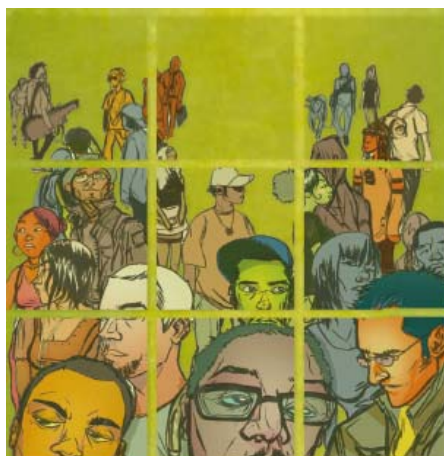


Fiscal space for health in resource-poor countries

Varatharajan Durairaj and David B Evans

**World Health Report (2010)
Background Paper, 41**



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Fiscal space for health in resource-poor countries

World Health Report (2010) Background Paper, No 41

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1 Introduction

The rationale to develop national health financing systems, particularly in low-income countries, is now well established.¹⁻⁴ These countries are challenged by a huge health financing gap since a large number of them suffer from the twin disadvantages of high disease burden (hence, higher need for resources) and low financial capacity or income to address it. Government spending is crucial to ensure better access to essential health services and financial risk protection since it is a stable and sustainable source of financing. However, these countries face challenges in finding adequate fiscal resources or fiscal space for health.

Fiscal space can be defined as "*the capacity of government to provide additional budgetary resources for a desired purpose without any prejudice to the sustainability of its financial position*".⁵ Governments could create fiscal space in many different ways - e.g. tax measures, external grants, efficiency gains, internal and external borrowing and reprioritization. In this context, fiscal space for health can be defined as 'additional budgetary resources for health without prejudice to a country's financial sustainability'. This paper analyses the pattern and prospects of general government health expenditure in a group of 26^a resource-poor^b low-income countries^c (labelled here as L-26 countries). While almost all low-income countries are disadvantaged with inadequate total and government health spending, L-26 countries are more disadvantaged than others. About 2.1 billion people or 31.0% of the world's population, of whom about one-third are poor, live in these countries.⁷⁻⁸ Their average life expectancy in 2008 was 56 years (range 42-65 years).^d Their low income, restricted internal resource base for health, high disease burden, and persistent inequities make them most vulnerable with probably the highest health financing gap.

1.1 Health financing pattern in L-26 countries

A vast majority of the bottom billion people live in L-26 countries characterized by low national income, poverty, poor health outcomes, inadequate health spending, and higher proportion of household out-of-pocket spending (OOPs). Health financing gap figured prominently among the list of major health financing concerns in almost all L-26 countries.⁹⁻²⁰ Evidence for resource inadequacy can be found in the literature too.²¹⁻²³ These countries have higher resource needs due to multiple disadvantages, but a narrow resource base. For instance, the average per capita GDP in L-26 countries in 2008 was US\$ 647 (range \$ 144-1,352) or Int.\$ 1,339 (range \$ 321-2,884).⁷⁻⁸ The level of inadequacy is found to be particularly high among countries housing the most disadvantaged population groups representing the bottom billion, whose progress is crucial for health and health system development since they are caught in the poverty-ill-health trap. Such countries (and their

^a Afghanistan, Bangladesh, Burundi, Cambodia, Central African Republic, Congo (Democratic Republic), Cote d'Ivoire, Eritrea, Ghana, Guinea, Guinea-Bissau, India, Kenya, Lao PDR, Liberia, Mali, Myanmar, Nepal, Nigeria, Pakistan, Rwanda, Sierra Leone, Sudan, Tajikistan, Togo, & Uganda

^b Reporting the lowest per capita total health expenditure (\leq PPP int.\$ 100) and government share (\leq 50%) of THE constituting 33rd percentile in their respective global distributions in 2006.

^c According to World Bank classification based on GNI per capita, 2006 \leq US\$ 905⁶ with the exception of Somalia, left out due to paucity of data

^d Average life expectancy in low-income countries was 57 years.

governments) are not in a position to effectively respond to diseases predominantly affecting the poor. This inability to adequately deal with complex situations impedes their economic growth further. At the same time, the global economic scenario is unfavourable to them and so, it is much harder for these disadvantaged nations to break out of the poverty trap and come out successful. As a result, these countries are drifting away from the rest of the world.

Poor health spending (US\$ 34 or Int.\$ 70 per capita in 2008) is the hallmark of many L-26 countries. It is lower compared to other low-income countries in all WHO regions (Table-1); the difference is 2.6 times in SEARO, 65.6% in WPRO, 51.7% in EURO and 34.5% in AFRO. The gap became much wider (except in SEARO) if the regional average, which includes all countries, was taken into account - 69 times in EURO, 12 times in WPRO, 2.8 times in EMRO, 1.6 times in AFRO and 95.2% in SEARO. Total health expenditure (in per capita terms) was generally low in AFRO and SEARO countries. More importantly, Bangladesh, India, Nigeria, and Pakistan housing a huge chunk of the world's poor spent less. Figure-1 indicates the level of per capita health spending (in US\$) in L-26 countries in 2008; their average health spending (US\$ 34 or Int.\$ 70) fell well short of the minimum amount of resources (Over US\$ 50)^e required to finance at least a minimum set of essential health interventions - prevention, promotion, treatment and rehabilitation.²⁴ Obviously, given their amount of resources allocated for health, these countries would not be able to buy any worthwhile care for their disadvantaged populations; less than 20% of births were attended by skilled health personnel during the period 2000-2008 in Afghanistan (14%), Lao PDR (20%) and Nepal (19%).⁷

Table-1

Per capita health spending across WHO regions (US\$, 2007)

WHO Region ^f	Total health expenditure			Govt. health expenditure			Out-of-pocket spending		
	L-26	OLI	All	L-26	OLI	All	L-26	OLI	All
AFRO	29	39	76	10	20	34	15	13	25
AMRO	-	35	2,911	-	8	1,374	-	16	430
EMRO	35	-	133	11	-	74	23	-	51
EURO	29	44	2,035	6	22	1,546	22	21	325
SEARO	21	75	41	6	60	15	13	15	22
WPRO	32	53	416	8	40	282	19	9	109

OLI - Other low-income; and All - All countries in the respective region

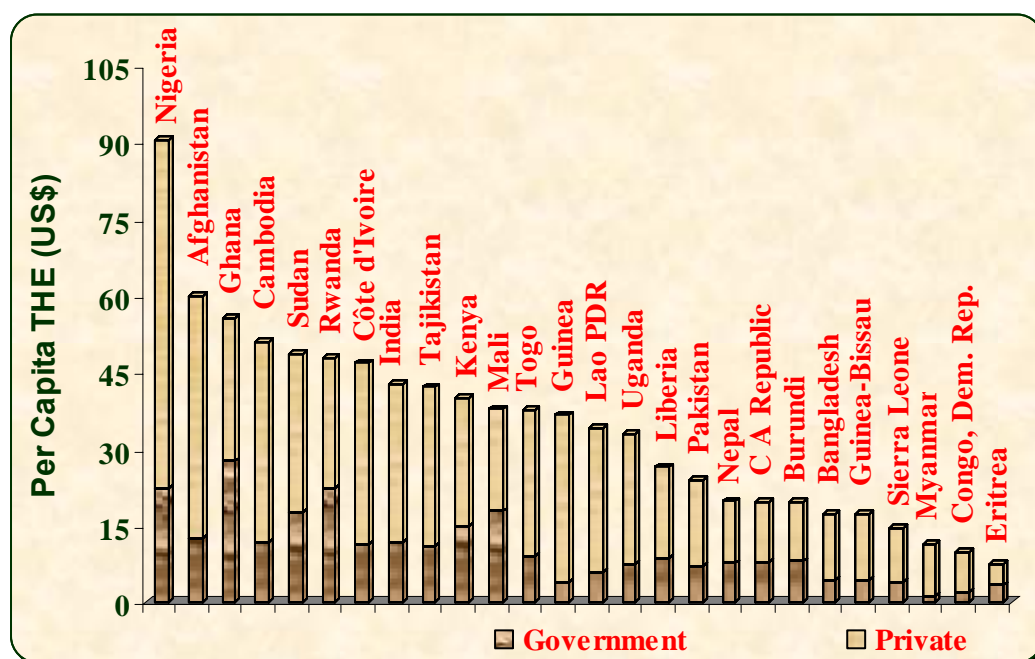
Source: WHO, 2010⁷

^e As estimated by the Taskforce on Innovative International Financing for Health Systems.³⁹

^f AFRO, AMRO, EMRO, EURO, SEARO and WPRO refer to the Regional offices for the African Region, the Americas, the Eastern Mediterranean Region, the European Region, the South-East Asian Region and the Western Pacific Region, respectively.

Figure-1

Per capita total health spending in L-26 countries (US\$, 2008)



Source: WHO, 2010⁷⁻⁸

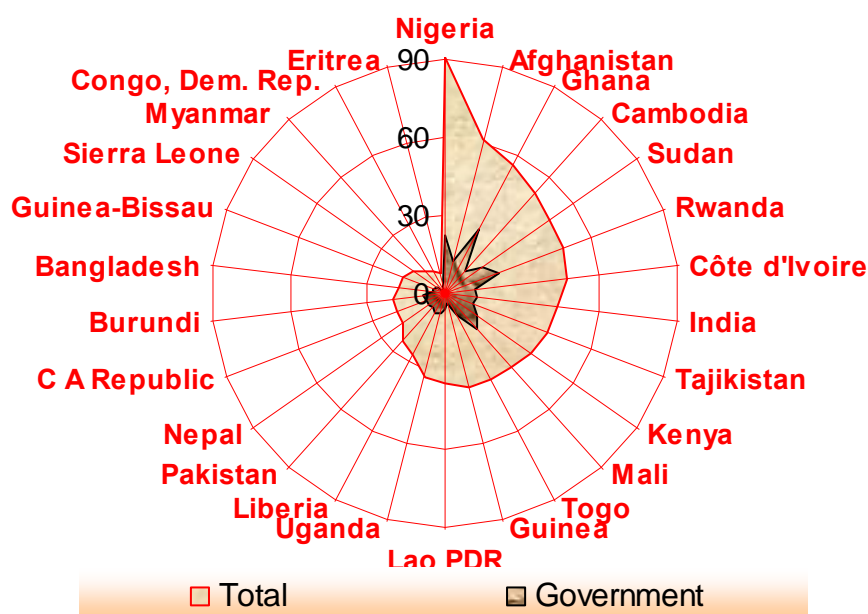
All the L-26 countries spent less than one-third of the global median - US\$ 248 in 2007. Figure-2[§] contextualises the health financing scenario in L-26 countries using US\$ 90 per capita as the yardstick; it corresponds to the maximum in a low-income country (Nigeria). While US\$ 90 (Int.\$ 134) may indicate the maximum achievable health spending by a low-income country, it is, however, not suggested that it would be sufficient to provide adequate health care in these countries. Average per capita health spending in L-26 countries falls below this mark by 162% (range 0% - 1,073%). Government health spending (indicated by the darker shade) is too small to have any significant impact on the health care of the disadvantaged populations. The huge gap between the light (total health spending) and dark shades also signifies that these countries rely heavily on private spending.

Health share of GDP in 2008 was 4.3% compared to the global average (2007) of 9.7% and the low-income country average (2007) of 5.3% (Table-2).⁷⁻⁸ Myanmar (2.1% of GDP) and Pakistan (2.9%) spent much less. Overall, total health expenditure as % of GDP marginally increased from 4.0% in 1995 to 4.3% in 2008.⁸ Per capita health spending increased from Int.\$ 39.58 (range \$ 7 - 75) in 1995 to int.\$ 69.84 (range \$ 17 - 138) in 2008; it grew at an annual rate of 5.9%. Yet, per capita total health expenditure declined in three countries - Eritrea (by 2.5% per annum), Guinea-Bissau (by 1.8%) and Côte d'Ivoire (by 0.7%). In 13 countries, it grew at an annual rate of 9.0% while the growth was moderate at 4.9% p.a. in six others; it was slow at 1.9% p.a. in 4 countries. In other words, these countries share certain similarities but are dissimilar in certain respects like health spending trend.

[§] In the figure, health financing gap is indicated by the area falling outside the inner shaded region. The darkest (i.e., the inner-most) shade indicates the level of government spending.

Figure-2

Health financing gap (per capita US\$, 2008)



Source: WHO, 2009⁶

Table-2

Composition of health spending - a comparison across different income groups

Countries	Total Health Expenditure (THE)		OOPs (% of private health expenditure)	External resources (% of THE)
	% of GDP	Govt. share (% of THE)		
Global (2007)	9.7	59.6	43.9	0.2
High-income (2007)	11.2	61.3	36.1	0.0
Upper middle-income (2007)	6.4	55.2	69.0	0.2
Lower middle-income (2007)	4.3	42.4	90.5	1.0
Low-income (2007)	5.3	41.9	83.1	17.5
L-26 countries (2008)	4.3	28.0	89.1	4.7

Source: WHO, 2010⁷⁻⁸

2 Government spending

Government intervention is crucial in these countries, given their high levels of disease burden, health inequities, vulnerable populations, and poverty; but, government contribution to health spending was only 28.0% (US\$ 11 or Int.\$ 27 per capita). National health systems in L-26 countries suffer due to insufficient health spending, particularly by the government. For example, in Tajikistan, reduction in government spending resulted in a decline in the bed and personnel availability for health care;²⁵ annual inpatient admissions fell sharply from 215 per 1,000 population in 1990 to 96 in 1999 while outpatient contacts dropped from 7.5 per person to 3.4 per person during the same period. At the same time, some countries are more

disadvantaged than others as indicated by the cross-country variation in health spending; Myanmar spends 2.1% of its GDP on health while Burundi spends 13.6%.⁷ Similarly, government share of health spending is not uniform - 11% in Guinea and 49.7% in Ghana.

The share of general government health expenditure (GGHE) in total health spending remained more or less steady during 1995-2008; in 2008, it was very low in Guinea (11.0%), Myanmar (11.8%) and Lao PDR (17.4%).⁸ It declined significantly in Eritrea and moderately in Lao PDR, Myanmar, Tajikistan, Uganda, Togo, Pakistan and Guinea-Bissau. Average per capita GGHE among L-26 countries in 2008 was US\$ 11.36 (range \$ 1.25 - 27.63) or Int.\$ 27.43 (range \$ 2.61 - 56.33); it fell below the level of other low-income countries in all WHO regions (Table-2). Even countries like India, where economic progress has been good in recent years, found it difficult to enhance the government share. The budgetary share of health^h too was uniformly low in L-26 countries in all WHO regions (Table-3).

Table-3
Budgetary allocations to health (2007)

WHO Region	Budgetary share (%)			External resources (% of THE)		
	L-26	OLI	All	L-26	OLI	All
AFRO	9.3	11.4	9.6	27.9	28.1	6.9
AMRO	-	9.2	17.1	-	37.7	0.0
EMRO	4.4	-	7.5	11.2	-	1.8
EURO	3.6	8.9	15.3	7.8	6.5	0.0
SEARO	5.9	10.7	5.3	8.6	19.6	1.7
WPRO	7.5	11.1	15.1	15.5	22.5	0.1

Source: WHO, 2010⁷

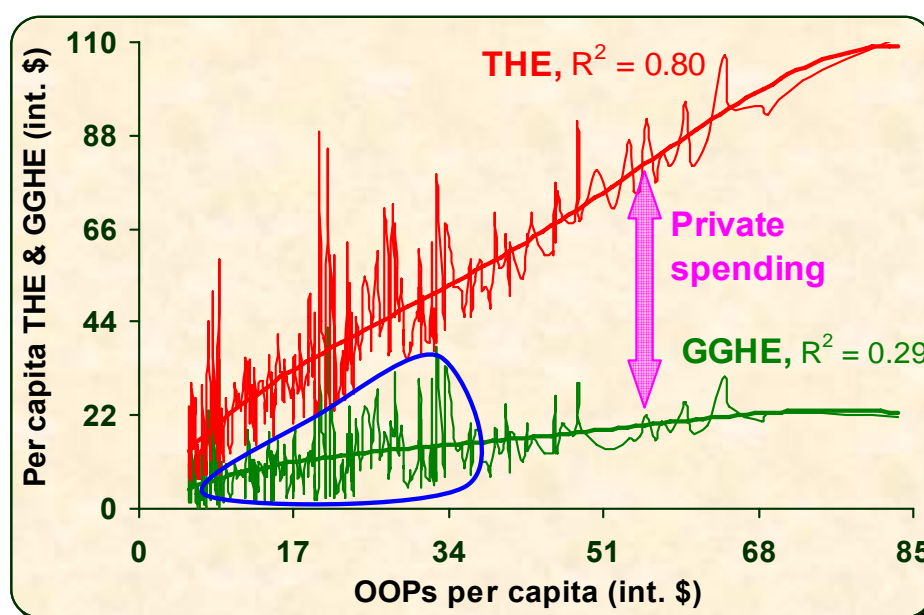
On the other hand, the share of household out-of-pocket spending in total health expenditure marginally declined from 70.1% in 1995 to 64.1% in 2008; the annual rate of decline was 0.7%. Yet, it registered an increase in Tajikistan, Lao PDR, Myanmar, Togo, Pakistan, CA Republic, Guinea and Eritrea. Contribution of external resources went up from 2.2% in 1995 to 4.7% in 2008. The increase in external resources was more pronounced in Rwanda, DR Congo and Guinea-Bissau.

An increase in household out-of-pocket spending does not appear to pull the government spending up (Figure-3); its trend during 1995-2007 is rather skewed and flat. It is particularly high at the lower level of total health spending and appears to taper down once the total health spending reaches a threshold level, say, Int.\$ 70. On the other hand, total health expenditure (THE) is steadily responsive to OOPs at all levels of health spending. In other words, the increase in THE was almost entirely brought out by OOPs beyond the threshold level of int.\$ 70. The trend indicates governments' inability to raise resources for health beyond a certain point suggesting that household out-of-pocket spending plays a dominant role once the government and total spending reaches a certain threshold. In other words, expansion of health sector beyond a point relies on the expansion of private health care resources. Even bulk of the government funding, as seen in Tajikistan, goes to secondary care hospitals, whose services are out of reach for the poor.²⁶

^h GGHE as a % of General Government Expenditure

Figure-3

Influence of OOPs on THE and government spending
(pooled time-series and cross-section data, 26 countries, 1995-2007)



Data source: WHO, 2010⁷⁻⁸

2.1 User fee as a source of government financing

User fee was almost an integral part of government health spending in many countries; National policies referred it as an alternative or sub-financing option. Strong references favouring *cost-sharing* were found in Myanmar²⁷ and Tajikistan.²⁸⁻²⁹ In Tajikistan, for example, both official and unofficial user fee existed in public health care institutions, which charged patients according to the Ministry's price list; some institutions even attained self-financing status. Other countries too made weak or implicit references favouring cost-sharing. India and Nigeria spelt out their desire to have some form of cost-sharing in at least curative health care services.^{9,17} Different Indian states too pursued user fee as a resource mobilization strategy.³⁰ It, however, contributed less than 5% to the hospital budgets in India although it fetched up to 10% in some states.³⁰⁻³¹ In Kenya, user fee constituted 6.5% of annual recurrent health expenditure by government.³² User fee's contribution to total health expenditure was less than 5% in Uganda as well.³³ Due to its insignificant net contribution to the government health budget and its other limitations, many African countries have either abolished or suspended user fee; Uganda abolished it in 2001.³⁴⁻³⁵ Simultaneously, the Ugandan government also increased its funding for district health services to compensate for any loss of revenue due to the abolition of user fee.

2.2 External resources

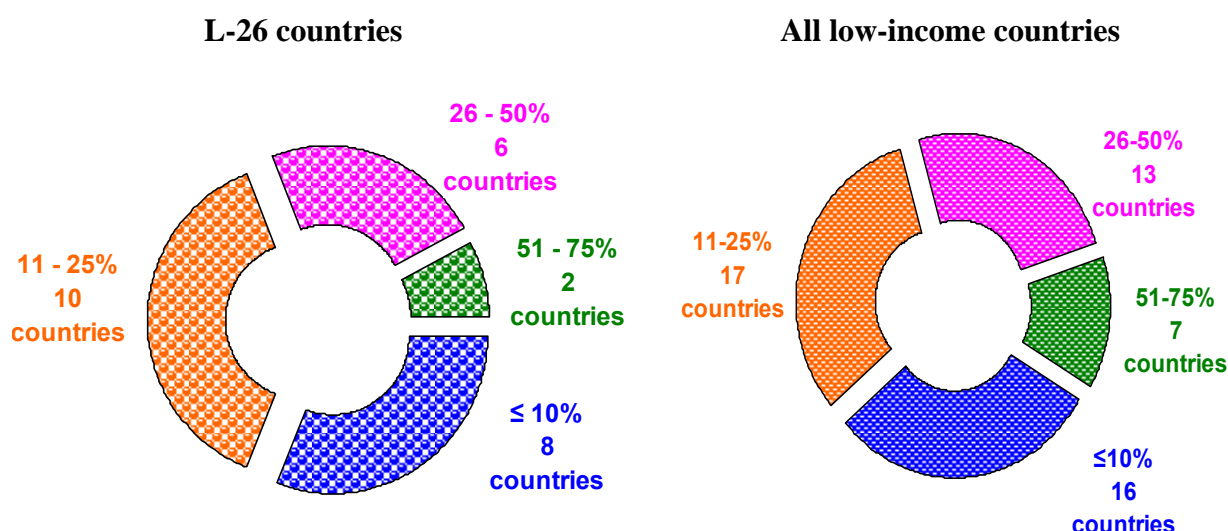
External resources, although increased since 2000 when MDGs were agreed, could not keep pace with the needs. These countries received lower share of external resources (4.7% of THE). External funding figured prominently as a major financing option, especially in smaller countries such as Lao PDR.³⁶ Some countries expressed their desire to continue with

external resources till their internal resource base gets stabilized. Bangladesh seriously advocated external resources through the widespread not-for-profit non-government sector. Nigeria, on the other hand, had an elaborate plan for mobilizing resources from both domestic and external development partners.³⁷ Similarly, Kenyan policy foresaw a continued greater role for external funding in health.³⁸

Globally, external resources for health increased substantially since the year 2000. However, it accounted for a mere 4.7% of THE in L-26 countries in 2008.⁸ Their volume is, therefore, insufficient to ensure universal access to even a minimum set of services. Contribution of external resources to total health expenditure varied across WHO regions between 0.0% in EURO and AMRO and 6.9% in AFRO for all countries and between 7.8% in EURO and 27.9% in AFRO among L-26 countries (Table-3). However, external resources are the predominant source of health spending in two L-26 countries (Figure-4).

Figure-4

Share of external resources in L-26 countries (2007)



Data source: WHO, 2010⁷⁻⁸

2.3 Resource use efficiency

While it is possible to argue that efficiency gains in resource use cannot be greater in L-26 countries, given their very low resource base, their national policies looked at efficiency as a source of additional funding. For example, Nigeria's primary health care set up was found to be ineffective serving only about 5-10% of the potential client load.¹⁷ Only 35.2% of births were attended by skilled personnel³⁹ and three out of five Nigerians received care when in need.⁴⁰ Inadequate funds and poor management resulted in non-functioning of equipments, lack of drugs, and poor standard of care.⁴¹ Moreover, system for budget preparation and control was also found to be weak. In Uganda, there seems to be a shift in hospital utilization away from less expensive General Hospitals to more expensive Regional Hospitals (Table-

4).³⁵ The loss in admissions in General Hospitals appears to have been compensated by increasing the length of stay thus resulting in higher bed-turn-over rate.^j

Table-4

Efficiency of government and private not-for-profit hospitals in Uganda

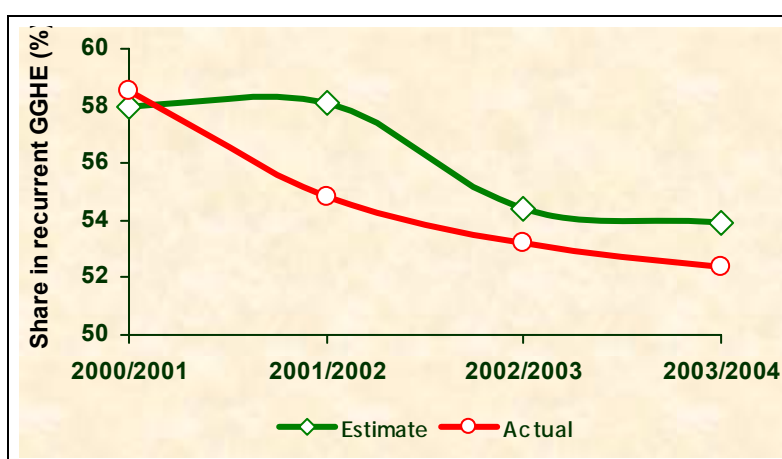
Efficiency Attribute	General Hospitals (8,236 Beds)		Regional Hospitals (3,879 Beds)	
	2007-08	2008-09	2007-08	2008-09
Bed occupancy rate (%)	73.0	66.0	73.0	84.0
Annual bed turn-over rate ^k	24.6	59.1	55.2	63.0
Outpatient per bed day	0.70	0.72	1.11	0.93

Source: Government of Uganda and WHO, 2010³⁵

Another efficiency challenge relates to spending and absorption of allocated resources even while facing resource crunch. Gaps in such skill and capacity make it difficult to effectively channel and utilize government resources. For example, India's Ministry of Health was found to have routinely surrendered budgets allocated to it;³⁰ similar situation existed in some states (including a better performing state like Kerala). Kenya provides another example for under-spending of resources (Figure-5);³² as it can be seen, actual spending on social health protection fell below the allocation during the three-year period from 2001-02 to 2003-04. In Uganda, human resource shortage, absenteeism and sub-optimal skill-mix probably limit the government in achieving its health care coverage targets.³⁵ While fiscal space for health is already limited, such constraints further limit the fiscal space and its full use.

Figure-5

Gap between allocated and actual spending on core poverty programmes in Kenya



Source: Government of Kenya, 2005³²

^j Higher length of stay could also be due to changed case mix.

^k Bed turnover rate = Total number of admissions/number of beds. That is, the number of times a bed is used in a year.

2.4 Equity and benefit incidence

It is generally observed that utilization of the available resources is biased towards hospitals, urban areas, men, and the rich.⁴²⁻⁴⁵ In Bangladesh, for instance, the richest 20% of the population received 47.7% of inpatient care, 24.2% of hospital outpatient care and 28.7% of non-hospital care from public facilities.⁴² Similar situation prevailed in India⁴² and Kenya.¹⁴ In Kenya, tertiary and secondary care hospitals absorbed about 70% of government health spending in 2004.¹⁴

Regional differences too existed. In Tajikistan, for instance, distribution of government funds varied between US\$ 1.30 in *Khatlon* region and US\$ 3.48 in *Dushanbe* region in 1998.²⁸ In Sudan, only 22% of the existing primary health care facilities provided the minimum essential package of services.⁴⁶ Differences also existed between various health care functions and activities as in Kenya; in 2001-02, 52.9% of the government spending went to inpatient/hospital care, more often used by the better-off (Table-5). Expenditure at the first contact point, for example out-patient care, which is more frequently used by the poor due to the proximity of these facilities to them, was a mere 10.2%. As a result, people seem to be incurring more OOPs on this. Also, salary constituted 52.2% of the total government spending on health.⁴⁷ Similar differences in resource allocation existed across different states in India (Figure-6); as it can be seen, there is a shift away from primary health care once the functioning of the health system reaches an advanced stage. In Uganda too, user fee removal has not significantly reduced OOPs because people do access private for-profit and not-for-profit health care facilities, which charge fees and the pre-payment mechanisms are not well developed.

Table-5

Uses of health care resources in Kenya - 2001-02

Function	Share in THE (%)	Approx. share in government health spending (%)
Outpatient care	45.2	10.2
Inpatient/hospital care	32.1	52.9
Prevention and public health	9.1	5.2
Pharmaceuticals	7.4	9.7
Health administration	5.0	11.7
Others ¹	1.2	10.3

Source: Government of Kenya, 2005^{14,47}

3 Prospects for expanding fiscal space for health

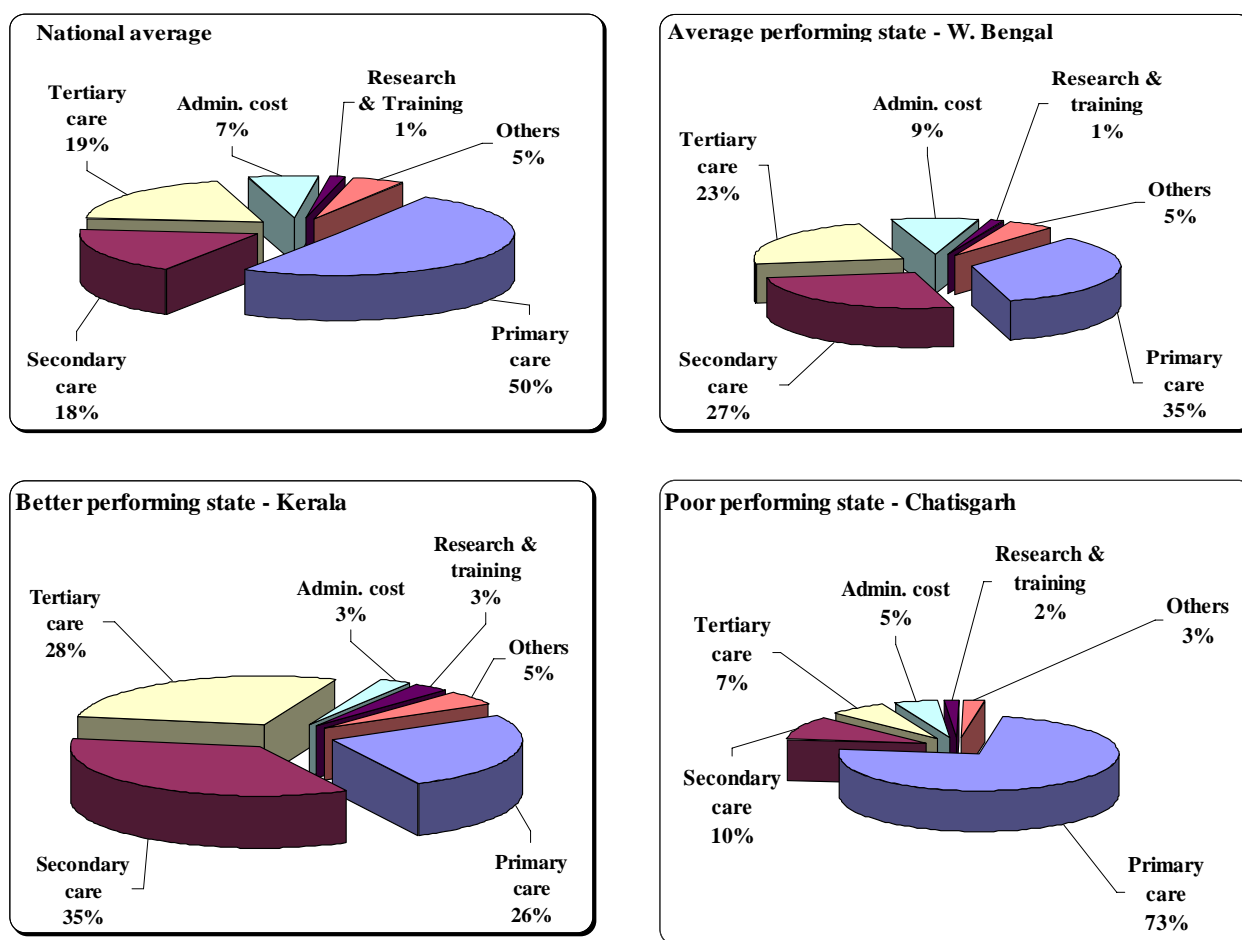
The recognition among the L-26 countries is that government funding strengthens the primary health care system, which in turn, enhances access to appropriate medical care and basic medicines for the poor. However, resource requirement for health care in these countries is far beyond what can be financed through domestic means even with optimistic assumptions concerning economic growth, resource mobilization, budgetary share of health,

¹ Includes research, teaching and training as well

and the effectiveness of public spending. Given that total government budget does not usually exceed 30% of GDP and that the budgetary share of health is unlikely to exceed 15%, fiscal space for health is unlikely to exceed 4.5% of GDP in these countries. Among the low-spending countries, Afghanistan, Burundi, Central African Republic, Côte d'Ivoire, DR Congo, Eritrea, Lao PDR, Liberia and Sudan are considered as fragile states facing unique set of problems and therefore, need special attention, as they may not be in a position to effectively raise resources, manage public expenditure, and provide services based on needs.⁴⁸ In India, fiscal deficit adversely affects government health spending, with per capita public health spending declining with the increase in the fiscal deficit in various states.³⁹ Hence, the low-spending countries continue to seek alternative fund-raising ways beyond the traditional means of taxation, but within the tax-financing framework. Many of them expressed their intention to try out new ways of financing without naming them. Obviously, high out-of-pocket health spending and inelastic response from tax resources are their concerns and they want to come out of these difficulties.

Figure-6

Differences in resource allocation pattern across states in India (2001-02)



Source: Government of India, 2005⁹

While there is a marginal improvement in the fiscal space provided for health in almost all countries, fiscal space for health seems to have narrowed down in Tajikistan; fiscal contribution to health declined from 40.9% in 1995 to 26.2% in 2008.⁸ However, there is an attempt to partially regain the lost ground through three additional tax-based financing mechanisms viz., extra-budgetary fund, the Social Protection Fund and the Road Fund. Tajikistan also seeks private resources into the public sector through user fee and partnership. Further health financing reforms are on the way too.⁵⁰ Perhaps due to all these efforts, the share of government in health went up from 20.2% in 2002 to 26.2% in 2008. Nigeria, India, Kenya and Myanmar are also looking for innovative ways to tap private resources into health.^{9,16-17, 38}

In Bangladesh, some stability to the health budget is provided by a reform that gives a medium-term (say, 3 years) budgetary allocation or resource envelope to different spending agencies, with freedom to prepare 3-year rolling budgets.¹¹ In return, the Ministry of Finance requires clear output and outcome targets, with explanations sought and agencies held accountable where performance has not been as agreed.

3.1 Economic growth as a source of expanding fiscal space

Health financing policies of the L-26 countries viewed tax-financing through expanded fiscal space as a stable long-term means to finance health sector, particularly by the government.^{9-14,16-20, 41,50-54} One of the most important determinants of the fiscal space is economic growth. Economic growth is expected to empower governments with expanded tax base and tax capacity. The size of tax funding and its growth are thus conditional on the size and growth of the economy. While wealth is a major determinant of health spending across and within nations, the government role is limited by their tax and revenue base. Broader the tax/revenue base, higher the possibility for government to invest in sectors like health and vice versa. Health financing strategies of some L-26 countries are given in Table-6. The most repeated health financing strategies, as mentioned in their policies, were economic growth, progressive taxation, user fee exemption and universal coverage. Article-15 (Part-II) of the Constitution of the People's Republic of Bangladesh aptly summed up resource mobilization policies of the low-spending countries when it stated:⁵⁵

"It shall be a fundamental responsibility of the State to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people, with a view to securing to its citizens the provision of the basic necessities of life, including food, clothing, shelter, education and medical care.....and the right to social security, that is to say to public assistance in cases of underserved want arising from unemployment, illness or disablement, or suffered by widows or orphans or in old age, or in other such cases".

Tax funding is being stated as a progressive source of financing for health without efficiency costs and is not constrained by the health or income status of the affected individual.⁵⁶ Earmarked tax is a specific case of tax funding which is likely to provide stable resources for health by insulating public health spending from competition from other sectors. Economic growth is considered as a major internal source of resource mobilization since governments are empowered with expanded tax/revenue base and capacity while health sector is expected to attract more resources from government, employers and households.

In Kenya, high priority to tax funding as a source of health financing is amply reflected in the fact that health ranks third in the government budget after education and office of the President.¹⁴ However, private financing option is being actively pursued in Myanmar, Tajikistan and to some extent, in Bangladesh.^{16,53,57} Myanmar attempts to increasingly engage the private sector in the delivery of health care through the involvement of cooperatives, joint ventures and non-governmental organizations in view of the changing economic system. Tajikistan prefers a reasonable mix of public and private financing even in the public sector. Pakistan also promoted private investment in the pharmaceutical sector by employing fair pricing of drugs as a strategy.¹⁸ Being the low-income countries, the L-26 countries had limited internal capacity to raise adequate domestic resources for health - partly because of inefficient domestic fiscal systems.²⁹ The estimated revenue raising capacity of the low-income countries is 18% of GDP against 32% in high-income countries; in Bangladesh, for instance, the revenue-GDP ratio was 11.2% in 2008-09 increasing from 8.5% in 1999-00.⁵⁸

Table-6

Resource mobilization and allocation strategies in some L-26 countries

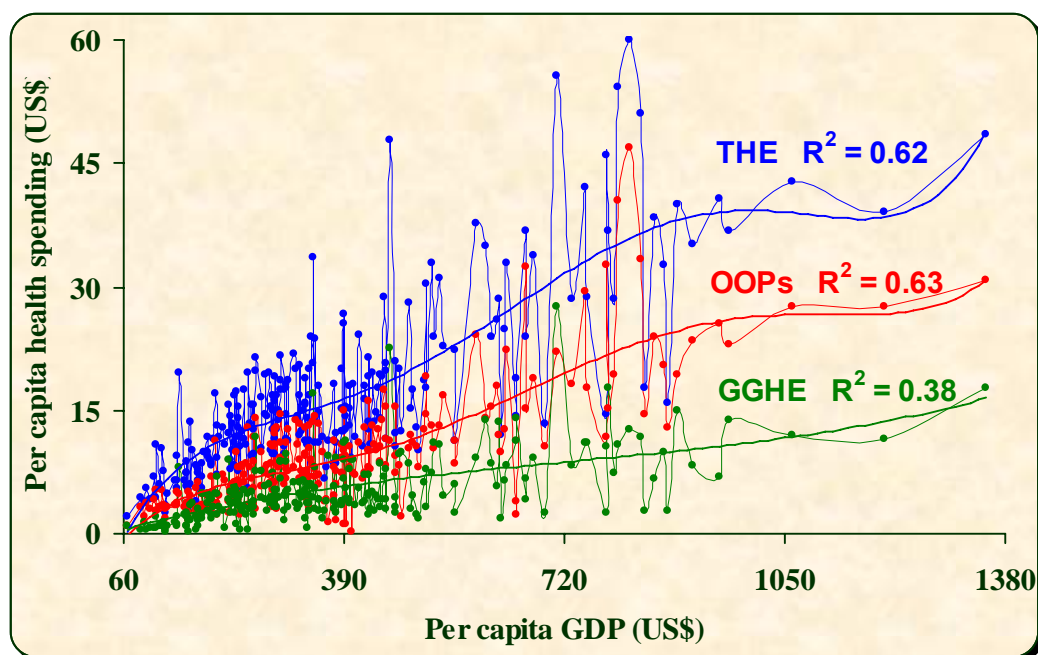
Resource mobilization/allocation strategy	Objective	L-26 countries promoting this strategy
Economic growth & progressive taxation	Resource mobilization & equity	Bangladesh, Burundi, CA Republic, Eritrea, India, Kenya, Lao PDR, Myanmar, Nigeria, Pakistan, Sudan & Tajikistan
	Increased taxing capacity & govt. spending	
Cost-sharing & private finance	Private participation, client ownership, & resource supply	Bangladesh, India, Kenya, Myanmar, Nigeria, Sudan & Tajikistan
External resources	Health system strengthening	Bangladesh, Burundi, CA Republic, Eritrea, Kenya & Lao PDR
Resource shifting	Reaching the un-reached and poverty alleviation	Bangladesh, India, Kenya, Lao PDR, Nigeria & Pakistan
Social health insurance	Prevention of negative effects of user fee	India, Kenya, Nigeria, Sudan & Tajikistan
Community financing	Community empowerment, & bottom-up approach	Bangladesh, India, Kenya & Nigeria
Resource targeting & need-based budgeting	Shifting focus/resources towards PHC and needs	Bangladesh, Kenya, Lao PDR & Nigeria
Essential service package	Cost-effectiveness	Bangladesh, Kenya & Tajikistan
Cross ministerial link	Equity & resource mobilization	Bangladesh & India
Demand side financing	Taking health care to the poor	
Rolling budget	Resource stability	Bangladesh
Public expenditure management unit	Expenditure tracking and bottom-up budget process	
Architectural correction	Equitable and efficient resource allocation	India

Resource negotiation	Resource mobilization	Kenya
Hospital revolving fund	Timely resource flow	Nigeria
Better governance	Resource saving	Pakistan
Extra-budgetary funds & private participation	Enhanced government spending	Tajikistan
Special purpose funds	Targeting population groups	
Per capita financing	Need-based resource allocation	

The trend among the L-26 countries during 1995-2008 shows that per capita health spending increases ($R^2 = 0.38 - 0.63$) with per capita GDP albeit at a slower rate (Figure-7); that is, it requires about 2% growth in per capita GDP to trigger a 1% growth in per capita THE and 2.6% growth in per capita GDP to get a 1% increase in per capita GGHE. Health received higher share of resources during few years and if such rates were maintained, resource availability for health would have been marginally better. However, per capita OOPs remained above the per capita GGHE throughout. The intensity of THE (as % of GDP) and GGHE (% of THE) declined after the GDP reached a certain threshold (say, US\$ 400: The share of external resources too declined gradually as the economy progressed; its trend suggests that it ceases to exist as a source of health financed beyond the per capita GDP level of about US\$ 1,300. Given the recent trend in countries like India and Bangladesh, where the economy is doing well, and given the elasticity of increase in GGHE in response to the economic growth, the share of government is unlikely to go up beyond a point (say, 1.5% - 2.0% of GDP). This has been observed in better performing countries (in terms of GGHE) like Sri Lanka too.⁵⁹ Further scope for health fiscal space is provided by non-Health Ministries; in Bangladesh, for example, Ministries of Defence and Railways contributed to health financing through their own health services.¹² Similar situation prevails in India as well.

Figure-7

Influence of the GDP growth on health spending
(Pooled time-series and cross section, 26 countries, 1995-2008)

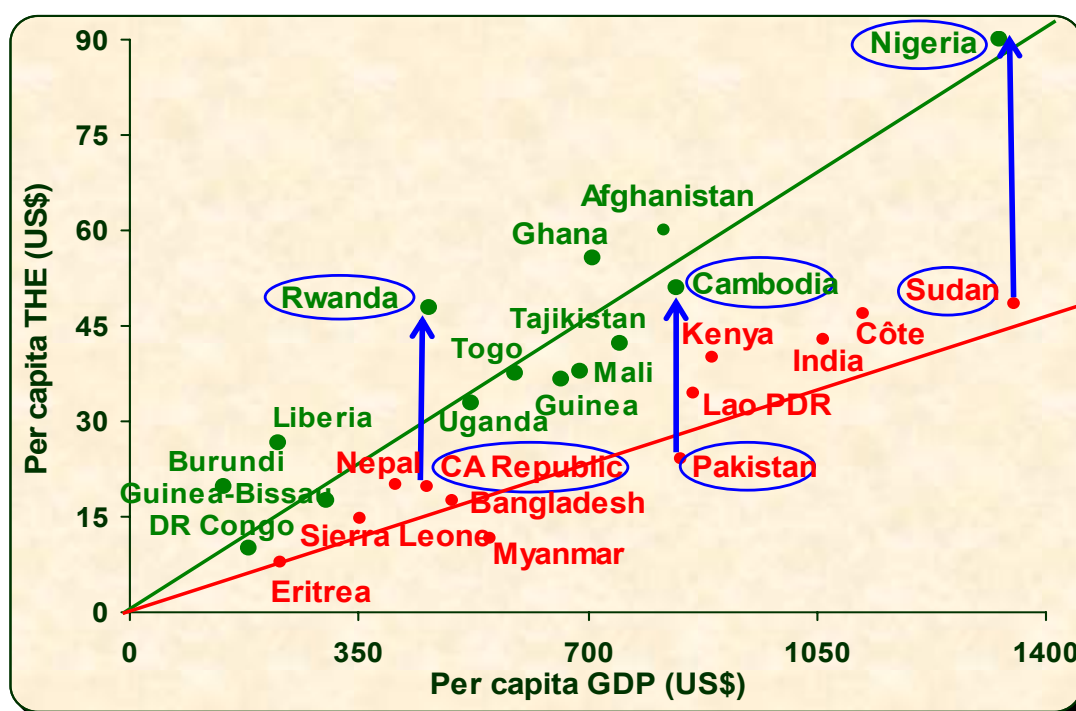


Data source: WHO, 2010⁸

Two distinct patterns are observed concerning the economic growth and its link with health spending among (Figure-8); one group of the L-26 countries (with green labels) was able to keep pace with the growth in per capita GDP while the other group (red labels) was slow in making the progress. For instance, Cambodia with almost similar per capita GDP spends more than double on health compared to Pakistan; similar comparisons can be made between Rwanda and CA Republic as well as Nigeria and Sudan. In those countries where THE is more responsive to the GDP growth, every percentage increase in per capita GDP appears to have resulted in a 1.5% increase in per capita THE. In countries where THE is not that responsive, every percentage growth in per capita GDP results in 0.75% increase in per capita THE. Given a large informal sector and rural population, expansion of the tax net, even with favourable economic growth, is found to be often limited in many low-spending countries. This restricts the increase in government spending on health. Apparently, total health spending increased in countries where private spending responded favourably to the GDP growth.

Figure-8

Dual pattern of the effect of GDP on THE



Data source: WHO, 2010⁷⁻⁸

Since these countries have low national income, even a higher share of GDP is not expected to fetch enough resources for health. For instance, countries like Burundi, DR Congo, Eritrea, Liberia and Guinea-Bissau, given their current GDP size, can only mobilize up to US\$ 30 per capita for health even if they allocate 10% of their GDP. Moreover, resource allocation to health is likely to increase only about 1% (or less) for every percentage increase in national income;⁶⁰ so, a 5% increase in real national income in L-26 countries is likely to result in an addition of about US\$ 1-3 per capita for health annually. The amount would be insufficient to

meet even the basic minimum health care needs. Therefore, the future scope for domestic health care resources does not look very bright in these countries.

3.2 Fiscal rigidity

Low-spending countries pledged a higher share of government resources for health with the highlight being the Abuja Declaration of 15% budgetary resources for health.⁶¹ Many low-spending African nations seriously expressed their desire to allocate up to the level pledged in the Declaration in 2001. Kenya hopes to achieve this target by 2015 by gradually moving up from 8.4% in 2006-07.³⁸ Additional resources are to be spent on upgrading infrastructure, procurement of medicines and implementation of community strategy. However, only about 70% of the funds voted are actually allocated to the recurrent budget thereby limiting the scope for higher resources for health. Sudan envisaged a government health spending of 1.5% of GDP by 2008 yielding a per capita government spending of \$15.⁶² This would be still less than the required minimum of \$34. Health is said to be one of the seven thrust areas in India and it is hoped that government spending would go up to 2% of GDP by 2010.^{13,63} But, this is 2.5 times higher compared to the 1999 level of government health spending. In Tajikistan, the collapse of the economy and the civil war have resulted in fiscal imbalance with poor tax collection and weak controls on expenditure.²⁸

The trend in per capita government spending on health in Bangladesh, India, Kenya, and Nigeria suggests that it almost remained static during the five-year period of 2000-2005. In fact, the trend in total health spending was solely determined by the movement of the private spending, especially the OOPs. This trend signifies that countries actively pursued alternative financing mechanisms although tax-based funding remained as the strong policy, which is likely to remain so during the next decade or so. Although government revenue generation improved, though moderately, in many countries, it was not translated into higher government allocation for health. Figure-9 explains the relationship between general government revenue and general government health expenditure (GGHE) observed in some L-26 countries from 1995-96 to 2005-06.^m As it can be observed, GGHE either remained inelastic (Bangladesh, Côte d'Ivoire, and India) or declined (Ghana and Zambia) while it increased marginally in Democratic Republic of Congo and Pakistan (from a very low level).

3.3 Public debt - a major fiscal constraint

Public debt and debt servicing (interest payment) were a major constraint in the process of expanding fiscal space in L-26 countries. Public debt was as high as 61.2% of GDP in India and 55.2% in Pakistan in 2006-07 (Table-7). Interest payment alone constituted 4.2% of GDP in Pakistan, 3.6% in India, 2.3% in Kenya, and 1.8% in Bangladesh⁶⁷⁻⁷¹ In other words, interest payment consumed 42.4% of tax revenue in India, 38.2% in Pakistan, 21.4% in Bangladesh, and 12.4% in Kenya. Tax funding was also found to be regressive in these countries; for instance, in Pakistan, indirect taxes accounted for 60.6% of the total tax revenue in 2006-07.⁶⁹

Some L-26 countries are emerging from crises. As a result, they rely more on emergency mechanisms at present. For example, National Health Insurance Fund in Sudan, covering around 15% of the population, predominantly included civil servants and their families.⁴⁶

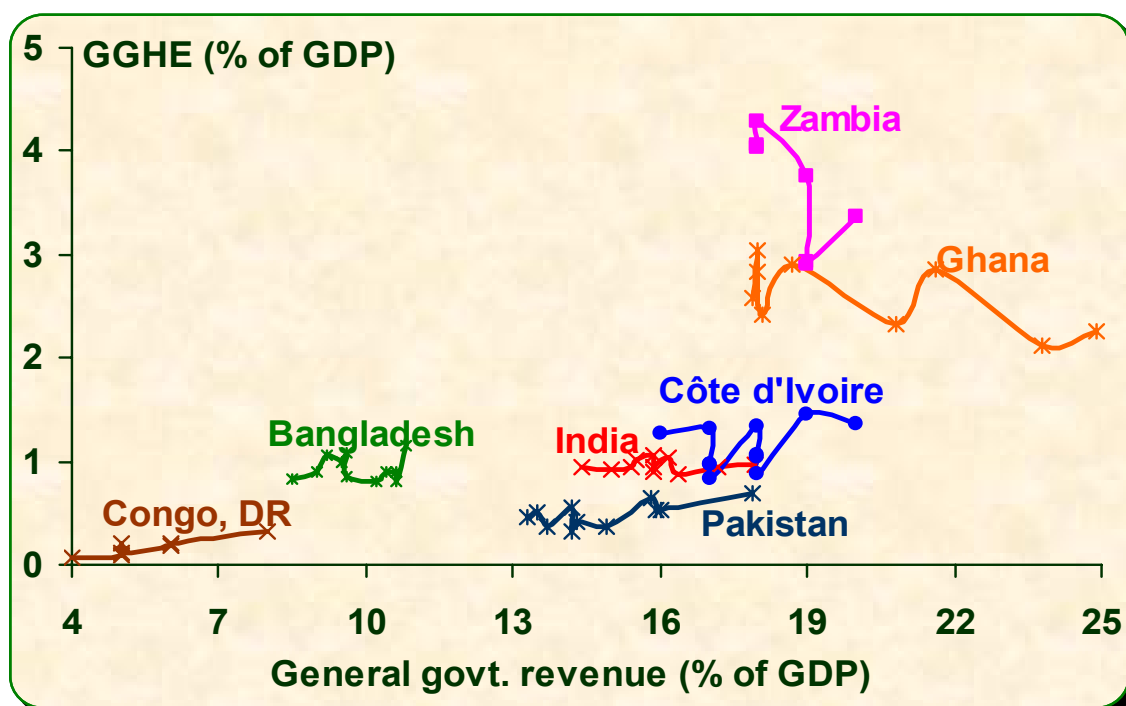
^m 1995-96 to 2001-02 for DR Congo and Zambia and 1997-98 to 2005-06 for Ghana

3.4 Pool fund and resource targeting as ways to enhance efficiency

Some measures were initiated by these countries to cope with fiscal rigidity and increase programme effectiveness. In order to improve the resource use efficiency, a Pool Fund targeting one-plan, one-budget and one-report at the national level appeared to be the favourable option in Bangladesh and Kenya.^{11,14} In Bangladesh, this mechanism was seen to have provided greater control to the Ministry over the implementation of national policies and budgets. Likewise, Tajikistan's 1994 Law on Local Government and the 1997 Law on Budget Organization and Budget Process were viewed to have resulted in better understanding of resource flow and effective tying up of the budget with its various line items.²⁸ Bangladesh also established a public expenditure management unit to strengthen the financial management and to provide central and district level financial analyses; its functions included improved budget preparation processes, basic financial reporting, expenditure monitoring by components and sub-components, resource tracking, developing information technology (IT) applications, improvements in management accounting, production and analysis of financial information, improvements in audit and internal control, preparing central accounts, financial statements, disbursement of funds, reimbursement claims, and production of Statements of Expenditure (SOEs).¹¹

Figure-9

Fiscal rigidity in some L-26 countries (1995-96 to 2005-06)



Data source: Reserve Bank of India, 2008;⁶⁴ Government of Pakistan, 2007;⁶⁵ World Bank, 2007;⁶⁶ and Government of Bangladesh, 2006.⁶⁷

The most favoured efficiency-enhancing option among the L-26 countries was the universal provision of an essential service package, with a particular focus on the disadvantaged populations. In Bangladesh and Kenya, this is a clear strategy to rationalize resource allocation to services with significant health impact.^{11,14} Since the package is developed keeping in mind the needs of vulnerable populations, it also acts as a shield against financial barriers to access, especially to essential services. However, making resources work for the poor was a particular concern to these countries because they were not able to effectively identify the poor. Given the context of poor accounting of individual incomes, identification of the poor and exempting them from making any payment at the point of delivery of services were found to be most expensive, yet considered as necessary, activity. For successful targeting, Bangladesh introduced need-based budgeting using a bottom-up approach, which, in turn, was aligned with the traditional budgeting system. Accordingly, the local-level planning at the *upazila* (sub-district) level identified annual activities, costs and identified funds for service delivery, and analysed revenue/development budget and associated source of funding. The challenge, however, remained as to how the need-based budgets would be integrated into the budget process. Prioritization of resource allocations to the essential service package was another policy instrument in Bangladesh for resource targeting.¹¹

Table-7

Public debt and fiscal space in some L-26 countries

Country	Share in GDP in 2006-07 (%)			
	Tax	Govt. revenue	Govt. expenditure	Public debt
Bangladesh	8.4	10.6	12.8	30.0 ⁿ
India	8.5	10.5	14.1	61.2
Kenya	18.5	20.6	22.3	40.3
Lao PDR ^o	10.4	14.6	19.7	NA
Pakistan	11.0	14.9	20.2	55.2

Source: Government of Lao PDR, 2006;¹⁵ Government of Bangladesh, 2006;⁶⁷ Government of Pakistan, 2008;⁶⁹ Government of India, 2008;⁷⁰ and Government of Kenya, 2008;⁷¹

Resource targeting in India was aimed through the establishment of new infrastructure in deficient areas and strengthening the existing infrastructure.¹³ Indian health policy also urged all state governments to consider decentralized implementation of national disease programmes through local self-governments. Decentralized provision of essential drugs with national funding was seen as an important strategy to revive the effective provision of primary health care.

In Kenya, revenue collecting public facilities were allowed to retain 75% of the user fee collection and the remaining 25% went towards financing of preventive and promotive services in the district.³² Pakistan aimed to increase government health expenditure to the extent of 4% of GDP to provide health care at the doorsteps of the people.⁶⁹ The focus was on

ⁿ Estimated using net annual figures between 1990-01 and 2006-07

^o The figures are for the year 2005-06

- Adequate financial power to district health officer
- Improvement of living conditions for doctors, nurses and paramedics to serve in rural areas. This activity was to be funded through poverty alleviation programme.
- Rural area compensatory allowance to serve in rural areas.

Pakistan also stressed on good governance as a means to achieve quality health care.¹⁸ Sudan proposed the establishment and institutionalization of a sustainable district or local health system with an aim of making them self-sufficient and responsible for a given population.¹⁹ In Myanmar, a national law was enacted to develop private health care services to effectively utilize the private resources in providing health care, to provide choice to the people and to ensure responsibility and quality at fair price.²⁷ Tajikistan's approach was to provide per capita financing for primary health care and to finance hospitals using treatment-based clinical cost groups.²⁶ Financial resources were to be distributed according to the number of people enrolled and specific regional and local conditions.

In addition to the pool fund and resource targeting, some other measures such as financial and administrative delegation/decentralization/autonomy, social audit and community management were either mentioned in the policy or tried out to improve the efficiency of government spending. Another strategy employed by some countries to address the issue of inefficiency was rationing.⁷²⁻⁷³

Usefulness of measures such as community financing, user fee and demand side financing is still in doubt.^{23,34,38,51,74-75} Demand side financing is a key financing strategy receiving increasing attention, particularly in Bangladesh and India.^{11,70} It aims to break the demand side barriers in service utilization by vulnerable groups such as unaffordable cost of care, household preferences, education and socio-cultural norms. A Demand Side Financing (DSF) pilot using health vouchers for poor pregnant women has already been launched in 21 *upazilas* in Bangladesh. Supply-side subsidies have also not proven to be a very effective way of directing scarce public resources to the health needs of the poor. The benefits 'leak away' to the rich when they demand treatments and when providers turn away poor people or fail to exempt them from informal charges. The underlying problem relates to the weak employment and management incentives under which government clinicians operate, issues that are addressed later in this Plan.

4 Key observations

Low-spending countries suffered from multiple and complex health financing problems, triggered from both inside and outside the national health financing system. The bottom-line, however, is the low and inequitable health spending. Household out-of-pocket resources played a predominant role in financing health in these countries. The budgetary share of health was uniformly low among the L-26 countries in all WHO regions. Facing multiple inequities, the disadvantaged population groups also received lesser share of government and private resources. External resources played a crucial role in few countries, but their share is limited in the L-26 countries.

The scope for further expansion of the fiscal space appears to be limited. Economic growth served as a source of health financing in some countries; while some countries were able to transform higher economic growth into reasonable health spending, some others were not able to do so. Overall, an increase in per capita GDP resulted in almost equal proportional

increase in per capita health spending. Limited expansion of the tax net/base has been a major limiting factor. While governments faced difficulties in tapping the benefits of economic growth, households in some countries seem to have succeeded in transferring a part of their increased income into health. Efficiency enhancing measures to overcome fiscal rigidities are under way in many countries and their usefulness is not yet fully known.

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Reference

1. French Ministry of Foreign Affairs (2007). *Social health protection in developing countries: breaking the vicious cycle between disease and poverty*. Paris: International conference, March 2007.
2. Rwanda Ministry of Health (2007). *Assuring quality health care through social health protection: the role of purchasing and quality management*. Kigali: Rwanda Ministry of Health, International Conference of the GTZ-ILO-WHO Consortium on Social Health Protection in Developing Countries in conjunction with the Rwanda Ministry of Health, October-November 2007.
3. ILO-GTZ-WHO (2006). *Berlin recommendations for action - final version*. Eschborn: German Technical Cooperation, International conference on social health insurance in developing countries, Berlin, December 2005.
4. OECD (2005). *Paris Declaration on Aid Effectiveness: ownership, harmonization, alignment, results and mutual accountability*. Paris: Organization for Economic Co-operation and Development, High Level Forum for Joint progress towards enhanced aid effectiveness.
5. Heller, P (2006), The Prospect of Creating 'Fiscal Space' for the Health Sector. *Health Policy and Planning*, **21(2)**: 75-79.
6. World Bank (2007). *Data & Statistics - Country groups*. Washington D.C.: The World Bank. <http://go.worldbank.org/D7SN0B8YU0>
7. WHO (2010). *World Health Statistics 2010*. Geneva: World Health Organization.
8. WHO (2010). *National Health Accounts - Selected indicators for expenditures on health*. Geneva: World Health Organization, Country information. <http://www.who.int/nha/country/en/#L> (accessed on 19th August 2010)
9. Government of India (2005). *Report of the National Commission on Macroeconomics and Health*. New Delhi: Ministry of Health and Family Welfare, National Commission on Macroeconomics and Health. http://mohfw.nic.in/reports/reports/Report_on_NCMH/ReportoftheNationalCommission.pdf
10. Government of Afghanistan. (2005). Health systems profile - Afghanistan. Kabul: Ministry of Public Health, report published by WHO (EMRO).
11. Government of Bangladesh. (2005). Health, Nutrition and Population Programme (HNPPP) July 2003 - June 2010 (preliminary document). Dhaka: Government of People's Republic of Bangladesh, Ministry of Health and Family Welfare. <http://www.mohfw.gov.bd/hnppp.htm>
12. Government of Bangladesh. (2000). Health policy of Bangladesh. Dhaka: Government of People's Republic of Bangladesh, Ministry of Health and Family Welfare. http://www.mohfw.gov.bd/health_policy.htm
13. Government of India. (2002). National health policy 2002. New Delhi: Ministry of Health and Family Welfare.
14. Government of Kenya. (2005). National health sector strategy plan II (2005-2010). Nairobi: Government of the Republic of Kenya, Ministry of Health, Health sector reform Secretariat. <http://www.hsrs.health.go.ke/publications.htm>
15. Government of Lao PDR. (2006). National socio-economic development plan; 2006-10. Vientiane: Committee for Planning and Investment. <http://www.undplao.org/official%20docs/NSEDP%20partI.pdf>
16. Government of Myanmar. (2008). National Health Policy. Yangon: Government of the Union of Myanmar, Ministry of Health, Health policy, plans and legislation. <http://www.moh.gov.mm/file/Health%20Policy,%20Plans%20and%20Legislation.pdf>
17. Government Nigeria. (2004). National Health Policy 2004. Abuja: Government of Federal Republic of Nigeria, Federal Ministry of Health.
18. Government of Pakistan. (2001). National health policy 2001 - the way forward: agenda for health sector reform. Islamabad: Ministry of Health. <http://202.83.164.26/wps/wcm/connect/?MOD=PDMProxy&TYPE=personalization&ID=NONE>

[&KEY=NONE&LIBRARY=%2FcontentRoot%2Ficm%3Alibraries%5B127%5D&FOLDER=%2FMinistry+of+Health%2FHealth+Division%2FPolicies%2F&DOC_NAME=%2FcontentRoot%2Ficm%3Alibraries%5B127%5D%2FMinistry+of+Health%2FHealth+Division%2FPolicies%2FNHP.pdf&VERSION_NAME=NONE&VERSION_DATE=NONE&IGNORE_CACHE=false&CONVERT=NONE&MUST_CONVERT=false](#)

19. Government of Sudan. (2007). National Health Policy 2007. Khartoum: Sudan Government of National Unity, Federal Ministry of Health. <http://www.fmoh.gov.sd/English/Health-policy/doc/Sudan%20National%20%20Health%20Policy%2011.6.07.pdf>
20. Government of Tajikistan. (2006). Poverty Reduction Strategy of the Republic of Tajikistan 2007-2009. Dushanbe: Government of the Republic of Tajikistan. http://www.unhj.org/files/reports/PRSP_Draft_2007-2009_Eng.pdf
21. Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). [Resources for mental health: scarcity, inequity, and inefficiency](#). *The Lancet*; **370** (9590): 878-889.
22. Dixon, A., McDaid, D., Knapp, M., & Curran, C. (2006). Financing mental health services in low- and middle-income countries. *Health Policy and Planning*; **21**: 171-182.
23. Palmer, N., Mueller, D., H., Gilson, L., Mills, A., & Haines A. (2004). [Health financing to promote access in low income settings - how much do we know?](#) *The Lancet*; **364** (9442): 1365-1370.
24. Taskforce on Innovative International Financing for Health Systems. (2009). *More money for health, and more health for the money: final report*. Geneva: International Health Partnership. http://www.internationalhealthpartnership.net/CMS_files/documents/taskforce_report_EN.pdf [accessed 19 August 2010].
25. Falkingham, J. (2004) [Poverty, out-of-pocket payments and access to health care: evidence from Tajikistan](#). *Social Science & Medicine*; **58** (2): 247-258.
26. Government of Tajikistan. (2006). Poverty Reduction Strategy of the Republic of Tajikistan 2007-2009. Dushanbe: Government of the Republic of Tajikistan. http://www.unhj.org/files/reports/PRSP_Draft_2007-2009_Eng.pdf
27. Government of Myanmar. (2008). National Health Policy. Yangon: Government of the Union of Myanmar, Ministry of Health, Health policy, plans and legislation. <http://www.moh.gov.mm/file/Health%20Policy,%20Plans%20and%20Legislation.pdf>
28. European Observatory on Health Care Systems. (2000). Health care systems in transition - Tajikistan. Copenhagen: WHO Regional Office for Europe. <http://www.euro.who.int/document/e69820.pdf>
29. UNDP. (2005). Investing in sustainable development: Millennium Development Goals needs assessment. Dushanbe: United Nations Development Programme, MDG Need Assessment.
30. Government of India. (2005). Financing and delivery of health care services in India. New Delhi: Ministry of Health and Family Welfare, NCMH Background Papers. http://mohfw.nic.in/reports/reports/Report_on_NCMH/BackgroundPapersreport.pdf
31. Varatharajan, D., Rajeev Sadanandan, Thankappan KR, Mohanan Nair V. (2002). Idle capacity in resource strapped government hospitals in Kerala: Size, distribution and determining factors. Thiruvananthapuram: Sree Chitra Tirunal Institute for Medical Sciences and Technology, Achutha Menon Centre for Health Science Studies.
32. Government of Kenya. (2005). Public expenditure review 2005: delivering ERS priorities. Nairobi: Government of the Republic of Kenya, Ministry of Health, Health care financing and expenditure. <http://www.health.go.ke>
33. Okuongzi SA (2004). Dying for economic growth? Evidence of a flawed economic policy in Uganda. *The Lancet* 364 (October 30), 1632-1637.
34. Xu, K., Evans, D., B., Kadama, P., Nabyonga, J., Ogwal, P., O., Aguilar, A., M. (2005). The elimination of user fee in Uganda: impact on utilization and catastrophic health expenditures. Geneva: WHO, Department of Health Systems Financing, Health Financing Policy, Discussion paper no. 4. http://www.who.int/health_financing/documents/dp_e_05_4-user_fee_elimination_uganda.pdf

35. Government of Uganda and WHO. 2010. *Health financing review; 2009-10*. Kampala: Ministry of Health.
36. WHO. (2006). *Country health information profiles: Lao People's Democratic Republic*. Vientiane: World Health Organization.
37. Government of Nigeria. (2004). *Draft National Health Bill 2004*. Abuja: Government of Federal Republic of Nigeria, Federal Ministry of Health.
38. Government of Kenya. (2007). *Health sector working group report (MTEF 2007/08 - 2009/10)*. Nairobi: Ministry of Finance.
39. World Bank. (2007). Nigeria's seven-point agenda. Abuja: The World Bank.
40. World Bank. (2007). Nigeria and the Millennium Development Goals. Abuja: The World Bank.
41. Government of Nigeria. (2004). Health sector reform programme: strategic thrusts with a logical framework and a plan of action 2004-07. Abuja: Government of Federal Republic of Nigeria, Federal Ministry of Health.
42. O'Donnell, O., van Doorslaer, E., Rannan-Eliya, R., P., Somanathan, A., et al. (2005). Who benefits from public spending on health care in Asia? Thessaloniki, Greece: University of Macedonia, EQUITAP Project, Working paper no. 3. <http://www.equitap.org/publications/wps/EquitapWP1.pdf>
43. Bonu S, Rani M, Baker TD. (2003). The impact of the national polio immunization campaign on levels and equity in immunization coverage: evidence from rural North India. *Social Science and Medicine*; **57(10)**: 1807-19.
44. Data International Ltd, Nepal, Health Economics Association, & Institute of Policy Studies. (2001). Equity in financing and delivery of health services in Bangladesh, Nepal and Sri Lanka: Results of the tri-country study. Colombo: Institute of Policy Studies.
45. ADB. (1999). Health sector reform in Asia and the Pacific – Options for developing countries. Asian Development Bank, Manila, The Philippines, 1999.
46. Government of Sudan. (2007). Five-year health sector strategy - investing in health and achieving the MDGs: 2007-11. Khartoum: Republic of Sudan, Federal Ministry of Health. http://www.fmoh.gov.sd/English/St_Plan/doc/Health%20Five-year-strategy%201.5.2007.pdf
47. Government of Kenya. (2005). Kenya National Health Accounts 2001-02. Nairobi: Government of the Republic of Kenya, Ministry of Health, Health care financing and expenditure. <http://www.health.go.ke>
48. World Bank (2007). The role of IDA in the global aid architecture: supporting the country-based model. Washington D.C.: The World Bank, International Development Association, Resource Mobilization Department, Board report no. 40034.
49. Serveroni, S. 2007. Tajik health sector overview. Dushanbe: WHO country office, Principals' Group Meeting, 13th December.
50. Government of Nigeria. (2004). Draft National Health Bill 2004. Abuja: Government of Federal Republic of Nigeria, Federal Ministry of Health.
51. Government of Nigeria. (2007). Development of a national health investment plan for Nigeria. Abuja: Government of Federal Republic of Nigeria, Federal Ministry of Health, Report of the Ministerial Consultative Retreats for consensus building and mobilization of all stakeholders for developing the National Health Investment Plan.
52. Government of India. (2005). Resolution on National Rural Health Mission. New Delhi: Ministry of Health and Family Welfare.
53. Government of Bangladesh. (2008). Budget speech 2008-09. Dhaka: Government of People's Republic of Bangladesh, Ministry of Finance, Finance Division. http://www.mof.gov.bd/mof2/budget/08_09/budget_speech/08_09_en.pdf
54. Government of Bangladesh. (2004). The constitution of People's Republic of Bangladesh (as modified up to 17 May 2004). Dhaka: Government of People's Republic of Bangladesh, Chief Advisor's Office, Dhaka, 2004.
55. Government of Bangladesh. (2004). The constitution of People's Republic of Bangladesh (as modified up to 17 May 2004). Dhaka: Government of People's Republic of Bangladesh, Chief Advisor's Office, Dhaka, 2004.
56. World Bank. (2006). World Development Report 2006. Washington D.C.: The World Bank.

57. WHO. (2007). Biennial Collaborative Agreement (BCA) between the Ministry of Health of Tajikistan and the Regional Office for Europe of the World Health Organization. *Copenhagen: WHO Regional Office for Europe*. <http://www.euro.who.int/document/bca/tjk0809.pdf>
58. Government of Bangladesh. (2009). Bangladesh Economic Review 2008-09. Fiscal policy and fiscal management. Dhaka: Government of People's Republic of Bangladesh, Ministry of Finance. <http://www.mof.gov.bd/en/budget/er/2009/c4.pdf> (accessed 26th August 2010)
59. Varatharajan, D. (2006). Economy and health: taking Sri Lanka towards the global best. Colombo: Ministry of Healthcare and Nutrition, National Commission on Macroeconomics and Health, Study Report No. 8.
60. WHO (2001). Macroeconomics and health: investing in health for economic development. Geneva: World Health Organization, Report of the Commission on Macroeconomics and Health. <http://whqlibdoc.who.int/publications/2001/924154550X.pdf>
61. African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. (2001). Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. Abuja: OAU/SPS/ABUJA/3, 24-27 April 2001.
62. Government of Sudan. (2006). Sudan National Health Policy 2006: Draft-1. Khartoum: Republic of the Sudan, Federal Ministry of Health.
63. Government of India. (2007). Annual report 2006-07. New Delhi: Ministry of Health and Family Welfare.
64. Reserve Bank of India. (2008). Handbook of statistics on Indian economy. Direct and indirect tax revenues of central and state governments. Mumbai: Reserve Bank of India. <http://www.rbi.org.in/scripts/PublicationsView.aspx?id=10639>.
65. Government of Pakistan. (2007). Fiscal Policy Statement 2006-07. Islamabad: Ministry of Finance - Debt Policy Coordination Office. <http://www.finance.gov.pk/admin/images/publications/fiscalPolicy.pdf>
66. World Bank. (2007). Selected world indicators. Washington D.C.: The World Bank. <http://ddp-ext.worldbank.org/ext/DDPQQ/member.do?method=getMembers&userid=1&queryId=16>
67. Government of Bangladesh. (2006). Bangladesh Economic Review 2006-07. Fiscal policy and fiscal management. Dhaka: Government of People's Republic of Bangladesh, Ministry of Finance. http://www.mof.gov.bd/en/budget/07_08/economic_review/chapter_04.pdf
68. Government of India. (2007). NRHM – Progress so far. New Delhi: Ministry of Health and Family Welfare, National Rural Health Mission. <http://mohfw.nic.in/NRHM/NRHM%20-%20THE%20PROGRESS%20SO%20FAR.htm>
69. Government of Pakistan. (2008). Pakistan Economic Survey 2007-08. Islamabad: Ministry of Finance. http://www.finance.gov.pk/finance_survey_chapter.aspx?id=18
70. Government of India. (2008). Economic Survey 2007-08. New Delhi: Ministry of Finance. <http://indiabudget.nic.in/es2007-08/esmain.htm>
71. Government of Kenya. (2008). Statistical annex to the budget speech for the fiscal year 2008-09. Nairobi: Ministry of Finance. http://www.treasury.go.ke/budget_documents/Statistical_annexe08-09.pdf
72. Ensor, T., & Ronoh, J. (2005). Effective financing of maternal health services: a review of the literature. *Health Policy*; **75(1)**: 49-58.
73. Peters, D., H., Yazbeck, A., S., Sharma, R., R., Ramana, G., N., V., Pritchett, L., H., & Wagstaff, A. (2001). Better health systems for India's poor: findings, analysis and options. Washington DC: The World Bank, Health, Nutrition and Population Series, Human development network.
74. Janovsky, K., & Peters. D. (2006). Improving health services and strengthening health systems: adopting and implementing innovative strategies - an exploratory review in twelve countries. Geneva: World Health Organization, Department of Health Policy, Development and Services, Making Health Systems Work, Working Paper No.5.
75. Preker, A., Carrin, G., Dror, D., Jakab, M., Hsiao, W., & Arhin-Tenkorang, D. (2001). A synthesis report on the role of communities in resource mobilization and risk sharing. Geneva: Commission on Macroeconomics and Health, CMH Working Paper Series, Paper No. WG3:4.

