



JOINT
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NETWORK
For Universal Health Coverage

Making the Case for Health: A Messaging Guide for Domestic Resource Mobilization

v.3

IN PARTNERSHIP WITH



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Additional knowledge products coproduced by members of the DRM Collaborative include:


The Dynamic Inventory of DRM Resources and Efforts is a compilation of existing databases, case studies, and other resources that can be used to support arguments around investing in health. The inventory also documents “practitioner perspectives” of country efforts with DRM for health, describing reforms and their impacts, including whether there was a sustained increase in public spending for health and other effects.

Narrative Summaries on Public Expenditure for Health present a picture of the health financing landscape at the country level with a focus on public expenditure trends over time. Health policy makers in each country have analyzed and presented their own budgetary data, supplemented as needed with global resources, and complemented this write up with a description of the policy trends that drove results. As a whole, narrative summaries exemplify how countries can use historical evidence as a tool for policy dialogue with finance stakeholders.

The Policy Dialogue Toolkit (accessible to MyJLN users) is a set of coproduced tried-and-tested materials from the various workshops, meetings, and proceedings of the DRM collaborative that have been used by more than 100 senior policy makers across 20 low- and middle-income countries in Africa and Asia. The Policy Dialogue Toolkit can be adapted by countries interested in mobilizing domestic resources for health to plan a policy dialogue workshop that engages finance stakeholders around health sector financing goals.

On Prioritizing Health: A Background Analysis includes a global review of health share of public spending across 20 low-, middle- and high-income countries, to identify successful cases of reprioritization. The Background Analysis provides a snapshot of trends in prioritization from a global review of health’s share of public spending. The discussion creates a methodological basis to identify successful cases of reprioritization, enabling a follow-up deeper dive focus on a sub-set of countries where recent sustained reprioritization efforts toward health are evident.

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Preamble

The most equitable, efficient and effective way to finance Universal Health Coverage (UHC) and other health system objectives is by using public, compulsory, and prepaid domestic funding (Box P.1)^{1-4,a} As a country's income grows, it typically manages to increase health expenditure funded primarily through public resources, while reducing reliance on out-of-pocket (OOP) financing and donor assistance (Figure P.1). But this transition does not happen on its own: Active reprioritization of health within the public budget plays a role in driving domestic government expenditure for health as average income grows. And of course, every context is different. Decision-makers must make a best judgement on the mix of domestic financing sources like taxes, and private sources like premiums and co-payments for financing health based on local circumstances. They must also manage the policies, systems and processes that pool and channel these funding flows, purchase services, and ultimately deliver quality care to the population without creating negative consequences.^{4,5}

While the type of funding used and the way that funds flow matter, there is no right number for exactly how much a country should spend to meet UHC.⁶ Regardless, health spending should remain sufficient: we know that economic shocks resulting from COVID-19 will mean projected declines in per capita government spending through 2022, a trend that will be tougher on countries that started with already low levels of health spending or high shares of OOP expenditure and external financing, and despite initial funding increases at the start of the pandemic.⁷ Prior to the COVID-19 pandemic, numerous global and regional commitments involving domestic funding have been used as tools to create an impetus to increase resources for health. The 2001 Abuja commitment called on heads of African states to allocate 15 percent of their annual budget to the health sector, while the World Health Report, 2010 proposed 4 percent to 5 percent of GDP as a minimum threshold of public

Box P.1 Universal Health Coverage

UHC means that all people and communities can use the promotive, preventive, curative, rehabilitative, and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose them to financial hardship. There are three policy dimensions of UHC, namely, who is covered, for what services, and for how much? Health financing predominantly concerns itself both with the question of volumes (“how much”), and the question of composition (how financing structures should be organized in order to best achieve UHC or other health goals). This includes looking at three separate issues: how and what financial resources are mobilized; how these resources are pooled to ensure equity and efficiency objectives; and whether these resources are used strategically to purchase health services or commodities.⁷

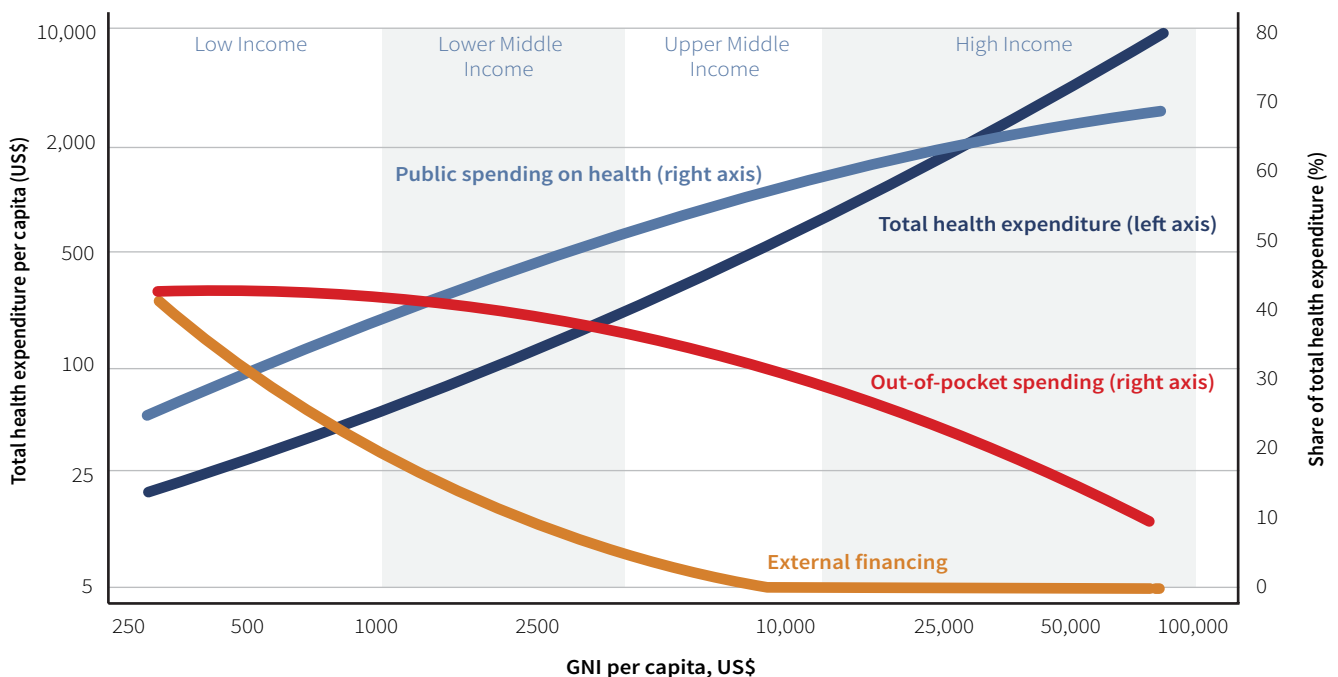
a WHO SHA2011 and the WHO Global Health Expenditure Database (GHED) defines public funds for health as General Government Health Expenditure (GGHE; GHED categories FS1,2,3), which includes expenditure using: general domestic government revenue including internal transfers, grants, subsidies, and transfers on behalf of specific groups (FS1), external revenues from foreign governments that flow through the public system (FS2), and funds created from social insurance contributions in the form of prepayment or premiums from employers, employees and the self-employed; but not co-pays from individuals (FS3). Domestic General Government Health Expenditure (GGHE-D) includes expenditures using funds from FS1 and 3 (domestic public) and thus includes all public excluding external resources. Thus where this guide refers to expenditure using ‘public funds’ it includes FS1, FS2, and FS3. When it refers to ‘domestic public’ it includes just FS1 and FS3. However where it references ‘domestic government’ it is meant to refer to general domestic government revenue (FS1).

funding for achieving UHC.^b In 2015, the Addis Ababa Agenda for Action stressed the mobilization and effective use of domestic funds, and more recently, the 2019 G20 Finance Ministers and Central Bank Governors both identified public funds for UHC in developing countries as a priority in support of “high-performance health financing (HPHF)”, and stresses the critical importance of how funds flow to achieve UHC targets and broader economic gains.^c

Many countries are able to make progress toward UHC with variable levels of spending, while still ensuring that it is high-performing: adequate, sustainable; sufficient, efficient, and equitable. For instance, Thailand’s public spending on health was at 2.2 percent of GDP when its UHC scheme was introduced in 2004, and increased to 4 percent by 2016.⁶ In 2011, a set of 24 countries that implemented pro-poor UHC programs spent an average of US\$39 in per capita health expenditure, or 1.4 percent of GDP per capita.⁸ What was common to these countries was that they began with a pro-poor approach aimed at ensuring access and thus reduced financial hardship for their populations. These countries also funded expansion of services to the poor using a non-contributory, tax-financed system, with financing linked to outputs and not historical budgets or other input-based funding streams.⁸

Determining how domestic health resources can be secured in a way that helps ensure that health financing is high performing is critical for achieving UHC and other goals, including economic growth, human capital improvements, and protection from economic and epidemiological shocks.² This becomes even more relevant as economies stagnate or contract whilst the health needs of their populations have intensified forcing difficult prioritization choices to be made.

Figure P.1 Health Financing Transition¹⁸



Source: Authors’ estimates using data from WHO Global Health Expenditure Database (2020)

- b The report set this threshold as it identified that few countries had been able to approach UHC where health spending from general revenues and compulsory insurance were less than 5 percent to 6 percent of GDP, as it was otherwise difficult to adequately subsidize the poor.
- c High-performance health financing for UHC includes funding that is adequate and sustainable, pooling that is sufficient to spread the financial risks of ill-health, and spending which is both efficient and equitable to assure the desired levels of service coverage, quality, and financial protection for all people. An additional critical attribute is that the system regularly reassesses progress and risk and adjusts to challenges, while recognizing that financial and capacity constraints differ across countries.

Making the case for health financing

Choices around public resource mobilization are determined by finance decision-makers who must juggle multiple fiscal objectives such as revenue raising and resource allocation across competing and interacting priorities. They must also create an enabling environment that supports efficient and strategic purchasing as well as monitoring of expenditure to ensure equity, financial protection, and poverty reduction, all while assuring sustainable growth and economic stability.

There is a growing realization of the need for a stronger dialogue between sectors to frame requests for resources in a way that resonates with finance decision-makers, and takes their priorities into account. Beyond finance decision-makers, the political economy of health financing encompasses communities, civil society, and academics, as well as executive and legislative-level actors like Presidents, Prime Ministers, and parliamentarians who have unique roles to play in impacting the level of investment for health. However, these actors may not all see the political salience of investing in health, making it critical that health actors connect within a shared vantage point.

Engaged officials will respond to both technical and political arguments to support domestic investments in health, especially when the arguments are framed around economic interests.^{9,10} Traditionally, health sector actors have relied on making arguments about the benefits of investing in health from a human rights and health outcomes perspective (Box P.2). While human rights and health outcome arguments are critical, they may not resonate with finance decision-makers, who expect arguments focused on an economic rationale—such as economic growth, productivity, and human capital—for using domestic government revenue as the primary source for funding health care.

In increasingly constrained fiscal environments, the health sector must also still compete with other government sectors such as education and defense to demonstrate better value and ensure that resources are put to the best use, in a way that reflects broader social priorities and given the constraints.

Additionally, the health sector may sometimes put forward well-intentioned suggestions on revenue raising; but in the absence of a deeper understanding of tax policy and existing government revenue mobilization efforts, such suggestions may not conform to accepted best public finance practice, the country's macroeconomic management framework, the realities of established public financial management (PFM) systems, or well-accepted revenue raising principles.

Finance decision-makers may well understand the merits of investing in health but must also seek to minimize inefficiencies in the health sector. Such inefficiencies, whether real or perceived, raise the question of whether the health sector is able to effectively absorb additional resources for health. It is therefore critical that health actors know inefficiencies in the health sector and anticipate how to communicate these issues effectively with

Box P.2. Health as a right: an effective argument for investing in health?

The Universal Declaration of Human Rights established health as a human right nearly 60 years ago.¹⁵ It has been followed by other commitments, including The UN General Assembly's commitment (2015) to Universal Health Coverage. Today more than 70 percent of the world's constitutions have a provision addressing health, including many countries with limited resources or difficult decision making contexts.¹⁶ A statement on health as a right within a constitution represents a policy imperative and formal commitment which can motivate future legislative and administrative actions and help justify additional resources, though these can also 'judicialize' health sector allocation decisions.¹⁶ However, guaranteeing this right may precede a country's capacity to finance and deliver upon it. In some cases, health as a human right has been used to effectively instigate government investment and action. Though stakeholders may broadly agree on health as a policy and budget priority, more nuanced arguments are still necessary to ensure sustained investment.

finance decision-makers. Otherwise, the health sector may unintentionally lose its opportunity to make the case for more resources or worse, reduce its credibility, in spite of all good intentions and worthy goals.

Stronger, more economically grounded arguments for increased funding for health can, therefore, be helpful in making the case for investing in health. Recent global efforts have helped to establish useful ground to build upon. High level and joint efforts between finance and health stakeholders, including the G20 HPHF framework and the Human Capital Project, have helped build arguments that emphasize the connection between health, UHC and sustainable and inclusive economic growth and can be used as a framework to orient messaging.

What does this Guide do?

Making the Case for Health is a compilation of messages and related practical country examples that build off of the concept of HPHF, integrate human capital concepts, and can be used to facilitate communication across health and finance sectors to make the case for investment in health as a way to achieve health sector objectives, including Universal Health Coverage goals. This work is not intended to be an advocacy tool to be used to make general or over-stated arguments around more money for health. Rather, it expands the finance lexicon of health actors, articulating how to frame rationales for investing in health by couching arguments and related health and health financing functions in terms of fiscal space for health and underlying economic principles that more effectively resonate with finance sector actors.

Who is this Guide for?

The primary audience for this Guide are Ministry of Health officials who are engaged in dialogue with finance decision-makers, including parliamentarians and other high-level finance actors, and are seeking to more appropriately frame their evidence and rationale for investing in health for these counterparts. The Guide has benefitted from the joint participation of health and finance policy makers from Joint Learning Network (JLN) countries in distilling and refining these messages in a way that they help bridge the communication gap.

What is the scope of this Guide?

Framed as a messaging and communication tool, this Guide tries to retain simplicity and brevity. It does not provide detailed analytical advice on how to most convincingly use data to make the case for investing in health, nor aim to provide a primer on principles of strategic communications. Other knowledge products are already available from the JLN to meet these additional needs.^d As a quick-reckoner of select essential concepts, this Guide provides links to existing resources and information that allow the reader to go deeper where there is a need, and to compile country-specific evidence to support the messages.

The Guide also does not try to quote the vast body of literature that deals with the implementation issues around health financing and UHC. However, it recognizes that process and evidence-based rationale matters, as also political economy considerations.¹¹ In many cases, the way that health decisions are made often has little to do with presenting the ‘right’ data, evidence or arguments—and may be constrained by data access in the first place. These decisions may also be limited by other contextual or political factors that present barriers to action. As such, the Guide acknowledges that these factors are a critical part of the bigger picture, recognizes them in its framework, and calls for other work that will flesh out step-by-step cases or examples of how effective DRM decisions were made and the factors that ultimately facilitated decision-making.

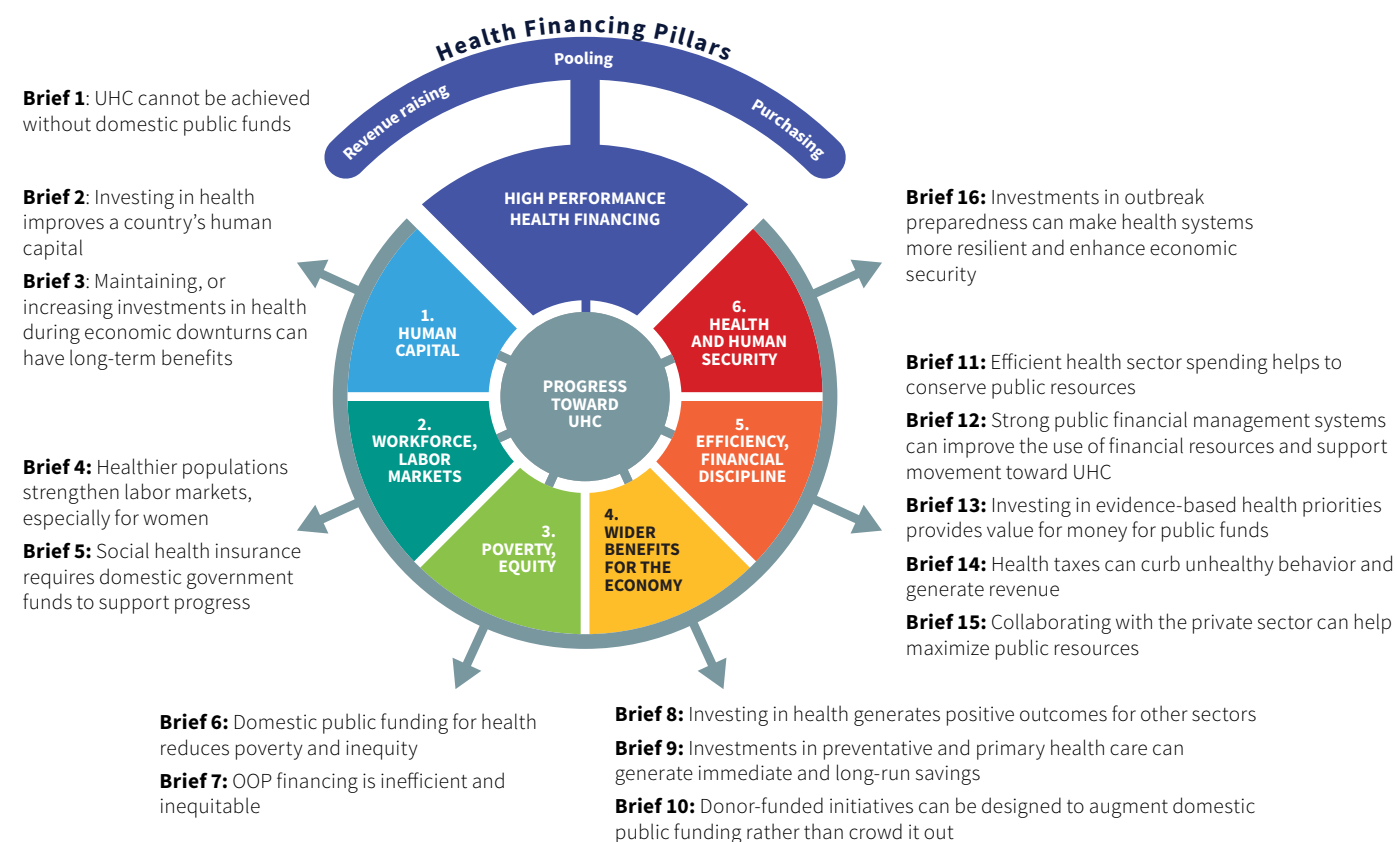
^d See page 5 of this guide for list of DRM Collaborative products as well as Strategic Communications for UHC Guide and Planning Tool: <https://www.jointlearningnetwork.org/type/strategic-communications-for-uhc/>

Conceptual Framework

Many frameworks have been put forward to examine the links between health financing, health systems, political economy and higher-level UHC and health objectives.¹²⁻¹⁴ Rather than start from scratch, this Messaging Guide builds upon work already done to combine these concepts and link them to broader economic and social objectives through the G20 Finance Ministers’ High-Performance Health Financing for UHC framework. This framework focuses attention on the relationship between the three health financing pillars—revenue raising, pooling, and purchasing via the concept of HPHF—and draws additionally from the concept of Domestic Resource Use and Mobilization (DRUM), which aims to maximize fiscal space or the room to invest in the health sector through a balance between domestic resource mobilization and efficiency gains.^e

How countries finance their health systems matters. However, effective health financing, which entails the mobilization, pooling, and allocation of financial resources, is of course only one component of an effective health system. But effective health financing is a critical enabler that allows other resources—humans, infrastructure, medicines and supplies—to be provided in support of service delivery, impacting directly on population health outcomes, and human welfare, and with other spill over benefits for the economy. HPHF ensures that the resources being used to finance UHC are adequate and sustainable, sufficient to spread risk, as well as efficient and equitable, but in doing so also promotes UHC and wider economic gains through six pathways (Figure P.2)¹⁵:

Figure P.2 Messaging Guide Briefs Within the HPHF Framework



^e The five pillars upholding fiscal space for health are: conducive macroeconomic conditions, reprioritization of health within the government budget, health sector-specific resources, efficiency in existing health expenditure, and health sector-specific grants and external aid.

What do the HPHF components mean?

- 1. Human capital.** Improving health drives gains in human capital—the sum of a person’s health, education, capabilities and skills—which in turn improves productivity over a lifetime.
- 2. Workforce and labor markets.** Better health builds up a more productive, more innovative labor workforce with greater labor mobility and increased rates of labor market formalization.
- 3. Poverty and equity.** By improving health service coverage and financial protection, UHC has the potential to reduce poverty and income inequalities.
- 4. Wider benefits to the economy.** UHC reduces the need for precautionary savings for health emergencies and strengthens countries’ market competitiveness through human capital and efficiency gains.
- 5. Efficiency, financial discipline.** Progressively expanding access to and quality of care and financial protection while controlling costs and improving revenue generation positively support a country’s overall fiscal outlook.
- 6. Health and human security.** Better preparedness and capacity to respond to outbreaks, strengthen human security through more socially cohesive, equitable societies.

How is this Guide structured?

This Guide is organized around a set of 16 messages aligned to these six pathways, that draw on key health financing principles and functions. Each message is succinct in order to zero in on critical concepts. Simple and clear language has been used in order to make it easier to apply and adapt the presented information to local contexts. Formative literature has been drawn on to craft each message and is highlighted in the references that can be of help for a deeper dive into the concepts, as needed.

Each brief includes a box “From Principles to Practice” that lays out applied examples of concepts within the brief or refers readers to key additional references. Examples of principles in practice draw from low- and middle-income country experience; however, there is a dominance of examples from middle-income countries, where there are significant contextual differences in terms of the health financing and governance landscape. The Joint Learning Network will continue to work with members to identify and document more examples of principles in practice and use this information to update the Messaging Guide.

Each message is intended to stand alone so that readers may read and use individual messages as they need. Therefore, concepts within each brief may overlap with others. Throughout the Guide, briefs are cross-referenced to help the reader connect ideas, and refer to complementary briefs to expand their understanding.

Summary of key messages

Brief 1. Universal Health Coverage cannot be achieved without domestic public funds

- Domestic public sources can finance Universal Health Coverage (UHC) in a way that is adequate, sustainable, efficient and equitable
- While domestic public spending is critical to achieving UHC, there is no right number for exactly how much countries should spend on health
- Identifying diverse pathways to increase domestic government resources for health is critical for achieving UHC

Brief 2. Investing in health improves a country's human capital

- Health and education are the cornerstones of human capital
- Investments in health profoundly impact growth in human capital and productivity over time
- Improved health of a population drives demographic changes over time that translate into human capital gains
- Better health in early childhood establishes the foundation for later human capital gains
- Improving health of school-age children can support educational achievement, and gains in human capital
- Human capital gains among adults translate into increased productivity through labor market opportunities
- Human capital investments may not manifest equitably across genders and socioeconomic levels.

Brief 3. Maintaining or increasing investments in health during economic downturns can have long-term fiscal benefits

- During periods of economic stability, establishing adequate allocations for health within the national budget can safeguard domestic public health funding from future economic shocks
- During economic downturns, investments in health should be sustained to avoid the emergence of more costly health conditions
- Increasing investments in health and broader social welfare programs during periods of economic decline can insulate populations from losses in human capital and productivity

Brief 4. Healthier populations strengthen labor markets, especially for women

- Improving child and maternal health can have a profound impact on female workforce participation
- Universal health coverage protects the health and productivity of female workers in the informal sector, who lack access to protections from employment-based social health insurance schemes
- Investments in health can have a multiplier effect on the health workforce, which is disproportionately female

Brief 5. Social health insurance requires domestic government funds to support progress toward Universal Health Coverage

- Public insurance works best when the majority of funds come from domestic government resources, and when entitlement is delinked from ability to pay
- Payroll taxes including social health insurance (SHI) can reduce the rate of labor market formalization by raising costs of labor
- Establishing SHI can be associated with implementation and uptake challenges
- Collecting contributions from the informal sector can be difficult due to issues including identification, administration and enforcement

Brief 6. Domestic public funding for health reduces poverty and inequity

- Domestic public funding is not always spent on those most in need
- The proportion of people impoverished by health spending makes up a growing share of the global poor
- Domestic public finance can help delink service use with ability to pay
- Domestic public funding for health care can contribute to reductions in poverty
- Targeting priority populations with domestic public funds can deepen impact and protect populations

Brief 7. Out-of-pocket financing is inefficient and inequitable

- Out-of-pocket (OOP) financing is inefficient because it limits the ability to set fair prices, does not allow for risk pooling, and can constrain purchasing
- OOP financing is inequitable because it impacts the poor disproportionately.
- Economic growth can catalyze a health financing transition, reducing reliance on OOP financing and contributing to a virtuous circle that propels gains in human capital
- Until sufficient growth or reprioritization can be realized, moving from OOP payments and user fees in particular must be supported by complementary policy actions

Brief 8. Investing in health generates positive outcomes for other sectors

- Health is a key determinant of a productive labor force, especially within industries relying on physical labor
- Improved health enables more people to enter into work and contribute for longer
- Better health of children and elderly populations enables more working-age people to participate in the workforce

Brief 9. Investments in preventative and primary health care can generate immediate and long-run savings

- Improved coverage of primary health care services is associated with reduction in all-cause mortality, which can contribute to substantial economic gains
- High-quality primary health care (PHC) systems can create efficiencies by preventing future costs
- Primary health care promotes equitable access to health care, which can reduce welfare loss
- Allocating or reallocating domestic public resources toward PHC is both technically and politically challenging, but is critical to ensuring progress toward UHC

Brief 10. Donor-funded initiatives can be designed to augment domestic public funding rather than crowd it out

- Few donors direct funding toward health system strengthening, which can further spur fragmentation and verticalization
- Donor funds that are well aligned to country processes and priorities can achieve greater value for money and help public resources go further
- Transition represents an opportunity to proactively plan for domestic resource use to be more efficient and sustainable
- Practices that support transparency and control over resource flows and the use of financial incentives can help maximize public resources

Brief 11. Efficient health sector spending helps to conserve public resources

- There is not always a direct relationship between what is spent on health and what benefits (health or otherwise) accrue at the country level
- Unavoidable market failures that are unique to the health sector drive inefficiency and require government intervention
- Tackling the top causes of inefficiency can help the health sector do more with what it has

- Creating an enabling environment for health financing reforms, particularly those focused on purchasing, can help change the way these inputs are used
- Some actions to improve efficiency are in the purview of the health sector alone

Brief 12: Strong public financial management systems improve the use of financial resources and support movement toward Universal Health Coverage

- Strengthening the link between budget formulation and evidence-based policy priorities enhances effectiveness and efficiency
- During budget execution, flexibility to purchase and procure through changes to Public Financial Management (PFM) rules allows the health sector to make smart choices
- Improving the linkage between how health resources are monitored and how they are allocated can increase accountability and transparency, minimizing resource loss
- Ultimately, PFM systems that are well aligned with health financing goals can help improve health outcomes

Brief 13: Investing in evidence-based health priorities provides value for money for public funds

- A central requirement for an efficient health system is that the services being purchased are prioritized and aligned with available financial resources
- Many health sector investments have been shown to be highly cost-effective
- The evidence-driven process of Health Technology Assessments (HTAs) can inform development of Health Benefit Packages (HBPs) that make best use of public funds
- It is critical that HTAs consider evidence of cost-effectiveness alongside financial protection criteria, and consult local sources of evidence
- Quantifying the value of investing in health against investments in other sectors can support budget proposals that maximize value and welfare to society

Brief 14. Health taxes can curb unhealthy behavior and generate revenue

- Health taxes can curb unhealthy behaviors considered as risk factors for COVID-19 morbidity and mortality, and reduce future burden on the health sector
- Health taxes raise revenue, which may be prioritized for the health sector
- Some negative claims made against health taxes have been largely refuted
- Where standard budget processes fail to prioritize health, health taxes may be subject to cautious soft earmarking, and can promote pro-poor objectives

Brief 15: Collaborating with the private sector can help maximize public resources

- Engaging the private sector through health public-private partnerships (PPPs) can help public resources go further.
- Private sector actors can be engaged through contracting arrangements that extend service coverage, helping to maximize existing public resources.
- Governments can move toward Universal Health Coverage by engaging the private sector, but must establish a supportive governance and regulatory environment

Brief 16. Investing in outbreak preparedness can make health systems more resilient and enhance economic security

- The COVID-19 pandemic has demonstrated the massive economic damage and development backslide that can result from poor preparedness
- Investing in preparedness averts larger future health care costs
- Many countries lack the resources to prepare, especially as they balance investments needed to control COVID-19 against other health needs, and restart their economies

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Brief 1.

Universal Health Coverage cannot be achieved without domestic public funds

Domestic public finance is essential for making progress toward Universal Health Coverage (UHC).¹ However, not all public funds are domestic: public finance refers to all government health related expenditures (national and subnational), including on-budget external aid, as well prepayment collected by social health insurance agencies where they exist, but does not include co-pays levied on individuals.^{1, 2, a} No country has been able to make progress toward Universal Health Coverage (UHC) without relying on domestic government funds, the component of public funds that comes from general government revenue like taxes. Government revenues are the dominant source of financing in low- and middle-income countries (LMICs) that have implemented successful UHC programs.³ While there is no right number for exactly how much countries should spend on health,⁴ how various public funds comes together and are used is what matters most in the movement toward UHC. The concept of high-performance health financing for UHC emphasizes that resources must be adequate and sustainable, pooling sufficient to spread the financial risks of ill-health, and spending is efficient and equitable to assure desired levels and quality of coverage.^{5, 6} In this way, progress toward UHC can support other pathways that influence economic growth including improved human capital, stronger labor markets, reduced poverty, and enhanced equity, human security, and efficiency.⁵ Identifying diverse ways to increase public resources for health, with a focus on raising domestic government revenue, is the best way to achieve these objectives.

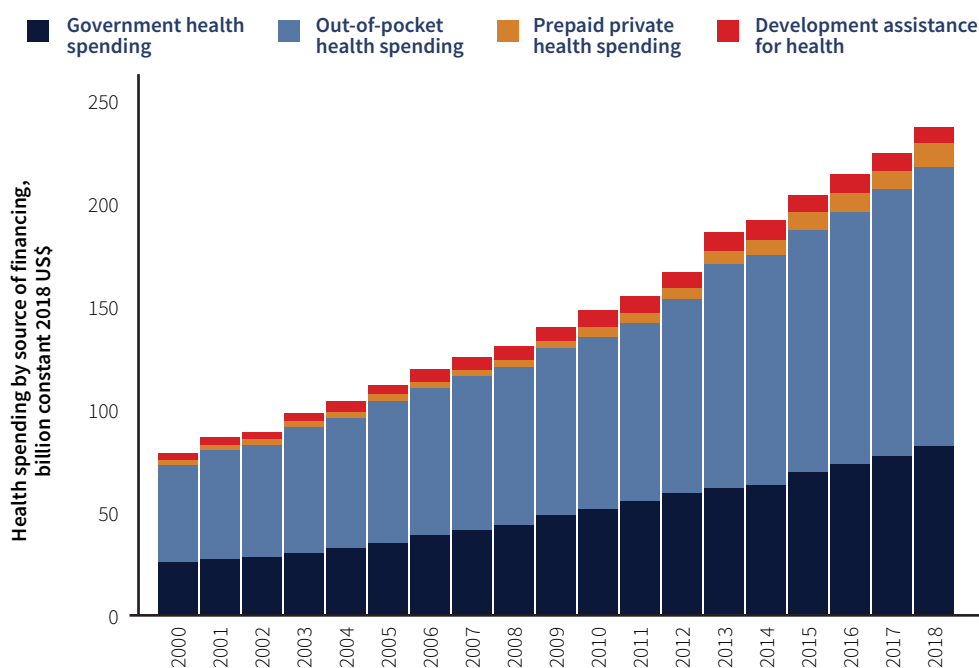
Domestic public sources can finance UHC in way that is adequate, sustainable, efficient and equitable. The economic rationale for public intervention in the health sector is strong and based on equity considerations, externalities, and market failures (refer to Brief 11).^b Private financing mechanisms like point of care out-of-pocket (OOP) spending play a major role in financing health systems (Figure

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- a WHO SHA2011 and the WHO Global Health Expenditure Database (GHED) defines public funds for health as General Government Health Expenditure (GGHE; GHED categories FS1,2,3), which includes expenditure using: general domestic government revenue including internal transfers, grants, subsidies, and transfers on behalf of specific groups (FS1), external revenues from foreign governments that flow through the public system (FS2), and funds created from social insurance contributions in the form of prepayment or premiums from employers, employees and the self-employed; but not co-pays from individuals (FS3). Domestic General Government Health Expenditure (GGHE-D) includes expenditures using funds from FS1 and 3 (domestic public) and thus includes all public excluding external resources. Thus where this guide refers to expenditure using 'public funds' it includes FS1, FS2, and FS3. When it refers to 'domestic public' it includes just FS1 and FS3. However where it references 'domestic government' it is meant to refer to general domestic government revenue (FS1).
- b Such characteristics may include: (1) information asymmetries, where providers have more information than patients, which creates opportunity for exploitation; (2) adverse selection, where insurers might for example selectively enrol low-risk individuals while high-risk individuals seek out more expensive, generous health insurance; (3) moral hazard, where coverage may incentivize higher costs and increased use of marginally beneficial services; (4) unpredictability in the services and volume of services needed, making it difficult to moderate a supply stream based on consumer demand.

1.1), but cannot adequately or sustainably finance UHC (refer to Brief 15). Relatively low levels of public spending for health in LMICs leads to individuals needing to finance their own care, and thus higher levels of OOP spending^{7,8,9}—contributing to inefficiency as a result of fragmented pooling, as well as inequitable access based on ability to pay, forgone care, and increased risk of catastrophic health expenditures among vulnerable populations—which can drive poverty and reduce individuals ability to participate in the economy (refer to Brief 7).¹⁰ Voluntary health insurance (VHI) schemes, including those publicly funded or managed, play a marginal role in generating revenue for health, rarely exceeding 5 percent of total health expenditure in LMICs.^{3, 11, 12} Levels of external assistance for health are not only stagnating, but can be unpredictable and tied to external political priorities and global economic conditions (refer to Brief 10).⁷ Domestic public sources are the most predictable and stable source of financing, enabling more efficient utilization of funds.¹³

While domestic public spending is critical to achieving UHC, there is no right number for exactly how much countries should spend on health.¹⁴ There are numerous global and regional commitments involving domestic public funds^{c,d} including targets for how much governments should spend per person on health.^{e, 15, 16–21} One scenario demonstrates that 85 percent of resources needed to meet SDG targets can be met with domestic resources.²² However, how much countries should and do spend is influenced by

Figure 1.1 Health Spending by Source of Financing, lower- middle-income group total



Source: WHO Global Health Expenditure Database, (2020).

- c The 2001 Abuja commitment called on heads of African states to allocate 15 percent of their annual budget to the health sector, while the World Health Report 2010 proposed 4 percent to 5 percent of GDP as the threshold of public funding for achieving UHC. In 2015, the Addis Ababa Agenda for Action stressed the mobilization and effective use of domestic funds.
- d The 2019 G20 Finance Ministers and Central Bank Governors commitment identified public funds for UHC in developing countries as a priority in the support of “high-performance health financing” (HPHF).
- e See also Jowett et al. (2016) for summary of efforts from 1980-2014. The 2001 Commission on Macroeconomics and Health and the 2009 High Level Task Force on Innovative International Financing for Health Systems estimated the per capita requirements by 2015 as US\$38 (in 2002 dollars) and US\$54 (in 2005 dollars) respectively. McIntyre et al. (2017) use the US\$54 per capita figure expressed in 2012 dollar terms, which translates to US\$86 per capita. This figure is selected given the comprehensiveness of the underlying assumptions, as cost of medicines, staff and other strengthening efforts at the PHC level are included as well as a comprehensive set of PHC services. The 2017 Global Price Tag study estimates an additional US\$274 billion would be needed per year by 2030, with an ambitious scenario estimating US\$371 billion, translating to an additional US\$41 or US\$58 per person by the final years of scale up.¹⁸ 2019 IMF estimates show additional spending in 2030 of US\$5 trillion for low-income economies and US\$2.1 trillion for emerging economies.²⁰

many factors, including the efficiency of the health system, flexibility and alignment of the public finance system to health sector goals, and political desire to reach the poor.²³ Some countries are able to make progress toward UHC without spending at target levels, but there is a wide variation in UHC performance relative to public spending when spending levels are low, with variation driven by differences in how much is spent and what services are delivered (Box 1.1).^{14, 26} In 2011, health expenditure in 24 countries that implemented UHC programs averaged US\$39 per person, or equivalent to 1.4 percent of GDP.²⁴ These countries all began with a pro-poor approach aimed at ensuring access and reduced financial hardship for their populations. They also funded expansion to the poor using a non-contributory, tax-financed system, with incremental, complementary program financing linked to outputs rather than historical budgets or other input-based funding streams. In spite of these examples of good health outcomes with low cost, greater domestic government investment in health is still needed to mitigate issues with efficiency, equity, and financial protection caused by a high proportion of OOP.²⁵

Identifying diverse pathways to increase domestic government resources for health is critical for achieving UHC. As countries' economies grow, they are in a position to raise and allocate more domestic government resources for the health sector. As this spending increases, countries become less reliant on external aid and private financing. Given the current fiscal context it is necessary to identify alternate channels to increase domestic government resources for health. Key strategies include improving resource mobilization through health taxes (refer to Brief 10) and improving how existing funds are prioritized, allocated, and used. This may be achieved by examining PFM mechanisms that improve purchasing or pooling to determine the extent to which they can contribute to UHC (refer to Brief 13).¹⁰ It may also be achieved by examining how prioritization can help to redirect funds to support UHC goals: often domestic public funds are channelled to nondiscretionary health spending and higher-end care rather than for services that promote equity and financial protection.⁸

Box 1.1 From Principles to Practice.

Country Experience: Cambodia and Cameroon

Similar levels of public spending on health in Cambodia and Cameroon, but variation in UHC performance reflect the influence of how funds are allocated and spent. In a 2016 analysis,²³ Cambodia and Cameroon were identified as two countries with similarly low levels of public spending on health in 2016 (approximately PPP\$41 in 2016), and good, but significantly different performance on UHC outcomes. In particular, Cambodia performed significantly better on all UHC service coverage indicators (however, both countries performed poorly in terms of financial protection, due to low absolute levels of health spending). Though Cameroon allocated more government resources to health than Cambodia, Cambodia's introduction of performance-based incentive payments to midwives and the use of vouchers to promote maternity care may explain differences in UHC performance at the same level of public spending. Cameroon had introduced programme-based budgeting in 2013, but at the time of analysis, budget execution was low and there was poor allocation of resources in the health sector.⁴

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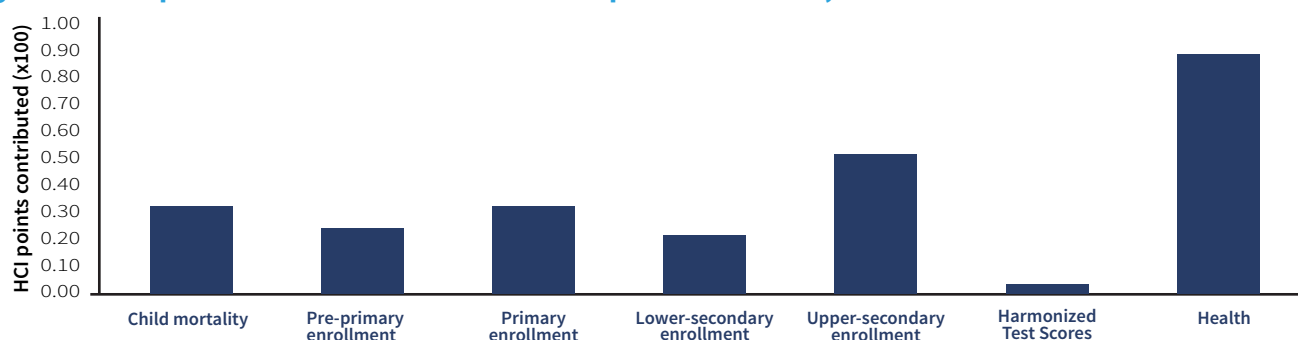
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Brief 2. Investing in health improves a country’s human capital

Human capital consists of the knowledge, skills and health that people accumulate over their lives, enabling them to realize their potential as productive members of society.^{1,2} Investments in human capital complement investments in physical, natural, or other types of capital that can be used to advance both national and global economies.³ In countries like South Korea, upfront investments in human capital have proven to be a major ingredient for sustained growth acceleration.⁴ Greater human capital is associated with higher individual earnings and higher income for countries, and is a driver of sustainable growth.⁵ Investing in both health and education across the life cycle—from infancy through early childhood and into adulthood—promotes the accumulation of human capital which translates into future gains in productivity. As such, health is an important component of human capital.

Health and education are the cornerstones of human capital. Human capital can be measured through the Human Capital Index (HCI),^a which captures the amount of human capital that a child born today would have by the age of 18 given the current status of health and education in each country (see Box 2.1). The HCI is based on three components: child survival, education and health. More than half of the gains in human capital between 2010 and 2020 have been due to improvements in child survival, stunting, and adult survival (Figure 2.1).⁵ Improved survival and health status achieved through investments in health help to optimize investments in the education sector, ensuring that children are better equipped to learn. Together health and education in childhood create a stronger workforce leading to improved productivity over time.

Figure 2.1 Component Contributions to Human Capital Index Gains, 2010-20



Source: *The Human Capital Index 2020 Update: Human Capital in the Time of COVID-19*,³ with World Bank data.

a The Human Capital Index (HCI) is complementary to UNDP’s Human Development Index, which is a summary measure of human development reflecting healthy life, education, and decent standard of living. HCI is also a summary measure of human development which reflects healthy life and education, but which additionally captures productivity and income levels to support an economic argument for investing in people.²⁴

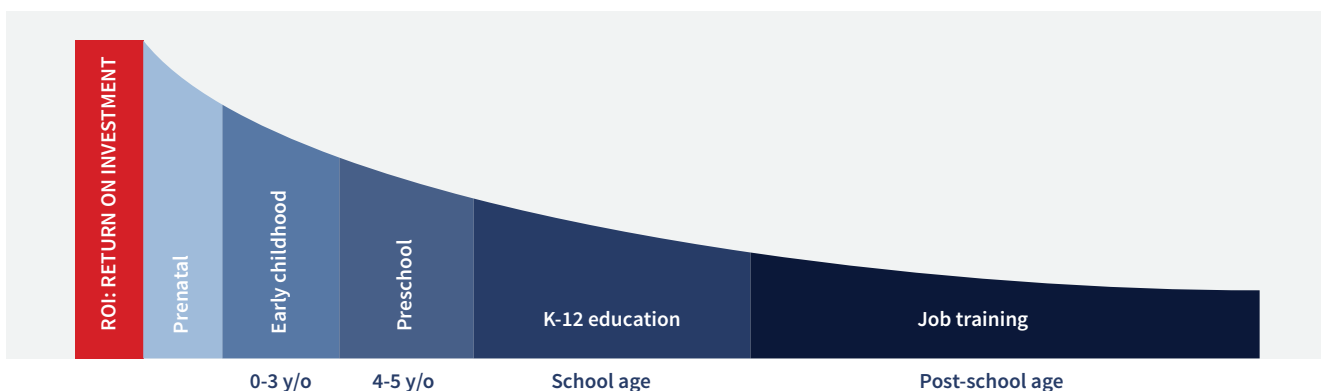
Investments in human capital can also build social capital that comprises shared norms, values, and understandings that facilitate cooperation within or among groups, thus contributing to economic growth.^{2,6} Social capital emerges from human capital investments across health and education, as better health fosters the cognitive and socio-behavioral skills which promote educational attainment and the development of civic skills needed for social capital development.²

Investments in health profoundly impact growth in human capital and productivity over time. Human capital investments, including those in the health sector, can take longer to materialize than investments in physical capital, such as bridges and roads. The impact of health on human capital is substantial but takes longer to manifest, compared to the immediate impact of better health on current workforce productivity (refer to Brief 4). Budget makers often want quick returns on investments or must direct resources to immediate material needs, which can contribute to underinvestment in the health sector and missed opportunities for human capital gains and future economic growth by way of improved health.⁷ Human capital accumulates and compounds over the long-term, meaning that small differences in the short-term translate into enormous future gaps. Individual returns in human capital add up to big benefits for economies through positive societal spillovers.² If the rates of human capital investment observed in high-performing countries were to be achieved in each of the other countries around the world, global GDP would be 12 percent higher by 2050 – with most gains concentrated in low income countries.⁸

Improved health of a population drives demographic changes over time that translate into human capital gains. Investments that lower child mortality, and in turn contribute to lowered fertility rates, can lead to improvements in human capital through a “demographic dividend.” The demographic dividend is where health and social policies, if put in place at the right time, harness changes in the population age structure, and produce economic benefits. In South Korea, Hong Kong, and Singapore, health-driven demographic changes were coupled with investments in family planning, education, and economic policies to strengthen the labor market and achieve a demographic dividend.¹³

Better health in early childhood establishes the foundation for later human capital gains. Early childhood development directly influences economic, health and social outcomes for individuals and society. Adverse early environments create deficits in skills and abilities that drive down productivity and increase social costs—thereby adding to financial deficits borne by the public. A critical time to shape productivity is from birth to age five, when the brain develops rapidly to build the foundation of cognitive and character skills necessary for success in school, health, career and life. Early childhood education fosters cognitive skills along with attentiveness, motivation, self-control and sociability—the character skills that turn knowledge into know-how and people into productive citizens (Figure 2.2). Fundamentally, reductions in child mortality create opportunities for human capital gains in more young children over their full lifetime. Beyond survival, better health in early childhood ensures that children can become

Figure 2.2. The Heckman Curve: Economic Impact of Investing in Early Childhood Learning^b



^b Figure downloaded from the Heckman Equation Website on 04/20/21: <https://heckmanequation.org/resource/the-heckman-curve/>

stronger learners when they reach school age by supporting the development of their cognitive skills. Child stunting, which occurs before the age of two due to poor nutrition, repeated infections, and inadequate psychosocial stimulation—has irreversible negative impacts on cognitive and physical development.⁹⁻¹¹ Stunting can prevent children from reaching their full potential in school and during adulthood, and has been shown to translate to lower productivity and lower pay in the workplace.¹²

Improving health of school-age children can support educational achievement, and ultimately human capital. Beyond early childhood, school participation and a child’s ability to learn and accrue human capital is largely determined by health.^{14,16} Ill health affects a child’s ability to learn while in school, and can cause excessive absences, leading to poor performance and increased dropout rates.¹⁵ Nutritional interventions are particularly powerful in supporting education, as maternal and childhood undernutrition have been found to be strongly associated with less schooling.¹⁵ In China, an intervention targeting anemia in rural elementary school students found that mathematical test scores increased when students were provided better in-school nutrition.¹⁶ In turn, childhood education improves economic productivity later in life: an analysis in 146 countries from 1950 to 2010 estimated rates of return for an additional year of schooling ranging from 5 percent to 12 percent.¹⁷ The benefits of human capital also transcend private returns; gains for one individual extend to others, and across generations.² For example, investments in maternal health support better infant and child health through increased ability to care for offspring.

Human capital gains among adults translate into increased productivity through labor market opportunities.⁵ People who have experienced better health in childhood develop stronger cognitive and socioemotional skills,^c and are able to take better advantage of opportunities in school and in professional training.^{1, 18-21} Economies are increasingly driven by industries that demand teamwork, flexibility, and innovation, as well as the increased use of technology and automation.^{2, 21} These industrial demands require workers that have greater cognitive and socioemotional skills, especially in professions like health care, information technology (IT), and engineering. In addition, as more than two-thirds of jobs, largely unskilled, in LMICs can be automated, retraining and career services for workers will be necessary to avoid unemployment.¹⁸ Importantly, when access to health care is not linked to employment, workers are more free to change jobs in response to opportunities (refer to Brief 7).^{22,23} Individuals often cannot afford to invest in, or do not prioritize, human capital development for themselves and their families. In light of the enormous positive, long-term economic and societal impact of human capital gains, governments have a critical role in making these investments on a large scale.²

Human capital investments may not manifest equitably across genders and socioeconomic levels. Importantly, human capital gains do not equitably manifest by sex: girls do well or slightly better than boys in terms of educational attainment and performance; however, they face unique barriers to utilizing their human capital such as child marriage, early childbearing, gender-based violence, and other barriers to female social and economic participation (refer to Brief 4).²⁴ To ensure that girls can realize the economic gains of human capital investments, it is critical for countries to address structural barriers that impede female participation in the labor workforce.⁵ Human capital is also not evenly distributed by socioeconomic group; substantial socioeconomic gaps in human capital outcomes exist within countries.²⁴

Box 2.1 From Principles to Practice. **The Human Capital Index**

To obtain country-specific and regional HCI and related indicators (such as under-five survival, childhood stunting, and expected years of quality-adjusted schooling), users may access the [Human Capital Index \(HCI\) database](#) through the World Bank.

c Cognitive skills are the aptitudes to perform mental tasks (for example, comprehension or reasoning), and socioemotional skills are personality traits, behaviors, attitudes, and beliefs (for example, conscientiousness and emotional stability).²⁶

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Brief 3.

Maintaining, or increasing investments in health during economic downturns can have long-term benefits

In times of economic downturn, continuing to invest in health is even more critical than in times of prosperity. While public resources are scarce during downturns, investing in people is more cost-effective than investing in physical capital as a means to achieve specified income or poverty goals.¹ Population health, especially for vulnerable populations in countries with volatile job markets and weak social protection systems, can be negatively impacted by economic decline, which can have both short- and long-term impacts on the health system and wider economy.² Prioritizing health within national budgets during periods of economic stability can help establish health systems that are more resilient to future shocks. When economic crises do occur, sustaining or even increasing domestic investments in health are needed.

During periods of economic stability, establishing adequate allocations for health within the national budget can safeguard domestic health funding from future economic shocks.^{3,4} Globally, public spending has increased since the early 2000s relatively passively, and largely as a result of conducive macroeconomic conditions (for example, increasing gross domestic product (GDP), rising incomes) rather than as a result of reprioritization.^{5,6} Establishing adequate allocations for health within the national budget makes health systems more resilient to future economic shocks. Additionally, incremental resources from periods of economic growth can be used to increase allocations for health without reducing allocations to other sectors. An analysis of per capita public financing for health in real terms of 151 countries between 2000 and 2015 found that per capita public financing for health in low- and middle-income countries (LMICs) increased by 5 percent per year, especially in East Asia and Pacific Regions, with more than half of the increases observed globally due to economic growth.⁷ With the novel coronavirus (COVID-19) pandemic, public debt levels are expected to increase in LMICs to over 60 percent of GDP, and to 70 percent of GDP in high-income countries, which will significantly change this picture and make the efficient use of limited public resources even more imperative.^a

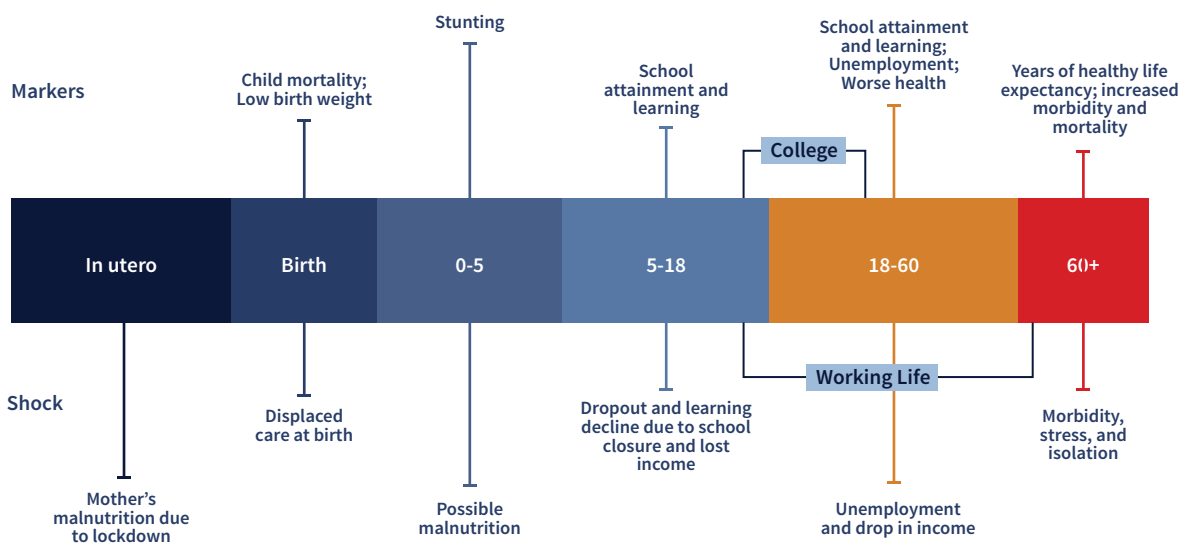
During economic downturns, investments in health should be sustained to avoid the emergence of more costly health conditions. Maintaining investments in health foundationally safeguards future economic growth by protecting against the emergence of more costly health conditions that lead to losses in human capital (refer to Brief 1). The COVID-19 pandemic has caused losses in income, disruption of health services and education, and worsened nutritional status of children, all of which threaten to roll back a

a Authors calculated these values using the latest data from the IMF World Economic Outlook

decade of gains in human capital (Figure 3.1).⁸ As a result, this backsliding can contribute to the emergence of more costly conditions, or the accumulation of other basic conditions that remained untreated as a result of service disruptions leading to pent up demand. For example, an analysis of the 2014-16 economic crisis in Brazil found that increases in unemployment during economic recession contributed to 30,000 additional deaths from mostly cancer and cardiovascular disease. The greatest increases in mortality were seen among populations that were already in poor health and who were more likely to be informally employed, have lower incomes, and be at higher risk of falling into poverty. The study also found that municipalities which maintained health and social protections had no unemployment-associated increases in mortality.¹ On the flip side, some research has shown that the savings from foregone care for most US states is greater than the cost of treating COVID-19 patients, benefiting margins for health insurance plans.⁹

Increasing investments in health and broader social welfare programs during periods of economic decline can insulate populations from losses in human capital and productivity. In previous economic downturns, some countries protected populations despite declining economic levels by increasing per capita spending on health and other social protections,^{9,10} whilst others decreased health spending in line with decreases in GDP.^{11,12} During the COVID-19 pandemic, many countries increased spending to fund the immediate health response triggered by the pandemic. However, it is hard to say if that funding will be maintained in the face of fiscal pressures over the next few years.¹⁰ During a recession, living conditions for individuals can deteriorate due to diminished household income,^{2, 13, 14} creating vulnerabilities for worsened health, especially due to reduced nutritional intake and forgone health care.¹⁵ Economic shocks have been found to negatively impact school enrollment, nutrition, and infant mortality rates in low- and middle-income countries,⁶ with spillover effects that are especially devastating for women working in the informal sector in LMICs.¹⁴ Large-scale health issues emerging from economic downturn can drive both present and future health care expenses and result in lost economic productivity (Box 3.1). Adequate public financing for health, as well as introduction of health and other social support programs (including lowered copayments, reimbursement of indirect health costs, sick leave benefits, income protection measures) can prevent losses in human capital by maintaining a productive and healthy population (refer to Brief 2). Further, shifting the basis for entitlement in health coverage from formal employment to residency is another strategic investment in UHC, improve coverage of services that are particularly vital for low-income households.^{10, 17, 18}

Figure 3.1 Impact of Economic Shocks on Health, Education, and Human Capital Across the Life Cycle



Source: *The Human Capital Index 2020 Update: Human Capital in the Time of COVID-19.*⁷

Box 3.1 From Principles to Practice.**Country Experience: Former Soviet Union**

In times of fiscal strain, continuing to invest in health can be even more important than in times of prosperity, especially for vulnerable populations. During the 1990s in the former Soviet republics, TB rates soared (following the economic crisis that resulted from the fall of the Soviet Union) due to a disruption in the health system and declining social and living conditions such as overcrowding, poor ventilation, poor nutritional status—factors which together were conducive to TB and drug-resistant TB. Without lengthy and very costly treatment, drug resistant TB is contagious, with high mortality. The enormous economic impact of TB and drug-resistant TB in the former Soviet Union persist today. In fact, multidrug-resistant TB incidence has markedly increased and continues to be exceptionally high. Though the lack of health resources in the 1990s that contributed to their onset was largely due to political unrest, it demonstrates that continuing to invest in health in times of economic downturn can avert such economic and health impacts.¹⁹

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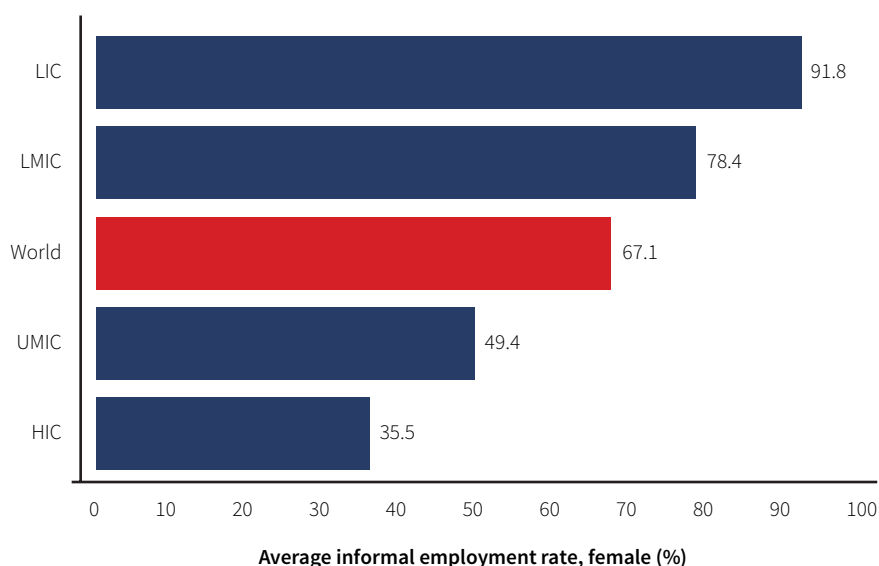
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Brief 4.

Healthier populations strengthen labor markets, especially for women

Women represent a growing proportion of the global workforce, making up to 37.7 percent of the labor market in low- and middle-income countries.¹ Most of these women work in the informal sector and are therefore excluded from employment-based health insurance schemes (Figure 4.1).^{2, 3} Women are also disproportionately responsible for unpaid care work, which impacts their ability to engage in labor markets.⁵ Healthier populations are more productive populations: universal health coverage positively impacts the ability of women to participate in the labor market by improving child and maternal health, and driving economic growth.⁴ If gender equality in the labor market increased in Africa, countries could gain between 1 percent (Senegal) and 50 percent (Niger) of GDP.⁶ Targeted investment in health issues facing women and children and general investment in the health sector can have positive impacts on gender equity in the labor market and the broader economy.

Figure 4.1 Average Female Informal Employment



Source: International Labour Organization, ILOSTAT database (2021).

Note: Number of countries included in the averages: LIC – 15; Lower middle income countries (LMIC) – 29; UMIC – 27; HIC – 7.

Improving child and maternal health can have a profound impact on female workforce participation.

Interventions addressing conditions that disproportionately affect females, like iron deficiency anemia, can result in major productivity gains. Multiple studies have found that iron supplementation of female agricultural workers results in significantly increased productivity.⁸ Health interventions benefiting girls also improve economic well-being. An evaluation of a mass deworming campaign in South Korea showed that infection could result in up to two years of lost schooling and a reduction of 5 percent in adult earnings, effects of which more profoundly affected females.⁸ Improving child and maternal health can also decrease fertility rates and time caring for ill children,⁹ facilitating greater female workforce participation. Early investments in family planning and population health can reduce dependency ratios, lowering the share of young and elderly in the population relative to those in the working age group, and setting countries on the path toward reaping a potential demographic dividend (refer to Brief 2).^a As women have fewer children, their productivity increases as they have fewer family responsibilities such as childcare.¹⁰ An analysis of data from 1960 to 2000 in 97 countries estimated that reductions in fertility can substantially increase female labor force participation: there is an average reduction of about four years of paid work over a woman's lifetime for each birth.¹¹

Universal health coverage protects the health and productivity of workers in the informal sector, who lack access to protections from employment-based social health insurance schemes (Box 4.1).³

Female workers in the informal sector lack access to public or private social protections that could facilitate access to health care, especially regarding maternal and infant health which are critical for early childhood development and human capital accrual (Brief 2).¹⁰ In economies with a small tax base, it is challenging to extend social health insurance schemes to the informal sector, leaving informal workers (who earn lower and more variable wages) to pay out-of-pocket for health services (refer to Brief 5).¹³ Women's significant presence in the informal economy (Figure 4.1) makes informal work a core feature of gender inequity, and a key pathway to meeting SDG goals related to health, gender equity, decent work and economic growth.¹² For women, low and insecure incomes combined with lack of access to health services may lead to forgone or delayed care-seeking for themselves and young children.¹² In order to improve child and maternal health, Ghana has exempted children under 18 years and pregnant women from paying premiums under the National Health Insurance Scheme. Previously, out of pocket payments affected pregnant women access to healthcare but when the exemption was granted, it increased their health care utilization.

Investments in health have a multiplier effect on the health workforce, which is disproportionately female.

The health sector employs a significant proportion of a country's total workforce and involves substantial recurring investments in physical capital. A healthier and more productive health workforce can maximize investments in health infrastructure and resources, leading to improved delivery of services and better outcomes.¹⁴ There is also a virtuous cycle between investments in health and strengthening workforce gender equity.¹⁵ Women make up 60 percent to 70 percent of the health workforce in most countries,^{16,17} meaning that investments in the health sector contribute directly to female employment.

a The demographic dividend is a period of accelerated economic growth that can accompany a transition in a country's demographic structure wherein improvements in childhood survival are accompanied by declines in fertility over time, leading to growth of the workforce and an increase in the proportion of healthy adults of working age compared to dependents.^{18,19} If social and economic policies accompany the demographic changes that come from effective investments in health, the growth in the workforce can result in accelerated economic growth.

Box 4.1 From Principles to Practice.**Joint Learning Network Country Experience: Thailand**

In 2001, Thailand introduced a subsidized Universal Coverage Scheme (UCS). The scheme was launched with minimal co-payments, no joining fee, and with everyone covered automatically with a 100 percent subsidy. While the scheme was somewhat less generous than the social security scheme, social security also did not cover dependents. At least prior to UCS, this gave an incentive for household members to seek formal sector jobs. Labor Force Survey data indicated that the introduction of UCS increased employment rates among women, especially married women. Furthermore, UCS increased informal-sector employment, especially among married women. Research posits that by removing financial risk of health shocks from informal sector employment, more married females were able to enter informal sector work as an alternative to unemployment or working in the formal sector. The reform also reduced formal sector employment at least among married men, which may have allowed couples to switch from situations where spouses must co-locate for another's urban formal sector job but without working themselves.^{13, 20}

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Brief 5.

Social health insurance requires domestic government funds to support progress toward Universal Health Coverage

In many countries, public insurance schemes like Social Health Insurance (SHI) or National Health Insurance (NHI) have become synonymous with Universal Health Coverage (UHC). More important than how the schemes are labeled is how they are financed, and how these financing arrangements influence coverage at the population level.² SHI usually refers to public insurance that collects contributions or premiums from populations and employers through earmarked payroll or other mechanisms, while NHI is largely tax-funded.^{1,2} However, for NHI models premiums (and private copays) alone do not cover the cost of movement toward UHC. No country with an SHI scheme functions without relying on general domestic government revenue.³ Additionally, SHI can be expensive to implement. Beyond administrative outlays, it raises costs of labor, hampers mobility, and reduces the rate of labor market formalization. Where there are large poor or informal sectors, uptake may remain low and the cost of collecting contributions often outweighs the benefits. Social health insurance financed by labor taxes is not the most efficient and effective way to finance UHC.¹ Noncontributory approaches funded by general domestic government revenues can help cover the hardest to reach and most in need. No country can make progress toward UHC without domestic government funds, regardless of the scheme they have in place (refer to Brief 1).^{3,4}

Public insurance works best when the majority of funds come from domestic government resources, and when entitlement is delinked from ability to pay. Funding health care through general tax revenues is more sustainable and efficient than through contributions, and can benefit poor and informal sectors which were previously excluded by delinking entitlement from employment status.⁵ For instance, enrollment in Mexico's Seguro Popular program was funded through taxation from general revenues. It was designed to cover the 50 million workers and other target populations who were previously excluded from state social insurance. Implementation of the scheme resulted in an 8 percent reduction in the probability of catastrophic health expenditure.^{6,7}

Payroll taxes including SHI can reduce the rate of labor market formalization by raising costs of labor. Payroll taxes may also reduce mobility due to lack of portability. If people can't bring their coverage with them, moving jobs in response to need or employment demand can impose the risk of catastrophic or impoverishing health expenditure.⁸ When higher income countries rely on SHI contributions, on average these contributions cover around a quarter of public spending for health, and still have to be

a Domestic public funds (GGHE-D) includes both general government domestic revenue and social insurance contributions (FS1 and FS3). Domestic government funds refers to general domestic government revenue (FSS1 only).

supplemented by domestic government funds.⁴ Social health insurance is often structured as an earmark on payroll. Many high-income countries are exploring diversifying their social health insurance earmarks by looking to other taxes and levies as well as general revenue, especially as populations age and labor markets contract.^{1,8} Social health insurance schemes also cannot feasibly extend coverage to the poor and informal sector until the economy has developed enough to create significant space to bolster domestic government resources for the health sector.⁵ In low- and lower-middle-income countries where there are larger informal sectors, use of payroll tax-based insurance provides only a small amount of revenue—in some cases contributing less than one percent to total revenue for health. In these contexts, there is little evidence to justify using payroll-based insurance schemes.¹ Revenue from payroll-based insurance is less than one percent of health spending in Bangladesh, Cambodia, Cameroon, Cote d'Ivoire, Ethiopia, Myanmar, and Uganda; less than 10 percent in India, Indonesia, Kenya, Lao PDR, Nigeria, Philippines, Senegal, and Sudan; and less than 20 percent in Mongolia and Vietnam.^{b,4} (refer to Figure 5.1, Tabel 5.1, and Box 5.1).^{9,10}

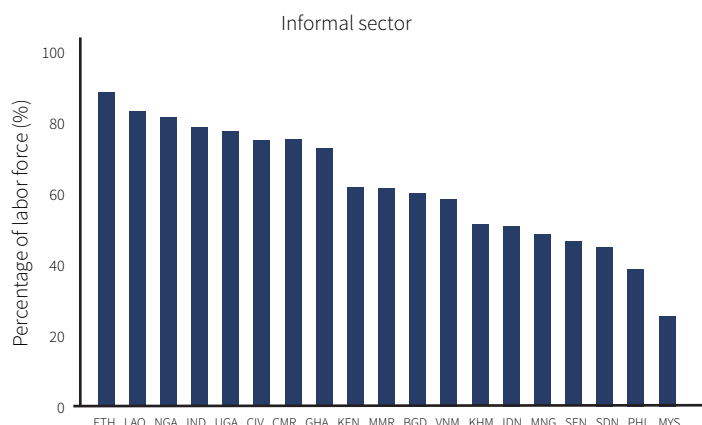
Establishing SHI can be associated with implementation and uptake challenges. Some countries have employed innovative strategies to collect revenue from the informal sector. For example, Ghana's National Health Insurance Authority (NHIA) introduced mobile renewal of membership in December 2018 where members could use money from their mobile phone wallets to renew their membership anywhere, which has increased enrollment and made revenue collection easier.^c In Ghana, the indigent population who are the core poor are exempted from payment of premiums. They include prisoners, mental health patients and people under the Livelihood Empowerment Against Poverty (LEAP). However, other countries have more persistent collection challenges, which may mean that putting in place SHI is not worth the investment, especially in contexts where there is limited capacity to implement and where enrollment remains voluntary. For instance, in the Philippines, provision of free access to care through SHI did not enhance utilization of care and deteriorated financial protection.^{11,12} In Vietnam, the existence of health insurance had only a modest impact on out-of-pocket spending.¹³

Collecting contributions from the informal sector can be difficult due to issues including identification, administration and enforcement (Figure 5.1).⁵ For instance, Thailand long struggled to collect informal contributions, finally extending noncontributory coverage to 75 percent of the population.¹⁴ Collection issues can also occur with formal sector contributions. For instance, in Colombia, evasion of contributions from both formal and informal workers cost the scheme 2.75 percent of GDP in forgone revenue. Even in Mexico, only 8 percent of those in the richest income quintile actually contributed, and those who did contribute provided less than half of what they should have.⁵ Instead of targeting the poor for subsidies, other options that focus on reducing the barriers to effective service delivery and improving financial protection for the informal sector and poor populations can be used; for example, use of noncontributory approaches where entitlement for benefits comes not from ability to pay, but from age or poverty levels, residency, citizenship, and which are funded through tax revenue.⁵

b Data from WDI and GHED presented in February 2019, JLN DRM Collaborative Meeting, New Delhi

c In Ghana, contributory approaches are supported by general tax revenue. Contributions are viewed as a measure of solidarity, with contributions defraying some operational cost of the scheme

Figure 5.1 Size of Informal Sector



Source: WDI 2021.

Table 5.1 Share of Total Spending for SHI Contributions

Social health insurance share of total health spending	
Vietnam	19%
Mongolia	16%
Indonesia	9%
Kenya, Philippines, Senegal	4-5%
Lao PDR, Nigeria, Sudan, India	1-2%
Malaysia, Cambodia, Cote d'Ivoire, Myanmar, Bangladesh, Cameroon, Ethiopia, Uganda	<1%

Source: WHO Global Health Expenditure Database (2020).

Box 5.1 From Principles to Practice. Country Experience: Estonia

In Estonia, a hard earmark on payroll tax contributions provides 90 percent of revenue for the Estonian Health Insurance Fund (EHIF). EHIF is an extrabudgetary fund that pools resources from health and pension contributions (13 percent and 20 percent, respectively of employee and self-employed earnings), with employers contributing on behalf of employees and the self-employed contributing through fixed premiums. However, the fund is also regressive and creates some distortion in the labor market. About 5 percent of the population is uninsured and 11 percent face employment insecurity and unstable coverage as a result. In 2013, revenue for the first time was not sufficient to cover expenses, and reserves were used to cover shortfalls. Because the earmark cannot be adjusted, the earmark had become a revenue ceiling rather than a floor for the insurance system with the EHIF receiving a fixed proportion of the state budget. Additionally, while the EHIF is required to maintain reserves, it does not have complete control over use; for instance, during the 2009 economic crisis, the funds were used to maintain the countries overall fiscal balance. After years of effort, Estonia has been able to decrease funding from payroll and increase general revenue for the national health insurance fund, driven in part by population aging.¹⁶

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Brief 6.

Domestic public funding for health reduces poverty and inequity

People should not have to make tradeoffs between their economic and physical well-being as a result of using health care.¹ Socioeconomic inequalities between the poorest and richest populations in most countries, including for women and children, are exacerbated by low coverage of Universal Health Coverage (UHC) services for the poor.^{2, 3} Foregone health care, often owing to prohibitive costs, also deepens inequities, leading to greater spending down the road, especially for poor households.^{4, 5} Targeted domestic government financing toward vulnerable populations can delink services from ability to pay, support reductions in poverty, and have a profound positive impact on human capital, freeing financial resources and improving productivity (refer to Brief 2). For these reasons, using public, compulsory and prepaid domestic funding is essential for countries to move toward UHC and help break the cycle of poverty and ill health (refer to Brief 1).^{9, 8, 10}

Domestic public funding is not always targeted to those most in need. In many low-income countries, out-of-pocket (OOP) financing remains the largest source of funding (refer to Brief 7), making up on average 39 percent of total health spending.¹³ Each year, individuals in developing countries spend half a trillion dollars via OOP spending, leading to catastrophic expenditure and pushing nearly 100 million people into poverty.^{3, 14} High-income OECD countries that have OOP levels less than 20 percent of total health spending, rely more on prepaid sources, and see a lower incidence of impoverishing health expenditure. A global assessment of benefit incidence of public health expenditure indicated that across 66 countries, total government expenditure on health (GHE) was significantly pro-rich, meaning that those who are able to pay actually benefit more from government spending than those who do not. Looking at individual countries, the pro-poorness of GHE decreases as the share of government facility revenues from OOP sources like user fees increases: the more that poor populations pay out of pocket for health care, the less the government contributes (refer to Brief 7).^{6, b}

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- a 10 percent or 25 percent of total income or consumption at household level are two common thresholds for catastrophic expenditure and are consistent with SDG indicator 3.8.2. Impoverishment can be measured using the international absolute poverty lines: US\$1.90 per day and US\$3.20 a day (PPP) dollar international poverty line (2011), or using a relative poverty line (e.g 60 percent of median consumption per capita).
- b There are two main types of private finance, or healthcare spending that is financed by a household's income, savings or loans: (i) prepayments such as premiums made to voluntary health insurance that are made in advance of care being received, and (ii) out-of-pocket (OOP) payments made by individuals at point of care.
-

The proportion of people impoverished by health spending makes up a growing share of the global poor. When targeted to poor and vulnerable populations, domestic government funds are more likely than other revenue sources to support those most in need; helping populations move away from high OOP that can exacerbate poverty, and ultimately driving further economic growth.^{7,8} The poor face sizeable financial hardships and are often pushed further below the poverty line as a result of having to pay for services out-of-pocket. While the share of the world population pushed into extreme poverty has decreased between 2000 and 2015, the relative share of people pushed into poverty as a result of out-of-pocket spending among the global poor has increased from about 7% in 2000 to 12% in 2015 (Table 6.1). These people are also usually those who are already poor and pushed further below the poverty line as a result.¹¹

Table 6.1 Impoverishment due to out-of-pocket and extreme poverty (at \$1.90)²⁵

	2000	2005	2010	2015
Global poor (million)	1695	1363	1109	741
Impoverished due to out-of-pocket (million)	123.9	116.8	103.4	89.7
Share of poor impoverished due to out-of-pocket (%)	7.3%	8.6%	9.3%	12.1%

Source: Global monitoring report on financial protection in health 2019; Sparkes et al, forthcoming.

Domestic public finance can help delink service use and ability to pay.¹² Without domestic public financing as the dominant source of system funding, users are exposed to financial risk, limiting financial protection especially for those who are already in the lowest wealth quintiles. While some countries may use simple, low and fixed copayments as a part of system design, even these may limit access for the poor (refer to Brief 7). Especially for those who are already financially constrained, household medical spending at point of care can threaten maintaining basic needs like food or shelter, detract from care seeking, and when medical spending is large or persistent over time, force individuals and families who already face economic hardship into poverty. OOP can also detract from household savings and reduce potential discretionary consumption that can stimulate the economy. While OOP in the form of cost sharing like premiums or copayments may help control overuse by the nonpoor, the poor suffer more when OOP expenses are linked to basic services.^{17, 13}

Targeting priority groups and known drivers of impoverishment with domestic public funds can deepen impact and protect populations.⁸ Outpatient medicines are the main driver of financial hardship in European countries, with a greater impact on the poorest.¹⁵ In Africa, it has been shown that the majority of OOP in health is also for medicines and outpatient services, and not tertiary care. Additionally, it is the accumulation of spending and not one-off events that causes financial hardship.^{15, 16} The mix of conditions and causes can also vary by context. In Ethiopia it is estimated that 75 percent of medical impoverishment is caused by OOP payments for diarrhea, lower respiratory infections and road injury alone.¹⁸ The COVID-19 pandemic can deepen existing inequalities without health and social protection safeguards. Indeed, governments support has not been sufficient to meet the basic needs of the unemployed, the elderly or children, and families. Where government financial support did occur, 41 percent was one off and has now significantly slowed.¹⁹ Public funds for health can be also used to fund expansion of existing schemes, or targeted programs that support the poor and most vulnerable who wouldn't otherwise be prioritized (Box 6.1). For instance, enrollment in Mexico's previous Seguro Popular program was funded through taxation from general revenues. Designed to cover the 50 million Mexicans, most of whom were poor and had been excluded from social insurance, the scheme resulted in an 8 percent reduction in the probability of catastrophic health expenditure.^{20, 21} Likewise in Vietnam, the government-funded Vietnam Health Care Fund for the Poor reduced OOP and shifted utilization from private to public outpatient care.²²

Box 6.1 From Principles to Practice.
Country Experience: Brazil

While domestic public funding can contribute to reductions in poverty, continuing and sustainable funding and political motivation for these programs can be a challenge. Brazil's conditional cash transfer program, Bolsa Familia, was responsible for lifting more than 30 million Brazilians out of poverty between 2003 and 2010. As of 2019, it supported more than 50 million people, or one quarter of the population including working age and children. So successful was the model that it was adapted for implementation in South Africa, Indonesia, Chile, Mexico and other countries, with 67 countries using the model by 2017. The program has been credited both with reviving the economy during crisis through improved consumption, as well as instigating long-term transformation through investments in human capital. However, in June of 2019 payments to existing families stopped and acceptance of new families slowed. The admittance numbers dropped from 275,000 families a month to fewer than 2,500.^{23, 24}

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Brief 7.

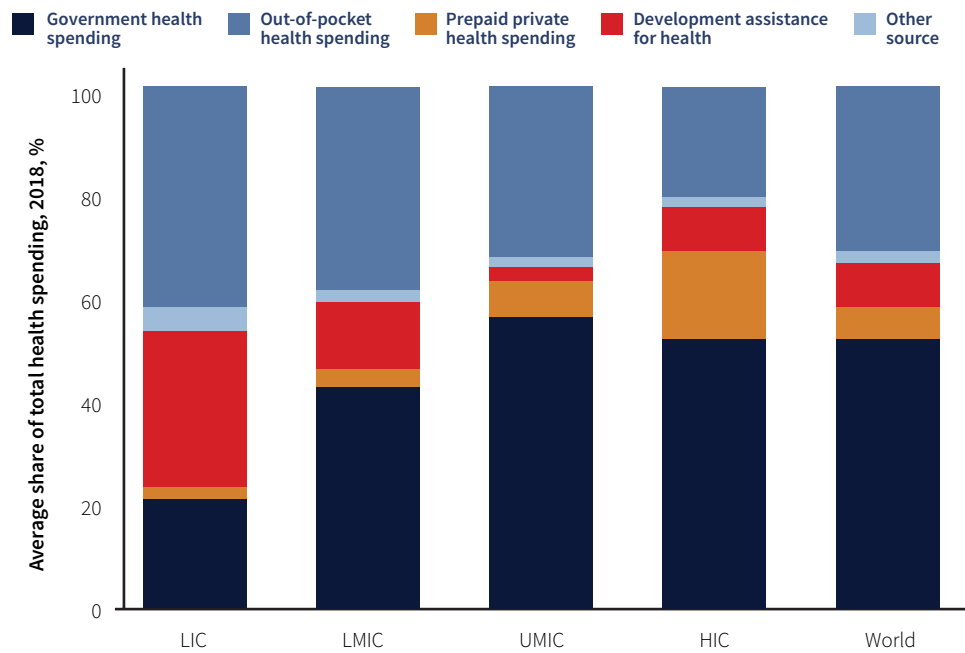
Out-of-pocket financing is inefficient and inequitable

Where public funds are insufficient to cover the cost of health care, private forms of payment take their place. There are two main types of private finance, or healthcare spending that is financed by a household's income, savings or loans: (i) prepayments such as premiums made to voluntary health insurance that are made in advance of care being received, and (ii) out-of-pocket (OOP) payments made by individuals at point of care. OOP spending at point of care can include user fees—explicit fee for service charges or copays (cost sharing) for services, drugs or commodities paid to private actors or specified by the government to cover a charge in part or full—informal payments made for services, drugs or commodities in kind and in cash, as well as practices like balanced billing where patients are charged above an established price of care.^{1, 2, 3, a} Reliance on private funding and OOP in particular generally decreases as economies develop and public spending increases as a share of GDP.² However, in most low- and middle-income countries (LMICs), OOP payment remains the largest source of financing for health making up on average 39 percent of total health spending.⁸ A majority of funds go to the private sector, which may often fail to provide for those most in need (Figure 7.1). Individuals in developing countries spend half a trillion dollars each year in OOP, leading to catastrophic expenditure and pushing nearly 100 million people into poverty (equivalent to 15 percent of all people facing extreme financial hardship).^{b, 4-7} OOP financing is inequitable and impoverishing (refer to Brief 6), as well as inefficient (refer to Brief 11). For these reasons, OOP funds should not be relied on as a major source of revenue for health systems.

OOP financing is inefficient because it limits the ability to set fair prices, does not allow for risk pooling, and can constrain purchasing. In the public sector, OOP financing can create inefficiencies by limiting the ability to set fair prices for services, contributing to variable costs across facilities for the same treatment. Facilities are allowed to establish what they will charge for care (refer to Brief 11). When OOP payments are collected through informal payments, it can create fragmentation and limit pooling as well as impact budgetary allocations by reducing transparency around what is being collected. Moving toward prepayment mechanisms and away from OOP financing can also improve pooling and purchasing agreements that increase efficiency, ensuring more value for each health dollar spent.^{4, 8, 9} However, shifting away from OOP financing is challenging, and must be done with a consideration of how to replace

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- a Costs incurred in accessing care such as transport are not included in the formal OOP definition which tend to focus on direct costs. These costs may be included in an indirect cost category.
- b 10 percent or 25 percent of total income or consumption at household level are two common thresholds for catastrophic expenditure and are consistent with SDG indicator 3.8.2. Impoverishment can be measured using the international absolute poverty lines: US\$1.90 per day and US\$3.20 a day (PPP) dollar international poverty line (2011), or using a relative poverty line (e.g 60 percent of median consumption per capita).

Figure 7.1 Sources of Health Spending by Income Level



Source: World Development Indicators; WHO Global Health Expenditure Database (2020).

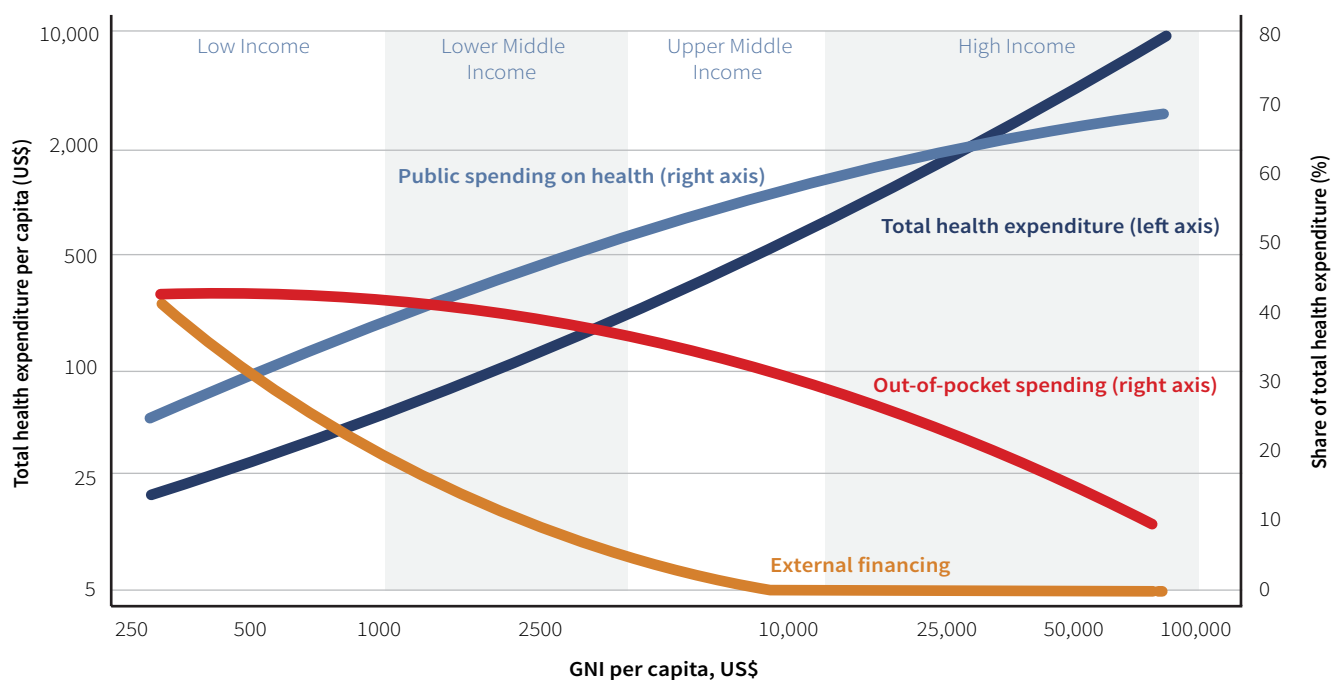
Low income countries (LIC); lower middle income countries (LMIC), upper middle income countries (UMIC); high income countries (HIC).

lost revenue in a timely, sustainable, and pro-poor fashion.¹⁰ In 2016, OOP payments accounted for 54 percent of total spending in the Philippines and pushed 1.5 million people into poverty annually. While the Philippines' Health Financing Strategy aims to ensure financial protection by reducing OOP payments through pooled funding and more strategic purchasing, issues like fee-for-service incentives and high OOP spending for pharmaceuticals persist.¹¹ In Cameroon, Burkina Faso, Ghana, Nigeria, and Zambia, policies intended to remove OOP payments in the form of user fees improved access to facility births, especially for poor, rural, and uneducated women.¹² However, despite these policies, OOP payments in these countries remain at high levels.^c

OOP financing is inequitable because it impacts the poor disproportionately. Research has shown that even where OOP financing is progressive and the share of poor is low, it may still impede access to services for the poor and increase further their risk of incurring catastrophic health expenditure.¹¹ This issue occurs in low- and high-income countries alike. Looking across 24 countries in Europe that provide access to the entire population through publicly financed services, catastrophic spending is concentrated amongst the poor and driven mainly by payments for outpatient medicines (refer to Brief 6).¹² In lower income settings, this pattern is consistent even when looking within countries and across states that may show various levels of economic development. For instance, one study looking at eight districts across three states in India found that the distribution of OOP payments were regressive in all districts, and more pronounced in rural areas.¹³ OOP payments can impact the poor even when they have coverage. In Ghana for those under the National Health Insurance Scheme (NHIS) who are insured, OOP payments can come from delays in the release of funds by Government to the National Health Insurance Authority to providers. To keep their operations running, some health providers levy illegal charges on NHIS members, causing OOP payments that make the poor more vulnerable, and affecting equity and access to health care. OOP spending can also result from delay in the review of the NHIS medicines list in line with market price, which

^c Global Health Expenditure Database, accessed 01/15/2021. OOP as a % of CHE (2018): Burkina Faso (36%), Cameroon (76%), Ghana (38%), Nigeria (77%), Zambia (10%).

Figure 7.2 Health Financing Transition



Source: Authors' estimates using data from WHO Global Health Expenditure Database (2020).

results in some providers withholding medicines due to non-competitive pricing and driving patients to the open market.

Economic growth can catalyze a health financing transition, reducing reliance on OOP financing and contributing to a virtuous circle that propels gains in human capital (refer to Brief 2). Domestic public funding for health leads to improved access to quality health services, and allows health to be maintained, productivity to be increased, and earnings to grow (refer to Briefs 2 and 3).⁹ As economies of countries improve, they can reliably inject more public resources into the health sector and become less dependent on sources like OOP funds in the form of cost sharing or informal payments paid at point of service over time, which negatively impact the poor. This “health financing transition” (Figure 7.2) can advance sustainability, equity and efficiency, and lead to better health and welfare, especially for the poorest populations.¹⁶ This in turn improves human capital, drives productivity, and allows individuals to save and invest in areas other than health (refer to Briefs 1 and 3) —further fueling the economy and completing a virtuous circle.

Until sufficient growth or reprioritization can be realized, moving from OOP payments, and user fees in particular, must be supported by complementary policy actions. Exploring how to reduce or abolish user fees and minimize the fiscal impacts of other forms of OOP spending without adverse consequences like disruption of services and worsened utilization require public resources for health. However, mobilizing this funding may be unlikely to happen in the near term, especially in the face of constrained growth while countries battle fallout from the COVID-19 pandemic, and in countries or regions that already rely heavily on OOP (refer to Brief 3).^{18, 19} In the absence of the ability to raise more from taxes or other sources, examining policy options that can improve efficiency, such as improving purchasing agreements to realistically and flexibly reimburse providers for the cost of services, can be one way forward. As countries explore additional sources of revenue, they must also keep in mind equity and access issues that may be instigated by charging for services or commodities related to COVID-19 or otherwise, and avoid relying more heavily on OOP sources, which may also give the perception that health is taken care of (Box 7.1).¹⁷ Where copayments are already in use to support health facility operations as a way to manage excess demand for specific services, the poor should be subsidized and protected from further impoverishment.¹⁰

Box 7.1 From Principles to Practice.

Joint Learning Network Country Experience: Ethiopia

Reliance on user fees can negatively impact revenue for health. Since 1950, health facilities in Ethiopia have charged user fees. However, before the 1998 Healthcare Financing Strategy, revenue collected from user fees at the facility was transferred to the Ministry of Finance and not retained at the facility level, decoupling revenue raised from ability to mobilize resources. The healthcare financing reforms introduced following the 1998 Health Care Financing Strategy allowed health facilities to retain these fees, transforming them into a significant share of the recurrent budget. However, besides equity issues imposed by this reform, the fees themselves are not additional as intended, and facilities see a reduced allocation from the local governments as a result of this revenue raised. Additionally, because other ministries see these user fees as a ‘ring-fenced’ source of funds, the resource negotiating capacity of the Ministry of Health and health authorities at different levels of government has been affected. As a consequence, there has been a reduction in non-salary recurrent budget allocated to facilities, a subsequent decline in service quality, and a push to collect more fees to make up for shortfalls.

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Brief 8.

Investing in health generates positive outcomes for other sectors

Governments generally assess arguments in favor of public investment in health against investments in other sectors like education, water and sanitation, and transportation—all of which can result in tangible and direct benefits to society and the economy.¹ However, the economic impact of poor health is enormous. A World Health Organization analysis estimated that from 2011 to 2025, non-communicable diseases (NCDs) alone would account for an output loss of US\$7.28 trillion in low- and middle-income countries due to disability, premature death, or time lost from work because of illness or care seeking.² Investments in health systems are the cornerstone of strong labor markets,³ creating indirect economic benefits for other sectors by helping to make people healthier and more productive.⁴ In turn, this improves earning potential and contributes to the overall economy, as income per capita is highly correlated with health across countries.^{a,5} Universal Health Coverage (UHC) can drive improvements in other sectors by building up a larger, more productive workforce.

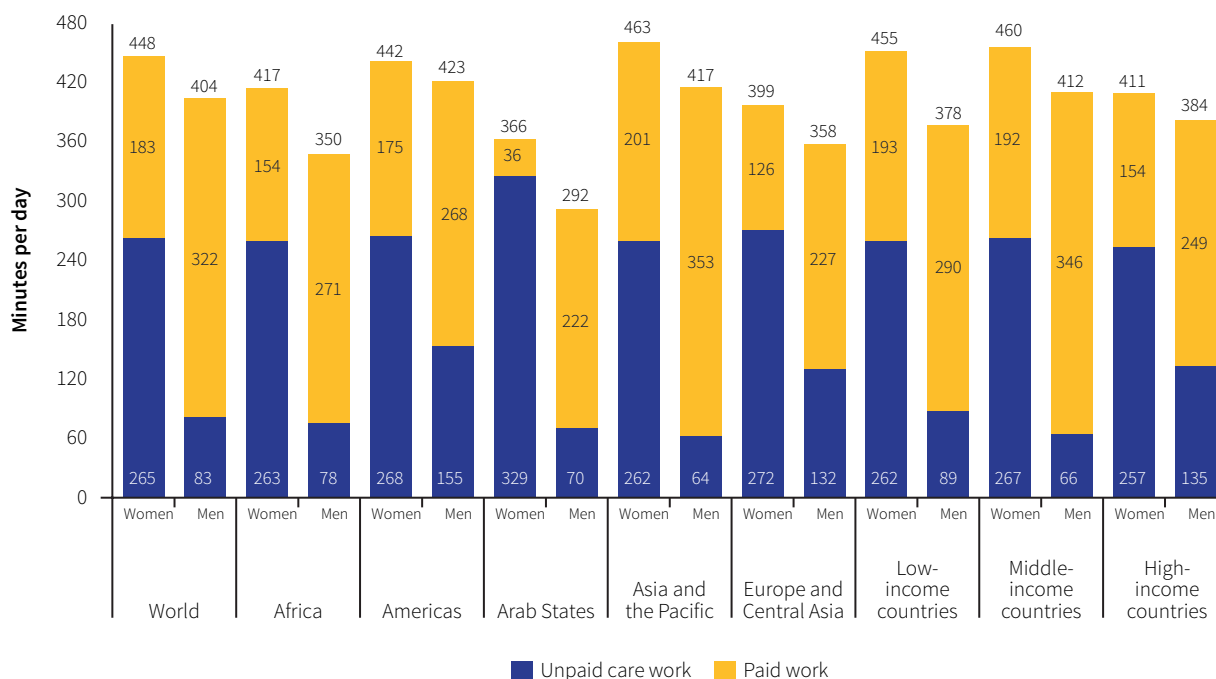
Health is a key determinant of a productive labor force, especially within industries relying on physical labor. Healthier people are more productive. They miss fewer days of work due to illness and care-seeking, are able to work longer, more productive hours, and earn more wages.⁶ Good health is especially critical in labor-intensive industries like agriculture and manufacturing, which together accounted for more than half of the GDP in low-income countries in 2018.⁷ Evidence from the agriculture industry shows that better health can drive improvements in labor productivity. In Nigeria, an intervention offering workplace malaria testing and treatment increased earnings and days worked by approximately 10 percent. Investments in high-impact, cost-effective interventions (refer to Brief 13) like HIV treatment, iron deficiency anemia, vitamin A and iron supplementation, and deworming can have an immediate impact on worker productivity, averting losses for a family by way of better performance and fewer missed days of work from sickness.⁸⁻¹⁰

Improved health enables more people to enter into work and contribute for longer. Premature death and long-term disability can result in substantial loss of healthy years of life, and fewer years spent in the workforce.^{13, 14} Universal health coverage, in combination with rising incomes and pension systems support healthier aging and later retirement,^{3, 15} creating a more conducive environment for healthy workforce participation later into life.¹⁶ As populations become older, creating opportunities for older adults who want to, and are healthy enough to participate in the workforce is increasingly important.¹⁷ As health intersects with other social sectors, multisectoral action linking investments in health to the creation of broader social supports is critical (Box 8.1).

a This relationship is also influenced by improvements in overall nutritional status, institutional quality, and human capital.

Better health of children and elderly populations enables more working-age people to participate in the workforce. Unpaid, informal care work for children, elders and those with disabilities, both in terms of daily care and seeking care for episodes of illness, have an enormous impact on the workforce participation of adults (Figure 8.1).³ The burden of informal care-giving is especially pronounced for women; a review of 66 countries containing two-thirds of the world’s population found that women took on an average of ten or more weeks per year of unpaid care work (refer to Brief 3).¹¹ If investments in education health and social work were doubled by 2030, 269 million new jobs could be created globally, providing stimulation to the economy.¹² Investing in the health of older people and children, though these populations are outside of the labor workforce, impacts productivity by allowing care-givers to enter into and remain in the workforce.²

Figure 8.1 Time Spent Daily in Unpaid Care Work, Paid Work, and Total Work, by Sex, Region, and Income Group, Latest Year



Source: ILO (2018).¹²

Box 8.1 From Principles to Practice.

Joint Learning Network Country Experience: Cambodia

Establishment of a National Social Protection Policy Framework in Cambodia across sectors furthered social protection schemes, including health. The Ministry of Economy and Finance led a Technical Working Group to develop a Social Protection Policy framework that included a broad group of line ministries like the Ministry of Education, Ministry of Health, and Ministry of Youth and Sport—all of which fall under Cambodia’s Social Protection System. This collaboration resulted in the National Social Protection Policy Framework 2016-2025 which reflected shared priorities across ministries in clear short-, medium-, and long-term roadmaps. The Framework was followed by the establishment of the National Social Protection Council (NSPC) in 2018, which is chaired by the Minister of Economy and Finance and consists of Ministers/Secretaries of State of the other 11 line ministries and public institutions. The NSPC is responsible for coordinating policy formulation on social protection, monitoring and evaluating policy implementation, and ensuring that the Social Protection System supports all social support schemes, not only health care.¹⁶

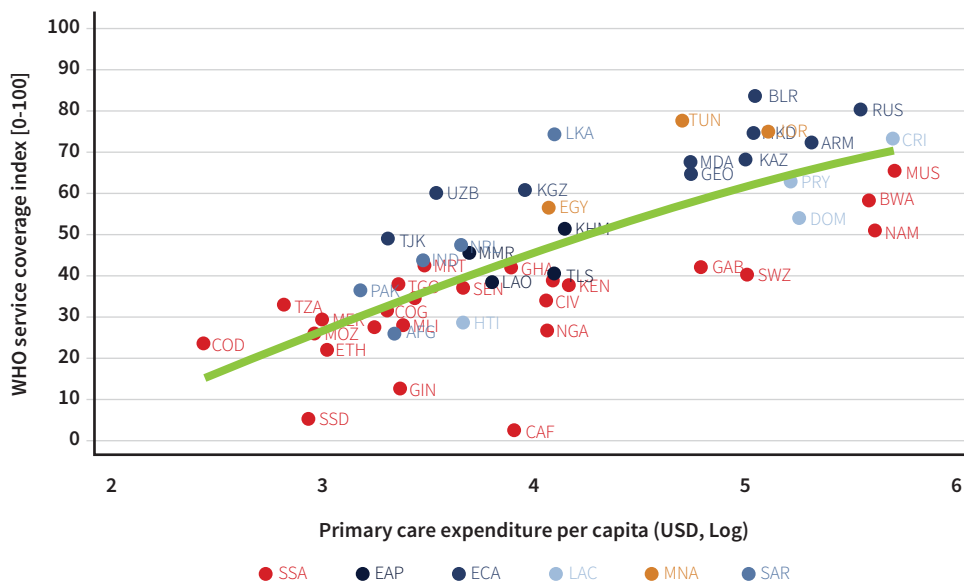
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Brief 9. Investments in preventative and primary health care can generate immediate and long-run savings

Primary health care (PHC) is a key platform for achieving Universal Health Coverage (UHC).¹ It is the first point of contact with the health system for the population, providing comprehensive care for most health problems, while aiming to stop problems before they begin through counselling and prevention services. PHC also entails long-term person-centered care that can improve care coordination across health system levels, reducing costs by managing unnecessary referrals.² Having strong, and well-financed PHC systems is also associated with increased service coverage (Figure 9.1), and can deliver social and economic benefits such as improved health outcomes, health system efficiency, and health equity—all of which contribute to broader economic gains. However, there is no global target for how much a government should allocate to PHC; the percentage of government health spending dedicated to PHC ranges from 31 percent to 88 percent of current health expenditure in low-income and lower middle-income countries.^{3,4} In addition, variability in the sources of funding for PHC, especially nonpublic sources, can create inequalities in access which lead to inefficiencies. A recent modelling study estimated that to universally provide essential PHC in 67 LMICs, up to US\$65 increase in per capita spending would be required.⁵ Allocating resources for PHC, though challenging, can support healthier and more productive populations and maximize public resources.

Figure 9.1 Primary Care Expenditure and Service Coverage in Low- and Middle-Income Countries



Source: World Development Indicators; WHO Global Health Expenditure Database (2020), latest available year.

Improved coverage of PHC services is associated with reduction in all-cause mortality, which can contribute to substantial economic gains.^{2,6–8} A major pathway by which increased population health contributes to GDP gains is through human capital—healthier populations are able to acquire more knowledge and skills over their lifetime, making them more productive economic and societal participants (refer to Brief 2). PHC is the most cost-effective way to comprehensively address health needs (refer to Brief 13). In the case of vaccines, PHC interventions are not only cost-effective, but highly cost-saving. Investment in preventative health care services like childhood immunizations in 43 LMICs between 2021 and 2030 is expected to be US\$52 for every US\$1 spent, using a value of statistical life approach.⁹ A recent modelling study found that increasing coverage of PHC interventions would avert more than 60 million deaths and increase average life expectancy by nearly four years.⁵ Such gains have significant economic implications; a study estimated that increasing life expectancy by five years can result in a GDP gain of up to 0.58 percent.¹⁰ Financing PHC systems, especially during economic downturns, is critical for equity and access and can provide value for money (refer to Box 9.1 and Brief 3).

High-quality PHC systems can create efficiencies by preventing future costs. By accessing PHC services at both lower cost and closer to their community, patients can avert unnecessary or avoidable expenditure associated with use of more expensive types of specialist care.^{6,8} Primary care providers use fewer resources than specialty care providers in terms of hospitalizations, prescriptions, and common tests and procedures.^{6,11} People with access to primary care are more likely to seek preventative care, which can avert chronic disease or the escalation of diseases into advanced stages that come at great cost to the individual and health system.² Furthermore, there is strong evidence that supply of and greater access to primary care physicians can reduce total hospitalizations, avoidable admissions, and emergency admissions.⁶ For example, a study found that the expansion of primary care in Brazil had an impact on reducing hospitalizations for chronic conditions like cardiovascular disease and asthma.¹² Similarly, expanding access to preventative care through major reforms in Chile was associated with a 11 percent drop in case fatality for hypertension, and a 48 percent decline for diabetes, alongside declines in hospitalization.^{13,14}

Primary health care promotes equitable access to health care, which can reduce welfare loss.^{2,15} Access to primary care is often more equitably distributed within a population than specialty care, meaning that populations would access primary care relatively closer to their communities as compared to specialty care.^{6,16} Inequities in health outcomes can have a significant economic impact: a study of health inequities in the European Union found that welfare losses associated with health inequities could account for 9.4 percent of GDP.¹⁷ More equitable access to good quality PHC services not only helps counter health disparities associated with socioeconomic disparities, but can reduce impoverishing health spending resulting from delayed access to PHC, leading eventually to economic growth.

Allocating or reallocating domestic public resources for PHC is both technically and politically challenging, but is critical to ensuring progress toward UHC. PHC is often underprioritized within national strategies and may not be sufficiently or transparently represented in budgets. Especially in countries that have experienced rapid economic growth, need for investment in PHC systems must compete with demands for access to higher-level services. In fact, in many countries hospitals receive a significant portion of the health budget.^{18,19} In addition, PHC services are often segmented into vertical elements like nutrition or maternal and child health, each with their own national strategy and funding elements. In the wake of the COVID-19 pandemic and the global economic downturn that has followed, fiscal space for health has shrunk, potentially reducing resources for essential health services and impacting access to PHC for vulnerable populations—both through reduced resources and as a result of foregone care during the pandemic itself.²⁰ Recently, a methodology was developed to track and measure PHC spending. Improved tracking and measurement of PHC allocations and spending can support future efforts to identify where increased or more efficient investments in PHC can be made.^{3,21} In the current context, it will be increasingly important for countries with restricted fiscal space for health to not only prioritize PHC within national strategies, but also reflect these priorities within budgets, demonstrating the

benefits that these investments can have in staving off future costs. For instance, Ghana's National Health Insurance Scheme (NHIS) allocates up to 10% of its revenue to support primary health and preventive care and health service investment, which have positive impact by preventing the occurrence of diseases and improving the health infrastructure to ensure quality delivery of care. This has the impact of reducing the cost of claims submitted by healthcare providers to the National Health Insurance Authority for reimbursement in the medium to long term. Some areas usually supported include vaccines, antiretroviral medicines, tuberculosis commodities, tetanus immunization, malaria vector control, ambulance service, construction of health training schools, lifts to public hospitals and health provider system integration.

Box 9.1 From Principles to Practice.

Country Experience: Costa Rica

Investments in PHC reforms in the wake of an economic downturn result in long-term gains as in Costa Rica. After decades of public investment, an economic crisis in the 1980s left Costa Rica's PHC system underfunded with low public satisfaction. Despite constrained fiscal space, the country leveraged domestic resources and external loans to implement major reforms to its PHC system. Reforms included establishing geographic empanelment and multidisciplinary capacity within its integrated health care teams (Equipo Básico de Atención Integral de Salud, EBAIS). In parallel, catchments were reorganized into seven health regions, each with approximately a dozen health areas, or counties. These reforms achieved high coverage, high quality PHC, and significant declines in infant and adult mortality. The return on investment of loans taken to support these PHC reforms has been estimated to be 70 percent. Today, the country continues to attain good health outcomes while spending 9.3 percent on health as a percent of GDP—less than the global average.⁹⁻¹¹

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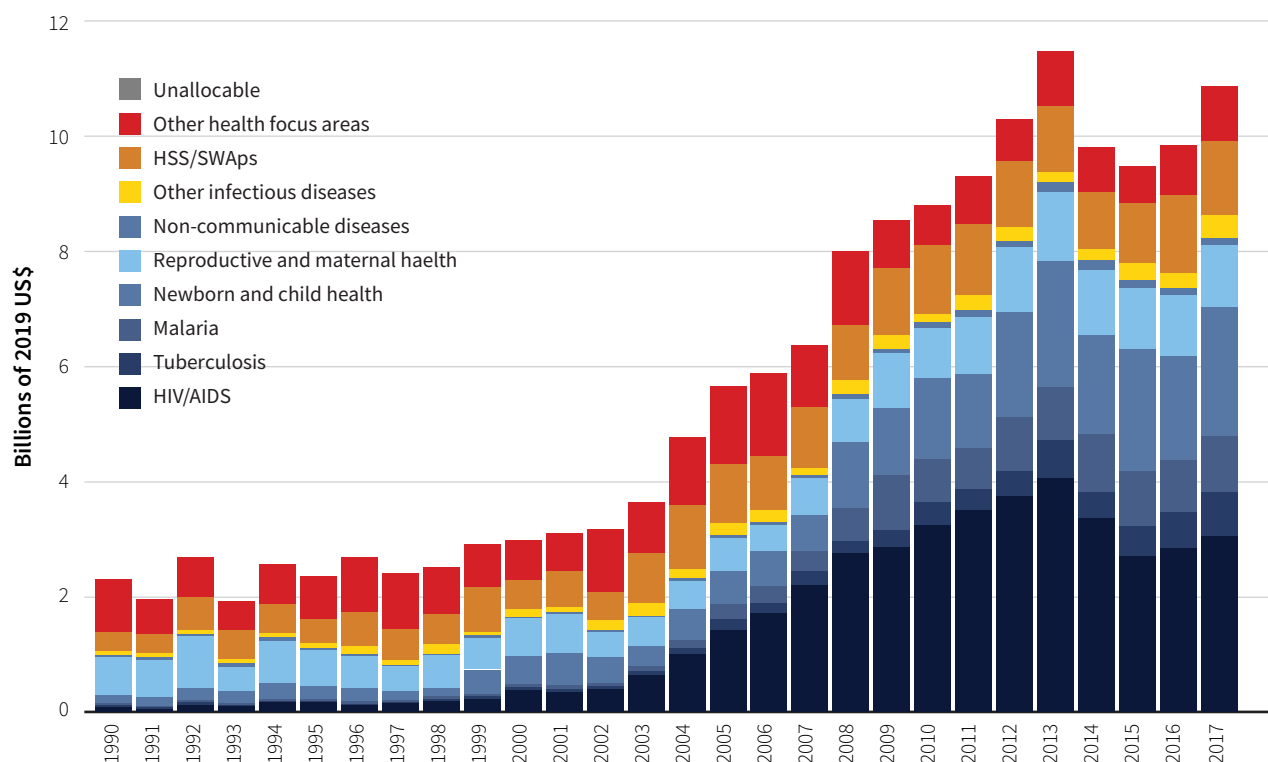
Brief 10.

Donor-funded initiatives can be designed to augment domestic public funding rather than crowd it out

Donor resources can provide critical funding that improve population health and spur economic growth.¹ While external financing or development assistance for health (DAH) makes up less than one percent of global spending on health, it is significant in that it is confined to low- and middle-income countries (LMICs) and within specific health areas (Figure 10.1).^{2, a} Traditionally, donor funding for health tends to decrease over time as economies strengthen, thereby increasing the role that domestic funds must play in health financing.⁵ However, global economic recessions constrain financing for all, and can result in sudden reductions in external funding, which in turn makes it harder for low-income countries (LICs) and lower middle income recipient countries to maintain progress toward Universal Health Coverage (UHC) and the health-related Sustainable Development Goals (SDGs).³ What complicates the issue further, however, is that it is also seen that government spending for health typically decreases for every dollar of development assistance invested in health, putting the health sector at further risk of being underfunded.⁶ There is direct evidence that DAH can crowd out government health spending: between 1995 and 2010, development assistance for health channelled to governments may have reduced government health expenditure by US\$152.8 billion.^{7, 8} Moving forward it will not be just by how much, but how the funds flow and to what priorities at the country level that will matter (refer to Brief 12).

Few donors direct funding toward health system strengthening, which can further spur fragmentation and verticalization. External funding can face even more fragmentation issues in the health sector than in other sectors due to the existence of multiple disease-specific, or vertical programs, and the lack of financing for strengthening health systems in particular,⁹ which can limit integration and hamper movement toward UHC. Long-term reliance on development assistance for health (DAH) may distort domestic resource allocation patterns within the health sector, creating reliance on external funds for specific programs and interventions, while crowding out worthy competing health priorities.^{7, 8} For instance, since 2000, more than US\$350 billion dollars have been spent on DAH, with just over a third of that total funding going to HIV/AIDS programs.^{10, 11} There is some evidence that donor funding to HIV/AIDS programs may have displaced funding for other health priorities, and failed to produce spill-over effects in areas such as health system strengthening, and population and reproductive health.^{12, 13}

a The top three sources of DAH in 2019 were the United States, the Bill and Melinda Gates Foundation, and the United Kingdom. Between 1990 and 2017, the main recipients of DAH in the past five years have been countries within Sub-Saharan Africa, and health focus area. The majority of DAH has been allocated for HIV/AIDS and newborn and child health.

Figure 10.1 Development Assistance for Health by Condition/Disease, LMICs, 1990-2017

Source: IHME. 2020. *Development Assistance for Health Database 1990-2019*. Seattle: Institute for Health Metrics and Evaluation.

Donor funds that are well aligned to country processes and priorities can achieve greater value for money and help public resources go further. More than half of overall aid never enters a government's budget.⁹ Despite global commitments, donors can be reluctant to contribute funds through a country's national budget due to perceptions of poor absorptive capacity or corruption. There are inefficiencies that result when resources do not flow through government channels.^{b, 9, 14} Systems become duplicated and best practices for health financing, like pooling which can improve equity and efficiency of fund use and allow for strategic purchasing, may be compromised, thus weakening the channels through which other public funds flow. Additionally, this can lead to duplication across programs where the ability to track funding flows becomes compromised. Further, in reaction to COVID-19, increased borrowing to counteract falling revenues will cause higher public debt levels in both LMICs as well as high-income countries, and may have a further impact on fragmentation of funding and progress toward UHC. This will lead to restrictions in the availability of donor resources and of countries' fiscal space for health that will extend beyond the current crisis. Donor funds must return to a growth path in order for LICs and some lower middle income countries to offset the projected falls in domestic spending on health and continue to attain their UHC goals by 2030.^{2, 4}

Transition represents an opportunity to proactively plan for domestic resource use to be more efficient and sustainable.¹⁵ However, for transitioning countries, both the shifting global financial landscape and existing the transition agenda provide an impetus to reframe progress toward country-owned results and using local systems to channel resources, which can help undo parallel structures that were in place to support programs, improve efficiency, and free resources for government priorities.⁵ Many development organizations have a threshold for development assistance, and some, like Gavi and the Global Fund, include explicit programs to transition countries from donor financing as they reach higher levels of economic development so as to prioritize their investments in less developed economies. However, the amount that

b See Paris Declaration and Accra Agenda for Action: <https://www.oecd.org/dac/effectiveness/parisdeclarationandaccraagendaforaction.htm>; IHP+ and UHC 2030: <https://www.uhc2030.org/about-us/history/>; as well as regional efforts such as Harmonization for Health in Africa (HHA): <https://www.who.int/workforcealliance/countries/hha/en/>

a country spends on health is not always proportional to the size of its economy: the proportion of public expenditures dedicated to health can range from less than 3 percent in Venezuela to almost 30 percent in Costa Rica.¹⁶ While there is no right number for funding health (refer to Brief 1), when countries do not sufficiently invest in their own systems, transition can pose a problem for maintaining progress.

Practices that support transparency and control over resource flows and the use of financial incentives can help maximize public resources. Many countries establish aid-pooling mechanisms to reduce fragmentation and improve visibility of donor funding flows (Box 10.1). Actions such as co-financing, disbursement-linked indicators, or linking of financial incentives to increase health budget shares can help to reduce displacement of public funds. Resource mapping and expenditure tracking initiated by the government can also help improve transparency and control. These exercises can be used to quantify financial gaps by identifying shortfalls, improve efficiency in allocating existing and committed resources, and support implementation monitoring, coordination and accountability. Tools for resource mapping and expenditure tracking can also be used to assess and mitigate the impact of COVID-19 on routine or essential service delivery, as well as support harmonizing emergency planning with longer-term investments and help to mobilize technical assistance for preparedness and response.¹⁷

Box 10.1 From Principles to Practice.

Joint Learning Network Country Experience: Ethiopia and Democratic Republic of Congo

Establishing aid-pooling systems can help support visibility of donor funding flows. In Ethiopia, the SDG Performance Fund, a mechanism by which available funding from a number of donors is combined and managed by the government via earmarked budgets, is used to align donor funds and priorities toward a national health plan. Decades of political instability and social unrest in the Democratic Republic of the Congo contributed to fragmented financing streams from multiple donors, duplication of parallel supply channels for essential medicines, and the inefficient distribution of the workforce across health centers. The introduction of a Health System Strengthening Strategy by the Government and the initiation of health financing reforms to improve the efficiency of donor aid increased savings of more than US\$56 million.¹⁸

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Brief 11.

Efficient health sector spending helps to conserve public resources

Efficient health spending aims to maximize outcomes relative to the resources allocated for health care. As the global economy contracts as a result of the COVID-19 pandemic, policy makers must untangle what spending is driven by inefficiencies or wastage at the country level in order to make the best use of increasingly limited public resources. Policy makers must do more with what they have. However, inefficiencies in the health sector are different than those in other sectors, and require public sector intervention. Efficiency can be realized in three ways: by doing the right things, by doing them in the right way, or by doing them in the right place.¹ The “right things or right place” refers to improving the way that resources are spread or allocated geographically across the health sector, or through the right mix of services to maximize benefits through prioritization, planning, and distribution of resources (allocative efficiency). The “right way” refers to improving directly how resources are spent, which may include how services are delivered, or the mix of inputs that are used to achieve a desired result (technical efficiency).² Tackling the main causes of inefficiency is key, and can be done by creating an enabling environment for change or addressing policy concerns that lie within the purview of the health sector alone.

There is not always a direct relationship between what is spent on health and what benefits (health or otherwise) accrue at the country level. A well-resourced health sector is critical to the development of human capital needed to spur economic growth (refer to Brief 2). However, health expenditure growth has exceeded GDP growth in nearly every country in the world over the past two decades.^{a,3} In fact, recent research shows that without efficiency gains in health, education, and infrastructure, spending needs across these sectors will increase from 15 percent to 25 percent of GDP in low-income countries.⁴ Twenty percent to 40 percent of all health resources are wasted due to inefficiencies in the health sector.^{5,6} As a result, the amount that a country spends on health is often not directly related to the benefits that it generates. For instance, the United States continues to have worse health outcomes and double the spending of other high-income countries, to a large degree as a result of inefficiencies in the health system.⁷ Further, inefficiencies can also be driven by issues of absorptive capacity, which can hamper achievement of goals.

Unavoidable market failures that are unique to the health sector drive inefficiency and require government intervention.⁸ If market forces or the private sector alone were relied on to provide care (refer to Brief 15) large efficiency and equity issues would arise, costing the health system more. When it

a Health expenditure growth is driven by rapidly ageing populations, growing burdens of noncommunicable and chronic disease, technological progress, and rising population expectations.

comes to health care delivery, inefficiencies are driven in many ways by market failures that are unique to health as a sector: unpredictable needs in terms of who will get ill, with what, and where in the system; benefits or negative side-effects that occur for individuals or society as a whole as a result of patterns of illness (externalities); lack of or unequal information between patients and providers (information asymmetry); or skewed incentives for patients and providers to either hide conditions, overuse the system or undertreat or overtreat for financial gain (moral hazard and adverse selection). Finally, while health is unique as a right, individual preferences linked to free will and choice can lead to negative health outcomes that are valued differently from person to person (bounded rationality and hyperbolic discounting).

Tackling the top causes of inefficiency can help the health sector do more with what it has. Inefficiencies are also caused by other nonmarket characteristics of the health sector including: fragmentation of funding sources like OOP (refer to Brief 7); vertical, disease-specific delivery systems; and difficulty linking resources invested to results. The costliest types of health sector inefficiencies are those that result from decisions about spending resources “in the right way” or resource allocation at the system, facility or physician level around how to use inputs (Table 11.1).^{1, 2, 8} The OECD recently estimated that between 20 percent to 50 percent of resources in OECD countries were wasted by doing things in the wrong way.^{6, 1}

Table 11.1 Leading Sources of Inefficiency⁸

Category	Source
Medicines	Underuse of generic drugs and higher than necessary drug prices
Medicines	Use of substandard and counterfeit medicines
Medicines	Inappropriate or ineffective use
Health care products and services	Overuse or oversupply of equipment, investigations, and procedures
Health workers	Inappropriate or costly staff mix, unmotivated workers
Health care services	Inappropriate hospital admissions or length of stay
Health care services	Inappropriate hospital size or low use of infrastructure
Health care services	Suboptimal quality of care and medical error
Health system leakages	Waste, corruption, and fraud
Health interventions	Inefficient mix or inappropriate level of strategies

Creating an enabling environment for health financing reforms, particularly those focused on purchasing, can help change the way these inputs are used. Strategic purchasing plays a particularly critical and unique role in supporting efficiency gains. For instance, in the Philippines, fragmentation amongst purchasing entities and the need to use provider payment mechanisms to incentivize behavior were identified respectively as major sources of allocative and technical inefficiency.⁹ Improvements in data quality and systems, in particular for claims data, can help identify and drive improvements in efficiency. Public financial management (PFM) rules must align with health financing objectives in order to support this environment—for instance, moving to output-based budgeting modalities that allow for the use of strategic purchasing reforms focused on generating results instead of counting each input (refer to Brief 12).¹⁰ Ensuring sufficient domestic public resources also helps reduce inefficiencies in resource flows instigated by OOP payments, delaying utilization, and incentivizing provision of unneeded care (refer to Brief 7).¹¹ Combining funding flows from OOP or other sources by bringing them into the system can also improve pooling. As another example, earmarked payroll funding can lead to inefficiency and redistribute resources toward the rich, whereas general revenue is more likely to be sustainable, efficient, and equitable.¹²

Some actions to improve efficiency are in the purview of the health sector alone. For instance, health policies that reduce negative incentives through standard setting can be done within the health sector and can also help tackle inefficiency (Box 11.1). In China, the introduction of an Essential Medicines List helped counter distorted financial incentives for providers to overprovide injections and medical antibiotics resulting in a 25 percent reduction in the average price of essential medicines, a decrease in the median price of 29 generic drugs in the public and private sectors (5.3 percent and 4.7 percent, respectively).² Indeed, efficiency improvements spurred by lowering drug costs can also have a positive impact on OOP as well as health outcomes. In Africa alone, at current spending levels improved efficiency could boost life expectancy by up to five years.¹³

Box 11.1 From Principles to Practice.**Joint Learning Network Country Experience: South Korea**

To prevent overprescribing and misuse of drugs, and to reduce national health expenditure, the South Korean government implemented a policy of separating prescribing and dispensing, which mandates that patients first visit a hospital to obtain a prescription from a doctor and then visit a pharmacist to dispense that prescription. However, there was strong resistance to the policy from doctors' associations. To appease this resistance, the fee schedule was increased several times, leading to an almost 30 percent increase of fees within a single year, which caused the budget to grow beyond its means. This new policy was one of the main causes of the 2000 financial deficit after multiple preexisting insurers were integrated into the scheme.

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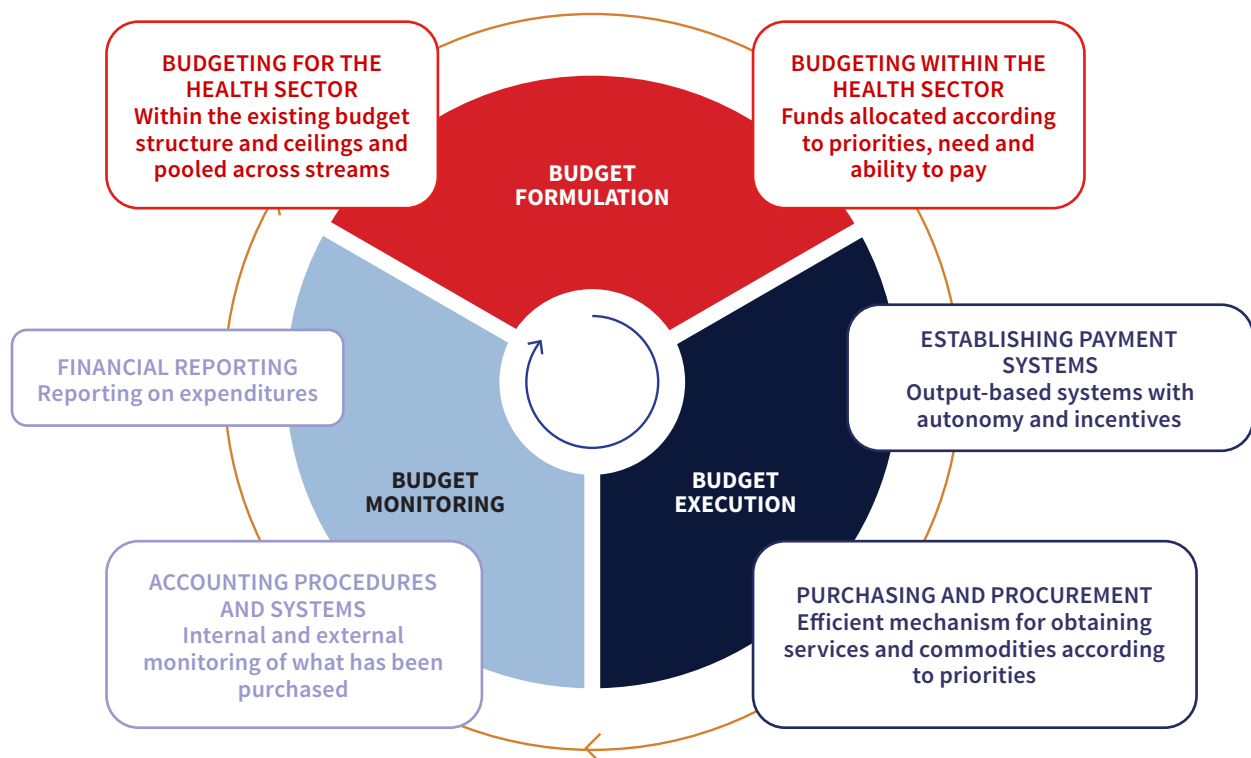
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Brief 12.

Strong Public Financial Management systems can improve the use of financial resources and support movement toward Universal Health Coverage

Using public resources efficiently can generate value for money, and help the health sector to make the case for greater or maintained budget allocations for health.^{1,2} There are many ways for improving the efficiency of health resource use, some of which deal with root causes and others which fix precipitating issues (refer to Brief 11). However, in many cases addressing the root causes of inefficiency can benefit from the “back to the basics” approach: examining how public financial management (PFM) systems support or detract from achieving health financing objectives, including Universal Health Coverage (UHC) goals.^{3,4} PFM systems comprise the foundational set of rules and institutions, policies and processes that govern the flow of public resources, including on budget donor aid. They are the main driver behind the formulation of health budgets and determine how health funds are spent, how they are monitored and reported, and ultimately how services are delivered and population health is improved.^{3,5} Health financing functions can all be seen in the context of the budget cycle (Figure 12.1).³ Conversely, each health financing function is impacted by how the PFM system works. Especially in the context of the deep global economic contraction caused by COVID-19, PFM systems that are well aligned to health financing goals can help make public resource flows to the health sector more transparent and accountable, efficient and effective.

Strengthening the link between budget formulation and evidence-based policy priorities enhances effectiveness and efficiency. Budget formulation includes the PFM functions of planning and allocation. In some cases, low spending in health can result in reduced allocations to the health sector—although it is often not clear if low spending is due to an efficiency gain or an inefficiency resulting from absorptive capacity challenges within the sector or lack of flexibility to reallocate to areas of need.³ Creating a clear link between policy priorities and budget allocations is one way forward, but this can also be hampered by incremental or ad hoc budgeting, or by objectives that are not specific and clear (Box 12.1). Improving the linkage between a multiyear budgeting process, annual budgets, and output-oriented policy targets can make budgets more responsive to need, and reduce efficiency issues like underspending.^{4,3} In Bangladesh, the Medium-Term Budget Framework (MTBF) is designed to link allocation to policies and priorities; however, different health services divisions have overlapping objectives and mandates, which can lead to issues with attribution. Additionally, when priorities are established, the objectives are broad and general without specific targets such as: “Establish an improved and efficient pharmaceutical sector” or “Upgrade quality health care services for all”. Such non-specific objectives pose challenges for monitoring. Budget rules can also impose challenges in mobilizing funds effectively and efficiently during health crises, limiting health resources when they are needed the most. For instance, during a 2017 cholera outbreak in Zambia, restrictions on passing supplementary budgets became a stumbling block to get resources to health and other sectors.⁶ In the first weeks of COVID-19, most countries provided flexibility to the executive branch to reprioritize budgeted allocations between line items or within program envelopes as a first action, as well as for activation of contingency funds.⁷

Figure 12.1 Alignment Between PFM and Health Financing Functions

Source: Cashin et al. (2017)³

During budget execution, flexibility to purchase and procure through changes to PFM rules allows the health sector to make smart choices. In budgeting there is a tension between the need for flexibility and control. Budgeting systems that allow for payment based on outputs, or what is achieved, instead of inputs, can help to improve flexibility needed for providers to move funds according to health priorities as they arise. For instance, although program-based budgeting has been put in place in both Tanzania and Zambia, execution is still done using line item controls. Health facility managers are not able to reallocate funds to evolving needs, such as for drug expenses, throughout the fiscal year, limiting their ability to procure effectively.⁶ Mechanisms that allow managers to purchase more strategically, such as capitation, can be used to improve efficiency during budget execution. In Indonesia, the capitation fund from the National Health Insurance (BPJS) at the First-Level Health Facility (*Puskesmas*) is controlled by the Regional Government. However, the *Puskesmas* experienced problems in management and utilization of capitation funds, because they were required to propose the use of these funds and receive transfers instead of accessing directly. A 2014 presidential regulation allowed for transfer of BPJS capitation funds directly to *Puskesmas*. Adjustments to strategic purchasing methods that are in line with PFM systems can also help improve flexibility during emergencies. In a recent survey of 54 countries' purchasing response to the COVID-19 pandemic, it was reported that half of respondents adjusted payment methods or rates, either by introducing per diem rates for COVID-19 patients, or allowing providers to use funds more flexibly.⁸

Improving the linkage between how health resources are monitored and how they are allocated can increase accountability and transparency, minimizing resource loss. For instance, evaluation can sometimes focus on how well financial rules are adhered to instead of results like efficiency or quality, which can lead to wastage.⁶ Poor information systems or capacity for monitoring can also make it difficult to track funds according to results, or to identify and reallocate underspent public resources. Having the right data can be critical to untangling what underspending is due to efficiency gains, or what is due to blockages like absorptive capacity challenges or waste (refer to Brief 11).³ Additionally, lack of a linkage between how budgets are allocated and tracked can diminish reforms that are meant to improve both flexibility and transparency. A recent multi-country assessment showed that while many countries reported that fund allocation takes place in line with sector priorities, only 30 percent tracked resources against these

priorities.⁹ A new Public Financial Management Act in Ghana (Act 921) has improved controls by ensuring that there is proper budgeting and usage of public funds and public institutions are required to operate within budget. This Act requires public institutions to use the Ghana Integrated Financial Management Information System (GIFMIS) to capture their budgets and process all financial transactions and it helps to ensure transparency, proper monitoring and accountability of public funds. Payment outside the GIFMIS is an offence which comes with sanctions.

Ultimately, Public Financial Management systems that are well aligned with health financing goals can help improve health outcomes.³ The way that PFM systems are structured can either help or hamper how domestic public resources move across the health system, supporting achievement of health system goals and enhanced population health.^{1,10} For instance, a study found that a one unit improvement in PFM quality is associated with a reduction in under-five mortality of 14 deaths per 1,000; and for countries that channel at least 75 percent of total health expenditure through the public system, this increases to 17 per 1,000.^{a,11} During the COVID-19 pandemic, countries are making efforts to try and accelerate funding flows to the front lines in order to support pandemic response. PFM systems that include flexibilities for policy options like virements, advance payments, direct to facility financing or robust transfer formulas can immediately benefit health outcomes, and support building resilience into the future (refer to Brief 16).^{7,12}

Box 12.1 From Principles to Practice.

Joint Learning Network Country Experience: Lao PDR

Under the Public Finance Development Strategy 2025 and Vision 2030, the Ministry of Finance has implemented PFM reforms in Lao PDR at the national level. This strategy was approved by the Prime Minister in July 2017 and provides the framework for medium- and long-term PFM reforms. Discussions with Ministry of Health are currently under way to pilot these reform initiatives to improve (i) the overall health budget planning processes, (ii) address key PFM bottlenecks in the health sector at budget formulation stage, including delays in budget approval and lack of clear linkages between sector policy priorities and budget allocations, and (iii) coordination and collaboration between the ministries in preparing credible budgets for the health sector. The Ministry of Health in cooperation with the World Bank and the World Health Organization are currently developing PFM guidelines and the health financing strategy 2021-2025 as a part of activities to improve policy-based budget formulation for the health sector.

^a As measured using the PEFA Score, a tool used to measure and monitor performance against a set of indicators across the range of important public financial management institutions, systems, and processes.

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Brief 13.

Investing in evidence-based health priorities provides value for money for public funds

Public revenues should be directed to those services that maximize progress toward Universal Health Coverage (UHC).¹ To this end, investing in processes that support the creation of evidence-based Health Benefit Packages (HBPs), and complementary tools like Health Technology Assessment (HTA) can help drive systematic prioritization of cost-effective health interventions that can enhance value for money and minimize opportunity costs of making other less impactful investments.² Health sector investments support healthy populations, which are the critical drivers of productivity and human capital needed to realize the success of investments in other sectors (refer to Brief 8).³ They are well justified when they fund health interventions which have been found to be cost-effective, equitable, and feasible within the existing resource envelope.⁴

A central requirement for an efficient health system is that the services being purchased are prioritized and aligned with available financial resources.^{15,16} An underfunded, ill-defined, or wide scope of services can create inefficiencies, leading to implicit service rationing that contributes to inequities and poor use of public resources (refer to Brief 11).^{15,1} A costed HBP that uses actuarially-informed estimates and is increased in line with available resources can inform allocation decisions, improve value for money, and enhance transparency around benefits available to the population.^{17, 15, 18} For example, the 2009 Universal Health Law in Peru enshrined the right to health through a minimum benefits requirement and principles of UHC, but the HBP that followed was not based on actuarial projections of the cost of care, the demographic and epidemiological profile of the population, or the capability of available services, and was therefore not fiscally sustainable.¹⁹

Many health sector investments have been shown to be highly cost-effective. Cost-effectiveness analysis (CEA)^{a,5} may be used to identify health interventions which can be considered for inclusion in UHC programs (Figure 13.1). Cost-effective interventions include the treatment and prevention of primarily infectious diseases (for example, malaria, TB, HIV/AIDS, and heart disease), basic surgical interventions (for example, basic trauma surgery, emergency obstetric care, surgery for cataracts, hernias), and other interventions like community-based neonatal care.⁶ The World Health Organization uses a CEA approach to maintain a list of “best buys”^b for the prevention and control of noncommunicable diseases, including increasing excise taxes and prices on tobacco products, reducing salt intake through behavior change

a CEAs are especially useful in making allocations within a health budget. They assess the impact of health sector investments using data like real health outcomes (for example, child deaths) or summary health measures (for example, quality-adjusted life years [QALYs] or disability-adjusted life years [DALYs]).

b ≤ US\$100 per DALY averted.

campaigns, and drug therapy and counselling for persons who have had or are at high risk of a stroke.⁷ In the case of routine immunization, health sector investments are proven to be highly cost-saving. It is estimated that between 2021 and 2040, the return on investment from immunization programs against 10 major pathogens in 94 low- and middle-income countries will be US\$54 per US\$1 spent.⁸

The evidence-driven process of Health Technology Assessments (HTAs) can inform development of HBPs that make best use of public funds. HTAs are a systematic evaluation of the costs and benefits of new health interventions. They are an institutional mechanism which can be used to develop and adjust HBPs that reflect health system priorities and achieve value for money. HTAs can be used to assess a range of health technologies, from medicines, to public health programs (such as immunization programs, smoking prevention programs), to support systems (for example, blood banks, telemedicine systems, drug formularies).⁹ Institutionalizing an HTA process is resource-demanding; in low-income countries, small technical units within Ministries of Health can be first established to influence HBP development with key evidence; over time these units can evolve into more institutionalized processes (Box 13.1).^{10,11}

Figure 13.1 Interventions for Adults Costing Less than US\$100 per DALY averted



Source: Horton et al. (2017)⁶

It is critical that HTAs consider evidence of cost-effectiveness alongside financial protection criteria, and consult local sources of evidence.¹² A cornerstone of high-performance health financing is that resources being used to finance UHC are both efficient and equitable. In some cases, there is tension between efficiency and equity objectives. Expanded HTA processes which take into account cost-effectiveness data and financial protection criteria, as well as evidence addressing equity of coverage, budget impact, and ethical issues, are best suited to support high-performance health financing.^{9, 12} Finally, in settings where evidence is being considered to establish rather than revise or marginally adjust an HBP, HTAs and the more general process of developing a HBP should not only take into account global cost and CEA, but local evidence on financial protection, values, and operational feasibility (refer to Box 13.1).¹¹ In addition, in-country expertise representing a wide range of stakeholders should be involved in commissioning, producing, and interpreting evidence.¹¹

Quantifying the value of investing in health against investments in other sectors can support budget proposals that maximize value and welfare to society. A complementary approach known as cost-benefit analysis (CBA), can be used to support allocation decisions across sectors, as it captures the economic benefits on investments by statistically assigning monetary value to lives saved.^{5, 13, c} CBA may be a more useful source of evidence to use (compared to CEA) where the impact of investments in the health sector are seen to accrue in monetary terms rather than in terms of health outcomes. Recently, guidelines and illustrative case studies were released to support countries in benefit-cost analysis.¹⁴

Box 13.1 From Principles to Practice. **Country Experience: Thailand**

In the midst of an economic recession (1997-2005), Thailand introduced a universal coverage scheme in 2001, and driven by the need for cost containment, a Health Technology Assessment (HTA) program in 2002. HTA has played a pivotal role in the Thai program, and in 2016, it evolved into the Health Intervention and Technology Assessment Program (HITAP).¹ HITAP engages key stakeholder groups to identify 10 topics each year that will be assessed for inclusion in the HBP according to six prioritization criteria:²

1. Size of population affected
2. Severity of disease
3. Effectiveness of health intervention
4. Variation in practice
5. Economic impact on household expenditure
6. Equity/ethical and social implications

The results produced by HITAP have been used by the government not only to design and update the HBP, but also to negotiate prices for its UHC package.^{20, 21}

c This metric is referred to as the Value of Statistical Life (VSL), which is the marginal rate of substitution between money and mortality risk in a defined time period.¹³ More intuitively, the VSL indicates how much individuals would be willing to pay to reduce the risk of death.

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Brief 14.

Health taxes can curb unhealthy behavior and generate revenue

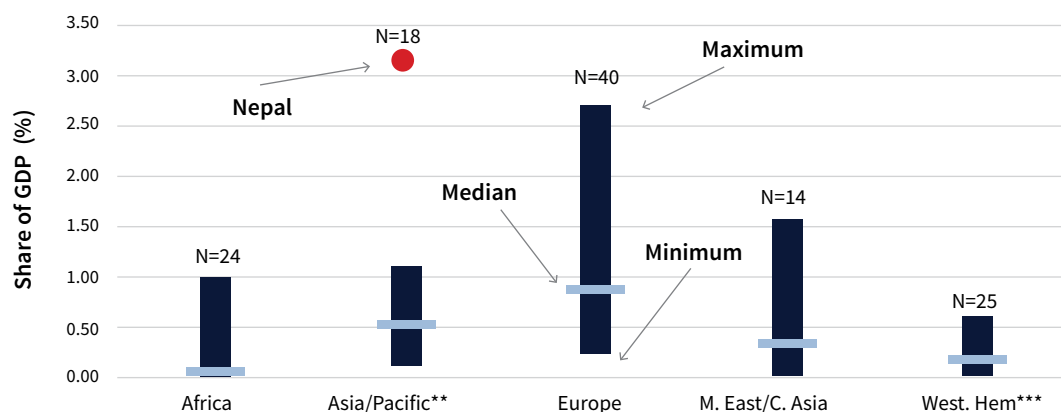
“Health taxes”, sometimes known as sin taxes, are imposed on products that have a negative public health impact, like tobacco, alcohol, or sugar-sweetened beverages (SSBs). They can also extend to environmental taxes on pollution that damage health (e.g. fossil fuels). Depending on how they are structured, these taxes can be borne by the producer or by society. While there are some arguments about whether they can contribute to negative side-effects like illicit trade or regressivity, health taxes can be a triple win: they have the potential to reduce non-communicable disease burden on the health sector, increase overall government revenue, and reduce risk factors for co-morbidities like obesity that are a risk factor for COVID-19—which can lead to passive increases in the health budget. If prioritized for health, they can also directly increase health sector resources. However, designation as a health tax does not mean that revenue is earmarked for the health sector. If budget processes fail to prioritize health, earmarking of health taxes should be done cautiously.¹

Health taxes can curb unhealthy behaviors considered as risk factors for COVID-19 morbidity and mortality and reduce future burden on the health sector. The primary objective of introducing a health tax is to improve population health through reduced consumption of unhealthy products. Risk factors for increased morbidity and mortality associated with obesity, diabetes, or smoking are associated with increased severity of COVID-19 and can be reduced through health taxes, leading to reduced strain on the health sector.²⁻⁷ Curbing unhealthy behaviors at scale helps to generate efficiency gains that can help existing resources go further. For instance, a study earmarking tobacco tax in nine countries stated the primary motivation for earmarking excise taxes was improvement in public health, rather than raising revenue.⁸ Raising taxes on tobacco is the single most effective tobacco control measure, with a 10 percent increase reducing consumption by between 5 percent and 8 percent in low- and middle-income countries and approximately 4 percent in high-income countries.⁹ A recent study of 500 million male smokers in 13 middle-income countries demonstrated that a 50 percent increase in cigarette prices would lead to 450 million years of life gained. Men in the poorest 20 percent of the population would gain 6.7 times more in life years than the top income group—with half of the gains concentrated in China—which also points to significant benefits in terms of equity, and spillover effects for gains in productivity, productive years of life, and human capital.^{11,12}

Health taxes raise revenue, which may be prioritized to the health sector. COVID-19 has kicked off a deep global economic contraction.¹³ Latest estimates indicate that per capita economic growth rates will decline on average by 6.4 percent globally, and between 4 percent and 8 percent across low- and lower-middle-income countries. The economic impact of COVID-19 will be compounded by the poor economic position many countries were already in before the pandemic.^{14,15} A global task force on fiscal policy

for health recently estimated that if all countries imposed a 50 percent increase in excise taxes aimed at reducing consumption of tobacco, alcohol, and sugar sweetened beverages, it could generate more than US\$20 trillion over the course of 50 years.^{a, 6} Overall, more recent estimates of short term revenue potential benchmark for tobacco, alcohol and sugar-sweetened beverages is 0.6-0.7 percent of GDP.^{10, a} To determine whether a health tax has potential in a specific context needs to take account the local administrative capacities and conditions, and overall prioritization of health within government budgets: Health taxes will only mean more money for health if revenue is prioritized to the health sector, or if health's position relative to other government priorities does not fall. However, in countries that have instituted or increased health taxes, particularly tobacco excise taxes, revenue gains are significant, and will continue to be so until consumption behaviors change significantly (Figure 14.1).^{2, 1}

Figure 14.1 Tobacco Taxes and GDP Minimum, Maximum, and Median (2013)*



Source: Petit (2018)²

Notes: *IMF and WHO data. Excise only, and excluding revenue from state enterprises

** Including Nepal (3.19 percent). The second highest is Solomon Islands (1.12 percent).

*** Excluding notably Canada, USA and Brazil. Many Caribbean Islands rely on import duties

Some negative claims made against health taxes have been largely refuted. These negative claims include that health taxes can slow the economy, encourage illicit trade, or drive inequity. However, these claims were generally shown to be unfounded.¹⁶ For instance, a recent study in South Africa demonstrated that the overall health impact of tobacco taxes were positive, resulting in lower medical expenses for the poor and more working years, which in turn generated spill-over effects for the economy.¹⁷ Additionally, in South Africa the estimates on illicit trade were shown to be overstated by industry. South Africa has implemented excise taxes on tobacco, alcohol, and SSBs which has indeed served to reduce sales volumes of these products while increasing revenue for health (R14.5 billion, R31.5 billion, and R2.9 billion respectively), although these revenues were not earmarked.¹

Where standard budget processes fail to prioritize health, health taxes may be subject to cautious soft earmarking, and can promote pro-poor objectives. The practice of earmarking refers to taking all or some of the revenue from a tax or group of taxes and setting it aside for a designated purpose, like health.⁴ However, earmarking can reduce the ability of finance actors to flexibly manage public resources. If a budget process works well and health is prioritized, then earmarking of health tax revenue or other sources may not be needed. If there is a failure to generate allocations that match priorities, or if a tax can help improve political support, soft earmarking may be useful in the short term. Soft earmarks may help inject funds if pursued with safeguards, an understanding of local conditions, and are pro-poor and

a These estimates update previous long-term revenue simulations prepared by the Task Force on Fiscal Policy for Health and are equivalent to an increase of total tax revenue of 3-6 percent depending on the level of total revenue. Estimates are lower than previously as a result of the shorter horizon and aligned with COVID-19 induced revenue shortfalls.

aligned with public financial management processes (Box 14.1).^b However, there is no guarantee that soft earmarks will lead to sustained revenue for health over time, and may in fact serve as a signal for budget holders to reduce net public funds for health, suggesting that these should also be time-bound or subject to periodic review.^{4, 18} Further, while earmarks are not necessary for health taxes to have an impact on financing the COVID-19 response, some spending package that supports health spending over the medium term could provide a reason to use health taxes as a part of the pandemic response.¹⁰

Box 14.1 From Principles to Practice.

Joint Learning Network Country Experience: Philippines

In the Philippines, soft earmarks that aligned to the standard budget process were introduced as a result of a political promise to move the country toward UHC. As a result, the 2012 Sin Tax Reform and subsequent adjustments led to substantial increases in revenue for health. By 2020, the corresponding shares earmarked for health were as follows: alcohol (100 percent), tobacco (50 percent), sugar-sweetened beverages (50 percent), heated tobacco (100 percent) and vaping products (100 percent). The earmarks have provided not only a sustained but significant source of revenue, tripling resources for health in a period of five years (2013–18). The earmarks have also helped to decrease the prevalence of smoking and improve equity by expanding coverage and paying for health insurance for the poor.^{1, 4}

Tool: [The WHO Tobacco TaxSim model](#) calculates the potential impact of tobacco taxation on tax revenues and the tobacco market. The model includes a forecast on smoking prevalence rate, can support tax policy analysis, impact assessment and decision-making around tobacco tax reform, and provides global data on tobacco prices and tax rates in a downloadable format.

^b 'Soft' earmarks are those designated for a specific purpose but do not determine the amount spent through legislated expenditure ceilings. They can be supplemented with general revenue and generally align with the standard budget process in a country. (Definition adapted from Cashin et al. 2017.)

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Brief 15.

Collaborating with the private sector can help maximize public resources

The private sector is a prominent part of the service delivery landscape in many countries; however, failure to engage the private sector and leverage their capacity effectively represents a market failure, and points to potential inefficiencies in public resource use.¹ The private health sector can serve as a partner to the public sector and enhance efficiency and the use of public resources when effectively engaged, contracted, and regulated. The private sector can leverage its comparative advantage to the government through capital for investment, or in terms of its expertise, capacity and existing reach.¹ Engaging the breadth of different private sector actors can improve use of public funds and support greater access to services, leading to gains in human capital and economic growth. This brief explores private sector collaboration through the lens of public private partnerships (PPPs)^a and contracting—with a focus on public engagement of the private sector for delivery of services.^b

Engaging the private sector through health public-private partnerships (PPPs) can help public resources go further. PPPs are a form of long-term contract (more than five years) between public and private partners focused on strengthening public resources. PPPs can come in six forms: (i) financing or co-financing; (ii) design, including for infrastructure or care delivery models; (iii) building, including construction and renovation of facilities; (iv) maintenance of hard infrastructure; (v) operation of applicable equipment, IT or other non-clinical services; or (vi) delivery and/or management of clinical or clinical support services.^{c,2,3} In these ways, PPPs can help augment public resources by bolstering capital budget or cash flow constraints.³ However, strong capacity and regulatory environments on the public side is needed to manage arrangements and help achieve health sector goals, and this is a challenge in many low- and middle-income country settings.⁵ Additionally, private investments may result in a frontloading of costs rather than additional revenue for health.⁴ The COVID-19 pandemic has strained existing PPP programs, with disrupted demand and operations leading to lost revenue. This has pointed to the need to assess projects so that they become more resilient to future shocks.⁶ For example, ensuring that the definition of PPPs allows for exploration of private sector innovations, including digital development and support of telemedicine, will be critical.^d

a Out-of-Pocket payments are discussed in Brief 6 and 7 and voluntary health insurance is addressed in Brief 7.

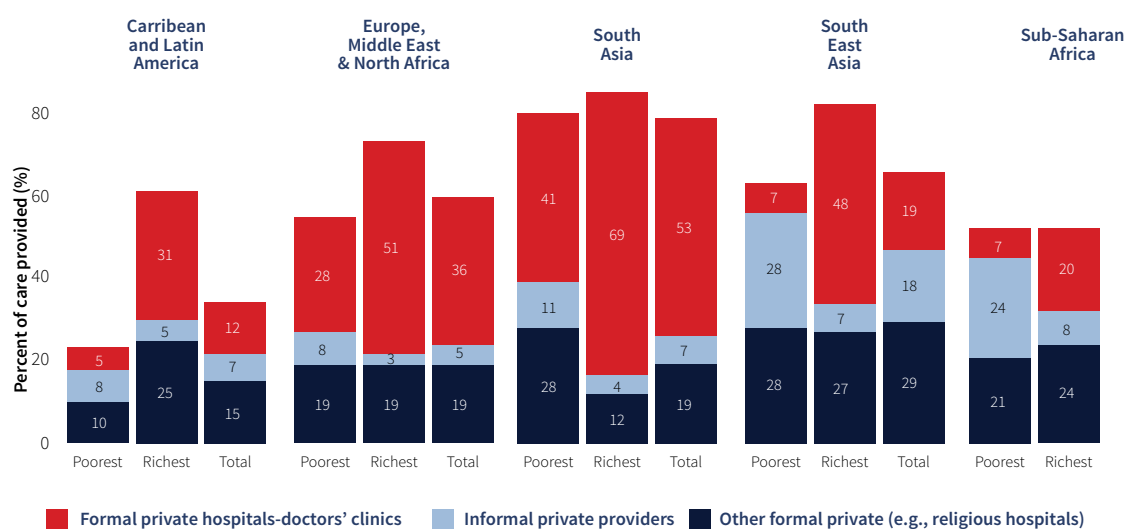
b Refers to both contracting in and out. Contracting out is when private entities are engaged to delivery government-financed services outside of public delivery systems, and contracting in is when private entities are engaged to manage or directly deliver services through public facilities.²

c The private health sector is often loosely regulated and highly fragmented;² policies and regulation of the private sector can be one way to improve efficiency.

d WBG Blog posts accessed on February 12, 2021: <https://blogs.worldbank.org/ppps/making-ppp-legal-frameworks-fit-post-covid-19>;

Private sector actors can be engaged through government contracting arrangements that extend service coverage, helping to maximize existing public resources. The private sector is a major actor in health care delivery systems (Figure 15. 1). It is estimated that private providers account for 50 percent of all treatment of basic conditions like diarrhea, cough and fever in sub-Saharan Africa, and provide almost 80 percent of all care across income groups in South East Asia.⁷ As a major player in the provision of health services, private providers often have considerable comparative advantage, especially regarding supply chain management and logistics (Box 15.1).^e Contracting of private providers to deliver services through PPPs or otherwise can reduce fragmentation and boost health systems in, supporting population health outcomes and development of human capital hard-to-reach areas or segments of the population where the private sector has comparative advantage. For example, in Pakistan, the government works with voluntary, private insurance companies to cover premiums for 50 percent of the poorest income quintile to enroll in private schemes.⁸ In Thailand, the gradual extension of a mix of public and private health insurance mechanisms expanded protection against OOP expenditure to 70 percent of the population.⁹ PPPs for service delivery can also meet needs for improved management and enhance quality, cost, and efficiency of health care services, stronger and more efficient procurement, growth to additional services or expanded service capacity.^{3,10}

Figure 15.1 Private Sector Provision of Treatment for Diarrhea and Fever/Cough in Children Under-five by Region, Provider Type and Income Group



Source: Original figure from Wadge et al. (2017)⁷ using Demographic and Health Survey data between 2000 and 2008.

Governments can move toward Universal Health Coverage (UHC) by engaging the private sector, but must establish a supportive government and regulatory environment.³ While there is fertile space for collaboration, there are key challenges in engaging the private sector to achieve UHC. Without a governance and regulatory environment to allow for efficient management and coordination within a mixed health system, the private sector may engage in monopolistic behavior and predatory pricing, or operate in a way that is not aligned with the objectives of UHC (that is, equity, access, quality and financial protection).⁹ Purely top-down regulation is not particularly effective; rather, it is better to rely on and support platforms for public-private dialogue to stimulate buy-in and the use of preconditions like licensure and accreditation, as well as strong and flexible contracts and contract management capabilities within the government to ensure key conditions are met before engaging in private sector contracting.¹¹

<https://blogs.worldbank.org/ppps/how-world-bank-looking-covid-19-and-public-private-partnerships-right-now-and-post-crisis>

^e Private players consist of a range of actors with varied skills and incentives, from social franchise networks, to private-for-profit hospitals, to small individual nurse practitioners, to capital investors and developers.

Box 15.1 From Principles to Practice.**Joint Learning Network Country Experience: Kenya**

The private sector can help governments manage complex supply chains for vaccines, especially for newer, more expensive vaccines like for COVID-19. The private sector is specialized and has enough resources to achieve increased efficiency by exploiting economies of scale, and can reduce costs by working with the Ministry of Health to assume responsibility for investments in areas like cold chain equipment, refrigerated trucks, and skills logisticians. For example, Kenya has developed a mature vaccine logistics market over the past decades through contracting out of vaccine transport services. In 2004, the Kenya Medical Supplies Authority established a diverse range of smaller contracts with private providers to encourage competition, and eventually shifted to larger contracts with dominant providers that could manage large-scale distributions.^{12, 13}

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Brief 16.

Investing in outbreak preparedness can make health systems more resilient and enhance economic security

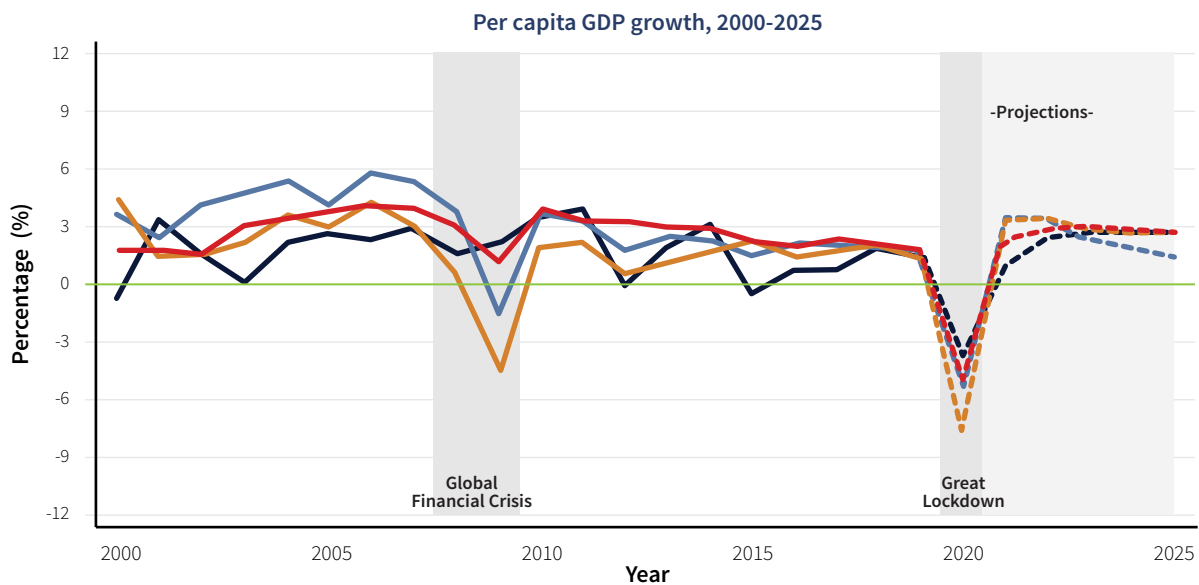
Preparing for outbreaks means having the capacity to better anticipate, detect, respond effectively to, and recover from the impact of health emergencies.^a Infectious disease outbreaks, such as malaria, respiratory viruses like novel coronavirus (COVID-19), or viral haemorrhagic fever like Ebola, pose enormous human and economic risk both within and across borders. Preparedness^b is considered a Common Good for Health^c and a major component of Universal Health Coverage (UHC) which can generate enormous societal benefits, but requires public financing as it has the characteristics of a public good.¹ However, trading off investments for future, unknown, and potentially unlikely events with current health system needs is challenging. Preparedness for outbreaks can not only improve health systems, making them more resilient, or able to flexibly absorb and rapidly respond to shocks (for example, pandemics, natural disasters, forced migrations), but also enhance human welfare and economic security.²⁻⁴ These investments can be critical to reduce loss of life, curb societal and economic disruption, and limit diversion of critical domestic resources during times of need.⁵

The COVID-19 pandemic has demonstrated the massive economic damage and development backslide that can result from poor preparedness.³⁰⁰ The most recent projections from the International Monetary Fund indicate that economies will contract in per capita terms by an average of 6.4 percent due to the COVID-19 pandemic, across all country income groups, making this the largest economic contraction in modern history (Figure 16.1).^{7,8} The COVID-19 pandemic is likely to return global poverty to 2017 levels, pushing upward of 88 million people into extreme poverty in 2020, and perhaps up to 150 million by 2021.⁷ This is even more dire than the loss seen from previous epidemics like SARS and Ebola. The global and national impacts of the 2003 SARS outbreaks in China and Hong Kong are estimated to be between US\$40 billion to US\$53 billion globally, with the higher estimate reflecting long-term loss in investments due to fear of a reoccurrence.⁹ The estimated economic and social burden of the 2014 Ebola outbreak in West Africa is more than US\$50 billion, with over a third of this loss from non-Ebola deaths due to diversion of resources.⁵

a Aligned to Global Preparedness Monitoring Board. A World at Risk: Annual Report on Global Preparedness for Health Emergencies [Internet]. Geneva: 2019. Available at: ISBN 978-92-4-151701-0.

b Defined by the Global Preparedness Monitoring Board as, “the ability (knowledge, capacities, and organizations systems) of governments, professional response organizations, communities, and individuals to anticipate, detect and respond effectively to, and recover from, the impact of likely, imminent or current health emergencies, hazards, events or conditions”.

c WHO defined Common Goods for Health as follows: “Common Goods for Health (CGH) are population-based functions or interventions that require collective financing, either from the government or donors based on the following conditions: 1. They should contribute to health and economic progress. 2. There is a clear economic rationale for interventions based on market failures, with focus on (i) Public Goods (nonrival, nonexclusionary), or (ii) large social externalities.

Figure 16.1 Per Capita GDP Growth, 1996-2025

Source: Kurowski et al. (2021)⁷

Investing in preparedness averts larger future health care costs. Investing in outbreak preparedness is a national and global responsibility. Local and national leaders should mobilize and align demand for investments in preparedness with international coordination mechanisms via commitment to the 2005 International Health Regulations (IHR)—an international agreement which compels 196 countries, including all the Member States of WHO, to develop core capabilities required to detect, assess, report, and respond to public health emergencies of international concern.¹⁰ The Joint External Evaluation (JEE), a WHO tool used to assess country attainment of IHR standards, suggested that most countries would need to spend between US\$0.50 and US\$2 per person to attain an acceptable level of general preparedness.² Further, the World Bank estimated in 2018 that it would cost US\$3.4 billion annually to prepare health systems in low- and middle-income to prevent and control the spread of major zoonotic diseases (i.e., diseases transmitted from animals to humans like animal flu)^{11, 12} compared to the US\$6.7 billion that was spent annually in response to zoonotic disease outbreaks between 2007 and 2009, although these estimates are likely to shift with COVID-19.^{13, 14} Beyond the sticker price of epidemic response, the wider health system is impacted when outbreaks escalate, as financial, human, and material resources must be diverted to response measures. For example, during the Ebola outbreak in Sierra Leone, public funds were diverted to Ebola containment, with routine services in the health and nutrition sectors bearing disproportionate direct and indirect effects of the epidemic.^{15, 16}

Many countries lack the resources to prepare, especially as they balance investments needed to control COVID-19 against other health needs, and restart their economies.^{17, 18} Investments in preparedness will include systems needed for early detection and prevention of outbreaks before they escalate, such as monitoring ports of entry, establishing surveillance and response, strengthening laboratory capacity, and human resource development. Such investments will avert larger costs of a future epidemic or pandemic^{6, d} as well as result in a surge in manufacturing capacity, support demand forecasting for stockpiling, and build up a solid base of skilled human resources for health to respond to outbreaks and pandemics.¹⁹⁻²¹ In the wake of the 2003 SARS outbreak, Taiwan invested in a public health response mechanism for enabling rapid response to SARS-like events, and was able to make rapid domestic resource allocations for preparedness and containment measures which have played a major role in the

d Some diseases are endemic to specific regions and may emerge as outbreaks within a community or geographical region, that is, those initially-limited outbreaks which can more easily spread rapidly to become an epidemic (many countries) or pandemic (global).

containment of the COVID-19 pandemic.²² Of course, securing consistent domestic financing for these measures can contribute to preparedness by establishing systems that can help prevent the escalation of biological risks and facilitate more timely and effective responses when they do occur. As countries transition into a COVID-19 recovery phase, government budgets will be more restricted, whilst health budgets within those are stretched to meet basic health needs let alone prevention and financing of the current pandemic or preparedness. Indeed, costs to achieve adequate levels of vaccination coverage alone amount to approximately 2.1% of GDP in low-income countries and 0.7% of GDP in lower middle income countries.⁷ Spending on these measures will save lives right now, and are the only way to curb current and future economic fallout.⁷ However, countries also cannot lose sight of the need to consider preparedness now, including formulation of national plans that can set out a pathway to avoid the tremendous loss in human and economic capital incurred by major outbreaks.²⁷ Countries may explore creating synergies for domestic resource mobilization for preparedness by way of regional networks or global health networks,^e or designating donor resources for preparedness.¹¹

Box 16.1 From Principles to Practice.

Joint Learning Network Country Experience: India

To create a mechanism for disaster preparedness, India passed the Disaster Management Act in 2005 and created the National Disaster Management Authority (NDMA) that is chaired by the Prime Minister and tasked with establishing policies, plans, and guidelines for management of disasters. A National Disaster Relief Fund was later established under the NDMA, funded through a hard earmark of tobacco, fuel, and motor vehicle taxes. In March 2020, the NDMA was able to dedicate 35 percent of its annual resources (approximately US\$700 million) to COVID-19 response activities through the State Disaster Response Funds. Additionally, at least 16 states in India significantly increased taxes and excise duty on alcohol to mobilize additional revenue post- COVID, including: a) increase of excise duty on alcohol ranging from 6 percent in Karnataka to about 75 percent Andhra Pradesh; b) 25 percent increase in cess on alcohol in Assam, Arunachal Pradesh, and Meghalaya; c) 14 cents to US \$3 increase in the price of liquor per bottle in Uttar Pradesh and Uttarakhand; and d) levying a new “COVID fee” on maximum retail price ranging from 11 percent in Karnataka to 50 percent in Odisha.^{25, 26}

e Global health networks are defined by Shiffman (2016)²⁴ as “Cross-national webs of individuals and organizations linked by a common concern about a particular global health problem...[They] connect various types of institutions such as United Nations agencies, donors and foundations, national governments, nongovernmental organizations (NGOs), medical associations, research institutions, and think tanks.²³

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