although increased grant funding is badly needed, the large amounts of funds often targeted to a few countries and for specific diseases and interventions raise questions of country absorptive capacity, potential distortions of health systems' priorities, and interactions with IMF fiscal ceilings. Concomitantly, LICs must improve their institutions in order to increase absorptive capacity and increase the effectiveness of all official development assistance. It is also critical for the international community to reassess the entire official development assistance and DAH structure; to develop country-compatible mechanisms to reinforce promised international redistribution; and to improve the targeting, levels, predictability, and timeliness of external assistance.

### **HEALTH FINANCING ISSUES IN MICs**

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. Chile, Colombia, the Republic of Korea, Mexico, Poland, and Thailand are implementing universal coverage reforms or have already done so. However, they and many other MICs still face challenges similar to those facing LICs.

#### **Alternative Risk Pooling Arrangements**

Country experience shows that the critical factors for increasing coverage—that is, the number of individuals covered and

**Table 12.4** MIC Reforms and Innovations for Achieving Universal Coverage

Organizational arrangement	Reforms or innovations
Social security	Opening affiliation to self-employed and informal sector workers Mandating universal participation Providing direct public subsidies to the organization for including the poor Subsidizing premiums for the poor, self-employed, and workers in the informal sector
MOHs and NHSs	Separating the purchase and provision of care Using public and private purchasing Reforming provider payments
Private health insurance	Regulating voluntary health insurance Making private insurers eligible for mandatory social security for health Providing demand-side subsidies for health insurance
Integration reforms (reforms that allow synergic interaction of multiple organizational arrangements)	Using public and private purchasing Providing demand-side subsidies for health insurance for the poor and for high-risk groups Setting up risk equalization and solidarity funds Providing health education to stimulate demand Having a virtual single pool

Source: Authors.

the extensiveness of the benefit package—are increased risk pooling and prepayment and better access to equity subsidies. As discussed earlier, most MICs face fragmented risk pools (ILO and STEP 2002b). Table 12.4 presents MIC approaches to reforming risk pooling arrangements for achieving universal coverage.

Most MICs face an additional strategic decision: whether to pursue aggregation of all pools in a single organization (a single pool) or whether to allow for the existence of multiple risk pooling organizations, which would explicitly or implicitly compete for members and would be subject to the same rules regarding benefit packages, revenue collection mechanisms, and portability of benefits (that is, a virtual single pool). Colombia and Turkey have opted for the virtual single pool reform, whereas Costa Rica has chosen a single risk pool. In the OECD context, Germany and the Netherlands have virtual single pool arrangements, whereas New Zealand and the United Kingdom have single pool arrangements.

**Reforms of Social Security.** Because SSOs traditionally cover salaried formal sector workers from whom payroll contributions can be collected, requiring informal sector workers or self-employed workers to join is difficult. The reforms for confronting this issue range from voluntary enrollment to various types of subsidization, as detailed in table 12.4.

Country experiences are also illuminating. For instance, Chile and Mexico have opened SSOs to the informal sector and the self-employed through voluntary affiliation, yet they still

face risks of adverse selection because of the voluntary nature of enrollment and the exclusion of the poorest (Bitrán and others 2000; Instituto Mexicano de Seguro Social 2003). Chile, Colombia, Costa Rica, and the Philippines have addressed exclusion either by subsidizing the SSO directly or by subsidizing premiums for the poor and informal and self-employed workers who join. The Republic of Korea and Taiwan, China, have implemented mandatory universal participation, including gradual expansion to the whole population, whereas Panama has expanded coverage to dependents of contributing members.

Some of the most important advantages underlying SSO innovations include the existence of organizational capacity and of pools of funds (or sometimes a single large fund) that allow newly enrolled individuals and groups to take advantage of the risk and income cross-subsidization mechanisms and purchasing arrangements that are already in place. This approach results in an immediate enlargement of the risk pool in contrast to creating other pooling organizations as intermediate steps for the future merging of schemes. However, SSOs usually cover only a relatively small portion of the total population, and their focus on formal sector workers and use of payroll contributions as their main revenue collection mechanisms might be an insurmountable obstacle for reaching the informal sector and the poor, particularly those in rural areas.

In countries where a SSO is well established and covers a large population, it might face problems in including informal sector workers in the absence or even the presence of public

subsidies if the incentive structure is not well designed. For instance, in the case of Mexico, the SSO operates a scheme that is partially subsidized by the central government, yet the scheme still has experienced severe adverse selection and has few participants, which has also discouraged actively promoting enrollment (World Bank 2004c).

**Reforms of MOHs and NHSs.** MIC reform approaches for MOHs and NHSs include introducing internal markets, including separating the purchasing function from the provision of health services; using public-private purchasing; reforming provider payment systems; and decentralizing. In theory, efficiency gains in the system could be used to provide access to new enrollees, to increase the number and quality of services to all participants in the system, or to do both. Success in these areas has been limited (Baeza and Packard 2005). Effective modernization of public sector management and civil services statutes has to date been missing from most provider payment and health sector reform efforts.

**Private Health Insurance Reforms in MICs.** Since the 1980s, MICs have seen two main reforms related to private insurance: (a) the facilitation and promotion of voluntary health insurance, including formal recognition of competing private health insurance, and (b) the integration of regulated private insurance as one component of mandatory social security schemes for formal workers. Many MICs, such as Indonesia, Mexico, and the Philippines, now recognize and regulate voluntary private health insurance. In Chile and Colombia, private insurers participate in the provision of mandatory risk pooling for social security.

The literature provides some evidence of the potential benefits and problems resulting from the introduction of private health insurance and competition in the insurance market (Londoño and Frenk Mora 1997; Sheshinski and López-Calva 1998). However, an ample literature also deals with the equity and efficiency problems of private health insurance competition, including risk selection (insurers seeking to enroll low-risk individuals) and underservice (insurers setting barriers to the use of services, for instance, by not contracting with providers of expensive interventions or in low-income areas) (Arrow 1963; Hsiao 1994, 1995; Laffont 1990; Milgrom and Roberts 1992).

As to whether harnessing private health insurance contributes to or damages MICs' chances for achieving universal coverage, the question is whether MICs can take advantage of the benefits of introducing health insurance competition and avoid the related efficiency and equity problems. MICs must confront the feasibility of introducing specific financial, regulatory, and organizational reforms at a level of transaction costs that would not offset the benefits of competition and privatization (Baeza and Cabezas 1998; Coase 1937; Newhouse 1998; Williamson 1985).

**Single Pool versus Virtual Single Pool.** Most MICs must also decide whether to aggregate all pools into a single organization or to aim for a virtual single pool (Baeza and Packard 2005). The implementation of more effective and efficient cross-subsidies between groups with different income and health risks is facilitated by merging smaller pools into large pools—in some cases, national pools. Indeed, the main preliminary lessons emerging from Costa Rica, the Republic of Korea, and Taiwan (China), all of which have achieved universal coverage, suggest that the combination of a clearly defined benefit package and reforms for enlarging risk pools plays a paramount role in achieving greater inclusion through solidarity in financing and increasing access.

Yet for most MICs, the reality is that multiple pooling arrangements 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 is likely the most feasible option for these countries.

### Sources of Health System Financing in MICs

As discussed earlier in this chapter, health systems use different sources of financing and revenue collection, including general taxation, payroll contributions, risk-rated premiums, and user fees. However, concern is increasing about the use of payroll contributions as a mechanism for collecting revenue. In a recent study on financial protection in Latin America, Baeza and Packard (2005) argue that to extend effective risk pooling to the informal and nonsalaried sectors and to achieve universal participation in risk pooling arrangements, policy makers need to delink health insurance financing and eligibility from labor market status or employment sector, by gradually reducing and eventually eliminating payroll contribution financing. In addition to extending protection against health shocks, this delinking might also have a positive effect on labor market mobility and formalization. This delinking can be achieved through shifting health financing toward general taxation, which is likely preferred on equity and efficiency grounds, or through risk-rating premiums as a transition if fiscal constraints do not permit full fiscal financing.

### Donor Disengagement from MICs

As demonstrated both by the composition and recipients of DAH and by new health financing and policy agendas, global health financing policy is currently focused on LICs, leaving most MICs under the radar. The MDG agenda is predominantly a LIC agenda, or at least most MICs perceive it as such. Thus, the question is what to do with the MIC policy dialogue. Is the status quo tantamount to disengagement? If so, the

international community is in danger of losing important financing lessons that would most likely be of great use for LICs. In addition, a more concerted effort is needed to analyze what the MDGs mean for MICs—particularly in light of their increased noncommunicable disease and injury burdens, areas that the MDGs do not address—and to invest more in the evidence base for MIC-relevant reforms. It is important to maintain broad goals, but also important to develop new MIC-specific indicators, especially for financial protection, which is at the core of poverty alleviation in MICs as well as LICs but is not explicitly reflected in the MDGs.

The PRSP process also sends a clear signal to the international community to focus on the LICs. Unfortunately, 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. Such approaches are also critical in assisting LICs with their poverty reduction and health financing reform efforts in the future.

## CONCLUSIONS

Global health financing policy is in transition. Infusions of large amounts of grant money from new financing entities have changed the players involved in shaping global health policy. Decisions made by the World Bank and the IMF in 1999 requiring PRSPs as the basis for concessionary financing have pushed LICs to develop their health policies in the context of an overall strategy framework for poverty reduction that considers intra-sectoral, intersectoral, and macroeconomic tradeoffs.

Clearly, neither increased domestic resource mobilization nor future economic growth will provide the resources necessary for LICs to finance their health needs, whether defined in terms of a basic package of essential health services or whether identified within the framework of the MDGs. Increasing official development assistance is thus critical for LICs to make progress in either respect. However, the projected magnitude and speed of scaling up raises serious questions about countries' absorptive capacity, aid effectiveness, predictability, and stability and about new investments' financial sustainability at the country and donor levels. Even though empirical evidence is still lacking, concerns have arisen that new sources and increased levels of funding for disease-specific programs will lead to verticalization and could distort health systems. The donor community and countries urgently need to reform the current system of DAH, to improve institutions in developing countries, and to develop mechanisms to ensure that donors meet their DAH commitments. Finally, MIC issues need to receive greater attention.

Global health financing policy makers face the following challenges:

- The architecture for formulating, coordinating, and implementing global health financing policy at the international and country levels needs to be improved.
- The donor community needs to harmonize procedures, ensure aid predictability, and guarantee longer-term assistance.
- Donors need to meet their development assistance obligations as well as provide more assistance to help countries improve their domestic resource mobilization efforts.
- The IMF needs to improve understanding of its fiscal programs and be more flexible in reconciling fiscal constraints with increased official development assistance and DAH.
- The global community needs to improve the knowledge base in terms of good (and bad) international practice with respect to health financing. In this context, absorptive capacity constraints on both the demand and the supply sides must be removed. Better use of existing tools, including cost-effectiveness analysis, and development of new tools are needed to help poor countries realistically prioritize their financing and spending options and deal with the tradeoffs between financing essential services and providing financial protection.
- The potential for verticalization as a result of increased levels of DAH needs to be assessed rigorously and empirically, taking into account the benefits of such assistance as well as its potential distortionary effects on other programs and on health systems as a whole. By focusing limited resources on a few targeted areas, countries can achieve impressive results in terms of disease control efforts; however, many disease eradication efforts have succeeded because such efforts enhanced overall system capacity.
- The existing assistance instruments need to be objectively and fully analyzed. Examples of potential inconsistencies, such as disease-specific program grants versus PRSPs, need to be highlighted and addressed.
- The issue of financial sustainability needs to be assessed objectively and apolitically. The international donor community needs to face up to the realities of those poor countries whose economies are not sustainable in the medium term and to consider redistributive policies to assist them.
- The donor community needs to put MICs on the 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.

Because of the different accountabilities of the various multilateral and bilateral organizations, global funds and alliances, and private foundations, coordinating global health financing

policy has become increasingly complex. Given that international redistribution of wealth is central to meeting basic needs in poor countries, the lack of an effective international mechanism to enforce agreed-on transfers of wealth is problematic. Under these circumstances, the global community must help countries prioritize on the basis of realistic expectations of promised donor assistance and harmonization.

Providing countries with advice on good practice and assisting both LICs and MICs to develop equitable and efficient institutional structures, revenue-raising mechanisms, and spending prioritizations are important areas worthy of more international focus and collaboration. Assessments of the costs and constraints in reaching the health MDGs, taking into account the large increases in marginal costs to cover the most difficult-to-reach 5 or 10 percent of the population, are important knowledge products in a resource-constrained world. Making better use of cost-effectiveness information and developing better-costing tools are necessary for assisting countries, and donors could help by providing better information on where to focus policies to remove bottlenecks to the absorption of additional resources, particularly in terms of achieving the MDGs. A needed step for assisting LIC and MIC governments is developing and disseminating evidence about effective health financing policies, both in severely resource-constrained LICs that have achieved good health outcomes and in MICs that have achieved universal coverage with good health outcomes at reasonable spending levels. Last, the donor community must harmonize its procedures, simplify aid instruments, ensure the predictability of assistance, and create a more effective global policy environment.

## DISCLAIMER

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## NOTES

1. For a detailed analysis of country-specific and global health expenditure trends, see Musgrove, Zeramini, and Carrin (2002).
2. In addition to aid, countries receive significant financial inflows through foreign direct investment, expatriate workers' remittances, special targeted assistance, South-South support, and so on, and these inflows must also be taken into account (World Bank 2004b).
3. Clemens, Radelet, and Bhavani's (2004) study shows that aid can be somewhat effective in countries with weaker policy environments.
4. More recent data for all LICs indicate per capita spending of US\$19 if the data are population weighted and US\$25 if they are country weighted. The public share is 52 percent (country weighted).

5. One of the main funding organizations is the Bill & Melinda Gates Foundation, which is investing approximately US\$1.35 billion per year, with a considerable portion of that allocated to global health issues.

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