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DOMESTIC RESOURCE MOBILIZATION FOR INCREASED HEALTH SECTOR FISCAL SPACE AND UNIVERSAL HEALTH COVERAGE

A Health Financing System Assessment "Drill-Down" Guidance Note

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Domestic Resource Mobilization for Increased Health Sector Fiscal Space and Universal Health Coverage
A Health Financing Systems Assessment "Drill-Down" Guidance Note

Overview

Guidance note objective:

This note provides guidance on how to carry out a "drill-down" examination of domestic resource mobilization (DRM) for increased health sector fiscal space to ensure progress towards universal health coverage (UHC). It is best used as a complementary tool when a country's broader health financing systems assessment (HFSA) has identified a low level of public financing as a key constraint. The guidance note specifically aims to identify a given country's most critical opportunities (and constraints) to increase domestically-resourced public financing for universal health coverage (UHC) so that policy-makers can make informed decisions to tackle primary challenges.

What is health sector fiscal space?

Health sector fiscal space refers to the willingness and ability of countries to increase public financing for health in a *sustainable*, *efficient*, and *equitable* manner in order to accelerate progress towards health system objectives such as UHC, which is a key target under the "ensure healthy lives and promote well-being for all at all ages" objective of the Sustainable Development Goals (SDGs).[1] Increasing fiscal space through domestic resource mobilization is central to achieving UHC.

Fiscal space is also itself an explicit SDG under the target of ensuring "significant mobilization of resources from a variety of sources, including through enhanced development cooperation, in order to provide adequate and predictable means for developing countries, in particular least developed countries, to implement programs and policies to end poverty in all its dimensions." One of the indicators under this SDG objective is the proportion of total government spending on health.[2]

In addition to assessing *why* additional public resource may be needed for health, fiscal space generally focuses on five pillars that outline systematically where funds could potentially come from, namely: (i) conducive macroeconomic conditions; (ii) reprioritization for health; (iii) sector-specific domestic revenue sources; (iv) development assistance for health from external sources; and (v) efficiency.[3]

The typical time horizon for a fiscal space assessment is 3-5 years.

How DRM can strengthen fiscal space for health

This "drill-down" module – that presents a structured set of questions which a domestic resource mobilization sub-component of a fiscal space assessment would seek to investigate – focuses on pillars (i), (ii), and (iii) of Figure 1, each of which is discussed in more detail below.

[1] Heller, P.S. 2006. "The prospect of creating 'fiscal space' for the health sector." Health Policy and Planning 21(2):75-9.

[2] See SDG Target 1.A (https://sustainabledevelopment.un.org/sdg1). The indicator is SDG 1.A.2, "Proportion of total government spending on essential services (education, health and social protection)."

[3] Tandon, A., and C. Cashin. 2010. "Assessing public expenditure on health from a fiscal space perspective." HNP Discussion Paper no. 56053. World Bank.

When conducting a fiscal space assessment, a few points should be noted. First, some issues – such as the impact of conducive macroeconomic conditions on DRM – are normally disconnected from and outside of the traditional domain of health policy-makers. Nevertheless, it is critical to assess the impact of such factors given the importance of a country's macro-fiscal context for public health financing. Second, while the three pillars are generic for any DRM assessment, and some of the questions within each of the three pillars outlined below are indicative and are meant to guide country teams in conducting DRM assessments, not all would be of relevance for a particular country at a given point of time. The exact set of questions that a DRM assessment would need to address in order to identify the priority areas of focus must be driven by country context.

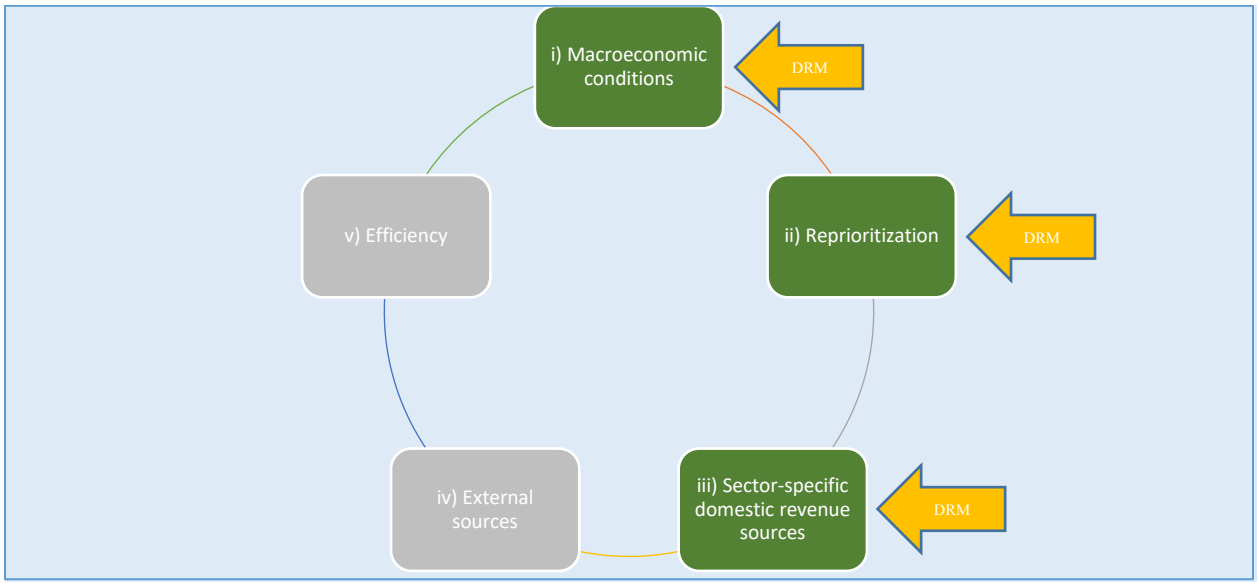


Figure 1: Five pillars of fiscal space for health and three pillars of DRM

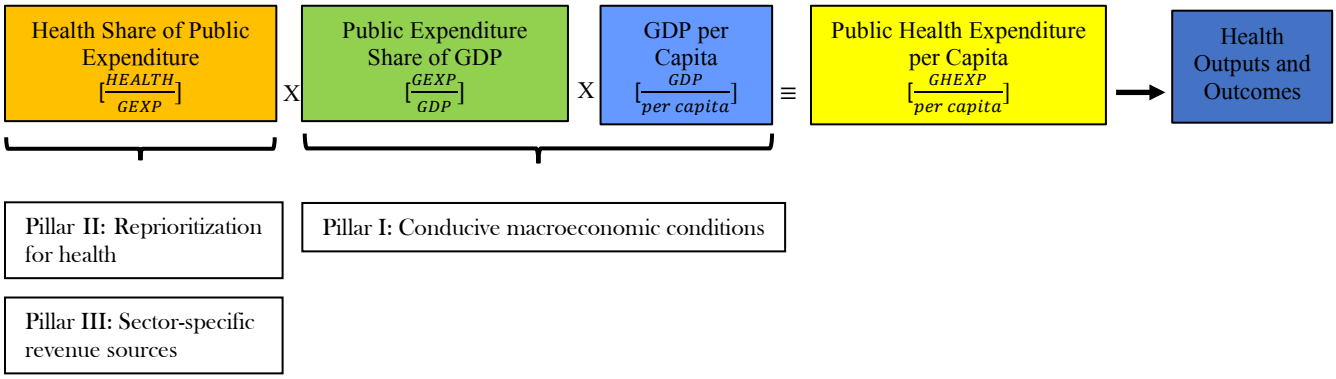
It is important to note that across all countries additional domestically-resourced public financing for health will not always be readily available and easily realized. In some countries, there will likely be short- and medium-term constraints to increasing public financing for health from domestic sources; in such cases, the options for fiscal space would be reduced to pillars (iv) and (v) (i.e., efficiency gains such that existing outlays can be used optimally and/or resources from external source of financing). Furthermore, regardless of country context, it is key that health entitlements be made explicit and commensurate with the amount of public financing for health that is currently available so that there is no implicit rationing and that these entitlements can then be adjusted over time as and when additional public financing becomes available.

In the remainder of the module, the term "public" health expenditure (*PHEXP*) is used to denote the combination of government budgetary spending on health (*GHEXP*) and social health insurance (*SHI*):

$$\frac{PHEXP}{per\ capita} = \frac{GHEXP}{per\ capita} + \frac{SHI}{per\ capita}$$

A simple way to frame the different levers through which DRM can contribute to increasing fiscal space for health is by decomposing government expenditure on health per capita into three key components. Government

expenditure on health per capita (*GHEXP/per capita*) is a product of three factors: (i) the proportion of total government spending on health (*HEALTH/GEXP*); (ii) the share of total government spending in GDP (*GEXP/GDP*); and (iii) GDP per capita of a country (*GDP/per capita*). This is represented mathematically by the identity in Figure 2 below. The resulting Public Health Expenditure per Capita in turn, and depending on the efficiency of public spending, influences health outputs and outcomes.



The three pillars of the DRM analysis can be mapped to the components of the public health expenditure per capita decomposition. The above identity can be used in different ways to inform the fiscal space analysis:

1. **In levels, using latest available data**, this relation gives an idea of the relative importance of conducive macroeconomic conditions (GDP per capita and government budget share) and prioritization for health in the public budget to account for public health expenditure per capita.
2. **In changes, using historical data**, this identity can inform on the key drivers of changes in public health expenditure per capita (e.g half of the increase in public health expenditure over the past 5 years was driven by increasing prioritization for health in country C's budget).
3. **Forward-looking projections.** Forward-looking trajectories for fiscal space can be calculated using projections on GDP per capita growth, on the public budget size, and on the degree of prioritization for health in the budget[4].
4. **Policy simulation.** Simulation of changes in one or several of the underlying drivers of public health expenditure can also be conducted using this relation to understand the implications on fiscal space for health.

[4] At the global level, Kurowski et al. (2021) use the IMF projections on GDP growth and on budget size across countries to assess the implications of COVID-19 on public health expenditure (*From Double Shock to Double Recovery –Implications and Options for Health Financing in the Time of COVID-19*).

Overview of this guidance note

The three pillars of the DRM analysis are presented in more detail below. In each section, a summary table gives examples of possible country-level applications using this framework, with recommendations framed around key questions and related data requirements.

DRM Pillar I: Conducive Macroeconomic Conditions

Conducive macroeconomic conditions -- such as sustained economic growth, increases in domestically-sourced government revenues, and low levels of government debt/deficits -- are key for DRM for health. National income is a key determinant of government spending on health and sustained increases in GDP per capita will, *ceteris paribus*, generally result in greater government financing for health.

	Recommended Information	Source recommendations and guidance
Core question: To what extent might conducive macroeconomic conditions result in additional government financing for health? Addressed through 8 sub-questions: 1.01: what is the relationship of GDP per capita and government financing for health? 1.02: How much are the expected gains from sustained economic growth? 1.03: How is overall economic growth trending over time? Is there a significant change in the economic growth trajectory of the country? Is slow-down in economic growth expected? Or is growth acceleration projected? 1.04: How is economic growth trending relative to global trends and key regional and income comparators? 1.05: What are the trends in the general government revenue/expenditure share of GDP and what is the impact of these trends on public spending for health? 1.06: Can revenue collections be improved? How does the country's revenue collection compare with other countries? How can health taxes contribute to increasing public resources available for health? 1.07: What is the responsiveness or elasticity of government health expenditure with respect to GDP? 1.08: What are the levels of the country's fiscal deficits and debt?		
1.01	**What is the relationship of GDP per capita and government financing for health?** a) [Population] b) [GDP] c) [GDP per Capita] d) [General Government Spending on Health] e) [Domestic Government Spending on Health] f) [Total Government Expenditure]	**Source:** WB World Development Indicators, WB staff reports, IMF World Economic Outlook, WHO Government Expenditures Database, country specific sources **Comments:** Assess the impact of an increase in GDP per capita through the mathematical relationship between GDP/capita and government spending on health, i.e., holding the size of government spending (government expenditure share of GDP) and the extent to which the government prioritizes health (health's share of government expenditure) constant, an increase in GDP per capita will lead to greater government expenditure for health.[5] High levels of economic growth alone can lead to significant increases in fiscal space for health. **Example/Application:** Box 1

[5] Assuming general inflation rates are the same as inflation rates for goods and services in the health sector.

BOX 1

Myanmar: In a recent year, Myanmar's *GHEXP per capita* was US$9; *GDP per capita* was US$1,200; *GEXP/GDP* was 25%; and *HEALTH/GEXP* was 3%. A doubling of GDP per capita – with government expenditure share of GDP and health's share of government expenditure remaining unchanged at 25% and 3%, respectively – will result in a doubling of public expenditure per capita to US$18:

$$3\% \times 25\% \times US\$1{,}200 = US\$9$$
$$3\% \times 25\% \times US\$2{,}400 = US\$18$$

Ethiopia: A similar calculation can be done for Ethiopia where GDP per capita is US$600, half of Myanmar's, and government expenditure share of GDP is 18%, also less than Myanmar's; health's share of government spending is roughly 9% (three times higher than Myanmar) yielding government health expenditure per capita of US$10 (about the same as that of Myanmar):

$$9\% \times 18\% \times US\$600 = US\$10$$

If GDP per capita doubles in Ethiopia to US$1,200, all else equal, government spending on health would also double to US$20:

$$9\% \times 18\% \times US\$1{,}200 = US\$20$$

India: India is an example of a country where public spending on health's share of GDP remained largely unchanged over 1995-2010. Public spending on health share of GDP fluctuated around ~1% of GDP over 1995-2010 (Figure 2). However, public spending on health *tripled* in real per capita terms over the same period (Figure 3). This is because GDP grew at an average annual rate of over 7% over 1995-2010 (GDP per capita grew at over 5% per annum). The example from India underscores the importance of strong economic growth for domestic resource mobilization for health, even if nothing else changes. Additionality of public resources for health underpinned expansion of the massive National Rural Health Mission (NRHM) program in India, a large infusion of financing for improvements of public sector primary care.

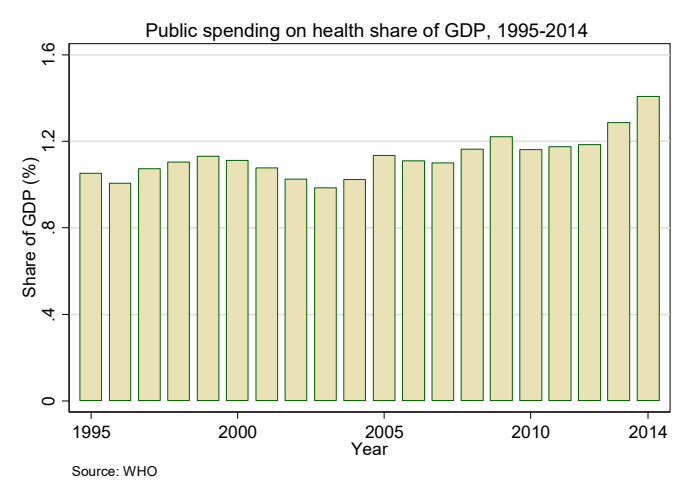


Figure 2: Public expenditure share of GDP in India, 1995-2014

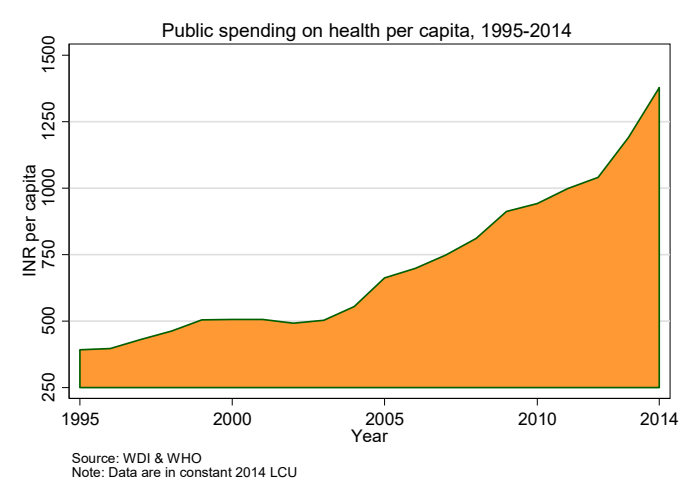


Figure 3: Public expenditure on health per capita in India, 1995-2014

	Recommended Information	Source recommendations and guidance
1.02	How much are the expected gains from sustained economic growth? a) [Annual GDP Growth Forecast]	**Source:** WB World Development Indicators, WB staff reports, IMF World Economic Outlook, country specific sources **Comments:** calculate expected DRM gains from sustained economic growth through the "rule of 70"; i.e., 70 divided by the expected annual economic growth rate equals the number of years it will take for national income to double **Example/Application:** An economy that is projected to grow at an average annual growth rate of 7%, for instance, can be expected to double in size in 10 years. Figure 4 shows that over the 2017-2021 5-year period, at projected annual growth rates of the time from IMF's *World Economic Outlook* database, several developing countries including Myanmar, Ethiopia, Lao PDR, India, and Tanzania were expected to double the size of their economies in per capita terms in less than 15 years (i.e., by 2030). On the other hand, several others -- including Nigeria, Kiribati, and Timor-Leste -- were expected to see their economies shrink in per capita terms if projected economic growth rates were sustained

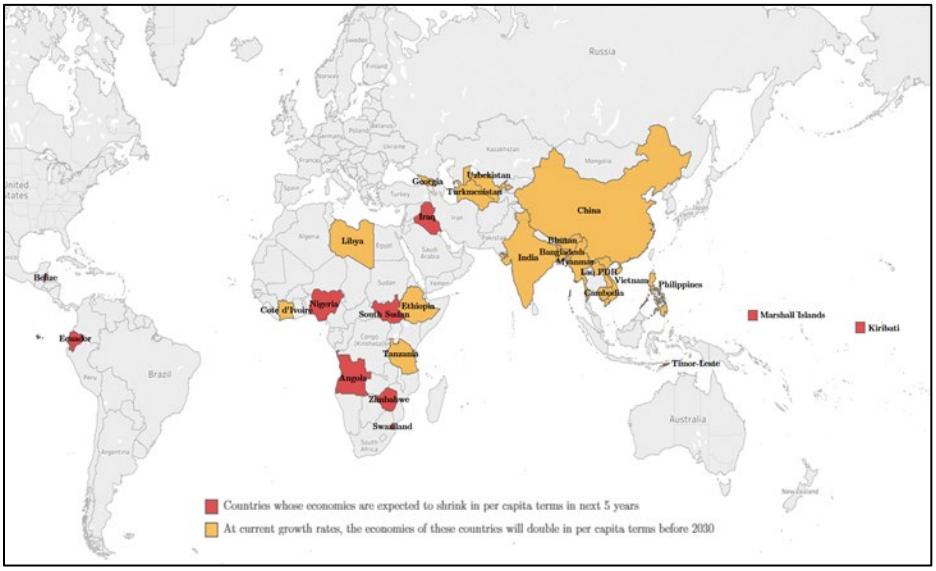


Figure 4: Expected economic growth trajectories for selected developing countries, 2017-2021

	Recommended Information	Source recommendations and guidance
1.03	How is overall economic growth trending over time? Is there a significant change in the economic growth trajectory of the country? Is slow-down in economic growth expected? Or is growth acceleration projected? a) [Historical real GDP per capita] b) [Projected real GDP per capita]	**Source:** WB World Development Indicators, WB staff reports, IMF World Economic Outlook, country specific sources **Comments:** Assess the trend in real GDP per capita over time including projections; typically, five years before and after year of assessment **Example/Application**: Figure 5 shows trends in per capita economic growth in four countries: economic growth is expected to accelerate in India and stabilize in Ethiopia, suggesting a relatively conducive macroeconomic environment in both countries; on the other hand, economic growth has been relatively volatile and is expected to be rather anemic in Papua New Guinea and the Solomon Islands.

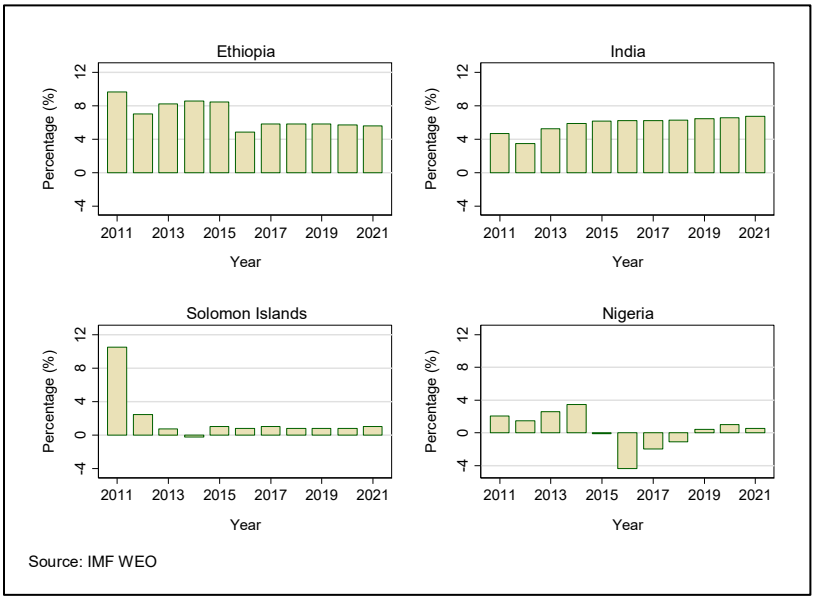


Figure 5: Annual per capita GDP growth rates for selected countries, 2011-2021

	Recommended Information	Source recommendations and guidance
1.04	How is economic growth trending relative to global trends and key regional and income comparators? a) [Regional GDP per capita] b) [GDP Per Capita of countries within Income Groups] c) [GDP Per Capita of comparator countries]	**Source:** WB World Development Indicators, WB staff reports, IMF World Economic Outlook, country specific sources **Comments:** Compare the country's growth trend with global and regional trends typically relative to regional and income comparators **Example/Applications**: Figure 6 shows a typical way of summarizing this information visually

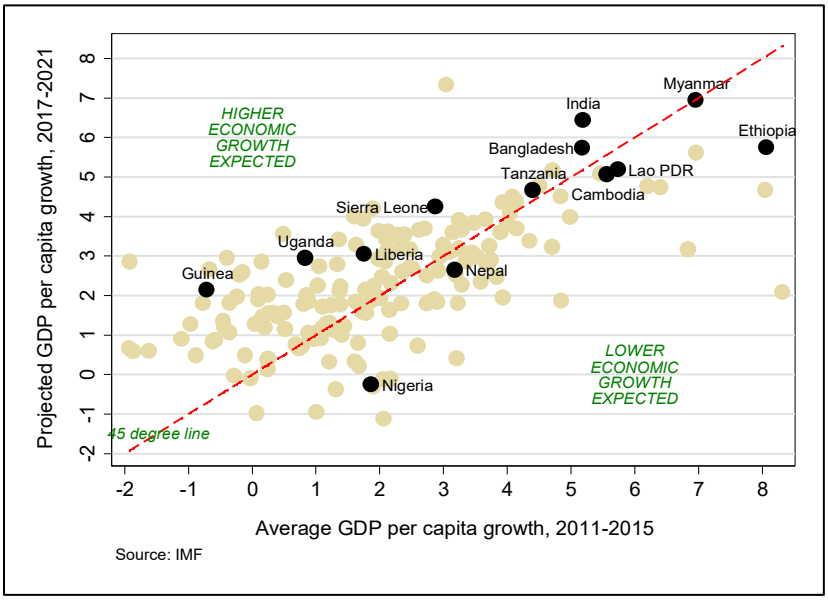


Figure 6: Average Annual per capita GDP growth rates for selected countries, 2011-2021

	Recommended Information	Source recommendations and guidance
1.05	What are the trends in the general government revenue/expenditure share of GDP and what is the impact of these trends on public spending for health? a) [Historical general government expenditure] b) [Historical government expenditure on health] c) [Historical government revenues]	**Sources:** WB World Development Indicators, WB staff reports, IMF World Economic Outlook, IMF Government Finance Statistics, IMF World Revenue Longitudinal Data, WHO Government Health Expenditures database, country specific sources **Comments:** Apply the mathematical relationship between economic growth and government expenditures on health; i.e., increases in general government revenue per expenditure share of GDP increases public spending for health even in situations when GDP per capita and health share of government expenditure remain unchanged **Example/Application**: Figure 7 shows country comparisons: on average, in low-income countries, the government expenditure share of GDP is 26%, rising to 30% for lower middle-income countries, 33% for upper middle-income countries, and around 40% for high-income countries

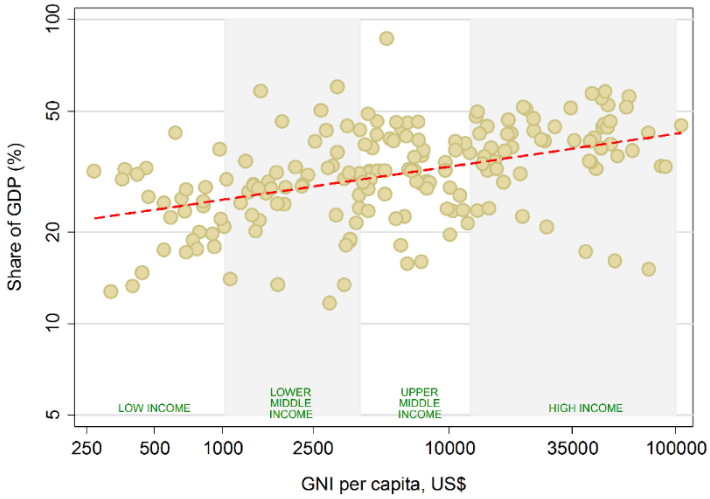


Figure 7: General government expenditures as a share of GDP versus income in 188 countries, 2014

	Recommended Information	Source recommendations and guidance
1.06	Can revenue collections be improved? How does the country's revenue collection compare with other countries? How can health taxes contribute to increasing public resources available for health? a) [Historical government revenues of countries within the same Income Group or Regional Clusters] b) [Revenues from tax collection of countries within the same Income Group or Regional Clusters] c) [Health taxes simulations]	**Source:** WB World Development Indicators, WB staff reports, IMF World Economic Outlook, IMF Government Finance Statistics, WHO Government Health Expenditures database, country specific sources **Comments:** Assess if low levels of tax and other revenue collection efforts are constraining public financing for health (as well as other sectors). Compare the share of GDP government revenues/expenditures to known benchmarks (e.g., against income and regional comparisons) and determine if the country is a negative outlier. WB/IMF research shows that if developing countries could simply increase their revenues collection by 2-4% of GDP, the amount they would raise would eclipse the amount of development assistance they are receiving. Consider using WB/IMF Tax Administration Diagnostic Assessment Tool (TADAT). This tool can help identify areas of weaknesses and make tax systems more efficient and fairer. More information on TADAT can be found at http://www.tadat.org/. Also consider using WHO health tax modelling toolkit. **Example/Application:** Box 2.

BOX 2

Figure 8 below looks at 184 countries in 2014 and illustrates that higher general government revenue is associated with higher general government expenditure. In addition, 177 countries during the same year show that higher general government expenditure is associated with higher public expenditure on health (Figure 9).

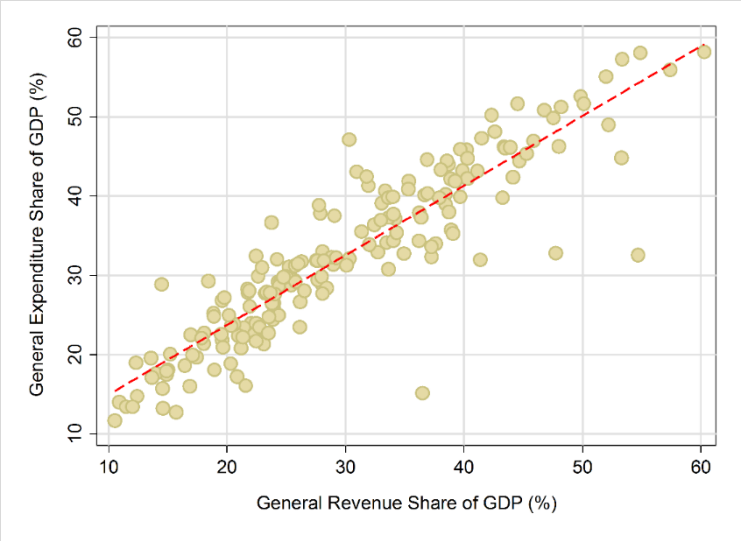


Figure 8: General Government Revenue versus Expenditures in 184 countries, 2014

Figure 9: Public health expenditure vs general government expenditure in 177 countries, 2014

	Recommended Information	Source recommendations and guidance
1.07	What is the responsiveness or elasticity of government health expenditure with respect to GDP? a) [General Government Expenditure on Health] (at least 2 points in time) b) [GDP] (at least 2 points in time)	**Source:** WB World Development Indicators, WB staff reports, IMF World Economic Outlook, IMF Government Finance Statistics, IMF World Revenue Longitudinal Data, country specific sources **Comments:** Calculate the elasticity of government health expenditure with respect to GDP by dividing the annual percentage change in public spending on health by the annual percentage change in GDP. This can vary across countries and across time for each country. Use the estimated elasticity to forecast future public spending on health based on economic growth projections under the assumption that elasticity stays the same. **Example/Application**: Refer to Box 3.

BOX 3

Armenia: Over 1995-2014, the elasticity of public spending on health to GDP per capita in Armenia was 1.2, implying that - for every 1% change in GDP - per capita public spending changed by 1.2% (Figure 10). Given current growth trends projecting a 22% increase in GDP per capita by 2021, this implies that public spending on health could be expected to increase by 26%. Given the 1.9% share of public health expenditure to GDP in 2014, public health spending then is projected to reach about 2% of GDP by 2020.

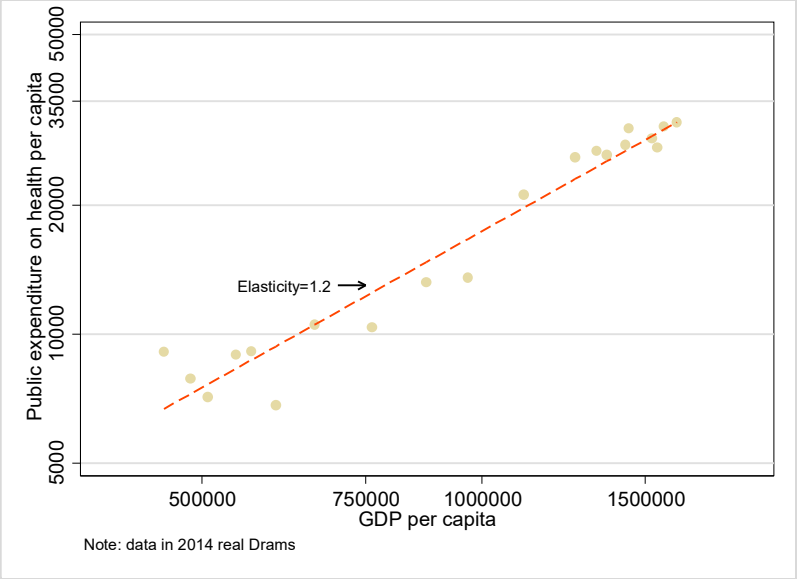


Figure 10: GDP per capita vs public health expenditure per capita in Armenia, 1995-2014

	Recommended Information	Source recommendations and guidance
1.08	**What are the levels of the country's fiscal deficits and debt?** a) [Historical government deficits] b) [Historical government borrowings] c) [Debt Sustainability Analysis country reports] d) [Joint WB-IMF Debt Sustainability Framework for Low-Income Countries]	**Sources:** WB World Development Indicators, WB staff reports, IMF World Economic Outlook, IMF Government Finance Statistics, IMF Debt Sustainability Analysis reports, country specific sources **Comments:** Assess how the country's fiscal health and discipline affect how economic growth translates to increased resources for health by looking at how governments are able to service debts and decrease budget deficits. Countries with low levels of fiscal deficit and debt, according to recent trends and projected levels, are more able to increase spending levels for any purpose, including for health should they choose to do so. In cases where the fiscal health of the country is weak, the roots of the fiscal stress should be highlighted and the implications for increasing spending for health discussed. If fiscal stress is high because of high rates of public subsidies, for example, the implications for fiscal space for

		health are different than if the fiscal stress is due to increasing productive investment. **Example/Application**: Figure 11 shows how countries with high levels of fiscal deficits and debt levels, such as Lao PDR and Vietnam, are limited in their opportunities to increase fiscal space, and Figure 12 shows the government revenue and debt trajectories for aggregate income and regional groups between 2009 and 2019.

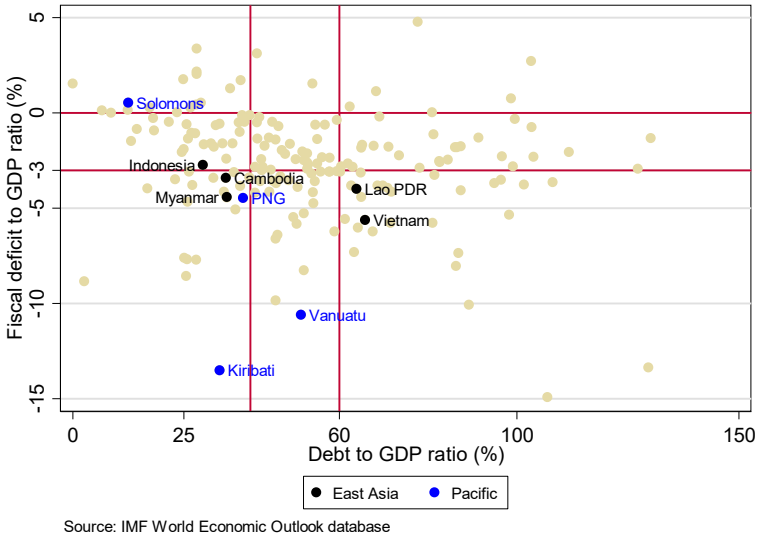


Figure 11: Fiscal Deficit and Debt Ratio, 2012-2015

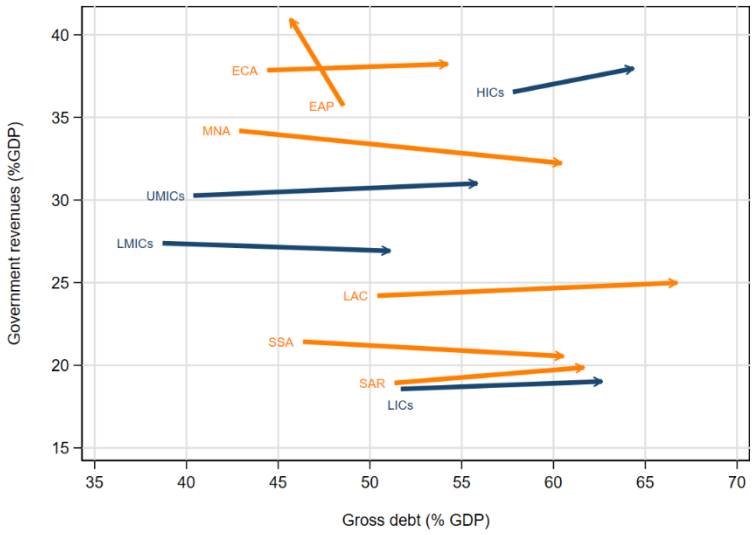


Figure 12: Government Revenues and Debt, 2009-2019

Pillar II: Prioritization of Health

A second source of fiscal space for health is through increasing the degree of prioritization for health within the overall budget of the government. The share of health spending in the government budget serves as a key indicator of the government's commitment to health. It is also a key intermediating factor in translating the extent to which changes in overall macro-fiscal environment have an impact on public financing for health. If this percentage is high, then more funds flow to public health spending as the economy expands. In cases when the economy is contracting or stagnant, there may be scope for raising health's share of overall government spending, particularly if the share of health in the government budget is lower than comparator countries in the same region with similar income levels.

Increasing prioritization of health within the government budget is not an easy source of fiscal space. As the table below shows, the health sector in many countries does not receive as much priority as other sectors, such as education. Infrastructure, agriculture, and national defense also usually take higher priority than either health or education. The relatively low prioritization of the health sector when compared with other sectors may, in part, be due to limited planning, budgeting, and expenditure management capacity in ministries of health, which makes it harder to make a case for health as an efficient sector. Another challenge is that health is often perceived by ministries of finance and planning as being an inefficient and a non-productive sector. A fiscal space analysis can be used to make the case for why a higher share of public resources should be allocated to the health sector.

Region	Share of government expenditure (%)			
	Health	Education	Military	Debt Service
Latin America & Caribbean	12%	15%	7%	10%
East Asia & Pacific	12%	17%	8%	5%
Sub-Saharan Africa	10%	18%	9%	8%
Europe & Central Asia	10%	15%	10%	3%
Middle East & North Africa	8%	18%	12%	5%
South Asia	7%	14%	15%	11%
Global	11%	15%	9%	5%

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

	Recommended Information	Source recommendations and guidance
Core question: Is health "appropriately" prioritized relative to other sectors?		
Addressed through 4 sub-questions: 2.01: Are social sectors prioritized in the government budget? 2.02: How do General Government Health Expenditures (GGHE) as a % of Total Health Expenditures compare with GGHE as a % of Total Public Expenditures?		

2.03: How does the allocation in health compare with other countries? 2.04: Are there opportunities or constraints to improve prioritization?		
2.01	Are social sectors prioritized in the government budget? a) [Government budget by administrative composition]	**Source:** WB staff reports, IMF Government Finance Statistics, country specific sources **Comments:** Compare budget allocations between the social and non-social sectors. Aggregate the share of social (education, health, military, etc.) sectors and compare this with the rest of the budget allocation. In making decisions regarding sectoral budget allocations, governments often first decide between social and non-social sectors. It is only after this initial decision that governments decide how much to spend on health (or education, or housing, or social protection) within the social sector. In particular, compare public spending on health with education. The educational sector is often perceived to compete with the health sector for public resources. Also, assess military spending. It has been observed that many governments choose to spend on the military (part of which is viewed as being unproductive) at the expense of other sectors such as health. **Example/Application**: Box 4

BOX 4

Vietnam: In general, there is a very wide variation in the extent to which health is prioritized by governments across countries (and even among countries of similar income level); this variation ranged from 2.4% to almost 27.9% in 2014 (Figure 13). The share of health spending (as a share of total government expenditure) in Vietnam was 14.2%, which is relatively higher than the 12.5% average in the East Asia & Pacific (EAP) region.

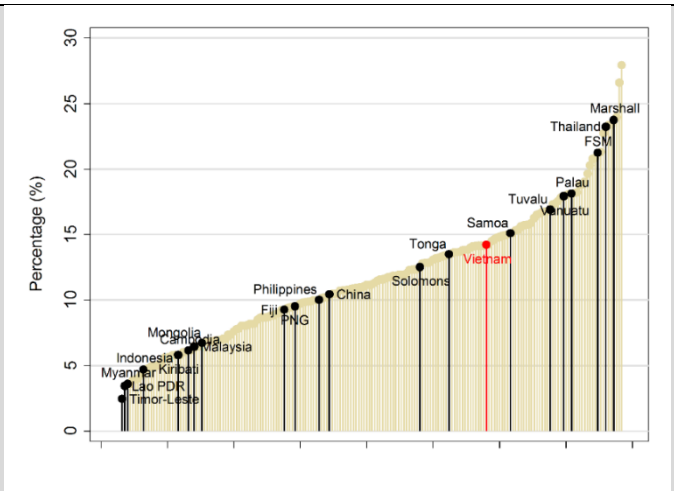


Figure 13: Health share of government budget, 2014

In 2009, unification of all existing contributory and non-contributory social health insurance schemes took effect in Vietnam. As a result, a few years later 70% of the population was covered under the social health insurance program and the government planned to attain UHC by 2020. Despite expansion of social health insurance, government budgetary financing for health continued to remain important, for example for payment of premiums for the poor and supply-side budgetary spending for public health facilities. The National Assembly passed Resolution No. 18/2008/NQ-QH12: "…to increase the share of annual state budget allocations for health, and to ensure that the growth rate of spending on health is greater than the growth rate of overall spending through the state budget". (Figure 14)

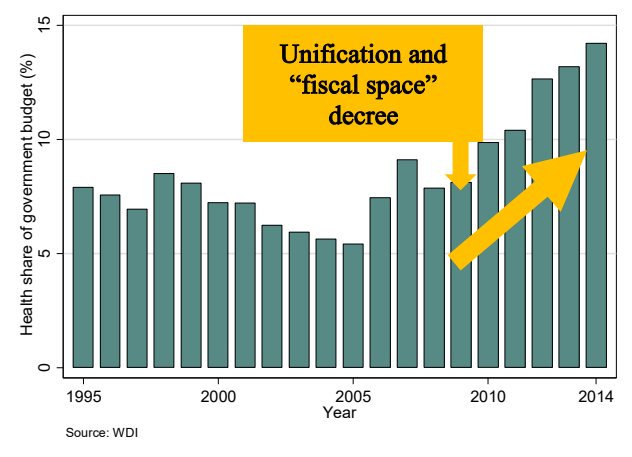


Figure 14: Health share of government budget in Vietnam, 1995-2014

	Recommended Information	Source recommendations and guidance
2.02	How do General Government Health Expenditures (GGHE) as a % of Total Health Expenditures compare with GGHE as a % of Total Public Expenditures? a) [General Government Health Expenditure] b) [Total Health Expenditure] c) [Total Public Expenditure]	**Source:** WB staff reports, IMF Government Finance Statistics, WHO Government Health Expenditures Database, country specific sources **Comments:** Compare GGHE/Total Health Expenditure with GGHE/Total Public Expenditure. A high share of GGHE can indicate a high level of prioritization however, countries with a high GGHE as a share of total health expenditures might still show a low GGHE as a share of total public expenditure, and this can be at times an indication of lack of prioritization on health. **Example/Application:** Figure 15 shows low health prioritization for Lao PDR, Myanmar, and Timor-Leste despite these three countries having relatively high levels of government health spending as a share of total health spending.

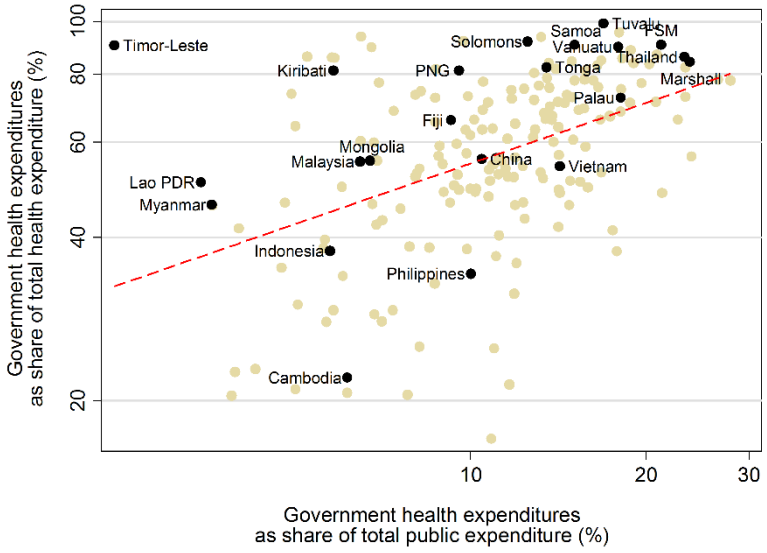


Figure 15. Government health expenditures as share of total health expenditures and total public expenditures

	Recommended Information	Source recommendations and guidance
2.03	How does the allocation in health compare with other countries? a) [Government budget by administrative composition of comparator countries]	**Source:** WB World Development Indicators, WB staff reports, IMF Government Finance Statistics, WHO Government Health Expenditures Database, country specific sources **Comments:** Compare the share of health in total public expenditure with comparator countries or regional peers. The literature suggests that National Income is a key factor in explaining the variation in prioritization of health in government budgets across countries. Economic growth tends to be associated with not only a higher overall level of resources but also a higher share of public resources devoted to health. Rising incomes are often associated with a greater demand for, and supply of, health care. Richer countries tend to have older populations with more non-communicable diseases and a greater need of chronic care. The relative price of health care therefore rises with income, which in turn drives up spending. Revenue-collection capacities of governments also increase as income of the population increases and this is often accompanied by a change in societal preferences, leaning towards more public financing for health. Empirical evidence also suggests the importance of other factors such as the prevalence of corruption, ethno-linguistic fractionalization, and average education levels in the population as determinants of the extent to which health is or is not prioritized by governments. **Example/Application**: Box 5

BOX 5

In 2013, public spending on health reached US$90 and US$17 per capita in LMICs and LICs respectively. Taking per capita government health spending for illustrative purposes, 46 countries allocated less than the average of total government spending for their income group. Moving these countries to the average would raise an additional US$42 per capita and US$6 per capita in LMICs and LICs respectively. For some countries, this would represent more than double the size of the current level of spending.

	Recommended Information	Source recommendations and guidance
2.04	Are there opportunities or constraints to improve prioritization? a) [Explicit budget amounts/shares allocated to health]	**Source:** WB staff reports, IMF Government Finance Statistics, IMF reports, IMF Strategy for Engagement on Social Spending (with background papers, case-studies, and operationalization framework), WHO reports, country specific sources **Comments:** Look into mandated floors and ceilings pertaining to budget allocations on health. Mandated floors and ceilings (or explicit budget amounts/shares that should be allocated to health) can facilitate or limit public spending on health and therefore may be a source of fiscal space. For instance, it may be easier for the ministries of health to convince the ministries of finance and treasury to increase allocations if a law mandates an allocation of a certain percentage of total government expenditure to health, that is currently not being met. In the aftermath of the COVID-19 crisis, a renewed attention has been given to social spending in general and health spending in particular (COVID-19 response, pandemic preparedness). Consider using the IMF framework for engagement on social sectors (2019-21)

Pillar III: Changes in Sector-Specific Revenue Resources

New health-specific resources, e.g., earmarked taxation or the introduction of mandatory health insurance, can be an additional source of fiscal space for the health sector. These policy options might entail considering specific user charges in public health facilities, taxes and/or premiums in order to increase the resource base for public spending on health. Earmarking can involve dedicating an entire tax to fund a particular program (e.g. dedicated payroll tax earmarked for social health insurance) or setting aside a fixed portion of a particular tax to fund the program (e.g. a fixed proportion of general tax revenues allocated to the health budget).

Whether taxes on alcohol and tobacco can and should be increased and/or earmarked for health in a country is highly dependent on many economic and political conditions that will determine: whether increasing taxes will raise total tax revenue and by how much (related to the elasticity of demand); whether there will be impacts on employment; and whether earmarking the tax revenue for the health sector is politically feasible.

Social Health Insurance can also be a means of capturing and pooling private out-of-pocket health spending and utilizing those resources for public financing of health care and improving financial risk protection. Social insurance involves the mandatory collection of contributions from designated segments of the population, typically through payroll taxes, and the pooling of these contributions in independent funds to pay for services on behalf of the insured.

Assessing the feasibility of introducing a system of SHI in a country is a highly complex endeavor and is likely to require an in-depth assessment that is beyond the scope of fiscal space analysis. For the purposes of a fiscal space for health analysis however, the basic pre-conditions for SHI should be assessed to determine whether it is justified to include this option in further policy dialogue.

	Recommended Information	**Source recommendations and guidance**
	Core question: What other sector-specific domestic revenue sources exist? Addressed through 6 sub-questions: 3.01: Given the current political environment, are there opportunities to earmark current sources of revenues to finance public health? 3.02: Are there opportunities and political appetite to introduce or increase sin taxes (tobacco, alcohol, sugar sweetened beverages) to be earmarked to finance public health? 3.03: Will the introduction of or increase in sin taxes hurt the poor? 3.04: What is the share of the taxed good in total revenues? 3.05: How does the current sin tax rates compare with comparator countries? 3.06: What is the current Social Health Insurance Rate? Is there an opportunity to introduce and/or expand SHI?	
3.01	Given the current political environment, are there opportunities to earmark current sources of revenues to finance public health? a) [Government policies earmarking revenues to health]	**Source:** WB staff reports, IMF reports, WHO reports, WHO Health Systems in Transition Reviews, country specific sources **Comments:** Look into legislation and administrative policies that are earmarked to health expenditures. Earmarked taxes for health

		sector funding are generally supported by political rather than economic arguments. If health spending is low or unstable, an earmarked tax may be seen as a way to insulate health spending from other competing publicly funded activities. From an economic perspective, earmarking is often viewed as an imposition of an unnecessary constraint on fiscal policy-making, one that reduces flexibility and allocative efficiency. In addition, there are numerous examples of situations where earmarked funds have been diverted to other activities, especially in poor governance settings. It is also important to ensure that any new resources raised by earmarked taxes or similar such means be additional and not simply be offset by reductions from other domestic sources (such as from general taxation, for instance). **Example/Application**: Box 6

BOX 6

In 1995, government-sponsored health insurance was expanded in the Philippines, replacing Medicare with the National Health Insurance Program. However, by 2010, only 21% of poor households, and less than 75% of the total population were enrolled.

To meet the challenge of expanding coverage, the 2012 Philippines Sin Tax Law was enacted that reformed tobacco and alcohol taxation. It simplified and increased excise taxes and was framed primarily as a health measure.

Since the passing of the law, the share of tobacco and alcohol excise collections to GDP increased from 0.5% in 2012 to 0.9% in 2013 (highest since 2000). The Department of Health budget increased by 57% and revenues from reform were used to finance expansion of fully-subsidized social health insurance, especially for the poorest 40% of the population.

These changes resulted in a dramatic increase in social health insurance coverage from 65 million (70% of the entire population) in 2013 to 86.2 million (87%) in 2014. Coverage for the poor also increased from 5.2 million families in 2013 to 14.7 million families (43 million individuals) in 2014.

	Recommended Information	Source recommendations and guidance
3.02	**Are there opportunities and political appetite to introduce or increase sin taxes (tobacco, alcohol, sugar sweetened beverages) to be earmarked to finance public health?** a) [Government pronouncements] b) [Household survey data on consumption expenditure]	**Source:** WB staff reports, IMF reports, IMF Note on the design of excise taxes, WHO reports, country specific sources **Comments:** Consider revenue sources that can be earmarked to health spending. Assess whether the government will be inclined to earmark these sources to health spending. Increasing taxes specifically on goods that adversely affect health, most notably tobacco, sugar sweetened beverages and alcohol (also known as "sin taxes"), can generate revenue that can be earmarked for the health sector and that can be justified by the externalities associated with those consumption goods. The consumption of alcohol and tobacco generates costs for society beyond those to the individual consuming the products. Taxation to reduce consumption is therefore considered to be beneficial not only from a public health perspective, but also from an economic perspective. Even if they are not earmarked for health, higher taxes can discourage consumption and reduce illness and accidents (in the case of alcohol), and possibly reduce demand for health services, which benefits all of society. **Example/Application**: Australia, the US, and Korea are examples of countries that have successfully implemented earmarked taxes on tobacco and used the revenues for public health purposes. Other forms of innovative "financing": include earmarking of VAT in Ghana and Chile. Refer to Box 7 for more examples.

Box 7

Earmarked Taxes as a Source of Government Health Revenue

Type of earmarking	Country	Description
Specific taxes earmarked for financing UHC programs	Colombia	Earmarked payroll tax from parallel formal sector insurance program
	Costa Rica	Taxes on luxury goods, liquor, beer, soda, and other imported goods to finance noncontributory regime
	India	Earmarked taxes on alcohol for RA
	Jamaica	Earmarked taxes on tobacco, alcohol, petroleum, and motor vehicles; earmarked payroll tax in parallel formal sector insurance program
	Tunisia	Earmarked transfers from parallel formal sector insurance program
Specific taxes earmarked for financing general government health spending (or for financing other non-UHC program health programs)	Chile	Tobacco taxes, customs revenues, and sales of shares in public health enterprises earmarked for financing SHI reform (AUGE)
	Colombia	Earmarked state-level taxes on tobacco and alcohol for financing general government health spending
	Guatemala	Earmarked alcohol and tobacco taxes for financing general government health spending
	Mexico	Earmarked alcohol and tobacco taxes for financing general government health spending
	Thailand	Earmarked alcohol and tobacco taxes to support the Thailand Health Promotion Fund
General taxes earmarked for financing UHC programs, other non-UHC program health programs, or general government health spending	Chile	Earmarked 1% VAT for AUGE
	Ghana	Earmarked 2.5% VAT
	Brazil	Federal health spending equal to health spending in previous year adjusted for changes in nominal GDP; minimum 12% of state expenditure and 15% of municipal expenditure earmarked for health
	Vietnam	Increase in government spending on health has to be higher than increase in overall government spending by law (Resolution No. 18/2008/NQ-QH12 in 2008)

Sources: UNICO studies; for Vietnam general taxes: Grover 2011.
Note: The taxes are other than mandatory SHI premiums.

3.03	**Will the introduction of, or increase in, sin taxes hurt the poor?** a) [Household survey data on consumption expenditure]	**Source:** WB staff reports, IMF reports, WHO reports, WHO health tax primer, WB Policy Note on Tobacco Taxation , Household surveys (e.g., Household Income and Expenditure Surveys, Living Standards Measurement Study surveys, country specific sources **Comments:** Assess whether the introduction, or increase in, sin taxes is regressive. Is the consumption of the taxed good concentrated among the poor? Conducting a detailed benefit-incidence analysis is needed to determine whether earmarking the revenues for health would disproportionately benefit the poor and somewhat offset the regressive tax. **Example/Application:** In India, while only 38.6% of males in the highest income quartile use tobacco, 74% of males in the lowest income group consume tobacco products.

3.04	What is the share of the taxed good in total revenues? a) [Government revenue by source]	**Source:** Country specific sources **Comments:** Assess the possible adverse effect of taxing a sin product to revenue collection. Does the major share of excise duties come from tobacco and alcohol? Increasing tax rates may also lead to increased smuggling and the consumption of products of lower, even potentially dangerous, quality. Some have argued, however, that better enforcement and harmonization of taxation levels across borders rather than lowering tax rates can reduce incentives for smuggling.
3.05	How do the current sin tax rates compare with comparator countries? a) [Tax rates by product] b) [Tax rates of the same product in comparator countries]	**Source:** Country specific sources **Comments:** Compare the current tax rates on alcohol and tobacco with those of comparator countries. If tax rates are low, this may indicate an opportunity to increase the taxes. Estimates of the price elasticity of demand for alcohol and tobacco, if available, can be used to estimate potential changes in revenue with a tax increase. The current policies in the country related to alcohol and tobacco use should also be examined to determine whether "sin tax" increases may be politically feasible. Countries with aggressive anti-smoking or alcohol control policies, for example, may be more willing to raise these taxes and earmark them for public health purposes. Furthermore, the distribution of tobacco and alcohol rates across income groups is important to determine whether increasing taxes would be regressive, with a disproportionate burden falling on the poor. To make a case for the introduction of sin taxes, a DRM assessment should discuss briefly the current tax rates on harmful products (such as tobacco, alcohol, and cigarette), and where possible, use regional and income benchmarks to compare the rates with comparator countries. WHO estimates suggest that, in countries with relatively low tax rates, increasing excise taxes on tobacco products could raise additional revenues between 10 to 25% of current health expenditures.

		Example/Application: Indonesia has not historically signed international declarations on tobacco control, which indicates the country's unwillingness to increase or earmark taxes on public health grounds. In China, tobacco production is important for the economy so it is less likely that public health arguments will take priority over economic concerns
3.06	**What is the current Social Health Insurance Rate? Is there an opportunity to introduce and/or expand SHI?** a) [Current poverty rate] b) [Projected poverty rate] c) [Share of formal sector in employment] d) [Current SHI premiums] e) [Level of wages and salaries] f) [Average family size/dependency ratio]	**Source:** WB World Development Indicators, WHO Health Systems in Transition Reviews, country specific sources **Comments:** Assess the potential of introducing SHI into the country by looking at the characteristics of a country's economy, the most relevant indicators of which are those enumerated on the left. In addition, for SHI to be successful, there must be a mechanism to bring the population excluded from the formal sector labor force into a risk pool that can eventually be linked to a national SHI system (e.g. community-based insurance schemes). A discussion of these issues should be included in an assessment of the potential for SHI to generate fiscal space for health in a country. Other issues to include in such an analysis and discussion are: the capacity of the country to enforce compliance with the tax/premium, managerial capacity to administer the system, the organization of the provider network and feasibility of contracting, and others. The poverty rate is a good proxy for the size of the population that the government needs to potentially subsidize health services for, and to estimate the additional resource envelope required for subsidization. Where possible, use regional and income benchmarks to show historical and projected patterns in poverty. Premium contributions to a SHI scheme are directly dependent on the size of the formal sector (proxied by wage and salaried workers as % of total employed). A high level of informality is often a constraint for expanding contributory SHI. Since not all wage and salaried workers may be

		covered by the SHI, it would be useful to indicate the share of formal sector workers that are covered, and those that are not. Expanding SHI coverage to those uncovered can bring additional revenues, and therefore, is a relatively easier source of fiscal space. On the contribution rate, it may be useful to mention how the contribution rate varies. Depending on whether the contribution rate is flat, proportional, or progressive, the scope for additional fiscal space may be limited. **Example/Application:** Box 8, 9.

BOX 8

Although SHI has been most effective in high- and middle- income countries, several low-income countries also have had some success with SHI. While it is feasible to introduce health insurance for formal sector workers, however, several barriers exist to scaling up health insurance to the entire population in low-income countries. Most countries in Europe, Latin America and Asia began by insuring formal sector workers. The availability of employment and earnings records means this segment of the population are relatively easy to reach and to collect premiums from. Once the formal sector is covered, most countries face significant challenges in extending insurance to informal sector workers, as well as the elderly, the poor and the unemployed. Individuals in the informal sector are typically not affiliated with an organization through which they can be enrolled in SHI and via which premiums can be collected. Informal sector workers are also poorer, and less able to afford premiums. Therefore, the share of the population engaged in formal sector employment tends to be one of the most important factors that determines whether SHI may be a feasible source of fiscal space for health in a country.

SHI employee and employer contribution levels vary; below are some country examples:

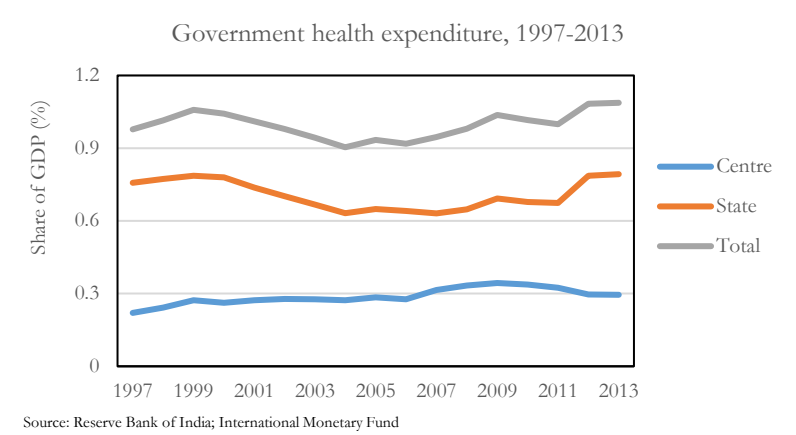
- Vietnam: Insured: 1.5% of gross earnings, with maximum monthly earnings used to calculate contributions being US$ 20,000 (20 times the minimum wage for civil servants). Self-employed: flat rates. Employer: 3% of payroll.
- Philippines: Insured: 1.25% of gross earnings, with maximum monthly earnings used to calculate contributions being 1,000 USD (50,000 pesos). Self-employed: two-tier flat rate premium. Employer: 1.25% of the employee's basic monthly salary.
- Turkey: Insured: 5% of monthly earnings. Self-employed person: 12.5% of declared monthly earnings. Employer: 7.5% of employees' monthly earnings.
- Indonesia: Civil servants pay 2%, employer 3%; Private formal sector: employer 4%, insured 0.5%; three-tiered flat-rate premium for non-poor informal sector.

BOX 9

Decentralization continues to be a widespread international trend. One of the many drivers of this trend is that sub-national governments have advantages over central governments in providing many types of public services (Smoke and Kim, 2003). Decentralization in health systems and spending is already a feature in many developing countries such as Cambodia, China, India, Indonesia, Nigeria, Pakistan, and the Philippines (Glassman and Sakuma, 2014). Given the political economy and decentralized public health financing structure in these countries, a detailed assessment at the national level would need to be conducted to better analyze and outline possible additional options for financing universal health coverage (UHC). It is expected that there can be tremendous variability if one looks across sub-national units. Similar to fiscal space assessment at the national level, the analysis of fiscal space specifically for health at the sub-national level rests on a forward-looking assessment of the availability of additional resources for the health sector, without prejudice to a sub-national unit's financial sustainability.

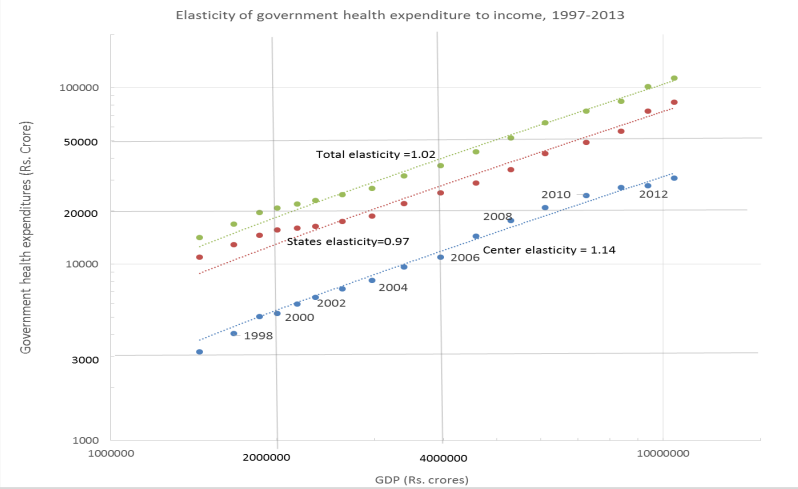
In India, given its federal structure, health is considered largely a "state subject" and the bulk of government health expenditure occurs at the state level (La Forgia and Nagpal, 2012). Analysis of recent trends in the center-state shares of public spending on health can be informative from the perspective of fiscal space. The following examines prospects for generating sufficient fiscal space for health in a decentralized context using India as an example.

Conducive Macroeconomic Conditions. The steady increase in central health spending as a share of GDP in India since 1990 was offset by declining state allocations to health for most of 1990 to 2007. This decline has been traced back to the fiscal crisis that beset the states in the 1990s. State health spending, however, began an upward trend as of 2008. This sustained increase is partly due to mandated state contributions to the National Rural Health Mission (NRHM) and, to a lesser extent, state contributions to Rashtriya Swasthya Bima Yojana (RSBY), the government-run health insurance program for the poor. The NRHM, in particular, is part of the government's commitment to increase financing for basic health care services in rural areas with a special focus on 18 lagging states. The growth of government health funding is based on shared responsibility, with increased central level allocations and matching contributions from the states of at least 15% of the center's contribution each year (Tandon and Cashin, 2010).



Source: Reserve Bank of India; International Monetary Fund

In India, government health spending has historically not been very responsive to economic growth, and this is even more pronounced at the state level (Tandon and Cashin, 2010). Using data from 1997-2013, the elasticity of total government health spending to GDP (i.e., including both center and state) is estimated to be about 1.02 (Figure 9). This, however, is low when compared with the average of other low-and lower-middle income countries. Furthermore, comparing across the two levels of government shows that the elasticity of central health spending to GDP is markedly higher than the elasticity aggregate state health spending to GDP over the same period. Aggregate state health spending elasticity is about 0.97, implying that state health spending has grown at a lower rate than GDP growth. The disparities in responsiveness between the center and the states may be partially due to fungibility of central transfers to states (Tandon and Cashin, 2010).



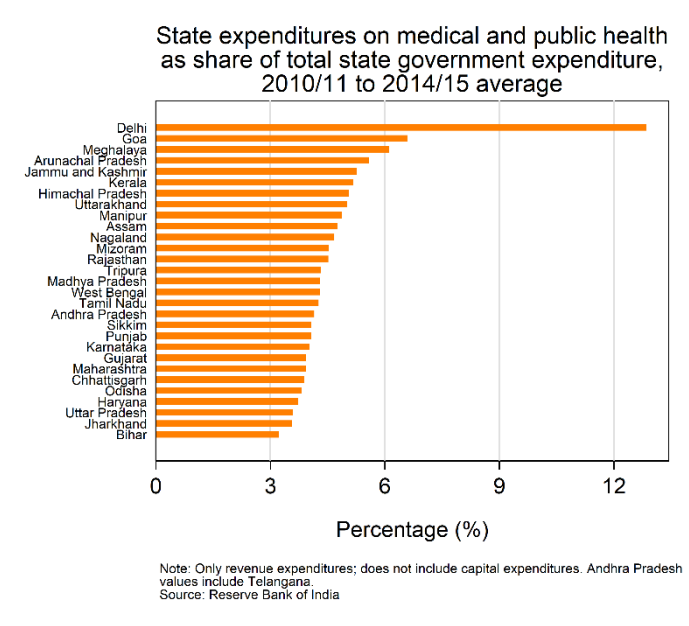
The foregoing analysis shows that the scope for additional fiscal space at the state level for health arising from the macroeconomic situation is limited and is likely to be more of a challenge in India. Past growth rates and income responsiveness of aggregate state health spending have been significantly lower than growth and responsiveness of the central government.

Health sector-specific resources. There are several options that could be considered for increasing health sector-specific resources for fiscal space for health at the state level in India. These include earmarked taxes and user charges (Tandon and Cashin, 2010). There is no earmarking of general taxation for health but as several countries have done, India could consider a tax on alcohol or tobacco products earmarked for health. It is not clear how feasible this would be for the country given that prices for tobacco and alcohol are already higher than in most countries and that such a tax is likely to be regressive (a 2009 survey shows 74% of males in the poorest quartile consume tobacco products, while the share among the males in the richest quartile is only 39%).

Grants from central government. Akin to external sources of health spending in the more general fiscal space framework, transfers from the central government are a potential source of fiscal space for Indian

states (Tandon and Cashin, 2010). General purpose transfers from the center to the states can be a source of fiscal space, but only to the extent that the states themselves choose to prioritize health over other sectors. Earmarked health-specific transfers, in addition to NRHM funds, have been implemented in the past and could be a source of additional fiscal space for health in states where government health spending is low. The common limitation to these central government transfers is that they are tied to specific programs and therefore may provide states with a lack of flexibility in using the funds.

Reprioritization of health and efficiency. An increase in state outlays required to finance UHC based on current projections may require a major reprioritization of the health sector at the state level and/or substantial improvements in the efficiency of current health spending for many of the states. The level of state public spending on health is still low and does not significantly vary across states. Except for Delhi, Goa and Meghalaya, states are spending less than 6% of total government spending on health on average from 2010-2015: from 3.2% in Bihar to 5.6% in Arunachal Pradesh.



The massive variation in attainment of health outcomes across states is itself indicative that there are massive opportunities to improve the efficiency of government health expenditures in India to increase effective fiscal space for health (Tandon and Cashin, 2010). In the context of NRHM, there is little evidence that increases in resources have translated into improved health outputs or outcomes. One study showed that absenteeism in public sector primary health centers ranged from 40% to 50%, indicating significant inefficiency in wage expenditures. Issues of leakage and corruption have also reduced the effective use of health sector resources.

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