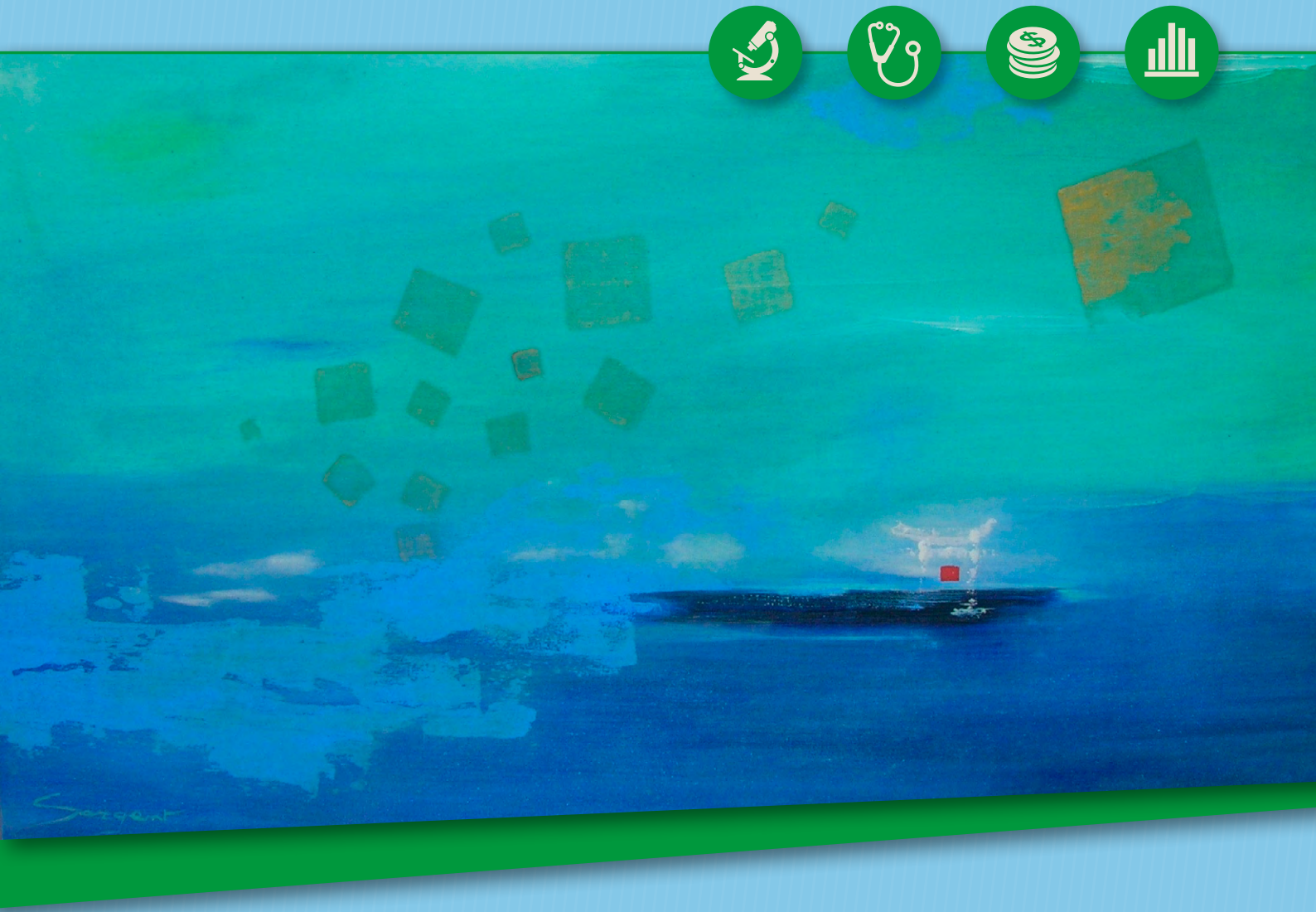
HEALTH FINANCING WORKING PAPER NO 7

TOWARDS UNIVERSAL HEALTH COVERAGE: THINKING PUBLIC

OVERVIEW OF TRENDS IN PUBLIC EXPENDITURE ON HEALTH (2000-2014)



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ISBN 978-92-4-151242-8

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Suggested citation. Barroy H.; Vaughan K.; Tapsoba Y.; Dale E.; Van de Maele N. Towards universal health coverage: thinking public. Overview of trends in public expenditure on health (2000-2014). Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.

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Printed in Switzerland.

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ACKNOWLEDGEMENT

The team which developed this analysis included: Helene Barroy (WHO, Health Financing Unit), Kelsey Vaughan (consultant), Yann Tapsoba (consultant), Elina Dale (WHO, Health Financing Unit), and Nathalie Van de Maele (WHO, Health Financing Unit). The paper was reviewed by Joseph Kutzin (WHO, Health Financing Unit, Coordinator) and Agnès Soucat (WHO, Health Systems Governance and Financing, Director). We would also like to thank Gary Humphreys for editing assistance.

Financial support for the work was provided by the UK Department for International Development (DFID) under the Program for Improving Countries' Health Financing Systems to Accelerate Progress towards Universal Health Coverage, and the Ministry of Health and Welfare of the Republic of Korea, under the Tripartite Program on Strengthening Health Financing Systems for Universal Health Coverage.

SUMMARY

Key Messages

- Public financing is central to making progress towards universal health coverage (UHC).
- Despite its known importance for UHC, the role of public funds from *domestic* sources to finance health stagnated between 2000 and 2014 in low-and middle-income countries (LMICs).
- There is no evidence that the replacement of private with *domestic* public financing started, especially in low-income countries (LICs).
- Per capita public expenditure on health, net of external aid, increased less rapidly than overall public spending between 2000 and 2014.
- Domestic budget prioritization towards health is subject to sharp decline and high volatility between 2000 and 2014 in LICs.
- External health aid negatively impacts the level of *domestic* resources allocated and spent on health.
- More public revenues do not necessarily lead to higher budget prioritization for health, while debt service tends to slightly reduce budget allocations to health across countries LMICs.
- *Domestic* public funds are disproportionally spent on non-discretionary health expenditure and higher-end care, reducing opportunity for better efficiency and equity in spending.
- Monitoring and evaluation strategies should be refined to provide a more accurate and comprehensive picture of public financing for health on the road to UHC.

ABSTRACT

Background: Past quantitative research on health financing has focused mostly on the level and distribution of total expenditure, with little emphasis on the specific role of public funds, despite their known importance for universal health coverage (UHC). Achieving a better understanding of public financing for health in the context of the overall macro-fiscal environment is of fundamental importance to the development of future health financing policy, notably in low- and middle-income countries (LMICs).

Objective: The main objective of the study is to examine key dimensions of the changing relation between public financing for health and the economy, the budget and sector financing over the period 2000-2014. The study specifically examines trends in public expenditure on health from *domestic* sources, separating out external sources channeled through the budget, in the context of transitioning from health aid.

Methods: As a preliminary step, we separated public expenditure on health (PEH) into *domestic* and external sources. We analysed patterns and elasticities of PEH, from both *domestic* and all sources, in the context of macro-fiscal conditions for the period 2000-2014 and for sub-periods by country and income group. We then undertook a more detailed examination of the levels and trends in budget prioritization towards health, from both *domestic* and all sources, and their evolving relationship with per capita spending. We also used panel data analysis to explore the relationship between budget prioritization for health and a set of macro-fiscal and health financing factors to identify possible determinants of higher prioritization across LMICs between 2000 and 2014. Finally, we analysed the specific role of public expenditure in the broader health financing landscape, and conducted a distribution analysis of *domestic* public funds on health by inputs, functions and levels of care. All analyses were conducted using the latest editions of WHO's Global Health Expenditure, IMF's Government Finance Statistics, and country Health Accounts databases.

Findings: Our analysis shows that the transition from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs) has been marked by an overall deterioration in the role of *domestic* public funds for health spending, especially in low-income countries (LICs). The period is characterized by reduced sensitivity of PEH to fiscal expansion and declining prioritization towards the sector, both contributing, among other factors, to weakening the relative contribution of public funds in financing the sector in LICs between 2000 and 2014. Prioritization of *domestic* budgets towards health in LMICs has been negatively affected by the level of external resources and service debt. Irrespective of their levels, *domestic* public funds have been predominantly spent on non-discretionary expenditures and high-end care, reducing opportunity for better efficiency and equity in spending.

Discussion: Taken together, these findings signal the need to find new ways to reinforce public commitments to the health sector, and refine health financing monitoring and advocacy strategies in support of countries moving towards UHC. To accelerate progress towards UHC, public financing should be at the centre of health financing policy and research. For a more comprehensive and accurate picture of public financing for health, future monitoring efforts should track budget allocations from *domestic* sources, combine relative and absolute measures, and aim for output-oriented reporting of expenditure.

1. INTRODUCTION

Optimizing health financing is central to making effective progress towards universal health coverage (UHC), and in particular to reducing the gap between the need for and use of services and improving financial protection.[1] The composition of health financing affects health system performance and a country's ability to achieve UHC goals.[2–4] While private funds play a role in all health systems, evidence shows that it is public, compulsory, pre-paid financing that helps countries move towards UHC.[5–7] Low levels of public financing are associated with reduced overall financial protection and worsened health outputs.[4,6,8–10]

Despite the acknowledged importance of public financing for health in the context of UHC, to date there has been limited quantitative research focused on public financing. With a few noticeable exceptions,[11-13] past quantitative health financing research has mostly focused on total health spending, examining trends and levels of health expenditure, with less attention being paid to the specific contribution of public funds.[14-16] Quantitative research has also focused on tracking external resources for mixed.[11,12,18,19] There is also little systematic exploration of the elasticity of public spending on health relative to *domestic* finance and to factors other than income.[20] In general, despite a continuous push for higher health sector prioritization within budgets[21] at global and regional levels, published literature of health prioritization trends also remains scarce.[19,22,23] Additionally, a common challenge of past analyses of public expenditure on health has been the absence of disaggregation of public spending by source of funds. While crucial to inform future *domestic* resource mobilization strategies, very few attempts in the recent past[12,24] have been made to disentangle the respective contribution of *domestic* and external financing sources. For a sector that still largely depends on external aid in LMICs, analyses that merge *domestic* and external sources of public spending can provide a biased picture, e.g. budget prioritization may be over-estimated.[23]

To support progress towards UHC and achievement of the new Sustainable Development Goals (SDGs) target 3.8, there is a clear need to better understand the trends, factors and distribution of public financing for

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