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For Universal Health Coverage

Global Landscape: Fiscal Space for Health

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Public financing is essential for making progress towards universal health coverage (UHC), a United Nations Sustainable Development Goal (SDG) policy commitment which emphasizes that everyone should have access to quality health services they need and that the use of these services does not expose individuals to undue financial hardship. Public financing for health typically refers to all health-related expenditures incurred by governments (national and sub-national) as well as by social health insurance agencies (where extant). The focus on both effective service coverage as well as financial risk protection under UHC implies that how countries finance their health systems matters. Financing for health in most low- and middle-income countries (LMICs) is dominated by high levels of out-of-pocket (OOP) spending, an inefficient and inequitable modality which contributes to foregone care among vulnerable populations and puts them at risk of impoverishment from illness-related catastrophic expenditures. Relatively low levels of public spending for health contribute to high levels of OOP spending in LMICs. Identifying ways to increase public spending on health – i.e., to realize 'fiscal space' for health -- is thus critical for the achievement of UHC. Ensuring adequate and sustainable public financing for health is also a policy concern for high-income countries, given challenges related to ageing, shrinking labor force participation rates, and increasing demands for financing of long-term care.

Although there are many different definitions and conceptualizations of fiscal space, one of the seminal references is Heller 2005 where he defines fiscal space as '…the availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government's financial position.' This definition did not specify fiscal space for any specific sector; it was presumed that additional government spending would be for some meritorious purpose. As introduced in Heller 2006 and subsequently elaborated in Tandon and Cashin 2010, fiscal space for health can potentially be realized in several ways: (i) via conducive macroeconomic conditions, increases in general government revenues resulting from economic growth and by improving revenue-collection efforts; (ii) by increasing health's share in government budgets (i.e., via 'reprioritization'); and, (iii) by introducing or expanding earmarked consumption and income taxes, the latter including via introduction or expansion of social health insurance. Effective expansions of public financing across countries have typically resulted from a combination across all three dimensions of fiscal space, in addition to improvements in efficiency of spending. In some lower-income countries – e.g., Lao PDR and Cambodia -- external financing has also played a key role in increasing fiscal space, especially for expanding coverage for the poor.

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Options for realizing fiscal space are not mutually independent and each option comes with its own set of costs and benefits: whereas increasing general government revenues may ease fiscal constraints, the way in which additional revenues are raised is a crucial consideration; regressive, inefficient, and excessive taxation could stifle economic growth. Similarly, external financing may help ease budgetary shortfalls in low-income countries that lack domestic financing to cope with the costs of high disease burdens but can also come with its own set of negative externalities. As countries become richer, public financing for health generally tends to rise; however, there are huge variations around this trend, reflecting in large part the intermediating influence of other factors such as the extent to which health is prioritized over other sectors as well as the ways in which health systems are organized and financed. In assessing the availability of fiscal space, it is imperative to situate the health sector in a broader macroeconomic context as well as carefully evaluate the costs and benefits of different options and cross-sectoral trade-offs that may or may not lead to availability of additional public financing for health.

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Although how money is expended is just as critical as the overall resource envelope, analyzing changes in per capita public financing for health in real terms, a proxy for realized fiscal space, allows for an assessment not just of trends but also of contributions from three macro-fiscal drivers -- economic growth, changes in aggregate public spending, and reprioritization for health -- exploiting a macroeconomic identity that captures the relationship between these factors. Analysis of data from 2000 to 2017 showed per capita public financing for health increased by 3.7 percent per year on average across countries. Although there are important country-specific differences, it is notable that more that almost half of the increase in public financing for health was due to economic growth alone, facilitated by higher government revenues and borrowing. For the remainder of the increase, aggregate public spending contributed more than reprioritization across low and lower-middle-income countries, whereas the reverse was true in high-income countries. Although country context matters, the importance of economic growth for public financing for health underscores the critical need to situate, integrate, leverage, and proactively manage health financing reforms within a country's overall macro-fiscal context and to assess different pillars of fiscal space holistically.

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In addition to economic growth, higher general government revenues can be conducive for increasing public financing not only for health but also for other sectors. General government revenue collection in most developing countries is far below potential, with the bottlenecks usually being in the collection of 'direct' taxes such as those on income, wealth, and on corporations. High levels of informality and poverty compound the challenges of increasing general government revenues. Estimates in IMF 2011 indicate that even modest improvements in general government revenue collection could dwarf the amount of external financing that many developing countries receive.

Increasing health's share of government spending is another critical source of additional public financing, especially in countries where this share has historically been low. Differences are striking with regard to the global distribution of prioritization: health's share of public expenditure ranges from less than 3% in Venezuela to a high of almost 30% in Costa Rica. 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 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. A range of factors – political triggers, disease outbreaks, macroeconomic shocks, among them – are common triggers that can sometimes lead to sustained reprioritization for health. Over 2010-2017, Myanmar was a country that had the highest increase in health's share of the government budget. General elections in the country in 2011 put in place a semi-civilian government with the National League for Democracy (NLD) party winning some seats; this led to increased spending on social sectors including health. General elections in 2015 which saw a landslide victory for NLD sustained the focus on social spending, with some indications that the share of defense spending declined to make room for health, as well as education and social protection.

Country-specific political economy considerations are key and results-focused reform efforts are more likely to result in sustained and politically feasible prioritization of health from a fiscal space perspective.

It is also to note that advocating for any specific socially optimal normative level or share of public financing for health (e.g., 15% of government budget for health, or 5% of GDP for health) across countries has not been an effective strategy in helping realize fiscal space for health. Although sometimes these numbers can be used as benchmarks to demonstrate low commitments for health or of low levels of health spending relative to size of the economy, they should not be used as targets since financing is a means to an end and levels of financing ought not be the objectives in of themselves. Evidence to date suggests that country-specific political economy considerations are key and that results-focused reform efforts — in particular efforts to explicitly expand the breadth and depth of health coverage as opposed to efforts focused only on government budgetary targets — are more likely to result in sustained and politically feasible prioritization of health from a fiscal space perspective. Absorptive capacity constraints and perceptions that the health sector is inefficient are two of the largest bottlenecks for reprioritization.

Sector-specific resources - e.g., earmarked consumption and income taxes, including social health insurance - can, with some caveats, result in additional public resources for health. The most prominent of these has been the use of earmarked payroll contributions – following the model set by Bismarck in Germany in 1883 – to finance expansions in coverage. Many developed countries -- including Japan, Czech Republic, Korea, Estonia, France, and Poland -- raise a significant share of resources for health using social health insurance. Although many developing countries have also introduced social health insurance, high levels of informality and poverty have constrained the revenue generation impact of such arrangements. In part, the challenge has been persistence in levels of informality, despite robust economic growth and poverty reduction, leading to increasing shares of the population belonging to the non-poor informal sector in many developing countries. Whereas previously levels of informality were observed to decline with sustained economic growth, due to a variety of factors -- including globalization, changes in the supply chain with outsourcing of intermediate inputs, weakening unionization of labor, among others – similar trends have not been observed in developing

countries in recent decades. Some countries have addressed the challenge of collecting social health insurance contributions from 'direct' sources such as on income by instead earmarking 'indirect' taxes on consumption. Ghana and Nigeria have followed the latter strategy, although the results can sometime be counter to what was intended and the net effects will not be additional if budget-holding authorities reduce general revenue allocations to compensate for higher earmarked revenues for health.

In some countries, the health sector has been actively involved in raising taxes to deter consumption of 'harmful' products – e.g., on tobacco, alcohol, and sugary products – that can help raise the overall public resource envelop (even if revenues are not earmarked for health) while also helping reduce the subsequent burden of disease on the sector. Given the growing burden from air pollution, carbon taxes are another possible area where the health sector can play an active role in raising revenues and reducing risk-factor exposure following in the footsteps of experiences from developed countries. Again, the challenge from a fiscal space perspective – as opposed to a fiscal policy for health perspective – is the amounts of resources generated using such a strategy and whether or not they can be earmarked, and if earmarked whether over time such resources are truly additional. Philippines is a recent example of a country that has used earmarked tobacco and alcohol taxes to finance premium payments for the indigent and to realize fiscal space for health.

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Efficiency is another critical area for realizing fiscal space – not only from the perspective of getting more from current envelopes of financing – but also as a factor facilitation reprioritization for health. WHO estimated that 20-40% of resources are wasted: due to a range of factors including care not being provided at the appropriate levels of care, underuse of generics, unnecessary diagnostic tests, lack of priority for prevention and promotion, and lack of adequate financing for frontline health services. Yip and Hafez 2015 summarize a range of efficiency-enhancing initiatives – from changes in provider payment mechanisms in China, merger of difference pooling mechanisms in Korea, and specification of prioritized interventions in a harmonized benefits package in Chile – that led to measurable savings that

	Low- and middle-income				High-income			
Rank	Country	Health share 2010 (%)	Annual growth health's share 2010-2017 (%)	Health share 2017 (%)	Country	Health share 2010 (%)	Annual growth health's share 2010-2017 (%)	Health share 2017 (%)
Five highest	Myanmar	1.6	13.3	4.1	Kuwait	5.2	7.7	8.9
	Sao Tome and Principe	5.2	11.7	11.9	Singapore	7.5	7.3	12.6
	Equatorial Guinea	1.5	10.5	3.1	Ireland	12.3	7.0	20.0
	Iran	11.9	9.4	22.9	Qatar	4.1	5.9	6.3
	Timor-Leste	3.6	9.2	6.8	Saudi Arabia	6.8	5.5	10.1
Five lowest	Venezuela	8.2	-25.5	1.4	Bahamas	17.3	-6.1	11.3
	Guinea-Bissau	16.9	-16.4	5.3	Antigua and Barbuda	13.1	-4.7	9.5
	Uganda	15.3	-12.1	6.3	Monaco	9.2	-4.4	6.7
	Gambia	14.5	-12.0	6.5	Luxembourg	13.7	-3.4	10.8
	Ghana	13.8	-8.9	7.4	Greece	12.4	-2.8	10.2

yielded improvements in value for money for resources across a range of areas.

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In lower-income settings, development assistance for health – especially in priority programs such as immunization and HIV – has been a source of additional financing for health. In countries where economic growth has been anemic, this pillar can remain an important source of financing. In most other countries, however, the challenge from a fiscal space perspective is how to replace external financing with domestically-sourced public financing for health as countries transition from lower to middle-income status.

REFERENCES

Heller, P (2005), "Understanding Fiscal Space," International Monetary Fund Policy Discussion Paper No. PDP/05/4, Washington, DC.

Heller, P (2006), "The Prospects of Creating 'Fiscal Space' for the Health Sector," Health Policy and Planning, 21(2): 75-79.

Tandon, A and C Cashin (2010), "Assessing Public Expenditures on Health from a Fiscal Space Perspective," Health, Nutrition, and Population Discussion Paper, Washington, DC.

Yip, W and R Hafez (2015), "Reforms for Improving the Efficiency of Health Systems: Lessons from 10 Country Cases", World Health Organization, Geneva.

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