

A WORLD BANK STUDY

# Health Financing Policy

THE MACROECONOMIC, FISCAL, AND PUBLIC  
FINANCE CONTEXT

Cheryl Cashin



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*The Macroeconomic, Fiscal, and  
Public Finance Context*

Cheryl Cashin



WORLD BANK GROUP

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## About the Author

**Cheryl Cashin** is a health economist and senior program director at Results for Development Institute. She has more than 20 years of experience in the design, implementation, and evaluation of health financing policies in low- and middle-income countries, with a particular focus on health purchasing and provider payment for universal health coverage. She is currently leading the Provider Payment technical initiative of the Joint Learning Network for Universal Health Coverage (JLN). She has provided technical assistance and health financing policy advice to governments of more than 20 low- and middle-income countries, and has served as a health financing consultant for the World Bank, the World Health Organization, and other international agencies. She holds a master's degree in applied economics from Cornell University and a PhD in economics from the University of Washington with a specialty in health economics.



## Abbreviations

CSG	Generalized Social Contribution (Contribution Sociale Généralisée)
DRG	diagnosis-related group
EAP	East Asia and Pacific
GDP	gross domestic product
GFM	Global Fiscal Model
GFS	Government Finance Statistics
GNI	gross national income
HCP	Health Coverage for the Poor
HNP	Health, Nutrition, and Population
IMF	International Monetary Fund
JKN	Jaminan Kesehatan Nasional
JLN	Joint Learning Network for Universal Health Coverage
LMIC	low- and middle-income country
MOH	Ministry of Health
NHA	National Health Accounts
NHI	National Health Insurance
NHIS	National Health Insurance Scheme
NHSO	National Health Security Office
OECD	Organisation for Economic Co-operation and Development
OOP	out-of-pocket health expenditure
PEAS	Essential Health Services Plan (Plan Esencial de Aseguramiento en Salud)
PEPFAR	President's Emergency Plan for AIDS Relief
PFM	public financial management
PHRD	Partnership for Human Resources Development
RBF	results-based financing
SHA	System of Health Accounts
SIS	Comprehensive Health Insurance (Seguro Integral de Salud)
SSNIT	Social Security and National Insurance Trust



SUS	Sistema Único de Saúde (Unified Health System)
UHC	universal health coverage
VAT	value-added tax
VSS	Vietnam Social Security
WHO	World Health Organization

# Introduction

## Background

Universal health coverage (UHC) requires adequate financial resources to pay for necessary health services. These resources must be able to be both pooled (to provide financial protection) and redistributed (to maintain equity), and should be raised efficiently and equitably. Because individuals will not voluntarily choose to contribute to insurance pools if it is too costly or if they do not perceive a benefit for themselves, mandatory participation with cross-subsidization is necessary to reach universal coverage (Fuchs 1996). As it is only government intervention that can compel participation and cross-subsidization, it is government revenue that is raised most efficiently and is most effectively pooled and redistributed to maintain equity. In fact, no country has reached universal population coverage relying mainly on private voluntary funding sources (Kutzin 2012). The goal of universal coverage therefore requires some fiscal commitment from the government, as well as pooling and redistributive mechanisms that ensure financial protection and equitable subsidization of coverage for the poor. Finally, fiscal resources are limited, so expenditures should be managed carefully to get the most value for money—cover the most people with access to the highest quality services with the most financial protection possible within the available resource envelope.

The World Bank and the World Health Organization (WHO) have long supported analysis and policy dialogue for stronger health financing systems that can achieve health system goals, including reaching and sustaining universal health coverage. Notable examples include WHO's 2010 World Health Report ("Health Systems Financing: The Path to Universal Coverage") and the World Bank's Health Financing Revisited (Gottret and Schieber 2006) and Good Practices in Health Financing (Gottret, Schieber, and Waters 2008).

Much of the dialogue on health financing has framed health as an essential investment and enabler in the process of economic development. The analysis and advice has focused on providing the arguments and evidence base to support claims for increased spending in the health sector based on sound health policy and public finance principles, and on strengthening the health financing functions

of revenue generation, pooling, and health purchasing. As such, most analytical work in health financing has focused on the expenditure side, or how funds are used. Through its Global Health Expenditure Database, WHO makes available comparable data from 1995 to 2012 on national health expenditure patterns categorized according to version 1 of the System of Health Accounts (WHO 2015). Information on the sources of revenue for the health sector, however, has been more difficult to obtain. The issue of fiscal space, or how much budgetary room governments actually have for increasing health spending and from which sources, was included in the dialogue in *Health Financing Revisited 2006*, the World Bank 2007 Health, Nutrition and Population (HNP) Strategy, the World Bank Fiscal Space for Health Guidelines (Tandon and Cashin 2010), and the 2010 World Health Report. Nevertheless, a clear framework to analyze both the revenue and expenditure sides of government health financing has been lacking.

The global movement toward universal health coverage is accompanied by large requests for increases in government health spending in some countries. This combined with the global economic situation and stagnant economic growth across many low- and middle-income countries make it more critical than ever to place health financing discussions firmly in the context of macroeconomic and fiscal realities (Gillingham 2014). Unfortunately most health policy makers are still largely removed from the broader public finance and macroeconomic implications of decisions related to the health sector. There is often a disconnect between macroeconomic and health sector policy making, with key fiscal decisions made in the absence of a clear understanding, on the one hand, of the potential consequences for the health sector, and on the other, the consequences for the country's macroeconomic and fiscal position of increasing or reallocating government spending (Goldsborough 2007).

A basic framework that places health financing in the broader context of macroeconomic and fiscal policy and public financial management (PFM) rules would help support a more informed dialogue between health sector leaders and central budget authorities (typically the ministries of health and ministries of finance). Increased funding for the health sector may be needed, but it is not an objective of health financing policy dialogue per se. Improving the stability of funding and timeliness of disbursements, as well as easing constraints on the pooling of funds, resource allocation within the health sector, and purchasing approaches may be equally or more important for the health sector to get better value from existing funds (Kutzin, Cashin, and Jakab 2010).

### **Objectives of the Guidance Note**

The main objective of this Guidance Note is to outline the key components of the macroeconomic, fiscal, and public financial management context that need to be considered for an informed health financing discussion at the country level.

The Guidance Note is intended to be useful to country policy makers for discussions between health sector and financing agencies, as well as by

international partners contributing technical inputs, such as situation analyses for health financing and public expenditure reviews for health. The Guidance Note draws on case studies from 11 countries moving toward or sustaining universal health coverage (UHC) conducted as part of the Japan–World Bank Partnership Program on UHC (Maeda et al. 2014), as well as from other country examples.

The Guidance Note is organized around **four sets of questions** that are key to placing the health financing dialogue firmly in the context of a country's macroeconomic and fiscal context (table 1.1). Each section points to measures,

**Table 1.1 Key Issues and Questions for Health Financing Policy Dialogue**

---

**1. Realistic government health spending scenarios**

*What are realistic scenarios for total government health spending given macroeconomic and fiscal realities and competing budget priorities?*

- What is the overall size of the economy; how fast is it likely to grow over the medium-term horizon (approximately the next five years)?
  - How effectively does economic growth translate into total revenue available to the government?
  - How important is development assistance in the economy and how do aid inflows affect the macroeconomic and fiscal context?
  - How much more of the total government budget could feasibly be allocated to health spending, given the competing priorities and rigidities in the budget?
- 

**2. Potential new sources of revenue for the health sector**

*Which potential new sources of revenue for the health sector could generate additional funds in the most efficient and equitable manner and create the least macroeconomic and fiscal distortion?*

- Which new revenue sources would be acceptable within current macroeconomic and fiscal policy?
  - Which of these potential revenue sources are administratively and politically feasible?
  - Which new revenue sources could generate additional funds without simply offsetting existing government health spending?
  - Which revenue sources align with the other health financing functions of pooling and purchasing?
- 

**3. Opportunities for better aligning health spending with health system objectives**

*What constraints in the current public financial management system could possibly be eased to improve pooling and purchasing to better direct existing government health spending to health system objectives?*

- To what extent does the level of and approach to fiscal decentralization support or inhibit pooling, redistribution, and cross-subsidization of health funds?
  - How many different funding pools exist in the health sector (across geographic areas and administrative levels, from different revenue sources and different purchasers)?
  - Are there mechanisms to accumulate and redistribute health funds across different pools—geographic areas, administrative levels, and revenue sources?
  - To what extent is it possible to develop, disburse, and account for health sector budgets based on priority populations, programs, and services rather than inputs?
  - What accountability measures can be put in place to ensure that funds are being used effectively for priority populations, programs, and services?
- 

**4. Fiscal sustainability of current health spending patterns**

*To what extent are health sector objectives being met by getting value for money without expenditure regularly exceeding revenue?*

- Do expenditures regularly exceed revenues in the health system or subsystems, such as national health insurance systems?
  - Are there efficiency gains that could make better use of existing funds and curb unproductive expenditure?
  - What institutional investments are needed to address the key inefficiencies over the short, medium, and long term?
  - What are the incentives at different levels of the system to generate efficiency gains, and which institutions capture the efficiency gains of different measures?
-

resources, and analytical tools that are available to assist in answering these questions for a specific country.

The Guidance Note is organized as follows. Chapter 2 presents the objectives for health financing policy dialogue and baseline indicators that can form the starting point for discussion. Chapter 3 discusses the key aspects of the macroeconomic and fiscal environment that will determine realistic government health spending scenarios, as well as aspects of the government budgeting practices that will influence allocation decisions. Chapter 4 discusses the different options for sources of revenue for the health sector, and how to assess their feasibility and potential adverse consequences. Chapter 5 discusses options and constraints in resource flows and PFM systems for better alignment of health funding with priorities through better pooling of health revenues and purchasing. Chapter 6 discusses how to assess the fiscal sustainability of health expenditure and identify opportunities for efficiency gains and for getting more value for money in health spending.

# Objectives of Health Financing Policy Dialogue

## Objectives

The objective of health financing policy dialogue is to reach a common understanding between health sector leaders and central budget authorities (typically the ministries of health and finance) about the role government plays in the health sector of a country; the goals for the health sector and the resources needed to achieve those goals; how much priority will be given to health in the government budget; and how the health sector will be held accountable for using funds effectively. This common understanding should be built on a realistic picture of the country's macroeconomic and fiscal context, the constraints and competing priorities in the budget-setting process, what the health sector needs to achieve the agreed objectives, and what it is willing to commit to in terms of performance and accountability.

## The Starting Point

There are two key questions:

- What are the strategies and supporting operational plans for the health sector, and what resources are required to implement them?
- To what extent do current government health spending patterns cover the resource requirements of the health sector, and what are the gaps?

Health financing policy dialogue should start by clearly articulating objectives and strategies for the health sector and by supporting operational plans to achieve them with realistic estimates of resources required. Analysis that demonstrates what investments are needed and the benefits they will bring to the broader socioeconomic development of the country will give the health sector a stronger position in the negotiation and budget priority-setting processes and make a stronger case for shifting spending priorities if needed.

Many countries develop detailed health sector plans with estimates of resource requirements, but these cost estimates are often far removed from realistic spending scenarios and generate projected gaps that cannot feasibly be closed over the short to medium term (table 2.1). Although estimates of resources required to achieve health sector priorities are important to support health financing policy dialogue and priority-setting in the budget, detailed bottom-up costing exercises of health programs, benefits packages, and care pathways are rarely useful in general for informing total resource requirements (Kutzin, Cashin, and Jakab 2010). Challenges to bottom-up costing of health programs and benefits packages arise because it is not possible to develop detailed costing for each particular service, and aggregating cost estimates of individual services typically leads to heavily inflated total cost estimates that almost always exceed even the upper bound of resources potentially available (Özaltın and Cashin 2014). Furthermore, bottom-up costing of health programs and benefits packages is based on current cost structures that may include inefficiencies or reflect chronic underfunding of the sector. Bottom-up service costing also does not take into account provider responses to new purchasing strategies. Even when cost estimates lead to reasonable aggregate estimates of resource requirements, it may be difficult to match funding flows with service priorities (box 2.1).

**Table 2.1 Examples of Costing Exercises for National Health Sector Plans**

<i>Country</i>	<i>Costing exercise</i>	<i>Estimated resource gap</i>
Ministry of Health of Ghana	Health Sector Medium-Term Development Plan 2010–13	US\$34/per person <i>113% increase in government health budget</i>
Ministry of Health and Family Welfare of India	India Draft National Health Policy 2015	US\$6.6 billion/year <i>40% increase in government health budget</i>
Republic of Zambia Ministry of Health	National Health Strategic Plan 2011–15	US\$1.2 billion over 5 years <i>35% increase in government health budget</i>

*Source:* Ministry of Health of Ghana 2010; Ministry of Health and Family Welfare of India 2014; Republic of Zambia Ministry of Health 2010.

### **Box 2.1 Attempts to Cost the Essential Services Package in Peru**

A new benefits package for the Seguro Integral de Salud (SIS) program, the Essential Health Services Plan (Plan Esencial de Aseguramiento en Salud, PEAS), was defined in Peru in 2010 and is estimated to cover 65 percent of the disease burden. With the support of international agencies, cost and burden of disease criteria were used as the basis of the PEAS package. The analysis examined epidemiological estimates of high-risk conditions based on a previous study of the disease burden, the standard care for 10 service packages associated with these conditions, and the unit costs of these services. However, effective implementation of PEAS has been hindered by a lack of coordination among the defined benefits package, the implementation plan, and the budget process.

*Source:* Francke 2013.



Estimates of funding requirements that demonstrate an understanding of the macroeconomic and fiscal constraints are likely to be more credible to ministries of finance, but appropriate tools and methods for costing health programs and benefit plans remain limited. The movement from input-based budgets to program budgets in many OECD countries has been accompanied by an increase in the use of tools to estimate and forecast health expenditure requirements (Astolfi, Lorenzoni, and Oderkirk 2012; NHS England 2013), but to date such tools have not been widely used in low- and middle-income countries.

The resource requirements to achieve health sector objectives should be weighed against the current level of total health spending per capita and relative to the economy as a whole, which gives a picture of the current total health resource envelope. Within total health spending, both the government's

**Table 2.2 Key Questions and Resources for Health Financing Policy Dialogue**

<i>THE STARTING POINT FOR HEALTH FINANCING POLICY DIALOGUE</i>	
<i>Key Questions</i>	<i>Indicators</i>
What is the total per capita health spending, and what is the health spending relative to the size of the economy?	Total health expenditure per capita (constant prices) Total health expenditure as a percentage of GDP
How much does the government contribute to total health expenditure?	Government health spending as a percentage of total health expenditure Out-of-pocket spending as a percentage of total health expenditure
How much of a priority is health in the government budget?	Government health spending as a percentage of total government expenditure
What are the main sources of government health revenue?	Percentage of government health revenue from general taxation Percentage of government health revenue from earmarked payroll taxes Percentage of government health revenue from other earmarked sources Percentage of government health revenue from donor contributions
Are health sector objectives being met?	Country-specific indicators

*Resources*

**World Development Indicators**

<http://data.worldbank.org/data-catalog/world-development-indicators>

The primary World Bank collection of development indicators is compiled from officially recognized international sources. It presents the most current and accurate global development data available, and includes national, regional, and global estimates.

**Global Health Expenditure Database, using National Health Accounts categories**

<http://apps.who.int/nha/database/StandardReportList.aspx>

National Health Accounts (NHA) is the national implementation of the System of Health Accounts (SHA) 2011, which is a framework to track all health spending in a country over a defined period of time for each entity that financed and managed that spending. NHA generates consistent and comprehensive data on health spending in a country, which in turn can contribute to evidence-based health financing policy dialogue.

Source: Author

**Table 2.3. Health Financing Baseline: Ghana and Indonesia**

<i>Key Questions</i>	<i>Indicators</i>	<i>Ghana</i>					<i>Indonesia</i>				
		<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>	<i>2013</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>	<i>2013</i>
What is the absolute level of health spending?	Total health expenditure per capita (current US\$)	57	71	77	86	100	64	86	99	108	107
How much is health spending relative to the size of the economy?	Total health expenditure as a percentage of GDP	5.2	5.2	4.8	5.2	5.4	2.8	2.8	2.9	3.0	3.1
How much does the government contribute to total health expenditure?	Government health spending as a percentage of total health expenditure	71.0	71.8	74.4	68.3	60.0	40.0	37.7	37.9	39.6	39.0
How much of a priority is health in the government budget?	Government health spending as percentage of total government expenditure	12.5	12.1	14.0	11.0	11.0	6.8	6.2'	6.0	7.0	7.0

Sources: WHO 2015; World Bank 2015.

contribution as a share of the total, as well as the share of the total government budget allocated to health, provide a picture of the current priority given to health by the government. The current resources the government allocates to the health sector should be examined in terms of the extent to which health sector objectives are being met. Table 2.2 provides key questions and indicators that provide necessary background information for health financing policy dialogue.

Table 2.3 shows baseline health financing indicators for Ghana and Indonesia. The governments of both countries have made political commitments to universal health coverage. In both countries while absolute total health spending per capita has increased significantly between 2009 and 2013, health spending as a share of GDP has increased only slightly. Government health spending as a percentage of total government expenditure has declined in Ghana over that period and increased marginally in Indonesia.

In both Ghana and Indonesia, progress toward achieving health sector objectives related to universal health coverage stalled along with relative levels of government health spending (table 2.4 and figure 2.1). Coverage of the National Health Insurance Scheme in Ghana stalled at under 40 percent of the population, and the out-of-pocket share of total health expenditure is growing. Indonesia saw a boost in coverage of its national health insurance program from 41 percent, where it had stalled for several years, to 49 percent in 2014. The jump in coverage came with the implementation of the new social security law mandating the government make health insurance available to every Indonesian citizen under Jaminan Kesehatan Nasional (JKN). Nevertheless, the gap in population coverage the government aims to close by 2019 remains large.

While increased government spending may be needed in both countries to make more rapid progress toward health sector objectives, the health financing policy context in both countries demands a more thorough unpacking of health financing challenges and further steps to improve both the revenue and expenditure sides.

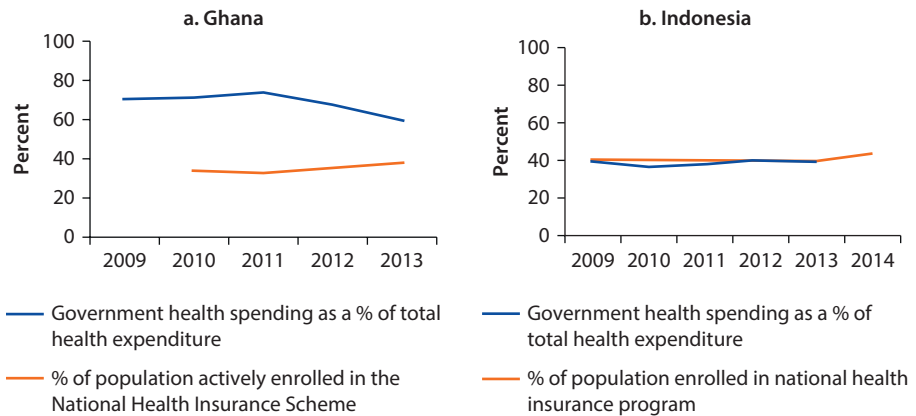
**Table 2.4 Progress toward Health Sector Objectives**

Country	Objectives	Indicators	Progress					
			2009	2010	2011	2012	2013	2014
<b>Ghana</b>	To increase geographical and financial access to basic services	Percentage of population actively enrolled in the National Health Insurance Scheme	—	34	33	35	38	39
		OOP as a percentage of total health expenditure	18.8	18.2	16.4	29.4	35.9	—
<b>Indonesia</b>	To enroll all Indonesian citizens in the national health insurance program by 2019	Percentage of population enrolled in the national health insurance program	41	41	—	—	—	49

Sources: WHO 2015; NHIA 2012; Otoo et al. 2014; Bi et al. 2013; National Team for the Acceleration of Poverty Reduction 2015.

Note: — = not available.

**Figure 2.1 Government Health Spending as a Share of Total Health Expenditure and Progress toward Objectives in Ghana and Indonesia**



Sources: WHO 2015; NHIA 2012; Otoo et al. 2014; Harimurti et al. 2013; National Team for the Acceleration of Poverty Reduction 2015.

## Unpacking the Health Financing Challenges

Constructive health financing policy dialogue goes deeper into government budget allocations to better understand constraints and opportunities for both increasing funding levels (the revenue side) and making better use of funds to achieve health sector objectives (the expenditure side). In low- and middle-income countries, health financing challenges emerge related to both revenue and expenditure.

**Macroeconomic and fiscal constraints are persistent.** Revenue challenges arise from persistent macroeconomic and fiscal constraints that limit overall government resources. Low per capita national incomes are compounded by low formal sector labor participation and ineffective tax collection in many countries.

**Stated priorities are not always reflected in budget allocations.** Within government resource limitations, budget allocations may not reflect stated priorities and objectives for the health sector because of the process that generates final budget allocations and total spending, perceptions that the health sector benefits disproportionately from international development assistance, and due to rigidities that arise from legislated budget commitments limiting the discretionary share of the budget.

**Fiscal decentralization and public financial management systems can pose challenges to aligning health spending with objectives.** Fiscal decentralization may conflict with the objectives of providing equity and financial protection since health spending needs are highly variable across populations and within populations across time. The PFM system—the way budgets are formed, executed, and accounted for—can pose challenges to effective purchasing and matching

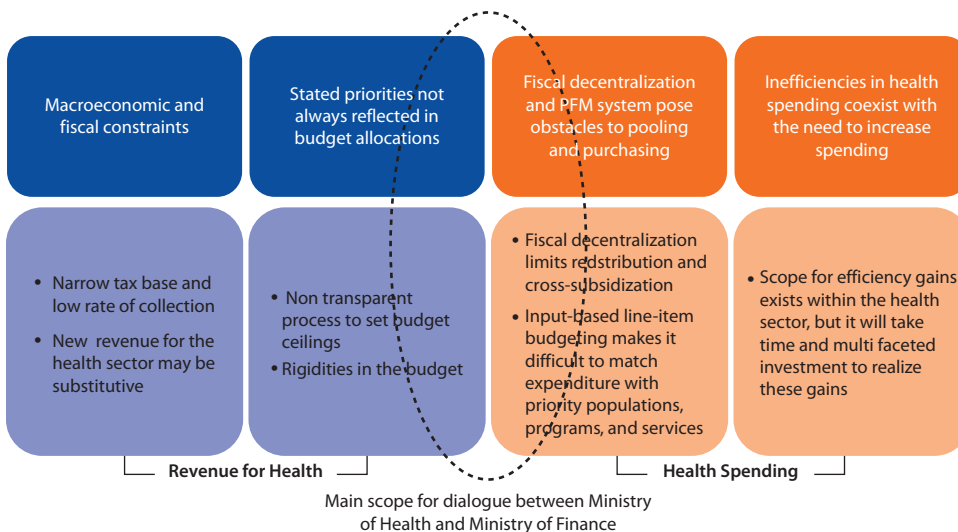
health spending with priority populations, programs, and services. For example, line-item budgets that are formed based on inputs may not flow directly to where service needs are greatest. Poor revenue projection and in-year budget adjustments can affect the stability and predictability of the revenue base for the health sector, which further erodes the ability to match spending with priorities.

**Inefficiencies in health spending coexist with the need to increase spending.** There are many sources of inefficiency in health spending, including low absorptive capacity and unproductive cost growth, which arise from decisions made within the health sector itself. These inefficiencies not only waste resources, but also affect the ability of the health sector to successfully argue for funding increases. Unproductive cost growth combined with revenue constraints can threaten the financial sustainability of the health system or subsystems, such as national health insurance programs.

The macroeconomic and fiscal context are outside of the control of the health sector, while many health spending decisions are outside of the public financial management system and are not directly influenced by the ministry of finance. Therefore, the scope for health financing policy dialogue between ministries of health and ministries of finance on the level and effectiveness of health funding lies largely in the areas of priority-setting and the rules of the PFM system (figure 2.2).

The remaining sections provide guidance for understanding health financing policy challenges and the opportunities for a more informed and productive health financing policy dialogue.

**Figure 2.2 Key Challenges in Health Financing in Low- and Middle-Income Countries**





# Macroeconomic and Fiscal Context: The Potential Government Resource Envelope for Health

## Key Questions

The following are some key questions about the macroeconomic and fiscal context:

*What are realistic scenarios for total government spending given macroeconomic and fiscal realities and competing budget priorities?*

- What is the overall size of the economy; how fast is it likely to grow over the medium-term horizon (approximately the next five years)?
- How effectively does economic growth translate into total revenue available to the government?
- How important is development assistance in the economy and how do aid inflows affect the macroeconomic and fiscal context?
- How much more of the total government budget could feasibly be allocated to health spending, given the competing priorities and rigidities in the budget?

Government health spending is part of overall fiscal policy, which is about managing *constraints* and *priorities* to achieve policy objectives. The constraints and priorities together determine the fiscal space for health, or the availability of budgetary room that allows a government to provide resources for expanding or sustaining coverage without jeopardizing the sustainability of a government's financial position (Heller 2006).<sup>1</sup> Fiscal space defines the boundaries, or envelope, of the resources *potentially* available for achieving and sustaining UHC. Fiscal space serves as a reality check for what is feasible in terms of raising revenue for UHC, and what can be achieved within a given spending level. For health financing policy dialogue, it is necessary to understand the



macroeconomic and fiscal constraints that affect the government's current and future ability to increase spending, the spending priorities of the government, and how priorities are set. Together this will give a realistic picture of the potential government health resource scenarios and whether and by how much government spending could feasibly be increased for the health sector. The revenue actually raised for the health sector may be far less than what is potentially available due to political pressures, rigidities in funding sources, and competing priorities.

Although government revenue generation and spending decisions, including health spending, affect the potential for economic growth, the health sector cannot directly influence macroeconomic and fiscal constraints. Nonetheless, it is important to understand the constraints for a realistic health financing policy dialogue. It is also important for health sector representatives to understand the language, perspectives, and mandates of those in government responsible for overall economic management.

### **Macroeconomic and Fiscal Constraints**

The macroeconomic and fiscal context dictates constraints on government spending, which is limited by how much income the government can earn through economic growth and revenue collection efforts, and how much additional finance it is willing and able to generate through borrowing, donor assistance, and money creation. If a country has low fiscal deficits and in general keeps debt under control, deficit financing is another way to generate fiscal resources. Together these factors dictate the overall size of the public budget, within which budget ceilings for health and other sectors are set.

Globally, economic development is highly correlated with health spending in general, and government health spending in particular. Health spending as a share of GDP, per capita health spending, the share of government spending in total health spending, and the share of health spending in the total government budget increase as national income increases. A recent World Bank analysis gives a picture of how closely government health spending is related to the macroeconomic and fiscal context across countries and within a country over time (table 3.1). The data also show, however, that the relationship between macroeconomic and fiscal performance and government health spending is not driven by per capita GDP alone. The ability of low-income countries to bring down debt levels and increase the effectiveness of revenue collection efforts also contributed fiscal space that allowed government health spending to expand faster than the GDP (Fleisher, Leive, and Schieber 2013).

Macroeconomic growth tends to lead to natural increases in government health spending, but there is wide variance among governments in how effectively growth translates into government revenue, and ultimately, increased health spending (Tandon and Cashin 2010). Most low-income countries achieve

**Table 3.1 Revenue Generation as a Share of GDP by Income Group, 2012**

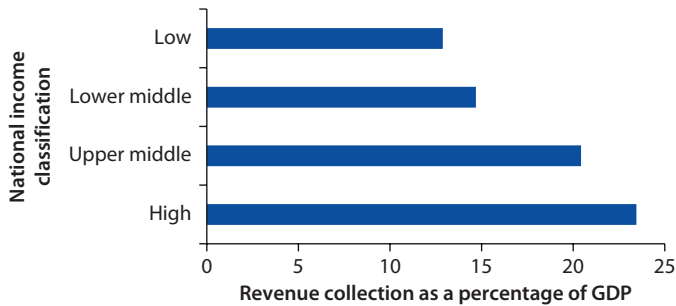
<i>Income group</i>	1995					2010				
	<i>Low</i>	<i>Lower-middle</i>	<i>Upper-middle</i>	<i>High</i>	<i>Total</i>	<i>Low</i>	<i>Lower-middle</i>	<i>Upper-middle</i>	<i>High</i>	<i>Total</i>
GDP per capita (\$US), real	380	1,903	7,341	24,636	6,768	363	1,550	4,706	23,168	7,355
General govt. debt (% GDP)	90.8	64.1	50.7	64.1	66.1	41.6	45.1	46.8	58.9	48.6
Govt revenues % GDP	20.4	28.0	31.1	40.5	29.5	24.0	30.6	32.7	39.0	31.8
Total health spending per capita (2,000 \$US)High	19	109	361	1,655	394	40	197	595	2,926	597
Total health spending (%GDP)	4.9	5.5	6.0	7.1	5.7	6.0	6.6	7.1	9.4	6.9
Govt health spending (%total health spending)	40.4	61.7	60.8	72.3	56.9	44.6	63.5	61.8	72.6	58.5
Govt health spending (%general govt spending)	8.2	10.1	10.8	12.2	10.0	9.4	12.1	11.5	14.9	11.5
Out-of-pocket health spending (%total health spending)	51.4	31.3	30.8	19.9	35.4	44.6	29.2	28.8	18.6	32.3
Number of countries	59	68	40	42	209	43	55	47	66	211

Source: Adapted from Fleisher, Leive, and Schieber 2013.

Note: GDP=gross domestic product.

a revenue generation rate below 15 percent of GDP, whereas high-income countries generate almost 25 percent of GDP in government revenue on average (figure 3.1). So there is scope in many countries for increasing total government budgets by improving revenue generation (IMF 2011b).

The revenue generation potential of the government is strongly affected by the employment rate and the share of employment that is in the formal sector; however, the size of a country's GDP does not predetermine tax rates and total revenues that are ultimately collected, which are shaped by fiscal policy choices (McIntyre and Meheus 2014). Many low- and middle-income countries are introducing measures to improve the effectiveness of revenue collection efforts, such as strengthening tax administration institutions; reducing

**Figure 3.1 Revenue Generation as a Share of GDP, by Income Group, 2012**

Source: World Bank 2015.

exemptions that do not serve a clear policy purpose; and broadening the base of specific taxes, such as value-added taxes (VATs) and corporate income taxes, among others (IMF 2011b). These measures can also be an important source of new revenue for the health sector. Ghana, for example, has had some success with such measures, with the increased revenue benefiting the health sector even as the share of health in the government budget has declined (box 3.1).

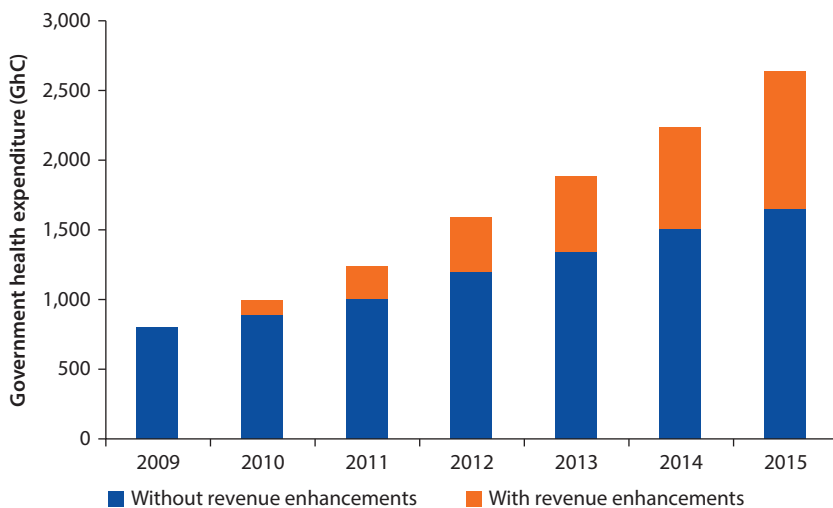
Many lower income countries rely on development assistance, in the form of grants and loans, to support their economies and government budgets, enabling greater investment in social and physical infrastructure. If development assistance is significant, the macroeconomic and fiscal context are also affected by expected inflows of development assistance, the reliability and flexibility of these funds, and how the government responds with any changes in macroeconomic

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### **Box 3.1 Revenue Collection Policies and the Government Health Budget in Ghana**

While the government was exploring potential new fiscal space for health in Ghana in 2009, new measures were being planned to improve the country's revenue generation effectiveness, including a new integrated revenue authority, reducing tax waivers and exemptions for foreign direct investment, a new communications service tax, and tightening tax enforcement (IMF 2011a). The potential additional revenue was considered to be an important source of new fiscal space for health, particularly when compounded by increased revenue expected from economic growth. Of new potential fiscal space for health, between 11 and 32 percent was estimated to be directly attributable to improved revenue collection. In fact revenue collection rates did improve (from 15.4 to 19.4 percent of GDP between 2009 and 2011), and the health budget increased, even while the share of the total government budget allocated to health stagnated.

*box continues next page*

**Figure B3.1.1 Projections of Fiscal Space for Health in Ghana, 2009–15**

Sources: Schieber et al. 2012; WHO 2013; World Bank 2015.

and fiscal policy. There is evidence globally that while development assistance generally contributes to economic growth over the long term, the effect on domestic resource mobilization and total tax revenues varies (Benedek, Crivelli, Gupta, and Muthoora. 2012. Fagnas and Roberts 2004). The implications for the macroeconomic and fiscal context will be sensitive to the composition, stability, flexibility and fungibility of aid, and the political and institutional environment in the country (Benedek et al. 2012).

When government spending, including health spending, ignores the macroeconomic and fiscal context, consequences can be severe for the general health of the economy and for household welfare. If government expenditures exceed revenues chronically and debt becomes excessive, interest payments grow, and it becomes more difficult for the government to borrow and it may face higher interest rates. This pattern can become a fiscal crisis when the government's ability to fund its programs is greatly reduced and fiscal adjustments (drastic reductions in spending or increases in revenue) are needed to bring debt under control (box 3.2).

### **Box 3.2 Government Spending Out of Line with Macroeconomic and Fiscal Realities in Ghana**

Ghana has experienced relatively robust economic growth for more than a decade. However, a sharp fiscal expansion between 2004 and 2008, and particularly the election year 2008, destabilized the economy, which was also hit by the global financial crisis. Public

*box continues next page*

**Box 3.2 Government Spending Out of Line with Macroeconomic and Fiscal Realities in Ghana** *(continued)*

expenditure grew by 55 percent, or 4.4 percentage points of GDP. The health sector benefited as the government health budget expanded from 0.93 to 2.50 percent of GDP. Overall government spending policies ignored macroeconomic and fiscal realities, however, and led to a near crisis. There were large overruns in public sector wage bills; fiscal deficits were nearly 15 percent of GDP; and inflation reached 20 percent. The stabilization program undertaken by the government in 2009 contracted the economy briefly but had rapid positive effects on the overall health of the economy. Nonetheless, imbalances reemerged in 2014, and Ghana again had to embark on a tough economic stabilization program.

*Sources:* Cashin, Schieber, and Micah 2011; IMF 2014.

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While there is general agreement that macroeconomic stability is important for growth, and governments need to maintain fiscal health, there is also growing awareness that overly strict macroeconomic policy can have negative consequences for growth, not only equity and social protection. In between these positions the right balance is highly country-specific and increasingly open for debate (IMF 2006; Goldsborough 2007). In any case, countries that maintain good fiscal governance have more flexibility to use fiscal policy as a tool to protect households during times of economic downturns (box 3.3).

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**Box 3.3 Countercyclical Policies and Health Expenditure**

Using macroeconomic and fiscal policy to both promote growth and protect population health and welfare is particularly important during economic downturns. During these periods, the need for social services, such as unemployment benefits and health protection, grows to buffer the consequences of reduced economic activity for the population. So while the economy contracts and government revenues decline, the need for increases in government spending is greater. Government spending needs typically move in the opposite direction of the performance of the economy. When government spending is adjusted to move in the same direction as need rather than in the same direction as the economy, spending is considered to be “countercyclical.” Countercyclical policies aim to neutralize the social impacts of economic cycles by increasing spending and allowing deficits to grow during economic downturns.

There is much evidence that countercyclical spending during crises is critical to protecting population health and mitigating household financial risk related to health care needs. In a number of countries, however, obligations to meet short-term fiscal targets, weak fiscal governance institutions, and limited access to credit markets inhibit the government’s ability to provide countercyclical responses in health. On the other hand, countries that manage macroeconomic and fiscal policies carefully during periods of strong economic performance have greater capacity for countercyclical policies during the downturns.

*Sources:* Calderon and Schmidt-Hebbel 2008; Velenyi and Smits 2014.

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## Key Questions and Resources to Understand the Macroeconomic and Fiscal Context

Opportunities and constraints in the macroeconomic context can be understood by examining trends in the size and rate of growth of the economy, the effectiveness of government revenue generation, and how much flexibility the

**Table 3.2 Key Questions and Resources to Understand Macroeconomic and Fiscal Context**

<i>UNDERSTANDING THE MACROECONOMIC AND FISCAL CONTEXT</i>	
<i>Key questions</i>	<i>Indicators</i>
<b>How large is the economy; how fast is it growing; and how stable and broad-based is the growth?</b>	GDP per capita (constant prices) Growth rate of GDP per capita Inflation rate Employment rate
<b>How effectively does the government translate economic growth into revenue?</b>	Revenue collection as a percentage of GDP Policies to improve revenue collection
<b>How important is development assistance in overall government revenue?</b>	Net overseas development assistance received as a percentage of GDP Overseas development assistance as a percentage of total government revenue
<b>How much flexibility does the government have to borrow to finance spending priorities?</b>	Gross debt as a percentage of GDP Government deficit as a percentage of GDP

*Resources*

**World Development Indicators**

<http://data.worldbank.org/data-catalog/world-development-indicators>

The primary World Bank collection of development indicators is compiled from officially recognized international sources. It presents the most current and accurate global development data available, and includes national, regional, and global estimates.

**The World Bank’s Assessing Public Expenditure on Health from a Fiscal Space Perspective**

<http://documents.worldbank.org/curated/en/2010/02/12614836/assessing-public-expenditure-health-fiscal-space-perspective>

This document delineates a simple conceptual framework for assessing fiscal space for health and provides an illustrative roadmap for guiding such assessments.

**Macro-Fiscal Context and Health Financing Factsheets**

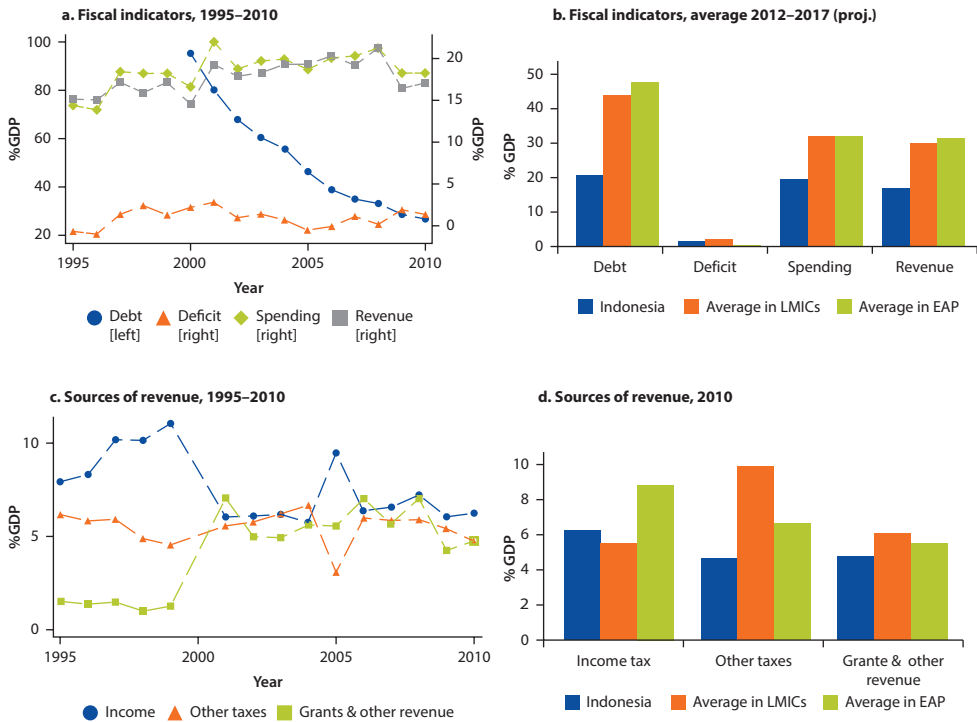
<http://documents.worldbank.org/curated/en/2013/05/17984788/europe-central-asia-macro-fiscal-context-health-financing-factsheets-much-can-country-spend-health>

The factsheets use graphical representations of 14 key indicators linked to the larger macro-fiscal environment in which a health system operates. The definition of each indicator as well as a guide for interpreting each one in the context of fiscal space for health is provided in all factsheets. The factsheets are available for 188 countries covering a period from 1995 to 2010. The data used in the factsheets are from the World Development Indicators (World Bank), World Economic Outlook (IMF), and World Health Statistics (WHO) of November 2012. Gross National Income (GNI) is based on the Atlas method (current US\$).

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**Table 3.2 Key Questions and Resources to Understand Macroeconomic and Fiscal Context** (continued)

**Figure T3.2.1 Indonesia: Macrofiscal Context and Health Financing Fact Sheet**

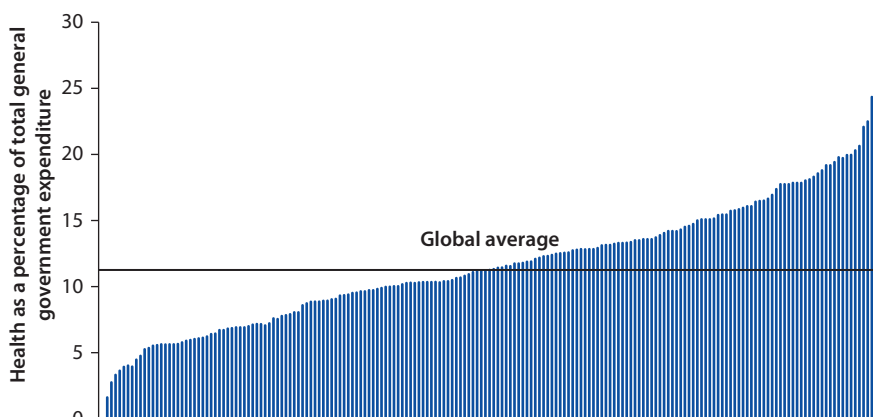


government has to borrow. The effect of donor aid on the macroeconomic situation may also be important in some low-income countries. Table 3.2 summarizes the key questions, measurement indicators, and resources to understand the macroeconomic and fiscal context.

**Government Budget and Spending Priorities**

Economic growth alone is often not sufficient to bring about adequate increases in real government health spending to achieve health sector objectives (Kutzin, Cashin, and Jakab 2010). Priority in the government budget for health, along with macroeconomic growth, has been important in enabling countries to expand population coverage, improve service delivery, and provide better financial protection (Maeda et al. 2014). The priority given to health in government budgets varies widely, with the share of total general government expenditure allocated to health averaging 11.5 percent across 157 countries (World Bank 2015). This share ranged from 1.5 percent (Myanmar) to nearly 28.0 percent (Costa Rica) (figure 3.2). Tandon et al. (2014) provide an overview of trends in



**Figure 3.2 Health as a Share of Total General Government Expenditure, 2012**

Source: World Bank 2015.

Note: Global trends are shown from lowest (Myanmar) to highest (Costa Rica).

priority given to health in government budgets and the theoretical and empirical factors affecting priority for health.

An important step in the health financing policy dialogue process is to assess the allocation to health in the budget against policy priorities, and whether and how much scope exists for shifting a larger share of the budget to health if needed. The health sector is in a better position to negotiate during the budget process if there is a clear understanding of how the overall budget is formed and priorities are set. It is also helpful to identify specific spending areas that could feasibly be reallocated to health because they are inefficient or exacerbate inequities.

### ***Budget Formulation Process***

During the process of budget formulation, governments try to balance the spending needs needs of line ministries with overall resource constraints, while at the same time ensuring that resources are allocated toward policy priorities. The process for how budgets are formed and spending priorities are set is highly country-specific. A common feature in low-income countries, however, is that existing processes often do not produce clear medium-term priorities that are effectively implemented through annual budgets (Goldsborough 2007; Abekah-Nkrumah, Dinklo, and Abor 2009). This may be due to fragmented budget processes that lack transparency. For example, budgeting for recurrent expenditures and capital investment may be fragmented if a separate planning ministry is responsible for capital investment. In addition, extra-budgetary funds and donor aid flows may not be fully integrated in the budget formulation process (Gupta et al. 2008). These factors reduce transparency and accountability and impede the allocation of resources according to priorities, and they also create bargaining that is separate from the budget process itself

(Dabla-Norris et al. 2010). The fragmentation and lack of full transparency further weaken the often already disadvantaged position of ministries of health in the budget process.

The processes for determining spending ceilings and budget needs can happen in parallel, and ministries of health often find it difficult to influence budget ceilings determined by central budget authorities. Even less transparent are the in-year budget adjustments that take place outside of the formal priority-setting process and often put the health sector at a further disadvantage (Goldsborough 2007).

Perceptions of high inflows of development assistance to the health sector also can weaken the position of the sector in the budget process. Aid to health has been found to be the most fungible, that is, the most likely to be offset by reductions in the sector budget (Farag et al. 2009). Understanding and accounting for external flows into a country's health system is a key component of effective health financing policy dialogue.

### ***Identifying the Discretionary Share of the Government Budget***

The scope for increasing the share of the total budget allocated to health will be limited in part by the share of the budget that is discretionary, or not already accounted for by mandatory expenditures. Nondiscretionary expenditure items include interest payments on debt, wages for civil servants, pensions, and social security contributions, and any other expenditures fixed by law. What is left, after nondiscretionary budget items have been covered, is the discretionary budget, which is allocated between the various sectors. Wage spending in particular is a nondiscretionary expenditure that often crowds out government spending on other priority areas. Public debt and debt servicing (interest payments) is also a major constraint. Debt relief initiatives, which reduce the volume of debt payments a government makes and thus reduce nondiscretionary expenditures, are an important opportunity to create room for more health spending. Understanding the actual share of the budget that is available for discretionary spending can keep health financing policy dialogue realistic (box 3.4).

### ***Identifying Specific Areas in the Budget for Reallocation***

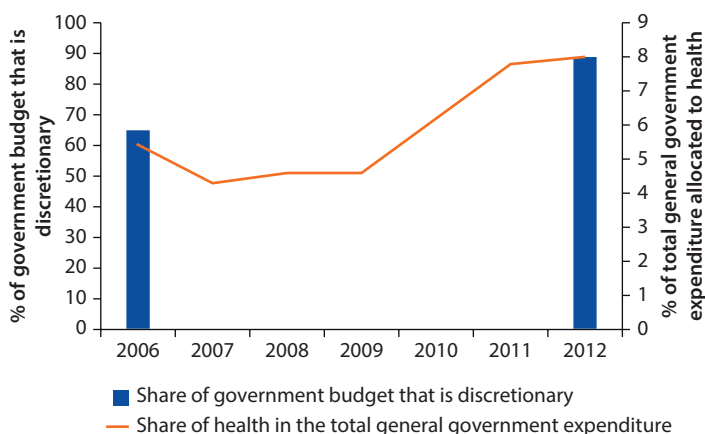
Priority setting within the budget should reflect the principle that all resources are put to their highest valued use (efficiency), and that worse-off households benefit disproportionately from government spending (equity). Within the discretionary budget, some expenditures may be inefficient or exacerbate inequities, and therefore be targets for dialogue about reallocation toward the health budget (IMF 2011b). Some subsidies and tax exemptions, for example, are driven by political pressures or compromises and can create both inequities and inefficiencies in addition to lost revenue.

Energy subsidies in particular are found to be highly inefficient, leading to overconsumption of fuel and reduced incentives for investment in

### Box 3.4 Increasing the Discretionary Share of the Government Budget in Kenya

In 2006 only 65 percent of Kenya's general government budget was discretionary. This budgetary rigidity made it difficult for the government of Kenya to allocate funds to policy priorities. Between 2006 and 2012 the discretionary share of the budget increased to almost 90 percent. The increased flexibility made it possible to increase the budget share for health from a low of 4.3 in 2007 to 8.0 percent in 2012.

**Figure B3.4.1 The Discretionary Share of the Government Budget and Allocation to Health in Kenya, 2006–12**



Source: Kenya, Ministry of Devolution and Planning 2013.

renewable energy (IMF 2013). Fuel subsidies are often intended to benefit lower- and middle-income households with lower-priced energy, but most often benefit the wealthy, who have higher per capita energy consumption (IEG 2008). Reducing unproductive subsidies and tax exemptions could make more room for health in the budget in many low- and middle-income countries (box 3.5).

### ***Understanding the Implications of Fiscal Decentralization***

Fiscal decentralization involves shifting some responsibilities for expenditures and/or revenue generation to lower (subnational) levels of government. Fiscal decentralization has become a major trend worldwide, with the idea that transferring authority and resources to local levels of government, in some cases bringing decisions closer to voters, will lead to a better match between resource allocation and local needs. The term decentralization has been used to describe a variety of reforms related to the transfer of fiscal, administrative, and/or political authority for planning, management, or service delivery from the central government level to subnational levels (Bossert et al. 2000). However,

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**Box 3.5 Opportunities to Increase the Priority for Health in the Government Budget in Indonesia**

In Indonesia, subsidies on fuel consumption have placed an enormous burden on the central government budget and crowd out other spending priorities while tending to benefit wealthier households. The share of the budget consumed by fuel subsidies often exceeds the share allocated to health and education combined. In 2006, Indonesia reduced fuel subsidies and brought down debt levels, which created additional overall fiscal space that resulted in a 20 percent increase in total government expenditure. However, fuel subsidies continued to consume up to 20 percent of the total budget in the country. A bold move by the newly elected president cut fuel subsidies by more than 30 percent at the end of 2014; the president pledged to allocate the savings to Indonesia's development priorities, including health.

*Source:* Bi et al. 2013.

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decentralization can weaken efforts to increase government budget allocations to the health sector as national policy priorities may not be reflected in local budgeting processes (box 3.6).

The implications for health expenditure and priority in the total government budget are different for decentralization of revenue generation responsibility and for decentralization of expenditure authority (box 3.7). Whereas greater authority at the local level to make expenditure decisions (accompanied by adequate resources from intergovernmental transfers) has led to improvements in allocations to health in some cases (Uchimura and Jutting 2007), transferring responsibility for revenue generation to the local level can lead to fragmentation in health financing and limited pooling, possibly exacerbating inequity (Kutzin, Cashin, and Jakab 2010). In many low- and middle-income countries the tax base at the local level is weak, and there is dependence on central government for subsidies to fund spending priorities such as health.

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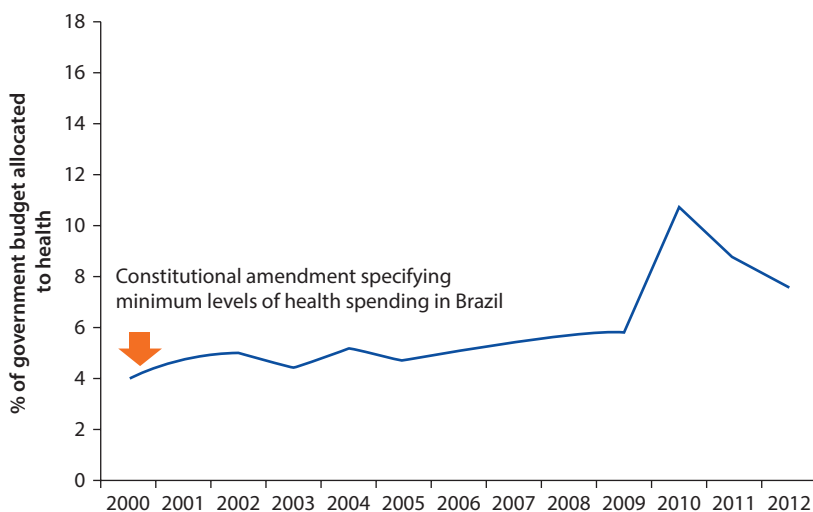
**Box 3.6 Fiscal Decentralization and Priority for Health in the Budget in Brazil**

In Brazil, legislation specifies the minimum share of budget funding to be allocated to health. Minimum health spending thresholds were set as part of 1996 legislation transferring much of the responsibility for managing and financing health care to states and municipal governments. States are required to allocate at least 12 percent of their total budget to health; municipal governments must allocate 15 percent. For the federal government, the previous fiscal year's allocation must be maintained, but adjusted by the nominal change in GDP. Although municipalities consistently meet or exceed their health earmark requirements,

*box continues next page*

**Box 3.6 Fiscal Decentralization and Priority for Health in the Budget in Brazil***(continued)*

spending has not kept up at state and federal levels. At state level in particular, a broad interpretation of health spending has eroded resources available to fund the Unified Health System (Sistema Único de Saúde, SUS). The result was a decade of stagnation in the share of total government spending allocated to health, with a boost only in recent years.

**Figure B3.6.1 Health as a Share of the Total Government Budget in Brazil, 2000–12**

Sources: Maeda et al. 2014; WHO Bulletin 2010.

**Box 3.7 Fiscal Decentralization and Reprioritizing Health in the Government Budget in India and Vietnam**

In India, although a specific pledge was made to increase public health spending as a share of GDP, fiscal decentralization has proven to be a barrier to achieving this goal. The prime minister pledged to increase public spending on health to 2–3 percent of GDP by 2012, up from about 0.9 percent of GDP in 2005. Although public financing for health has increased in recent years, the target has proven challenging to reach largely because of India's decentralized federal structure. Health is a "state subject," and aggregate state-level spending averages about 75 percent of total central and state health spending combined. For India to realize its health spending target, state health spending would have had to increase by 22–38 percent per year since 2005, virtually an impossible scenario.

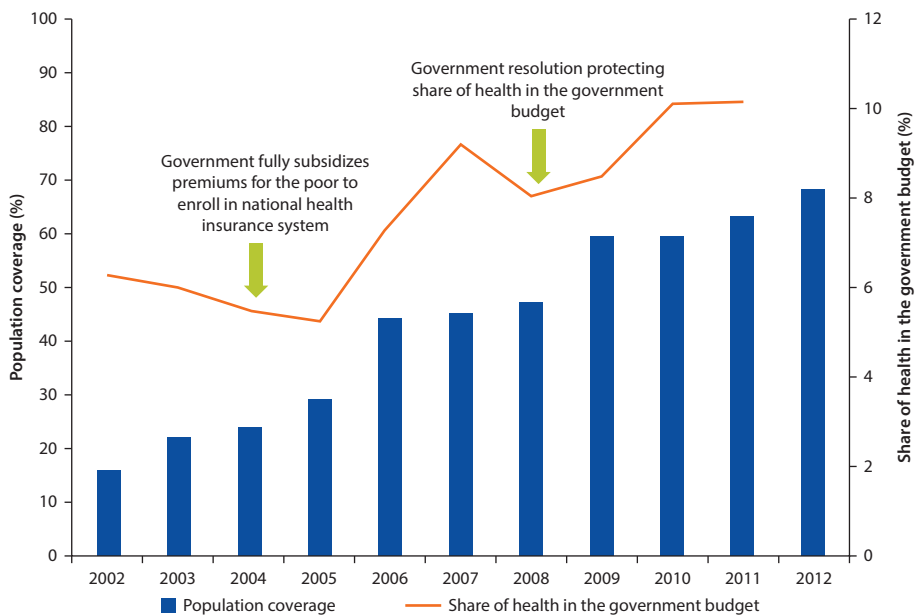
In Vietnam, on the other hand, fiscal decentralization has not kept the government from achieving its legislated pledge to increase the share of the government budget allocated to health. Spending authority has been assigned to subnational governments since the first

*box continues next page*

**Box 3.7 Fiscal Decentralization and Reprioritizing Health in the Government Budget in India and Vietnam** (continued)

five-year plan in 1978, while revenue generation remains the responsibility of the national government. The central management and reallocation of revenues to the provinces has helped maintain commitment to health in the overall budget. Government health spending in absolute terms and as a share of total government spending have increased, making it possible to expand subsidies and coverage of the national health insurance system. General government budget contributions for subsidized groups have risen sharply since 2005 and now account for 40 percent of the revenue of the National Health Insurance (NHI) system, up from only 5 percent in 2005.

**Figure B3.7.1 Health as a Share of the Total Government Budget and Coverage of the National Health Insurance System in Vietnam, 2002–12**



Sources: Tandon et al. 2014; Somanathan et al. 2014.

## Key Questions and Resources to Understand the Budget Process and Priority-Setting

The government budget process and priority-setting can be understood by examining trends in the total government budget and the share of that available for discretionary spending, and the political economy of how sector budget ceilings are set. To identify opportunities for reallocating a larger share of the budget to the health sector, expenditure items can be assessed to identify those that create inefficiencies (return on investment analysis) or exacerbate inequities (benefit incidence analysis).

Table 3.3 summarizes the key questions and resources to understand the budget process and priority-setting.

**Table 3.3 Key Questions and Resources to Understand the Budget Process and Priority-Setting**

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*UNDERSTANDING THE BUDGET PROCESS AND PRIORITY-SETTING*

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*Key Questions*

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**How large is the total government budget, and how much of that is discretionary?**

**How is the budget formed, and how are priorities set?**

**What share of the budget is made up of international development assistance, and has donor funding been offset by reductions in the government health budget?**

**Are there areas of the budget that could be targeted for reallocation to health because they are inefficient or exacerbate inequities?**

**What are the implications of fiscal decentralization for budgetary allocations to the health sector?**

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*Resources*

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**Fiscal Policy for Health Policy Makers**

*<http://documents.worldbank.org/curated/en/2014/03/19487496/fiscal-policy-health-policy-makers>*

This paper summarizes the basic principles that should form the basis of fiscal policy. These principles encompass decisions on the functions of government, its spending, and the financing of its spending that affect economic growth, employment, inflation, and economic welfare. Specific applications of fiscal policy to the health sector are discussed.

**Public Expenditure Reviews**

*<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPUBLICSECTORANDGOVERNANCE/EXTPUBLICFINANCE/0,,contentMDK:20236662~menuPK:2083237~pagePK:148956~piPK:216618~theSitePK:1339564,00.html>*

A Public Expenditure Review (PER) is a key diagnostics instrument used to evaluate the effectiveness of public finances. A PER typically analyzes government expenditures over a period of years to assess their consistency with policy priorities, and what results were achieved.

**Guidelines for Public Expenditure Management**

*<https://www.imf.org/external/pubs/ft/extend/index.htm>*

IMF guidelines for analyzing how the budget is planned, prepared, and executed.

**Results-Based Budgeting**

*<http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:22757604~pagePK:64257043~piPK:437376~theSitePK:4607,00.html>*

Results-based budgeting aims to shift budget management from inputs to tangible outputs and outcomes associated with public policy objectives.

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## Note

1. A government's fiscal position is characterized by its current and future ability to finance its programs with revenue or by incurring debt. A government's fiscal position is therefore determined by the balance of revenues and expenditures over time, whether credit is available to incur debt and at what interest rate, and whether the government has the ability to service that debt.





# Assessing Options for Raising Revenue for the Health Sector

### Key Questions

The following are some key questions about potential new revenue sources for the health sector:

*Which potential new sources of revenue for the health sector could generate additional funds in the most efficient and equitable manner and create the least macroeconomic and fiscal distortion?*

- Which new revenue sources would be acceptable within current macroeconomic and fiscal policy?
- Which new revenue sources could increase revenue for the health sector in the most efficient and equitable manner and create the least macroeconomic and fiscal distortion?
- Which new revenue sources could generate additional funds without simply offsetting existing government health spending?
- Which revenue sources are politically feasible and align with the other health financing functions of pooling and purchasing?

Within the government resource envelope for health, the mix of sources of funding is also important for achieving a stable resource base and raising funds in the most efficient and equitable way. Governments can raise revenue for the health sector through taxation (national and local general taxes and earmarked taxes), nontax revenue sources, and development assistance grants. Countries committed to achieving or sustaining UHC rely on multiple sources of revenue, and the mix of sources may change over time as fiscal and health system challenges change. Most countries rely on some combination of general tax revenues at the national and local government levels, earmarked revenues, and private contributions toward the cost of health care. In general, there is a trend toward greater diversification of revenue sources and some evidence of a shift toward general tax revenue and away from payroll tax financing (box 4.1).

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**Box 4.1 Diversification of Revenue Sources for the Health Sector: France, Japan, and Ghana**

France has a highly diversified public funding base for UHC. Until the end of the 1990s, the national health insurance system was funded almost exclusively by payroll contributions from employers and employees. Since 1998, most of the employee payroll contributions have been substituted by an earmarked tax, the Generalized Social Contribution (Contribution Sociale Généralisée, CSG), which is levied not only on wage income, but also on income from financial assets and investments, pensions, unemployment benefits, disability benefits, and gambling. The CSG is now one of the main sources of funding for the insurance system (37 percent). In addition, specific taxes on tobacco and alcohol consumption and on the pharmaceutical industry complement the revenue base. Revenue for the UHC system has therefore been partially disconnected from wage income. However, while this change has widened the revenue base of health insurance, it has not increased the actual amount of revenue collected (Chevreul et al. 2010).

In Japan, 49 percent of UHC is financed by social insurance contributions, 37 percent by general taxes (25 percent, national; 12 percent, local), and 14 percent by out-of-pocket contributions. In Ghana, the National Health Insurance Scheme (NHIS) is funded by an earmarked portion of the VAT and social security contributions, as well as by grants, investment income, and premiums paid by nonexempt individuals such as self-employed and informal sector workers (Schieber et al. 2012).

Source: Maeda et al. 2014.

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**Assessing Alternative Sources of Revenue**

All potential revenue sources for the health sector involve some trade-offs for the broader economy. All taxes will impose some inefficiency on the economy as they cause people to change their behavior. Taxes that are the least distorting, that is, they have the least impact on individual behavior and economic choices, are those with the broadest base (the most people and corporations contribute) and the lowest rates. Taxes also impose different burdens on individuals depending on their income groups. Taxes that have a proportionately higher impact on the incomes of wealthier individuals are considered to be progressive and lead to a more equitable redistribution. In general, the criteria for evaluating and selecting among public revenue sources are as follows:

- Efficiency: potential distortions to the economy; for example, effect on economic growth, labor supply, and savings/investment
- Equity: progressivity/regressivity
- Administrative simplicity and transparency.

Evidence from high-income countries shows that property taxes are least distorting and damaging for growth, followed by consumption taxes, the personal

income tax, and the corporate income tax (IMF 2011b). Taxation of capital income has a potentially strong impact on investment. Similar evidence is not available for low-income countries, however, and the efficiency impact of alternative tax instruments is likely to be highly context-specific depending on the composition of the economic activity and the strength of the institutions. The equity impact of taxes also may not be obvious, since the impact of a tax cannot be determined in isolation. “A regressive tax may be the only way to finance strongly progressive public expenditure” (IMF 2011b). On the other hand, the merit of the spending that is financed by new or increased taxes may not justify the negative consequences.

What matters is the combined impact of all tax measures and the benefit incidence of the spending they finance (box 4.2). Health sector advocates sometimes campaign for introducing or increasing taxes without understanding the potential impact on the broader economy, poverty, and equity. The theoretical impact of different taxes or the observed impact in high-income countries may not hold for low-income countries, so careful analysis is recommended before advocating for particular revenue-enhancing measures for the health sector.

### ***Additivity of New Revenue Sources***

Given macroeconomic constraints and competing priorities and rigidities in the budget, there is likely to be an upper bound on how much government health spending can increase. Beyond this upper bound, it is unlikely that there are “untapped” sources that will bring new revenue for the health sector without

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#### **Box 4.2 Unclear Combined Equity of the Revenue Sources for the National Health Insurance Scheme in Ghana**

A recent study shows that Ghana’s health care financing system is progressive, driven largely by the progressivity of general taxes, which make up the bulk of revenue sources for the health sector. The national health insurance levy (which is an earmarked portion of the VAT and social security contribution) is mildly progressive. The premium is considered progressive because of geographical differentials and the wide range of premium exemptions. There is a large exempt group whose premiums are fully subsidized by the central government, including adults over age 70, children under 18, indigents, pregnant women, and individuals with a mental health disorder.

In terms of the equity of the National Health Insurance Scheme (NHIS) itself, the results are mixed. Some research has shown that the wealthy are up to 50 percent more likely to enroll in the NHIS than the poorest residents (Jehu-Appiah et al. 2011). The financial protection effect and the impact on utilization, however, tend to be greater among the poor (Nguyen, Rajkotia, and Wang 2011; Schieber et al. 2012). The incidence of total benefits from both public and private health service utilization, however, is pro-rich. Public sector district-level hospital inpatient care is pro-poor, and benefits of primary-level health care services are relatively evenly distributed (Akazili et al. 2012).

*Sources:* Akazili et al. 2012; Jehu-Appiah et al. 2011; Nguyen, Rajkotia, and Wang 2011; Schieber 2012.

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simply displacing existing sources. When new revenue sources are identified for the health sector, budget authorities may offset the new revenue with cuts in other parts of the health budget to manage overall fiscal constraints. Innovative financing options should still be explored and may turn out to be additive, but other measures may have to be in place to ensure against offsetting.

### ***Alignment of New Revenue Sources with Pooling and Purchasing***

For the health sector, additional criteria that matter for assessing revenue options are whether sources of funds are in alignment with the other health financing functions of pooling and purchasing, and whether the sources provide a stable and predictable revenue base. It is particularly important that multiple revenue sources can be pooled, and that funds can be used flexibly for effective purchasing strategies. Several low- and middle-income countries have opted to introduce earmarked payroll taxes as a source of new revenue for the health sector because they could be collected in off-budget funds and avoid the restrictions in the public budget systems that limit the effectiveness of pooling and purchasing (Kutzin, Cashin, and Jakab 2010). Earmarked payroll contributions for formal sector health insurance schemes have posed obstacles to pooling in other countries (Maeda et al. 2014). Nongovernment sources of revenue, such as out-of-pocket payments and community-based or other private voluntary insurance schemes are not only typically inequitable, but also introduce fragmentation into both the pooling and purchasing functions of the national health financing system.

Stability and predictability of funding is important, particularly to support the strategic purchasing function. A health purchaser needs to be able to enter into contracts with providers and set stable payment rates so providers can plan their services and input requirements. When funds' flows vary greatly from year to year or are disbursed irregularly, purchasers cannot negotiate credible contracts and payment rates, may accumulate arrears to providers, or make payments that are too distant from the time services were delivered to create effective incentives.

### **Earmarked Taxes and Revenue**

To circumvent the annual process of setting budget ceilings and the uncertainty it creates for the health budget, some in the health sector advocate for a specific tax or a share of government revenue to be earmarked for health. Earmarking separates all or a portion of total revenue—or revenue from a tax or group of taxes—from general revenue and sets it aside for a designated purpose. Earmarked taxes can take various forms, including specific taxes on goods, a dedicated payroll tax, or a fixed share of total revenues set aside for a specific purpose. Earmarking the entire revenue from a tax or a portion of it to health, or earmarking a specific share of revenue is sometimes viewed as a way to protect or “ring-fence” government revenue allocated to the health sector, thereby increasing, or at least maintaining, both its level and stability. Opponents of earmarking argue

that it imposes constraints on fiscal policy, which reduces flexibility and possibly allocative efficiency (Tandon and Cashin 2010).

Many countries rely on earmarked taxes to fund part of the health sector, although there is some evidence that the overall reliance on earmarked payroll taxes is declining (Maeda et al. 2014). Earmarked payroll taxes may introduce inefficiencies in the economy by distorting labor market decisions. High-income countries such as France and Japan, for example, are seeking to reduce overreliance on earmarked payroll taxes, which not only have led to labor market distortions, but also no longer generate enough revenue given their aging populations (Maeda et al. 2014). Countries with a large informal sector, such as Thailand, have also found it difficult to expand coverage through payroll taxes alone and have expanded their allocation to health through general revenues. Earmarking a portion of broad-based taxes, such as the VAT as is done in Ghana and Chile, avoids the labor market distortion but may still introduce allocative inefficiency by adding to rigidities in the budget.

Increasing taxes specifically on goods that adversely affect health, most notably tobacco and alcohol (also known as “sin taxes”), can generate revenue that can be earmarked for the health sector, and also serve as a public health instrument that reduces consumption of goods with a negative effect on health. In addition, taxes on alcohol and tobacco can be justified on efficiency grounds by the externalities associated with those consumption goods, since the consumption of alcohol and tobacco generates costs for society beyond those to the individual consuming the products. Even if they are not earmarked for health, higher taxes can discourage consumption and reduce negative health consequences, and possibly reduce demand for health services, which benefits all of society (Tandon and Cashin 2010).

Arguments against “sin taxes” are often made on equity grounds, since these taxes may be regressive when consumption is concentrated among the poor. Benefit incidence analysis is needed along with projections of the actual amount of revenue that could be generated. As taxes increase, consumption may decrease to the extent that total revenue actually falls, depending on the elasticity of demand for these goods. Increasing tax rates on alcohol and tobacco may also lead to increased smuggling and the consumption of products of lower, even potentially dangerous, quality.

There is little empirical evidence to support either the potential positive consequences of earmarking in terms of revenue for health, or the potential negative consequences related to budget rigidity and inefficiency. Some empirical studies show that while earmarking in general may increase government expenditure overall, it does not automatically increase expenditure for the target program (Crowley and Hoffer 2012). The effectiveness of earmarking taxes or revenue for health appears to be mixed in terms of increasing overall funding or improving its stability (Maeda et al. 2014). In some cases earmarking may actually decrease expenditure on the target program if the earmarked revenues are more than offset by decreases in other parts of the budget (box 4.3).

### Box 4.3 New Source of Health Revenue Displaced the Government Budget in Kazakhstan

In 1996 the government of Kazakhstan introduced a mandatory health insurance system to generate new revenue for the health sector. The health insurance system was funded by a new earmarked 3 percent payroll tax paid to the Mandatory Health Insurance Fund by employers, self-employed individuals, and the nonregistered unemployed. Contributions were made from local budgets for the exempt population. The system was canceled after only three years, however, due to operational failures, as well as a failure to increase government health spending. While this system was in place, total government health spending actually declined in Kazakhstan from 3.0 percent of GDP in 1995 to 1.5 percent of GDP in 1998, the year the system was canceled.

Source: Sheiman et al. 2010.

### Innovative Revenue Sources

The international community has stepped up efforts to explore innovative sources of funding for health sectors in low- and middle-income countries, and more examples of innovative domestic funding sources are also emerging. The high-level Taskforce on Innovative International Financing for Health Systems reviewed a wide range of options for supplementing traditional bilateral funding for aid (Taskforce for Innovative International Financing of Health Systems 2009). The World Health Organization also presented an analysis of options for innovative domestic revenue sources and their potential revenue-raising strength (table 4.1). Based on this analysis, levies on large profitable corporations and currency transactions hold the greatest potential for contributing significantly to health sector revenue. The potential impact on efficiency and equity would have to be analyzed within each country context.

**Table 4.1 Innovative Sources of Domestic Revenue and the Estimated Revenue-Raising Potential**

<i>Option</i>	<i>Revenue-raising potential</i>
Special levy on large and profitable companies	Medium-high
Levy on currency transactions	Medium-high
Diaspora bonds	Medium
Financial transaction tax	Medium
Mobile phone voluntary solidarity contribution	Medium
Tobacco excise tax	Medium
Excise tax on unhealthy food	Low-medium
Selling franchised products or services	Low
Tourism tax	Low

Source: Adapted from WHO 2010.

## Key Questions and Resources to Assess Options for Sources of Government Revenue for Health

Table 4.2 summarizes the key questions and resources to assess options for sources for government revenue for health.

**Table 4.2 Key Questions and Resources to Assess Alternative Government Revenue Sources for Health**

<i>UNDERSTANDING THE STRENGTHS AND WEAKNESSES OF ALTERNATIVE GOVERNMENT REVENUE SOURCES FOR HEALTH</i>
<i>Key Questions</i>
<b>Which new revenue sources could generate additional funds for the health sector in the most efficient and equitable manner and create the least macroeconomic and fiscal distortion?</b>
<b>Which new revenue sources would be acceptable within current macroeconomic and fiscal policy?</b>
<b>Which of these potential revenue sources are administratively and politically feasible?</b>
<b>Which new revenue sources could generate additional funds without simply offsetting existing government health spending?</b>
<b>What is the relationship between these sources of funds and the other health financing functions of pooling and purchasing?</b>
<i>Resources</i>
<b>Fiscal Policy for Health Policy Makers</b>
<i><a href="http://documents.worldbank.org/curated/en/2014/03/19487496/fiscal-policy-health-policy-makers">http://documents.worldbank.org/curated/en/2014/03/19487496/fiscal-policy-health-policy-makers</a></i>
This paper summarizes the basic principles that should form the basis of fiscal policy. These principles encompass decisions on the functions of government, its spending, and the financing of its spending that affect economic growth, employment, inflation, and economic welfare. Specific applications of fiscal policy to the health sector are discussed.
<b>Benefit Incidence Analysis</b>
<i><a href="http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTPSIA/0,,contentMDK:20472485~menuPK:1108016~pagePK:148956~piPK:216618~theSitePK:490130~isCURL:Y~isCURL:Y~isCURL:Y,00.html">http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTPSIA/0,,contentMDK:20472485~menuPK:1108016~pagePK:148956~piPK:216618~theSitePK:490130~isCURL:Y~isCURL:Y~isCURL:Y,00.html</a></i>
Benefit incidence analysis estimates the distribution of benefits from public services across population groups, and describes the welfare impact of government spending on different groups of people or individual households. It does this by combining information about the <i>unit costs</i> of providing those services (obtained usually from government or service-provider data) with information on the <i>use</i> of these services (usually obtained from the households themselves through a sample survey).





# Opportunities for Better Aligning Health Spending with Health System Objectives

## Key Questions

The following are key questions to identify opportunities for better aligning health spending with health system objectives:

*What constraints in the current public financial management system could be eased to improve pooling and purchasing to better direct existing government health spending to health system objectives?*

- To what extent does the level and approach to fiscal decentralization support or inhibit pooling of health funds, redistribution, and cross-subsidization?
- How many different funding pools exist in the health sector (across geographic areas and administrative levels, different revenue sources, and different purchasers)?
- Are there mechanisms to accumulate and redistribute health funds across geographic areas, administrative levels, and revenue sources?
- To what extent is it possible to develop, disburse, and account for health sector budgets based on priority populations, programs, and services rather than inputs?
- Is it possible to use government health funds flexibly to pay health care providers for outputs and use other purchasing strategies?
- What accountability measures can be put in place to ensure that funds are being used effectively for priority populations, programs, and services?

More revenue for the health sector will not help achieve universal health coverage goals if the revenue is not aligned to specific objectives such as improving access to priority services, strengthening quality of care, and improving equity and financial protection. To meet universal coverage goals, it is not only the level of government health spending that matters, but also how that money flows

through the system and can be matched to priorities. Budgeting for health has specific challenges as health needs vary over time and across geography, and utilization and costs of services are influenced by health worker decisions and population choices. This means that the government does not always know what it is “buying” with its health budget funds and may not have the flexibility to get funds to the right place at the right time to buy the services that are needed.

To better match health funds with priority populations, programs, and services, many countries have implemented pooling and purchasing reforms that make it possible to move funds to where population needs are the greatest and to create incentives for efficiency and quality. The public sector budgeting process, however, is often not structured to accommodate the unique aspects of the health sector or pooling and purchasing reforms (table 5.1). An important part of health financing policy dialogue is to identify areas where existing funds could be used more effectively toward health sector objectives and which constraints in the public financial management system need to be addressed. This section focuses on how the institutional structure of revenue-raising, fiscal decentralization, and public financial management rules impact the options and effectiveness of pooling and purchasing.

**Table 5.1 Common Challenges in Public Financial Management (PFM) Systems to Match Health Funding with Objectives**

<i>Health Financing Function</i>	<i>Implementation Conditions</i>	<i>PFM Functions</i>	<i>PFM Challenges</i>
<b>Revenue collection</b>	<ul style="list-style-type: none"> <li>• Sufficient and stable resources to meet stated objectives</li> </ul>	<ul style="list-style-type: none"> <li>• Revenue forecasting</li> <li>• Budget formulation</li> </ul>	<ul style="list-style-type: none"> <li>• Poor revenue forecasting</li> <li>• The way sectoral budget ceilings are set does not reflect political commitments on level/source of funds, sector objectives, or strategic and operational plans</li> <li>• Budget envelope is not realistic, leading to ad hoc adjustments</li> </ul>
<b>Pooling</b>	<ul style="list-style-type: none"> <li>• Mechanism to accumulate and redistribute funds</li> </ul>	<ul style="list-style-type: none"> <li>• Budget formulation</li> </ul>	<ul style="list-style-type: none"> <li>• Fiscal decentralization means budgets are formulated at different administrative levels with no mandate/mechanism to transfer funds between budgets</li> <li>• Different budget formulation processes and pooling arrangements for different revenue streams (e.g., social health insurance)</li> </ul>
<b>Purchasing</b>	<ul style="list-style-type: none"> <li>• Mandate to purchase services for the population (benefits package, essential services, etc.)</li> <li>• Stable and predictable funding to enter into contracts with providers</li> <li>• Flexibility to make payments according to outputs, activity, or performance</li> </ul>	<ul style="list-style-type: none"> <li>• Budget execution (provider payment)</li> </ul>	<ul style="list-style-type: none"> <li>• Difficult to match health spending to priorities when budgets are classified, formed, and disbursed based on inputs</li> <li>• Number of outputs a facility delivers is not predictable, so need program rather than facility caps</li> <li>• Operational budgets largely consumed by salaries</li> <li>• Different purchasing arrangements and accounting for different revenue streams (e.g., health budget, SHI)</li> </ul>

The technical details of these health financing functions are not discussed, since they are elaborated in detail elsewhere (Gottret and Schieber 2006; Langenbrunner, Cashin, and O' Dougherty 2009; Kutzin, Cashin, and Jakab 2010; IMF 2011c).

### **Opportunities to Improve Pooling**

Providing universal health coverage and financial protection for the population as a whole requires a significant amount of cross-subsidization, both from rich to poor and from people at low risk of illness (for example, the young) to people with higher risk (for example, the elderly). Solidarity is the commitment to redistribution and cross-subsidization, but mechanisms are also needed (Maeda et al. 2014). Pooling funding sources and contributions makes it possible to redistribute funds from those with more ability to pay and less need to cover necessary services to those with less ability to pay and higher needs. Pooling is an important part of the health financing policy dialogue because some measures taken by the ministries of finance and other parts of government, particularly fiscal decentralization, have important consequences for the distribution of public health funds.

Constraints to better pooling in the current public health financing system can come from a number of sources, such as the following:

- Fiscal decentralization that assigns revenue generation and expenditure responsibility to lower administrative levels with limited redistribution of revenue
- Separate pools for different revenue sources (for example, payroll tax and general tax revenue)
- Separate pools for multiple public and/or private health insurance schemes or plans
- Parts of the health budget, such as health worker salaries, determined and paid directly by the ministry of finance or treasury.

### ***Pooling across Geography and Administrative Levels with Fiscal Decentralization***

There are many policy objectives for fiscal decentralization, but those objectives do not necessarily hold equally across sectors. In health, some fiscal decentralization objectives may conflict with the objectives of providing equity and financial protection in a sector with spending needs that are highly variable across populations and within populations across time (Costa-i-Font 2012). In systems such as in the United Kingdom that are mostly centralized in terms of revenue collection but have varying degrees of expenditure authority at subnational levels, health funding is pooled at the national level, then redistributed geographically using the mechanism of a needs-based allocation formula (UK Department of Health 2011). In Denmark, a national 8 percent income tax earmarked for health is collected (and pooled) by the central government, and then redistributed to five regions and 98 municipalities through a risk-adjusted capitation formula and some activity-based payment (Vrangbaek 2010). With this approach to fiscal decentralization within the health sector, the benefits of local priority-setting may be combined with the equity benefits of pooling at a

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**Box 5.1 Partial Fiscal Recentralization to Preserve Pooling of Health Funds in the Kyrgyz Republic**

Early in the transition period following the collapse of the Soviet Union, large-scale fiscal decentralization was undertaken in the Kyrgyz Republic. Decentralization was initiated in response to strong demand by local politicians for greater budget control, combined with an increasing willingness at the central level to give up budget responsibility due to economic collapse and the drastic contraction in public sector resources. Local governments were unable to meet budget commitments for the health sector, however, and a portion of budget authority was recentralized and allocated back to the local level in the form of block grants.

Source: Chakraborty et al. 2010.

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higher level, although this is not always the case (Costa-i-Font 2012). Particularly when fiscal decentralization with formula-based allocation replaces a budgeting and resource allocation process that maintains historical spending patterns driven largely by factors other than need, equity can be improved (Bossert et al. 2003). In countries with a high degree of fiscal decentralization for both raising revenues and setting priorities for expenditures without an equity-based mechanism for redistribution, pooling is more fragmented, and there are often negative effects on equity and financial protection (box 5.1).

***Pooling across Multiple Revenue Sources***

A common obstacle to effective pooling in low- and middle-income countries is the fragmentation between general tax revenues and other sources of financing in the health sector. In these systems, the collection and use of general tax revenues is through the budget system and largely disbursed as supply-side subsidies to maintain the health delivery infrastructure. Other sources of revenue may be pooled in an off-budget fund such as a public insurer and disbursed as payment for services. In a number of countries this fragmentation is being reduced as general tax revenues are increasingly shifted to subsidize coverage of individuals and services rather than to maintain inputs.

Some countries have multiple coverage schemes or insurers, which collect and pool funding separately. This arrangement often requires redistribution mechanisms to achieve equity and financial protection. In Germany, for example, the national health insurance system is operated by more than 130 competing schemes, or “sickness funds.” Maintaining equity and redistribution across the sickness funds has required ongoing adjustments across the pools through a variety of mechanisms (see below).

***Mechanisms Available to Redistribute Funds for Improved Pooling***

In the absence of a single national pool for health funding, mechanisms for transfers across government administrative levels, between the government budget and government health purchasers, and across multiple insurance programs are

the key levers within the public financial management system to improve pooling. Transfer mechanisms include both public financial management rules that allow funds to move across institutions and the technical formulas that inform them. The rules of budget formulation, execution, and accounting that affect how funds flow in the health sector will dictate the mechanisms available for transfer of funds and for how funds are pooled. The formulas used to reallocate funds are based on highly technical analysis that reflects objective examination of both needs and of political priorities.

Achieving redistribution across multiple revenue sources often requires complex formulas and mechanisms. In Germany for example, imbalances in revenues and expenditures emerged across sickness funds serving populations with different risk profiles. A 2009 reform required all funds collected by the sickness funds to be pooled in a new central fund, and then redistributed back to the sickness funds according to a risk-adjusted capitation formula (Busse and Stock 2010).

Some countries have achieved effective cross-subsidization with multiple pools by standardizing key facets of the system and cross-subsidizing or consolidating pools. Japan has improved effective pooling across several thousand insurance plans in its national health insurance system through effective standardization of aspects of the system and a series of intergovernmental transfers, while France has gradually consolidated multiple insurance programs into only three (box 5.2).

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### **Box 5.2 Effective Cross-Subsidization with Multiple Insurance Programs in Japan and France**

Japan and France have achieved largely effective cross-subsidization with multiple insurance programs by standardizing key facets of the system and cross-subsidizing or consolidating pools. Japan uses a combination of standard benefits and provider payments across plans, and not only makes intergovernmental transfers, but also transfers across health plans at the secondary level. As a result, the insurance plans for large corporations actually transfer about 40 percent of the premiums they collect directly to the elderly care risk pool managed by the government. This transfer is on top of the general revenue subsidies going to these plans. The cross-subsidization is imperfect, however, and disparities in premium rates remain, with plans covering wealthier individuals able to offer lower premium rates. France, on the other hand, has consolidated into fewer programs with larger pools, with more than 80 percent of the population covered by the largest (*Regime General*).

Source: Maeda et al. 2014.

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In some low- and middle-income countries, the administrative, political, and technical obstacles to redistributing funds across pools established by multiple insurance programs or schemes have been too difficult to overcome; these countries have attempted to improve redistribution and equity by integrating multiple programs, but the results have been mixed as the challenges of integration have also proved formidable (box 5.3).

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### Box 5.3 Integrating Multiple Insurance Schemes or Programs to Improve Pooling

Turkey integrated its multiple insurance programs and achieved integration and highly equitable cross-subsidization (Atun et al. 2013). Ghana's universal coverage system started with district-level mutual schemes, which were consolidated into one national program, the National Health Insurance Scheme (NHIS). The NHIS has effectively redistributed funds to cover the exempt populations across districts. The consolidation of the NHIS pool was greatly facilitated by the fact that over 70 percent of its revenue comes from an earmarked portion of a general tax (the VAT), and that most of the revenue is held in an off-budget fund (the National Health Insurance Fund).

Vietnam, on the other hand, integrated its multiple programs, including its program for the formal sector and the Health Coverage for the Poor (HCP) program, without effectively pooling the revenues for the different insured groups. So although all beneficiaries fall under the same organizational structure and management of the purchaser, Vietnam Social Security (VSS), the revenue available to cover services is highly inequitable across beneficiary groups (Somanathan, Dao, and Tien 2013).

In Peru the 2010 Universal Health Insurance Law created a regulator framework to achieve UHC through a coordinated institutional integration process of the SIS and ESSALUD programs, but actual integration has stalled and commitment to full institutional integration remains unclear.

Finally, Indonesia is the latest country to integrate multiple programs in an effort to improve equity and efficiency and make the final push to achieve UHC. These programs were integrated into one national system in 2014. It remains to be seen whether the integration will proceed smoothly and lead to better redistribution and equity.

Source: Maeda et al. 2014.

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### Key Questions and Resources to Understand the Opportunities and Constraints to Improve Pooling

Table 5.2 summarizes the key questions and resources to understand the opportunities and constraints to improve pooling.

**Table 5.2 Key Questions and Resources to Understand Opportunities and Constraints to Improve Pooling**

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*UNDERSTANDING THE OPPORTUNITIES AND CONSTRAINTS TO IMPROVE POOLING*

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*Key Questions*

**What is the nature and level of fiscal decentralization and what opportunities and constraints does that create to improve pooling?**

**How many different funding pools exist in the health sector (across geographic areas and administrative levels, different revenue sources, and different purchasers)?**

**How much inequity is there across the pools in terms of contribution rates and benefits or expenditure/covered person?**

**Are there mechanisms to accumulate and redistribute health funds across geographic areas, administrative levels, and revenue sources?**

**What are the key elements of the necessary reallocation formulas?**

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*table continues next page*

**Table 5.2 Key Questions and Resources to Understand Opportunities and Constraints to Improve Pooling** (continued)

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<i>Resources</i>
<b>World Bank Fiscal Decentralization Indicators</b>
<a href="http://www1.worldbank.org/publicsector/decentralization/fiscalindicators.htm">http://www1.worldbank.org/publicsector/decentralization/fiscalindicators.htm</a>
The World Bank Decentralization Indicators are derived from the International Monetary Fund's <i>Government Finance Statistics</i> (GFS), which provides data on fiscal variables with consistent definitions across countries and years. The GFS includes more than 50 variables disaggregated at the level of state or provincial and local government.
<b>The World Health Organization's OASIS (Organizational Assessment for Improving and Strengthening Health Financing) Excel Aid</b>
<a href="http://www.who.int/health_financing/tools/systems_review/en">www.who.int/health_financing/tools/systems_review/en</a>
WHO's Department of Health Systems Financing developed an analytical approach and framework that can help guide systematic health financing system reviews including a health financing performance assessment. The OASIS framework includes a module to assess pooling arrangements.

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## Opportunities to Improve Purchasing

Health purchasing refers to the way financial resources are allocated to health care providers for delivery of services guaranteed to the population (for example, benefits package, essential services package). When health services are purchased with government funds, this can be considered a part of budget execution. Health purchasing is strategic when the purchaser actively uses policy to influence the cost of services, their quality, and how they are delivered (see below “Strategic Purchasing for Efficiency and Value for Money”).

Strategic health purchasing requires institutional authority to make purchasing decisions and enter into contracts with providers, flexibility to allocate funds to pay for outputs and outcomes, and well-functioning information systems to design and implement purchasing mechanisms (Fuenzalida et al. 2010). A large purchaser or multiple purchasers operating under a unified set of rules and regulations can exert influence over how health care resources are used and how providers deliver services. Systems with fragmented pooling typically also have fragmented purchasers, greatly weakening the strength of this lever to match resources with health sector priorities. In countries with a single or few large purchasers covering the entire population—given the flexibility to allocate funds to pay for services rather than inputs, and high technical capacity and sophisticated information systems—the power to shape overall health sector resource use can be profound.

In addition to fragmentation of pools, which limits the power of the purchaser, public financial management (PFM) rules governing how health budgets are formed, disbursed, and accounted for continue to constrain health purchasers in a number of countries. In particular, PFM rules that form and disburse budgets based on inputs constrain the ability of purchasers to align funding with service



priorities. Ministries of finance are often more comfortable releasing funds according to input-based line items rather than releasing funds more flexibly. This is particularly the case when budget monitoring systems are weak. How budgets are executed can also create unpredictability and inefficiencies when there are delays in the transfer of funds and within-year budget adjustments.

It is possible at times to address PFM constraints through changes in the way budgets are formed, executed, and accounted for. For example, program budgeting, which organizes the budget according to objectives and related activities rather than administrative and input lines, increases flexibility in the allocation and use of resources in some cases and makes it more feasible to pay providers for outputs. In some countries, these changes have been difficult to achieve and alternative funding flows that are off-budget have been established (for example, new insurance funds) or made possible through special programs (for example, RBF programs). In the Central Asian Republics, for example, rigidities in the PFM system and treasury made it difficult to pay health care providers through output-oriented payment systems. Furthermore, in the traditional line-item budget, any efficiency gains achieved from rationalizing excess supply in the service delivery system resulted in a reduction in the health budget in the following year rather than reinvestment to upgrade and streamline the delivery system. A new purchasing agency was set up to allow funds to flow outside of the treasury and be used more flexibly. Even when new purchasers are set up to bypass rigid PFM rules, however, the majority of public money for health still typically comes from the general budget, and it is important that transfers from the budget to health purchasers are timely, complete, and flexible.

An objective of health financing policy dialogue should be to identify obstacles to effective purchasing that arise from the lack of institutional authority to make purchasing decisions, rigidities of the PFM system that make it difficult to pay health care providers through output-oriented payment systems, inadequate information systems, or fragmented purchasing power. Furthermore, health purchasers and providers sometimes claim they can operate within existing funding if funds are transferred completely and on time and can be allocated flexibly (Box 5.4). Health financing policy dialogue should also address these very practical (and likely solvable) obstacles to effective health purchasing.

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#### **Box 5.4 Constraints of the Line-Item Budget for Improving Health Purchasing in Mongolia**

Under the former centralized Semashko model, the health delivery system in Mongolia was publicly owned, hierarchically organized, and financed by general tax funds paid to health facilities using input-based line-item budgets. Mongolia has moved away from this financing and service delivery model. Although the MOH continues to finance most public health

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*box continues next page*



**Box 5.4 Constraints of the Line-Item Budget for Improving Health Purchasing in Mongolia** *(continued)*

facilities using historical line-item budgets, health centers are paid by a flexible capitation model to deliver basic primary care, and the social health insurance agency purchases inpatient services using a case-based payment system based on diagnosis-related groups (DRGs).

Even with the introduction of some output-oriented payment systems, however, strategic health purchasing has been limited by continued strict management of all public funds through the budget law; all provider payment is still ultimately calculated, disbursed, and accounted for according to input-based line items. Health care providers interviewed during a provider payment assessment claimed that the restrictiveness of the line-item budget was a greater barrier to efficiency and quality of care than the low level of funding they received.

*Source:* Cashin et al. 2015.

**Key Questions and Resources to Understand the Opportunities and Constraints to Improve Purchasing**

Table 5.3 summarizes the key questions and resources to understand the opportunities and constraints to improve purchasing.

**Table 5.3 Key Questions and Resources to Assess Opportunities and Constraints to Improve Purchasing**

<i>UNDERSTANDING THE OPPORTUNITIES AND CONSTRAINTS TO IMPROVE PURCHASING</i>
<i>Key Questions</i>
<b>To what extent is it possible to develop, disburse, and account for health sector budgets based on priority populations, programs, and services rather than inputs?</b>
<b>Is there a purchaser that is separate from the providers of care with institutional authority to make purchasing decisions?</b>
<b>What changes in the PFM rules would be required to allow output-oriented payment systems for providers?</b>
<b>Does the purchaser have access to adequate information systems to design and implement strategic purchasing approaches?</b>
<b>What accountability measures can be put in place to ensure that funds are being used effectively for priority populations, programs, and services?</b>
<i>Resources</i>
<b>Toolkit for Ministries of Health to Work More Effectively with Ministries of Finance</b>
<i><a href="https://www.hfgproject.org/new-toolkit-ministries-health-work-effectively-ministries-finance/">https://www.hfgproject.org/new-toolkit-ministries-health-work-effectively-ministries-finance/</a></i>
(Kanthor and Erickson 2013; Todini 2013.)
<b>World Bank How-To Manual on Designing and Implementing Provider Payment Systems</b>
<i><a href="http://elibrary.worldbank.org/doi/book/10.1596/978-0-8213-7815-1">http://elibrary.worldbank.org/doi/book/10.1596/978-0-8213-7815-1</a></i>
The How-To manuals provide step-by-step guidance for designing and implementing a per capita payment system for primary care, case-based payment for inpatient services, and global budgets to pay hospitals. The manuals also address the supporting systems, including the information and billing systems.

*table continues next page*

**Table 5.3 Key Questions and Resources to Assess Opportunities and Constraints to Improve Purchasing** (continued)

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**Costing of Health Services for Provider Payment: A Practical Manual**

*<http://www.jointlearningnetwork.org/resources/costing-manual-tool-kit>*

This manual developed by the Joint Learning Network for Universal Health Coverage (JLN) provides technical guidance and practical examples for planning and implementing a costing exercise for provider payment in low- and middle-income countries. It provides step-by-step instructions for designing a costing exercise, developing data collection tools, collecting and analyzing cost data, and using the results to shape provider payment policy and set payment rates.

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# Fiscal Sustainability of Current Health Spending Patterns and Potential Efficiency Gains

## Key Questions

The following are key questions to assess the fiscal sustainability of current health spending patterns and identify potential efficiency gains:

*To what extent are health sector objectives being met by getting value for money and without expenditure regularly exceeding revenue?*

- Do expenditures regularly exceed revenues in the health system or subsystems, such as national health insurance systems?
- Are there efficiency gains that could make better use of existing funds and curb unproductive expenditure?
- What institutional investments are needed to address the key inefficiencies over the short, medium, and longer term?
- What are the incentives at different levels of the system to generate efficiency gains, and which institutions capture the efficiency gains of different measures?

All countries face resource constraints in achieving or maintaining universal coverage, so managing spending efficiently is critical for maximizing available funding in terms of coverage. Countries at different stages of UHC face different expenditure management challenges. In the early stages, countries are focused on getting more resources into the system and increasing public spending. Cost pressures almost always emerge, however, as coverage expands, and fiscal sustainability nearly always becomes a concern (Maeda et al. 2014). Fiscal sustainability of the health system means expenditure does not regularly exceed revenue, and “open-ended” expenditure commitments are limited for the system as a whole and in subsystems, such as national health insurance systems. Fiscal sustainability is a constraint under which UHC must be managed (Thompson et al. 2009). This requires both a stable and diversified resource base, and explicit measures to manage costs in the system.

If expenditure is not managed and regularly exceeds the resource base, countries have the option to increase expenditure by rearranging government budget priorities, increase taxes, scale back coverage (explicitly or implicitly), or incur debt. Therefore, the way countries manage cost pressures will have implications not only for fiscal sustainability but also for whether coverage can be expanded and sustained. Finding the right balance of policies to contain costs (even while overall spending may need to increase) without eroding coverage is an ongoing challenge that requires close cooperation between the ministry of health and the ministry of finance (Maeda et al. 2014).

The revenue side of fiscal sustainability was addressed in earlier sections. Simply increasing public expenditure in the health sector, however, may not significantly affect health outcomes if efficiency in spending is low. In this section health expenditure is discussed from the perspective of fiscal sustainability—or balancing cost and expenditure pressures with available resources—and achieving greater efficiency and value for money. There are many sources of inefficiency in health spending and unproductive cost growth due to decisions made within the health sector itself, which sometimes threaten the financial sustainability of the health system or subsystems, such as national health insurance programs. Health systems in low- and middle-income countries therefore face the dual challenge of increasing health spending to meet stated health system objectives, while at the same time managing excessive cost growth—which is unrelated to achieving health sector goals—in the least efficient parts of the system. Expenditure management is critical, as simply pursuing cost containment may erode coverage. Countries that are more successful at managing expenditure growth in the system without eroding coverage put in place some combination of global expenditure targets or controls and strategic purchasing approaches. For example, policies that support strategic payment systems, or lead to better-negotiated medicine prices and well-targeted subsidies, can be coverage-enhancing policy choices, freeing up resources to provide more people with better access to high-quality services with greater financial risk protection (Maeda et al. 2014).

The dialogue between MOH and MOF should therefore focus on using the policy and institutional levers more effectively to ensure that expenditure growth is related to achieving objectives. Ministries of finance may also request concrete analysis demonstrating how expenditure will be managed and which efficiency gains can be achieved by different approaches. A key issue for dialogue is how efficiency gains will be used by the system—for instance, will savings be reinvested more cost-effectively in the health system or will they be absorbed by other areas of the government budget?

### **Expenditure Targets and Caps**

Some countries actively enforce fiscal discipline by negotiating or imposing expenditure caps at different levels of the system—including global, subsector,

geographic area, and/or provider. This is an increasingly common practice in OECD countries. Denmark, for example, established a national government health expenditure cap, and Sweden imposes budget caps at the county and municipality level. Germany negotiates budget caps for different health subsectors, such as overall budget caps for ambulatory physicians and prescription caps (initially global caps but now at the physician level).

France and Japan manage expenditure within global targets for health spending. France monitors expenditure against spending targets throughout the year (Box 6.1), and Japan adjust payment rates downward when global volume targets are exceeded. Budget caps on health facilities are used for public hospitals in Australia, and general practitioners receive capitation primary care budgets in the United Kingdom. Both Thailand's UC Scheme and Turkey's Social Security Institution also impose caps at the provider level.

In low- and middle-income countries, the MOH and MOF typically set spending targets in accordance with health sector budget ceilings. The issues for policy dialogue center more around whether and how expenditure targets are set at subsystem levels and how they are enforced. For example, health expenditure in many low- and middle-income countries is often dominated by spending on tertiary care rather than on public health and primary care. Spending on tertiary care may not be the most efficient use of resources for achieving health system objectives, but it may continue to grow while overall spending is controlled. Also, while the budget may be tightly controlled, spending in social insurance systems may be more difficult to manage, particularly when payment to providers relies on fee-for-service and is open-ended. In Ghana, for example, while there is general consensus that government spending for health must continue to increase to meet health sector and universal coverage goals, the cost growth per member within the National Health Insurance Scheme (NHIS) may become fiscally unsustainable. (Schieber et al. 2012)

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### **Box 6.1 Expenditure Targets and "Early Warning Systems" in France**

In France, 20 years of deficits in the national health insurance (NHI) system have started to decline over the past several years through a series of concerted measures, such as the introduction of national health spending targets, including subtargets for ambulatory care and hospitals, and close expenditure monitoring through "Alert Committee" reporting to parliament throughout the year. The rate of growth of health spending in France is now better controlled, declining to 3 percent per year since 2010, from a high of 7 percent in 2002. The problem is far from solved, however, as the economic downturn has put further strain on budget revenues and new cost pressures have arisen, such as the reclassification of general practitioners as specialists, which allows them to raise fees by about 10 percent (Durand-Zaleski 2010).

*Source:* Maeda et al. 2014.

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## Strategic Purchasing for Efficiency and Value for Money

Strategic purchasing and provider payment has been a key expenditure management strategy in countries that have achieved universal health coverage. Comprehensive strategic purchasing approaches in some cases show results for managing costs while at the same time pushing the system toward more value for money and making UHC achievable or sustainable (Maeda et al. 2014). Strategic purchasing strategies include leveraging provider payment systems to drive efficient service delivery (Langenbrunner, Cashin, and O'Dougherty 2009), strong negotiation with pharmaceutical suppliers to manage drug costs, and incentives to limit high-cost services. Strategic purchasing can reduce “rents” or excess revenues accumulating to interest groups, such as tertiary care providers and pharmaceutical companies, rather than cutting back benefits. A strong purchasing agency with the leverage and capacity to negotiate prices and payment conditions with providers and suppliers on behalf of the covered population can help manage costs without eroding coverage (box 6.2).

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### Box 6.2 The Power of the Large Purchaser in Thailand

The National Health Security Office (NHSO) is the single purchaser for three-quarters of Thailand's population (or about 50 million beneficiaries) under the Universal Coverage Scheme. The NHSO therefore has substantial bargaining power. The NHSO negotiated with pharmaceutical companies to bring down the price of medicines, medical products, and interventions. For example, the price of hemodialysis decreased from US\$67 to US\$50 per cycle (which could save US\$170 million a year), prescribing generic medicines, appropriate dispensing of medical technologies, and effective prevention intervention (Health Insurance System Research Office 2012).

Source: Maeda et al. 2014.

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A critical part of strategic purchasing and expenditure management is keeping drug expenditures in check. Spending on drugs typically makes up a large share of both spending in UHC systems and out-of-pocket spending. Some options are reference-pricing and other regulations in Ghana and France, mandatory discounts and rebates and other negotiations with pharmaceutical companies in Thailand and Turkey, and refusing to cover drugs that do not meet minimum effectiveness or cost-effectiveness criteria in France and Thailand (Maeda et al. 2014). In Japan, pharmaceutical expenditure is kept in check not by regulation or strong negotiation with pharmaceutical companies, but by capturing drug price reductions that come about through competition (Maeda et al. 2014).

More in depth discussions of strategic health purchasing strategies are available elsewhere (Figueras, Robinson, and Jakubowski 2005; Langenbrunner, Cashin, and O' Dougherty 2009; Fuenzalida et al. 2010).

## Supply- and Demand-Side Controls

In addition to global and subsector spending targets and controls, more micro-level strategies are needed to manage costs and get value for money by managing access to certain services, either within or outside of strategic purchasing approaches. Countries sometimes adopt specific policies to direct supply and utilization toward those parts of the system that are more cost-effective through such strategies as primary care gate-keeping (United Kingdom, France, Sweden, Switzerland, Thailand, and Turkey); waiting lists for elective services (New Zealand); and health technology assessment to establish criteria such as cost-effectiveness for covering additional services (Denmark, the Netherlands, New Zealand, and Thailand).

Implicit expenditure management through a focus on primary care has enhanced efficiency of UHC systems in Brazil, Thailand, and Turkey. These countries have focused on primary care as either an implicit or explicit expenditure management policy. While Brazil's focus on primary care in its UHC system was an implicit expenditure management strategy, Thailand and Turkey made an explicit decision to focus on expanding primary care coverage as an expenditure management policy (Maeda et al. 2014; Health Insurance System Research Office 2012). Although France and Japan had less of a focus on primary care in the early stages, France is attempting to reorient its system toward primary care and prevention. Recent preventive programs introduced for immunization and cancer screening are now covered by insurance, although general public health programs continue to be funded through direct budget funding.

## Key Questions and Resources to Understand the Fiscal Sustainability of Current Spending Patterns

Table 6.1 summarizes the key questions and resources to assess the fiscal sustainability of current health spending patterns and identify opportunities for efficiency gains.

**Table 6.1 Key Questions and Resources to Assess Fiscal Sustainability of Current Spending Patterns**

<i>UNDERSTANDING THE FISCAL SUSTAINABILITY OF CURRENT SPENDING PATTERNS</i>
<i>Key Questions</i>
<b>Do expenditures regularly exceed revenues in the health system or subsystems, such as national health insurance systems?</b>
<b>Are there efficiency gains that could make better use of existing funds and curb unnecessary expenditure?</b>
<b>What investments are needed to address key inefficiencies over the short, medium, and longer terms? Are there estimates of cost savings and efficiency gains that could be achieved from these approaches?</b>
<b>What are the incentives at different levels of the system to generate efficiency gains, and which institutions capture the efficiency gains of different measures?</b>

*table continues next page*

**Table 6.1 Key Questions and Resources to Assess Fiscal Sustainability of Current Spending Patterns** *(continued)*

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*Resources*

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**Data for Efficiency: A Tool for Assessing Health Systems' Resource Use Efficiency**

*<https://www.hfgproject.org/wp-content/uploads/2014/10/04-Data-for-Efficiency-A-Tool-for-Assessing-Health-Systems-Resource-Use-Efficiency.pdf>*

(Heredia-Ortiz 2013)

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**Assessing Health Provider Payment Systems: A Practical Guide for Countries Working Toward Universal Health Coverage**

*<http://www.jointlearningnetwork.org/resources>*

This guide developed by the Joint Learning Network for Universal Health Coverage (JLN) provides a systematic framework and step-by-step process for a country or institution to assess the design and implementation arrangements of current provider payment systems and identify refinements or reforms that can help achieve their health system goals.

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# Conclusions

Government health spending will need to increase in many low- and middle-income countries to achieve stated health sector goals, such as pursuing universal health coverage. Given the macroeconomic and fiscal realities in many of these countries, however, the growth in government health spending will be constrained in the short to medium term, and health financing policy dialogue will have to consider a more holistic approach grounded in these realities. Constructive health financing policy dialogue goes deeper into government budget allocations to better understand constraints and opportunities for both increasing funding levels (the revenue side) and making better use of funds to achieve health sector objectives (the expenditure side). When ministries of health and ministries of finance have a common understanding of macroeconomic and fiscal constraints, discussions can focus productively on using funds within the potential health resource envelope in the most effective way to achieve health system objectives.

Ministries of health should be prepared to enter into health financing policy dialogue with clearly articulated objectives, strategies and operational plans for achieving the objectives, and realistic estimates of the resources required. They should also demonstrate that they understand the overall macroeconomic and fiscal context of the country and the constraints faced by the central budget authorities. Ministries of finance should be aware of the particular challenges of budgeting for the health sector, and in particular understand what the government is purchasing for the population—access to needed health services with financial protection. Budgeting for health is different from budgeting for other sectors, as health needs vary over time and across geography, and utilization and costs of services are influenced by health worker decisions and population choices. This means that the government does not always know what it is “buying” with its health budget funds and may not have the flexibility to get funds to the right place at the right time to buy the services that are needed.

The part of health financing policy dialogue that is often ignored is how public money can be put to better use within the health financing system. The way health sector budgets are formed, executed, and accounted for provides ample

scope for better alignment between public health funds and health sector priorities. But ministries of finance are often reluctant to modify these systems away from traditional approaches that are built around inputs—buildings, staff, and beds—which can be counted and accounted for. Poor information systems and weak capacity to monitor budgets in the health sector pose further challenges to increased flexibility in the use of budget funds. Health financing policy dialogue should explore opportunities to obtain both flexibility in budget allocations (i.e., a move away from strict line-item controls) while still ensuring output-oriented accountability for the use of public funds. Ultimately accountability for the use of government funds on both sides should be linked to whether funds reach priority populations, programs and services, and achieve health sector objectives.

To expand opportunities for productive health financing policy dialogue, ministries of health should strive to demonstrate strategic plans with realistic cost estimates, address and quantify potential efficiency improvements, and commit to clear measurable objectives for which the health sector will be held accountable. Poor information systems and monitoring capacity, weak internal and external audit functions in the health sector, and weak capacity in procurement and inventory management need to be addressed as part of health financing system improvement. Ministries of finance, on the other hand, should understand the unique requirements of health budgeting and the importance of pooling and purchasing arrangements to direct limited public funds to priority populations, programs, and services. They should be willing to allow flexibility in PFM rules that make it possible to match funding to health sector priorities, while at the same time ensuring accountability.

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The global movement toward universal health coverage is accompanied by requests for large increases in government health spending. This, combined with the global economic situation and stagnant economic growth across many low- and middle-income countries, makes it more critical than ever to place health financing discussions firmly in the context of macroeconomic and fiscal realities. Unfortunately, there is often a disconnect in decision making, with key fiscal decisions made in the absence of a clear understanding of the potential consequences for the health sector.

Constructive health financing policy dialogue aims to reach a common understanding between health sector leaders and central budget authorities about policy objectives for the health sector and the resources needed to achieve those objectives, how much priority will be given to health in the government budget, and how the health sector will be held accountable for using funds effectively. When ministries of health and ministries of finance have a common understanding of macroeconomic and fiscal constraints, discussions can focus productively on using funds within the potential health resource envelope in the most effective way to achieve health system objectives.

*Health Financing Policy* outlines key components of the macroeconomic, fiscal, and public financial management context that need to be considered for an informed health financing discussion at the country level. Each section of the book points to measures, resources, and analytical tools that are available to assist in answering these questions for a specific country. *Health Financing Policy* draws on case studies from 11 countries moving toward or sustaining universal health coverage conducted as part of the Japan–World Bank Partnership Program on universal health coverage as well as from other country examples.