



Background Paper

Beating the DRUM in Lower-Income Countries:

Domestic Resource Use and Mobilization for SDG3

Acknowledgements

This paper has been prepared to inform discussion at the conference “Beating the DRUM - Domestic Resource Use and Mobilization for accelerating progress towards SDG3,” on 5 November 2018, in Oslo. The current document is an advance conference draft and will undergo further revision. Following “Beating the DRUM,” key outcomes of the conference deliberations will be incorporated to create a final version of the paper.

The paper has been prepared by a small drafting team designated by the conference co-host institutions: The Governments of Burkina Faso and Norway, the Bill & Melinda Gates Foundation, and the World Bank Group. The drafting team gratefully acknowledges comments received on earlier drafts from experts within the co-host institutions and partner organizations. While every effort has been made to incorporate this input, the drafting team assumes full responsibility for the current version of the paper. This document does not necessarily reflect the views of the co-host institutions.

Executive Summary

Many countries face critical shortfalls in domestic resource use and mobilization (DRUM) for health, threatening to push health goals out of reach.

Health targets under Sustainable Development Goal 3 (SDG3) include Universal Health Coverage (UHC), ensuring that all people have access to needed health services without financial hardship. To reach UHC and SDG3, low-income countries (LICs) will need to spend an average of US\$112 per capita on health by 2030 and lower middle-income countries (LMICs) \$146. Average 2015 government health spending per capita was \$12.24 in LICs and \$26.54 in LMICs. This includes the development assistance for health (DAH) channelled through government budgets. Unless they can raise substantially more domestic health resources and invest the funds effectively, many countries may soon lose any realistic chance of reaching SDG3.

DRUM failures weaken human capital formation, a vital input to economic growth.

Health goals matter in themselves and because of what they mean for countries’ economic future. Health and education are the most important components of human capital, which determines countries’ competitiveness. As they advance towards UHC and SDG3, countries will make health gains that build human capital and drive inclusive growth.

Countries need more and better health spending.

As they mobilize more funds for health, many countries urgently need to improve how they use those funds: the efficiency and equity of their health spending. On aggregate, between 20 and 40 percent of health resources are typically wasted, while stark health inequities persist across social groups in many countries, even where coverage with basic services and financial protection are expanding on average.

The first step is to apply already-proven DRUM solutions, adapting them to new contexts.

Known solutions exist to improve DRUM, based on successful country experiences. By adapting and aggressively deploying these approaches, countries can: raise more total government revenue as a share of GDP; increase health's priority in budget allocations; tackle key sources of inefficiency in health systems; and improve the equity impacts of health-financing decisions. Not all previously successful policies will work in all countries. Countries need a process to select the most promising policy options, identify barriers and solutions, and adapt design and implementation to local conditions.

However, in many countries, even the best achievable DRUM performance will not be enough.

Despite optimistic assumptions – about fiscal policy improvements, increased budget execution, and greater priority for health in budget decisions – most LICs and LMICs will not be able to raise enough resources domestically to reach UHC and SDG3 targets. While improvements in efficiency and equity are critical, they will only help countries move closer to these targets, not fully achieve them. Resource shortfalls are exacerbated by recent stagnation in DAH and the limited involvement of the private sector in tackling DRUM challenges. The situation is especially concerning in some 35 countries that are expected to transition from key DAH funding streams in the coming years.

New solutions are needed, including private-sector engagement and a next generation of DAH.

Even as they adapt and implement established models, countries must create and test new approaches to DRUM. Private-sector innovation may play a critical role when public-private partnerships are structured to target challenges with the greatest value for DRUM, such as strengthening payment systems and optimizing resource use. DAH will remain critical to support countries in closing current health-finance gaps, yet it must increasingly help create foundations for future self-sufficiency. A key challenge is ensuring that DAH complements and enhances but does not substitute for countries' domestic health spending efforts.

The “Beating the DRUM” conference offers a platform for countries and partners to dialogue and build joint strategy.

“Beating the DRUM” aims to build consensus around a global agenda on how to improve DRUM in lower-income countries through better implementation of known solutions and accelerated identification and adoption of new approaches. The central value proposition of “Beating the DRUM” is elevating and learning from country experiences, with an eye to understanding where new approaches are most critical. The conference is organized around three roundtables. The first is on domestic resource mobilization - the DRM of DRUM. The second addresses efficiency and equity in domestic resource use - the DRU of DRUM. The third roundtable asks how DAH can better support and complement DRUM in the future.

While each country's situation is unique, shared lines of action are emerging.

The evidence and country experiences reviewed in this background report point to principles that the conference co-hosts propose for consideration, and which discussion among policy makers and partners at “Beating the DRUM” will clarify and refine:

1. Strengthen social and political demand

Demand for DRUM needs to come from the people. Better data, transparency, and accountability foster this engagement. Sharing information shows citizens what is at stake for them in health financing choices and encourages communities to voice their views. The World Bank's Human Capital Index is one tool for empowering governments and stakeholders to track the impact of public investments in health and education. This will facilitate collaboration and whole-of-government working on agendas to build human capital. It will also empower civil society to promote accountability.

2. Jump-start progress with efficiency gains

Correcting inefficiencies and inequities in the current use of resources can help countries get closer to UHC, even without large new finance inflows up front. Quick efficiency boosts can come from actions under immediate MoH control, like improved procurement and payroll management. Major gains can also come from win-wins that improve both efficiency and equity – like strengthening PFM systems in health more broadly and shifting resources into frontline services. Leaders can apply efficiency and equity analyses to all health financing policy debates, while securing improvements in data to track progress and strengthen accountability. This will institutionalize the commitment to continuously improve value for money. Taken together, these actions may reinforce trust with the Ministry of Finance (MoF) and external partners, leading to more investment in health.

3. Tap private-sector innovations

Governments that engage effectively with the private sector may access innovations that can improve revenue mobilization and the efficiency and equity of resource use. For example, digital and mobile technologies offer opportunities to make financial transactions cashless, including payment for health services. This can increase transparency and accountability, reduce fraud and corruption, expand financial protection, and generate important data for health policy making. Public-private partnerships can rapidly democratize these and other solutions to unresolved DRUM challenges. At the same time, healthcare financing provider payment systems must evolve to facilitate rather than hamper innovations in service delivery: for example, by introducing payment methods that help providers manage clinical resources more flexibly to get the best results for patients.

4. Transform health finance partnerships

Relationships between countries and financial partners are being redefined. In some cases, new collaborative models are emerging that firmly anchor country leadership. Benefits in the nearer term are likely to include reducing transaction costs for countries and the accompanying strain on local capacities. Current DAH streams can be more deliberately combined to leverage additional funds, both external and domestic, for country health priorities. Better communication is key, and easier to achieve with advancing technology. Institutionalizing regular exchange between external financing partners at country level can ensure that joint financing options and opportunities are frequently reviewed and assessed in light of evolving country priorities.

1. Introduction

Today, many lower-income countries need not only to accelerate progress on the unfinished 2000-2015 agenda of the Millennium Development Goals (MDGs), but also to expand coverage to the broader range of health services targeted under Sustainable Development Goal 3 (SDG3), including non-communicable disease control and public-health emergency response. Progress towards universal health coverage (UHC) – the goal that people can use quality health services they need without facing financial hardship – is included in SDG3 and is a critical foundation for all health targets. In turn, progress toward health and financial protection under UHC and SDG3 is key to building countries' human capital, a principal input to inclusive economic growth.

Health goals “plus.” Health leaders also need to consider how their own policies can best support progress toward the other SDGs and which actions in other sectors should be encouraged to promote health. The SDG3 health targets combined with multisectoral actions that support them have been termed “SDG3+.”

The critical role of DRUM for health. The United Nations Conference on Financing for Development called upon countries to harness all possible sources of finance for the SDGs. In addition to global and regional action on issues such as tax evasion, countries agreed on an array of domestic measures to sustainably raise additional funds and spend them effectively. The options include increasing domestic resource mobilization through tax system reform and improving the efficiency and equity of spending. While countries work towards raising more general revenue, they must also decide how much priority to give to health in allocating available funds and ensure that assigned funds are spent wisely. In this document, the term Domestic Resource Use and Mobilization (DRUM) refers to this comprehensive agenda for more and better domestic spending on health.

Progress in some countries, but many left behind. A number of lower-income countries have taken bold steps to strengthen DRUM. However, many more countries lag far behind the quantity and quality of domestic investment needed to accelerate UHC and reach SDG3. Few if any have applied the full range of measures that are known to strengthen DRUM for health. The first urgent question is: how can countries better adapt and implement such proven measures rapidly and effectively?

Even if they aggressively apply proven DRUM strategies, the analysis presented in this paper reaffirms that many countries will still not have sufficient resources to meet their 2030 SDG3 targets. The international community is also reassessing how best to support these countries and supplement their efforts. The challenge is how to ensure that development assistance for health (DAH) complements and enhances but does not substitute for domestic efforts, and that DAH contributes to improving the efficiency and equity of all health spending.

“Beating the DRUM” and the aim of this paper. On November 5, 2018, the eve of the replenishment conference for the Global Financing Facility (GFF), stakeholders will gather in Oslo for the conference “Beating the DRUM - Domestic Resource Use and Mobilization for accelerating progress towards SDG3.” The purpose of the conference is to build consensus around a global agenda on how to improve DRUM in lower-income countries through faster implementation of known solutions and accelerated identification and adoption of new approaches.

This paper is not an overview of all aspects of health financing. Its purpose is to inform discussion and strategy building at “Beating the DRUM.” It first summarizes current status and trends in DRUM and DAH, showing that health financing failures threaten to push UHC and SDG3 beyond many countries' reach. The paper then presents key data and formulates targeted questions around the topics of the three conference roundtables: (1) domestic resource mobilization; (2) efficiency and equity in domestic resource use; and (3) the role of DAH in supporting DRUM. The main body of the paper briefly summarizes the main challenges in each area; proven solutions; barriers to progress; and practical options for country action. More in-depth technical discussions of the three topics are placed in Annexes.

2. Health Goals: Slipping Out of Reach

How much must countries spend to reach SDG3? Countries are shaping their own sustainable development policies, strategies, and plans, and each country's situation is unique. To gauge the overall scale of the challenge, however, it is useful to estimate how much, on average, countries would need to spend to reach the SDG3 targets. Stenberg et al (2017) calculated that, to meet the goal, low-income countries (LICs) will need to boost their average total health spending to \$112 per capita by 2030, while lower middle-income countries (LMICs) will need to spend \$146 per capita.

Defining government health expenditure. Because many people are unable to pay the full costs of the health services they need out-of-pocket, funding to cover these costs should come primarily from compulsory prepaid and pooled sources. Prepayment and pooling spread the financial risks of ill health across the population and allow the poor to obtain needed services. The funds come from general government revenues or compulsory payments for health, such as social health insurance premiums. Expenditure from these sources is typically called general government expenditure, and we use the term general government expenditure in this document to mean expenditure from all forms of compulsory prepaid and pooled funds. We further distinguish between government expenditure derived purely from domestic sources, and government expenditure that includes the DAH that passes through government channels.

What do governments currently spend? The average compulsory prepaid and pooled (i.e., government) spend per capita from domestic sources alone was \$7.32 for LICs and \$25.56 for LMICs in 2015, the latest year for which data are available. If we add DAH passing through government, in 2015, government health expenditure per capita was \$12.24 for LICs and \$26.54 for LMICs. In 2015, one-third of the world's population live in countries where government investment in health is less than \$25 per capita (including both DAH and domestic sources), and for close to 1 billion people, it is less than \$10.

How much more could governments raise? Economic growth, raising more government revenues as a share of GDP (i.e., fiscal reforms), and giving more priority to health in budget decisions all contribute to increasing government health expenditures over time. We have projected the growth in government expenditure from domestic resources that would be possible from IMF projections of economic growth and optimistic assumptions about countries' capacity to raise additional domestic government revenues for health as a share of GDP, whether through fiscal reforms to increase revenues overall or giving more priority to health. Calculations were carried through only to 2023, because this is the furthest horizon for which IMF projections of GDP are available. Results suggest that the average spending from domestic sources could rise from \$7.32 to \$13.39 in LICs and from \$25.56 to \$39.23 in LMICs with, of course, substantial variation across countries.

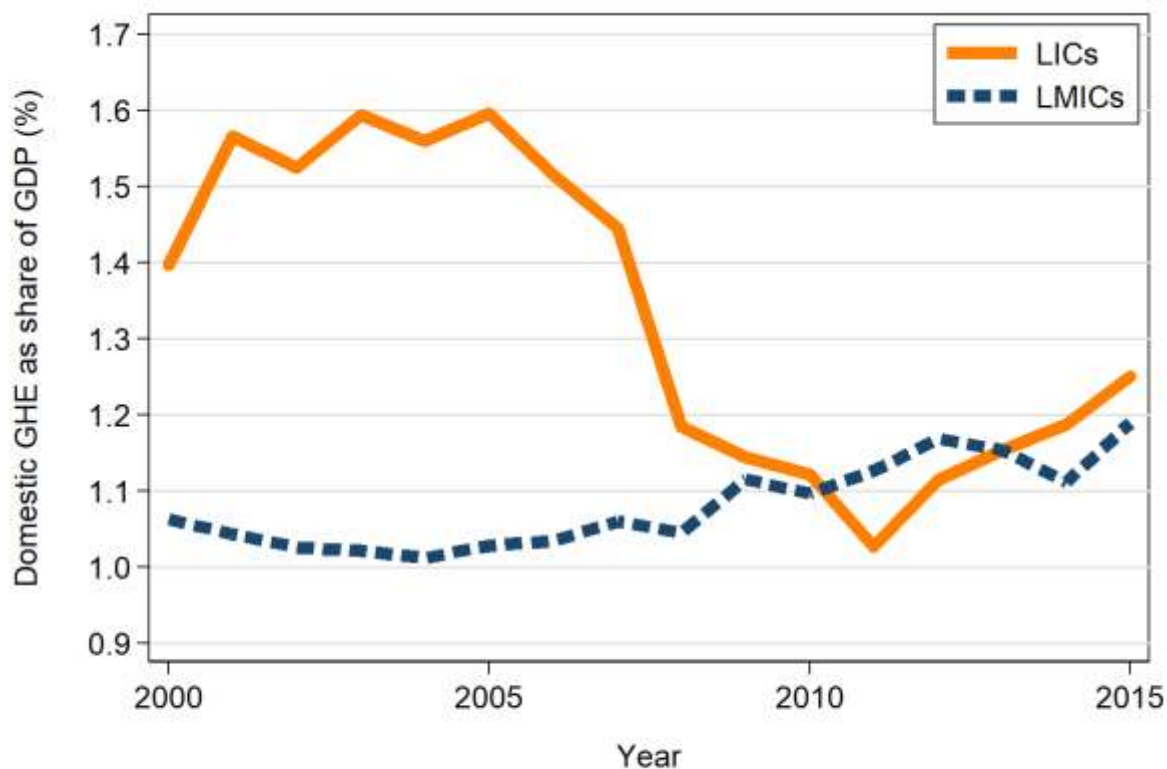
Financing needs exceed capacities. This estimated capacity of countries to raise additional domestic resources for health can be compared with the estimates for 2023 from Stenberg et al. Assuming a linear scale-up from 2015 actual expenditures (from domestic sources) to 2030 needed expenditures, the necessary total expenditures in 2023 on the path to reaching SDG3 would be \$74 and \$117 per capita for LICs and LMICs, respectively. If we assume that governments would need to spend between 80% and 100% of the total need, then the requirements per capita would be between \$59 and \$74 for LICs and \$94 and \$117 in LMICs. This is considerably more than our estimates of what governments might be able to raise on average from domestic resources.

How has DRUM changed over time? We now look specifically at how countries have recently fared in the three core dimensions of DRUM: raising total government revenues as a share of GDP; elevating health among government investment priorities; and improving efficiency and equity in public spending. We also discuss how DAH is influencing the current picture. The results must be interpreted carefully, because it is not currently possible to separate out development assistance passing through total government expenditures in the same way as has been done for health spending.

2.1 Recent progress in raising domestic government revenues

Increasing government revenues across the board is one way to generate more funds, including for health. Figure 1 shows the ratio of average government expenditure to GDP in LICs and LMICs for the MDG period. Both groups of countries increased the share over the period, with a greater proportionate increase in LICs. The rates, however, remain very low compared to high-income countries, which raise on average more than 40%.

Figure 1: Trends in the share of government expenditure in GDP, LICs and LMICs, 2000-2015, population weighted averages



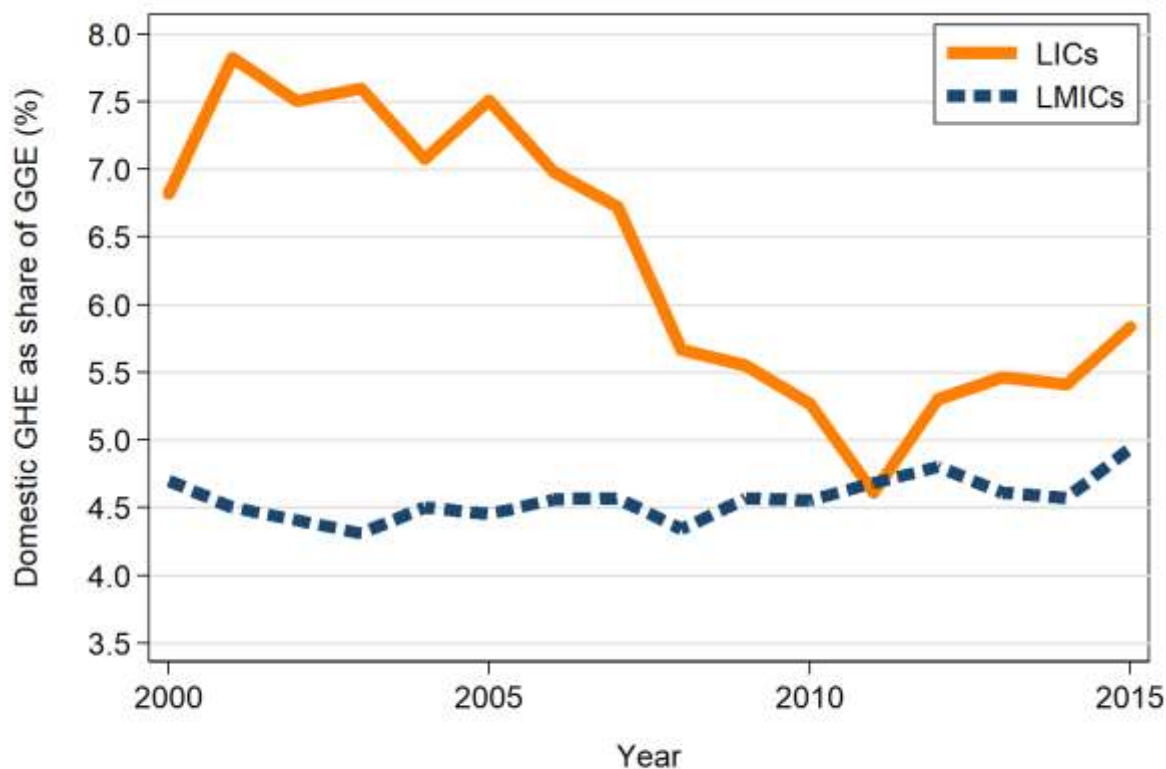
Source: WHO Global Health Expenditure Database

Of note, these numbers are population-weighted averages for the different groups of countries, and so mask considerable variation among countries within the same income class. For example, in 2015 the share was only 11% in Nigeria and Sudan, and over 40% in Bolivia and Lesotho.

2.2 Trends in elevating health among government spending priorities

Countries can also raise health spending by increasing the share of general government expenditure (GGE) that is assigned to health. In LMICs, health's share of GGE has risen only slightly since 2000, and these countries have, on average, given lower priority to health than the LICs. In LICs, the priority to health fell consistently to 2011, before rising again, but only back to the proportions observed in 2008, still well below the 2000 level.

Figure 2: Trends in the share of domestically sourced government health expenditure in total government spending, LICs and LMICs, 2000-2015, population weighted averages.



Source: WHO Global Health Expenditure Database

Again, the average numbers mask considerable variation across countries. In 2014, the ratio ranged from a low of less than 2% in Eritrea and Mozambique to more than 15% in Madagascar and El Salvador.

2.3 Efficiency and equity concerns in domestic spending

It is important to understand not just how much countries are spending on health, but how efficiently they are spending, and how the resulting benefits are shared across population groups. Evidence from countries at all income levels reveals great potential to move closer to UHC by making better use of available funds.

The World Health Report 2010 suggested that between 20 and 40% of all health resources are wasted through 10 common causes of inefficiency, including disproportionate spending on high-cost hospital interventions and persistent underinvestment in primary care. The other side of the coin is that public or donor funds allocated to health frequently remain unspent; in the case of government funds, if on budget, they typically have to be returned to treasury. Recent estimates from five countries show that, if all the money allocated to health had been spent, public health spending could have increased by between \$1 and \$3.5 per capita.

Inequities in service coverage and in financial protection are also rife. In many settings, inequity manifests as poor people foregoing needed health services that the more affluent routinely access. For example, in Sub-Saharan Africa, 8% of women in the lowest income quintile delivered their children in the presence of a skilled birth attendant in 2014, compared to 88% in the highest income quintile. Households without any form of health insurance, and those headed by women or with elderly members, are frequently more likely to suffer financial catastrophe and impoverishment when they do seek care, because they need to pay out-of-pocket for the services they receive.

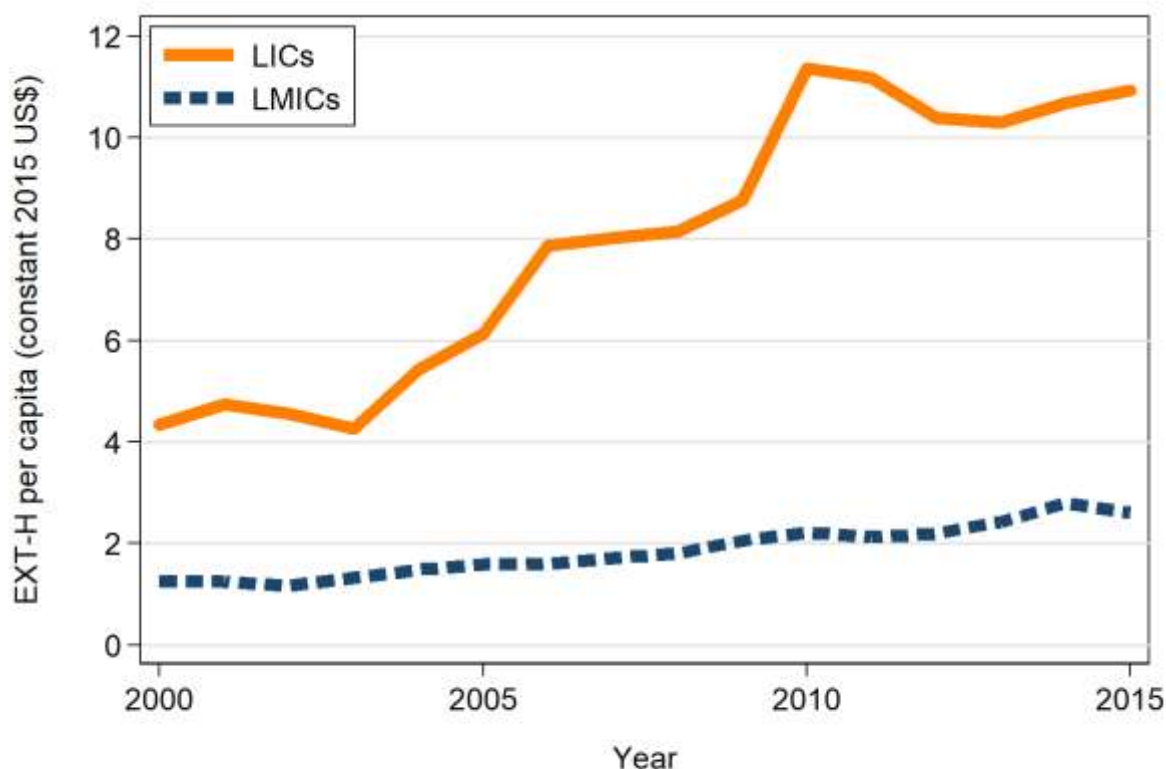
Recent experience suggests that movement towards UHC goals on aggregate can hide increasing inequality in coverage with health services or financial protection. Unfortunately, few lower-income countries routinely seek to identify and address the major causes of inequity or inefficiency in their health financing strategies.

2.4 How does DAH change the picture?

DAH contributions. DAH increased rapidly over the MDG era. DAH spending in 2015 averaged \$4.81 per capita in LICs (up from \$1.12 in 2000) and \$1.03 per capita in LMICs (up from \$0.61 in 2000). These funds helped countries to attain substantial improvements in service coverage and outcomes for priority diseases and conditions. Population coverage with a set of nine basic health services increased, for example, at an annual rate of 1.3%, or more than 20% overall, with particularly impressive rates of increase in coverage with antiretrovirals and with insecticide-treated mosquito nets. Likewise, the annual number of deaths fell substantially, particularly among women during pregnancy and children under five.

Since the great recession that started in 2007, DAH receipts have, however, declined in LICs, though very recently they appear to have risen slightly. DAH receipts in LMICs continued to increase to 2014 but fell back slightly in 2015 (Figure 3). This is true when considering DAH per capita in US\$ or DAH as a share of current health expenditures. Meanwhile it is increasingly clear that many LICs and LMICs will not be able to raise sufficient funds for UHC and SDG3 from domestic sources alone. More DAH, not less, would be needed to complement increased domestic resource mobilization and advance efficiency and equity at the country level.

Figure 3: Changes in DAH per capita, constant 2015 US\$ 2000-2015, population weighted averages



Source: WHO Global Health Expenditure Database

The interplay between DAH and DRUM is slightly different in the approximately 35 countries that will transition from sources of development assistance such as Gavi, the Vaccine Alliance and the International Development Association (IDA) in the next few years. These countries have no option but to raise additional domestic resources, not just to replace the DAH that is withdrawn, but also to expand coverage in pursuing UHC.

Opportunities to improve DAH. Despite the remarkable health progress that accompanied the rise in DAH from 2000-2011, well-known problems have kept DAH from achieving even more:

Alignment: DAH spending has often been seen as guided by donor-country priorities rather than those of recipient countries. This has resulted, for example, in limited investment in health system strengthening with a heavy focus on disease-specific interventions. Significant shares of donor funds have continued to flow independently of country budget cycles or completely off-budget, undermining government planning and budgeting efforts.

Effectiveness: Fragmentation among donors and programs has reduced DAH effectiveness. This has translated as duplication of systems, with multiple donors sometimes unknowingly funding the same activities, and simultaneously as gaps, with the donor community missing opportunities to bundle support in key strategic areas. The lack of coordination has raised transaction costs, further strained local capacities, and made it harder to ensure the smooth transition from DAH to self-sufficiency.

Substitution. There are concerns that DAH has resulted in reductions of government expenditures on health from domestic sources. Some governments appear to have used large increases in DAH to reallocate their limited domestic resources to other sectors that do not receive as much external assistance. This has been less than a 1-for-1 reduction, so DAH has resulted in net increases in health spending at country level.

Together, these problems have often resulted in uncoordinated, therefore subpar investments, fragmentation and duplication of efforts and systems, with high transaction costs. DAH has certainly enabled important health gains, but some approaches used to deliver donor funds can weaken national systems and compromise long-term sustainability, including for efforts to support DRUM.

3. Opening a path for shared action

Despite remarkable progress over the MDG years, many countries face a health financing situation in the SDG era in which multiple negative factors converge. These include: insufficient domestic funds for health at baseline; limited attention to increasing funds through fiscal reform or more priority to health; insufficient action to spend what is available and spend it better: for example, by improving the efficiency and equity of health investments. At the same time, DAH has stagnated and declined, with a need to improve its impact. Together, these conditions threaten many lower-income countries' capacity to achieve their UHC and SDG3 goals.

Many technical options exist for tackling these problems, some with proven records of success. Importantly, however, even if the known solutions to increase the availability of domestic resources are broadly implemented immediately, the scenario analysis reported above shows that the resulting increase in funding will be insufficient (though important). These reforms will have to be complemented by new solutions. An effective DRUM agenda must combine aggressive deployment, adaptation, and integration of proven strategies with an accelerated effort to identify, nurture, and disseminate new answers.

At "Beating the Drum," countries and partners will seek to outline a shared response to these challenges. While each country will define and implement its own agenda for UHC and SDG3, much can be achieved by sharing experiences, results, lessons learned, and plans.

This exchange will be structured by the conference's policy roundtables. The three sessions focus on: (1) increasing domestic resource mobilization (the DRM in DRUM); (2) efficiency and equity in domestic resource use; (the U in DRUM); and (3) the role of DAH in supporting DRUM. The technical annex of this paper presents detailed background discussions on these topics. In the following pages, we summarize main points from the analyses. The aim is to bring selected issues and options rapidly into focus for the political leaders, technical experts, and other stakeholders participating in the roundtable discussions.

3.1 Domestic resource mobilization

The problem: In many LICs and LMICs, progress in increasing domestically sourced government revenues for health is too slow to assure accelerated progress toward the goal of UHC. This puts the attainment of the UHC and other SDG3 targets at risk. The private sector, while participating in service provision, continues to have a limited role in raising domestic revenues for health in these countries.

What could fix it? In many lower-income countries, domestic government revenue as a share of GDP remains relatively low. Low budget execution rates mean that, of the meagre funds available, a substantial portion often remains unspent. In many settings, the priority given to health in allocating available revenues is also low. There is room for most LICs and LMICs to raise considerably more funds for health domestically by addressing these problems, and technical options to do this are well known. For example, simply improving the efficiency of collecting existing taxes and charges can yield significantly more revenues. Improving budgeting in Ministries of Health (MoHs) has sometimes resulted in MoFs allocating more funding to health, because it gives them greater assurance that the funds will be well spent.

Areas of continued debate: One of the most debated questions is whether to earmark government revenues for health. Similarly, vigorous discussions continue on whether it is possible to raise additional revenues for health by introducing social health insurance to systems that have traditionally been funded from general government revenues. Views have also diverged on whether the private sector can play a useful role in raising additional revenues for the health of poor and vulnerable people in lower-income settings.

What holds countries back? Their low GDP limits how much domestic revenue poor countries can raise. In many jurisdictions, a large informal sector makes it difficult to collect income-based taxes. Countries lack adequate Public Financial Management (PFM) capacity to collect, prioritize, spend and monitor. People's distrust of government and unwillingness to pay taxes compound these challenges. Corruption and lack of political will are major obstacles in some settings.

What practical options can countries consider? Evidence is emerging on approaches that have worked for some countries. Promising ideas are numerous, here, we highlight solutions that can be substantially driven by the health sector. The following are selected examples:

- **Building accountability.** An emerging lesson is that both higher overall revenue generation and greater priority to health are more likely to gain momentum where there is strong domestic demand for responsive government and for health spending (usually expressed as a demand for an improved range and quality of affordable health services). Better data can feed this process. For example, the World Bank's new Human Capital Index tracks the progress of health and education outcomes that are vital for productivity and growth, providing inputs for evidence-based advocacy. This may contribute to building an effective "fiscal social contract", in which people accept the need to pay taxes because they are confident that the revenues will be used to provide good quality services that benefit the population. Such a social consensus would strengthen the culture of accountability and help develop more effective tax systems.
- **Dropping distorted subsidies.** Eliminating inefficient or inequitable subsidies can help increase the government revenues available for priority areas, including health. Examples

are subsidies on fuel which harm the environment and disproportionately benefit richer population groups.

- **Taxing "bads."** Taxes on products that are harmful to health or the environment (e.g., tobacco) are win-win-win. They improve health, they raise additional funds (all or some of which can be used to improve health and financial protection), and they are generally more palatable to the public than other types of tax increases.

3.2 Efficiency and equity

The problem: In all countries, not just LICs and LMICs, a considerable proportion of all health resources are wasted. However, waste has a much more damaging impact in lower-income settings, where health needs are greatest. Low spending itself can be a contributing cause of inefficiency. Inequities abound in access to health services, service quality, and the extent of financial protection in health. While there has been good progress in improving aggregate service coverage for maternal and child health and some communicable diseases, these gains have sometimes been accompanied by widening inequalities in coverage between the poor and the rich.

What could fix it? The most common causes of inefficiency in health are well established: a recent WHO report identified ten, and they were expanded in the 2017 Second Annual UHC Financing Forum. The nature of inequalities in service coverage for some services – e.g., maternal and child health – are also well known, though this is less clear for non-communicable diseases and financial protection. Experts have described key ways health financing can improve efficiency and equity. Shifting health resources into frontline services, while strengthening the incentives that enable and encourage their efficient use, is a way to advance both goals. Improvements in public financial management can reduce waste and focus expenditure on results that strengthen equity. Reducing out-of-pocket health expenditures (OOPs) through prepayment and pooling also improves both efficiency and equity. More proactive, strategic purchasing can boost efficiency.

Areas of continued debate: How the private sector can best contribute to efficiency and equity gains in health action remains debated, though the potential may be high. Open questions persist on how to fund, and thus foster, innovations in service delivery. Relatedly, experts' views diverge on the appropriate role of results-based financing mechanisms as a means to improve health-service quality and efficiency in lower-income settings. A specific area of ongoing investigation concerns these mechanisms' integration into payment and public financial management systems.

What holds countries back? Obstacles slowing countries' progress against inefficiency and inequity often have to do with (1) political economy and (2) difficult trade-offs with ethical and financial dimensions. The realities of political economy are often the strongest barriers. Particular interest groups, likely to be politically powerful, frequently benefit from existing inefficiencies or inequities. These constituencies will resist change. Moreover, even when political openings for action appear, additional complex trade-offs may weaken efforts. While strategies such as moving resources to the frontline can improve both equity and efficiency, sometimes the two imperatives are in tension. Locating health services in isolated areas improves equity but might not be the most efficient choice. As countries pursue UHC, consensus is often lacking around the trade-offs between improvements in service coverage and financial protection, with implications for both equity and efficiency. Adjudicating such tensions is made more challenging because many country information systems do not routinely measure inefficiency or inequity and so cannot reliably track progress in fighting them.

What practical options can countries consider? A number of countries have made good progress in reducing coverage inequities for the health services targeted by the MDGs, though there is less evidence about financial protection. Policy measures that have enabled efficiency gains at the system level include developing strong PFM capacities and moving away from fee-for-service payment for both in-patient and out-patient care.

Country experiences suggest that progress on efficiency and equity requires:

- Strong leadership from the highest level of government, specifically the ministries of finance and the highest level of ministries of health (as well as subnational governments where they are involved);
- Extensive consultation with the private sector, civil society, and health care workers, who can make or break reforms;
- Strong public financial management (PFM);
- Structuring private-sector engagement around sharply defined problems and objectives, to avoid losing direction amidst a sea of “innovations” whose relevance is uncertain;
- The capacity to measure current levels of both inefficiency and equity, and to track progress.

3.3 Development assistance for health

The problem: DAH increased rapidly from the beginning of the MDG era to 2011. This was accompanied by substantial improvements in service coverage and health outcomes associated with the MDG health targets. Since 2011, however, DAH has stagnated overall and fallen in some countries. Persistent difficulties in some settings include: non-alignment of DAH to country priorities; fragmentation and associated inefficiencies; and substitution, whereby DAH has sometimes supplanted domestic investments in health, rather than being additive. This pattern has impeded some countries from successfully advancing towards self-sufficiency. The capacity of many lower-income countries to raise domestic funds and use them effectively remains weak, with limited financial and technical support to date. This has worrying implications in particular for the approximately 35 low- and middle-income countries expected to transition shortly from development assistance provided by agencies like Gavi, the Vaccine Alliance and IDA.

What could fix it? Applying agreed principles of aid effectiveness more broadly would help. Core principles have been progressively clarified by donor and recipient countries in Rome (2003), Paris (2005), Accra (2008), and Busan (2011), leading to a set of practices for external financial partners and recipient countries to improve aid effectiveness. The IHP+ partnership and more recently UHC2030 have supported country progress, for example by promoting a set of seven behaviours shown to strengthen collaboration and results. Some of these involve health financing. For example, DAH inputs should be recorded on budget and in line with national priorities; financial management systems should be harmonized and aligned with those of recipient countries using country systems; national financial management capacities should be strengthened; and joint monitoring of process and results should be undertaken, based on one information and accountability platform. To advance this agenda, countries and funding partners are working together in new ways, for example by combining different financing instruments to leverage additional external and domestic funds for country health priorities. Such collaboration is especially important where countries are starting to meet some funders’ graduation and transition criteria.

Areas of continued debate: The critical question of how to best use DAH to support domestic resource mobilization remains open. For example, controversy persists on whether external funding should be conditional on counterpart domestic funding. While it could spur DRM, this requirement may also limit a host government’s flexibility to allocate domestic funds to other national priorities that might not receive external funding. There is also no consensus about what constitutes a reasonable government response to significant inflows of DAH when other sectors, eventually contributing to health outcomes, remain relatively underfunded.

What holds progress back? Bilateral donors are responsible to parliaments and populations in their home country. Since the 2008 financial crisis, appetite to raise DAH has been limited. The time horizons of many external partners are also relatively short, since they must show results rapidly to satisfy their boards or parliaments. Sometimes viewing each other as rivals, funding agencies have been slow to join forces in helping countries build sustainable UHC financing. Yet nurturing robust DRUM institutions and capacities, essential for countries’ ultimate self-sufficiency in health finance, demands donor collaboration as well as sustained engagement.

What practical options are available? There has been a recent rekindling of interest in these issues, including sustainable financing. The GFF is one example. It supports countries to synergize domestic resource mobilization with international assistance for maximum impact on health priorities. GFF works with other funders, including IDA, on new approaches to expand countries' access to robust DAH while keeping their levels of debt distress as low possible. At the same time, the intent is to jointly increase efficiency and equity in the use of all resources, domestic and external. Another example relates to the action plan for reaching UHC and SDG3 that WHO is leading in collaboration with other global health agencies. Participants agreed to accelerate sustainable financing, including through collaboration among external partners to support countries' DRUM efforts.

4. Conclusions: action on health finance now

Health goals are under threat. Today, countries' aspirations for UHC and SDG3 hang in the balance. Major barriers to progress include the availability and use of financing. Lower-income countries urgently need to raise more domestic resources for health, improve the equity and efficiency of health spending, and work with donors to strengthen aid effectiveness. Progress in all these areas remains far too slow. And, even as lower-income countries struggle with daunting DRUM challenges, DAH has stagnated overall. It has actually fallen in some countries and will fall in the future in at least the 35 "transition countries."

Known solutions and approaches can go a long way but are not enough. In all the key dimensions of DRUM, solutions exist that have shown efficacy. The first priority is to implement these proven strategies well. By doing so, countries can substantially expand their domestic health resources and ramp up impact. This is an opportunity no country should forego. However, even if they adopt an array of proven methods and implement them effectively, many countries will still not be able to secure all the resources they need. Even as countries apply established solutions aggressively, new approaches must be found.

Collective learning from country experience. The "Beating the DRUM" conference and this paper do not attempt to cover all areas of health financing that might facilitate gains towards UHC and SDG3. Our focus is on three strategic areas: domestic resource mobilization; efficiency and equity; and the role of external partners in DRUM. Valuable lessons can come both from successful policies and those that failed to yield anticipated results. The conference roundtables will draw on country experiences to ask:

- Where rapid progress has been made, what enabled it to happen? Where measures fell short, why did they do so?
- What role might civil society play in establishing a social compact around DRM and better public services (including health)?
- What are common obstacles encountered in improving DRUM, and how have they been overcome?
- Are there areas where known solutions will not get countries to their goals, and where new approaches or solutions are critical?
- How can countries and external partners best work together on these issues?

Paths for action. Based on the evidence and country experiences reviewed for this study, the conveners of "Beating the DRUM" propose four best-bet strategies that may help countries break health finance bottlenecks and speed gains towards UHC and SDG3:

1. Strengthen social and political demand

Demand for DRUM needs to come from the people and the institutions that represent them. Publishing reliable information primes the process. Good data show citizens what is at stake for them in health financing policy choices. This encourages communities to engage and voice demands. The World Bank's Human Capital Index is one tool to help governments and their constituents track the effects of public investments in health, education, and other social sectors. This will facilitate collaboration and whole-of-government working to build human capital, while empowering civil society to press for accountability.

2. Jump-start progress with efficiency gains

By correcting inefficiencies and inequities in the current use of resources, countries can get closer to UHC, even without large new finance inflows up front. Quick efficiency gains can come from actions under direct MoH control, like improved procurement and payroll management. Strengthening PFM systems more broadly and shifting health resources into frontline services can yield win-wins: boosting efficiency while also improving equity. Such measures will help institutionalize the commitment to continuously improve value for money. Taken together, these actions may reinforce trust with the ministry of finance and external partners, leading to more health investment.

3. Tap private-sector innovations

Governments that engage effectively with the private sector may access new tools that can improve revenue mobilization and the efficiency and equity of resource use. For example, digital and mobile technologies now being deployed by firms in lower-income countries can make financial transactions cashless, including payment for health services. This can increase transparency and accountability; reduce fraud and corruption; expand financial protection; and generate important data for health policy making. Public-private partnerships can rapidly democratize these and other solutions to unresolved DRUM challenges. At the same time, healthcare financing provider payment systems must evolve to facilitate rather than hamper innovations in service delivery: for example, by introducing payment methods that help providers manage clinical resources more flexibly to get the best results for patients.

4. Transform health finance partnerships

Relationships between countries and financial partners are being redefined. In some cases, new collaborative models are emerging that firmly anchor country leadership. Benefits in the nearer term are likely to include reducing transaction costs for countries, and the accompanying strain on local capacities. DAH funding streams are increasingly being combined to leverage additional funds, both external and domestic, for country health priorities. Better communication is key, and easier to achieve with advancing technology. Institutionalizing regular exchange between external financing partners at country level can ensure that joint financing options and opportunities are frequently reviewed and assessed in light of evolving country priorities.

Annex 1

Domestic resource mobilization: towards a joint agenda

Identifying problem areas

The first focus of this annex is on what is commonly called government health spending. This consists of spending from compulsory prepaid and pooled funds. Prepaid and pooled funds for health come from tax and other government revenues and compulsory health insurance contributions. We focus first on this kind of spending because, in most LMICs and LICs, coverage for the poor and most of the informal sector, the bulk of the population, must come from these sources. We return to options for private-sector contributions subsequently.

The core problem that concerns us here is how LICs and MICs can raise the additional revenue needed to advance towards UHC and execute their plans for SDG3. How countries can use the funds they mobilize in the most efficient and equitable ways is the subject of Annex 2.

Known solutions

Technical options for increasing domestic government spending are well known. Economic growth boosts government revenues even if the government does nothing additional. Fiscal reform increases the share of government revenues in GDP. Assigning higher priority to health increases health spending from available government revenues. These options apply to national governments as well as to subnational units of government in those countries where subnational authorities can raise money and/or decide on how funds are allocated to the different sectors.

Fiscal reform. Despite steady increases in the share of government revenues in GDP since 2000 in both LICs and LMICs on average, this share remains low compared to higher income settings (Figure 1, main report). There is also substantial variation across countries, with the ratio varying from less than 11% to more than 40%. There is, therefore, considerable room in many countries to increase government revenue generation.

The exact nature of the actions that will be most effective, and equitable, will differ according to country circumstances. They can include one or more of the following: improve efficiency in collecting the taxes and charges already on the books; eliminate corruption, tax-avoidance, and tax evasion; increase the number of people/firms contributing (i.e., increase the tax base); and/or expand the range of taxes and charges.

As part of this agenda, new taxes or increases in taxes on products that are harmful to health ("sin taxes") or the environment are win-win-win: they improve health, can raise additional funds, and are generally more palatable to the public than other types of taxes. All or some of the revenues can be used to improve health and financial protection depending on the country.

Social health insurance contributions are essentially taxes earmarked for health because they are compulsory. These revenues are sometimes managed separately from general government revenues, often by semi-governmental authorities.

Eliminating inefficient or inequitable subsidies can also help expand available government revenues for priority areas, including health. Examples are subsidies on fuel which harm the environment and commonly benefit richer population groups more than the poor.

Priority to health. In 2015, the average share of total government spending allocated to health was very low, at less than 5% in LMICs and just under 6% in LICs. Of note, the figure had been considerably higher in LICs earlier in the MDG period (Figure 2, main report). Health's share in total government spending has increased only slightly in LMICs since 2000, and fell substantially in LICs to 2011, rising thereafter, but only back to 2008 levels. There is also considerable variation across countries in this ratio – from less than 2% to more than 15%, so many countries have room to increase the priority given to health.

Higher priority can be obtained through the normal budget appropriation process or through earmarking the revenues of particular taxes/charges for health. Compulsory health insurance contributions are an example. As previously noted, taxes on products harmful to health are also often earmarked for health, although there is frequently resistance from ministries of finance, which prefer to enjoy greater flexibility in how to allocate revenues.

Improved public financial management (PFM) can also help generate additional spending from allocated budgets, and sometimes additional revenues. For example, budget execution rates remain low in some countries, and improvements will allow more to be spent in any given time period. Moreover, the simple act of improving the MoH budgeting process has sometimes given the MoF confidence to invest more in health, reassured that the funds will be used in line with explicit spending priorities linked to results. PFM reforms that increase timely disbursement and spending through all levels of the health system effectively also increase the ability to use allocated resources.

Private-sector finance. There is growing interest in the role of the private sector in health in low and middle-income countries. Most attention has focused on the use of private health service providers. That issue lies beyond the scope of this paper.

Increased mobilization of private revenues in the form of direct out-of-pocket payments in LICs and LMICs is undesirable, as argued in the main report. Thus, we focus here on other possible private-sector contributions. The role of voluntary health insurance remains a matter of debate and is discussed later.

Recently, there has been a rapid increase in foreign direct investment (FDI) from private sources for healthcare in lower-income countries. Between 2002 to 2004, such flows totalled only US\$6.6 million, but for the period 2014 to 2016, foreign private investment in health increased to US\$21 billion. East Asia and Latin America have seen the largest inflows.

These investments have generally been directed towards goods and services aimed at people who can afford the OOPs necessary to make the investments profitable. Such goods and services include inpatient care, pharmaceutical and medical products, and outpatient services for cardiovascular, oncology, and metabolic/lifestyle diseases. Domestic private investments in health have tended to be even narrower in scope. Similar concern for profitability is likely to be at work. Domestic private investments have often focused on a few clinical procedures within a small catchment area.

Private investment in hospitals, medicines and/or other medical products can facilitate the immediate delivery of infrastructure and/or capital equipment that the government cannot afford. However, the high recurrent maintenance costs require additional revenue generation. Some governments have welcomed the "frontloading" through private finance of investments in infrastructure or particular types of health services that were beyond the fiscal reach of the public sector at the time. The private sector has provided the up-front cash, and the government repays it over time.

A possible additional contribution of the private sector lies in its capacity as a source of innovation: for example, developing simpler and cheaper management or delivery models that enable the participation of new consumers previously excluded from traditional markets.

Two additional ways in which the private sector contributes to domestic resource mobilization in lower-income countries are considered now: private sector philanthropy and impact bonds.

Philanthropy. In 2018, Forbes magazine classified 2,208 people in the world as billionaires (in US dollar terms), with an average net worth of \$4.1 billion. An increasing number come from low- and middle-income countries, particularly China. Between them, they controlled assets of more than \$9 trillion. Little, however, is known about whether they contribute financially to improving health in their own countries beyond their personal health expenses and paying taxes. The extent of investment in health by private foundations or private companies in lower-income countries is also unknown.

However, the OECD has recently tried to estimate the extent of private philanthropy for development. Only 77 of the 143 foundations surveyed responded, while data were accessed from publicly available records for another 53 philanthropies. Over 90% of the funding that was identified for the period 2013-15 emanated from foundations in North America or Europe. Most of the funds from foundations in middle-income countries were spent domestically, but beyond that, little is known on patterns of expenditure. While there is likely to have been under-reporting from foundations in low- and middle-income countries, the available evidence suggests that, to date, private-sector philanthropy has added little to DRM in those settings.

Impact bonds. These instruments are gaining in popularity among donor agencies. The greatest experience with Social Impact Bonds (SIBs) has been in the UK. However, SIBs are now beginning to be developed, commonly with donor support, in lower-income settings, where they are now commonly called Development Impact Bonds (DIBs). The private sector provides the up-front investment and gets paid by donors or governments based on results. If the agreed targets are not met, as assessed by an independent arbiter, the private sector does not get paid. There are two main benefits for the government or donor: the private sector provides investment capital that might be beyond the capacity of the guarantor; and the risks of the investment are transferred to the private sector.

Of the 108 impact bonds the Brookings Institution could identify, only six were contracted in developing countries. Another 22 were in design, with an increasing emphasis on the health sector. Most were small, covering relatively few beneficiaries. Because impact bonds are comparatively new, there are few rigorous studies of their impact. An exception is a review of one of the earliest, a bond funding education for girls in India. That study reported that the agreed targets of increased enrolment of out-of-school girls and improved educational attainment were more than achieved. Other reviews suggest reasons for caution. Concerns include the high costs of establishing the bonds and of monitoring progress, and the changes that come from shifting to a dialogue held largely between the funder and the private-sector implementor, rather than governments and people in need. , Certainly, there is no evidence that impact bonds are currently playing a large role in DRM in lower-income settings, although their importance seems likely to grow.

Areas of ongoing debate

While the technical options for raising greater domestic resources for health are well established, there are still some controversies and areas of uncertainty. These include:

Social health insurance. Governments in LICs and LMICs are increasingly seeing social health insurance as a way of raising additional funds for health, partly on the grounds that taxes earmarked for health may be more acceptable to populations than other taxes, and partly because the funds are often held separately from general government revenues, thus considered less amenable to political influence, but also with greater flexibility in their use (e.g., roll-over from year to year and payment methods). The question of whether moving from financing health through general government revenues to additional funding from compulsory health insurance actually increases overall funding for health in lower-income settings is still unanswered. The question of how best to collect premiums for people outside the formal sector also remains unresolved.

Voluntary insurance, including community health insurance. Voluntary insurance raises additional revenue for health and increases both financial protection and access to services for those who join.

On the other hand, the poor and disadvantaged generally cannot afford to pay. There are also possible spill over effects: for example, scarce human resources can be diverted to serve the privately insured population, and the demand for health workers by the private insurance sector can exert upward pressure on input wages (and the prices of other inputs). Reflecting this debate, some countries and external partners still promote voluntary and community insurance, while others are opposed to it. Recently, private-sector led programs have aimed to invigorate voluntary health insurance by facilitating contributions through mobile money systems. Some models have incorporated design nudges and high value e-health services. This may work to counterbalance the short-sightedness that tends to curtail savings and insurance decisions. The emerging business models also increasingly target also the near poor to benefit.

Appropriate role for the private sector. We have discussed various modalities of private-sector engagement in DRUM. However, views continue to diverge on the extent to which the profit motive can reliably be harnessed to raise additional funds for covering the poor and vulnerable. Some public/private partnerships show promise, but there is disagreement about whether they do ultimately improve the welfare of those most at need.

Obstacles

The fundamental question remains why many LICs and LMICs have not increased the share of government revenues and spending from domestic resources in GDP, nor have they increased the priority given to health in budget allocations. Among the obstacles that have been identified are the following:

On revenue as share of GDP: Their low GDP places a limit on how much poor countries can raise. It is also important that the poor, who form a large portion of the population, not be taxed unfairly. Other frequently noted obstacles are: a large informal sector that makes it difficult to collect income-based taxes; limited PFM capacity to collect, enforce, prioritize, spend and monitor; corruption; and political will. Distrust of government and unwillingness to pay taxes also contribute. In higher-income settings, implicit fiscal social contracts have helped: people pay taxes because they value the services they receive. In lower income settings, building this trust between government and the people on tax issues has proved complicated.

On health spending as a share of government spending (both from domestic and external sources): The health sector is often perceived as inefficient by the MoF and parliamentary committees. Furthermore, the MoH's use of available funds is often low, so governments are reluctant to invest more in the sector. Weak political commitment to health may be linked to the perceived importance of other sectors and to the belief that health spending is consumption, rather than productive investment in future growth and wellbeing. Weak political will can also reflect a lack of organized public demand. Development aid has been disproportionately devoted to health, so some governments have shifted their domestic resources to other priorities that receive less attention from external partners.

Lessons from country experience

Some countries have consistently raised an unusually high share of GDP in government revenues (e.g. Liberia, Mozambique), while others have consistently allocated an exceptionally large share of public resources to health (e.g. El Salvador, Guatemala, Madagascar). Other countries have in the recent past made more rapid improvements than their peers in increasing government health expenditures (e.g. Ethiopia, Lao PDR). One of the emerging lessons is that both higher overall revenue generation and greater priority to health are more likely to emerge where there is strong, organized domestic demand for a robust government and for health spending (usually expressed as a demand for an improved range and quality of affordable health services). The development of more effective tax systems can be accelerated by an effective “fiscal social contract,” in which the population does not seek to avoid tax contributions, because it trusts that they will be used to provide good quality social benefits.

Discussion

Objectives for Roundtable 1:

Draw on country experiences to:

- Identify ways countries can sharply boost domestic health investment
- Assess whether there is a role for the private sector in raising revenues in LICs and LMICs
- Consider if there are new DRM approaches/solutions that have not been widely implemented and that may enable much faster progress.

Points for discussion:

- Where more rapid progress has been made on DRM, why has this happened? Where it has not occurred, why?
- What are the most common obstacles to increasing government revenues as a share of GDP, and to increasing the priority given to health in spending decisions?
- How have these obstacles been overcome?
- Are there special issues of decentralized systems? Are there effective mechanisms for central governments to use to influence the level and patterns of spending at decentralized levels?
- Has the private sector played a role in raising additional funds for health that are used to increase coverage for the poor? Where there is extensive private-sector involvement in revenue generation, what are the spill over effects?

Annex 2

Efficiency and equity: towards a joint agenda

The conference's second Roundtable considers the efficiency and equity problems and opportunities posed by DRUM. Efficiency and equity are examined together.

Identifying problem areas

Efficiency can be understood as obtaining the greatest possible benefit for the resources used. Equity means the elimination of unfair differences among individuals or groups. The most prevalent sources of inefficiencies within health systems are relatively well known. These factors are responsible for the 20-40% wastage of resources described earlier (Box 1). Inequities can be found in financial contributions (e.g. the poor contribute a higher proportion of their incomes than the rich); in the extent of coverage from pooled funds (e.g. civil servants and formal sector workers obtain more complete cover than others); and in the benefits derived from the pooled funds (e.g. the rich obtain more and better health services than the poor).

Box 1: Common Causes of Inefficiency in Health Systems

Spending on the wrong things

Imbalances between: population-based promotion and prevention versus personal services, particularly treatment; high-cost, low-impact health services versus low-cost, high-impact services; governance and public health functions versus personal health services.

Spending in the wrong settings

Imbalances between spending across levels of care and between inpatient and outpatient settings (e.g., inpatient care where people could be treated on an ambulatory basis); and spending on infrastructure, health workers, medicines, and other health products located in the wrong places.

Spending badly

This typically includes: paying too much for inputs such as medicines and other health products; overuse (or underuse for people who cannot pay) of investigations, equipment, tests and procedures; inappropriate length of stay for inpatients; medical errors and low-quality care, medicines, and other inputs; leakages and waste; and inappropriate mixes of inputs – e.g. wrong mix of health workers for the health needs of the population, or inappropriate mix between staff and other inputs.

Source: Based heavily on WHO 2010, reorganized and condensed

Known solutions

Health leaders have long sought solutions to make health systems more efficient and equitable. On both fronts, some policy options are now well understood. Importantly, while efficiency and equity can conflict, some solutions promote both at once.

Two birds with one stone. Proven options to make health spending more efficient while accelerating coverage among those with the greatest health needs and the poor and vulnerable include:

- **Focusing on the front lines.** Countries have boosted health system efficiency and improved coverage in marginalized groups by moving health-system resources to the front lines – typically to the first level of care (e.g. health clinics) and sometimes at the community level. This requires good referral pathways to allow for patients who need more specialized care.
- **Pro-poor service packages, covered from pooled funds.** Countries can boost both efficiency and equity by developing essential packages of services to be covered from pooled funds, while ensuring that the covered services address the major health needs of the population. This should include conditions disproportionately found among the poor.
- **Prevention and promotion.** Pro-poor service packages can generally improve equity and efficiency by reinforcing prevention and promotion. The impact may be especially powerful among communities that have historically lacked these options. Such measures enable poor people to better maintain and enhance their own health.
- **Public financial management reforms.** This can cover improvements in budget formulation, execution, and fiscal oversight. A focus on results in budget formulation can increase both efficiency and equity, while better budgeting can increase flows from the ministry of finance and donors. Improved oversight and accountability reduce waste and leakages.

Additional efficiency solutions. Along with these win-win solutions, efficiency in health spending can be promoted by addressing the individual issues identified in Box 1. Rarely, however, does a single option make a substantial difference by itself. Identifying the appropriate combination of interventions for each setting is key. Some options include: discouraging inpatient care for those who could be treated as outpatients; introduction of treatment network models to help providers do the right things in the right places; and development of a generic medicines policy. This type of efficiency improvement can be influenced by improvements in purchasing arrangements. For example, blended provider payment mechanisms that include an element of paying for results encourage quality and a focus on results. Forms of contracting that have a clear focus on results are another example. Further upstream, there are also a variety of technical solutions for countries to improve the efficiency of their revenue generation systems through reducing the cost of enforcement and administration and increasing the yield generated from existing taxes.

Additional ways to advance equity. Decision-makers can have a powerful effect on equity by ensuring that the broad design of fiscal policy is pro-poor. This requires consideration both of: (a) how much people pay into the system; and (b) how much they benefit from it in the form of fiscal transfers or the use of services subsidized by government. Much is known about the equity effects of different instruments for raising money and ensuring that the poor benefit from fiscal transfers. Further downstream, equity can be improved by reducing reliance on direct out-of-pocket payments in health, which cause the poor to forego needed care or result in financial hardship for those that use services. Another effective approach is equalizing different social groups' levels of financial protection and access to services from pooled funds.

Areas of ongoing debate

Several areas that are either controversial or not yet well understood remain, and trade-offs are inevitably complex. Some of the most important follow:

Questions persist on results-based financing. Results-based financing involves paying for a set of specified results. Such models have become popular in recent years, though many have been financed by donors without yet going to scale using only domestic financing. Higher-income countries have sought to introduce elements of payment for results into provider payment packages, as a form of blended payments, although many questions remain, including which blend is most effective, and how frequently the mix should be modified. The challenge for lower-income settings is to decide how feasible is it to implement such a model and how to embed any approach in domestic processes and systems, including budget formulation, expenditure control, provider autonomy and information management.

Trade-offs won't go away. Some trade-offs are well-known and require policy-makers to consider them explicitly: for example, locating health services among underserved populations in isolated areas improves equity but comes at a relatively high cost. Policy-makers routinely consider these dilemmas. However, some trade-offs are not so well understood. One is the question of what weight should be given to reducing impoverishment due to OOPs, or increasing the quality of services, for the poor? Different views of social justice legitimately influence the weight people and countries decide to assign to the different components. However, health-sector policy makers have only begun to consider these issues explicitly since the inclusion of financial protection alongside service quality and coverage as part of UHC. To assist their deliberations, the third Annual Forum on Financing for UHC developed a set of principles to help countries consider which trade-offs might be judged unacceptable from a policy perspective because they might exacerbate current inequities (Table 1).

Obstacles

Countries that set out to strengthen efficiency and equity with known solutions may struggle to get policies implemented and then obtain the desired results. They may also find it challenging to measure progress. Implementation obstacles can blunt the effect of well-designed policies, while inadequate measurement makes it hard to track performance and demonstrate impact.

Personal interest versus the greater good. Many implementation challenges reflect tensions in political economy. Some interest group always benefits from an existing inefficiency and inequity and will resist its correction. For example, health providers often benefit financially from fee-for-services payments. Urban elites have a stronger influence on political processes than the rural poor. Moving resources from tertiary hospitals or high-tech medicine to the primary level can result in backlash and rising pressures from elites. Health workers themselves may resist efforts to change payment methods.

A related issue is that motivating institutions and health workers to implement reforms is made more complicated, because the financial and other benefits of efficiency gains do not always accrue to the people who implement change. For example, provider incentives to reduce unnecessary inpatient treatment will not reduce inpatient occupancy rates in countries where there is under-capacity of inpatient beds -- the backlog of patients will fill up the beds. Even though they have helped make the system more efficient, overstretched frontline providers who cut down on unnecessary treatment will see no change in their own workloads and conditions.

Data and evaluation gaps. Inadequate data weakens decision-makers' capacities to track results and make timely course corrections. Tracking progress in reducing overall inefficiency is complicated both conceptually and practically, while inequities linked to UHC outcomes are not routinely measured in most countries. Most frequently, countries track improvements in overall coverage with particular types of health services, but only a few monitor how inequalities in coverage across different population groups are changing as aggregate coverage expands. Fewer still track inequalities in the quality of health services received, or the extent of financial risk protection linked to OOPs. Thus, progress along these performance dimensions and differences across population groups remain largely unknown. This makes it difficult for governments to assess whether their health financing strategies are increasing financial protection among the most disadvantaged.

Table 1. Ten Unacceptable Trade-offs Linked to Health Financing Policies

<p>Financial Burden: financial contributions to the system:</p>	<p>It is unacceptable to:</p> <ol style="list-style-type: none"> 1. Increase OOPs for universally guaranteed personal health services without an exemption system for the poor or other compensating mechanisms 2. Raise additional revenues for health in ways that make contributions to the public financing system less progressive without compensatory measures that ensure that the post-tax, post-transfer final income distribution is not more unequal 3. Raise additional revenues for universally guaranteed personal health services through prepaid and pooled financing arrangements based largely on health status, including pre-existing conditions and risk factors
<p>Benefits from the system:</p>	<ol style="list-style-type: none"> 4. Change per capita allocations (of domestic general government revenue or donor funds) across prepaid and pooled financing schemes that worsen inequities, unless justified by differences in need or the availability of funds from other sources 5. Change per capita allocations from higher to lower administrative levels (e.g. from central to provincial government) in ways that worsen inequities, unless justified by differences in need or the availability of funds from other sources 6. Within financing schemes or pools, change allocations of funds across diseases in ways that worsen inequities in the availability of funds, unless justified by differences in need, cost-effectiveness or the availability of funds from other sources 7. Introduce high cost, low benefit interventions to a universally guaranteed service package before close to full coverage with low cost, high benefit services are achieved 8. Increase the availability and quality of personal health services that are universally guaranteed in ways that exacerbate existing inequities unless justified by differences in need 9. Increase the availability and quality of core public health functions in ways that exacerbate existing inequities unless justified by differences in need 10. Expand the availability and quality of key inputs to produce a universally guaranteed set of personal health services in ways that exacerbate existing inequities unless justified by differences in need

Source: Background paper to 3rd Annual UHC Financing Forum

1 Proof that these systems and mechanisms are critical.

2 Net of the value of health services received, which are treated separately.

3 This includes changes to requirements for counterpart funding taking domestic resources from relatively under-funded areas to those that are relatively well funded.

Disagreement about trade-offs. As countries pursue UHC, there are often profound differences in society and among policy makers around the trade-offs discussed earlier – e.g. between improvements in service coverage and financial protection, or in broader social goals versus improving equity. These often take time to resolve, delaying reform.

Lessons from country experience

Because tracking is not routine, it is difficult to understand which countries have made the most rapid progress in improving efficiency and reducing inequalities in coverage with health services and/or financial protection. But there are exceptions. Among the examples of successful efficiency reforms are changes to provider payment methods that constrain cost escalation and improve quality of care in Thailand (capitation at primary level, Diagnostic Related Groups at hospital level), internal contracting in Burkina Faso in which the central government transfers funds to lower levels in return for agreed outputs, and the establishment of third party payers that separate purchasing from provision in Lao PDR and Cambodia and enhance transparency and accountability.

On equity, data from available DHS surveys analyzed by the World Bank suggested that Rwanda, Cambodia, and Burundi are among the countries that made the most rapid progress in increasing coverage with skilled birth attendants among women in the lowest wealth quintile. Burkina Faso, Mozambique, Bangladesh, Guatemala, Vietnam and Zambia are among the countries showing progress on improving overall financial protection from OOPs, but it is not possible to know if inequalities across population groups improved.

Experiences from these and other countries suggest a number of emerging “how-to” lessons on strengthening efficiency and equity through domestic health finance. These tentative reflections may inform discussions at “Beating the Drum.”

Improving efficiency and equity requires:

- Strong leadership from the highest level of government and the highest level of ministries of health;
- Making efficiency and equity concerns fundamental to all health financing policy debates, to enable countries to identify and redress current inequalities and to avoid inadvertently exacerbating existing inequities;
- Extensive consultation with the private and NGO sectors and health care workers, who can make or break reforms;
- Strong public financial management (PFM) to ensure efficiency in allocating and managing public resources. While financial management can be improved within the health sector itself, strong PFM requires the active involvement of all levels of government and the rule of law to enforce the required standards.
- Tracking progress in such a way that the impact on both efficiency and equity can be evaluated regularly. For equity, this requires data disaggregated by the socioeconomic characteristics important in the particular country, most commonly income/wealth, gender, and place of residence

Public trust for these actions can be nurtured by developing a system of process fairness and accountability in health financing so that the public trusts the way decisions are made and is involved in them, recognizing that there will not be universal agreement about the outcomes.

Discussion

Objectives for Roundtable 2:

Draw on country experiences to:

- Identify what would sharply accelerate progress in getting more value for money and reducing inequity in health resource use
- Consider if there are new approaches/solutions that have not been widely implemented that would help to move much more rapidly than before in reducing inefficiency and inequity.

Points for discussion:

- What health financing strategies have been introduced by LICs and LMICs to increase efficiency and equity in DRUM?
- How do leaders know if these strategies are working, and which of them offer the greatest potential for other countries?
- What are the most common obstacles to improving efficiency and getting more value for money? How have they been overcome?
- What are the most common obstacles to improving equity in DRUM? How have they been overcome?
- Where are innovations and new approaches needed most critically?

Annex 3

Development assistance for health: towards a joint agenda

Identifying problem areas

Volume of DAH. DAH per capita increased substantially in LICs, and steadily in LMICs as a group, in the first part of the MDG era. This changed, however, after the financial crisis that hit HICs in 2008. Currently, DAH receipts per capita (real terms) in LICs as a group remain below pre-crisis levels, and those in LMICs have recently fallen despite the increasing funding provided by the Bill & Melinda Gates Foundation post-crisis. Nevertheless, DAH was important in supporting countries to rapidly expand coverage with key health interventions and to improve the associated health outcomes.

The WHO global health expenditure data base does not yet show data on country receipts of DAH for 2016 or 2017, but IHME estimates that disbursements from donors for 2017 fell slightly. The prospects for immediate increases in DAH flowing to LICs and LMICs do not seem bright, particularly for the approximately 35 low- and middle-income countries that are expected to transition from key external financing streams like Gavi and IDA.

DAH Effectiveness. The problems described in the main paper were associated with the rapid increase in DAH over the MDG era. Well-recognized and documented, these difficulties include non-alignment with country priorities, fragmentation with subsequent reduction in effectiveness, and possible substitution of domestic resources.

Known solutions

Reducing the apparent decline in DAH can only be achieved through a change in the policies of external partners, or by countries' finding new partners.

On aid effectiveness, four high-level meetings on the topic took place during the MDG era - in Rome (2003), Paris (2005), Accra (2008), and Busan (2011). From them, a set of practices for development partners (external financial partners and recipient countries) to improve aid effectiveness were developed.

The IHP+ partnership emerged to foster more effective development cooperation in health. This effort has recently given rise to a new collaborative structure, UHC2030. A set of seven behaviours outlining how partners could change for the better were agreed, with intermittent self-reporting of progress based on score cards. Some of these behaviours link directly to health financing: e.g. DAH inputs should be recorded on budget and in line with national priorities; financial management systems should be harmonized and aligned with those of recipient countries using country systems, strengthened through capacity building where necessary; joint monitoring of process and results should be undertaken, based on one information and accountability platform.

There is now some experience with external partners working together to address some of these financing issues. For example, they are increasingly seeking to combine their separate financing instruments to leverage additional external and domestic funds for country health priorities.

Areas of ongoing debate

The critical question of how to best use DAH to support domestic resource mobilization remains open. One of the most debated concerns is whether external funding always requires counterpart funding. Imposing this requirement gives an incentive to DRM but limits a host government's flexibility to allocate domestic funds to domestic priorities. There are strong differences of opinion at donor and country level. There is also no consensus about what constitutes a reasonable government response to significant inflows of DAH when other sectors, eventually contributing to health outcomes, remain relatively underfunded.

Constraints

Bilateral donors are responsible to their own parliaments and populations, where the appetite for increasing DAH has fallen since the 2008 financial crisis. Moreover, the time horizons of external partners are relatively short, since agencies are required to produce rapid results to satisfy their boards or parliaments. Supporting countries to build the institutions and capacity to increase and improve DRUM takes time to produce results. These two perspectives are difficult to reconcile.

Lessons from experience

The last round of voluntary IHP+ reporting, though some time ago, suggested that, if anything, donors had moved backwards in applying the agreed principles of aid effectiveness – for example, the self-reported share of external funds being channelled through government had declined for many donors.

Recently, intensified efforts have been made to address some of these issues, including those relating to health financing. For example, the GFF supports countries to bring together domestic resource mobilization and international assistance for greatest impact on country health priorities. GFF also works with countries and other partners to reduce inefficiency and inequity in resource use, whether funding derives from domestic or external channels. As countries raise more domestic resources, it is hoped that they can obtain financing from other global sources, including from the International Development Association (IDA) and the International Bank for Reconstruction and Development (IBRD).

Another example relates to the action plan for reaching UHC and SDG3 that WHO is leading, in collaboration with a number of other global health agencies. The partnership seeks ways of rapidly accelerating sustainable financing, including through intensified collaboration among these agencies themselves and in support of DRUM.

Recognizing the imperative of country leadership, a set of supporting actions have been proposed that are designed to facilitate more rapid change than in the past, including:

- Supporting countries to increase DRM through fiscal reforms and/or greater priority to health, and helping them build the capacities, institutions, and dialogue with other external agencies necessary to do this;
- Better-coordinated and intensified advocacy to generate demand for increased domestic spending on health and the above reforms;
- Support to explore innovative ways of raising additional funds at country level, drawing on the experience of innovative health financing at the global level;
- Increased deployment of joint financing mechanisms that, when combined with domestic resources, will allow a critical mass of funding for key country priorities;
- Increased engagement on efficiency reforms in the use of all funds, external and domestic;
- Enhanced and sustained support for improvements in public financial management to reduce waste and rapidly increase coverage, making optimal use of available funds, both domestic and external.

These and other activities suggest that change is now happening to support DRUM.

Discussion

Objectives for Roundtable 3:

Draw on country and partner experiences to:

- Identify what would sharply accelerate progress in ensuring that countries can access the DAH they need; that DAH funds are used effectively; and that DAH functions additively, not substituting for domestic health investment
- Consider if there are new approaches/solutions that have not been widely implemented that might advance these agendas much more rapidly.

Points for discussion:

- The GFF partnership involves countries and external partners including foundations, bilateral and multilateral organizations, and private-sector entities. The sustainable financing accelerator for SDG3 is in its infancy, but to date has involved only multilateral health agencies. A number of other coordination platforms exist, including UHC2030 in health systems and P4H in health financing. Is this going to be enough? If not, what else needs to be done among external partners, and in partners' relationships with LICs and LMICs, to obtain the necessary changes towards sustainable financing?
- Will any of the known options make the sea-change required to help countries move more rapidly to UHC and SDG3, or are fresh solutions necessary?

1 Unless indicated otherwise, all financial data are expressed in US\$ 2015.

2 By payment systems, we mean any system to settle a financial transaction.

3 United Nations, 2015. Addis Ababa action agenda of the third international conference on financing for development. UN, New York. http://www.un.org/esa/ffd/wp-content/uploads/2015/08/AAAA_Outcome.pdf

4 Source: World Bank, 2018. Business unusual: Accelerating progress towards universal health coverage, Washington, DC: World Bank. WB calculations based on WHO Global Health Expenditure database and OECD Creditor Reporting System.

5 World Bank staff calculations based on data from IMF, WBG, and WHO. These results are consistent with earlier estimates from Stenberg, K., Hanssen, O., Edejer, T.T.T., Bertram, M., Brindley, C., Meshreky, A., Rosen, J.E., Stover, J., Verboom, P., Sanders, R. and Soucat, A., 2017. Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries. *The Lancet Global Health*, 5(9), pp. e875-e887.

6 This includes the costs of foundational health-system strengthening, as well as scaling up specific programs.

7 Figures reflect population weighting and are in constant 2014\$. This is total cost of scale up. Stenberg et al. also assume government would meet only 81% of the need in LICs and 60% in LMICs.

8 World Bank, 2018. Equity on the path to UHC. Deliberate decisions for fair financing. Background paper to 3rd Annual UHC Financing Forum. Washington DC: World Bank.

9 These projections assume that, on top of the increased revenues from economic growth, by 2023 countries completely reduce the gap between themselves and the ratio of the share of government health spending from domestic sources in GDP of the country at the 80th percentile. The added restriction was that no country below that level could increase the share by more than 0.1 percentage points per year, the maximum considered feasible based on historical trends.

10 A Chatham House (2014) working group recently proposed a normative target, arguing that countries should increase their annual government health spending to 5% of GDP in order get close to UHC. By 2023, this goal would require government health spending per capita to reach \$41.70 for LICs and \$141.63 for LMICs (in constant 2015 prices), again higher than the estimates of countries' capacity to raise additional resources by 2023. Chatham House, 2014. Shared Responsibilities for Health. A Coherent Global Framework for Health Financing. Final Report of the Centre on Global Health Security Working Group on Health Financing, Royal Institute of International Affairs, London. https://www.chathamhouse.org/sites/default/files/field/field_document/20140521HealthFinancing.pdf

11 Because we cannot separate out ODA passing through government from domestically sourced government expenditures, these ratios overestimate the ratio of domestically sourced government expenditure in GDP. The trends will be similar to Figure 1 if the share of ODA passing through government has not changed.

12 Because DAH is extracted out of government health expenditure, but ODA remains in total government expenditure, these ratios underestimate the share of priority given to health in allocating domestic resources. Observed trends can be due to changes in total development assistance and to the share of development assistance going to health as well as to the way governments prioritize the use of domestic resources.

13 World Health Organization (WHO), 2010. *The World Health Report 2010. Financing for Universal Coverage*. Geneva: WHO.

14 A recent OECD study confirmed that inefficiency is rampant even in the highest-income countries. The report argued that up to 20% of all expenditures in OECD states did not contribute to desired health outcomes.

15 World Health Organization (WHO), 2016. *Public Financing for Health in Africa: from Abuja to the SDGs*. WHO/HIS/HGF/Tech.Report/16.2

16 World Health Organization and World Bank, 2017. *Tracking universal health coverage: 2017 global monitoring report*. World Health Organization and International Bank for Reconstruction and Development / The World Bank, 2017.

17 Source: WHO Global Health Expenditure Database <http://apps.who.int/nha/database>. This is the DAH reaching countries that is captured in country health accounts. This is not the disbursements donors report to OECD or which are captured by IHME, which in general are higher and can include disbursements for expenditures in the home country.

18 World Health Organization and World Bank, 2017. *Tracking universal health coverage: 2017 global monitoring report*. World Health Organization and International Bank for Reconstruction and Development / The World Bank, 2017

19 United Nations, 2015. *Millennium development report 2015*.

[http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20\(July%201\).pdf](http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf)

- 20 Attempts to stimulate domestic resource mobilization have often been poorly coordinated, often involving multiple parallel efforts to lobby the MoH or MoF for counterpart funding for the activities that each donor thinks are important. External health funders have shown a limited capacity to engage with ministries of finance and their partners, such as the IMF. Fragmentation imposes considerable transaction costs on recipient countries and strains local capacities. Fragmented processes also lead to additional inefficiencies through duplication of systems such as laboratories, budgets, accounts, and M&E. Multiple budget and reporting cycles have often been aligned to donor rather than recipient needs, as have multiple appraisal missions. Meanwhile, donors' competition for the most able national staff to run these parallel systems further saps government resources and weakens systems.
- 21 Barroy, H., K. Vaughan, Y. Tapsoba, E. Dale, N. Van de Maele, 2017. Towards universal health coverage: thinking public. Overview of trends in public expenditure on health (2000-2014), Health Financing Working Paper No. 7, WHO, Geneva.
- 22 Morrissey, O., 2015. Aid and Government Fiscal Behavior: Assessing Recent Evidence. World Development, Volume 69, pp. 98-105.
- 23 Dieleman & Hanlon (2014) suggest that government spending from domestic sources only seems to change when DAH increases, but when it falls there has not yet been a subsequent corresponding increase in domestic spending on health. This is worrying for the 35 countries that will shortly graduate from eligibility for key DAH streams. Dieleman, J. L. & Hanlon, M., 2014. Measuring the Displacement and Replacement of Government Health Expenditure. Health Economics, Volume 23, pp. 129-140.
- 24 Even if countries immediately eliminated all forms of inefficiency, they would generate improvements equivalent to a maximum of 40% (the maximum proportion of health spending wasted) of current spending, or 40% of \$7.32 for LICs and \$25.56 for LMICs. This is valuable, but small compared to needs.
- 25 This discussion of the private-sector excludes the option of increasing patient out-of-pocket payments (OOPs) which, in lower-income settings, are generally undesirable.
- 26 See Annex 1 for more details of the technical options.
- 27 see <http://www.worldbank.org/en/publication/human-capital>
- 28 World Bank, 2017. Greater efficiency for better health and financial protection. Background paper, USAID/WBG 2nd Annual UHC Health Financing Forum, Washington DC: World Bank.
- 29 World Bank, 2018. Business unusual: Accelerating progress towards universal health coverage. Washington DC: World Bank.
- 30 World Health Organization (WHO), 2010. The World Health Report 2010. Financing for Universal Coverage. WHO, Geneva. World Bank, 2016. Financing universal health coverage. Raising funds for health. Background paper, USAID/WBG 1st Annual UHC Health Financing Forum. Washington, DC: World Bank.
- 31 Elovainio, R. & D.B. Evans. "Raising and spending domestic money for health", Working Group on Financing Paper 2, Centre on Global Health Security Working Papers, Chatham House, May 2013. <https://www.chathamhouse.org/publications/papers/view/191335>
- 32 World Bank, 2018. Equity on the path to UHC: deliberate decisions for fair financing. Background report for the 3rd Annual UHC Financing Forum. Washington, DC: World Bank, 2018.
- 33 www.oecd.org/dac/effectiveness/thehighlevelforaonaideffectivenessahistory.htm
- 34 www.internationalhealthpartnership.net
- 35 <http://www.internationalhealthpartnership.net/en/news-videos/ihp-news/article/seven-behaviours-how-development-partners-can-change-for-the-better-325359/>
- 36 GFF and IDA work together to maximize support to countries while streamlining administrative processes and keeping debt distress at the lowest possible levels. The IDA grant framework recognizes a countries' level of debt-distress, among other factors, to determine the level of concessionality, ranging from 100 percent grant financing to soft loans referred to as credits. All countries fill up their entire IDA envelope. Specific uses of the loans are negotiated between the MoF and World Bank. GFF adds value by offering an additional grant to enable much more coordinated total investment from both domestic and other external sources.
- 37 Kaboré, R.M.C., E. Solberg, M. Gates, J.Y. Kim, 2018. Financing the SDGs: mobilising and using domestic resources for health and human capital. The Lancet, 392, 3 Nov 2018: pp. 1605-1607. Please note: publication embargoed until 1 November 2018, 23:30 hours, UKT.
- 38 Langenbrunner, J. C., Sheiman, I. M. & Kehler, J. C., 2008. Sources of health financing and revenue collection: Reforms, lessons, and challenges. In: J. Kutzin, C. Cashin & M. Jakab, eds. Lessons of Health Reforms in Eastern Europe and Central Asia. Brussels: European Observatory.
- 39 Tandon, A. & Cashin, C., 2010. Assessing Public Expenditure on Health from a Fiscal Space Perspective, Washington, DC: The World Bank.
- 40 World Bank, 2016. Financing universal health coverage. Raising funds for health. Background paper to the 1st Annual UHC Financing Forum. Washington DC: World Bank.
- 41 Remember from the main report that Figure 1 overestimates the share of domestically sourced government spending in GDP, so the gap between LICs and LMICs and higher income countries, which receive virtually no development assistance, is even more.
- 42 As explained in the main report, these numbers underestimate the share of domestic health spending in domestic government funds because of the inability to extract development assistance passing through government from the denominator.
- 43 See Barroy et al., 2017, op. cit.
- 44 World Bank, 2013. Private Health Policy Toolkit for Africa. Washington DC: World Bank.
- 45 International Finance Corporation (IFC), Healthy Partnerships: How Governments Can Engage the Private Sector to Improve Health in Africa. Washington, DC: The World Bank.
- 46 Reported in World Bank, 2016. op cit.
- 47 <https://www.forbes.com/billionaires/list/3/#version:static>
- 48 OECD, 2018. Private sector philanthropy for development. The Development Dimension. Paris: OECD Publishing.
- 49 Gustafsson-Wright, E. & I. Boggild-Jones, 2018. Paying for social outcomes: A review of the global impact bond market in 2017. Brookings on line. <https://www.brookings.edu/blog/education-plus-development/2018/01/17/paying-for-social-outcomes-a-review-of-the-global-impact-bond-market-in-2017/>
- 50 Gustafsson-Wright, E. & I. Boggild-Jones, 2018. op cit.
- 51 Edmiston, D. and Nicholls, A., 2018. Social Impact Bonds: The role of private capital in outcome-based commissioning. Journal of Social Policy, 47(1), pp.57-76.
- 52 Tan, S., A. Fraser, C. Giacomantonio, K. Kruihof, M. Sim, M. Lagarde, E. Disley, J. Rubin, and N. Mays, 2015. An evaluation of social impact bonds in health and social care. Interim Report. PIRU Publication 2015 – 12.
- 53 Measured in terms of increases in the share of domestically sourced health expenditure in GDP, which can be due to changes in fiscal policy to raise more revenues, higher priority to health, or both.
- 54 In economics, technical efficiency is achieved when a particular set of inputs achieves the maximum possible output(s). Technical efficiency could be achieved with a very expensive set of inputs, so production efficiency is when the inputs used to produce the output have the least cost. Allocative efficiency requires the production of the set of outputs that people value the most for the given resources (e.g. see Hollingsworth 2008). Health economics has generally talked about only technical efficiency and allocative efficiency, where the latter is defined as achieving the greatest population health benefit for the available financial resources. Production efficiency is, therefore, mostly subsumed under allocative efficiency (see Cylus, J., Papanicolas, I., & Smith, P., 2013. Health system performance comparison: an agenda for policy, information and research. McGraw-Hill Education (UK). We have translated these technical terms into everyday language using the three categories in Box 1, modifying Yip, W. and Hafez, R., 2015. Improving Health Systems Efficiency. Geneva, World Health Organization. http://apps.who.int/iris/bitstream/10665/185989/1/WHO_HIS_HGF_SR_15.1_eng.pdf.

- 55 World Health Organization Commission on Social Determinants of Health (CSDH), 2008. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization.
- 56 World Health Organization (WHO), 2010. op cit.
- 57 Including from government revenues.
- 58 Because of the shortage of available information, the joint WHO/WBG global UHC monitoring report was only able to report on inequalities in coverage with a set of 7 services for child and maternal care, reporting that 17% of people in the lowest wealth quintile in LICs and LMICs received at least 6 of these services (data coming from various years between 2005-2015) compared to 74% in the richest quintile. In only 23 countries was it possible to consider changes over time, and in them, the largest improvements in coverage were in the poorer quintiles, suggesting a reduction in inequality. 97 million people were impoverished in 2010 due to paying OOP for health services (at a poverty line of \$1.90 in PPP), making it more difficult to achieve SDG1.
- 59 World Bank, 2018. Equity on the path to UHC. Deliberate decisions for fair financing. Background paper, 3rd Annual UHC Financing Forum. Washington DC: World Bank. This thinking was influenced strongly by WHO Consultative Group on Equity and UHC, 2014. Making fair choices on the path to UHC. Geneva: WHO.
- 60 These and other examples of efficiency reforms are taken from World Bank, 2018. Business unusual: Accelerating progress towards universal health coverage. Washington DC, World Bank.
- 61 World Bank, 2018. Business unusual: Accelerating progress towards universal health coverage. op cit.
- 62 Disbursements reported by donors rarely match receipts at country level because, for most donors, some disbursements are used in the home country.
- 63 World Bank, 2018. Equity on the path to UHC. Deliberate decisions for fair financing. Background paper to 3rd Annual UHC Financing Forum. Washington DC: World Bank.
- 64 For a discussion of issues additional to the fall in resources that need to be faced by transition countries, see Kutzin, J., Sparkes, S., Soucat, A. and Barroy, H., 2018. From silos to sustainability: transition through a UHC lens. The Lancet 392, 10 October 2018: 1513-1514.
- 65 www.oecd.org/dac/effectiveness/thehighlevelforaonaideffectivenessahistory.htm
- 66 www.internationalhealthpartnership.net
- 67 <http://www.internationalhealthpartnership.net/en/news-videos/ihp-news/article/seven-behaviours-how-development-partners-can-change-for-the-better-325359/>