JOINT LEARNING NETWORK
For Universal Health Coverage

On Prioritizing Health: A Background Analysis

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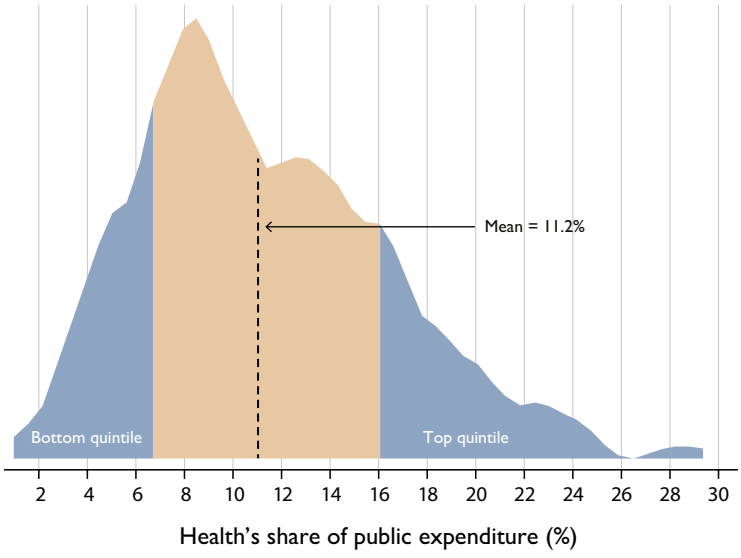
As part of the domestic resource mobilization (DRM) collaborative of the Joint Learning Network (JLN), a global review of health's share of public spending is being conducted, with a follow-up deeper dive focus on a sub-set of countries where recent sustained reprioritization efforts towards health are evident. In many countries, lack of government prioritization for health is a major constraint to increasing public financing for health, and especially so where broader economic growth and overall public revenue generation efforts are weak. Reprioritization is a key challenge for health ministries when dealing with ministries of finance and planning, especially as health is often perceived to be an unproductive and inefficient sector. Understanding the what, why, and how of reprioritization efforts from countries that have recently successfully managed to do so can provide important insights for others where this DRM policy option has the potential to overcome a key bottleneck for health financing.

Globally, based on the latest available cross-country data from WHO, the average share of health in public expenditures stands at about 11.2 percent (Figure 1). However, there are large and notable variations across countries: e.g., health accounts for less than 3 percent of public expenditures in Venezuela, Iraq, and Equatorial Guinea to almost 30 percent in Costa Rica.[1] Countries where health's share is below 7 percent (such as Afghanistan, Bangladesh, India, Cameroon, Egypt, Lao PDR, Haiti, Mongolia, Cambodia, Cote d'Ivoire, Nigeria, and Myanmar) are in the bottom quintile whereas those where health's share is greater than 16 percent (such as Burkina Faso, Guatemala, Japan, Malawi, Rwanda, Madagascar, Kosovo, Yemen, and Sierra Leone) are among the top quintile globally. Some of the observed differences in health's share of public spending across countries are, unsurprisingly, related to differences in national income: cross-country comparisons show that higher-income countries generally spend a larger share of aggregate public expenditure on health than

Figure 1: Health's share of public expenditure, 2016



[1] In comparing prioritization across countries, it is important to note that the relationship between health's share of public expenditure and public financing for health as a share of GDP is not monotonic since the size of public expenditures are different across countries. A country such as Cuba has a lower health share of public expenditures relative to Iran but a higher share of GDP because its size of public expenditures is higher. Indonesia, on the other hand, has roughly the same health share of public expenditures as Bhutan but is lower as share of GDP because the size of public expenditure in Indonesia is lower than that of Bhutan's.

those at the lower end. Health care costs tend to be higher in richer countries, driven by relative price differences as well as the availability of higher-technology care, among other factors. Richer countries also tend to have more educated and ageing populations with preference structures that expect higher levels of public financing for social protection programs, including for health. Higher costs of and more demand for publicly financed health care -- combined with a greater fiscal and institutional ability to do so -- are some reasons governments tend to spend a greater share of public expenditure on health as countries become richer. However, significant variations exist in health's share of public spending even after controlling for national income. To date, empirical work on prioritization has been sparse: available cross-country econometric analyses suggests that factors such as democratization, lower levels of corruption, ethnolinguistic homogeneity, and more women in public office are correlated with higher shares of public spending on health; however, these findings are not robust and are sensitive to model specification.

Despite large country-specific variations, health's share of public expenditure does tend to vary systematically by a country's income classification and region. As might be expected, affluent countries are more likely to prioritize health: the mean share for health among high-income OECD countries is 15.7 percent versus 10.2 percent in low-income countries (LICs). Among low- and middle-income countries, prioritization varies significantly across regions: health's share is only 5.7 percent in South Asia Region (SAR) whereas Latin America and the Caribbean (LAC) countries set aside 14.4 percent for health. Except in high-income OECD countries, education's share of public expenditures is higher than that for health; in some regions and income classifications, education's share is more than double that of health's. In SAR and Middle East and North Africa (MNA) countries, defense and debt service expenditures dominate health's share of public spending.

Table 1: Share of health in public expenditures versus other sectors

	Health (%)	Education (%)	Defense (%)	Debt Service (%)
Low- and middle-income	10.2	16.6	6.6	6.7
LIC	10.2	17.2	6.8	6.1
LMI	8.8	18.2	7.7	7.7
UMI	11.5	14.7	5.6	6.2
SSA	9.9	17.6	7.3	6.7
SAR	5.7	17.2	8.2	10.5
MNA	10.5	19.3	12.1	9.9
EAP	7.7	17.6	6.2	4.6
ECA	9.8	12.3	6.0	4.1
LAC	14.1	17.8	3.7	8.4
High-income	14.0	12.7	5.9	2.4
Non-OECD	9.7	12.3	12.0	0.6
OECD	15.7	12.8	3.9	3.1
All	11.2	15.3	6.4	5.6

Over 2010-2016, the average annual growth rate in reprioritization for health was 0.9 percent but with large variations across countries: ranging from a low of -20.1 percent to a high of 19.2 percent. About two-thirds of all countries in the sample posted positive growth rates in prioritization, with the remainder seeing a decline. The secular increase in prioritization appears to have impacted countries across all income classifications and regions roughly equally (Figure 2). Myanmar, Guinea, and Equatorial Guinea were the three countries with the highest rates of increase in priority for health, albeit in all three cases this was from a relatively low base of less than 5 percent in 2010. Among High Income Countries (HICs), Ireland posted the largest increase in prioritization: with health's share increasing from 12.3 percent to 19.7 percent over 2010-2016. Among low- and middle-income countries, those that saw the largest declines in prioritization were mostly those that were classified as Fragility Conflict and Violence (FCV) countries.

Figure 2: Trends in prioritization for health by income and region, 2010-2016

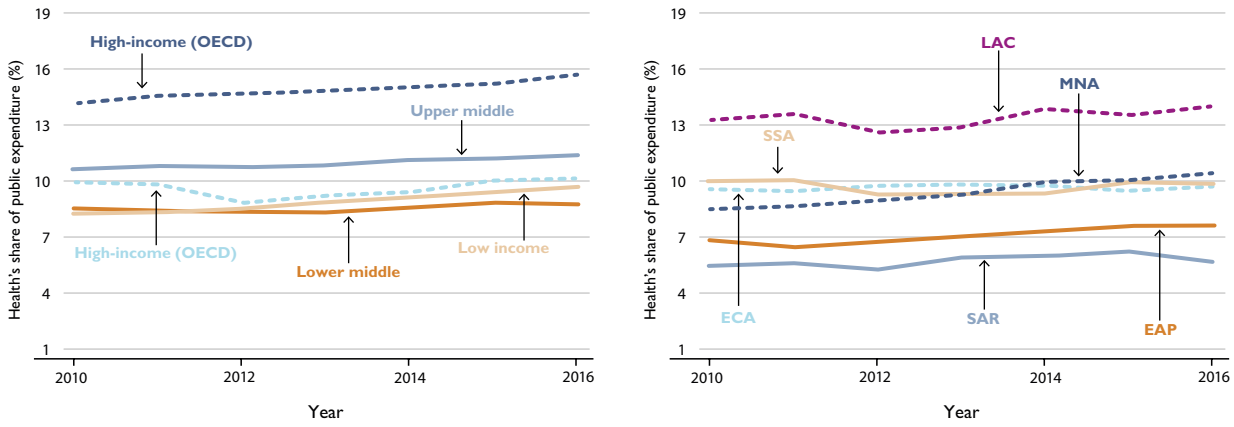


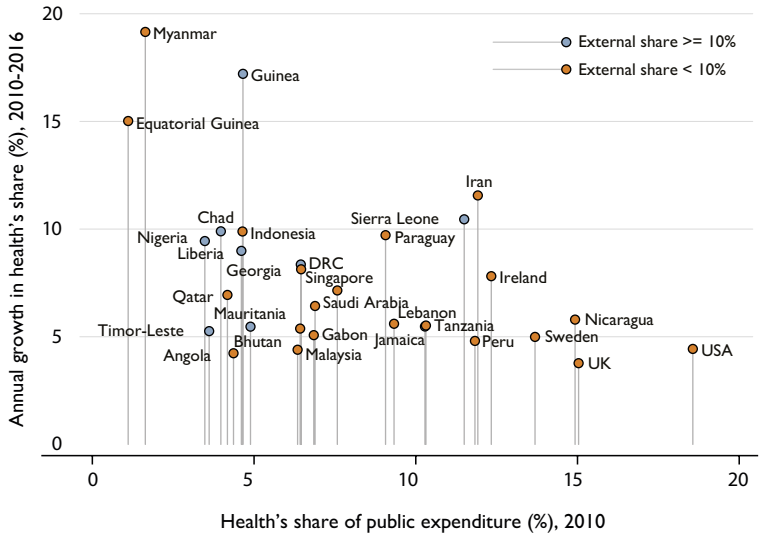
Table 2: Countries with the highest and lowest change in priority for health, 2010-2016

	Low- and middle-income				High-income			
Rank	Country	Health share 2010 (%)	Annual growth health's share 2010-2016 (%)	Health share 2016 (%)	Country	Health share 2010 (%)	Annual growth health's share 2010-2016 (%)	Health share 2016 (%)
Five highest	Myanmar	1.6	19.2	5.0	Ireland	12.3	7.8	19.7
	Guinea	4.6	17.2	13.0	Singapore	7.6	7.1	11.6
	Equatorial Guinea	1.1	15.0	2.6	Qatar	4.1	6.9	6.3
	Iran	11.9	11.6	23.8	Saudi Arabia	6.8	6.4	10.1
	Sierra Leone	11.5	10.5	21.5	Sweden	13.7	5.0	18.5
Five lowest	Venezuela	6.2	-20.1	1.9	Greece	12.4	-3.1	10.3
	Iraq	4.8	-17.3	1.7	UAE	8.5	-1.3	7.9
	Gambia	14.5	-16.1	5.5	Italy	14.1	-0.7	13.5
	Djibouti	8.1	-11.6	4.0	Bahrain	8.5	-0.1	8.4
	Uganda	15.3	-11.3	7.8	Portugal	13.2	0.2	13.4

About one-third of countries that were among the top quintile in terms of annual percentage increases in health's share of public expenditures over the period 2010-2016 were LMI followed by UMI and LIC countries. Almost half were from the Sub-Saharan Africa (SSA) region, followed by four each from LAC and East Asia and the Pacific (EAP). Four high-income OECD countries (USA, UK, Ireland, and Sweden) were also in this group of top quintile countries. Countries generally prioritized at a faster rate the lower their initial levels of priority for health was in 2010, although there were some notable exceptions such as Iran, Paraguay, and Sierra Leone (Figure 3). About one-third of the countries that increased priority for health were also significantly dependent on on-budget external financing; for example, in countries such as Guinea, Mali, Sierra Leone, Liberia, and DRC on average more than 50 percent of public financing for health was externally financed over the period 2010-2016. About one-fifth of the focus countries – Chad, Myanmar, Lebanon, Timor-Leste, Liberia, and DRC – were classified as FCV.

As next steps, the DRM collaborative of JLN is conducting a follow-up exercise to understand what some of the triggers of reprioritization in selected countries were: i.e., whether or not sustained increases in health's share of public spending resulted from changes in the political and economic environment within countries, or resulted from implementation of key reform efforts or other such factors. Information on the mechanics of implementation of reprioritization is also being collected – e.g., whether there were cuts in the levels and growth of unproductive sectors to make room for health, and whether reprioritization resulted from implementation of new or expanded earmarked income or consumption taxes – and what the net consequences of such efforts have been in terms of improvements in health outputs and outcomes and crowding out of out-of-pocket (OOP) expenditures for health, especially among the poor and vulnerable.

Figure 3: Health's share of public expenditure among top growth quintile: initial versus growth 2010-2016



[2] A more relevant sample would limit attention to domestically-financed public resources. However, global databases do not contain complete cross-country data on the share of overall public expenditure that is externally financed.

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