Implications of fiscal context for health financing policy in LMICs:

“It’s the budget, stupid…”

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Global Health Economics and Public Policy: health financing and managing the macro-fiscal outlook for health

Universal Health Coverage Financing Forum

What is UHC and what it brings to public policy on health coverage

- Framing of policy objectives: equity, quality, financial protection

- Coverage as a “right” (of citizenship, residence) rather than as a condition of employment
  - Major shift from 19th century roots, beginning after WW-2

- **Unit of Analysis**: system, not scheme
  - Effects of a “scheme” or a “program” is not of interest per se; what matters is the effect on UHC goals considered at level of the entire system and population
Not “how-to” manual, but some guiding principles on health financing for UHC

- Move towards predominant reliance on compulsory (i.e. public) funding sources
  - From Victor Fuchs onward

- Reduce fragmentation to enhance redistributional capacity (more prepayment, fewer prepayment schemes, leading to larger pools covering more diverse risk mix) and reduce administrative duplication

- Towards strategic purchasing to align funding and incentives with promised services, promote efficiency and accountability, and manage expenditure growth to sustain progress
First lesson is simple and important: PUBLIC SPENDING MATTERS

Voluntary prepayment is not an answer … Public spending - provides the “insurance function”

Source: WHO health expenditure database, 2013 estimates. Excludes countries with population < 600,000
Core challenge for LMICs

- Lower income countries tend to suffer from poor tax collection
  - Harder to tax rural and informally employed people

- Implications for health spending:
  - More private; more out-of-pocket; more regressive

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<tr>
<th>Country income group</th>
<th>World Bank data c. 1994</th>
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<td>Government revenues as % GDP</td>
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<td>Low</td>
<td>20%</td>
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<td>Middle</td>
<td>31%</td>
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<td>High</td>
<td>42%</td>
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Source: Schieber and Maeda 1997

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Source: WHO health expenditure database
But can’t just spend your way to UHC; must ensure efficiency and results

- “Strategic purchasing” as a critical strategy for this
  - links the allocation of resources to providers to information on their performance and/or the health needs of those they serve
  - Manage expenditure growth (no open-ended or empty promises)

- Ideally, systems should pay for services, and design incentives for efficient use of resources

- But most funding has to come from general budgets, and most public budgets can only pay for buildings and inputs
Where does this context leave our core principles?

- Fiscal/labor market context constrains public revenue raising, especially from direct taxes (including SHI)
- Budget funds often locked into rigid, input-based line-item allocation process, contributing to inefficiencies
General government budget revenues (how exciting!) at the core of the response

- We want to take UHC seriously. Implies
  - Respecting what we know about health financing, while adapting to the fiscal context
  - Institutionalize (not merely pilot) and lay foundation for future

- This means
  - Softening/eliminating the contribution-entitlement link
  - Explicit complementarity of different funding sources
  - Integrate pools (at least top/middle and bottom, as a start)
  - Re-direct budget revenues to the purchaser, move to output oriented system, unify underlying information platform

- The “heavy lifting” of health/finance dialog
  - New ways to form budgets and be accountable for their use
  - Towards output-oriented provider payment and PFM
  - New forms of accountability for use of public funds
Many examples of approaches to extend coverage

A. Non-contributory-based

- Universal, budget funded, population-based system
  - UK, Sri Lanka, Brazil

- Budget-funded for those without explicit social security mechanism
  - Thailand, Mexico

- Entitlement for poor people to range of services
  - Targeted insurance (India); “buying” fee exemptions (Cambodia)

- Universal population guarantee for specific services
  - Chile, Moldova, Burundi

B. Contributory-based

- De facto voluntary prepayment for coverage, unsubsidized
  - Many countries have tried and failed. And no doubt they will still try.

- Fully (for poor) and “heavily” subsidized prepayment for coverage (complementarity)
  - European/Asian universal “SHI” arrangements, Rwanda CBHI, China RCMS
Why the path to UHC runs through PFM (reason for our “Montreux agenda” on fiscal sustainability, PFM, and health financing)

Coverage as a right
- Foundation for UHC

Towards compulsory sources
- What the evidence tells us

General gov’t budget is main source
- Context of informality

Strategic purchasing
- Efficiency key to sustaining progress

Align PFM & HF to sustain progress
- Flexibility and new forms of accountability