

## 2. Revenue Collection for Health

### Highlights

- ❖ The challenges governments face in revenue collection include how to raise revenues efficiently and equitably to finance health care. In low-income countries, direct payments made by patients to providers are the main source of revenue, raising concerns about access to care for the poor.
- ❖ The Bank did not take an ideological stance in its work in revenue collection for health; rather it worked within the different country contexts. Bank advice focused on increasing the health budget in low-income countries. In middle-income countries, the Bank recommended managing the level of public spending and subsidizing insurance enrollment. Some timely advice on a greater role for alcohol and tobacco taxes has been given but this is very limited. The Bank gave limited attention to user payments through lending operations. In few countries did it help institutionalize monitoring and evaluation to examine the effect of health financing.
- ❖ There have been some notable successes. Bank support has helped raise domestic revenues for health and subsidize contributions to risk pools for low-income groups. Support to reduce user payments lacked the necessary fiscal and equity analysis, and evidence is missing that it has improved service use and financial protection.
- ❖ Bank support was more successful with strong government commitment at both the economy-wide and sector levels and when Bank staff drew on a variety of skills across sectors to engage government.

Revenues for health are collected from public and private sources and allocated to health care providers. Governments face challenges in raising revenues efficiently and equitably. Chapter 2 introduces these challenges, describes how the Bank supported countries in addressing them, and evaluates the effect of this support.

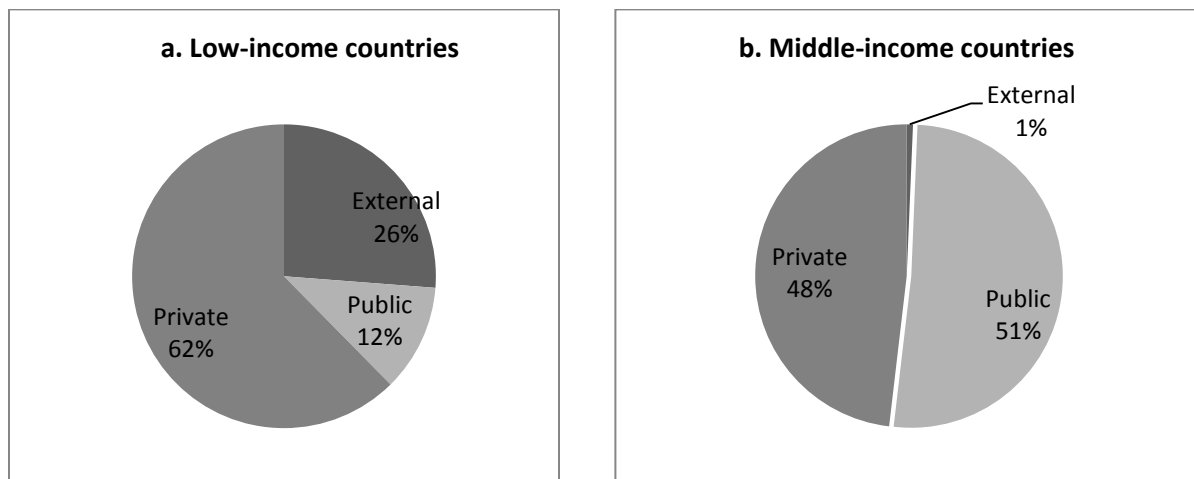
### Challenges

While some countries set targets for public revenues for health, such as the Abuja target of allocating at least 15 percent of the annual government budget to health,<sup>1</sup> there is no consensus on how much revenue governments should allocate to health. The reasons for this diversity reflect different economic circumstances and the range of social contracts that governments have with their citizens for ideological or historical reasons. The economic rationale for devoting public revenues to health are (i) to correct for market failures (e.g., private markets do not work well when consumers and providers have different levels of information regarding the appropriate type and amount of care to purchase); (ii) to ensure that public goods are correctly funded (e.g., immunization may be undervalued if the benefits flow to

society at large); and (iii) to ensure that the poor and other disadvantaged groups are not excluded (to meet equity objectives). The concern in many developing countries is that the very low amount that many governments now devote to health is too low to fund these necessary functions.

A government's revenue-raising capacity is affected by factors such as the country's economic development, institutional constraints, level of formalization of the labor market, and tax administration capacity. Where these are weak, countries rely more on revenues from private and external sources for health. Private revenue – mainly user payments on fees charged by providers – amounts to 62 percent of total health funds in low-income countries (Figure 2.1). User fees have raised concerns about the financial consequences for poor households and the negative effect on health service use (Table 2.1). As countries grow economically, public revenue for health comes to predominate.

**Figure 2.1. Share of Total Health Revenues in Low- and Middle-Income Countries in 2011**



Source: World Development Indicators.

Note: Private = user payments. Voluntary insurance is negligible and is not shown.

Recent syntheses of impact evaluations find that increasing public spending and lowering payments for patients positively affects health outcomes. Using a large panel dataset at the country level, with annual data for 14 years (1995–2008), Moreno-Serra and Smith (2011) applied a two-step instrumental variables approach that directly estimates the reverse causal effects of mortality on coverage indicators. They found that higher public spending on health leads to better population outcomes, measured either by under-five or adult mortality rates.<sup>2</sup> A synthesis report of 16 impact evaluations found that introducing user fees decreases utilization of care, whereas removing them sharply increases utilization of curative services (Lagarde and Palmer 2011). A systematic review of 20 impact evaluations of user fees for maternal health services found that the removal of such fees contributes

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to increased facility delivery but has no clear impact on health outcomes (Dzakpasu et al. 2013).

**Table 2.1. Incentives and Challenges in Revenue Collection**

Revenues Types	Incentives	Challenges
General taxes	Individuals underreport income to pay lower taxes; governments allocate funds to other sectors for political reasons	Low tax ratios; inadequate levels of public revenues allocated to health in low-income countries
Labor taxes and contributions to health insurance	Individuals reduce work in formal sectors; employers underreport number of employees and their salaries to tax authorities	Increased informality; increased revenue collection costs in tax authority
Voluntary premium paid by individual <sup>a</sup>	Individuals hide true health status to pay lower premiums	Few people can pay high premium; financial sustainability
User payments by patients	Poor seek care with lowest-price provider (e.g., pharmacies)	Poor report lower utilization of care and worse health
External sources from donors	Governments allocate funds for political reasons and to priority diseases	Rigidity because of fragmented and earmarked funding

a. Private insurers charge premiums that reflect the risk of illness for an individual or a group of individuals.

However, many developing countries struggle to mobilize adequate and stable resources because they report low tax ratios, with tax revenues often below 15 percent of gross domestic product (GDP) (IMF 2011). Thus these governments have little room to increase spending on health through domestic revenues. Still, the financing of increasing demand for costlier treatment for noncommunicable diseases (such as diabetes) and the treatment of infectious diseases put a heavy strain on their budgets. In response, governments try to manage public spending on health by setting caps on sector spending, prioritizing spending within the sector, and using central oversight (IMF 2011).

Governments have introduced taxes on wages and alcohol and tobacco to raise additional revenues for health, which can have efficiency and welfare implications.<sup>3</sup> If governments impose taxes on wages to finance insurance enrollment, this may affect efficiency if it leads to a reduction in the quantity of hours worked and increases informality (Table 2.1). Indirect taxes levied on goods with externalities, such as alcohol and tobacco, can increase efficiency because they aim to influence individual behavior, reduce negative externalities on others, and subsequently curb the incidence of costly diseases caused by alcohol and tobacco consumption (Begg et al. 2000). Although excise taxes on alcohol and tobacco are regressive, they have a welfare effect if the poor benefit disproportionately more than the rich in health. Nor do excise taxes have adverse effects on labor and capital (IMF 2011).

Only a small share of total health revenue comes from voluntary premiums paid to private insurance. Outside the United States, revenues from voluntary health insurance contribute less than 15 percent of total health revenues in Organisation for Economic Co-operation and Development (OECD) countries (OECD 2013). In developing countries, voluntary private health insurance raises a negligible share of total health revenues (Gottret and Schieber 2006). Few countries have community-based health insurance (CBHI), which is financed by individual contributions and in some countries subsidized by government and donor funds.

Despite the low share of government spending in low-income countries, governments still have much influence as most external resources are routed through them to finance the public health sector. External funds can, however, contribute to fragmentation in financing and service delivery, especially if they are earmarked for specific diseases, and draw away health workers and other resources from general care (Table 2.1). External funding can also be driven by external priorities, introducing both rigidity and instability into a country's health sector funding.

### **Bank Group Support to Revenue Collection for Health**

The World Bank Group has tried to help countries address the above challenges. Two-thirds of the Bank's health financing portfolio includes interventions related to public revenue collection for health; however, this type of Bank support has been decreasing over time. Development policy operations are almost twice as likely as investment lending projects to advise governments on public revenues (appendix Table B.4).

The Bank's approach has been to help countries raise revenues to address market failure, public goods, and equity objectives. The Bank assisted countries in raising adequate levels of revenues to finance the government health budget and health insurance. It advised governments on revenues raised in the form of labor taxes and other contributions to social health insurance paid by employees, employers, and the self-employed, and on user payments made by patients to providers.

#### **ANALYTICAL WORK**

Multisector Bank teams produced analytical work, including Public Expenditure Reviews (PERs), tracking surveys, and fiscal space analysis, that informed governments and other donors about the level of public revenues for health and the allocation of funds within the sector (appendix Table A.9). Bank teams conducted 98 and at least 10 Public Expenditure Tracking Surveys since 2006 (appendix Table

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A.10). However, the number of PERs with a health chapter has fluctuated and decreased over time to less than 10 reviews per year. Medium-term expenditure frameworks were supported by the World Bank in Madagascar, Nepal, and Rwanda, and helped inform governments and donors about health expenditure planning. In 2010 the Bank developed a conceptual framework for assessing fiscal space for health (Tandon and Cashin 2010). Since 2009 the Bank has conducted about eight fiscal space analyses to advise governments on how to feasibly increase revenues for health in a way consistent with the country's macroeconomic fundamentals. More recently in 2013, the Bank produced a series of macro-fiscal context and health financing fact sheets for all Regions (Pande et al. 2013).

#### **DOMESTIC REVENUES FOR HEALTH FROM GENERAL TAXES**

The Bank tailors its advice to the country context. In low-income settings the Bank advised governments to increase their budgets for health, often with the support of Poverty Reduction Support Credits. In some countries tobacco taxation is earmarked for health and other social spending. Bank analytical work advised on using tobacco taxes to create fiscal space for health, mainly in middle-income countries, including China (2003), Estonia (2004), Morocco (2004), Indonesia (2005), Brazil (2007), The Gambia (2012), and the Philippines (2012) as well as the Southeast Asia Region (2004).

#### **COMPULSORY CONTRIBUTIONS AND VOLUNTARY PREMIUMS TO INSURANCE**

In a few European countries the Bank advised on labor taxes and on domestic revenue financing for social health insurance mainly through development policy operations. Where labor tax rates were already high, the Bank warned about adverse effects for the labor market and for informal workers.

The World Bank and the International Finance Corporation (IFC) did not advise on the level of premiums paid to voluntary private health insurance.

#### **USER PAYMENTS**

Only 14 percent of Bank health financing projects advised governments, (mainly in the Africa and Europe and Central Asia Regions), on the level of user payments (appendix Table B.5). The Bank through development policy operations recommended introducing copayments with exemptions for lower-income groups in Romania and for preventive services in Burkina Faso. Analytical work by the Bank on under-the-table payments made by patients to providers (Cherecheş et al. 2013) has not been followed up in projects, even though the measurement of progress toward the objective of improved governance, accountability, and transparency is an indicator in the Health, Nutrition, and Population (HNP) strategy.

## Effectiveness of World Bank Group Support to Revenue Collection

This section focuses on how Bank advice has affected institution building and the level of revenues for government health budgets and social insurance. It presents evidence on Bank support to nonpooled funding in the form of user payments and how they have affected service use. Increased domestic revenues and subsidized contribution payments to social insurance mean that more pooled public funds are available for health. The effects associated with pooled financing are presented in chapter 3.

### STRENGTHEN REVENUE RAISING INSTITUTIONS

In its analytical work, the Bank emphasized that strong institutions are crucial in ensuring that higher public spending positively affects the provision of care. Several Bank studies find a correlation between public health spending and utilization of care when institutions are strong, and Bank teams found that public sector spending improves health indicators in low-income and transition countries, mainly those with good governance systems (Gupta et al. 2002; Baldacci et al. 2008). In 2009, during the financial crisis, the Bank's Europe and Central Asia Region reiterated the importance of good governance in revenue management in its Knowledge Briefs for client countries and staff.

The Independent Evaluation Group (IEG) found that the Bank through lending and policy dialogue helped governments build institutional and technical capacity, and in some countries, Bank teams worked well with government staff. Institution building took place in Argentina where the Bank helped re-establish the ministerial and provincial health committee to coordinate health financing decision in the country (IEG 2011). The Bank supported technical capacity building through the introduction of National Health Accounts in governments to track the flow of funds, mainly in middle-income countries in the Europe and Central Asia Region (including Albania, Armenia, Kosovo, Moldova, Serbia, Tajikistan, and Uzbekistan) as well as in Mauritania and Vietnam. Information produced by government National Health Accounts was used by Bank public expenditure review teams, other donors and the government in health expenditure planning. While health accounts proved to be useful and informative, this support did not always succeed in institutionalizing the health account function within Ministries of Health (IEG 2014).

Because many institutions are involved, coordination is important. IEG found that in Tanzania, the Ministry of Health and the Bank produced their own individual PER in 2011, drawing from different datasets and thus producing different results. The Bank's PER was distributed but never published officially. As the discrepancies between the two PERs were not reconciled, the Ministry of Health uses its own

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report. Collaboration between the Bank and government teams could have helped ensure that health financing analysis is coordinated and institutionalized in Ministries of Health.

#### **INCREASED AND PROTECTED HEALTH BUDGETS**

With the support of the Bank's development policy operations and policy dialogue, health budgets increased during the loan period in several lower-income countries (for example, Afghanistan, Albania, Bolivia, Burkina Faso, Cape Verde, El Salvador, Lao People's Democratic Republic, Mali, and Niger). However, these budget increases were not always sustained. IEG found in Tanzania, the Bank worked closely with other donors to ensure the government would maintain the share of public funding for health. Donors and the Bank decided to disburse earmarked funds to local government health budgets (in a sectorwide approach) and not move to general budget support when concerns were raised that this change would lead to a decrease in overall public spending for health. Despite these efforts, government spending on health decreased from 16 percent in 2007 to 11 percent of total government expenditures in 2011. The reasons for this decrease included a shift in government priorities from social sectors to infrastructure as outlined in the 2010 National Strategy for Growth and Reduction of Poverty, commonly known as MKUKUTA. Similarly, in the Kyrgyz Republic, Bank policy lending in 2002 supported the government in increasing its budgetary share for health to finance health insurance coverage for pensioners and unemployed persons and implement a categorical grant formula for health financed from the central government with the goal of decreasing the share of user payments among the poor. Until 2006, government spending on health increased steadily but then declined again to similar levels as in early 2000 because of increased government priorities for other sectors, including education (IEG 2008). The decline in budget financing for health was addressed under a Bank-supported follow-up operation (sectorwide approach), and the government implemented a set of rules governing the allocation and execution of public funds to the health sector. Subsequently, spending on health increased from 10.3 percent of total government spending in 2005 to 13 percent by 2012. Thus, competing government priorities play a role in raising revenue for health.

Bank advice through lending and technical assistance helped raise additional taxes. One Bank policy operation (Romania) advised an increase in tobacco taxes in 2009; however, as Romania follows European Union rules,<sup>4</sup> this increase would have happened without the Bank's input. In the Philippines, the Bank responded quickly with a multisector team to government requests to help it get the "sin tax on tobacco" through a reluctant Congress. The government of the Philippines reports substantial revenue increases from the tax, which will translate into higher funding for health

programs (AER 2014). While some countries have increased tobacco taxation, recent studies from Brazil (Euromonitor International 2013) and Indonesia (Nasrudin et al. 2013) suggest that the tax rate is not high enough. There is scope for the Bank to address tobacco taxation in low-income countries. At the same time, impoverishing effects caused by regressive taxation need to be addressed.

Bank advice on managing or protecting public revenues for health was informed by analytical work and implemented in close collaboration between the Health and Public Sector teams. IEG's review of project completion reports found that in Bosnia and Herzegovina, Colombia, and Serbia the Bank's Public Sector and Health teams (mainly through development policy operations) supported improvements in the tax collection from employers and employees which increased revenue transfers from the tax authority to social health insurance. In Eastern Europe, including in Croatia and Turkey, the Bank recommended budgetary caps on spending to manage spending growth. Bank policy lending protected the level of budgetary spending from cuts in Latvia and Tajikistan during the financial crisis, and thereby helped the government implement recommendations from recent PERs. During the economic crisis in 2010, Bank policy lending advised the Latvian government to subsidize health payments for low-income households and raise the number of nurses in health facilities to accommodate increased patient demand. In light of fiscal austerity in Argentina, Bank lending and policy advice ensured that basic and cost-effective health programs were protected and financed by the government, including the availability of reproductive health care services for low-income groups in public facilities (IEG 2011). In these countries, the Bank's Health and Public Sector teams leveraged support through a program of policy and investment lending that was informed by analytical work such as PERs and fiscal analysis.

### **SUBSIDIZED CONTRIBUTION PAYMENTS**

The Bank also helped increase revenues for health by subsidizing contributions to various insurance institutions for low-income groups. This type of Bank support was implemented through lending and policy dialogue in countries such as Benin, Bolivia, Cambodia, the Dominican Republic, Ghana, Mexico, Rwanda, Turkey, and Vietnam. The Bank supported the explicit targeting of subsidies to finance contributions for low-income groups through means testing in Georgia, Rwanda, and Turkey and through geographic location in Cambodia and Egypt.

In other countries, similar support served to subsidize access to health insurance for low-income groups. Vietnam's public insurance fund is financed from payroll taxes and general tax revenues. For households not active in the formal sector, the government makes contributions, defined as a proportion of the minimum wage, from the state budget. In Vietnam's Mekong Region the Bank health project



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cofinanced enrollment for near-poor households in the Health Care Fund for the Poor. In Georgia, Bank lending supported the publicly funded Medical Insurance Program for the poor, which provides an extensive benefit package with zero copayments. Low-income beneficiaries receive a publicly funded voucher to enroll with a private insurance company (Bauhoff et al. 2011). IEG found that in Rwanda the Bank provided technical assistance on the law for CBHI.<sup>5</sup> Under this law, the government and donors subsidize CBHI enrollment for the three lower-income quintiles through means-tested targeting while the remaining households pay full contributions. By 2010 about 44 percent of CBHI revenue was from the government budget, 31 percent from households, and 22 percent from donors. As a result of this Bank support, insurance enrollment has increased in these countries. Whether these subsidized contribution payments have also improved service use among pool members is discussed in chapter 3.

### **SERVICE USE AND FINANCIAL PROTECTION**

As shown in Figure 2.1, user payments are the most important revenue source for the health sector in lower-income countries. Bank advice on reducing user fees and copayments has fiscal and equity implications. However, this type of support often lacked the necessary analytical underpinnings, and – contrary to findings from other researchers (Lagarde and Palmer 2011; Dzakpasu et al. 2013) – evidence is missing that reducing copayment levels improved service use and financial protection. While the Bank had recommended introducing copayments with exemptions for lower-income groups in Romania, a recent study found that, compared with those in neighboring countries, households in Romania are far more likely to forgo care because they cannot afford the fees, and young people are more likely to borrow or sell assets to pay for care (Tambor et al. 2013). In El Salvador the Bank supported the elimination of copayments in hospitals but did not prepare providers enough for the resulting demand increase. A 2011 evaluation finds a 40 percent increase in service use after user fees were abolished, and raises concerns about transparency and corruption in finances at unaudited hospitals. It recommends increasing staffing in hospitals to reduce waiting lists caused by the higher number of patients (AfGH 2011). A case study prepared by IEG for this evaluation found similar concerns in Kenya where the new government had just eliminated user fees for primary care in 2013 and was to allocate higher public funding for primary care to compensate for forgone revenues from user fees. The Bank estimated that an additional \$8.1 million is needed to compensate providers. It also identified challenges on the flow of health funds to health facilities in a decentralized system. The Bank could analyze the fiscal and equity implications of changes in user fees, as emphasized in the HNP strategy, and inform governments on the amount of public funds needed to compensate providers for reduced or eliminated fees.

In sum, most Bank support in health financing went to public revenue collection for health. As a result of the Bank's help, government health budgets were increased; health spending was protected against budget cuts during an economic crisis; advice on fiscal space for health was considered; and governments were assisted in subsidizing compulsory contributions to various health insurance for low-income groups. Some timely advice on a greater role for alcohol and tobacco taxes has been given, but this is very limited. Public Sector and Health teams emphasized strong institutions and monitoring and evaluation to ensure revenues positively affect the provision of care. While this type of support has been decreasing over time, there have been some notable successes. Evidence indicates that these have occurred with strong government commitment at both the economy-wide and sector levels that the Bank has supported and when Bank staff drew on a variety of skills across the Bank to engage government. Bank advice and operations have also supported governments which have tried to lower user payments as a source of revenue. However, this type of support often lacked the necessary fiscal and equity analysis, and evidence is missing that Bank support to reduce copayments has improved equity in service use and financial protection.

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<sup>1</sup> In April 2001, heads of state of African Union countries met and pledged to set a target of allocating at least 15 percent of their annual budget to their health sector. <http://www.who.int/healthsystems/publications/Abuja10.pdf>

<sup>2</sup> An increase of \$100 in government spending per capita results in a reduction of 13.2 per 1,000 in under-five mortality as well as a decrease of 2.6 and 2.2 per 1,000 in adult female and male mortality rates, respectively.

<sup>3</sup> Governments raise direct taxes from earnings, indirect taxes on consumption, and wealth taxes. A tax system is considered fair if it generates higher taxes on the rich to finance public goods and services, such as health services, predominantly used by the poor. Indirect taxes on consumption (e.g., value-added taxes) are regressive if the poor spend a higher proportion of their income on goods subject to these taxes than the rich. While such indirect taxes reduce the redistribution effect from the rich to the poor, they may still have a pro-poor effect if they finance public services predominantly used by the poor (Begg et al. 2000; IMF 2011).

<sup>4</sup> According to a directive from the European Commission's Taxation and Customs Union, member states must apply to cigarettes a specific excise duty per unit of the product and a proportional excise duty calculated on the basis of the weighted average retail selling price. For more information visit [http://ec.europa.eu/taxation\\_customs/taxation/excise\\_duties/tobacco\\_products/legislation/index\\_en.htm](http://ec.europa.eu/taxation_customs/taxation/excise_duties/tobacco_products/legislation/index_en.htm).

<sup>5</sup> On December 30, 2007, Parliament passed Law No. 62/2007 on establishing and determining the organization, functioning, and management of the community-based health insurance. For more information visit <http://lip.alfa-xp.com/lip/AmategekoDB.aspx?Mode=r&pid=7586&iid=2031>.