Strengthening Health Financing in Partner Developing Countries

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The Health Challenges Confronting Developing Countries

Three serious health challenges confront developing countries and require health to remain a core issue in global development: 1) many partner developing countries are not making adequate progress toward the health-related Millennium Development Goals (MDGs), 2) large gaps in social health protection make a major contribution to impoverishment in many countries, and 3) deficiencies in health systems increasingly impair human security not only in partner developing countries but also in middle- and high-income countries.

The centrality of health in the development agenda is reflected in the fact that three of the eight MDGs are health related (MDGs 4, 5, and 6) and that G8 members have made substantial commitments in previous meetings. Nevertheless, while substantial progress is being made toward most MDGs, the most serious shortfalls that have emerged are clearly in human development and health.[1] Despite substantial progress toward the disease-focused MDG 6

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(HIV/AIDS, malaria, and other diseases), much of the developing world is off track to achieve the more general, and ultimately more important, MDGs 4 and 5 (child and maternal mortality respectively). In sub-Saharan Africa and South Asia, most people live in countries that are actually doing worse in terms of progress than before the 1990s, despite the MDG commitments.[2] Improving progress toward the health-related MDGs will require substantial increases in access to services and the performance of health systems, which is simply not possible until more effective financing policies are established in partner developing countries.

The past decade has seen growing evidence that households are likely to be confronted with catastrophic expenses when they are forced to pay out-of-pocket for healthcare. Globally, more than 100 million people each year fall into poverty because of the cost of medical treatment,[3] exacerbating and perpetuating poverty in the poorest countries. Health-related expenses remain the most important reason for households being pushed back below the poverty line, even in some of the fast-growing countries of Asia, such as China, Vietnam, and Bangladesh.[4]

The recent increased awareness of the need to improve financial risk protection from catastrophic health expenditures has forged a convergence between the previously separate agendas for health and social protection. It places the issue of health coverage directly within Japan's guiding framework of human security, and it coincides with the joint interests of EU member states to make social health protection a second pillar in EU strategies to strengthen health systems.[5] At the same time, moving toward social health protection is central to the World Health Organization's (WHO) renewed emphasis on the primary healthcare approach to strengthening health systems.[6] This shift in attention to the social protection aspects of health policy also marks an alignment in global health policy with core motivations of social protection and solidarity that have always guided health financing in the G8 nations themselves.

Alongside these developments, the growing interconnectedness of G8 members and partner developing countries as a result of globalization forces a broader view of human security that takes into account emerging transnational threats to health. With the poorest economies often being the likely foci of future pandemics,[7] as well as presenting new risks to global food and supply chains,[8] the G8 countries have a keen interest in ensuring that partner countries adequately and effectively finance core public health functions in their health systems.

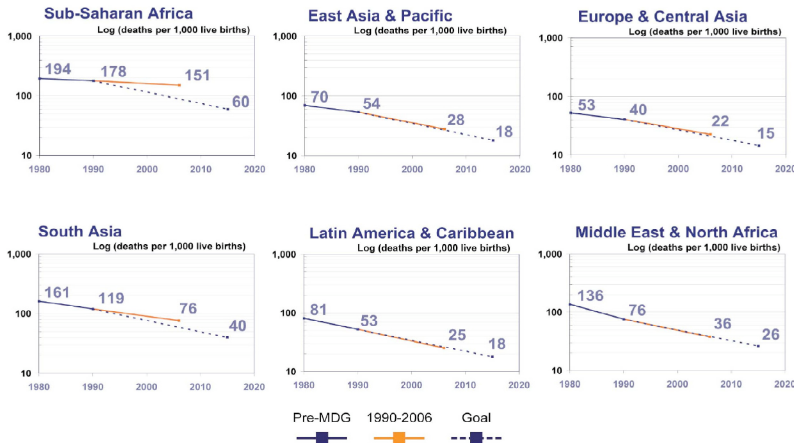
What Drives these Problems?

Progress to date

The G8 has responded to the health-related MDGs in the past decade by committing significant new resources for health sectors in developing countries. Since the 2002 Monterey Summit, external financing flows for health have been scaled up from both official partners and private sources, especially for HIV/AIDS and maternal and child health.[9] Partner developing countries have also increased domestic financing, with significant increases in Africa achieved through a mix of fiscal expansions and increased prioritization of health in government budgets.[10] Indeed, as Dr. Margaret Chan, the head of the WHO, observes, "health has never before seen such wealth."[11]

Yet, despite this scaling up of both external aid and domestic financing, rates of progress toward attaining MDGs 4 and 5 have not significantly changed, especially in the most critical regions of sub-Saharan Africa and South Asia,[12] where the recent data suggest even a slowing of progress in the years since 1990 (fig. 1).[13] In no developing region has performance dramatically improved. Money alone has proved sufficient neither to achieve better health gains, nor to reduce impoverishment from catastrophic medical bills.

Figure 1: Progress toward MDG 4 by region, 1980–2006[14]



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Key reasons

There are several reasons why partner developing countries have often failed to improve progress toward health goals or social protection. In failed states, the explanation is undoubtedly the lack of any functioning health system and the general disruption of normal life. In these conditions, where we may have to accept that attaining the MDGs is not feasible, the only effective response will often be external humanitarian assistance, including donor-led delivery interventions.

In the case of other developing countries, the critical problems lie at the level of the health system for the most part and require concerted policies and action by and with partner developing countries. It is no coincidence that the greatest lags in progress occur with those MDGs—4 and 5—that require improvements at a broad level across the whole health system and which are not as susceptible to disease-focused interventions as is the case with MDG 6. There are several key reasons for this:

- inadequate funding for health in many countries
- ineffective and inefficient health financing and delivery systems that give rise to significant shortfalls between what is achieved and what was potentially feasible with the funding that was available
- lack of integration between funding for vertical and horizontal programs, resulting in competition for resources and undermining national strategies and
- lack of information on what countries know about the operation of their health systems and potential solutions

Inadequate funding is critical, but how much is needed?

Despite the considerably higher burden of disease and ill health in developing countries, overall health spending in partner countries is significantly less than that in developed countries. The average G8 nation spent more than 10 percent of GDP on health in 2007, compared with 5 and 6 percent in low- and middle-income partner countries respectively.[15] Even after adjusting for purchasing differences, health spending in the poorest countries, at US$20–50 per capita, is one-thirtieth the level of that in developed countries, and less than US$30 in most of the partner countries of greatest concern. This lower level of spending buys developing countries lower levels of coverage by effective health

interventions. For example, in the typical developing country the average person is able to see a doctor only one or two times a year, while the much healthier citizens of G8 nations visit a doctor five to seven times a year on average.[16] Increasing spending can clearly help to improve coverage and access.

The clear emphasis on increasing official development assistance (ODA) for health since at least 2000 demonstrates the G8's recognition of this constraint.[17] While both G8 and partner countries have certainly delivered in terms of increased funding for health, especially in areas linked to MDGs 4, 5 and 6,[18] it is worth pausing and asking whether this has been enough.

There have been many efforts since the early 1990s by the UN, World Bank, WHO, and others to answer how much financing is required either to scale up access to basic minimum services or to achieve some or all of the health-related MDGs. Their estimates suggest that the required public and external financing in low-income countries ranges from US$30 to US$50 per capita (and higher in middle-income countries).[19] In contrast, actual public spending in low-income countries is less than US$15, of which up to 40 percent, on average, is from external financing.

Although further increases in external financing are needed, it has to be accepted that even without the current global financial crisis, achieving levels of US$30–50 per capita from both public and external sources in the poorest countries was never realistic by 2015. Such target levels of expenditure represent 10–20 percent of GDP in the poorest countries, and are, on average, much higher than their overall tax revenues, implying that the shortfall could only be met by external flows. That level of external flows would, in most countries, present serious challenges in terms of absorption and macroeconomic stability.

However, the likely shortfalls in funding compared with the global targets do not necessarily eliminate any likelihood of substantial progress toward key health goals. There are three reasons for thinking this.

First, most of the global cost estimates appear to be overestimated, when estimated using actual country data. Recent efforts have responded to such criticism by applying methods that use country-level data. Such projects by the UN, UNICEF, the World Bank, and others have tended to produce much lower estimates on required funding, of the order of US$20–35 per capita.[20]

In addition, current global cost estimates assume that future expansions in health service coverage will cost as much as current service delivery. This ignores the potential for countries to partly fund expansions in coverage by improvements in the technical efficiency of service delivery, i.e., by reducing the average unit cost of a service. This assumption not only runs counter to histori-

cal experience in Organisation for Economic Co-operation and Development (OECD) nations, where efficiency gains have typically reduced costs,[21] but it also ignores evidence of similar 1–2 percent efficiency gains in developing countries.[22] Developing countries that have been able to generate such efficiency gains in the past have been able to expand services considerably with only modest increases in spending, since a 2 percent annual increase in efficiency implies a doubling of service delivery every 20 years without any increase in funding. Past examples include Botswana, which doubled service coverage during 1960–1980 without increasing health budgets as a share of GDP, and Uganda, which financed a tripling of service delivery during 1955–1969, half through increased spending and half via efficiency gains.

Finally, several low-income and lower-middle-income developing countries have been able to achieve universal access to basic health services and also stay on track to achieve their health-related MDGs, but almost all of them have done so by spending far less than the global targets for spending. For example, Sri Lanka, a low-income country, had largely achieved universal access by 1990, with government and private spending being less than US$10 per capita each. Vietnam today is well on track with similar levels of financing.

This suggests that even if funding does not attain currently identified global targets, it does not mean that countries cannot make substantial progress toward the MDGs and in expanding access to health services. More attention, therefore, needs to be given to increasing the value obtained from current and future spending on health in developing countries.

Inefficient and ineffective health financing and delivery systems

The notion that health spending is often inefficient and that more spending does not necessarily result in better outcomes is well known to G8 nations. For example, in the United States, health spending per capita varies more than three-fold across the country, and yet higher spending does not necessarily result in better outcomes, nor does lower spending translate into lower quality, with such centers of medical excellence as the Mayo Clinic able to deliver high-quality care at half the cost or less of other centers.[23] Problems of how money is transformed into effective, accessible, quality healthcare are also well documented in many developing countries.[24] These problems of inefficiency fall into two types: allocative and technical. Allocative inefficiency is the sub-optimal distribution of available public resources across the potential uses or programs. For example, in many developing countries, preventive health services

may be underfunded, while another service, such as family planning, may receive disproportionately more resources despite there being a similar need.

Technical inefficiencies further impair the effectiveness of money invested in programs or interventions. Such inefficiencies might mean that providers do not use the least-cost method for delivering a service or provide the best quality for any given level of resources. Examples include the use of antibiotics when oral rehydration solution is sufficient for cases of diarrhea, procurement systems' failure to purchase medicines at the lowest available prices, or an inefficient mix of medicines and personnel being used to provide a service. Technical inefficiencies can also be due to low productivity of healthcare workers, who see fewer patients than they might. The impact of such inefficiencies can be large, and, in some countries, can be seen in as much as a tenfold variation in the unit cost of delivering similar services at different facilities.[25]

The existence of such inefficiencies, and the potential they imply for improving the results from health spending, have been recognized since the early 1990s, for example in the World Bank's *World Development Report 1993* and by the WHO Commission on Macroeconomics and Health.[26] However, not much weight was placed on addressing this problem—in contrast to that of inadequate funding—since it was felt that not enough was known about what actions could be taken.[27] While this may have been a sensible strategy in the 1990s, it has not been without consequence. The problem of inefficiency has largely been neglected for the past decade, with minimal efforts being made to understand the problem and identify possible solutions. Now that funding levels have improved, and the variation in the value that different countries achieve for their spending is even clearer, the time is long overdue focus attention on this area.

Lack of integration between health systems and vertical programs

Frustration at the difficulties of rapidly expanding health systems coverage, considerations about the efficiency of different approaches to delivering critical interventions, as well as changing priorities in health, have led to the development of vertical health programs in many countries. However, while these initiatives have certainly been successful in promoting specific communicable diseases on the global health agenda, vertical programs have themselves created three major problems. First, the selective, external financing of such programs often leads to distortions within health systems, as better-funded vertical programs compete for and deprive other parts of the health system of critical

inputs, such as staffing. Second, vertical programs often make it harder for countries to effectively plan the development of an integrated health service delivery system, which must remain at the core of any sustainable expansion in overall health services coverage. Third, such programs may fail to benefit from the synergies of integrated services.[28]

These problems are not new. The original Alma Ata Declaration of 1978 with its commitment to integrated health service delivery, a commitment that is encapsulated in the WHO concept of primary healthcare, was a reaction to the perception that investments in selective primary healthcare and other vertical interventions had undermined the development of developing country health sectors. In the 1990s, the pendulum swung back, as growing frustration with actual progress in developing primary healthcare, and the apparent inability to deal with increases in devastating and costly communicable diseases, led to increased investments in vertical programs. The G8 has been on both sides of this debate, committing to supporting overall health systems but also investing heavily in vertical programs through such channels as the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the US President's Emergency Plan for AIDS Relief (PEPFAR). However, it is now readily apparent that greater focus is needed to assist countries to strengthen their overall health systems and integrated delivery, as the Global Fund and other initiatives run up against the limitations of weak health systems with often restricted capacity for scaling up. This is a significant motivation for the WHO's new call to refocus on primary healthcare in its *World Health Report 2008* and is reflected concretely in the International Health Partnership and Related Initiatives (IHP+) and Providing for Health (P4H) initiatives that stress harmonization and health system strengthening.

Lack of information and evidence to manage health systems effectively

Inadequate information and evidence are critical constraints to improving the performance of health systems. Problems exist in two areas. First, health information systems in most developing countries continue to be weak and cannot provide health managers with the information required to effectively monitor and improve service delivery and financing strategies. Common deficiencies include 1) the lack of reliable information systems, such as national health accounts, to track overall spending, whether it be public financing, external resource flows, or private spending;[29] 2) the lack of routine information systems to track equity in health services, which are

vital both to identify inequities and to develop responses;[30] and 3) the lack of information systems that provide managers with data to understand the operational efficiency of their health services, and which can support improvement of overall service delivery. It must be stressed, though, that in most developing countries, the lack of such systems is not due to the lack of information tools or platforms but to the severe lack of domestic capacities to implement and sustain such tools.

Second, as countries face the challenge of improving their health systems and financing strategies, we often know which countries have done well and might be good models for emulation, but we know far less about the operational details of how they did it. Such a lack of easily accessible knowledge about best practices in financing and delivery, and the lack of mechanisms to share such knowledge among developing countries, mean that good performance is rarely shared and learned from.

The Importance of Health Financing Policies

The half-way mark in the 15-year timeframe for achieving the MDGs, which began in 2000, has already passed. Yet, it is hard to demonstrate that increased investments in partner countries have accelerated progress toward MDGs 4 and 5. Even after allowing for the fact that HIV/AIDS seriously slowed or reversed health gains in Africa, progress in other regions has not appreciably improved, and in some it has even slowed (fig. 1).

Money is essential for delivering healthcare, but it alone does not translate into better health or effective risk protection. In developing countries, as in the G8, there is little, if any, relationship between the amount that countries spend and health outcomes, or indeed, between total spending and risk protection.[31] In the coming years, the fiscal pressures facing G8 members and partner developing countries will be severe. It will require significant efforts to increase expenditures for health, but there will be constraints on how much spending can be further increased. In this context, and given what we already know about the often poor correlation between total spending and health outcomes, it is critical to complement the G8 focus on increasing spending with an emphasis on improving the value of health spending in partner health systems.

Health financing is the most important control knob that policymakers have to influence the operation of a health system. Health financing includes not

only the processes that mobilize funding but also how funds are channeled and applied to obtain health services. Other than the need for more money, there is broad consensus among technical agencies and experts that developing countries face three key challenges in their health financing strategies:

1. how best to expand risk pooling
2. how to improve efficiency in the use of resources and
3. how to ensure access of the poor to needed services[32]

The first challenge is shifting from out-of-pocket financing to public or private pooling arrangements that ensure effective financial protection and coverage. Out-of-pocket payments remain a dominant source of healthcare financing in developing countries, accounting for 30–85 percent of total health spending in the poorest countries. Large out-of-pocket payments to obtain needed care often impoverish households. The global evidence shows that the extent to which households face such catastrophic expenses is directly related to the extent to which health systems rely on out-of-pocket financing.[33] Without significant risk pooling, developing countries are unable to prevent a high incidence of financial catastrophe associated with sickness or achieve basic social protection objectives.

The second challenge countries face is ensuring that financing mechanisms support better allocation and use of inputs. When provision is direct, governments can simply plan the allocation of resources, but whether the allocation of resources is efficient and equitable cannot be guaranteed. When provision is indirect, in the sense that governments purchase services from independent providers—as can occur in insurance-based systems—the allocation of resources depends on how providers are paid and on what basis. How resource allocation is linked to financing and the details of actual implementation matter for the overall efficiency of the health system.

The third challenge is expanding access by the poor to needed and effective medical services, which are critical to health improvements. In most countries, the poor lack adequate access, either because they cannot overcome the financial barriers or because funding fails to bring services close to them. Unless this gap is addressed, overall health indicators will not improve substantially. Whether they are public sector user fees or payments made to private providers, out-of-pocket payments are significant barriers to health improvement. They discourage use and reduce coverage of available preventive and personal curative services, both of which are needed to improve health outcomes. A principal justification for removing public sector user fees is that it provides a

free alternative to private provision, thus expanding the availability of services that are affordable to the poor. Recent work in Africa has shown how even small payments associated with the social marketing of mosquito nets reduce uptake and make such social marketing investments far less cost-effective than free public distribution.[34] By increasing utilization of critical services, abolition of user fees can also improve their cost-efficiency.

Health financing policies in partner countries thus must serve three key functions:

1. Revenue collection—This refers to how funds are mobilized, e.g., general revenue taxation, social health insurance (SHI), out-of-pocket payments, etc. This determines the overall level of funds mobilized and how sustainable these levels are. In general, revenue collection capacity depends on a country's economic and institutional development, which is least in the poorest countries
2. Risk pooling—This is critical for financial protection. It depends on the ability to prepay and share across the population the expenses involved in medical treatment. Both tax and insurance financing can serve this function, but, as with revenue collection, country capacity for risk pooling increases with income, with capacity being weakest in the poorest countries
3. Resource allocation and purchasing—This involves how resources are allocated to inputs, services, and patients and how providers are paid. When provision is directly organized through government-operated services, it can be difficult to ensure efficient allocation. Yet, when provision is indirect through purchasing, it requires a minimum degree of government capacity to do effectively, and this is more likely to be lacking in the poorest countries

Strengthening policies for health financing is critical for partner developing countries. Failure to do so continues to be the main constraint, preventing the realization of better outcomes from current investments. Where developing countries have put effective policies in place, they have been able to achieve universal coverage, effective risk protection, and sustained improvement in health outcomes, and they often do so at below-average levels of expenditure.[35]

What Do We Know and What Do We Not Know?

What financing options do developing countries have?

In practice, there are only four different financing methods available to countries other than out-of-pocket financing and external aid: 1) tax-financed national health services (NHS), 2) SHI, 3) community health insurance, and 4) private or voluntary insurance.[36]

The first two—tax-funded NHS and SHI—are the predominant forms in G8 nations with the exception of the United States, where private health insurance plays a major role. The problem for developing countries is to know which methods to use and how to implement them effectively in order to expand risk pooling, ensure access for the poor, and maximize efficiency in use of resources.

Tax-financed national health services

Tax-financed NHS are the most common strategy that developing countries have adopted. In this, public revenue collection is through general revenue taxation, with the funds directly financing government-operated healthcare services, which are made available to the whole population on a universal basis at zero or minimal price. The approach integrates public financing and provision.

Tax financing has many advantages. First, it achieves the highest degree of risk pooling and has proved the most equitable in being able to distribute costs most fairly across the whole population.[37] Second, taxation offers a broader revenue base than social insurance and one less likely to act as a disincentive for formal sector job creation. In poor countries, while most people cannot make significant insurance contributions, almost all of their governments are still able to raise taxes. Third, a key selling point is that it makes services available for free, thus eliminating financial barriers to access.

Unfortunately, most developing countries that rely on this approach fail to achieve equitable access to health services and adequate risk protection. Despite the promise of universality, in many countries the rich capture the available public services, leaving the poor without access. Such public systems often operate with great inefficiency, resulting in low quality and inadequate, unresponsive provision.[38] However, as in G8 nations, there is no empirical evidence that public sector provision is any more inefficient than the alternative private provision.

Nevertheless, several countries at all income levels successfully use the tax-financed NHS mechanism to provide the poor with access to services and effective risk protection. Examples include Sri Lanka, Kerala in India, Honduras, Malaysia, Botswana, and many Caribbean and Pacific Island states. Most do so at low cost, with government health spending being less than average, and less than 2–3 percent of GDP. Most are also exceptional health performers, on track to achieve their health-related MDGs. However, it is important to appreciate that these are not replicas of the NHS systems found in G8 nations, such as the UK, where the public sector provides almost all services. All of these developing countries have privately financed private health sectors accounting for a substantial 35–60 percent of overall financing and provision. Unlike G8 nations, these poor countries cannot afford to allocate the level of tax revenues (4–5 percent of GDP) that is necessary to ensure that almost all service provision is publicly financed. So their ability to manage their public-private mix in financing and delivery is critical. Unlike other poor countries, they manage to use the public system to reach the poor, while persuading the rich to self-pay for private services. Among high-income economies, Hong Kong SAR (China) and Cyprus provide comparable cases.[39]

Crucially, the only low-income countries that have been able to ensure universal and pro-poor access to health services,[40] and which are able to ensure effective risk protection,[41] all employ this tax-financed, government delivery approach complemented by private financing and provision. Unfortunately, there is only limited understanding of what these best practice countries do differently to be so successful and what lessons they can give to others. Abolition of user fees might be one element, but we do not fully understand how they are able to deliver services efficiently so as to meet the inevitable increases in patient demand, which have challenged African countries that have recently abolished fees.[42] Similarly, most do not means-test access to services, but we do not fully understand how they are able to ensure that public services serve mostly the poor.

Social health insurance

SHI is the main financing method in many developing countries, particularly middle-income ones. It involves the mandatory collection of contributions from designated segments of the population (typically through payroll taxes), and pooling of these contributions in independent funds that pay for services on behalf of the insured. In the classic SHI model, which originated in

Germany, there is an explicit link between making contributions and the right to benefits.[43] SHI can achieve significant risk pooling and equitably distribute the burden of payments between rich and poor, but not as much as general revenue taxation.[44]

Many middle-income countries have successfully used SHI to achieve universal access and effective risk protection. However, although often seen as a solution to failed tax-financed NHS systems, it has proven much harder to implement in the setting of low-income countries. To date, no country whose income is below US$1,000 per capita has been able to achieve universal access to healthcare services through SHI.[45] The central problem is that in poor economies with small formal sectors, SHI premiums are much harder to collect than general revenue taxes. Effective premium collection also requires a high degree of state capacity, (government technical and administrative capability), which tends to be most limited in low-income countries. Consequently, most developing countries have not been able to extend SHI coverage to the informal sector and rural populations.[46]

Nonetheless, a few poorer countries have had significant success in extending social insurance coverage despite having large informal sectors. None of them follow the classic SHI model, where insurance coverage is linked to insurance payments. All of them deviate by employing substantial tax monies to fund their SHI schemes and by extending insurance coverage mostly on a noncontributory basis. For example, both Mongolia[47] and Thailand[48] extended coverage with SHI to 90–100 percent of their population, but in order to finance the majority of the population who were outside the formal sector, 60 percent or more of the insurance fund comes from general revenue taxes. In both cases, increases in taxation were necessary. In Mongolia, these allocations could not be sustained and coverage fell, illustrating how difficult it is for poor countries to use SHI when their tax base is small. It is also worth noting that both countries have largely used the expanded SHI schemes to pay for public provision, suggesting that public provision can still play an important role under SHI.

Currently, some low-income countries, such as Ghana and Rwanda,[49] are attempting to use SHI to achieve universal coverage. However, none have been able to raise coverage levels to over 75 percent.[50] We do not know enough about the limitations they face or how well coverage actually benefits the poor. Countries such as these need much more information than we currently have on how other best-practice countries with small formal sectors succeeded in achieving universal SHI coverage.

Community-based health insurance

Community-based health insurance (CBHI) differs from SHI in that it involves voluntary membership and is controlled by community organizations rather than state agencies. Although CBHI was once important in some G8 nations (i.e., Germany and Japan) where it preceded the establishment of SHI, it is not used today by any developed country and is only found in the poorest countries.

CBHI takes diverse forms, but it typically operates where those in the informal sector incur out-of-pocket costs in order to obtain healthcare, and they lack access to other insurance. Evaluations by the World Bank, the International Labour Organization, and others conclude that in low-income settings CBHI schemes make only modest contributions to overall coverage and only as a complement to other formal schemes.[51] With the exceptions of China and a few schemes in India, CBHI has not proven able to cover large numbers of people (coverage rarely exceeds 10 percent of the population) or reach the very poor.[52] The main reasons are that the voluntary contributions of poor people are usually insufficient to fund the required levels of coverage, the risk pooling provided is inadequate, and scaling up such informal arrangements proves to be difficult.

Although many continue to advocate CBHI as a potential stop-gap solution, the evidence clearly indicates that CBHI approaches are not able to scale up to achieve universal coverage or provide high levels of effective risk protection.

Private or voluntary health insurance

Private or "voluntary" health insurance provides some element of risk pooling, which can be substantial if coverage is arranged through organized employee groups. However, well-known problems in insurance markets of adverse selection and cream-skimming severely limit its ability to cover people outside organized employee groups.[53] Private insurance schemes tend to be highly cost-inefficient, as they incur significant administrative costs and provide few pressures for cost control. Thus, in G8 nations, private health insurance has never been able to extend health coverage to most people, and its main purpose in Europe is only to provide complementary coverage to other public schemes. Even in the United States, where private health insurance is most developed, it leaves more than 45 million people uncovered[54] and is a significant factor behind high overall health expenditures.[55] In developing countries, the smaller

formal sector and weaker financial markets generally limit coverage of private health insurance to less than 2–5 percent of the population, and to less than 5 percent of overall healthcare financing.[56] Strong adverse selection effects usually eliminate the market for many types of coverage relevant to MDGs 4, 5, and 6, with items such as maternal care, routine outpatient treatment, and HIV/AIDS care often excluded.

There have been frequent claims (for example in Africa in the 1990s) that private insurance initiatives might provide a way to scale up healthcare coverage in low-income countries.[57] Yet experience has shown that none have been able to surmount the basic problems that prevent private insurance from scaling up or being cost effective in the G8 setting.[58] Currently, there are initiatives to support private health insurance schemes in Africa, but none have demonstrated the ability to scale up coverage in the poorest African countries. Indeed, one project in Namibia proposes to spend more than US$35 per capita to extend subsidized private health insurance schemes for upper-middle-income workers, which does not appear to provide a cost-effective, sustainable, or equitable way to use scarce donor funds for extending coverage to the poor in a region where per capita spending on the poor is typically less than US$10.[59]

What do we know to improve healthcare financing policies in developing countries?

In the past three decades, we have accumulated considerable knowledge about what works in healthcare financing in developing countries and what does not, to supplement what has been learned in G8 countries themselves. There is now broad consensus among technical experts and development agencies that the key to increasing coverage of health services in the poorest countries, and improving equity and risk protection, is to expand and rely on public financing.[60]

The general principles by which developing countries and their donor partners should improve health financing are clear:

1. to improve coverage of the poor and to improve financial risk protection, countries must shift financing from out-of-pocket payments toward reliance on public financing, involving tax financing and/or SHI
2. although the ability to mobilize tax financing in the poorest countries is inherently limited, many countries have room to increase current levels and should do more to promote such funding for health[61]

3. increased external assistance can help, but its effectiveness depends on better pooling and integration with domestic sources of financing and better design
4. if SHI is relied on to expand public spending in poor countries, it must be partly financed by taxation to enable coverage extension to the poor; given the constraints to increasing taxation in the poorest countries, this makes SHI less feasible in these countries
5. where tax-financed NHS are the main channel for public spending, countries will need to share the burden of financing with the private sector; yet, the public-private mix must be managed effectively so that public spending preferentially reaches the poor
6. user fees for health interventions whose coverage needs to increase should be reduced or eliminated where possible so as to improve access by the poor
7. countries should not rely on private health insurance or CBHI to expand coverage of the services to the poor, since experience in both G8 and developing countries has repeatedly shown that they are not effective

Where are the gaps in what we know?

While the broad principles are clear, we often lack detailed knowledge of how to achieve such improvements in actual and diverse country settings. There are several reasons. One is that health financing has tended to suffer from conflicts over ideology and analytic approaches. The debates between market and non-market perspectives in particular have hindered consensus formation on what the evidence shows. Nevertheless, there is now consensus that in the area of healthcare financing, a strong state role is universally needed to address inherent market failures in financing, and there is acceptance that market approaches may sometimes benefit the delivery side.

Another reason is there has been insufficient effort to explain and learn from the past experience of best practices in health financing in the developing world. Technical experts find it easier to research and evaluate programmatic interventions, which lend themselves more easily to experimental methods, than to research and explain successes at the level of national financing systems, where more historical and reflective approaches are needed. Consequently, we know surprisingly little about what lessons can be drawn from such successes and how they can be applied to others.[62]

A third reason relates to the way in which development agencies broker global knowledge about what works in health financing. These agencies source much

of this knowledge from what is generated through their own country investment and advisory activities, but because their mandates lead them to focus on countries with poor health financing policies, their in-house knowledge on best practice countries is often limited.

There are four areas where critical knowledge gaps have emerged:

1. A few developing countries operate tax-funded, integrated health services alongside private provision to achieve effective and equitable coverage of the poor, despite limited spending. They often do this without explicitly targeting public services. How they do this and manage the public-private mix needs to be better understood since it has direct relevance to the poorest countries with limited fiscal capacity and capabilities to use more sophisticated strategies.
2. New public sector management has been advocated for developing countries to split purchasing from provision and to use the financing mechanism as a lever to improve the performance of public services. However, success with this approach has been rare in poor countries, often due to weak institutions. Knowledge is limited on how to assess institutional preconditions for such reforms, how to address weaknesses, and whether such reforms are beneficial.
3. Expansion of SHI from already established formal sector groups to the informal and rural sectors confronts significant challenges in many countries. Not enough is known about how successful countries tackled this in the past and how such expansions should be implemented so as to make universal coverage feasible.
4. Several developing countries achieve high levels of health service coverage and sustain rapid improvements in health indicators despite small expenditures, certainly far below currently recommended international targets. What explains their ability to obtain such good value from little financing and what role the financing system plays are not sufficiently understood.

Challenges for the G8 in Health Financing and Global Initiatives

The G8 plays a lead role in influencing the global health agenda, and its member countries provide crucial assistance to partner developing countries. The past decade has seen significant increases in funding for health, but the impact in terms of accelerated health progress has often been modest or negligible.

Looking forward, the G8 needs not only to raise support but also to work with partner countries to improve financing policies so as to increase the returns to health investments. To do this, the G8 faces five challenges:

1. The G8 cannot impose better policies on partner countries. How does the G8 encourage countries to increase their commitment and take ownership of better policies?
2. Donor assistance is not without limits. How should funding gaps be prioritized?
3. Despite broad consensus on the key principles of effective health financing, the G8 countries themselves often contribute to policy confusion in developing countries. How can this be resolved?
4. Vertical funds and initiatives are a key channel for external financing, but they often cause tensions within health systems. How can this be addressed?
5. The global financial crisis will squeeze the fiscal capacity of both developed and developing countries. What should the response be?

Improving the policy environment in partner developing countries

World Bank and OECD work on aid effectiveness shows that health ODA is only effective in improving health outcomes in countries with sound policies and institutions. Conditionality only works if governments are committed to the conditions they agreed to. Donors cannot force policies, only help to design them, and since aid is fungible, external investments often effect little change in spending patterns.[63]

The emergence of good policy is evidently not just a result of evidence. Germany did not introduce SHI, or Thailand move toward universal coverage, simply because of technical analysis. Politics and political leadership also matter. However, national capacity to assess policy options, to adapt international and domestic experience, and to analyze challenges is a necessary tool to facilitate policy change and to extend healthcare coverage in a sustainable manner. Japan is a powerful reminder of this: from the late 1800s, its capacity to assess international experiences and decide for itself what was most appropriate drove the establishment and design of its health system. Similarly, the United States has significantly expanded the policy analysis capacity available to its policymakers as it confronts the challenges of improving coverage and achieving better value for public health spending.[64]

For improvements in financing policy to be sustained, countries—more than donor partners, must be convinced that policies are desirable, and they must have the adequate capacity to implement those policies. Most developing countries lack the technical capacity to make their own assessments, which would also enable them to retain ownership over these choices. Consequently, they often mistrust or reject evidence. Thailand is known for its recent reforms, but these were made possible by a sustained effort to build national capacity for health systems policy research. In contrast, many African countries lack even one qualified health financing expert, let alone institutions.

Although this gap in national capacities has been recognized,[65] there has been little improvement in practice in the past decade. There are a few examples of best practice in using ODA to build capacity, such as in the Kyrgyz Republic and China, but these are exceptions. In the spirit of partnership, the G8 needs to facilitate the building of in-country policy analysis capacity to complement its other efforts to support policies.

Prioritizing funding gaps for external assistance

Country policies and institutions matter. At the same time, it is not realistic to expect that all assistance should only be given to countries with good policies and institutions. First, countries with weak institutions are the ones that are most likely to fail to achieve the health-related MDGs, and thereby the most in need. Second, humanitarian considerations matter to the governments and publics of G8 nations, and in the case of failed or highly vulnerable states, it is not realistic to link assistance to the actions of the government. In stronger countries, the direction may be to link external assistance to performance. However, even this is not straightforward. The relationship between investment and outcomes is often difficult to show, so basing performance on outcomes is not easy. More importantly, if the performance goals that donors use are not related to a country's own strategies, then this will only undermine national coordination and planning.

Thus, the G8 needs a more strategic approach to allocating external assistance. In the weakest, most vulnerable or failed states, humanitarian objectives must predominate, and direct support to health services may be required, if necessary through nongovernmental providers. At the same time, in weak states, the key development goal of building state capacity cannot be ignored. External assistance to Afghanistan has often bypassed state institutions because of frustration with weak capacity. Yet such policies have almost certainly undermined

state development, overall aid effectiveness, and critical G8 interests in that country.[66]

Where countries are stronger, assistance should focus on encouraging better policy strategies and not specific programmatic objectives. This is best done through arrangements that ensure that ODA objectives are aligned with national plans, such as through sector-wide agreements.[67] G8 nations have recognized this through their support for initiatives such as IHP+ and P4H, both of which embody the principles of aid harmonization, support for country policies, and public financing. These have the potential to significantly improve health financing in partner countries, and the G8 should substantially expand its support for both.

Resolving mixed donor messages on health financing

Lack of consensus among technical experts and G8 members, as well as a consistent failure to take a systemic approach to health financing, have led the development community to frequently change the recommendations that it makes on health financing to country partners. For example, in the past three decades, leading agencies have advised African countries that the solutions to the region's health financing problems include introducing user fees,[68] revolving drug funds,[69] private health insurance,[70] and community health insurance; increasing taxation;[71] removing user fees; and introducing SHI and private health insurance again.[72]

Other than reducing the credibility of global evidence, these contradictions cause uncertainties at the country level and undermine coordination between donor and partner countries. The most serious problem is the differing interpretations by G8 members on the choice between the SHI model and tax-financed NHS. The choice between the two is a nuanced one and depends critically on the specific country circumstances. It is embodied in the P4H initiative and reflected in many high-level documents issued by the OECD, the EU, and others,[73] as well as in the relevant WHO resolution,[74] which some G8 members have endorsed. However, this consensus is frequently negated by the practical differences that often arise between agency officials in the messages delivered to countries.[75] At the same time, the general consensus on public financing that has been achieved by most experts and is reflected in international consensus documents has not translated well into clear policy commitments. So, for example, although the G8 countries have committed to supporting public financing mechanisms through P4H, and several European

governments have committed to supporting the abolition of user fees as a first step, the development community continues to provide conflicting signals. Given the central importance of this issue, there is a role that the G8 should play in advocating a clear and robust common position, building on the consensus represented by P4H.

Resolving tensions between vertical initiatives and health systems

The many vertical health initiatives, such as the Global Fund and PEPFAR, represent a major source of new funding for health systems. The tensions that they cause are well known. Although new initiatives, such as IHP+, are working to harmonize donor investments, these vertical initiatives will continue. One response to this problem has been to urge them to allocate part of their funding toward health system strengthening and cross-cutting activities.

The efforts of the Global Fund to do this are instructive. Its mandate prevents it from substantially changing what it can finance, but when the Global Fund opened up channels for health system strengthening support, actual take-up by countries was poor. The main reason for this appears to be weak capacity within countries to prepare effective proposals exploiting such new funding windows. This reveals that the real issue is not that vertical funding initiatives undermine country planning but that the capacity of overall country planning and management to effectively coordinate external funding flows is typically weak. These are problems that need more attention not by such vertical initiatives but by those agencies whose remit is to support health system strengthening, such as the World Bank and the WHO. In this respect, the P4H initiative can make an important contribution by supporting countries to better link domestic and external financing.

The implications of the emerging global financial crisis

The current financial crisis will lead to severe pressures on the budgets of both developed and developing country partners. In the past, this has resulted in reductions in ODA from developed countries and reductions in public spending by developing countries. There will be temptations to use policy to shift the burden of health financing back to private sources and to cut back on support to the poorest countries. Is this the appropriate and inevitable response this time? The lessons of the past, as well as pragmatic considerations, suggest not.

First, past experience in both developed and developing countries clearly shows that at times of severe economic slowdown, the poorest people are least able to fall back on private resources in order to meet health and social needs. This was the case in countries as diverse as Japan and Sri Lanka in the early 1930s and in Thailand and Indonesia following the 1997–1998 currency crisis. In each instance, recognition of the failure of private mechanisms led to stronger national commitments to use public financing for health. Such situations indeed provide the rare political opportunities to expand social protection (as it did in the United States in the 1930s), and donor countries would do well to support developing countries in doing this. Second, as the global economy slows, both developed and developing nations must respond to the International Monetary Fund's call to take concerted action to increase domestic consumption.[76] The G8 countries have an interest in encouraging policies that boost consumption at lowest fiscal cost in both developed and developing countries. Expansions of health coverage can represent one of the most effective fiscal multipliers to do this. In fact, in the case of China, a significant expansion in public spending on basic health services is likely to be one of the most effective ways of boosting domestic demand.

Finally, the G8 and partner developing countries have a mutual interest in preventing the financial crisis from leading to protectionism that reverses past gains in trade liberalization. A sustained recession, with its negative impacts on large numbers of workers, has the potential to undermine confidence in the global market economy and in an open trading system. It is precisely in this situation that investing in effective and expanded publicly financed social protection mechanisms, including health, to assist vulnerable groups will be most valuable in maintaining support for an open global economy.

Recommendations for G8 Action

Despite substantial increases in investments in global health by G8 members, overall performance by developing country partners toward the health-related MDGs has not visibly accelerated. Weaknesses in health financing policies at the country level play a major role. More money is necessary, but improving the value of health spending through improvements in financing policies is also crucial. The global financial crisis has increased fiscal and credit constraints in both developed and developing countries and increases the vulnerability of those without access to health coverage. This increases the need for effective social health protection measures, strengthening moves toward universal coverage.

The G8 should respond with three actions:

1. The G8 should complement its efforts on increasing money for health with efforts to improve the value of health spending through support for better country-led health financing and systems policies.
2. The G8 should build on the existing consensus among technical experts with an explicit G8 commitment to prioritize support for country health financing policies that place public financing for health, in the form of tax financing and/or SHI, as the core of efforts to expand coverage for poor people and vulnerable groups in society.
3. The G8 should invest in the ability of developing country partners to make better financing policies. This will require increased investments in building national capacity for health systems policy assessment and in the mechanisms to understand and share the lessons of best practice countries.

Implications

The commitment to prioritize support for country health financing policies that place public financing at their core recognizes that the key goal is to increase risk pooling and reduce financial barriers to access by the poor, if health coverage and human security are to be improved. In concrete terms, this should translate into the following:

1. Explicit support and encouragement for partner developing countries who wish to abolish user fees in their public sectors, recognizing that the abolition of user fees must be accompanied by appropriate investments in health systems to ensure that free services are actually available to and used by poor people. Such policies might start first with the provision of services relevant to MDGs 4, 5, and 6.
2. Bolstering the IHP+ and P4H initiatives, with directions to G8 countries' aid agencies and multilateral agencies to ensure a clear and coherent message to partner developing countries that both taxation and SHI financing are recommended options but that their choice will depend on the specific country circumstances. This should reflect the global evidence indicating that SHI mechanisms are more feasible in middle-income country settings, while tax-financed mechanisms have worked even in low-income country settings.

Investing in country capacity to make good health financing policy choices recognizes that only when developing countries can take ownership over these decisions will the necessary country commitment be forthcoming. In concrete terms, this requires the following:

1. Scaling up of investments to develop country capacity for health systems policy analysis;
2. Significant investment to support partner developing countries in improving the evidence base on best practices in country financing and delivery that is needed to inform better policies and in a way that encourages joint learning; and
3. A fresh look at what has worked before in capacity building, and how agency practices can be improved, to avoid the lip service to capacity building that has unfortunately characterized past activities.[77]

Opportunities

It would be wrong to think that the current economic climate is a bad time to expand the G8's commitments to improve health in developing countries. Indeed, it is a unique opportunity to address key challenges in health sectors.

In past meetings, the G8 has laid a credible basis for addressing the health problems facing partner countries, demonstrated by their scaled-up external assistance for health and their commitments to support health system strengthening. More recently, the IHP+ and P4H initiatives pushed by G8 nations, such as France, Germany, and the UK, justify enhanced engagement that is based on alignment with country-led policies, support for public financing to improve coverage and equity, and enhanced social health protection. Both initiatives also stress the importance of investing in the capacity of countries to assess their own progress and learn from each other's own experience. So the IHP+ and P4H initiatives provide an important framework to advance the key recommendations of this chapter.

The G8 should build on and enhance the two initiatives, by providing a clear message of its support for translating the principle of public financing for better health into increased reliance on taxation and SHI, improving the value of health spending, and enabling developing countries to take greater ownership. This can and should explicitly identify the progressive attainment of universal coverage and strengthening of social health protection as the two motivating goals.

At the same time, the G8 should challenge fears that the crisis will reduce available funding for health. As noted, the current financial crisis requires fiscal expansion, and not contraction, in both developed and developing nations. Instead, the crisis provides an opportunity to support increases in health spending that are linked to better coverage and which can strengthen health systems to achieve better value for their spending. In this respect, the High-Level Task Force on Innovative International Financing for Health Systems can play an important role. It can learn from past efforts to identify new ways for G8 nations to financially support health systems and capacity building, at a time when conventional ODA budgets may be under pressure. At the same time, it should recognize that the key driver for better health systems is the health financing policies of countries themselves and that innovative new external financing mechanisms will only be effective if they link to and encourage better domestic policies in countries.

Notes

1. International Monetary Fund and World Bank, *Global Monitoring Report 2008: MDGs and the Environment: Agenda for Inclusive and Sustainable Development* (Washington DC: International Monetary Fund and World Bank, 2008).
2. Adam Wagstaff and Mariam Claeson, *The Millennium Development Goals for Health: Rising to the Challenges* (Washington DC: World Bank, 2004).
3. Ke Xu et al., "Protecting Households from Catastrophic Health Spending," *Health Affairs* 26, no. 4 (2007). cited in *WHO World Health Report 2008*, xiv.
4. More than 70 million people a year have been estimated to fall below the poverty line in selected countries of Asia, with as many as 2.6 percent of households in China and 3.8 percent in Bangladesh doing so in a given month. Eddy van Doorslaer et al., "Effect of Payments for Health Care on Poverty Estimates in 11 Countries in Asia: An Analysis of Household Survey Data," *Lancet* 368, no. 9544 (2006).
5. EU Presidency/Commission, "Background Paper for Informal Meeting of Development Ministers of the European Union, 29–30 September 2008—Working Session: Strengthening Health Systems in Developing Countries" (Brussels: EU Commission, 2008).
6. World Health Organization, *World Health Report 2008: Primary Health Care Now More Than Ever* (Geneva: World Health Organization, 2008).
7. As recent experiences with HIV, SARS, and avian influenza have shown, the most significant global risks of new pandemic pathogens arise in the poorest economies where there is the greatest risk of new pathogens emerging, owing in particular to agricultural practices, and where public surveillance and control systems are weakest.
8. This is well illustrated by the global impacts of the contamination of milk products with melamine in China in 2008.
9. Giulia Greco et al., "Countdown to 2015: Assessment of Donor Assistance to Maternal, Newborn, and Child Health between 2003 and 2006," *Lancet* 371, Special issue Countdown 2008 (2008).
10. Ke Xu et al., "Protecting Households from Catastrophic Health Spending,"
11. Margaret Chan, *Address by Dr. Margaret Chan to Executive Board of WHO* (WHO, 2007 [cited 25 September 2008]); available at http://www.who.int/dg/speeches/2007/eb120_opening/en/index.html.
12. Ke Xu et al., "Protecting Households from Catastrophic Health Spending."
13. To achieve MDGs 4 and 5, countries must reduce child and maternal mortality by two-thirds of their 1990 levels by 2015. This translates into an average annual reduction in mortality rates of 4.3 percent a year. Historically, the annual rates at which individual countries have been able to reduce mortality have tended to be quite steady over time for individual countries. So for most countries, the MDGs imply accelerating the rate of decline in mortality. For child mortality (MDG 4) for which data are the most reliable, the evidence shows that for the critical regions of South Asia and sub-Saharan Africa, the rates at which countries have been reducing mortality have in fact slowed during the 1990s, with progress being slower than in the preceding decades. To some extent, this is due to the impact of HIV in sub-Saharan Africa, but elsewhere, such as South Asia, this is clearly not the reason.
14. Child mortality estimates from the Inter-Agency Group for Child Mortality Estimation, as described in Edilberto Loaiza, Tessa Wardlaw, and Peter Salama, "Child Mortality 30 Years after the Alma-Ata Declaration," *Lancet* 372 (2008).
15. World Health Organization, *World Health Statistics 2008* (Geneva: World Health Organization, 2008). See also note 7 above.
16. In OECD countries, annual rates of doctor consultations range from 4 to 15 per year, as detailed in OECD, *Health at Glance 2007: OECD Indicators* (Paris: OECD, 2007). This is

4–10 times more than in most low-income countries. In the case of hospitalizations, the disparity is even greater, with annual rates in OECD countries being 5–10 times higher.

17. At the 2000 Okinawa Summit, the G7 committed to finding and mobilizing substantial new financial resources for HIV/AIDS and health in general in order to support expansion of coverage of critical health services in developing countries.
18. Figure 1 shows that overall external flows for health have increased in the past decade. In addition, other data suggest significant increases in recent years in the specific areas of HIV/AIDS and also maternal, neonatal, and child health [Greco et al., "Countdown to 2015: Assessment of Donor Assistance to Maternal, Newborn, and Child Health between 2003 and 2006." *Lancet* 371 (2008): 1268–1275]. Other data show that domestic financing has also increased in most partner countries.
19. A large number of estimates of the global financing needs have been published. They range considerably in their implied amounts because of differences in the methodologies used and also in what they attempt to estimate. Some, for example, focus on the marginal increases in public spending required to achieve just the health-related MDGs, while others attempt to estimate overall financing levels (both public and external) required to achieve universal coverage with basic health services. The key estimates are given by the WHO Commission on Macroeconomics and Health, *Macroeconomics and Health: Investing in Health for Economic Development* (Geneva: World Health Organization, 2001), which estimated a public financing need of US$34 per capita in 2001 in low-income countries, and other more recent World Bank estimates, which have suggested a requirement of US$30-50 per capita in the poorer developing countries.
20. Pablo Gottret and George Schieber, *Health Financing Revisited: A Practitioner's Guide* (Washington DC: World Bank, 2006). For a discussion of the UN MDG Needs Assessment Model, the UNICEF/World Bank/WHO Marginal Budgeting for Bottlenecks Model, and other alternative cost estimates, see Chapter 7.
21. Ernst R Berndt et al., "Chapter 3: Medical Care Prices and Output," in *Handbook of Health Economics*, ed. A. J. Culyer and J. P. Newhouse (Amsterdam: Elsevier Science BV, 2000). The authors review the considerable efforts that have been made to estimate health service efficiency changes in mostly developed economies. See also Martin Hensher, *Financing Health Systems through Efficiency Gains*, Paper No. WG3:2, *CMH Working Paper Series* (Geneva: Commission on Macroeconomics and Health, 2001).
22. Ravindra P. Rannan-Eliya, "Towards a Model of Endogenous Mortality Decline: The Dynamic Role of Learning and Productivity in Health Systems" (A thesis submitted to the Faculty of the Harvard School of Public Health in partial fulfillment of the requirements for the degree of Doctor of Public Health, Harvard University, 2004).
23. Peter R. Orszag, "Increasing the Value of Federal Spending on Health Care," in *Statement of Peter R. Orszag, Director, CBO, before the Committee on the Budget, U.S. House of Representatives, July 16, 2008* (Washington DC: Congressional Budget Office, 2008).
24. World Bank, *World Development Report 2004: Making Services Work for Poor People* (New York: Oxford University Press, 2003);.Gottret and Schieber, *Health Financing Revisited: A Practitioner's Guide*.
25. Rannan-Eliya, "Towards a Model of Endogenous Mortality Decline."
26. Hensher, *Financing Health Systems through Efficiency Gains*.
27. Observations by Christopher J. L. Murray, Institute for Health Metrics and Evaluation, at the International Conference on Global Action for Health System Strengthening, November 3–4, 2008.
28. *World Health Report 2008* (p.49) provides an example of how comprehensive health centers are more effective in increasing coverage rates for vaccination than more selective delivery facilities.
29. Although there have been significant investments by the WHO, the World Bank, and several

G8 members to support the development of such NHA systems in partner developing countries since the early 1990s, very few of these investments have resulted in sustained capacity in developing countries to maintain such systems [Anna H. Glenngård and Frida Hjalte, "Findings from a Study of Regional NHA Networks" (Stockholm: SIDA, 2005)].

30. The importance of developing national systems to routinely monitor and understand inequalities is a key recommendation of the WHO Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health.* (Geneva: World Health Organization, 2008).
31. See note 7 above.
32. Gottret and Schieber, *Health Financing Revisited*.
33. Eddy van Doorslaer et al., "Catastrophic Payments for Health Care in Asia," *Health Economics* 16, no. 11 (2007). See also note 4 above.
34. Jessica Cohen and Pascaline Dupas, "Free Distribution or Cost-Sharing? Evidence from a Randomized Malaria Prevention Experiment" (Cambridge, MA: Poverty Action Lab, Massachusetts Institute of Technology, 2008).
35. Several examples of this, such as Sri Lanka, Thailand, Costa Rica, and Tunisia, are discussed in Gottret and Schieber, *Health Financing Revisited*.
36. Gottret and Schieber, *Health Financing Revisited*.
37. Comparative analyses of who pays taxes in Europe and in other developing regions consistently find that taxation is the mechanism that places the least burden on the poor and mobilizes the most from the better-off [Eddy van Doorslaer, Adam Wagstaffe, Frans Rutten, ed., *Equity in the Finance and Delivery of Health Care: An International Perspective* (Oxford: Oxford University Press, 1993)]. Although there has been concern that indirect taxation, which predominates in many developing countries, is regressive, largely based on this being the situation in Europe, actual studies have demonstrated that in most developing countries even indirect taxation is progressive in its incidence [Owen O'Donnell et al., "Who Pays for Health Care in Asia?" *Journal of Health Economics* 27 (2008)].
38. Gottret and Schieber, *Health Financing Revisited*; Hensher, *Financing Health Systems through Efficiency Gains*.
39. Although Hong Kong SAR and Cyprus are high-income economies, their health financing strategies have until recently looked more like other developing economies, with public financing only paying for about half of overall healthcare services.
40. Owen O'Donnell et al., "The Incidence of Public Spending on Healthcare: Comparative Evidence from Asia," *World Bank Economic Review* 21, no. 1 (2007); Lucy Gilson et al., "Challenging Inequity through Health Systems: Final Report of the Knowledge Network on Health Systems" (Johannesburg: Centre for Health Policy, University of the Witwatersrand, 2007).
41. See note 4 above.
42. Lucy Gilson and Di McIntyre, "Removing User Fees for Primary Care in Africa: The Need for Careful Action," *British Medical Journal* 331 (2005).
43. It is often argued that this link can make SHI more politically sustainable than tax financing.
44. In contrast to the NHS model, SHI usually involves a separation of financing from provision, which allows for purchasing and the use of direct financial incentives to motivate providers. However, this reliance on payment for services can induce inefficiencies as providers face incentives to provide excess care or to raise costs.
45. See note 4 above.
46. William C. Hsiao and R. Paul Shaw, eds., *Social Health Insurance for Developing Nations, WBI Development Studies* (Washington DC: World Bank, 2007).
47. P. Nymadawa and K. Tungalag, "Mongolia," in *Social Health Insurance: Selected Case Studies*

from Asia and the Pacific (New Delhi: WHO Regional Office for South-East Asia and WHO Regional Office for Western Pacific Region, 2005).

48. Viroj Tangcharoensathien et al., "Thailand," in *Social Health Insurance: Selected Case Studies from Asia and the Pacific* (New Delhi: WHO Regional Office for South-East Asia and WHO Regional Office for Western Pacific Region, 2005).
49. Rwanda is often described as relying not on SHI but on community health insurance, but the high level of public subsidies for the Rwandan *mutuelles* (more than 50 percent) and the considerable degree of state involvement and management mean that it resembles a form of SHI.
50. Coverage is less than 40 percent still in Ghana and has reached just under 75 percent in Rwanda.
51. ILO and STEP (Strategies and Tools against Exclusion and Poverty), "Extending Social Health Protection in Health through Community-Based Health Organizations" (Geneva: International Labor Organization, 2002); Bjorn Ekman, "Community-Based Health Insurance in Low-Income Countries: A Systematic Review of the Evidence," *Health Policy and Planning* 19, no. 5 (2004); Melitta Jakab and C. Krishnan, "Review of the Strengths and Weaknesses of Community Financing," in *Health Financing for Poor People: Resource Mobilization and Risk Sharing*, ed. Alexander Preker and Guy Carrin (Washington DC: World Bank, 2004); Gottret and Schieber, *Health Financing Revisited*.
52. M. Kent Ranson et al., "Equitable Utilisation of Indian Community Based Health Insurance Scheme among Its Rural Membership: Cluster Randomised Controlled Trial," *BMJ* 334, no. 7607 (2007).
53. William C. Hsiao, "Why Is a Systemic View of Health Financing Necessary?" *Health Affairs* 26, no. 4 (2007); Gottret and Schieber, *Health Financing Revisited: A Practitioner's Guide*.
54. Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2007, Current Population Reports, P60–235" (Washington DC: US Census Bureau, 2008).
55. Gerard F. Anderson et al., "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22, no. 3 (2003).
56. Gottret and Schieber, *Health Financing Revisited: A Practitioner's Guide*; see also note 16 above.
57. R. Paul Shaw and Charles C. Griffin, *Financing Health Care in Sub-Saharan Africa through User Fees and Insurance*, *Directions in Development* (Washington DC: World Bank, 1995).
58. Mukesh Chawla and Ravi P. Rannan-Eliya, "Experiences with Resource Mobilization Strategies in Five Developing Countries—What Can We Learn," *Data for Decision Making Publication Number 31-2* (Boston: Harvard School of Public Health, 1997).
59. This is based on a review of the available documentation for initiatives supported by the Dutch Health Insurance Fund in Nigeria and Namibia.
60. ILO, "Social Health Protection: An ILO Strategy Towards Universal Access to Health Care," (Geneva: Social Security Department, International Labour Organization, 2007); World Health Organization, *World Health Report 2008: Primary Health Care Now More Than Ever*; Gottret and Schieber, *Health Financing Revisited: A Practitioner's Guide*; see also note 7 above.
61. Gottret and Schieber, *Health Financing Revisited: A Practitioner's Guide*.
62. Ibid.
63. Ibid.
64. Peter R. Orszag, "Increasing the Value of Federal Spending on Health Care."
65. Ministerial Summit on Health Research, "The Mexico Statement on Health Research—Knowledge for Better Health: Strengthening Health Systems" (Mexico City: Ministerial Summit on Health Research, Mexico City, November 16–20, 2004).
66. World Bank, "Afghanistan: Managing Public Finances for Development (Report No. 34582-

Af)" (Washington DC: World Bank, 2005); Matt Waldman, "Falling Short: Aid Effectiveness in Afghanistan" (Kabul: Agency Coordinating Body for Afghan Relief (ACBAR), 2008).
67. Ke Xu et al., "Protecting Households from Catastrophic Health Spending"; Gottret and Schieber, *Health Financing Revisited*.
68. John Akin, Nancy Birdsall, and David De Ferranti, *Financing Health Services in Developing Countries: An Agenda for Reform, A World Bank Policy Study* (Washington DC: World Bank, 1987).
69. UNICEF, "The Bamako Initiative; Reaching Health Goals through Strengthened Services Delivery" (New York: Bamako Initiative Management Unit, UNICEF, 1990).
70. World Bank, *Better Health in Africa, Development in Practice Series* (Washington DC: World Bank, 1995); Shaw and Griffin, *Financing Health Care in Sub-Saharan Africa through User Fees and Insurance, Directions in Development*.
71. Ke Xu et al., "Protecting Households from Catastrophic Health Spending."
72. In 2006, the Dutch government invested €100 million in the Health Insurance Fund to support development of private health insurance schemes in Africa (see http://www.hifund.nl).
73. WHO, *World Health Report 2008: Primary Health Care Now More Than Ever*.
74. WHO World Health Assembly Resolution 58.33—"Sustainable health financing, universal coverage and social health insurance."
75. For example, conflicting recommendations on tax financing and SHI by different European donors and international agencies have led to fierce disputes between donor partners in Bangladesh and Tanzania (personal communications from relevant officials to author).
76. International Monetary Fund, "Letter from IMF Managing Director Dominique Strauss-Kahn to the G-20 Heads of Governments and Institutions, 6 November 2008" (Washington DC: International Monetary Fund, 2008).
77. WHO Alliance for Health Systems and Policy Research reviewed what might be done in its 2007 Biennial Review, but this initiative needs to be followed up on.

Task Force on Global Action for Health System Strengthening

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