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FS SERIES # 2: HEALTH SECTOR FINANCING IN DEVELOPING COUNTRIES

PRIMER AND DIAGNOSTIC CHECKLIST

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INTRODUCTION

The United States Agency for International Development (USAID) Bureau for Economic Growth Agriculture and Trade (EGAT) created the Financial Sector Knowledge Sharing Project (FS Share) to collaborate with USAID missions to develop effective and efficient financial sector programs that increase access to financial services and develop well-functioning markets worldwide. USAID awarded Chemonics International Inc. the FS Share delivery order under the Financial Sector Blanket Purchase Agreement.

Through the FS Share task order, USAID EGAT and Chemonics proactively collaborate with missions to identify financial sector priorities and develop strategies and programs for growing the financial sector. FS Share identifies financial sector best practices and aggregates those best practices through model scopes of work, primers, diagnostic tools, best practice case analyses, and other tools. These deliverables are disseminated to USAID missions to integrate into financial sector programming. On a case-by-case basis, FS Share can assist with implementation and connect mission staff to external resources on best practices. In response to mission demand, FS Share delivers presentations and other knowledge-sharing endeavors.

Objective of this Primer

The objective of the primer *Health Sector Financing in Developing Countries* is to assist U.S. government program designers implementing health sector projects integrate considerations for program financial sustainability into the design of health programs as a fundamental requirement of project sustainability. As such, this primer includes a summary of the current state of health financing in low- and middle-income countries, including the sources of health sector funds and health financing mechanisms, a diagnostic checklist to assist in evaluating the financial sustainability of health interventions, and a proposed plan to introduce financial sustainability design tasks into USG health sector-related procurement documentation.

The primer and diagnostic checklist were prepared by Robert Brookes and Saul Helfenbein of Chemonics International Inc. with support from USAID EGAT.

FS Share Rapid Response Hotline

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EXECUTIVE SUMMARY

The purpose of this primer is twofold. First, it aims to introduce the audience to health financing — the core functions, common mechanisms and approaches, and financing issues frequently faced in low- and middle-income countries. This is based on a review of current literature on the topic. As health financing is one of the building blocks of sustainability, the second objective is to provide tools for assessing the financial sustainability of health programs and for integrating financing sustainability into the design of health programs.

While there are a large number of documents on health financing available, few documents were found when conducting research for this primer that focused on providing a comprehensive and in-depth introduction to the topic. Since this primer is intended as an introduction to the topic of health financing, the sources used and recommended herein were selected because they provide comprehensive discussions on health financing and serve as tools and resources for the reader to further their learning on the topic. Those sources commonly cited herein and highlighted in Annex B are recommended by the authors of this primer as the "next step" to those readers who wish to further their knowledge on health financing.

The primer centers on the three main functions of health financing:

- *Revenue collection and allocation*: encompasses the sources of funds — their structure and means by which they are collected. The objective of this function is to raise enough revenue in an equitable, efficient, and sustainable manner to allow for individuals within a population to be provided with essential health services and financially protected against poverty that may result from high health care costs caused by illness or injury.
- *Pooling of funds (or risk)*: involves the management of revenue to equitably and efficiently pool health risks. It addresses the unpredictability of illness at the individual level, the inability of individuals to mobilize sufficient resources to cover unexpected health care costs, and consequently the need to spread health risks over as broad a population and period of time as possible.
- *Purchasing*: relates to the transfer of pooled resources to health care providers in a manner that ensures appropriate, efficient and quality services are available to the population (Gottret and Schieber, 2006, pp. 2, 5-6; McIntyre, 2007, p. xii; World Health Organization, 2000, pp. 95-97).

In review of current literature, specifically Gottret and Schieber (2006), on the above functions and the mechanisms through which they are implemented, a few common, important themes and issues arise:

- Improving and expanding universal health care coverage for a country's population requires that the financing mechanisms employed result in the collection of sufficient revenue to cover health care costs, pool revenue in an efficient and equitable manner, and efficiently purchase appropriate health care services. Multiple financing

mechanisms can be utilized concurrently to achieve universal coverage. However, if multiple mechanisms are used, it is important that they are integrated to allow for maximum pooling and cross-subsidization of risk. Highly fragmented financing mechanisms reduce this pooling potential and leave individual mechanisms vulnerable to solvency issues.

- In assessing financial sustainability, health care costs have to be affordable for the country and the individual. Therefore, it is important to not only think about the costs, but also to determine how expansion will impact costs in the long term. In this context, it may be important to promote and include primary health care services in benefits packages. Coverage of primary care services leads to increased utilization, most notably among the poor and near poor. Further, investments in preventive and primary health care services improve health status and lower overall health care costs by reducing dependence on more expensive secondary and tertiary care.
- According to Gottret and Schieber (2006), donors will need to commit billions of dollars in additional development assistance if the Millennium Development Goals are to be met in health (p. 123). Recent increases in financial assistance have not matched recipient countries' ability to effectively absorb and manage the funds that have been made available, or may distort systems in ways that may not be sustainable. Donor assistance is often unpredictable, volatile, and misaligned with the recipient country's priorities and/or budget processes. For assistance to be effective, donors must be willing to make more flexible, long-term commitments that align with the recipient country's development priorities, and recipient countries must improve capacity and accountability in managing external funding (Gottret and Schieber, p. 123).

Based on the core functions of health financing, we propose a checklist for evaluating the financial sustainability of assistance programs. The checklist is designed to function as a general guide for evaluation with the intent that it may later be readily adapted to a specific health program, adjusting for country context, program objectives, and stakeholders, as appropriate. The checklist centers on three essential components that may translate to financial sustainability of a health project: resource mobilization, effective use of resources, and reliability of resource availability. Finally, this primer provides a guide based on these three components to incorporating financial sustainability considerations into program design and related procurement documentation.

SECTION I. PRIMER

The current focus on poverty reduction within the development community, as reflected in the Millennium Development Goals and other international initiatives, has prompted increased attention on the need for health care financing mechanisms that protect the populations of low- and middle-income countries from the potentially impoverishing effects of high health care costs (McIntyre, 2007, p. xii). The estimated "financing gap" between the health care costs required to achieve the Millennium Development Goals and the potential for low-income countries to mobilize domestic resources to cover these costs is large. To give a sense of this gap, for many low-income countries the ratio of government health expenditures to gross domestic product (GDP) would have to grow from an average of about 2.3 percent of GDP in 2000 to an average of 30 percent by 2015 for Millennium Development Goals on reduction in child mortality to be reached. This would mean that the level of public expenditures to GDP ratio at the end of 2015 would have to be much larger than 20 percent, which is well above the ratio of total tax revenues to GDP for several countries (Gottret and Schieber, 2006, p. 216). In other words, the amount of domestic revenue required to achieve health Millennium Development Goals would significantly exceed the amount of domestic revenue several low-income countries are able to generate.

Accordingly, development assistance programs have begun to increasingly focus on strengthening the health systems — public and private — that affect health outcomes. The World Health Organization has defined six core components, or "building blocks," of a health system: service delivery, health workforce, information, medical products, vaccines and technologies, financing, and leadership and governance (World Health Organization [WHO], 2007, p. 3). The purpose of this primer is to provide an overview of one of these components — health financing — as an essential consideration when developing assistance programs that seek to sustainably improve the health status of underserved populations. It is important to recognize, however, that while these "building blocks" help clarify the essential functions of a national health system, the challenges health systems typically face seldom are compartmentalized in such a manner (WHO, 2007, p. v). Interventions to address health system failures or inadequacies often require an integrated approach that considers the relationships and linkages between each component of the health system (WHO, p. v).

In order to incorporate health financing considerations into the design and evaluation of health programs it is first important to have a basic understanding of health financing. The primer presents the basics of health financing, the core principles and functions, common system models and approaches, and the common issues confronting health financing systems in developing countries. The overview is intended to provide an introduction to the current thinking on this subject matter and on different approaches being utilized in low- and middle-income countries. The primer then discusses the U.S. government's approach to and involvement in improving health financing systems in developing countries and provides resources and tools available to USG program designers considering interventions in this area. To enhance the primer's practicality in designing assistance programs, Section II presents an assessment checklist that may be

used by USG program designers in evaluating the financial sustainability of health programs, and Section III provides a planning tool to integrate financial sustainability design tasks into USAID health sector procurement documentation.

In providing the overview on health financing, the authors of this primer relied primarily on three sources which they felt provided the most comprehensive and in-depth introduction to the current thinking on and approaches to health financing. These main sources serve as tools and resources for the reader to further their learning on health financing and include the following:

1. *Health financing revisited: A practitioner's guide* (2006) by Pablo Gottret and George Schieber. Produced by the World Bank.
2. *Learning from experience: Health care financing in low- and middle-income countries* (2007) by Dr. Diane McIntyre. Produced by the Global Forum for Health Research.
3. *The World Health Report 2000: Health systems: Improving performance* (2000) by the World Health Organization.

A. Health Care Financing: The Basics

Health care financing is commonly defined and discussed in current literature using the framework for assessing financing mechanisms for health adopted by the World Health Organization. The framework centers on the core functions a financing system must perform to be accepted for implementation by a country (or lower levels of governance). The key functions of a health financing system are as follows:

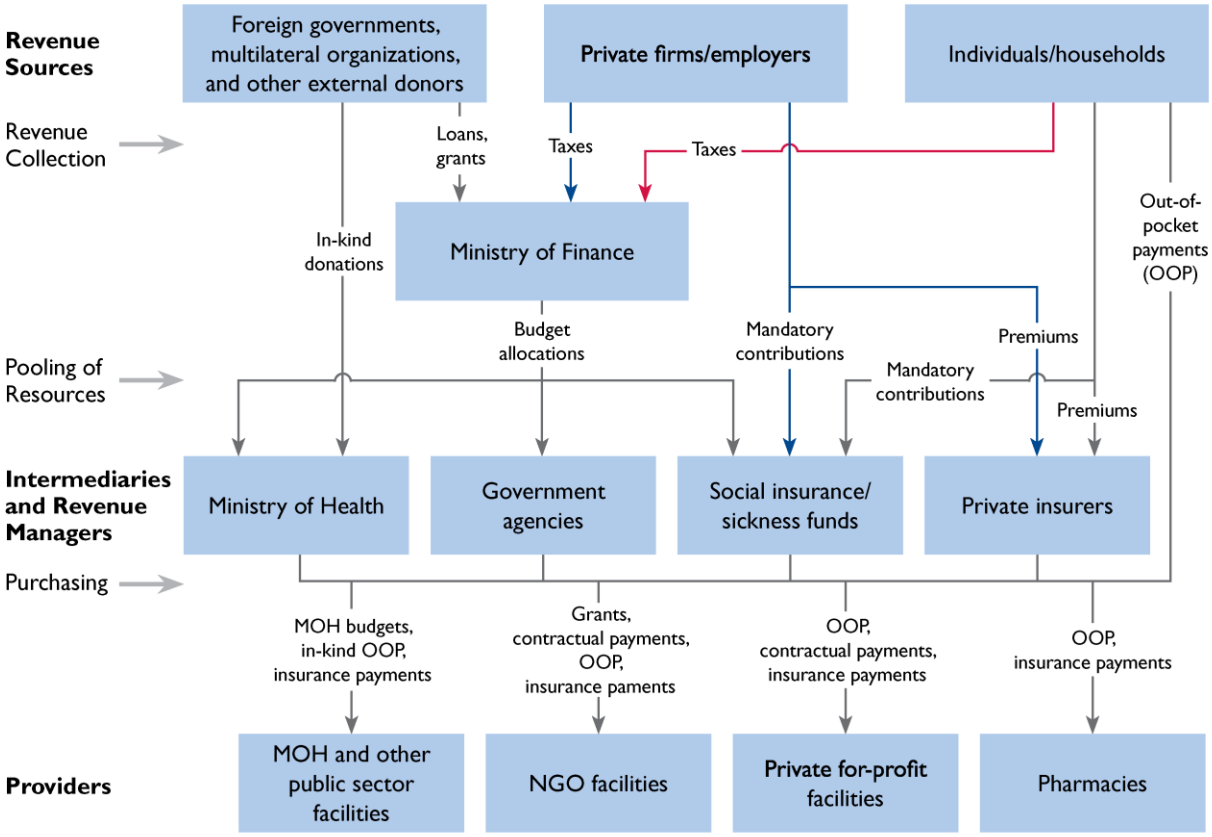
1. *Revenue collection and allocation*: encompasses the sources of funds — their structure and means by which they are collected. The objective of this function is to raise enough revenue in an equitable, efficient, and sustainable manner to allow for individuals within a population to be provided with essential health services and financially protected against poverty due to costs associated with unpredictable catastrophic losses caused by illness or injury.
2. *Pooling of funds (or risk)*: involves the management of revenue to equitably and efficiently pool health risks. It addresses the unpredictability of illness at the individual level, the inability of individuals to mobilize sufficient resources to cover unexpected health care costs, and consequently the need to spread health risks over as broad a population and period of time as possible.
3. *Purchasing*: relates to the transfer of pooled resources to health care providers in a manner such that appropriate, efficient, high-quality services are available to the population (allocative and technical efficiency) (Gottret and Schieber, 2006, p. 2; McIntyre, 2007, p. 7; WHO, 2000, p. 95).

Although these functions are presented and discussed separately in this primer, it is important to recognize the linkages between them in enabling access to quality health care services and providing financial protection for the population. Figure 1 on the next page illustrates the flow of funds through the health care system, identifying where each function takes place. Further, although there may be differences between financing systems in composition and organization, all health care financing systems are driven by and constructed upon these basic functions. Defining health financing per the framework allows financing systems (current or proposed) to be evaluated whether and to what extent they fulfill the essential functions of a good financial mechanism (Kutzin, 2001; McIntyre, 2007, p. 7; WHO, 2000, p. xii). The main challenge faced by every country — regardless of level of development — is to establish and manage the technical, organizational, and institutional arrangements required for these functions to be carried out efficiently and effectively so that people are protected financially (and in an equitable fashion) against high health care costs, and providers are incentivized to improve health status (WHO, 2000, p. 95).

A1. Revenue Collection

In the context of the health financing framework, revenue collection refers to the source of funding, the funding structure or composition, and the entity responsible for collection (McIntyre, 2007, p.8).

FIGURE 1. HEALTH FINANCING FLOWCHART



Source: Health Systems 20/20 Assessment Tool = Islam, 2007

- *Sources of funds*. Issues concern the mix of funding sources — the balance between: 1) external and domestic sources; and 2) within domestic sources, the balance between employer contributions and individuals (or households).
- *Structure of funds*. Addresses the way in which contributions to the financing system are structured and, for domestic resources, how equitable they are.
- *Collection entity*. Concerns the type of organization that is responsible for collection of revenue. For example, the collecting organization could be the government, a quasi-governmental organization, or a private organization (and, if a private organization, for-profit or not-for-profit) (McIntyre, 2007, pp. 8-9).

In general, governments have several sources of revenue — both public and private, domestic and external — with the mix of and dependence on sources varying between countries. All domestic funding for health care, regardless of the mechanism through which it is collected, comes from two main sources — companies and individuals (or households) (McIntyre, 2007, p.9). Determining the amount of funding to collect from companies and households — via taxation or contributions to social insurance schemes — is an important consideration in funding health systems and is influenced by many factors. For example, the extent to which and the amount of funds that may be garnered from taxes on companies may be influenced by the size of the formal sector and balanced with how much the government wishes to encourage investment in and development of

the formal sector. Similarly, poverty level and income distribution in a population influence the extent to which and amount of funds that can be feasibly garnered through taxes on individuals (McIntyre, p. 9). External funding is another important consideration for low- and middle-income countries in determining how to finance health care. Specifically, the balance between domestic and external funding and, with external sources, the funding type — loans (i.e. debt) or grants — must be determined (McIntyre, p. 10). These issues are discussed in greater detail below.

There are two basic options in considering how domestic contributions to finance health care services should be made: out-of-pocket, where the user pays a fee at the time of receiving the health care service, or prepayment, whereby the user contributes to the financing of health care services through mandatory contributions to a social health insurance scheme or tax payments or a mix of the two (McIntyre, 2007, p. 10). In the literature reviewed, it is widely felt that out-of-pocket payments are the most inequitable form of health care financing because of the heavy financial burden (relative to income) that direct payments can impose on the poor and near poor. For example, as shown in Table 1, private payments constitute approximately 60 percent of all health expenditures in sub-Saharan Africa, and of these private payments, approximately 80 percent are out-of-pocket (Gottret and Schieber, 2006, p. 41). Studies in Burkina Faso, Kenya and other countries have further initially demonstrated that introduction and/or increasing user fees may lead to a decrease in utilization of health care services, although further research is needed (Lagarde and Palmer, 2008, p. 843).

Predominant mechanisms of revenue collection include taxation, health insurance contributions (social and voluntary), donor funding, and out-of-pocket payments. Most high-income countries rely on either general taxation or mandated social health insurance contributions to finance health systems. Conversely, low- and middle-income countries typically depend more on out-of-pocket financing (Gottret and Schieber, 2006, pp. 36-37). Table 1 below illustrates this point.

Table 1. Composition of Health Expenditures (Source: Gottret and Schieber, 2006, p. 41)

	Public Expenditure as % of Total Health Expenditure	Social Security Expenditure as % of Total Health Expenditure	Private Expenditure as % of Total Health Expenditure	Out-of-Pocket Expenditure as % of Total Private Expenditure	External funding as % of Total Health Expenditures
Region					
Latin America & the Caribbean	50.3	32.5	49.7	74.3	1.4
Sub-Saharan Africa	39.6	1.9	60.4	79.2	17.6
Eastern Europe and Central Asia	61.3	41.4	38.7	85.1	1.6
Middle East and North Africa	44.9	23.6	55.1	84.8	1.0
East Asia and the Pacific	35.3	39.4	64.7	91.9	0.7

	Public Expenditure as % of Total Health Expenditure	Social Security Expenditure as % of Total Health Expenditure	Private Expenditure as % of Total Health Expenditure	Out-of-Pocket Expenditure as % of Total Private Expenditure	External funding as % of Total Health Expenditures
South Asia	23.7	8.0	76.3	97.1	2.5
Income Level					
Low-income countries	29.1	6.2	70.9	92.8	7.9
Lower middle-income countries	41.6	35.6	58.4	86.0	0.9
Upper middle-income countries	56.3	53.4	43.7	82.9	0.4
High-income countries	65.2	44.0	34.9	55.8	0.03

General taxation. Raising revenues to fund health systems through taxes can be problematic in low- and middle-income countries. Economic hardships and low administration capacities limit low-income countries' use of efficient and effective revenue generating taxation instruments (see Table 2 below) (Gottret and Schieber, 2006, p. 49). For example, populations may be geographically dispersed with many individuals living in rural, hard-to-reach areas, making tax collection difficult. Further, large income inequalities within a population pose additional problems for creating equitable and politically feasible taxation policies as taxes would need to target the wealthy minority (Gottret and Schieber, p. 50). Consequently, low- and middle-income countries tend to rely more on indirect taxes, such as consumption taxes on sales and on production (e.g., payroll), than on direct taxes (e.g., taxes on income and property) (Gottret and Schieber, p. 52).

Regressive vs. Progressive Tax

In discussing health financing an equally important concept to understand is regressive versus progressive taxation. A regressive tax is one in which the poor pay a larger fraction of their income than the wealthy. Conversely, a progressive tax is one in which the wealthy pay a larger fraction of their income than the poor.

Table 2. Average Central Government Revenues (Source: Gupta and others, 2004; as cited in Gottret and Schieber, 2006, p. 51)

	Total revenue as % of GDP	Tax Revenue as % of GDP	Social Security Taxes as % of GDP
Region			
Americas	20.0	16.3	2.3
Sub-Saharan Africa	19.7	15.9	0.3
Eastern Europe and Central Asia	26.7	23.4	8.1
Middle East and North Africa	26.2	17.1	0.8
East Asia and the Pacific	16.6	13.2	0.5
Income Level			
Low-income countries	17.7	14.5	0.7
Lower middle-income countries	21.4	16.3	1.4
Upper middle-income countries	26.9	21.9	4.3
High-income countries	31.9	26.5	7.2

In general, because of limited resources, low income levels, and poorly developed administrative capacities, low- and middle-income countries do not generate as much revenue from taxes as high-income countries and they tend to have low ratios of tax to GDP (Gottret and Schieber, 2006, p. 50). While this might suggest that there is room for increasing revenues through taxation, political, economic, and institutional constraints such as those discussed above make it difficult for developing countries to enact tax reforms to effectively further revenue generation (Gottret and Schieber, p. 50).

Health insurance. Contributions, both employer and individual, to health insurance schemes — social (or mandatory) and voluntary (and/or private) — are also a source of revenue for health financing systems. Social insurance refers to mandatory universal coverage under a publicly mandated system that is financed by employee and employer contributions (through payroll contributions) as opposed to financing from general revenues. Private insurance refers to employer-based or personal purchase of non-public health insurance and can occur at the individual or the community levels (Gottret and Schieber, 2006, p. 48). As with taxation, to attain equity contributions to insurance schemes should be progressive in nature. Depending on structure, contributions to mandatory health insurance vary in progressivity among low- and middle-income countries (EQUITAP, 2005, p. 11; McIntyre, 2007, pp. 12-13). In countries where contributions to a mandatory insurance scheme are proportional (i.e., the same percentage is levied on income regardless of amount earned) rather than progressive and/or a ceiling is placed on the contribution amount, mandatory insurance is more likely to be regressive (McIntyre, p. 21; Van Doorslaer and Wagstaff, 1993). To enable equity of contributions to a health insurance scheme within a population, contributions should maintain the following structure:

- Calculated as a percentage of income;
- Rates are adjusted to income (higher income groups pay a higher percentage);
- No ceiling is imposed (or if imposed, not set at too low) (McIntyre, 2007, p. 21).

Social health insurance schemes, such as in Vietnam (see text boxes on pp. 15-16), can also attain equity in revenue collection by using tax revenues to subsidize contributions of the poor who possess limited or no ability to pay. However, in low- and middle-income countries, the ability of health insurance schemes to generate sufficient revenue to adequately finance health care services is often constrained. According to McIntyre (2007), this is principally due to:

- Income level and distribution of income within a country (i.e., ability to pay, and breadth of population with ability to pay).
- Size of the formal employment sector. The smaller the formal sector the less potential to generate revenue. This may lead to higher income taxes, and as a result, opposition from prospective beneficiaries.
- High administrative costs. This is particularly true of voluntary insurance, which has to invest in marketing activities to attract members. Further, private voluntary health

insurance may face substantial actuarial costs, particularly if contributions are risk-rated (McIntyre, p. 22).

Donor funding. Governments can also increase revenues for health financing by obtaining money from external revenues. A significant number of low- and middle-income countries depend on external funding as a source of revenue to finance health services. If a country depends on external funding to finance health services, a key consideration is whether funding is received as a loan or grant (McIntyre, 2007, p. 23).

Repayment of loans reduces revenue available for expenditure on health services. Many low- and middle-income developing countries already maintain sizeable debts. As interventions to sustainably improve health systems frequently require increased recurrent expenditures, such as medications and salaries, more permanent and dependable funding sources are frequently needed to maintain sustainable improvements. Obtaining debt relief could free revenues to potentially apply to the health financing system. Programs such as the Heavily Indebted Poor Countries Debt Initiative have been enacted to provide debt relief tied to poverty reduction strategies and measurable outcomes, such as increased domestic expenditures in social sectors (Gottret and Schieber, 2006, p. 221). However, evidence that debt relief automatically results in increased available revenues and subsequent increased domestic investment in social sectors is lacking (Gottret and Schieber, p. 210).

SWAp

A SWAp pools funds received from donors to support the overall health sector of the recipient country. The objective is to ensure coordination and improve effectiveness of donor funding by directing resources to priority activities identified through strategic health sector plans developed jointly by the health ministry and donors. Health sector SWAps have been introduced in many countries, including Ghana, Mozambique, Tanzania, Uganda, and Bangladesh.

— McIntyre, 2007, p. 23

GBS

Through GBS, an approach adopted by DFID, donor funds are given directly to the country's Ministry of Finance rather than the Ministry of Health. The decision about how the funds are distributed between the health and other sectors thus rests with the Ministry of Finance (which, in turn, consults with the donors and other government ministries). Given that GBS funds are managed through the recipient government's established management systems, it is envisioned that GBS may improve efficiency in the management of public expenditures and align donor funding with national priorities and budgeting processes. DFID provided GBS to 13 countries in 2006/2007.

— McIntyre, 2007; DFID, 2004; DFID 2008

Donor funding, whether a loan or grant, can take the form of project funding, a sector-wide approach (SWAp), or general budget support (GBS). In the case of project funding, donor funding is restrictive in its use in that it is typically earmarked for a specific project and/or targeted geographic regions within a country (McIntyre, 2007, p. 23). However, a SWAp (or basket fund) or GBS allows the recipient government to directly manage the utilization of donor funds, as described in the box at right.

It is also important to note that donor assistance may not be recorded in the recipient country's balance of payments (as aid/funds received) or may be recorded in the balance of payments but not in the government's budget (i.e., off-budget), depending on how it is provided (Gottret and Schieber, 2006, p. 130). Donor funding not recorded in the balance of payments primarily encompasses technical assistance contracted and paid for by donors. Funding that is recorded "off-budget" typically refers to funding for projects implemented directly by donors through nongovernmental organizations and/or targeted

populations (e.g., health care providers), skirting the government's financial management systems. Earmarked funding, which is considered "on-budget," includes funding for a particular purpose or project, such as for building health facilities (Gottret and Schieber, pp. 130- 131). On-budget increases in health expenditures that result from external funding and/or expenditure structures imposed by donor agreements may contradict and encounter opposition from expenditure adjustment initiatives of the recipient country to lower general public expenditures.

Donor funding via grants can have negative effects on health systems in developing countries. According to Schieber et al. (2006) , aid may cause country priorities to be replaced with donor priorities and subsequently divert limited resources from areas of immediate need (p. 232). Further, a country may have insufficient human resources, physical infrastructure, or managerial capacity to absorb and use funds effectively. New resources may overwhelm the system, and donor reporting and administrative requirements may impose additional, difficult-to-meet burdens on recipient countries (Schieber et al., p. 232). Aid predictability and the ability of countries to sustain services once donor funding stops are also problematic. Additionally, with recent trends in development assistance for health directed to interventions for specific diseases, there is growing concern about the waste and inefficiencies that can result from creation and management of separate delivery silos for specific diseases (Schieber et al., p. 234).

Out-of-pocket payments. Out-of-pocket payments are direct payments made by a patient to a health care provider. User fees paid directly to a health care facility are a form of out-of-pocket payment as are copayments made by members of a health insurance scheme. Many low- and middle-income countries impose user fees — charges for public or private health care services — though effectiveness of this practice is highly debated. Opponents argue that the fees may provide a disincentive for seeking health care, particularly among the poor, and the administrative costs of collection are often higher than the revenue generated. Proponents counter that user fees improve quality of care (as it provides incentives to providers and enables direct investment in facilities), reduce unnecessary demand, and when managed correctly with waivers for the poor, remain an important revenue source for weak institutions (Gottret and Schieber, 2006, p. 234). These arguments are summarized in Table 3 on p. 10.

Table 3. Debate on User Fees (Gottret and Schieber, 2006, p. 234)

Arguments in Favor of User Fees	Arguments Against User Fees
Generate additional revenue with which to improve health care quality	Are rarely used to achieve significant improvements in quality of care, either because their revenue-generating potential is marginal or because fee revenue is not used to finance quality improvements
Increase demand for services owing to improvement in quality	Do not curtail unwarranted demand because in poor countries there is a lack, not an excess, of demand
May reduce out-of-pocket and other costs, even for the poor, by substituting public services sold at relatively modest fees for higher priced and less-accessible private services	Fail to promote cost-effective demand patterns because the government health system fails to make cost-effective services available to users
Promote more efficient consumption patterns, by reducing spurious demand and encouraging use of cost-effective health services	Hurt access by the poor, and thus harm equity, because appropriate waivers and exemption systems are seldom implemented; where they are, the poor receive lower quality treatment
Encourage patients to exert their right to obtain good quality services and make health workers more accountable to patients	
When combined with a system of waivers and exemptions, serve as an instrument to target public subsidies to the poor and to reduce the leakage of subsidies to the non-poor	

The final issue concerning revenue collection is the organization responsible for collecting revenue. The collecting entity utilized is determined by the contribution mechanism: taxes are collected by government organizations and mandatory health insurance contributions may be collected by a government, quasi-governmental, or private organization (McIntyre, 2007, p. 25). Who collects the revenue can affect the amount of revenue available and collected. For example, McIntyre (2007) states that "in countries where the government is not seen as accountable to the population or has not gained its confidence, tax evasion can be high." (p. 25)

A2. Pooling of Resources

The goal of pooling is to prevent individuals from falling into poverty because of medical expenses and to ensure financial access to care. It is difficult to predict the future health care needs and costs on an individual level. However, according to McIntyre (2007), it is possible, based on epidemiological and actuarial data, to estimate probable health care needs (and thus costs) of a group — this is the foundation of pooling resources (p. 25). Accordingly, individuals contribute on a regular basis to a pooled fund, so that when they require health care the fund will cover their health care costs. In pooling funds, healthy members of the pool are able to help pay for the health care costs of those who are sick. The risk of incurring high health care costs is therefore shared among those in the pool. The greater the number of individuals in a pooling group, the easier it is to project health care expenditure (i.e.,

Resource Pooling

Resource pooling is the accumulation and management of revenue so that members of the pool share collective financial risks, thereby protecting individual contributors from paying full out-of-pocket expenses in the event of illness.

— Gottret and Schieber, 2006, p.46

predicted health care costs of the pool will be less influenced or skewed by an individual high cost). Frequently, the organization responsible for the collection of contributions is also responsible for the pooling of these resources (McIntyre, pp. 25-26).

According to McIntyre (2007), the key components of risk-pooling funds (or revenue collected) are:

- The size of the population and the socioeconomic groups covered by the financing mechanism;
- The mechanisms used to allocate resources from pooling to purchasing organizations (p. 26).

Where government or mandatory health insurance encompasses most health care financing, maximum risk pooling is, in theory, achieved since the risk is shared across the entire population. It is also possible to achieve universal coverage using several financing mechanisms within one country. However, if the health care financing mechanisms are highly fragmented, often a significant portion of the population remains excluded (McIntyre, 2007, p. 26). Some countries, such as Vietnam (see text boxes on pp. 15-16), prefer to develop and implement several financing mechanisms with the intent of individual mechanisms targeting specific population groups. The reasons for this vary — there may be limited social solidarity (enabling a national scheme) or income levels and economic growth rate may allow for insufficient funding to finance the health system entirely from taxes or mandatory insurance (McIntyre, pp. 31-32). However, the problem with having a vast range of financing mechanisms is that it results in fragmentation of risk among a large number of small risk pools — the smaller the risk pool, the less sustainable the financing mechanism because it tends to increase health care costs.

Another aspect of risk pooling is the need to ensure that resources are equitably distributed across a population in accordance with their care needs and risk of future care costs. Risk-adjusted allocation mechanisms can be applied either to insurance or public funds and promote equity of access to health care on the basis of need. According to McIntyre (2007), the indicators most commonly used to measure relative need for health services are population size, demographic composition, levels of ill-health, and socioeconomic status (p. 33). In low- and middle-income countries, adjustments are also often made for the higher cost of providing care in remote rural areas (McIntyre, p. 33).

Purchasing

Purchasing, or financing of the supply side, refers to the mechanisms through which public and private agencies spend money to either provide or purchase health care services for the populations they serve. Purchasers of health services can include Ministries of Health, social security agencies, district health boards, insurance organizations, and individuals and households (from out-of-pocket expenses).

— Islam, 2007

A3. Purchase of Services

How health services resources are allocated reflects the priorities of policymakers as well as the emphasis they place on reducing inequalities in access to care. Many factors may go into the final decisions and the process is affected by political, social, and economic realities and may not always result in the most equitable

choice (Schieber et al., 2006). McIntyre (2007) states that the key issues in the purchasing function of health care financing are:

- The choice of benefit package — including type of service and type of provider, and the route by which different services should be accessed;
- The choice of mechanism for paying providers or transferring resources from purchaser to provider (p. 37).

Coverage Trade-offs

"There is an important trade-off between what are frequently referred to as the breadth (how many people) and depth (which services) of coverage. If universal coverage under a health care financing mechanism is the objective, it may be possible to offer only a very limited benefit package; a more comprehensive package may be possible but only if coverage is confined to a limited section of the population."

— McIntyre, 2007, p. 40

The purchaser, regardless of the financing mechanism they operate within, must have a solid understanding of what is most influencing the health of targeted populations in order to determine the benefit package that will best meet the population's needs. The design of a benefit package should consider the population's ability to pay while being reasonably comprehensive to protect individuals from catastrophic health care costs. The revenue available to purchase services — now and in the future — will influence the services (and subsequently the providers) selected in the package. This is often reflected in policy debates over what constitutes a minimum package of primary health care services (McIntyre, 2007, pp. 37-39).

Once the contents of a benefits package have been decided, the next step is to determine the types of providers that beneficiaries can use to secure services. The purchaser may require that the full costs of services included in the benefit package are covered if they are provided by select facilities (e.g., public sector facility). Contracts may also be entered into between the purchaser and provider if they are clearly separate entities (e.g., private sector) (McIntyre, 2007, p. 40).

Provider payment mechanisms involve how funds are transferred from the purchaser to the provider. The following are the main forms of provider payment mechanisms:

- Payment of providers:
  - — Salary: determined prospectively, paid retrospectively;
  - — Fee for service: determined prospectively, paid retrospectively;
  - — Capitation (i.e., a flat payment per person covered): determined prospectively, paid prospectively.
- Payment of facilities:
  - — Budget allocations: determined prospectively, paid prospectively;
  - — Fee for service: determined prospectively, paid retrospectively;
  - — Per diem (a flat payment per day of hospitalization): determined prospectively, paid retrospectively;
  - — Case-based fee (a flat payment per treatment package): determined prospectively, paid retrospectively (McIntyre, 2007, p. 41).

For example, in Colombia, financing intermediary entities have been created, known as "health promotion enterprises." These "enterprises" compete for membership of the insured population (formal sector) and contract with service providers (public and/or private) for provision of benefits packages. Regulations stipulate the minimum benefit package that must be covered by the enterprises and a mechanism that enables income-related cross-subsidies between populations has been established. There are two benefits packages available — one for those with the ability to contribute in full, and one for those who require subsidization — however, each maintain the same contribution rate. (Gaviria et al., 2006; Homedes and Ugalde, 2005; McPake and Mills, 2000; as cited in McIntyre, 2007, p. 41).

In the context of purchasing, it is also important to understand the concept of "moral hazard." Moral hazard means that "those entitled to benefit from coverage have a strong incentive to consume more and 'better' health care and a weaker incentive to maintain a healthy lifestyle than if they did not have this entitlement" (McIntyre, 2007, p. 41). User fees and copayments are commonly used as a mechanism to mitigate moral hazard. However, as discussed previously, user fees may undermine the use of health service by poor and near poor populations.

B. Financing Mechanisms

According to Gottret and Schieber (2006), there are four health financing mechanisms commonly used in both developing and developed countries through which the three health financing functions (i.e., revenue collection, pooling of funds, and purchasing) are implemented. These mechanisms include: 1) national health services; 2) social health insurance; 3) voluntary private health insurance; and 4) community-based health insurance (Gottret and Schieber, p. 7). Each model is linked to specific revenue collection instruments (taxation, mandatory contributions, etc.) as well as health services purchase procedures. It is noteworthy that in practice, country health systems are typically a mix of features and characteristics from each of these mechanisms.

B1. National Health Services (or Ministries of Health)

National or state-funded services provide, or intend to provide, universal health coverage and can receive revenue from many different resources, such as taxation, sale of country resources, donor funding, etc. They represent the main health financing mechanism used in 106 of 191 members of the World Health Organization (Gottret and Schieber, 2006, p. 75). Because they are also relatively simple to manage (relative to other financing mechanisms and in that fragmentation of the financing system under one entity is, in theory, minimal), national health services are also the most widespread form of health financing in low- and middle-income countries (Gottret and Schieber, p. 73). Ideally, national health service systems should function as universal risk pooling schemes where the entire population has access to public services financed through general revenues. However, in reality, and especially for low-income countries, national health services are usually blended with other risk pooling arrangements, such as community-based health insurance, social health insurance, or private insurance to cover different segments of the population (Gottret and Schieber, p. 76). While the strength of a state-funded system is

that it can offer comprehensive health coverage and a large risk pool, the fragmentation of the system into different risk pooling arrangements potentially makes national health service systems administratively complex, costly, and inefficient. In addition, because state-funded systems compete for their share of the annual budget, their resources may be unstable making long-term planning difficult. National health services generally function best in countries with sound institutional structures, stable economic growth, good tax administration capacities, and enough resources to specifically target the poor for inclusion in the system (Gottret and Schieber, p. 8).

B2. Social Health Insurance

An increasing number of low- and middle-income countries are considering implementing, or are in the early stages of implementing, some form of social health insurance. Approximately 60 countries, mostly high- and middle-income countries, currently employ large-scale social insurance programs as a health financing mechanism (Gottret and Schieber, 2006, p. 226). Social health insurance refers to mandatory universal coverage under a publicly mandated system that is financed by employee and employer contributions (through payroll contributions) rather than financing from general revenues. They are typically characterized by: 1) independent or quasi-independent insurance funds; 2) a reliance on mandatory earmarked payroll contributions (usually from individuals and employers); and 3) a clear link between these contributions and the right to a defined package of health benefits (Gottret and Schieber, 2006, p. 82). If the goal of implementing a social insurance scheme is to attain universal coverage, a single insurance scheme is not requisite — several schemes can be maintained within the universal mandatory insurance system as long as mechanisms are in place that link the different schemes together. In most cases, however, universal coverage cannot be attained solely though social insurance contributions, as the number of contributors are much fewer than the number of people needing coverage. Therefore, general taxation is still used as a revenue source to finance the health system in countries where social health insurance schemes are in place (Carrin and James, 2004, as cited in Gottret and Schieber, p. 83).

Advantages of social health insurance schemes include greater transparency in comparison to the way taxes might be spent on health care, and more active participation by individuals in contributing to health coverage. However, it has been shown that implementation of social health insurance schemes tends to divert resources from the poor to the rich, and also tends to increase health care costs as the wealthy tend to demand higher quality services as well as “non-essential” services. In implementing social health insurance schemes, mechanisms for protecting the poor and for containing costs often need to be incorporated (Gottret and Schieber, 2006, p. 74).

B3. Voluntary Health Insurance

Voluntary health insurance is defined as a health insurance to which an individual or group can subscribe without a legal requirement to do so (McIntyre, 2007, p. xii). Voluntary insurance is usually purchased from private insurance organizations, although in some cases it may also be purchased from public or quasi-public entities. The roles voluntary health insurance can play in a country's public or social coverage include the following:

- Primary — as the main source of coverage for a population or subpopulation;
- Duplicate — covering the same services or benefits as public coverage, but differing in the providers, time of access, quality, and amenities;
- Complementary — covering cost-sharing under the public program;
- Supplementary — for services not covered by the public program (Gottret and Schieber, 2006, p. 11).

Vietnam Health Insurance Reform

Vietnam has experienced rapid and sustained economic growth — averaging 7-8% per year — since the initiation of its economic and social reform program known as "Doi Moi" in the mid-1980s. In conjunction with the low population growth during the same period, per capita growth rates have been equally significant (GNI per capita is $620 per capita, which is above the average GNI for a low-income country). Enabled by economic improvements, in 1992 the Vietnam government began introducing health insurance at a national level as a means to raise funds for health care and to provide a mechanism for financial risk protection. The health insurance system developed consists of two parts, *mandatory (or compulsory) health insurance* and *voluntary health insurance*. The compulsory health insurance is further divided into two separate programs, one *social health insurance scheme for the formally employed* and one *targeted, subsidized program for the poor*. In addition, children under the age of 6 are provided with free health care. The voluntary health insurance targets self-employed and informal sector workers, dependents of members of the compulsory health insurance, and students.

— Source: Ekman, et al., 2008

Apart from out-of-pocket expenditures, contributions for voluntary health insurance are the major component of private health expenditures. Voluntary private health insurance is in the initial stages of development and acceptance in low- and middle-income countries — accounting for only 5 percent (on average) of total health expenditures in these countries (Gottret and Schieber, 2006, p. 228).

Voluntary health insurance may be beneficial to individuals in low-income countries as it pools financial risks, thereby lessening the potential for catastrophic medical costs pushing individuals toward poverty, and provides an additional source of revenue to the health care system. However, economic and institutional constraints thus far have made establishing and maintaining voluntary health insurance markets difficult in low-income countries. Voluntary insurance schemes are also vulnerable to adverse selection — where individuals with the greatest risk of becoming sick comprise the majority of the population seeking coverage (McIntyre, 2007, p. 32). A pool of beneficiaries that is of high risk of becoming sick limits the potential for cross-subsidies within the scheme from the healthy to sick. Conversely, if not legislated, insurance schemes can engage in "cream-skimming" — where the insurance scheme aims to attract low-risk (healthy) individuals and discourages enrollment of high-risk individuals. This also mitigates the potential for cross-subsidies, not within the scheme but the overall health system, as the healthy are maintained under the insurance scheme and high-risk populations under publicly funded mechanisms (McIntyre, p. 32).

Results: Vietnam Health Insurance Reform

Results from implementation of the national insurance program have been positive.

- The *mandatory social insurance* covers approximately 41% of the population, including the formally employed (around 9%), the poor (18%), and children under 6 (11%).
- The *voluntary health insurance* program covers approximately 11% of the population, most of which are students and school children.
- Review of data from Vietnam's national health accounts shows that overall health spending has remained consistent at approximately 5% of GDP in the period 1996 to 2005.
- As for composition of health spending, public expenditures on health (as a percentage of total health expenditures) decreased from 32% in 1996 to 22% in 2005, which resulted in increased private spending.
- During this period social health insurance spending increased from less than 10% of total public spending on health care to more than 20%, and out-of-pocket payments as a share of total private spending decreased from 95% to 88%.

Relative to other low-income countries, Vietnam has done well in terms of key health outcomes:

- Life expectancy at birth is around 70 years for both men and women (compared with an average of 59 years for low-income countries (LIC).
- Health service coverage rates are high compared with other low-income countries: immunization of children is around 97% (LIC average, 63%); almost 90% (LIC average, 41%) of births are attended by a skilled health worker.

— Source: Ekman, et al., 2008

Lessons Learned: Vietnam

Health insurance reform requires mobilization of significant resources. Low-income countries that aim to achieve universal health insurance coverage need to create the necessary revenue (or fiscal space) to do so sustainably. The sustained economic growth of Vietnam over the past decades has greatly enabled implementation of health financing reforms.

Health insurance reform needs to be examined comprehensively. Vietnam is making use of several health insurance approaches to reach universal coverage, including social health insurance, targeted subsidies and voluntary health insurance. While attaining significant coverage levels under the voluntary health insurance scheme is proving challenging, it may be a relevant and viable option moving forward if an attractive and affordable package can be provided.

Health insurance reform takes time. After 15 years of implementation, Vietnam has attained health care coverage for approximately half of the population, and it appears that the most difficult population groups are yet to be covered. Moreover, evidence from other countries that have implemented national social insurance schemes suggests that covering the final portion of the population takes longer than the initial population groups (such as the formal sector).

— Source: Ekman, et al., 2008

B4. Community-based Health Insurance

Under community financing, communities (e.g., villages, districts or other defined geographic areas, or a certain ethnic or socioeconomic group) finance the costs of health care services and participate in the management and organization of the services (Carrin et al., 2005, p. 800). Community-based health insurance (CBHI) refers to voluntary health insurance organized at the community level. CBHI schemes serve relatively small populations in low-income countries though interest in their use has been growing. CBHI programs are relatively new so there are issues that need to be resolved before they gain traction. These issues include the affordability of premiums, trust in the managers, and quality of care. In addition, many communities are too small to effectively pool risk and very few CBHI schemes reach the poorest individuals as they cannot afford premiums (Carrin et al.,p. 801; Gottret and Schieber, 2006, pp. 101-102).

Mutuelle de Sante:
Community-based Health Insurance in Rwanda

Community-based health insurance (CBHI) schemes — called Mutuelle de Sante — are being implemented and used in Rwanda to mobilize financial resources for health. Begun formally in 1999, community-based health insurance schemes have been implemented nationwide, and in 2006 covered 73% of the population. Health service use has increased significantly during this time period. The scheme is managed by an autonomous organization (apart from the government) and is partially subsidized by the central Rwandan government. Basic health care services are provided under the scheme — this includes family planning, antenatal care, consultations, normal and complicated deliveries, basic laboratory examinations, generic drugs, treatment for malaria, and some tertiary care. In the event of a health disaster (or catastrophic event), a central reserve fund has been established to cover costs. The administrative costs represent 5-8% of the total revenue. Each member of the scheme contributes 1000 Rwandan Francs ($2) per year and also pays a 10% fee for each service received. Decisions relating to the scheme —benefits package, providers contracted, etc. — are made through an elected village committee, who also decides which community members are too poor to pay. The cost of the insurance scheme for the poor is then subsidized by donors.

As this and other health interventions have been implemented, initial improvements in health outcomes have been positive. Most notably, during the time period in which the Mutuelle de Santes have been formalized and expanded, under 5 child mortality has decreased by 22% and maternal mortality by 30%.

The Government of Rwanda is currently planning to have other insurance schemes contribute to and reinforce other health insurance schemes — such as the social insurance scheme for civil servants and the Military Medical Insurance. Should this occur, it will greatly lend to pooling risks across the population and potentially result in an improved package of care.

—Source: Logie, et al., 2008

Both community-based health insurance and voluntary insurance can benefit from strong public sector institutional capacities. Because they tend to generate revenue through user fees and premium payments, these systems, unless government subsidized, can only include those who can afford to pay. In addition, risk pooling may be limited as the private insurance markets are typically small in low- and middle-income countries, and issues surrounding long-term stability and equitable provision of services and allocation of resources need to be resolved (Gottret and Schieber, 2006, p. 75).

In summary, each of the common financing mechanisms discussed here faces challenges and must be considered in the country context when evaluating its ability to ensure equity and ability to improve health status.

B5. Public-Private Partnerships

In addition to the four mechanisms discussed above, public-private partnerships have emerged as a mode to finance health. As noted in Table 1, private sector funding for health in low-income countries far exceeds the level in higher-income countries. This is mainly through out of pocket expense (OOP) for primary through tertiary care, in many cases the majority of OOP expenses going for drugs. The recent International Finance Corporation (IFC) study on the Business of Health in Africa estimates that 60 percent of $16.7 billion for health care went to OOP and 50 percent was captured by private providers (International Finance Corporation [IFC], 2008, p. 5). Conversely, a disproportionate share of public sector funding went to the higher income groups, ranging from 70 percent of public hospital funding serving 40 percent of higher income groups in Mauritania to one third of public spending serving the richest quintile in Ghana (IFC, pp. 9-10).

The private sector role in financing development has also grown in importance over the past three decades. A 2006 OECD report by Drechsler and Zimmerman gives an overview of the private sector role in development assistance over the last three decades. Since the 1980s, it has emerged as an identifiable and separate stream of financing, through global health initiatives, NGOs, private philanthropy and the private commercial sector (Drechsler and Zimmerman, 2006, p. 5). The same report observes that the flow of resources in general from the private sector has reduced the role of government Official Development Assistance (ODA). From 1980 to 2004, for example, in some countries such as Brazil, Mexico, Malaysia and Indonesia, where commercial bank loans, trade lending and equity and portfolio investments have been notable, ODA has fallen from 35 percent to 15 percent; even in poorer countries the ODA share has dropped from 65 percent to 40 percent (Drechsler and Zimmerman, p. 7). Remittances are also growing in importance in some countries, where they account for 15 percent or more of GDP and are being used to fund education, nutrition and health. Private philanthropy has also rapidly expanded via NGOs, private foundations, and international public-private partnerships. In the five-year period from 1998 to 2003, donations to the Partnership for Quality Medical Donations from 10 major pharmaceutical companies reached $US 2.7 billion. (Drechsler and Zimmerman,p. 9).

Figure 2: Total Overseas Health Expenditure by U.S. Nongovernmental Organizations from 1990-2007 (Ravishankar, et al., 2009)

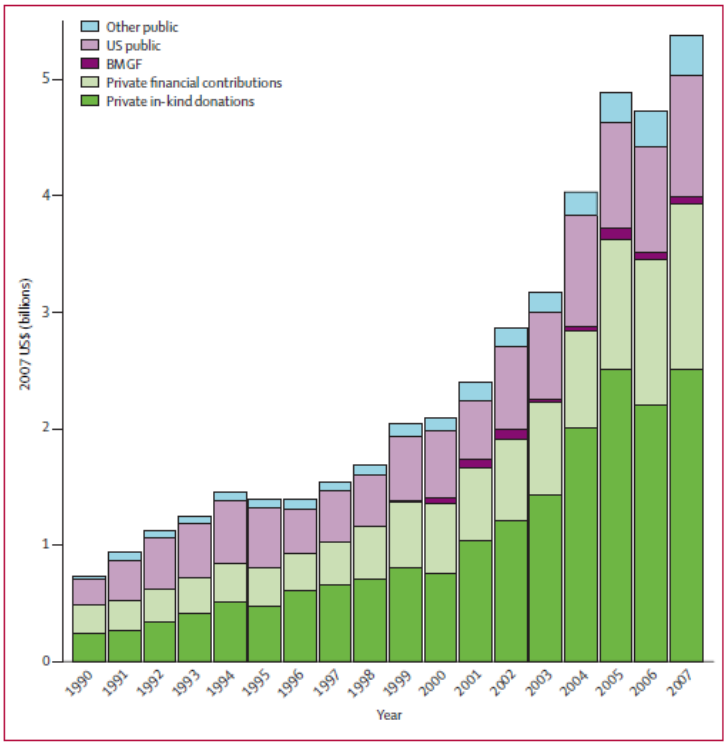


Figure 5: **Total overseas health expenditure by US non-governmental organisations from 1990 to 2007**
Funds are separated by proportions of revenue received from the US Government, other public sources of funding, from the Bill & Melinda Gates Foundation (BMGF), financial donations from private contributors, and in-kind donations from private contributors. Since revenue and expenditure data for 2007 are not currently available, the overseas health expenditure for 2007 was estimated from yearly growth rates in the previous 5 years.

Looking specifically at international development assistance for health (DAH), a review of private sector funding in a June 2009 article in *The Lancet* shows a parallel growth trajectory. From 2001 to 2006, the amount of DAH more than doubled ($5.6 billion to $13 billion) with a corresponding increase in share of private funding (19 percent to 27 percent). The Bill and Melinda Gates Foundation was the largest contributor (Ravishankar, et al., 2009). Funding through NGOs and through global public-private partnerships has also moved the private sector into the forefront of providing development assistance. Figure 2 illustrates the rapid growth of nongovernmental resources for health development from various private sector sources. In the same issue of the *Lancet*, an in-depth World Health Organization (WHO) analysis of global trends looks at the effect of such financing on international public-private partnerships (which WHO refers to as Global Health Initiatives) that address HIV/AIDS, malaria and other diseases (World Health Organization Maximizing Positive Synergies Collaborative Group , 2009). The WHO review makes the following observations: 1) for HIV/AIDS, overall out of pocket expenses has dramatically fallen, but aggregate out of pocket expenses were not affected in the 1997-2007 period; and 2) for Global Health Initiatives, overall the impact on health financing in general has been a “substitution effect ” than

one of "additionality." That is, these funds have not incentivized recipient governments to channel replaced resources into underfunded health areas (World Health Organization Maximizing Positive Synergies Collaborative Group , 2009). An earlier article on private clinics in South Africa published in the *Bulletin of the World Health Organization* had questioned whether the private sector could relieve service delivery burdens on the public sector to allow it to reach poorer segments of society. However, the article acknowledged that private providers tend to offer lessons on how to efficiently use human and material resource, a critical element in financing health services (Palmer, et al., 2002).

The 2006 OECD report cited above argues that as public-private partnerships have grown in international DAH, private-sector financing has also begun to emerge as an important national strategy for health development in both higher and lower income countries (Drechsler and Zimmerman, 2006). Health sector financing in Ghana, for example, as described in the 2006 OECD report, incorporates foreign remittances, donations from pharmaceutical companies, Global Health Initiatives, and loans from local banks for capital investment in health infrastructure. In 2005, bank loans constituted 15 percent of the Ghanaian Ministry of Health's budget (Drechsler and Zimmerman, p. 19). The IFC report on the Business of Health in Africa argues that that the private sector role in health development will outpace that of the public sector by 2016. The report estimates that $25-30 billion in investment in physical assets will be needed during the 2005-2016 period to meet growing demand for health services, and that the private sector can potentially contribute $11-20 billion in investments (IFC, 2008).

The private sector through local public private-partnerships now figures as a major component of health development strategies. USAID[1], the World Bank and other donors are promoting private sector development. They support health through policy initiatives to create enabling environments; to build entrepreneurial skills of private organizations; to promote privatization of services through franchising and making capital available for private sector initiatives through banking services; and to encourage local pharmaceutical companies to promote health product development for providers and users. According to USAID, the local private sector for the promotion of reproductive and maternal child health covers individual private providers, clinics, and hospitals. The private sector also covers for-profit companies, including large multinationals, NGOs, manufacturers, wholesalers, and distributors; pharmacies, shops and retail outlets; advertising, marketing, and market research agencies; micro-financing institutions and banks; and health insurance schemes (USAID, 2009).

The range of private-sector financing initiatives is growing beyond donations. Multinational corporations are investing in technologies that support services for the poor, such as the m-health initiative in using mobile phone technology promoted by a partnership between the UN Foundation and mobile phone companies. Companies have begun to discover the base of the economic pyramid where people earn less than $2 per day. In a recent presentation at the 2009 Global Business Coalition for Health, SC

[1] USAID has a number of initiatives, for example, the Private Sector Project, the Credit Development Authority and the Global Development Alliance which are promoting private sector partnerships globally, in addition to private sector initiatives promoted through country projects.

Johnson discussed how the company is trying to penetrate the market in Nairobi slums with household cleaning products via small franchises that clean public latrines. This effort helps the public, SC Johnson's profitability and the environment (DeMoszkovsky, 2009). Social entrepreneurship is expanding. The June 4 issue of *The Economist* in its Technology Quarterly gives an example of mobile telephone companies in Nicaragua and Pakistan that provide incentives to subscribers who take their TB medications by offering them free airtime. (*The Economist*, 2009). Credit availability is another major pathway for private-sector initiatives. USAID's Credit Development Authority programs provide incentives for banks to issue loans to high-risk ventures and individuals to make borrowers more creditworthy. A USAID project, Banking on Health, encompasses a number of strategies for bringing businessmen and banks together to support the expansion of the private sector in reproductive health services. By June 2009 this project had leveraged close to $191 million in loans (USAID, 2009, p. 37).

As noted above, investing in health infrastructure will be an important driving force behind public private partnerships. A series of papers from a 2008 conference organized by the University of California, San Francisco discuss contracting-in and contracting-out models of investment partnerships around the world. Da Rita, Green, and Ashbee's (2008) paper describes the range of partnerships. Over the years governments have regularly contracted "out" various infrastructure support services from construction, maintenance to catering. Recently systems support from IT to medical procurements is being increasingly contracted out. Contracting "in" has also emerged as a public-private partnerships strategy, where the government contracts private services to run laboratories, pharmacies and management operations in public facilities. Building capacity in contracting skills is becoming increasingly important in developing enabling environments for private partnerships.

Another paper examines the pros and cons of various financing variations of the BOT (build, operate and transfer) approach that provide incentives for private-sector investments in health infrastructure (Loening, 2008). They involve varying degrees of public and private involvement and control over the ventures, along with different conditions for implementation and viability, as well as financial and political risks. Moreover, Loening's paper notes that the "contracting model" that underlies these approaches depends on a number of other important financial factors: bidding capacity, funding availability for clients to use facilities (usually health insurance), payment efficiency and pro-private sector policies (Loening, pp. 5-6) . In some countries, the private sector is regarded with suspicion and so the more neutral state/non-state partnership label is being promoted by WHO in order to facilitate the evolution of these models (Bennett, et al., 2005). Loening's paper provides a snapshot of such partnership models. One example is the "concession" model in Georgia, presented in the side box.

On the international public-private partnerships front, new mechanisms are being developed to raise funds to improve health care either through service delivery and research. A recent publication from the International AIDS Vaccine Initiative (June, 2009) describes several of these mechanisms that involve various combinations of government, foundations, corporations, and international financing organizations. There is the "international health funds" to facilitate access to treatments for neglected diseases; the "product development partnerships" to develop products for diseases that disproportionately affect low- and middle-income countries; the "international

Privatizing Health Care in Georgia

The Republic of Georgia is an anomaly in the region. Like the other countries, public funding has essentially collapsed, precipitating a massive loss of resources for social services such as health care. Out-of-pocket payments have become the predominant mode of health financing, amounting to 80% of total health revenue. In an attempt to decentralize financing responsibility, in the 1990s the government permitted most hospitals to become legal entities, i.e., limited liability companies (LLCs) or joint stock companies (JSCs). The government had hoped that an oversupply of hospitals could be reduced through free-market mechanisms (Gamkrelidze, Atun et al. 2002; Mossialos and Dixon, 2002; as cited in Loening, 2008, p. 13). However, hospitals and bed capacity did not rationalize as expected. As a result, the government has recently embarked on an alternative approach, including the privatization of 90 percent of public hospitals and clinics. By early 2008 it is expected that hospital beds will be rationalized to 7,800 from 17,000, with 100 new hospitals equipped to modern international standards.

Concession Case

Privatization in Georgia is accomplished by having bidders bid on blocks of hospitals, which typically consist of a large hospital in Tbilisi with regional and rural hospitals. The winning bidder will build a new facility replacing the specified blocks and operate them for seven years. Following the opening of the new hospital, the investor is allowed to tear down the old structure and re-build as commercial or residential property. Investors are required to follow the master plan in terms of the various departments/services to be available in each hospital, with only minor changes allowed with the government permission. As a result, various consortia of bidders have formed from medical equipment suppliers, pharmaceutical companies, and real estate investors.

Source: Loening, 2008, p. 13

finance facility" to generate revenue for immunizations and improved health systems; the "advance market commitment" to incentivize investment in vaccines for neglected diseases; and "UNITAID" to increase access to HIV/AIDS treatment via taxing airline passengers. Several low-income countries and developed countries have agreed to this (IAVI, 2009). The future in public-private partnerships seems to augur a "partnership" between international and local public-private partnerships. The long-term question as raised by the June 2009 WHO review is how to maximize their impact on health outcomes in reducing morbidity and mortality.

C. Examples of Donor Approaches to Health Financing

Several donors and/or donor initiatives are working in the area of health financing, although donor assistance efforts do not typically center exclusively on health financing. Rather, health financing is commonly a component of larger efforts to strengthen health systems. Below is a brief summary of select donor initiatives. Due to the amount of funds being provided, these initiatives may significantly impact financing mechanisms, recipient countries, and donors working to address issues within financing systems concerning revenue collection, pooling of resources, and purchasing.

The United States Agency for International Development (USAID). USAID has been working to address health financing issues in low- and middle-income countries for several decades. Current USAID projects that address health financing issues, normally as a component of health systems strengthening, include the following:

- TASC3-Global Health — TASC3-Global health primarily works to improve health in the areas of population health, nutrition, and infectious diseases, which includes working to strengthen systems affecting service delivery in these areas. It is an indefinite quantity contract with a ceiling of $1 billion.
- Health Policy Initiative (HPI) project — HPI aims to "strengthen multi-sectoral engagement and host country coordination in the design, implementation, and financing of health programs," specifically for maternal and reproductive health as well as infectious disease programs. It is an indefinite quantity contract with an overall ceiling of $325 million.
- Private Sector Program (PSP) — PSP provides technical assistance and tools to improve financing for private sector provision of health services, and

Signs of Success: Supply side PBF in Rwanda

Performance-based financing is in the process of scaling up to a national level and becoming institutionalized in Rwanda. Starting as pilot schemes — distinct in implementation but common in aim to improve service utilization through supply-side PBF — in three regions in 2001-2005, the government of Rwanda enacted PBF as a national policy in 2005. In Cyangugu, a pilot region, PBF was managed in four phases: planning, service delivery, monitoring and control, and contract renewal.

- *Phase 1, planning:* The fund-holder, an independent entity operating at a district level created to negotiate contracts with providers, monitor output, and disburse performance-based subsidies, worked with management of health care facilities to develop business plans that provided how they could deliver a quality essential health package (preventive, primary care, and curative care) to the catchment population at an affordable cost.
- *Phase 2, service delivery:* The business plan was implemented: the provision of services to the population.
- *Phase 3, monitoring and control:* Simultaneously, the fund-holder, district health teams, and CBOs monitored for results of output and quality of care. If more patients used the services within the accepted business plan, the health facility was rewarded with more subsidies.
- *Phase 4, contract renewal:* The final phase involved included reviewing the results on realized output, quality and patient satisfaction, and renegotiating and renewing contracts with facilities.

The initial results of PBF in the pilot regions, although unadjusted for other potential determinants of performance, were promising. In Cyangugu, out-of-pocket expenditures decreased by 62%, respondents declaring that user fee payments had been "catastrophic" decreased by 72%, and births attended by skilled health care personnel increased by 144%.

— Sources: Health Systems 20/20, 2007; Logie, et al., 2008; Soeters, et al., 2006

reduce financial barriers to access, specifically for reproductive health and family planning services. It is an indefinite quantity contract with an overall ceiling of $395 million (U.S. Agency for International Development [USAID], 2009).

Currently, USAID's core project addressing issues with health financing systems in developing countries is Health Systems 20/20. Health Systems 20/20 is a Leader with Associates cooperative agreement with an overall ceiling of $125 million. The project's principal objective in health financing is to ensure that financial barriers do not prevent people from seeking needed health services, and that health services are delivered effectively, efficiently, and equitably among targeted populations (Health Systems 20/20, 2009). This includes:

- Addressing ineffective incentives faced by providers to provide high-quality health services via improved provider payment mechanisms, performance-based financing (see box on previous page), conditional cash transfers, accreditation, and strengthened management information systems;
- Tracking health expenditures via National Health Accounts (see box on page 28) and informing policy makers' decisions for health resource allocation;
- Reducing financial barriers and promoting equitable access to health services via community-based health financing, social health insurance, and improved targeting of subsidies;
- Improving financial flows to priority services (via cost and cost-effectiveness analysis to address the mobilization and allocation of financing);
- Leveraging opportunities from partners and donors (President's Malaria Initiative, GAVI Alliance, PEPFAR, Global Fund to Fight AIDS, Tuberculosis and Malaria, etc.) to optimize health resources and reduce financial barriers to the use of health care (Health Systems 20/20, 2009).

PEPFAR. The President's Emergency Plan for AIDS Relief is a U.S. government initiative to fight the global HIV/AIDS pandemic. It has three core components: prevention, care, and treatment. PEPFAR funds are used to finance USAID programs (as well as other USG agencies) that address HIV/AIDS, tuberculosis, and malaria. This includes but is not limited to programs that aim to strengthen health systems such as service delivery, health workforce, information, and supply chain. Since its inception in 2003, $18.6 billion has been committed to HIV/AIDS programs through PEPFAR, and in July 2008, PEPFAR was renewed and expanded to a $48 billion commitment through 2013 (Office of U.S. Global AIDS Coordinator, et al., 2009).

GAVI Alliance. The GAVI Alliance is an alliance between stakeholders in both the public and private sectors — including developing country and donor governments, the World Health Organization (WHO), UNICEF, the World Bank, and the Gates Foundation — that works to reduce child morbidity and mortality through expansion of childhood vaccination programs. GAVI's efforts are considered critical to achieving the Millennium Development Goal on child health. To receive funding, recipient countries must develop, submit, and receive approval of a formal plan to initiate and/or expand national immunization programs and gradually increase domestic funding to ensure sustainability.

In 2005, based on findings that health systems issues outside of immunizations systems/programs constrained efforts to increase and maintain immunization coverage, GAVI initiated a health systems strengthening program. Country applications for funding under this program must demonstrate alignment with national policy and planning, alignment with health system financial planning, and complement current or planned health system strengthening initiatives. Since its inception in 2000, the GAVI Alliance has received $3.8 billion in contributions from public and private sector donors (GAVI Alliance, 2009).

Performance-based Financing for Health

In many low- and middle-income countries, incentives to achieve desired health outcomes are often limited and ineffective on both the *demand* (individuals and households) and *supply* (providers) side of health care.

Supply side — At the *health care facility level*, budgets are often justified by the cost of inputs (equipment, staff, etc.) and not results. This provides no incentive to expand coverage or services, or the promotion of low cost health care services (i.e., primary health care). At the *provider level*, providers receive fixed salaries, and increases are not necessarily tied to performance. This enables low productivity, poor quality of care, and/or lack of innovation. Further, if certain services (i.e., curative care) generate higher fees for providers, incentive may be skewed for the provision of such services, and attention diverted away from promotion and provision of preventive and primary care services.

Demand side — Limited household incomes may cause individuals to seek care only when urgent (i.e., curative care) and forgo preventive and primary care services.

Performance based financing (PBF) is an approach to purchasing health care services that seeks to address these issues. It is defined as "the transfer of money or material goods conditional on taking a measurable action or achieving a predetermined target" (HS 20/20, 2007). PBF aligns resource use with results — payment is made for inputs and health outputs and outcomes. Consequently, as payment is made only after outputs and outcomes are verified, it imposes a financial risk on the targeted population (providers and/or households) for noncompliance.

— Sources: Health Systems 20/20, 2007; Logie, et al., 2008; Soeters, et al., 2006

Global Fund. The Global Fund to Fight AIDS, Tuberculosis and Malaria is a global public/private partnership — between governments, civil society, the private sector, and affected communities — committed to attracting and disbursing — via grants — funds to address HIV/AIDS, tuberculosis and malaria. It is now managed as an autonomous organization (formerly managed under the WHO) and serves as a financing mechanism rather than an implementing agency, working closely with bilateral and multilateral organizations to supplement their existing efforts — including those to strengthen health systems and infrastructure — to address these diseases. The Global Fund provides initial funding based on technical quality of applications, and subsequent funding based on performance (i.e., results achieved). Since its inception in 2002, the Global Fund has committed $11.4 billion to more than 550 grants in 136 countries (as of December 2008) (The Global Fund, 2009).

World Bank. The World Bank provides more than $20 billion in assistance to low- and middle-income countries each year. Funding is generally provided through two mechanisms: loans and indirectly through debt relief. Receipt of a loan is contingent on recipient country development of a formal poverty reduction strategy (embodied in a poverty reduction strategy paper). Health considerations (and systems development) are typically a component of the overall poverty reduction strategy. Provision of loans in this

manner is intended to strengthen country ownership, focus country programs on poverty reduction, improve recipient country governance and accountability, and strengthen priority setting (Gottret and Schieber, 2006, p. 14).

DFID. The British Department for International Development (DFID) maintains bilateral and multilateral aid programs, which include projects that address health financing systems. DFID provided approximately £4.9 billion via these mechanisms in 2006-2007. Through its bilateral programs, DFID also provided £461 million in budget support to low- and middle-income countries (DFID, 2008). As discussed earlier, in general budget support, funds from donors are given directly to the country's Ministry of Finance rather than the Ministry of Health. The decision about how such funds will be distributed between the health and other sectors rests with the Ministry of Finance, which in turn consults with DFID (and other donors providing general budget support) and relevant domestic government agencies to determine how funds will be utilized.

Understanding National Health Accounts

National health accounts (NHA) are an assessment "tool for summarizing, describing, and analyzing the financing of national health systems" (PHRplus, 2003). Their core purpose is to enable better use of health financing information to improve health system performance by informing health policy dialogue, resource allocation, policy and program design and implementation, and monitoring and evaluation of intervention performance. They provide data on health spending — public, private, and donor — and in essence monitor the flow and use of these resources through a county's health system — from the central government (and/or Ministry of Health) to each health care provider and health service. The accounts are designed to capture information on the main functions of health care financing: revenue collection and allocation, pooling of funds (or risk), and purchasing of care. Specifically, national health accounts provide answers on the following:

- Who pays for health care, and how much they spend on what types of services
- How funds are distributed across different health services
- Who benefits from health expenditures

The NHA framework is flexible — it can be set up to analyze expenditure data on targeted populations, such as children under 5, or disease-specific interventions, such as malaria. However, NHAs do not provide information on sources of government revenues (e.g., tax and nontax revenues, payroll tax contributions, out-of-pocket expenditures, etc.) (Gottret and Schieber, 2006, p. 34). Information generated from NHAs is useful to decision-making processes because it:

- Assesses current use of resources allowing for ready evaluation against performance objectives and benchmarks
- If implemented continuously, allows for tracking of health expenditure trends that can be useful for monitoring and evaluation purposes and for determining financial projections of health system requirements
- When used with non-financial data, such as disease prevalence and service utilization rates, allows policymakers to make sensible decisions.

Because NHA is centered on expenditures, it is also important to understand the definition and boundaries — geographic and time — of health expenditures. National health expenditure is defined as:

> *"all expenditures for activities whose primary purpose is to restore, improve, and maintain health for the nation and for individuals during a defined period of time" (PHRplus, 2003).*

NHA does not use geographical borders of a country but rather assesses the health expenditures of, and/or for, that country's citizens. It therefore includes expenditure data on citizens who are temporarily abroad, as well as expenditures by international organizations on health for the citizens of a recipient country. NHA further records expenditures in the time period in which the activity takes place, but not necessarily when the actual payment is made. For example, if a hospital stay occurs in 2008 it is recorded for that year, even if the payment is made in 2009. Currently, national health accounts are being used to varying degrees in more than 50 low- and middle- income countries (HS 20/20, 2009).

— Sources: PHRplus, 2003; World Health Organization [WHO], 2009; Gottret and Schieber, 2006; Health Systems 20/20, 2009

SECTION II. FINANCIAL SUSTAINABILITY CHECKLIST

In assessing financial sustainability of health programs it is important to first define what is meant by "sustainability." In the context of a development project (regardless of technical sector), we define sustainability as the capacity of the program's local counterpart(s) to continue to maintain program activities (or desired results of these activities) successfully in the future should the donor assistance for the program be withdrawn. This also includes the requirement that local counterpart(s) be able to expand activities as needed to keep up with increases in demand due to economic and/or population growth (Knowles et al., 1997, p. 39). Program sustainability has programmatic, institutional, and financial dimensions. Here we will examine only the financial dimension, but suggest that both programmatic and institutional factors need to be taken into account and assessed to evaluate true sustainability of a health assistance project.

Based on the three functions of health financing — revenue collection, pooling of resources (or risk), and purchasing —program financial sustainability can be defined as follows:

1. Mobilization of sufficient resources to maintain program activities;
2. Efficient use of resources (i.e., allocative and technical efficiency);
3. Reliability of resource availability (i.e., resources budgeted or allocated are actually spent on the program) (Financing Task Force of GAVI, 2004, p. 5).

The definition above further incorporates an element of time: maintaining the level of resources/funding needed in the long term, and to expand the level of funding over time as needed to meet demand. While self-sufficiency is the ultimate goal, it anticipates progress toward this goal — in this case, increases in domestic funding for health services — will take time and implies a shared responsibility of donor and recipient countries (Knowles et al., 1997).

The checklist presented below considers both health project intervention areas — services and products, policy reform, and capacity building — and sectors in which they may focus — public, private, and civil society. Given the breadth and depth of these categories, numerous checklists to guide evaluation of health programs could be developed. Therefore, we have developed a general guide for evaluation of program financial sustainability and a basic checklist focused on its critical elements, with the idea that it may later be readily adapted to a specific health program, adjusting for country context, program objectives, and stakeholders.

The checklist and suggested indicators for measuring and evaluating the financial sustainability of a program were adapted principally from the Health Systems 20/20 health systems assessment tool and the GAVI Alliance guidelines for preparing a national immunization program financial sustainability plan. The checklist and indicators require data that are relatively accessible, either in widely available secondary sources or available locally, and attempt to align with common definitions across countries or in

host country documents. The applicability of the suggested indicators may depend on the level — national, regional or community — at which the project operates. For example, the questions here presume a public sector focus. In some projects, the indicators may need to be adapted to include private sector funding, or a combination of public and private sector financing. Proposed indicators for evaluating the financial sustainability of a health program are the following:

Resource mobilization: these indicators provide information on the ability or likelihood of government to assure responsibility for continuing or scaling-up program interventions.

- Percent of total program spending financed by government;
- Percent of total program spending financed by donors and/or public-private partnerships;
- Percent of government health expenditure directed to the program/project/area of interest (Financing Task Force of GAVI, 2004; Health Systems 20/20, 2007).

Effective use of resources: these indicators provide information about the ability of the donor or eventually the recipient government to get the best value from the program costs.

- Actual program expenditure (per program component) as a percent of total program budget;
- Plan established to set aside or allocate funds to replace, maintain or upgrade capital items (or recurrent costs) essential to the program (Financing Task Force of GAVI, 2004; Health Systems 20/20, 2007).

Reliability of resources: these indicators provide information on the likelihood of a program being continued or expanded over the medium- and long-term.

- Program recurrent expenditures paid for with national resources within the past fiscal year divided by total program-specific expenditures;
- Program recurrent expenditures paid for with external resources (donor and/or public-private partnerships) within the past fiscal year divided by total program-specific expenditures;
- Donor actual expenditure expressed as a percentage of the gap between total estimated costs required and expected national/domestic expenditures;
- Multi-year financial plan developed that demonstrates what funds are expected to be spent and from where the funds are expected to come (Financing Task Force of GAVI, 2004; Health Systems 20/20, 2007).

Checklist for Evaluation of Health Programs

Key Questions	Notes/Comments
Project costs and national and local budgeting	
1. What are the components of the project with short-, medium-, and long-term financial implications?	Do health projects centered on services and products and/or capacity building typically work with local counterparts that maintain budgets for procurement, service delivery, staff training, etc.? For projects with a policy reform component, do policies consider mobilization of resources, efficiency in use of resources, and reliability of resources required to implement the policies?
2. Does the project develop an exit strategy in collaboration with counterpart organizations? If so, are there financial considerations and what are they?	Under what national or local budget(s) will the program be incorporated (i.e., local, national, disease-specific)? Are there specific line items in public or private sector organizational budgets to cover costs associated with project related services or procurements? How will recurrent costs be funded?
Resource mobilization	
3. How are resources for the program obtained by local counterparts?	What is the source and composition of the funds obtained by local counterparts for the program? For example, are resources garnered principally from government budgets, donors, public-private partnerships, etc., and if a mix, how much is provided through each source? Are the sources short-, medium- or long-term commitments?
4. What financial planning process is used by the local counterpart for the program?	Is there a process established? If so, does it involve all funders? What time period(s) does the financial plan cover (i.e., one year, multiple years, etc.)? Are there line items in the national budget to cover program recurrent costs?
Efficient use of resources (pooling component)	
5. What is the process or structure for allocating resources to and/or within the program?	What criteria are required/used for determination and approval of budgets? Is there an evaluation process to assess whether the budget is allocated appropriately to achieve program goals (short- and long-term)?
6. How is allocation and use of resources monitored?	For example, is there an accounting system where expenditures can be disaggregated by program components? Does it fit within government priorities? Is there a budgetary line item to secure continuous funding?
Reliability of resources (purchasing component)	
7. What are the actual program costs relative to coverage attained?	This assesses whether program funds have been expended relative to achieving coverage and quality results. Analyzing actual expenditures will help determine unit costs. Sustainability is often dependent on the ability to lower unit costs either through economies of scale or finding more efficient way of implementing program components, such as training, procurement, etc.
8. If funds are obtained from external sources (donors or public-private partnerships), what is the length of commitment for funding by these sources? How much have they committed over this time period?	This assesses the predictability and potential volatility of future resources. It also may identify whether and how much additional domestic resources may need to be generated to maintain the program in the long term.

SECTION III. INCLUDING FINANCIAL SUSTAINABILITY IN PROGRAM DESIGN TASKS

Based on the checklist provided in the previous section, we present here a planning tool to incorporate financial sustainability considerations into procurement documentation. The checklist and planning tool are intended as a guide for modeling a health program that offers the likelihood of achieving financial sustainability given the existing pre-conditions in the recipient country.

Project objectives are the basis for determining how much is needed to finance a project and how that financing should be structured. However, such objectives may need to be adjusted to mesh with financial realities. As a result, defining objectives and determining the right financing strategy should be linked in designing a project (Financing Task Force of GAVI, 2004, p. 1). In determining financial sustainability, it may also be important to consider the levels of governance within a country (national, regional, municipal, etc.) at which the project will operate to ensure that future funding will be adequate and reliable (Financing Task Force of GAVI, 2004, p. 2). The GAVI Alliance has done a significant amount of work in analyzing financial sustainability of proposed projects. To receive funding from the GAVI Alliance, countries must develop a financial sustainability (FS) plan for the program they are proposing. The GAVI Alliance reviews the FS plan and approves provision of funding only if the plan meets certain criteria. We present below an overview of the processes required to develop a FS plan for programs funded by the GAVI Alliance. From this overview we extract 4 planning steps that guide inclusion of financial sustainability considerations into USAID's health-focused procurement documentation.

A Two-Way Street

- Financing strategies are based on program objectives.
- Program objectives take into consideration financial realities.

— *Source:* Financing Task Force of GAVI, *2004, p. 1*

The FS plan, as part of the application for funding from the GAVI Alliance, is a stand-alone document "that assesses the key financing challenges facing the national immunization program, and describes the government's approach to mobilizing and effectively using financial resources to support medium- and long-term program objectives" (Financing Task Force of GAVI, 2004, p. 4). It is to be prepared by the national government (the Ministries of Health and Finance collaboratively), with members of other stakeholder groups (donors, civil society groups, etc.) as relevant. The FS plan should be part of the broader strategic planning processes for the health sector, building on and contributing to setting both national and health sector priorities and establishing mechanisms to finance those priorities (GAVI Alliance, 2004). The intent of the FS plan is not to divert government funding to fully finance immunization program(s) at the expense of other critical health programs, but rather to support immunization program(s) within the context of best possible use of health sector resources (Financing Task Force of GAVI, 2004). The FS Plan has three major components:

- *Diagnosis.* A systematic analysis of the current and future financing situation. This includes assessment of:

— *Key financing challenges and opportunities in the context of both the country and health system*. This takes into account: macroeconomic growth prospects; debt relief prospects; government commitment to social sectors overall and health programs; health sector organization and any financing changes that may affect the immunization program; financial role of donor agencies; and constraints associated with the budgeting, procurement, disbursement, and reporting systems;
— *Current program costs and sources of financing*. This includes: total program costs; total program cost as a share of total government health spending; total program cost as a share of total government health spending plus total donor support; and share of financing by government and major external funders;
— *Projected gap in financing during and after removal of the commitment from the GAVI Alliance*. This includes total future cost and total future funding, total projected funding gap, by year, through and after the end of the commitment from the GAVI Alliance (Financing Task Force of GAVI, 2004, p. 8).

- *Strategic Plan*. A detailed strategy to achieve financial sustainability as the program develops, with specific, time-bound short- to medium-term actions to be taken by the government and external stakeholders, and indicators (a few key indicators that link to main strategies) to monitor progress(Financing Task Force of GAVI, 2004, p. 8).

- *Comments*. Statements garnered from key stakeholders regarding their view of the FS Plan (Financing Task Force of GAVI, 2004, p. 8).

The processes used by the GAVI Alliance highlight considerations for planning the financial sustainability of an assistance program. Based on GAVI's experience and the evaluation checklist, we propose the following process for incorporating financial sustainability considerations into procurement documentation for USAID health projects.

A. Step 1 — Situational Analysis

Along with identifying and prioritizing the problem(s) affecting the population (or segment(s) of the population) that the project will target, conduct an analysis of the current and future financing situation of the program (from the counterparts' perspective).

According to the Financing Task Force of GAVI (2004), there are four basic aspects to consider in this context: "How much does it cost to achieve program objectives? How much funding is available now and in the future relative to what is required for program establishment, improvement, and expansion? How do the funds currently flow from source to the eventual use? How are the funds used?" (Financing Task Force of GAVI, 2004, p. 1). Specifically, in determining financial sustainability of a health program, the following may be assessed:

- Resource mobilization (what does it cost to achieve objectives and how much is available now?)
  — What (and/or how much/many) resources are needed to address the problem?

— What resources are currently being provided to address the problem and from whom and how are they being provided?
— Are the allocated resources sufficient to address the problem? (Financing Task Force of GAVI, 2004, p. 1)

- Efficient use of resources (how do funds flow from the source to eventual use and how are they used?)
  — What mechanisms and processes are utilized for planning and allocation of resources?
  — Are the current resources provided being used efficiently?
  — Are the current resources provided being allocated where they need to be? (Financing Task Force of GAVI, 2004, p. 1)

- Reliability of resources (how much funding will be available in the future?)
  — What and how do economic (macro- and socio-), political, demographic, and/or epidemiological conditions affect the availability of funding?
  — If domestic funding is being used to address the problem, what percentage of the total funding used does it constitute?
  — If external (donor and/or private) funding is being used, what percentage of the total funding used does it constitute? For what time period have external funding been committed? What are the financial planning processes used by the local counterpart for the program (is the program part of and/or included in a short-term, medium-term, long-term financial plan)? (Financing Task Force of GAVI, 2004, p. 1)

B. Step 2 — Stakeholder Analysis

Identify and assess the importance of key people, groups, and institutions (both domestic and external) that may notably influence the success of the proposed project (Electronic Resources Center, Management Sciences for Health, 2009).

In conducting this analysis consider the benefit(s) to the stakeholder(s) of the proposed project, changes the project would require the stakeholder to make, and potential harm or conflict the project could cause the stakeholder. Further, assess the importance of the stakeholder's interests to the success of the proposed project, i.e., the role the key stakeholder must play for the project to be successful, and the likelihood that they would take on this role (Electronic Resources Center, 2009). In the context of program financial sustainability, identify roles needed among stakeholders (including donors) to: 1) mobilize project resources; 2) improve program efficiency to minimize need for additional resources; and 3) increase the reliability of resource availability. With the results of this analysis, develop strategies to garner support and mitigate obstacles for implementation of the proposed project.

C. Step 3 — Participative Planning

Organize planning sessions among key stakeholders to develop and define the objectives and scope of the project, and garner stakeholder buy-in.

Although it is presented here as a distinct step, it is important to recognize that participative planning is a component of conducting both a situational and stakeholder analysis. Involving those directly and indirectly affected by the project in project design may: 1) strengthen the information upon which the project objectives and scope are founded and designed, and 2) increase stakeholder awareness and support of the proposed project. Participants may contribute to the development of strategies to address issues of resource mobilization, allocation and use, and reliability of availability.

D. Step 4 — Financial Performance Monitoring

In designing the proposed project and incorporating strategies for program financial sustainability based on the results of the above analyses and planning activities, include in the design how progress toward financial sustainability will be measured and monitored.

As discussed in the situational analysis, the program design should build into the implementation plan regular monitoring functions that address:

- Resource requirements
- Available financing
- Financing gaps
- Short- to medium-term resourcing that could be addressed by stakeholders

It is also critical that the design incorporate financial sustainability indicators. Both process and outcome indicators should be considered — such as those recommended with the evaluation checklist. The indicators should link to the sustainability strategies and exit plan(s) of the project.

SECTION IV. CONCLUDING REMARKS

The framework in this brief focuses on the three key health care financing functions: revenue collection, risk pooling, and purchasing. In review of current literature on the above functions and the mechanisms through which they are implemented, important themes and issues arise that need be considered in development of assistance programs in health:

- Improving and expanding health care coverage for a country's population requires that the financing mechanisms employed result in the collection of sufficient revenue to cover health care costs, pool revenue in an efficient and equitable manner, and efficiently purchase appropriate health care services. Multiple financing mechanisms can be utilized concurrently to achieve universal coverage. However, if multiple mechanisms are used it is important that they are integrated to allow for maximum pooling of risk. Highly fragmented financing mechanisms reduce this pooling potential and may leave individual mechanisms vulnerable to solvency issues.
- In assessing financial sustainability, health care costs have to be affordable for the country and the individual. Therefore, it is important to not only think about the costs, but also to determine how expansion of services will impact costs in the long-term. In this context, it is important to promote and include primary health care services in benefits packages. Coverage of primary care services lends to increased utilization, most notably among the poor and near poor populations. Further, investments in preventive and primary health care services improves health status and lowers overall health care costs by dependence on more expensive secondary and tertiary care.
- In order to meet the Millennium Development Goals in health, donors will need to commit billions of dollars in additional development assistance. Recent increases in financial assistance have not matched recipient countries' ability to effectively absorb and manage the funds that have been made available, or they may distort systems in ways that may not be sustainable. Donor assistance is often unpredictable, volatile, and misaligned with the recipient country's priorities and/or budget processes. For assistance to be effective, donors must be willing to make more flexible, long-term commitments that align with the recipient country's development priorities, and recipient countries must improve capacity and accountability in managing external funding (Gottret and Schieber, 2006, p. 14).

This framework for analyzing health financing can also serve as a framework for the evaluation of financial sustainability of assistance programs in health. Assistance programs, depending on structure, directly or indirectly feed into, and their long-term sustainability depends on, the health financing systems of recipient countries.

Systematic analysis of financial sustainability issues should also figure into health program design as a means of addressing financial sustainability. However, just as there is no "magic bullet" to solve health financing issues in developing countries, there is also no one design that will readily enable assistance programs to achieve financial sustainability (McIntyre, 2007, p. 2). Macroeconomic growth prospects, debt relief prospects, government commitment to health programs, health sector organization, the

financial role of donor agencies, and constraints associated with the recipient country budgeting, procurement, disbursement, and reporting systems all affect the availability of resources for health programs. Program designers must consider project financial sustainability in the context of these issues to determine resources availability in both the near- and long-term.

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ANNEX B. RESOURCES

Recommended Literature

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Health Systems Assessment

Islam, M., ed. (2007). *Health Systems Assessment Approach: A How-To Manual*. Submitted to the U.S. Agency for International Development in collaboration with Health Systems 20/20, Partners in Health Reform*plus*, Quality Assurance Project, and Rational Pharmaceutical Management Plus. Arlington, VA: Management Sciences for Health.

Recommended Web Sites

The World Health Organization (WHO) (www.who.int/health_financing/en/)
The World Bank (www.worldbank.org)
Health Systems 20/20 (www.hs2020.org)
ELDIS (www.eldis.org/healthsystems/financing/)
PubMed (www.ncbi.nlm.nih.gov/pubmed)
id21 (www.id21.org/health/index.html)
Diseases Control Priorities Project (www.dcp2.org)

Country-level Data Sources on Health Financing

Health Systems 20/20 Database (http://healthsystems2020.healthsystemsdatabase.org)
WHO Statistical Information System (www.who.int/whosis/en/)
World Bank (www.worldbank.org)

ANNEX C. GLOSSARY

Sources for terms are the European Observatory Glossary, McIntyre 2007, and USAID.

Accreditation. The process by which an authorized agency or organization evaluates and recognizes an institution or an individual according to a set of "standards" describing the structures and processes that contribute to desirable patient outcomes.

Allocative efficiency. The allocation of resources preferentially to health services providing care for those aspects of ill-health for which effective interventions exist and which are most common in the community being served, with priority given, among those preferential services, to the most cost-effective interventions, i.e., interventions offering the lowest cost per unit of health outcome.

Basket fund. The pooling of funds provided by government and donors into a single basket, which is then used to implement public sector health services in accordance with a strategic plan agreed by all contributors to the basket.

Breadth and depth of coverage. *Breadth of coverage:* the proportion of the total population covered by health insurance; *depth of coverage:* the composition of the health insurance benefit package — the more comprehensive the package, the greater the depth of coverage.

Capitation fee. Usually, a negotiated payment paid for an agreed period of time by an insurance scheme to a health care provider per person who is covered by the scheme and receives health care from the provider.

Catastrophic event. An episode of acute illness or a long-term illness that requires unexpected health care so costly as to risk impoverishing a household.

Catastrophic expenditure. Expenditure at such a high level as to force households to reduce spending on other basic goods (e.g., food or water), to sell assets or to incur high levels of debt, and ultimately to risk impoverishment.

Centralization. The concentration of managerial functions at one point within the system.

Civil society. A collective term for nongovernmental, mostly nonprofit groups (civic, educational, trade, labor, charitable, media, religious, recreational, advocacy, etc.) that help their society at large function while working to advance their own or others' well-being.

Cream skimming or risk selection (sometimes called "cherry-picking"). The practice whereby an insurance scheme enrolls a disproportionate percentage of individuals (e.g., young people) who present a lower than average risk of ill-health.

Community-based health insurance (also called "community-based prepayment scheme" or "community health fund"). An insurance scheme to which members of a local, often rural but also peri-urban, community pay a small contribution and which then pays the fees charged by local health services.

Copayment out-of-pocket. Partial payment by a health insurance member for health services used in addition to the amount paid by the insurance. The aim is to place some cost burden on members and thereby discourage them from excessive use of health services.

Cross-subsidy. Can be income or risk. *Income cross-subsidy*: whereby the wealthy make greater contributions to health care funding than the poor but all have access to the same range of health services *Risk cross-subsidy*: whereby people with a greater need for health care (i.e., high-risk individuals) are able to use more health services than those who are healthy (i.e., low-risk individuals), irrespective of the contribution made by each group.

Decentralization. Changing relations within and between a variety of organizational structures/ bodies, resulting in the transfer of the authority to plan, make decisions or manage public functions from the national level to any organization or agency at the subnational level. Decentralization can take various forms; the main ones are de-concentration, devolution, and delegation as well as privatization.

Earmarked Taxes. Taxes collected with the express purpose of using them for health care.

Equality. Principle by which all persons or things under consideration are treated in the same way.

Equity. Principle of being fair to all, with reference to a defined and recognized set of values.

Externality. The result of an activity that causes incidental benefits (desirable effects) or damages (costs, pollution) to others with no corresponding compensation provided or paid by those who generate the externality.

Fiscal space. "Room" or leeway within the government budget to direct resources to a specific activity that the government regards as important, without jeopardizing the sustainability of the government's overall financial situation.

Formal sector. The official sector of the economy, regulated by society's institutions, recognized by the government and recorded in official statistics (see also informal sector, below).

Fund pooling. Accumulation of prepaid health care revenues, such as health insurance contributions, that can be used to benefit a population. The aim is to share risk across the

population so that unexpected health care expenditure does not fall solely on an individual or household, with sometimes catastrophic consequences.

General budget support (or budget support). Financial support through donor funds that are all given to a country's Ministry of Finance rather than directly to the Ministry of Health. The ultimate decision about how the funds should be distributed between the health sector and other sectors rests with the Ministry of Finance. The resources, which are not tied to specific donor projects, support achievement of agreed-upon goals and objectives and are intended to activate and nurture host-government allocation, procurement, and accounting systems. *General budget support* is provided to a country's budget as a whole; *sector budget support* is provided to the budget of a specific sector.

General taxes. Direct taxes such as company and personal income tax, indirect taxes such as value added tax (VAT) (see below) or general sales tax (GST) (see above), and customs and excise duties.

Health insurance. A mechanism by which money is raised to pay for health services by financial contributions to a fund; the fund then purchases health services from providers for the benefit of those for whom contributions are made or who are otherwise covered by the scheme.

Informal sector. The unofficial sector of the economy in which income and the means used to obtain it are unregulated, and which coexists within a legal and social environment where similar income-producing activities are regulated. In the informal sector, labor relations, where they exist, are based mostly on casual employment, kinship, or personal and social relations rather than on contractual arrangements with formal guarantees (see also formal sector, above).

International financing. Institutions and organizations such as the World Bank and the International Monetary Fund that are multilateral (i.e., have a mandate from, and interact with, many governments) and that deal with financial issues.

Low- and middle-income countries. In 2007, low-income countries were classified by the World Bank as countries with a per capita gross national income (GNI) of US$ 935 or less and middle-income countries as those with a per capita GNI of US$ 936 to US$ 11,455.

Mandatory (or social) health insurance. A health insurance scheme to which certain population groups or the entire population must belong by law. Such schemes, which imply income and risk cross-subsidies (see above), are founded on the principle of social solidarity, whereby individuals contribute to the insurance according to their ability to pay (or their income) and benefit from coverage according to their need for health care.

Medium-term expenditure framework. A system of three-year (or longer term) rolling budgets (see below) which creates a predictable medium-term planning environment, gives the health sector an advance indication of allocations likely to be made over the

next few years, and thus allows policy development and implementation to be linked with resources over time.

Moral hazard. A tendency of entitlement to the benefits of health insurance to act as a strong incentive for people to consume more and "better" health care and a weak incentive for them to maintain a healthy lifestyle.

Multilateral debt relief initiative. An initiative to fully cancel the debt owed by some countries to international financing institutions (see above).

Mutual health insurance. See community-based health insurance (prepayment scheme), above.

National health accounts. Information, usually in the form of indicators, a country may collect on its health expenditures. Indicators may include total health expenditure, public expenditure, private expenditure, out-of-pocket expenditure, tax-funded and other public expenditure, social security expenditure, and public expenditure on health.

National health insurance. A mandatory health insurance scheme (see above) that covers all or most of the population, whether or not individuals have contributed to the scheme.

Out-of-pocket payment. Payment made by an individual patient directly to a health care provider, as distinct from payments made by a health insurance scheme or taken from government revenue.

Poverty reduction strategy papers. Documents that are prepared by developing country governments in collaboration with the World Bank, the International Monetary Fund, civil society, and development partners that set out a national strategy for promoting growth and reducing poverty and that specify the policies, programs, sources of financing, and external financing needed to implement the strategy. Poverty reduction strategy papers are needed by countries seeking to obtain debt relief under the Heavily Indebted Poor Countries Initiative.

Premium. A flat-rate payment for voluntary insurance. Premiums can be differentiated by age (at the time of entry into the scheme), sex, and pre-existing illnesses of insured persons, calculated upon the present value of the expected cost that an insured person is likely to incur or community-rated.

Prepayment funding. Payments made by individuals via taxes or health insurance contributions before they need to use a health service. Prepayment contributions are pooled (see fund pooling above).

Primary health care. The first level contact with people taking action to improve health in a community. In a system with a gatekeeper, all initial (non-emergency) consultations with doctors, nurses, or other health staff are termed primary health care, as opposed to

secondary health care or referral services. In systems with direct access to specialists, the distinction is usually based on facilities, with polyclinics, for example, providing primary care and hospitals secondary care.

Progressive (or equitable) contribution mechanism. A financing mechanism whereby high-income groups contribute a higher percentage of their income than do low-income groups.

Progressive tax. A tax in which the rich pay a larger fraction of their income than the poor.

Proportional contributions. A financing mechanism, whereby everyone contributes the same percentage of income to a health insurance scheme, irrespective of income level.

Regressive contribution. A financing mechanism whereby low-income groups contribute a higher percentage of their income than high-income groups.

Regressive tax. A tax in which the poor pay a larger fraction of their income than the rich.

Reinsurance. An insurance for insurers. In the case of health insurance, a process whereby several small health insurance schemes can transfer the risk of unexpectedly high health care expenditure (or of adverse selection, see above) to a single insurer (a "reinsurer").

Risk-adjusted capitation. A per capita (or per person) amount of money paid to a health care provider that is based on a person's likelihood, or risk, of requiring health care (judging from indicators of risk, such as age, gender, and the presence of chronic disease).

Risk-adjusted, or needs-based, resource allocation. The allocation of resources among several geographic areas (in the case of general tax-funded services) or individual insurance schemes (in the case of a mandatory health insurance system) based on the relative need for health care or the risk of incurring health care expenditure (based on indicators such as age, gender, and morbidity profiles) (see needs-based formula above).

Risk equalization. A mechanism whereby revenue accruing from contributions to several health insurance schemes or health funds acting as financing intermediaries (i.e., organizations that receive contributions and pay health care providers) for a social health insurance system is pooled and the individual schemes allocated an amount that reflects the expected costs of each scheme according to the overall ill-health risk profile of its membership (calculated on a risk-adjusted capitation basis, see above).

Risk pooling. Risk sharing across a group of people or across the entire population, so that unexpected health care expenditure does not fall solely on an individual or

household, and that individuals and households are protected from catastrophic expenditure (see above).

Secondary health care. Specialized ambulatory medical services and commonplace hospital care (outpatient and inpatient services). Access is often via referral from primary health care services. Does not include highly specialized, technical inpatient medical services (which is tertiary health care).

Sector-wide approach (SWAp). A mechanism for collecting funds to support a health policy and expenditure program that is implemented and managed by the government through a common approach across the health sector. The aim is to increase the coordination and efficiency of development aid and prompt beneficiary governments to take the leadership in strategy formulation and policy implementation.

Social health insurance. A mandatory health insurance (see above) to which only certain groups are legally required to subscribe or which provides benefits only to those who make insurance contributions.

Subsidy. A payment made by the government with the objective of reducing the market price of a particular product, or of maintaining the income of the producer.

Sustainability. The capacity to meet the needs of the present without compromising the ability to meet future needs.

Technical assistance. The provision of know-how in the form of personnel, training, and research, along with support for associated costs, to augment the technical knowledge, skills, or productive capacity of the recipient country.

Technical efficiency. A measure of the maximum number of health services that can be provided within a specific budget or a measure of the lowest cost needed for each health service to function without compromising quality of care (see allocative efficiency, above).

Tertiary health care. Refers to medical and related services of high complexity and usually high cost. Those referred from secondary care for diagnosis and treatment, and which is not available in primary and secondary care. Tertiary care is generally only available at national or international referral centers.

Transaction costs. The costs that are incurred by the process of negotiating between buyer (the third-party payer/ purchaser) and seller (the provider). Transaction costs, for example, include drawing up contracts, etc.; these reduce the profitability of doing business in that market.

Total expenditure on health. Total (or national) expenditure on health is based on the following identity and functional boundaries of medical care: Personal health care services + Medical goods dispensed to outpatients = Total personal expenditure on health + Services of prevention and public health + Health administration and health insurance =

Total current expenditure on health + Investment into medical facilities = Total expenditure on health. Another formula is: Total expenditure on health = Private health care expenditure + Public health care expenditure.

Under-the-table payments (**also called "envelope payments").** Informal, unofficial payments that are usually prohibited so as to have one's wishes/demands/needs fulfilled in a timely manner/to a larger extent than by following the official rules and regulations.

Universal coverage. A health system that provides all citizens with adequate health care, regardless of their employment status or any other factors.

User fee/charge. A fee charged at the place and time of service use within a public health facility and paid on an out-of-pocket basis (see above). Charges imposed on health services or drugs may be used to recoup the cost of providing the services and to influence demand for these products. They may also be used as a tax with the objective of raising revenue for government investment. User charges do not necessarily reflect the cost; the term is usually reserved for situations in the absence of health insurance (otherwise they are called copayments).

Voluntary health insurance. A health insurance to which an individual or group can subscribe without a legal requirement to do so. Voluntary insurance is usually purchased from private insurance organizations, although in some cases it may also be purchased from public or quasi-public bodies. Besides out-of-pocket expenditure, expenditure for voluntary health insurance is the major component of private health expenditure. *"Top-up" voluntary health insurance*: a voluntary health insurance scheme that covers the costs of services not funded from tax revenue or not covered by a mandatory insurance scheme providing a specified package of health services that is not comprehensive.

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