Review

Reprioritizing government spending on health: pushing an elephant up the stairs?

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ABSTRACT

Countries vary widely with respect to the share of government spending on health, a metric that can serve as a proxy for the extent to which health is prioritized by governments. World Health Organization (WHO) data estimate that, in 2011, health's share of aggregate government expenditure averaged 12% in the 170 countries for which data were available. However, country differences were striking: ranging from a low of 1% in Myanmar to a high of 28% in Costa Rica. Some of the observed differences in health's share of government spending across countries are unsurprisingly related to differences in national income. However, significant variations exist in health's share of government spending even after controlling for national income. This paper provides a global overview of health's share of government spending and summarizes some of the key theoretical and empirical perspectives on allocation of public resources to health vis-à-vis other sectors from the perspective of reprioritization, one of the modalities for realizing fiscal space for health. The paper argues that theory and cross-country empirical analyses do not provide clear-cut explanations for the observed variations in government prioritization of health. Standard economic theory arguments that are often used to justify public financing for health are equally applicable to many other sectors including defence, education and infrastructure. To date, empirical work on prioritization has been sparse: available cross-country econometric analyses suggest that factors such as democratization, lower levels of corruption, ethnolinguistic homogeneity and more women in public office are correlated with higher shares of public spending on health; however, these findings are not robust and are sensitive to model specification. Evidence from case studies suggests that country-specific political economy considerations are key, and that results-focused reform efforts – in particular efforts to explicitly expand the breadth and depth of health coverage as opposed to efforts focused only on government budgetary benchmarking targets – are more likely to result in sustained and politically feasible prioritization of health from a fiscal space perspective.

Key words: fiscal space, government health expenditure, political economy, prioritization, universal health coverage

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INTRODUCTION

Countries vary widely with respect to the share of government spending on health, a metric that can serve as a proxy for the extent to which health is prioritized by governments. World Health Organization (WHO) data estimate that, in 2011, health's share of aggregate government expenditure averaged 12% in the 170 countries for which data were available.[1] However, country differences were striking: ranging from a low of 1% in Myanmar to a high of 28% in Costa Rica (see Figure 1). Even within the WHO South-East Asia Region, health's share of aggregate government expenditure ranges from 14% in Thailand to 1% in neighbouring Myanmar.

Some of the observed differences in health's share of aggregate government expenditure across countries are unsurprisingly related to differences in national income: cross-country comparisons show that higher-income countries generally spend a larger share of aggregate government expenditure on health. Health-care costs tend to be higher in richer countries, driven by relative-price differences as well as the availability of higher-technology care, among other factors.

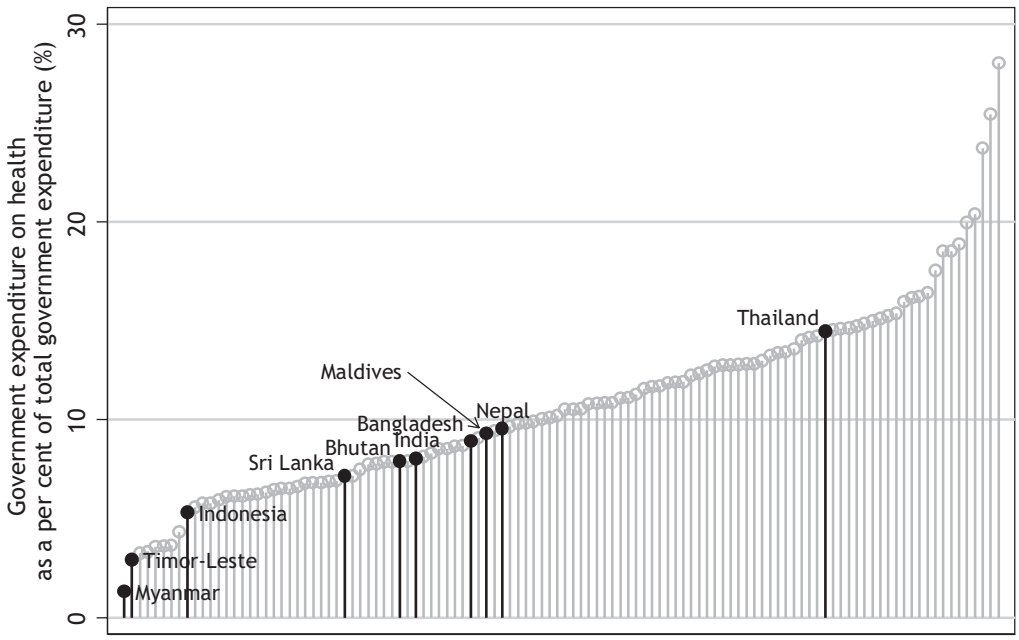

Figure 1: Government expenditure on health as a percentage of government expenditure, 2011

Countries with a population of less than 250 000 have been excluded.

Source: World Health Organization Global Health Expenditure Database.[1]

Richer countries also tend to have more educated and ageing populations with a preference structure that expects higher levels of public financing for social protection programmes. Higher costs of and more demand for publicly financed health care – combined with a greater fiscal and institutional ability to do so – are some of the reasons why governments tend to spend a greater share of aggregate expenditures on health as countries become richer. However, significant variations exist in health's share of government spending even after controlling for national income.

This paper provides a global overview of health's share of aggregate government expenditures and summarizes some of the key theoretical and empirical perspectives on why some governments spend more (or less) of public resources on health than others from the perspective of reprioritization, one of the modalities for realizing fiscal space for health. There are a variety of reasons why a focus on reprioritizing health's share of government spending is important and merited from a fiscal space angle. Foremost among these are indications that the sector is under-resourced and that additional public financing for health is key for many low- and middle-income countries wanting to improve the levels and distribution of population health outcomes (including the Millennium Development Goals [MDGs]), reduce out-of-pocket (OOP) spending for health, and attain and sustain universal health coverage (UHC) for their citizens. In addition, ageing populations and the rising incidence of noncommunicable diseases (NCDs) are impending challenges that will imply higher levels of health expenditures across developing countries. In many countries, lack of government prioritization for health is often perceived to be a major constraint to increasing public financing for health.

REPRIORITIZING HEALTH FOR FISCAL SPACE

Fiscal space can be defined as "the capacity of government to provide additional budgetary resources for a desired purpose without any prejudice to the sustainability of its financial position".[2] Assessing fiscal space for health hence entails an evaluation of the different sources of financing that may be available for increasing government health spending, assuming that a clear case has been made to merit such an increase and the net societal benefits of increasing government health spending are positive. A conducive macrofiscal environment, higher revenues, increased borrowing, seigniorage (inflationary finance) and higher levels of development assistance are all potential sources of fiscal space (not just for health, but for any sector). Each option brings its own costs and benefits. While increasing revenues may ease fiscal constraints, the way they are raised is crucial: regressive, inefficient and excessive taxes can do more harm than good to the overall economy. Similarly, borrowing to finance current spending may seem like a good idea in the short-run, but could become unsustainable over time. External development assistance may ease budget shortfalls in countries that lack the domestic finances to cover the costs of high disease burdens, but it can bring its own

set of negative externalities and inefficiencies. Seigniorage is rarely, if ever, a serious option to consider. Given clearly defined needs, the issue in any fiscal space assessment is one of identifying and assessing feasible, low-cost means of financing additional spending that minimize potential unintended adverse consequences, assuming multiple options have been identified and are available. From a sector-specific perspective, reprioritization implies that the government decides to increase a sector's share of total government spending, preferably at the expense of spending on activities with relatively fewer net societal benefits. Reprioritization is hence the key intermediating link between the overall macrofiscal context of a country and how much a government chooses to spend on health.

Despite recent progress, several low-income countries – especially in sub-Saharan Africa and South Asia – are far from attaining health-related MDGs by 2015.[3] This lack of progress in health outcomes appears even more egregious when one considers the fact that large proportions of child and maternal mortality are easily preventable via well-known cost-effective interventions. One key constraint to the attainment of health outcomes in low-income countries is the lack of adequate financial resources for health, recent increases in development assistance for health notwithstanding.[4] And the MDGs themselves are explicit in acknowledging additional resource needs: included among the targets is a call for developed countries to commit at least 0.7% of their gross national income towards overseas development assistance. The WHO Report of the Commission on Macroeconomics and Health estimated that a minimum of US$ 34 in per capita health expenditures in 2001 prices would be needed in low-income countries to provide a basic package of essential health services.[5] A more recent estimate by the Taskforce on Innovative Health Financing for Health Systems places the number at US$ 54 per capita.[6] However, very few low-income countries spent even these minimal amounts on health in 2011. UHC – the objective of providing everyone access to quality health care when needed, without creating financial hardship as a result – is now an explicit and prominent policy objective in many middle-income countries. For example, countries such as China and Thailand now provide near-universal coverage; others such as Indonesia, Philippines and Viet Nam cover 40–60% of the population. Coverage rates are lower in some lower-income countries, but even they have made progress in removing financial barriers for certain subgroups such as the poor, and for services such as those related to maternal and child health. UHC is also a likely post-MDG international development target. However, while strong policy commitments are evident, the design, organization and delivery systems for attaining UHC vary considerably, and remain a challenge. In particular, financing UHC programmes is a key constraint given the high levels of informality in labour markets, which make it difficult to collect premiums. At present, in many countries the poor are covered by general revenues and the formal sector is financed by contributions, leaving uncovered a large section of the population, consisting mainly of the nonpoor who work in the informal sector. Across many countries, the extent of UHC remains relatively shallow while OOP spending is generally high, even among those with coverage. The fiscal implications of expanding UHC to those still without coverage will largely depend on the extent to which costs are subsidized by governments. Also, governments are likely to face higher costs for supply-side expenditures to improve access to and the quality of care to meet growing demand, as well as to improve services to those already covered. Given the size of the informal sector and supply-side deficiencies, it is estimated that added fiscal resources of 1–2% of gross domestic product (GDP) will be needed to attain UHC targets in many low- and middle-income countries.[7]

In summary, trends and policy commitments – attaining the unfinished MDG agenda, increasing and improving UHC, ageing, the rise of NCDs – are increasing fiscal pressures for health spending across developing countries. Reprioritization (combined with donor financing in low-income countries) will be necessary to address the fiscal space for health challenge, and that contributions from other modalities including general revenue increases, additional borrowing and inflationary financing are likely to be minimal at best.[8,9] Making the case for reprioritization is also one of the key challenges faced by ministries of health, especially when dealing with ministries of finance, given that health is often perceived to be an unproductive and inefficient sector. The following sections provide an overview of the theoretical and empirical landscape on reprioritization for health to inform and motivate policy debates related to this issue.

REPRIORITIZING HEALTH: THEORETICAL PERSPECTIVES

Several theoretical approaches, gleaned primarily from the field of economics, address the role of government in economy and society. These approaches can be divided broadly into two approaches: a normative approach and a positive approach. The former focuses on how governments *should* make choices regarding overall expenditures and allocations to health, while the latter emphasizes the *reasons* behind observed government policy choices.

From a normative theory perspective, key economic rationales for government intervention in the health sector are market failures and equity-related considerations.[10] Government intervention can – under certain conditions and in principle – be used to improve *efficiency* when market failures lead to suboptimal social welfare outcomes, and to improve *equity* when market allocations lead to outcomes that are perceived to be unfair. Three broad forms of market failures prominent in the health sector as justifications for government intervention in health are: (i) the presence of externalities, (ii) the public good nature of certain health interventions, and (iii) the presence of extensive information asymmetries.[11] However, from the perspective of reprioritizing health, these same economic rationales also apply to government intervention in other sectors including national defence, education, food, housing, water, sanitation and infrastructure (although it could be argued that information asymmetries in health are more pronounced than in some of the other sectors). In terms of allocating resources across sectors, the normative economic theory perspective argues that – given real costs to society of

raising revenues – public expenditures should be undertaken as long as the benefits from such expenditures (for any given sector) exceed the costs of raising revenues, and that sectors should compete for the allocation of scarce resources up to the point where the marginal benefit of an additional resource unit of spending is equal across sectors.[12] From the perspective of reprioritization, normative theory implies that the health sector would need to demonstrate that the social benefits of additional public spending exceed the costs of financing this increase in spending, both in terms of the additional costs of raising revenues and in terms of foregone public spending in other sectors. Despite the clean logic underlying normative economic theory, it provides limited utility to understanding why some governments spend more of their resources on health than others. With its focus on the ideal or optimal role for policy intervention by a benign government that intends to maximize social welfare, the normative approach neglects the substantial disconnect between a theoretically ideal set of policies and what could actually be achieved in practice.

Unlike the normative approach, the positive economic approach to understanding government behaviour is more promising as a guide to understanding government prioritization choices and expenditure allocations across sectors. Positive economic theories are those that describe "…why existing policies are pursued and…which policies will be pursued in the future".[13] This approach attempts to bridge the disconnect between a theoretically ideal set of policies as outlined by normative economic theory versus what is actually implemented in practice. Wagner's law, mentioned earlier, is an early example of a positive perspective on public expenditure. Most positive theories of public expenditure invariably focus on political economy considerations: that is, on what influences policy-makers. Ultimately, because choices about policy directions are made and implemented by individuals, the most relevant positive theories on the role of government are those that seek to explain the behaviour of individuals in a political setting. Such positive theories emphasize that individuals in the political arena are no different than individuals in any other market and are guided to make decisions by their own self-interests. In other words, voters in democracies, for example, might be expected to support candidates and ballot propositions that they think will make them better off personally; bureaucrats would make choices based on considerations that advance their own careers; and politicians make allocation choices based on what is most likely to keep them in power. Whereas a normative economic perspective argues for a focus on *market failure*, positive economic perspectives argue for a focus instead on *government failure*, that is, on what might cause governments to deviate from making socially optimal choices. From the perspective of reprioritization for health, positive theories generally imply that demonstrations of social-welfare-enhancing aspects of additional government health spending will not necessarily be effective in increasing allocations towards health. Political economy considerations are key, and enhancing democratization, improving citizen information and increasing government accountability may be more effective strategies to ensuring that health is accorded the priority it merits.

REPRIORITIZING HEALTH: EMPIRICAL PERSPECTIVES

Cross-country empirical literature on factors determining why some governments spend more as a share of their total expenditures on health than others is scarce and, in some cases, focuses on government health spending as a share of GDP and not as a share of total expenditure, obfuscating the link to the issue of prioritization per se. One key determinant in cross-country empirical studies focusing on health's share of government expenditure is the level of democratization of a country. On average – perhaps a result of some of the factors discussed in the previous section – democratic societies and those with higher degrees of political liberty do tend to devote a larger share of government expenditure and GDP to health even after controlling for confounding factors.[14-16] The other factor to receive attention in empirical studies has been corruption.[17-19] Most empirical evidence concludes that higher corruption levels are generally inimical to government allocations for health and favour spending on defence and energy at the expense of health, perhaps because of the higher possibilities of rent-seeking of the generally larger scale of contractual procurement amounts in the former sectors. Other determinants of government allocations to health include the extent of ethnolinguistic heterogeneity in a country and female political representation.[20,21] Empirical research on the impact of heterogeneity on government spending on public goods suggests that governments generally tend to spend less on health in ethnolinguistically diverse societies, controlling for the level of development, education, availability of public resources and corruption. A study examining the relationship between female political representation and government spending on health as share of GDP in low-, middle- and high-income countries finds that there is a positive association between female political representation and government spending on health as share of GDP, although not a strong one. The numbers of cross-country empirical studies on this issue are few, and some of the findings are not robust and are sensitive to model specification. This is an area that could benefit from further research and analysis.

Other empirical evidence comes from the experience of countries that have attempted to reprioritize health in government spending in recent years, some more successfully than others. In this regard, the experiences of five countries – Brazil, India, Mexico, Thailand and Viet Nam – can be used to illustrate the following three modalities of reprioritization efforts. First, benchmarking expenditures: focused on setting broad benchmarks and targets for the share of government health expenditure. Second, earmarking revenues: earmarking certain taxes and other revenues to finance an increase in the share of health in government spending. Third, focusing on results: focusing on specific coverage targets or improvements in health-system outcomes.

India, a federation composed of 29 states and seven union territories, is a recent and prominent example of a country that has attempted to benchmark expenditures to reprioritize health. The Prime Minister of India pledged to increase government expenditure on health to between 2% and 3% of GDP by 2012,

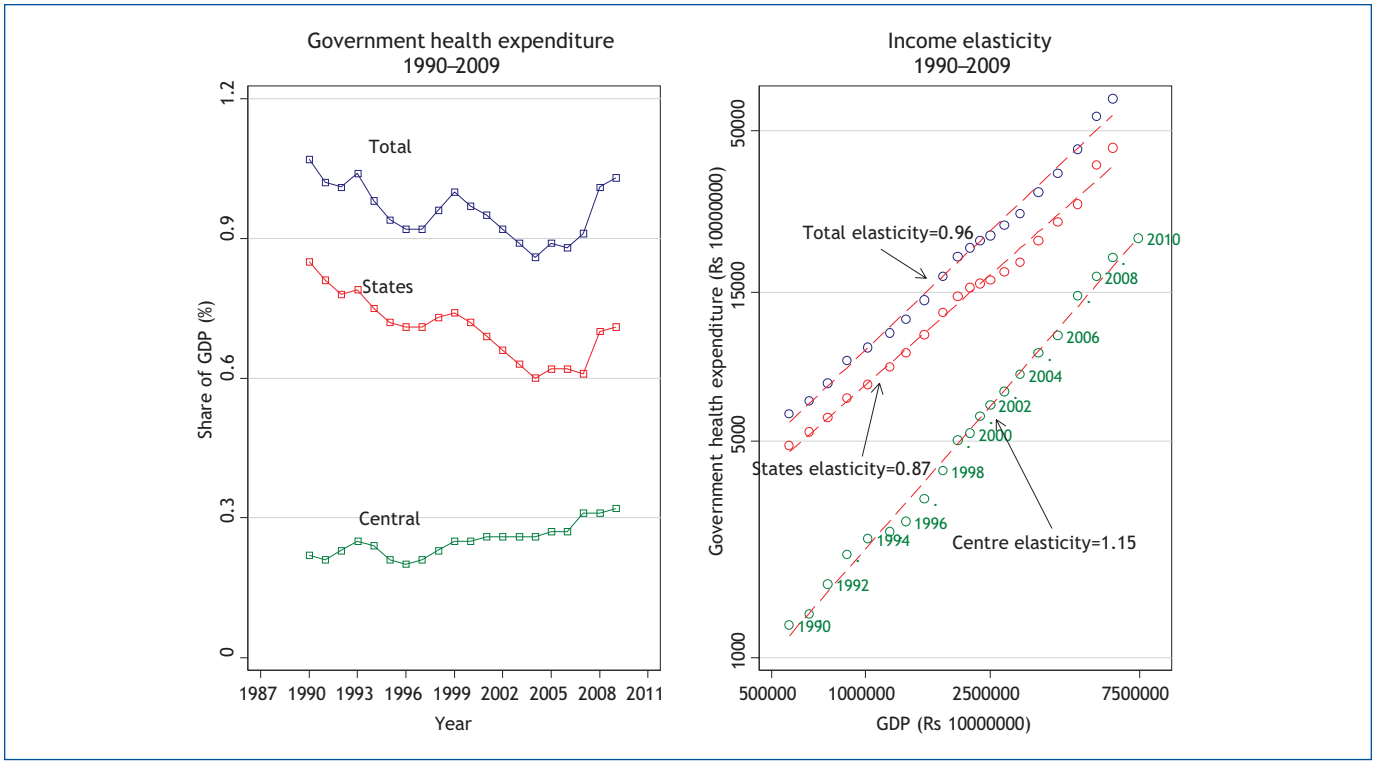

Figure 2: Trends and income elasticities of government health expenditure in India, 1990–2009

GDP: gross domestic product.

Source: La Forgia and Nagpal.[23]

up from about 0.9% of GDP in 2005. This pledge followed the 2004 election of an alliance led by the Congress Party that initiated several social protection schemes aimed at benefiting the rural poor, taking advantage of an increase in overall fiscal space resulting from a period of sustained and robust economic growth. For India to realize the 2–3% expenditure target, health expenditure by states would have had to increase by 22–38% per year over the period 2005–2012, a virtual impossibility.[22] Since 1990, there has been a steady increase in central government health expenditure as a share of GDP in India, but this was offset by *declining* state allocations to health for most of 1990–2010 (see Figure 2). The decline in state-level allocations to health can be traced back to the fiscal crisis that impacted the states in the 1990s. Although there has been an upward trend in state health expenditure beginning around 2008, the country remains far from attaining the 2–3% of GDP benchmark for government expenditure on health.[23] In 2011, India spent only 1.2% of its GDP on health.

India's experience of reaching health-spending targets is not unique: Generally, countries have not realized benchmarking pledges. Other examples include Lao People's Democratic Republic, which plans to increase its spending on health to 9% of the budget (it is unclear whether the target was for total or recurrent expenditures, and whether it included externally financed government health spending) to improve access to care and reduce OOP payments. Also, Bhutan is considering whether to earmark 9% of government revenues for health. The Abuja Declaration called for sub-Saharan African countries to allocate 15% of government spending for health, and countries in the WHO Eastern Mediterranean Region have agreed to earmark 8%.[24,25] In most countries, calls for benchmarking health's share of government expenditures (or of revenues or GDP) have been largely aspirational.

Reprioritization efforts have been somewhat more successful in some countries that have implemented earmarks, that is, legally binding mandates that determine how GDP or aggregate government spending will affect the share allocated to health, as opposed to benchmarks. For example, in Viet Nam, Resolution No. 18, which was passed by the National Assembly, commits the government "…to increase the share of annual state budget allocations for health, and to ensure that the growth rate of spending on health is greater than the growth rate of overall spending through the state budget".[27] As a result, health's share of the general government budget increased from 8% in 2008 to 9.4% in 2011.[27] In Brazil, states and municipalities have been responsible for financing and managing health care since the 1996 health-financing reforms. In 2000, a constitutional amendment was passed that committed budget resources at the federal, state and municipal levels. At the federal level, the amendment required a 5% increase in aggregate spending in 2000 in real terms, using the 1999 budget as a basis, adjusted according to the growth rate of nominal GDP from 2001 to 2004. At the state and municipal levels, earmarks for health were 12% and 15% of their revenues, respectively. The share of health in public expenditures increased from 4% in 2000 to 9% in 2011.[28] This earmarking of revenues appears to have:

(i) increased the share of state and municipal governments in health financing; (ii) provided incentives to decentralize primary care according to federal guidelines; and (iii) reduced the inequalities in per capita health expenditures among municipalities.

Some countries have raised resources by earmarking specific taxes (that is, other than dedicated payroll tax earmarked for social health insurance) such as on cigarettes and alcohol consumption. For example, Ghana earmarks part of its VAT revenues for its national health insurance fund. A study by the WHO indicates that more than 20 countries earmark tobacco tax revenue specifically for health.[29] Several countries earmark all of their tobacco tax revenue for health, while other countries, such as Mongolia, Thailand, Qatar and Bulgaria, earmark a small percentage (that is, 1–2%) of the total tobacco tax revenue to health. Still other countries, such as Tuvalu, earmark a fixed amount (that is, 2 cents) per cigarette for the health sector. Earmarking taxes on alcohol seems to be less common, although some countries (for example, Thailand) do have policies that allocate a portion of tax revenue from alcohol to health. After substantial opposition from interest groups, the Philippines Senate recently passed a Sin Tax Reform Law, which earmarks a portion of tax revenues for UHC and district and regional hospitals

Over the past decade, Mexico and Thailand have both witnessed substantial increases in the share of the government expenditure allocated to health, as reforms in both countries expanded coverage and reprioritized health issues, by focusing on results such as explicit coverage targets or health outcomes. Mexico embarked on a major health insurance reform process in 2003 with the intended result of including 50 million Mexicans who were previously excluded and to do so through "financial harmonization" of "imbalances". By the end of 2011, UHC was achieved with almost 98% of Mexico's citizens registered with one of the country's three health insurance schemes: the Instituto Mexicano del Seguro Social (IMSS), which covers salaried employees in the private sector; the Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE) for salaried workers in the public sector; and the Seguro Popular scheme for nonsalaried workers, self-employed and families outside the labour force.[30] Due in part to the mobilization of resources for implementation of these reforms, the ministry of health's budget increased 142% between 2000 and 2010, while the IMSS and ISSSTE budgets increased 42% and 103% in real terms, respectively. Some additional funding comes from earmarked taxes on cigarette sales, although the sequencing of reforms suggest that it is the focus on results that led to the demand for and absorption of these additional resources. The Mexican example of a focus on expanding coverage is not unique. In 2001, Thailand made an explicit policy decision to expand coverage to the remaining 18.5 million Thai not covered by existing health insurance schemes through the "30 baht treat all" scheme, funded initially by pooling budgets from public hospitals and other health facilities.[31] This Universal Coverage Scheme (UCS), together with the Social Security Scheme (SSS), which covers private sector employees (excluding their dependants), and the Civil Servant Medical Benefit Scheme (CSMBS) for government employees and dependants (parents, spouse and two children under 20), meant that Thailand had attained UHC, which subsequently increased the utilization of health services and led to a substantial increase in government health expenditure between 2001 and 2010.[32] Over this period, WHO data indicate that general government expenditure on health as a percentage of the general government budget increased from 9% to 13%. In addition, general government expenditure on health as a percentage of the total health expenditure increased from 56% in 2001 to 75% in 2010. Within just the first year of the launching of the UCS, general government expenditure on health increased by 42% to US$ 2.7 billion, from US$ 1.9 billion just prior the UCS in 2001. This upward trend has continued since, reaching US$ 7.4 billion in 2008, a 76% increase in real terms. Even during the Thai recession of 2009, when national GDP declined by 2% and various sectors faced spending cuts, government expenditures on health were sustained and protected.

CONCLUSION

The share of total government expenditure that is devoted to health is often used as a metric to gauge the extent to which health is prioritized by governments. While there is a clear income gradient in health's share of the government expenditure across countries, significant variations persist even after controlling for income. Although a government's spending on health is only one element that contributes to health outcomes in any country, understanding why some governments allocate a higher share of their resources to health than others is important given under-resourcing of the sector in light of policy objectives aimed at attaining MDGs and accelerating progress on UHC.

Theory and cross-country empirical analyses do not provide clear-cut explanations for the observed variations in government prioritization of health. Evidence from case studies on reprioritization is more promising, suggesting that country-specific political economy considerations are key, and that results-focused reform efforts – in particular, efforts to explicitly expand the breadth and depth of health coverage as opposed to efforts focused only on government budgetary benchmarking targets – are more likely to result in a sustained and politically feasible prioritization of health from a fiscal space perspective.

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