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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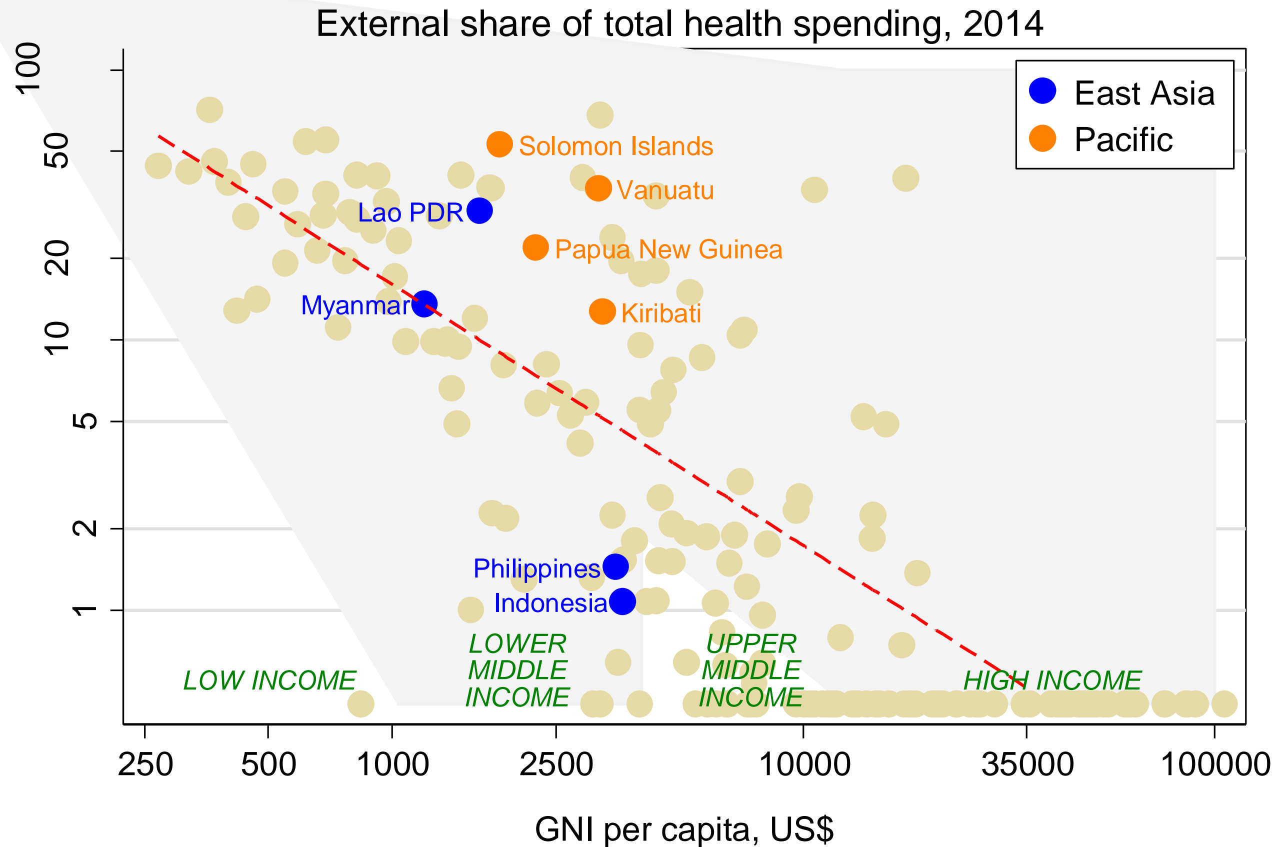
Multi-Donor Trust Fund on Integrating Externally-Financed Health Program

External Share of Total Health Spending



- 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.

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

"Health Financing Transition"

Health financing transition

Source: WHO

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Health financing transition

Total health expenditure per capita (left axis)

OOP share (right axis)

External share (right axis)

Share of total health expenditure (%)

LOW INCOME

LOWER MIDDLE INCOME

UPPER MIDDLE INCOME

HIGH INCOME

2500

500

100

25

5

50

40

30

20

10

0

250 500 1000 2500 10000 35000 100000

GNI per capita, US$

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

UHC

Transition

Sustainability

Time

Transition and Sustainability

UHC

The mechanism a country chooses to fund and implement health programs independent of external support.

Transition

Sustainability

The ability of health programs to maintain progress on service coverage and financial protection after the end of external support.

Time

Transition and Sustainability

UHC

The mechanism a country chooses to fund and implement health programs independent of external support.

Transition

Service Delivery
Health Financing
Governance

Programmatic Sustainability

Financial Sustainability

The ability of health programs to maintain progress on service coverage and financial protection after the end of external support.

Time

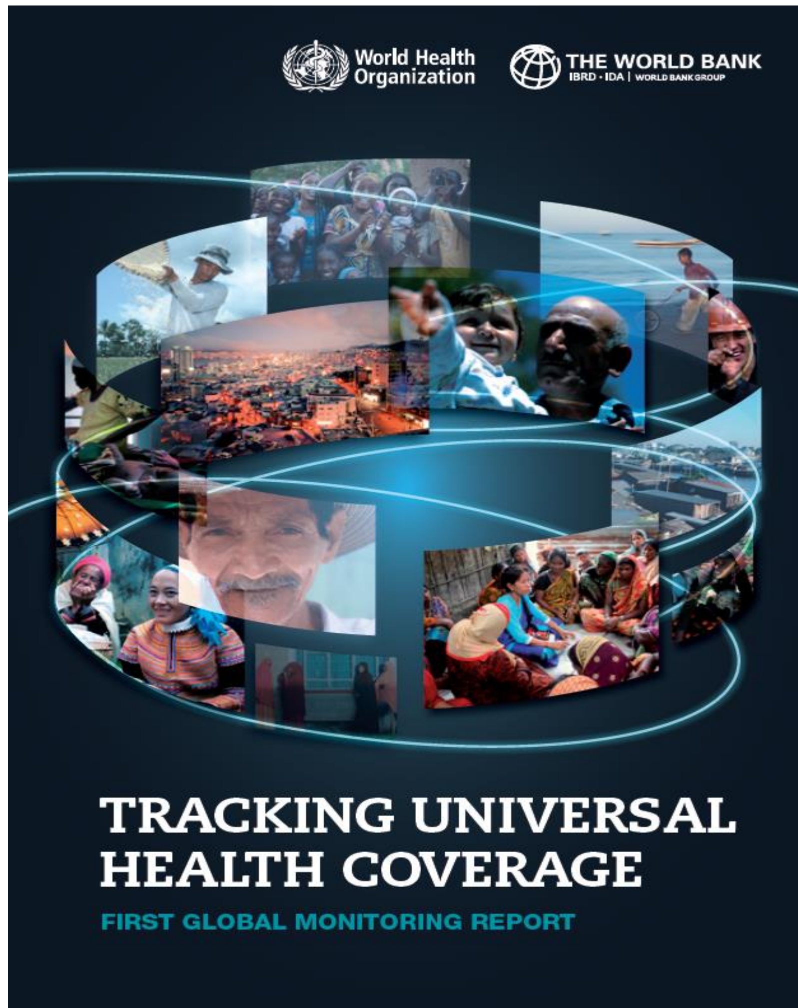
Transition/Integration Require Ensuring Both Programmatic and Financial Sustainability within the Overall Context of UHC

Programmatic Sustainability	Financial Sustainability
How to operate program features set up independently from country systems?	What resources will be available to replace external funding and finance transition?

Transition Planning & Management: Programmatic vs Financial Sustainability

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

Country	Family planning	ANC	Skilled birth	DPT3	Non-tobacco	Water	Sanitation	TB	Prepaid-pooled financing
PNG	32%	66%	53%	62%	64%	40%	19%	50%	90%
Lao PDR	50%	53%	42%	89%	67%	76%	71%	28%	61%
Kiribati	22%	88%	80%	87%	48%	67%	40%	65%	100%
Cambodia	56%	89%	89%	89%	77%	76%	42%	59%	26%
Indonesia	63%	96%	83%	81%	60%	87%	61%	28%	53%
Myanmar	46%	83%	71%	75%	81%	81%	80%	59%	49%
Solomons	35%	91%	86%	98%	73%	81%	30%	66%	95%
Vanuatu	49%	76%	89%	64%	84%	95%	58%	66%	94%
Vietnam	76%	96%	94%	97%	76%	98%	78%	68%	63%
East Asia	*60%*	*90%*	*82%*	*88%*	*73%*	*87%*	*71%*	*60%*	*61%*
Pacific	*48%*	*89%*	*84%*	*88%*	*77%*	*89%*	*73%*	*57%*	*70%*
LMICs	*48%*	*86%*	*78%*	*84%*	*77%*	*85%*	*61%*	*56%*	*62%*

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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	X	Public Expenditure Share of GDP	X	GDP per capita

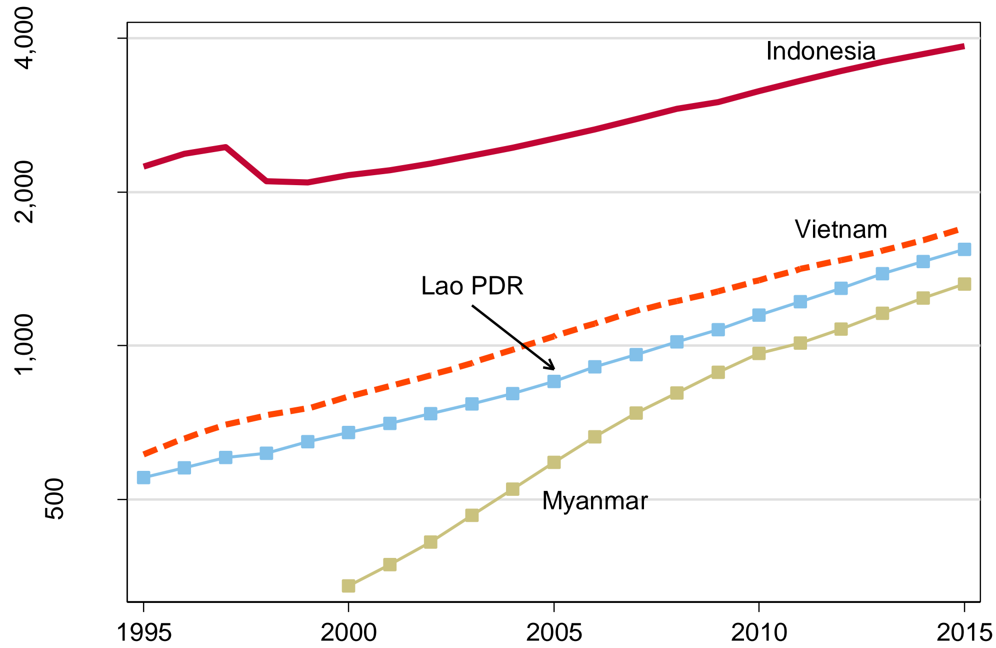
Mathematics of Public Spending on Health

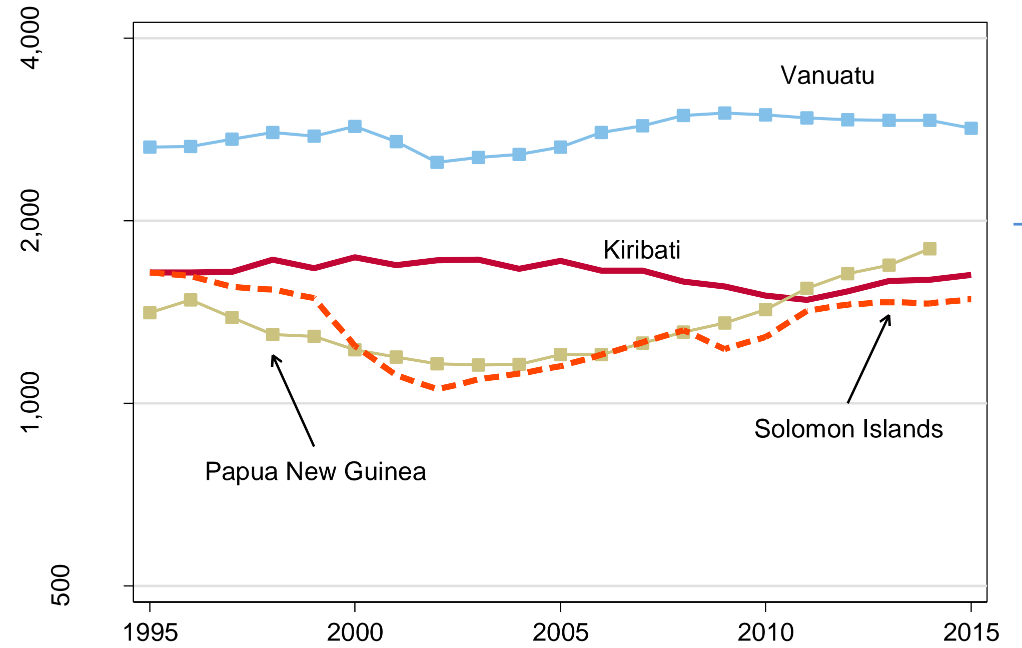
Health Share of Public Expenditure	X	Public Expenditure Share of GDP	X	GDP per capita	=	Public Health Expenditure per Capita

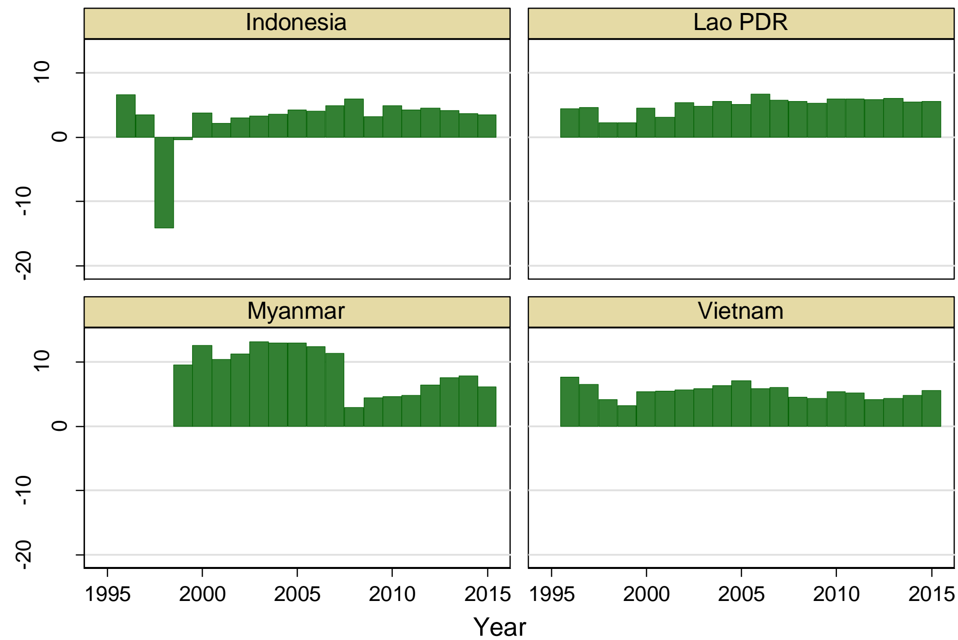
Mathematics of Public Spending on Health

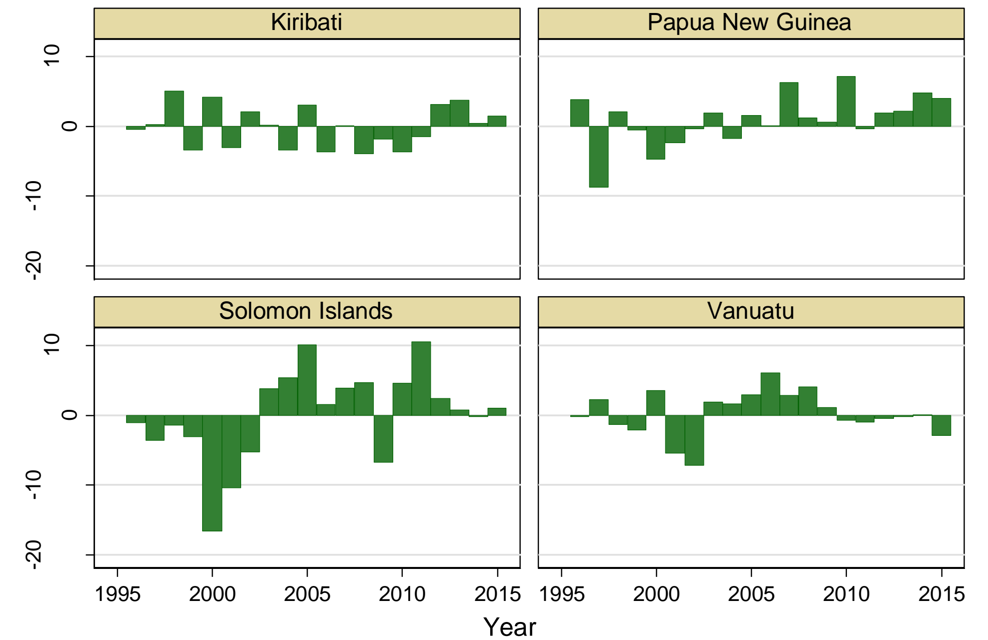
Mathematics of Public Spending on Health

Example from Myanmar: **3% X 25% X US$1,200 = US$9**
Example from Ethiopia: **9% X 18% X US$600 = US$10**


Indonesia
Vietnam
Lao PDR
Myanmar
4,000
2,000
1,000
500
1995
2000
2005
2010
2015


Vanuatu
Kiribati
Papua New Guinea
Solomon Islands
4,000
2,000
1,000
500
1995
2000
2005
2010
2015


GDP per capita growth, 1995-2015
Indonesia
Lao PDR
Myanmar
Vietnam
10
0
-10
-20
1995
2000
2005
2010
2015
Year


GDP per capita growth, 1995-2015
Kiribati
Papua New Guinea
Solomon Islands
Vanuatu
10
0
-10
-20
1995
2000
2005
2010
2015
Year

Actual/Projected Economic Growth, 2011-2021

HIGHER ECONOMIC GROWTH EXPECTED

LOWER ECONOMIC GROWTH EXPECTED

45 degree line

Myanmar

Lao PDR

Vietnam

Indonesia

Vanuatu

Solomon Islands

Papua New Guinea

Kiribati

-2 -1 0 1 2 3 4 5 6 7 8

Average GDP per capita growth, 2011-2015

Source: IMF

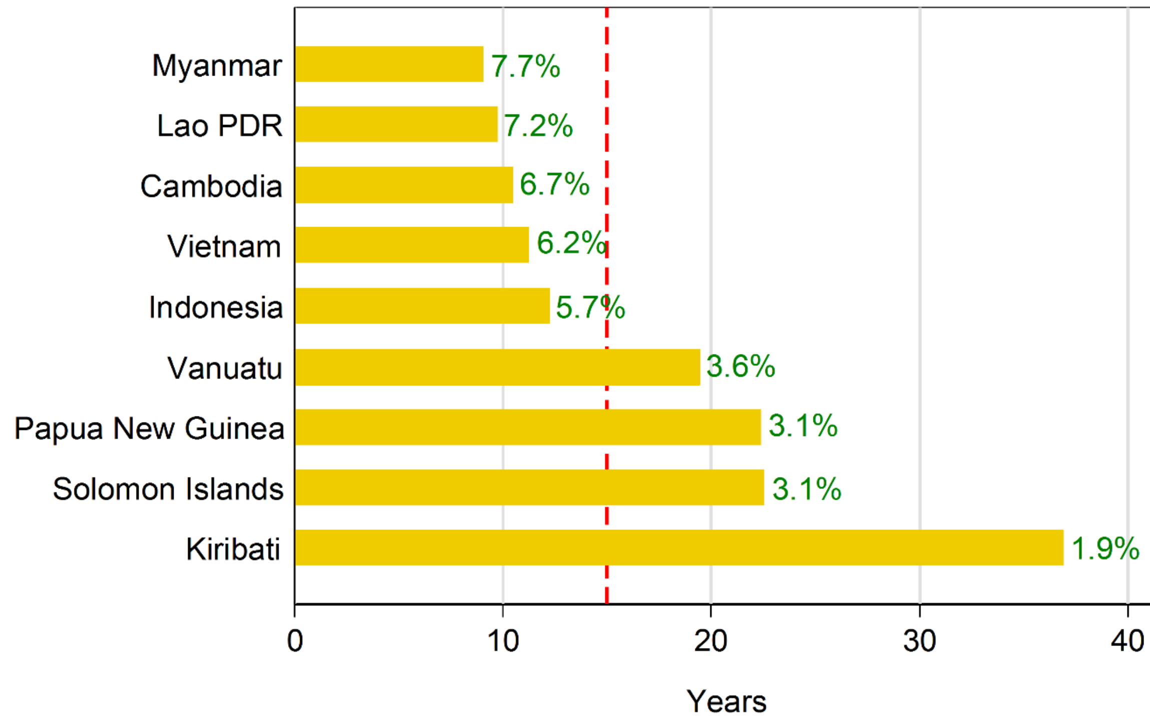
"Rule of 70": Economic Growth is Key

Countries whose economies are expected to shrink in per capita terms in next 5 years

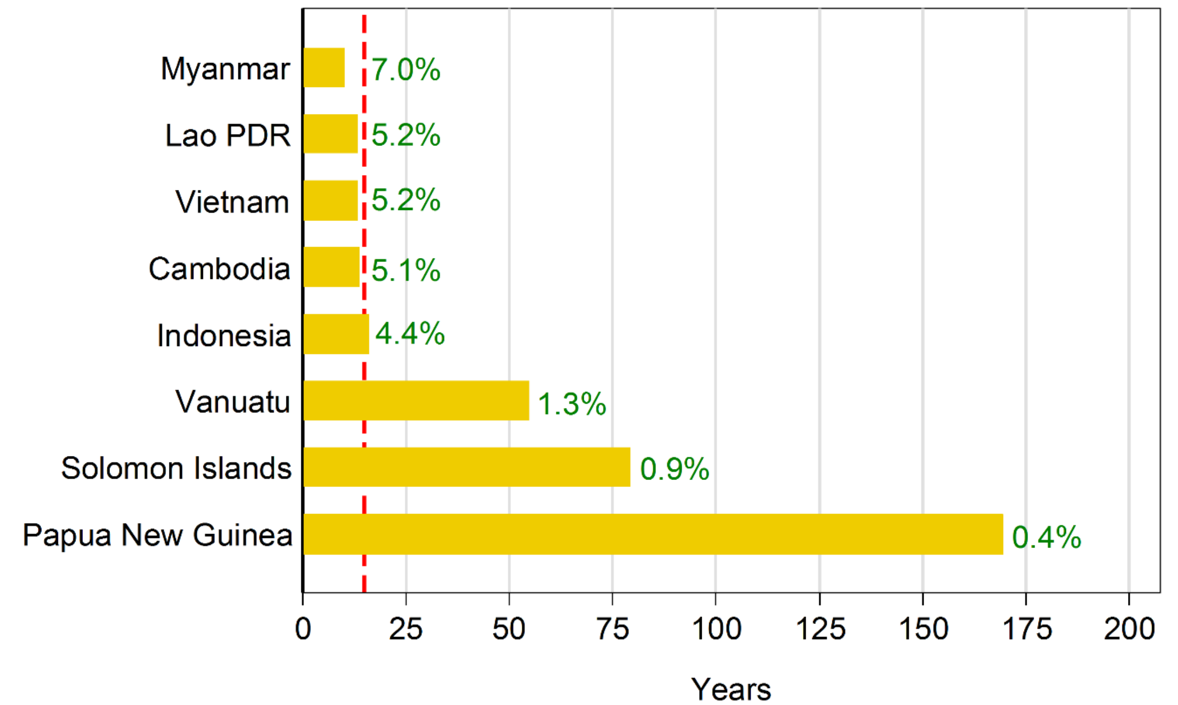
At current growth rates, the economies of these countries will double in per capita terms before 2030

- 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

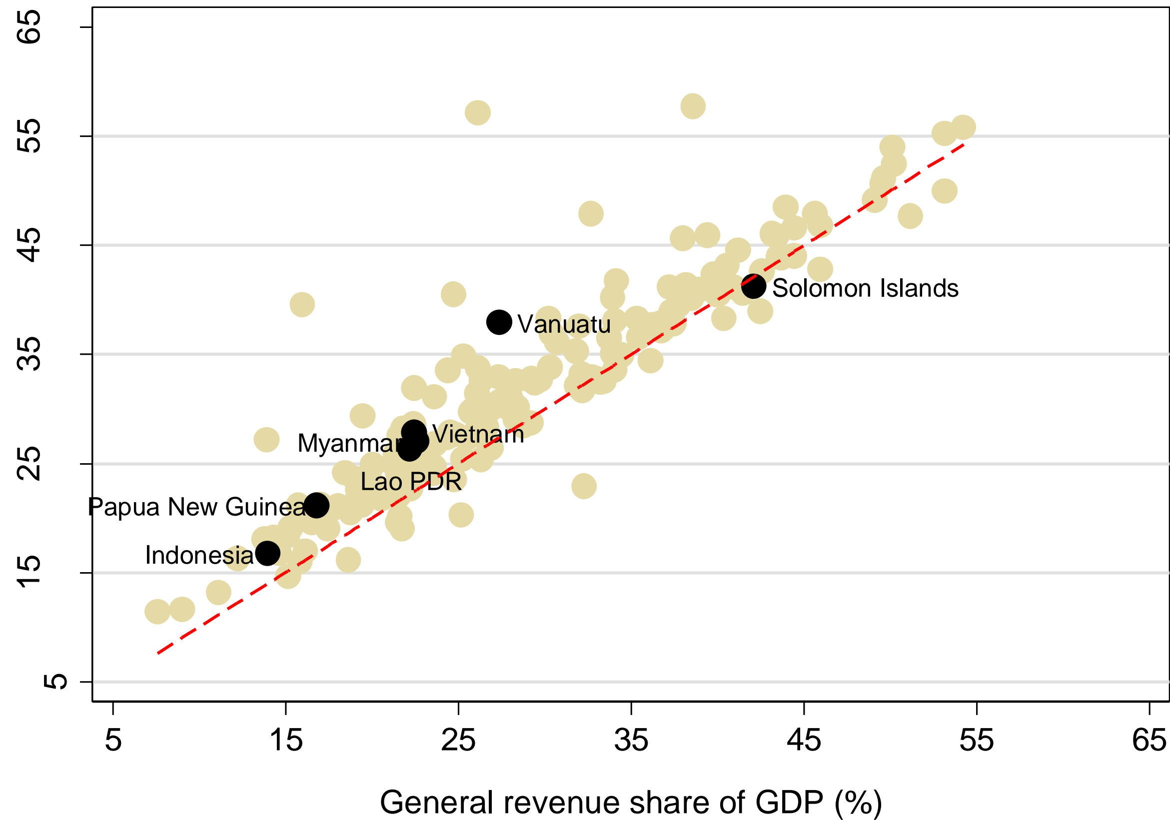


Source: Authors calculations based on IMF-WEO (2017)
Note: Percentages next to the bars are projected 2017-2021 average annual growth rates.

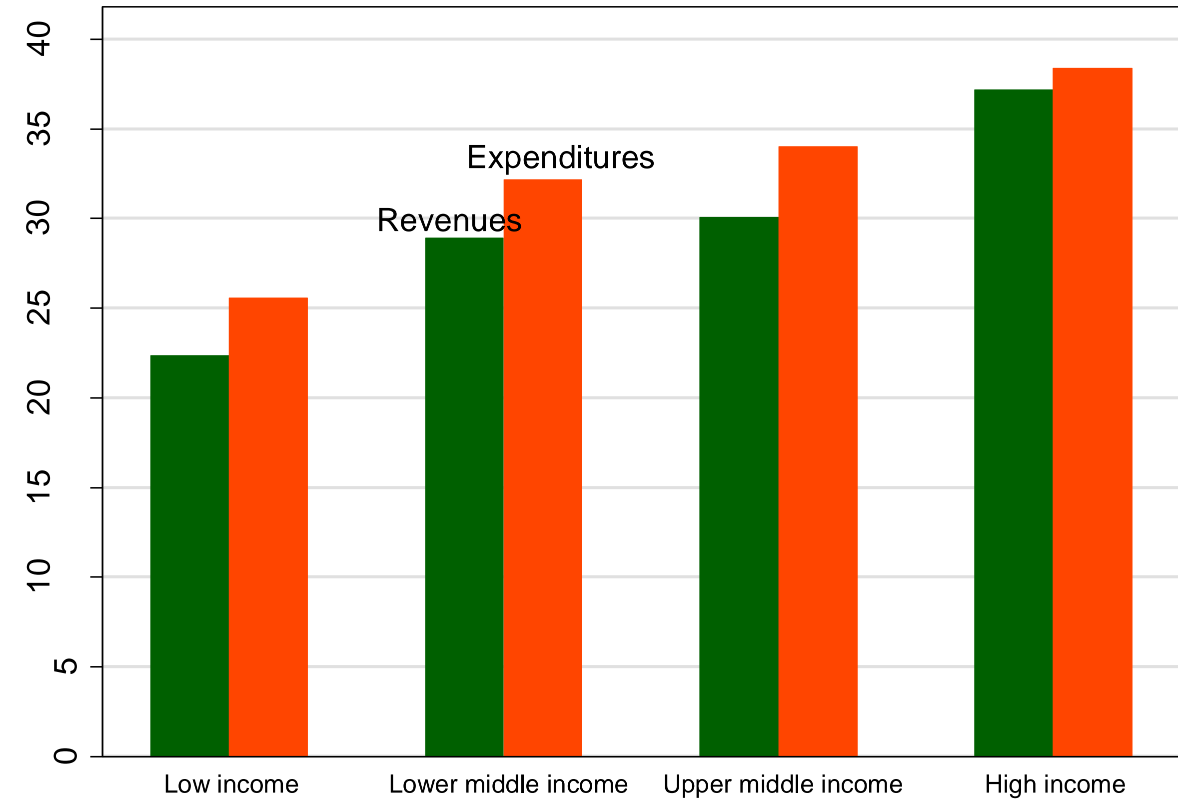


Source: Authors calculations based on IMF-WEO (2017)
Note: Percentages next to the bars are projected 2017-2021 average annual growth rates. Kiribati is projected to have a -0.1% average annual growth rate between 2017 to 2021. Calculating the time-to-double would yield -693 years. For presentation purposes, Kiribati is excluded from this graph.

Government Revenues & Expenditures 2017-2021



Source: IMF



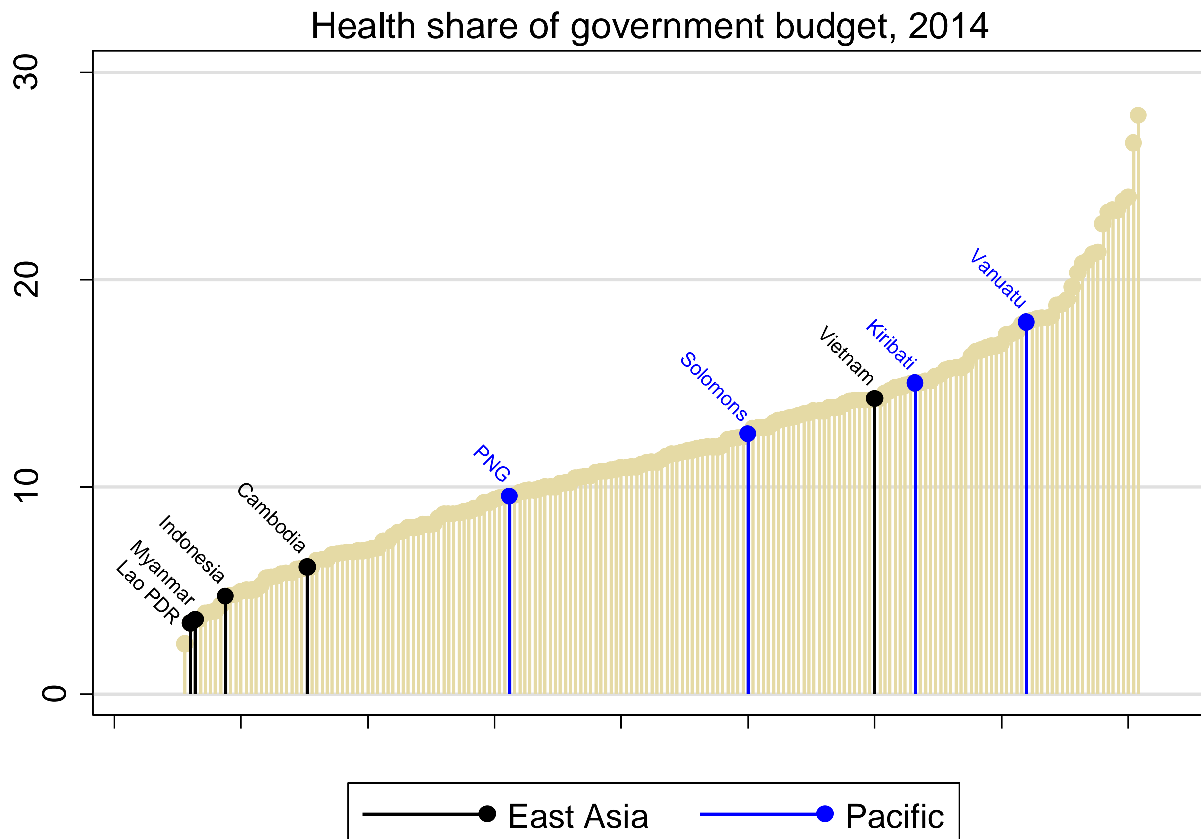
Source: IMF

Debt-Deficit Projections 2017-2021

5
0
-3
-5
-10
-15
0
25
60
100
150
Debt to GDP ratio (%)
Solomons
Indonesia
Cambodia
Myanmar
PNG
Lao PDR
Vietnam
Vanuatu
Kiribati
East Asia
Pacific

Source: IMF World Economic Outlook database

Increasing Health's Share of Government Budget



Source: WHO

- 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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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

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