FINANCIAL SUSTAINABILITY CHALLENGES IN TRANSITIONING FROM EXTERNAL SOURCES OF FINANCING

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UHC2030 WORKING GROUP MEETING ON SUSTAINABILITY, TRANSITION FROM AID, AND HEALTH SYSTEM STRENGTHENING
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Multi-Donor Trust Fund on Integrating Externally-Financed Health Program
All are lower middle income countries; incomes ranging from US$1,160 (Myanmar) to US$3,440 (Indonesia).

Wide range of external shares in total health spending: shares in Pacific countries tend to be much higher than expected relative to their income levels.
Financial sustainability implications of transition from external financing are different and non-linear across countries: in some occurring together with transition towards greater social health insurance financing and reduced OOP; in others such as Pacific, OOP spending already low.
“Health Financing Transition”

Total health expenditure per capita (left axis)

LOW INCOME
LOWER MIDDLE INCOME
UPPER MIDDLE INCOME
HIGH INCOME

Health financing transition

Total health expenditure per capita (left axis)

Source: WHO
Health financing transition

Total health expenditure per capita (left axis)
External share (right axis)
LOW INCOME
LOWER MIDDLE INCOME
UPPER MIDDLE INCOME
HIGH INCOME

Share of total health expenditure (%)

Total health expenditure per capita, US$
GNI per capita, US$

Source: WHO
“Health Financing Transition”

Source: WHO
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Ensuring and sustaining progress towards UHC is a good entry point for discussing issues related to transitions; many externally-financed programs provide support for enhancing coverage for indicators that are recommended by WHO-WB to measure progress towards UHC.
Transition and Sustainability
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The mechanism a country chooses to fund and implement health programs independent of external support.

The ability of health programs to maintain progress on service coverage and financial protection after the end of external support.
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The ability of health programs to maintain progress on service coverage and financial protection after the end of external support.
Transition/Integration Require Ensuring Both Programmatic and Financial Sustainability within the Overall Context of UHC

- **Programmatic Sustainability**: How to operate program features set up independently from country systems?
- **Financial Sustainability**: What resources will be available to replace external funding and finance transition?
Transition Planning & Management: Programmatic vs Financial Sustainability

Programmatic Sustainability
How to operate program features set up independently from country systems?

Financial Sustainability
What resources will be available to replace external funding and finance transition?
WHO-WB Recommended UHC Monitoring Indicators

Preventive/Promotive:
- Access to modern contraceptives
- Antenatal care (ANC) coverage
- Skilled birth attendance rates
- Full immunization rate
- Non-smoking rates
- Access to improved water sources
- Access to improved sanitation

Treatment:
- Diabetes treatment coverage
- Hypertension treatment
- TB cases detected and cured
- People with HIV receiving ART

Financial Protection:
- OOP spending as share of household consumption
- Household impoverishment due to OOP expenditure
## Selected UHC Indicators

<table>
<thead>
<tr>
<th>Country</th>
<th>Family planning</th>
<th>ANC</th>
<th>Skilled birth</th>
<th>DPT3</th>
<th>Non-tobacco</th>
<th>Water</th>
<th>Sanitation</th>
<th>TB</th>
<th>Prepaid-pooled financing</th>
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<td>PNG</td>
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Some Key Points Regarding Transitions & Financial Sustainability

Financial sustainability implications of transition from external financing are different and non-linear across countries: in some occurring together with transition towards greater social health insurance financing and reduced OOP; in others such as Pacific, OOP spending already low.

Ensuring and sustaining progress towards UHC is a good entry point for discussing issues related to transitions; many externally-financed programs provide support for enhancing coverage for indicators that are recommended by WHO-WB to measure progress towards UHC.

Financial sustainability invariably requires assessments of the macro-fiscal context in terms of willingness and ability of governments to increase public financing for health; macroeconomic environment critical for identifying opportunities for and constraints to public financing for health.
Mathematics of Public Spending on Health

GDP per capita
Mathematics of Public Spending on Health

Public Expenditure Share of GDP $X$ GDP per capita
Mathematics of Public Spending on Health

Health Share of Public Expenditure $\times$ Public Expenditure Share of GDP $\times$ GDP per capita
Mathematics of Public Spending on Health

Health Share of Public Expenditure \( \times \) Public Expenditure Share of GDP \( \times \) GDP per capita = Public Health Expenditure per Capita
Mathematics of Public Spending on Health

Health Share of Public Expenditure \( \times \) Public Expenditure Share of GDP \( \times \) GDP per capita = Public Health Expenditure per Capita \( \rightarrow \) Health Outputs and Outcomes
Mathematics of Public Spending on Health

Example from Myanmar: 3% X 25% X US$1,200 = US$9
Example from Ethiopia: 9% X 18% X US$600 = US$10
Actual/Projected Economic Growth, 2011-2021

Source: IMF
“Rule of 70”: Economic Growth is Key

- 70 divided by the economic growth rate gives the number of years it will take economy to double.

- Example: 7% growth = economy will double in 10 years; ceteris paribus, public spending on health will double in 10 years.
Time-to-Double

**GDP**

- Myanmar: 7.7%
- Lao PDR: 7.2%
- Cambodia: 6.7%
- Vietnam: 6.2%
- Indonesia: 5.7%
- Vanuatu: 3.6%
- Papua New Guinea: 3.1%
- Solomon Islands: 3.1%
- Kiribati: 1.9%

**GDP per capita**

- Myanmar: 7.0%
- Lao PDR: 5.2%
- Vietnam: 5.2%
- Cambodia: 5.1%
- Indonesia: 4.4%
- Vanuatu: 1.3%
- Solomon Islands: 0.9%
- Papua New Guinea: 0.4%

Source: Authors calculations based on IMF-WEO (2017)
Note: Percentages next to the bars are projected 2017-2021 average annual growth rates.
Debt-Deficit Projections 2017-2021

Source: IMF World Economic Outlook database
Increasing Health’s Share of Government Budget

- Globally, large variations in extent to which health is prioritized in government budgets: ranges from 1% to almost 30%.

- **Political economy** considerations are key, and that results-focused reform efforts – in particular efforts to explicitly expand coverage and improve quality of spending as opposed to efforts focused only on government budgetary targets – are more likely to result in sustained and politically-feasible prioritization of health.

- **Efficiency** considerations are important: efficiency is in itself a source of effective fiscal space; but can also be important for attracting additional public resources for health from ministries of finance and external sources.
Raising Resources from Sector-Specific Sources

- **Social health insurance** and other forms of **earmarked revenues** (e.g., from “sin” taxes, earmarking of VAT, etc.) are examples of sector-specific revenue sources.

  - Social health insurance often introduced as a way to collect additional revenues for health, especially from employers; Introducing and/or increasing contribution rates from formal sector often a key fiscal space question; Challenge in implementing mandates and collecting contributions in economies with large levels of informality.

- Use of **“sin taxes”** on tobacco and alcohol increasingly prevalent for financing health and are often justified from health as well as fiscal perspective, despite sometimes being regressive;

  - Earmarking often unpopular with ministries of finance: introduces rigidities in allocations across sectors, often viewed as second-best option.

- Key questions: why earmark, and are earmarked resources for health truly additional?
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Efficiency in how revenues are both raised and spent is key in helping realize additional public financing for health; in some countries, external financing will likely remain important: transition about replacing one external source of financing with another.