

# **Social health protection and health systems financing**

## *Enhancing cooperation for more effective action*

### **Background paper for the**

### **Technical Meeting on the Providing for Health Initiative**

**Bonn, 29-30 November 2007**

## **1 Introduction**

The need to develop domestic health financing systems that offer social health protection is now well established and much of the rationale was set out and discussed previously. Already in the Paris Declaration on aid effectiveness in March 2005, aid recipients were advised to reassessing their domestic health financing systems. Subsequently, an international conference on social health protection with a focus on social health insurance was organized in Berlin<sup>1</sup> in December of the same year.<sup>2</sup> Since then, the issue of social health protection and the need to develop the domestic health financing systems to support it were taken further by some recent conferences on the same topic<sup>3-5</sup>, including the international conference on social health protection in Paris, organized by French President Chirac, in Paris, March 2007.

In this paper, we briefly re-state the key issues and challenges facing domestic health financing systems, before moving to the main purpose of the meeting - consideration of what is currently being done to work with low and middle-income countries to develop their domestic health financing systems, and how the Providing for Health Initiative (P4H) could best add value to and connect itself to current international activities and already existing global health partnerships.

## **2 The need for social health protection**

Although health is increasingly recognized as a basic human right and an essential input to growth and development, a large number of countries suffer from the twin disadvantage of high disease burden and low incomes. This means that the available domestic resources are simply insufficient to allow the population to have access to even a basic set of key interventions and services. Disadvantaged countries are further confronted with constraints such as inefficiency in translating financial and other resources into health outcomes<sup>6</sup> and leakages in revenue raising and spending.<sup>7</sup> Inefficiency is found in the public sector, but not limited to it. For example, many studies have shown extensive use of medicines, diagnostics and procedures in the private sector which are not effective or not cost-effective.<sup>8</sup>

In addition, health financing in many settings relies heavily on unorganised out-of-pocket payments made at the point of delivery of services by the patients/clients. High

out-of-pocket payments prevent many people from seeking or continuing care, while some of those who seek care incur catastrophic financial burdens and some are pushed into poverty as a result. Each year, around 150 million individuals suffer severe financial hardship simply as a result of seeking care and having to pay for the services they receive.<sup>9</sup> Approximately 100 million are pushed under the poverty line as a direct result. These figures are worrying enough, but they exclude people who suffer financial hardship because they are unable to seek care and suffer extended period of ill-health as a result. More than 90 per cent of the people who are unable to seek appropriate care live in low-income countries. Within countries, the risk of severe illness, early death and financial catastrophe linked to high out of pocket health expenditures is highest among the poorest sections of the populations.

The incidence of financial catastrophe and impoverishment are directly linked to the extent to which a country relies on out-of-pocket payments to finance its health system. While the incidence is generally higher in low-income countries, financial catastrophe and impoverishment are not uncommon in middle and high income countries due to the existence of co-payments for health services in various forms. One of the major problems of global health financing is to develop systems that protect people against the financial risks of obtaining health - to allow them to seek needed care without the risks of financial catastrophe and impoverishment.

## **2.1 Enhancing the effectiveness of domestic health financing systems**

The international focus on raising more funds for health, while vitally important, has restricted the attention policy-makers nationally and globally have given to helping domestic financing systems develop appropriately. Systems to raise domestic resources, to pool them and to ensure funds are used effectively and equitably are often not in place. Sometimes, governments do not manage to raise the funding required to finance even the most basic health care needs. This is one of the rationales of P4H, complementing efforts to raise more external funds by helping countries develop their own domestic health financing policies, systems and institutions that can achieve and maintain universal coverage.

### **2.1.1 Need for sufficient resources**

Facing 56 per cent of the global disease burden, the low-income countries together account for a mere 2 per cent of the global health spending.<sup>10</sup> Annual health spending in these countries averaged 5.2 per cent of GDP in 2004 compared to the global average of 6.4 per cent.<sup>11</sup> The proportion was below 5 per cent in 29 of the 53 low-income countries. About 1.75 billion people or 27.1 per cent of the world's population, of whom about one-third are poor, live in these 'low spending' countries. Interestingly, these countries also receive proportionally lower contributions (14.8 per cent of their total health spending) from external resources compared to the other low-income countries (26.7 per cent).

Per capita spending, from all sources including external assistance, in low-income countries averaged \$20.33 in 2004<sup>11</sup> falling well short of the bare minimum quantum of

resources (\$34-50) required to finance even a minimum set of essential health interventions.<sup>12</sup> Per capita health spending is lower than \$34 in 51 countries - all but three are low-income countries.

Per capita government spending was only \$9.60 in these countries, relatively low because many of them have limited internal capacity to raise domestic tax resources for health - partly because of overall low economic capacity and/or weak domestic fiscal systems.<sup>11</sup> The share of total government revenue (from all domestic sources) in GDP increased only slowly in 25 of the poorest African countries in the 1990s, from 11.6 per cent to 13.2 per cent, well less than the 20 per cent regarded as an achievable level.<sup>13</sup> The average figure in the Asia-Pacific region was not much higher at 16.6 per cent of GDP.<sup>14</sup>

External resources are clearly needed to supplement these domestic funds. External funding for health in poor countries has increased substantially since 2000. This is very valuable and in 2004 it accounted for an average of 23.1 per cent of total health spending in the low-income countries. However, the volume is still insufficient to ensure universal coverage of even a minimum set of needed services (prevention, promotion, treatment and rehabilitation).

### **2.1.2 Need for an efficient organization and use of resources**

Countries like Sri Lanka and Malaysia have demonstrated that efficient organization of domestic health care resources is an essential pre-condition for any additional resources to work effectively. On the other hand, many low-income countries have acknowledged that their domestic health financing systems are weak and inequitable.<sup>15-24</sup> As stated above, a high proportion of domestic financing is raised directly from households at the time they need services in the form of user fees or other direct payments, something that is almost always regressive. Many governments allocate relatively low proportions of total government expenditure to health, resulting in government health expenditures being lower than one per cent of GDP in many settings. Furthermore, government revenue is often raised from indirect taxes which are also generally regressive. To add to this, external resources are often volatile and unpredictable, something compounded by volatile exchange rates.<sup>10</sup> External funding cycles and priorities are often not aligned with national budget processes and priorities and their use is often proscribed, limiting the ability of recipient countries to deal with sudden problems and crises.

At the same time, utilization of the available resources in many cases is biased towards hospitals, urban areas, men,<sup>25</sup> and the rich. In Bangladesh, for instance, high-income individuals are three times more likely to receive care from qualified providers than other people (Table 1). The difference is more than five times for in-patient care,<sup>26</sup> where middle-income people are also much more likely to benefit from government health services than the poor. Bangladesh is but one example, with similar patterns replicated in many other countries. This is partly related to incentives and disincentives which mean that health workers, government and non-government, are less likely to be found serving disadvantaged populations.

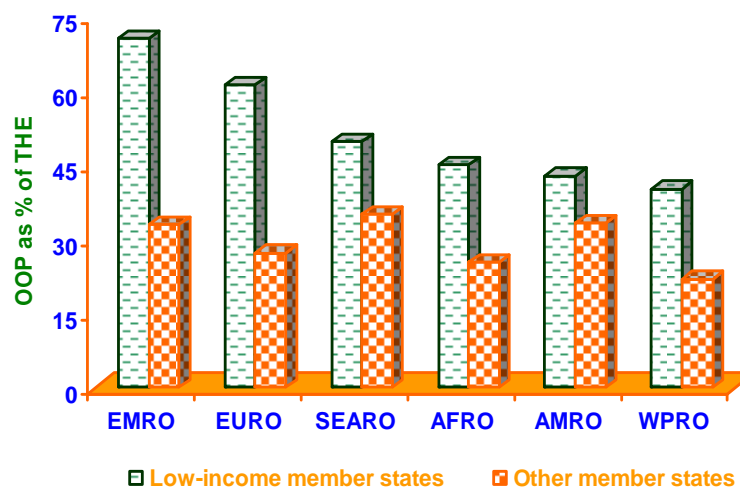
### 2.1.3 The need to streamline household out-of-pocket spending

Even in the poorest countries, over 75 per cent of total health spending is, on average, still funded by domestic resources despite increasing flows of external funding, and the global average is 90.1 per cent. In low-income countries as a group, household out-of-pocket spending accounted for 47.8 per cent of total health spending in 2004, rising to 68.2 per cent in the 16 countries with the lowest share of health expenditure to GDP; 94.4 per cent of private health spending is met from

**Table-1**

**Utilization of services among different deciles in Bangladesh<sup>26</sup>**

<b>INCOME DECILES</b>	<b>PERCENTAGE OF PEOPLE REPORTING SICK</b>	<b>PERCENTAGE OF SICK SEEKING CARE FROM QUALIFIED PROVIDERS</b>
1	6.7	14.2
2	7.6	14.4
3	7.7	12.2
4	7.5	18.0
5	7.7	20.0
6	7.3	19.3
7	7.3	21.0
8	6.6	20.8
9	6.5	30.3
10	6.1	36.3
Overall	7.1	20.3

**Figure-1****Share of household out-of-pocket spending (OOP) in WHO regions in 2004**

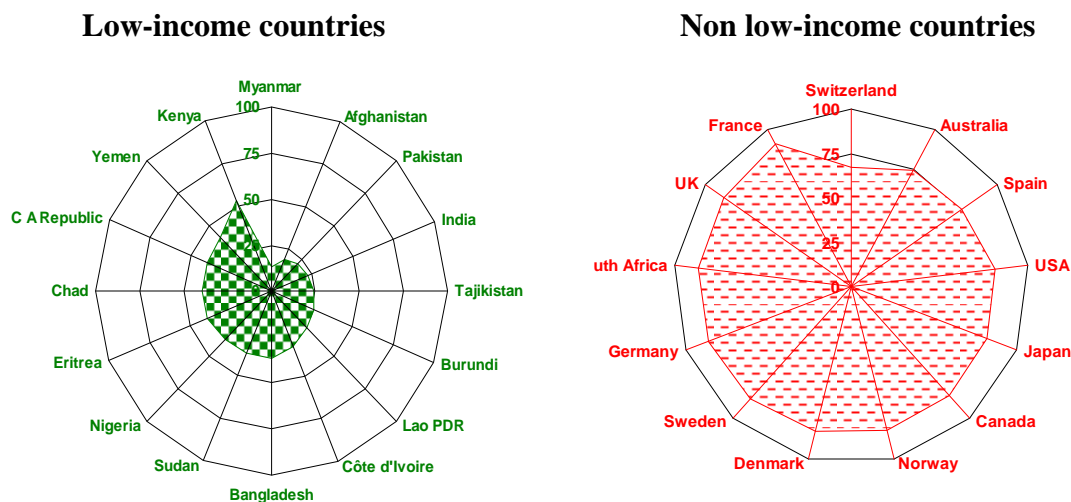
household out-of-pocket spending. Figure-1 illustrates the extent to which countries in the different WHO regions<sup>a</sup> rely on out of pocket payments to finance their health systems. In general, low-income countries rely more heavily on this form of health financing than other countries.

The other side of the coin is that low-income countries have the lowest share of pre-paid health care resources. This is illustrated in Figure 2 for 16 countries with very low levels of health spending as a percent of GDP, where less than 50 per cent of total health spending is pre-paid (taxes and all forms of health insurance). The picture is different in 13 non low-income countries, where the share of pre-paid resources is quite high. Hence, low-income countries should aim to get there although the path is not short, as it takes time and efforts to reach this level.

<sup>a</sup> AFRO, AMRO, EMRO, EURO, SEARO and WPRO refer to the Regional offices for the African Region, the Americas, the Eastern Mediterranean Region, the European Region, the Southeast Asian Region and the Western Pacific Region, respectively.

Figure-2

## Share of pre-paid (including government) resources



As stated earlier, high reliance on user charges and co-payments prevent people from seeking or continuing care. One estimate is that around 1.3 billion people cannot access effective and affordable health care.<sup>27</sup> In addition, almost half of the world's population has no social health protection at all and therefore, has to pay out-of-pocket for all health care and cope with any loss of earnings due to illness from their own resources. Not surprisingly, the poorest people in the low-income countries are the worst affected. The key to ensuring access to needed services, without the risk of financial catastrophe and impoverishment, is to reduce reliance on out-of-pocket payments by expanding spending funded through different forms of pre-payment.

### 3 What is being done: the international architecture

Raising more external funds for health is important, but it is also important to ensure that they are channelled in a way that strengthens domestic financing capacities and institutions. Realizing the importance of strengthening domestic financing, the (then) 192 members of WHO joined together in May 2005 to endorse a resolution entitled 'Sustainable health financing, universal coverage and social health insurance'<sup>28</sup> urging member states to develop their financing systems to ensure that their populations have access to needed services without the risk of financial catastrophe. The International Labour Organization also has defined a strategy "aimed at accelerating the achievement

of universal coverage, promoting equity and supporting global international efforts to alleviate poverty and improve health" as part of its Global Campaign on Social Security and Coverage for All.<sup>29</sup>

Partly as a result, there have been increasing demands from countries, both low- and middle-income, for technical support to develop their health financing and social security systems to increase the level of social health protection. These demands current exceed the ability of many of the international institutions working in this area to respond. The rest of this paper focuses on what currently is being done in this area before moving to the question of how P4H can add value.

The international architecture to deliver global health has become even more complicated in the last 10 years. The international players now include at least 26 UN agencies, 20 global and regional funds, more than 40 bilateral donors, and about 90 global health initiatives.<sup>30</sup> At the country level, there are numerous donors, aid instruments, and financial agreements.<sup>31</sup> For "recipient" countries, interacting with the large number of global players in health with complex identities, varied objectives, strategies and processes is an increasingly difficult challenge. Some of the major global health partnerships (GHPs), their size and focus areas are given in Table 2.

The philosophy of the most of the existing GHPs seems to have been that a substantial infusion of resources and technical advice in specific areas will enable countries to scale up health programs to a level commensurate with need.<sup>39</sup> Some, though not all, have raised significant levels of funding.<sup>54-55</sup> For example, partnerships such as the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) and the GAVI Alliance have brought additional resources into health aimed at particular diseases; they now account for 9 per cent of all official development assistance to health.<sup>56</sup> More recently, they both have sought to help countries improve their health systems in a way that will allow services aimed at their target diseases to be expanded.

While some of the global health partnerships provide a new window of opportunity for financing health care, the large increases in donor funding have also brought new problems or exacerbated old ones. Most importantly, it is now realized that some countries have not had the capacity to absorb these funds rapidly, one of the reason for very recent increase in global and national attention to improving health systems. Other issues of direct relevance to P4H include:

1. Lack of clear exit strategies: The providers of external funding have rarely helped governments increase their capacities to sustain higher levels of health financing, so that they will eventually be able to support their health systems once the level of external assistance falls. Some external partners have also withdrawn assistance at short notice, or not renewed it, without helping countries develop ways of handling these shocks.

**Table-2**  
**Global Health Partnerships<sup>30,32-53</sup>**

ALLIANCE	YEAR	FOCUS AREA	PARTNERS	RESOURCES P. A. (MILLION \$)
International health partnership	2007	Health & development	26	<sup>b</sup>
Germany/ILO/WHO Consortium on social health protection in developing countries	2004	Social health protection	3	
Foundation for innovative new diagnostics	2003	Diagnostics	3	6
International partnership for microbicides	2002	HIV prevention	16	26
The Global Fund	2001	HIV/AIDS, TB, Malaria	22	1,903
GAVI alliance	2000	Child health	9	720
Institute for one world health	2000	Medicines	Many	90
Stop TB partnership	2000	TB	Many	54
Global alliance to eliminate lymphatic filariasis	2000	Lymphatic filariasis	5	33c
International trachoma initiative	1999	Trachoma elimination	10	600
Vaccine fund	1999	Immunization financing	12	400
Roll back malaria	1998	Malaria	Many	149
Global TB vaccine foundation	1997	TB vaccines	3	67d
International AIDS vaccine initiative	1996	HIV vaccine	10	81
Micronutrient initiative	1992	Vitamin & mineral	9	28

<sup>b</sup> Actual size of resources committed is not yet known. For information, the combined contribution of all partners is estimated as \$7 billion (i.e., 50% of total global health aid.<sup>30</sup>

<sup>c</sup> Estimated based on US\$ 100 million required during 2003-05 as mentioned in the Alliance news letter

<sup>d</sup> Actual (2005) + average annual commitment from Bill & Melinda Gates Foundation in September 2007

		deficiency		
Global health council	1972	Global health	Many	6

2. Predictability and uncertainty of aid: Health aid, as stated earlier, is often promised only for short periods of time and has been very volatile. This means that recipient countries have been reluctant to use these funds for long term, recurrent expenditures such as wages and salaries.
3. Fragmentation of aid flows: This fragmentation strains the administrative capacity of countries to deal with external funds, particularly low income countries lacking accountants, auditors, economists and overall financial capacity.
4. Inadequate technical support: Concern that recipient countries receive limited support on how to absorb large increases in external funding, to allocate them efficiently in order to develop and sustain an equitable and effective health system.

Some of these problems have been addressed by the Germany-ILO-WHO Consortium on Social Health Protection<sup>40</sup> - established in 2004 to coordinate technical support to countries in the field of social protection in health and sustainable health financing. More recently the International Health Partnership (IHP),<sup>44-45,57</sup> has recognized the need for financial risk protection in its analytical framework. Other than these two, none of the GHPs have made the development of sustainable, efficient domestic health financing systems a major focus. Most of the technical support to countries in this area is still provided by a few bilateral and multilateral agencies that have been active for many years in this area. In addition, international NGOs, particularly *Médecins Sans Frontières* (MSF), The Save the Children Fund, and Oxfam, have been involved in overall advocacy aimed at reducing reliance on user-fees as well as in the implementation of social health protection schemes.

In providing technical support on domestic financing systems, the bilateral and multilateral agencies have acted in more or less independent ways at the global level in the recent past, although at the country level there is sometimes more active interaction and collaboration. Sometimes, however, the agencies find they do not have the capacity to meet the demands from countries for technical support, while at other times they find they are one of a number of agencies that have agreed to provide "competing" technical support to a particular country. The policy advice offered by different agencies for improving social health protection has ranged from developing strong government financing and delivery systems, other pre-payment mechanisms like social health insurance and community-based financing, pro-poor policies like subsidies or cash transfers (conditional or otherwise) and appropriate provider incentives.<sup>28,58-60</sup> P4H aims to address many of the challenges raised in this section.

### 3.1 The proposed role of P4H

The role for and the pathway of P4H need to be built around the objectives of the recent global responses such as the Paris Declaration, the Global Campaign on the Health

MDGs and the IHP. For instance, the IHP aims to improve the way that international agencies, donors and countries work together to develop and implement health plans, creating and improving health services for poor people and ultimately saving more lives.<sup>30</sup> Already, a first wave of seven countries - Burundi, Cambodia, Ethiopia, Kenya, Mozambique, Nepal and Zambia - have joined this initiative. One appropriate role for P4H in these and other countries might be to provide technical support on ways to develop options on financing structures and social health protection policies in close collaboration with partner countries and external partners.

## **4 The way forward**

### **4.1 Guiding principles**

#### **4.1.1 Expanding social protection in health**

Extension of the coverage of social protection in health is addressed by combining complementary mechanisms for resource mobilization with strategies to reach broader segments of the population (e.g. through subsidy structures for the poor, incentives for the informal sector, increasing coverage through health insurance schemes). These measures are aimed at strengthening the demand side for quality health services while ensuring the financing of those health services (supply side). The expansion of social protection in health needs to be in line with other complementary social protection interventions (such as basic social protection).

#### **4.1.2 Developing sustainable and effective health care financing systems**

The various mechanisms and the most effective mix to achieve sustainable health system financing need to be analysed in view of each country's specific context, in order to make best use of their advantages and minimize the disadvantages. A sound system which raises additional funds allows increased coverage and access for the population and improved quality of services. To this end, dialogue is necessary not only with ministries of health but also with ministries of finance, planning and labour. This is particularly important in the context of fiscal and financial sustainability, country competitiveness and the economy as a whole.

#### **4.1.3 Strengthening public financial and system management in health**

Building effective structures for health systems management requires increased transparency, good governance and accountability. Good public sector financial management is a prerequisite for sustainable and transparent national health sector budgeting, oversight and auditing processes, including improved inter-governmental financial relationships between central and local levels. Support for such governance structures should be based on capacity development and training of staff, policymakers and other stakeholders with a view to strengthening institutional, technical and administrative capacity so that the necessary conditions are in place to ensure sustainability and responsiveness to the needs of members.

#### 4.1.4 Making global funding work locally

The increased availability of money for specific interventions on a global scale (GFATM; GAVI etc.) calls for the efficient horizontal strengthening of national health systems and their organisation as well as improved aid effectiveness. Mechanisms need to be developed for the effective channelling of targeted international interventions through existing structures and for combining them effectively with national action to develop health systems at user level, so as to provide coherent health services that efficiently respond to national health priorities. There are many mechanisms that could be used to improve the efficiency and equity of the way resources in the health sector are used, and the choice will depend on the problems facing a particular country. One that is receiving considerable recent attention is performance-based funding (both supply-side and demand-side), which encourage the strengthening of local management capacity and help to bring about more equitable allocation of resources.

#### 4.2 Discussion

Much of the world's attention in recent years has been focused on raising more funds for health in poor countries. This is laudable, and more is needed. For example, if the rich countries could be persuaded to honour their commitments of providing 0.7 per cent of Gross National Income to external aid, there would be more than enough to meet the MDGs.<sup>12,62</sup> However, recent projections suggest that the share is likely to go up to only 0.32 per cent in 2010.

However, the key questions related to social health protection will not be solved simply by raising more external funding. Ensuring social health protection and building sustainable domestic health financing structures also requires active consideration of how these funds will be channelled, and how they can support the development of local financing institutions and capacity. It requires active consideration of how domestic funds, should be raised, pooled and used. Further discussion is needed whether all these questions could be part of the core business of P4H. Other related questions include:

- Should the international community be concerned with identifying the ways of channelling external funds to countries and reporting on the mechanisms that strengthen rather than weaken domestic financing institutions and capacities in recipient countries?
- As part of this, is it necessary to evaluate the many different mechanisms for channelling and reporting on external funds that are currently being used, to establish their impact on domestic financing institutions and capacities?
- How can countries be supported to develop mechanisms for tracking external funding for health that arrive in countries - currently it is very difficult for many national governments to obtain this information when funds are channelled in a variety of ways?
- Is it necessary to generate and disseminate more evidence on what works and what does not work in the areas of raising domestic funds, pooling them, and

using them effectively and efficiently, or is this area well covered by current institutions?

- How can technical support to countries in these areas be scaled up and coordinated more effectively? Which countries should be the focus?

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