

FINANCING TRANSITION IN THE HEALTH SECTOR - WHAT CAN DEVELOPMENT ASSITANCE COMMITTEE MEMBERS DO?

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Abstract

In the process of transition from low-income towards middle-income level and beyond, domestic actors bear an increasing share of the national health expenditure. This transition, however, is not automatic nor necessarily smooth. The challenges that emerge in the process are recently exacerbated by the COVID-19 crisis, which risks diverting resources away from basic health services. The role of development actors during this stage can be critical in setting up sustainable systems of health financing in those countries.

The paper starts with a review of the progress on the global health agenda by taking stock of past achievements and remaining challenges. Then, it explores how the health financing landscape transitions with the income level of a country, tracing how this can give rise to transition setbacks. Finally, the paper zooms in on the role of development finance and how it can be reshaped to better facilitate the transition process of countries.

Foreword

Health is at the core of sustainable development and has long been among the priorities of Development Assistance Committee (DAC) members and other development partners, who have contributed significantly to improving health outcomes over the last two decades. However, the increasing and overwhelming scale of new and rapidly evolving health challenges threaten to reverse development gains and cause devastation to the developing world. The recent COVID-19 crisis, which started as a public health crisis and later spread to have devastating effects on economies and societies across the globe, exemplifies the importance of health in pursuing sustainable development worldwide. At the same time, the shift in focus towards health security, risks diverting funds away from other health priorities, with adverse impacts on both access to essential health care services and financial protection, particularly of the most vulnerable.

The paper therefore takes a long-term view to assess the health financing landscape across countries undergoing a financing transition, with a particular focus on the role of development partners including members of the Development Assistance Committee.

In the process of transition from low-income towards middle-income level and beyond, domestic actors bear an increasing share of the national health expenditure. While the direction of this shift towards less reliance on external assistance is welcome and desirable, it can bring a suite of challenges that need to be carefully managed. The role of development actors during this stage can be critical in setting up sustainable systems of health financing in those countries, while bringing development co-operation closer to attaining the ultimate objective of making itself unnecessary.

This paper is part of a wider series that examines the financing landscape in specific sectoral contexts. Building on previous OECD research of sectoral allocation patterns of official development finance flows (ODF), this paper aims to assess the specific role of ODF as it articulates with other sources of financing including domestic public resources, private investment, etc. The paper has benefitted from with the views of the OECD Centre for Tax Policy and Administration (CTPA), and in particular from the two pilot reviews on mobilising tax revenues for health financing in Morocco and Côte d'Ivoire

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Executive Summary

Global health challenges are rapidly evolving, while profound shifts are taking place in the mix of resources that are available to finance these challenges. In light of these changing environments, members of the Development Assistance Committee (DAC) and other development partners need to adjust their support. In particular, two main areas call for renewed and strengthened attention.

Ensuring smooth transition management

The rise of innovative financing mechanisms and a surge in development finance often channelled through so-called vertical funds have led to great progress in the international health agenda. To ensure sustained progress after the exit of external support, development partners need to carefully stage and design the process and timing of their eventual phase-out. This involves:

- The phase-out of programmes should take into consideration a variety of factors including but going beyond income levels. A possible example is the composition of the health financing mix, the level of government health expenditure and the country's reliance on out-of-pocket payments.
- The level of concentration of the external finance that countries receive should also be considered in the transition process. As there is a growing tendency towards concentration, where few development partners dominate the health financing landscape in a country, the exit of those development partners could leave behind significant gaps.
- In preparation of programme phase-outs, it is important to sufficiently equip and train domestic institutions to successfully take over and continue on existing progress. Capacity building, especially regarding statistical and data management skills as well as financing and budgeting expertise, can help to boost spending efficiency.
- After the exit of development finance, neglect of vulnerable populations threatens to reverse health gains. Preparations for phase-out should be accompanied by precautionary measures to ensure continued care for vulnerable populations. This involves extensive dialogue and awareness-raising efforts with local governments and other public stakeholders.

Helping partner countries to tackle new health challenges by investing in domestic health systems

While development partners have focused most of their efforts in the health sector on tackling highly visible epidemics such as HIV/AIDS, tuberculosis and malaria, many other health challenges remain under-prioritised. As the global disease burden is shifting towards non-communicable diseases across all income groups, development finance alone will not be enough to effectively tackle these new challenges. However, but it can play a supporting role to domestic health systems.

- Development programmes should be designed and implemented in a way to maximise synergies with the health system strengthening agenda. Even if they target specific infectious diseases, such

programmes can have positive spill-over effects on the fight against other health challenges including non-communicable diseases.

- The ability to deal with emerging challenges critically hinges on the effective and sustainable financing of domestic health systems. Therefore, support for coping with health challenges should go hand in hand with efforts to catalyse other sources of finance notably domestic public resources.
- Since domestic resource mobilisation is often a long-term endeavour, development finance should be used to target critical financing gaps, especially for vulnerable segments of the population.
- Currently, a large part of development finance in the health sector is not channelled through domestic public institutions. More active engagement with these institutions will be key to bringing about health system strengthening.
- In parallel, DAC members can help to promote the quality of governance, leadership and accountability of domestic public sector organizations in the health sector. Support for health systems also includes investment in key domestic capacities including on budgeting, planning and financing of programmes.
- Development partners can fund research on health systems in developing country contexts, including on synergies between health and other SDGs. This would inform development co-operation strategies to make effective and strategic use of scarce funds.

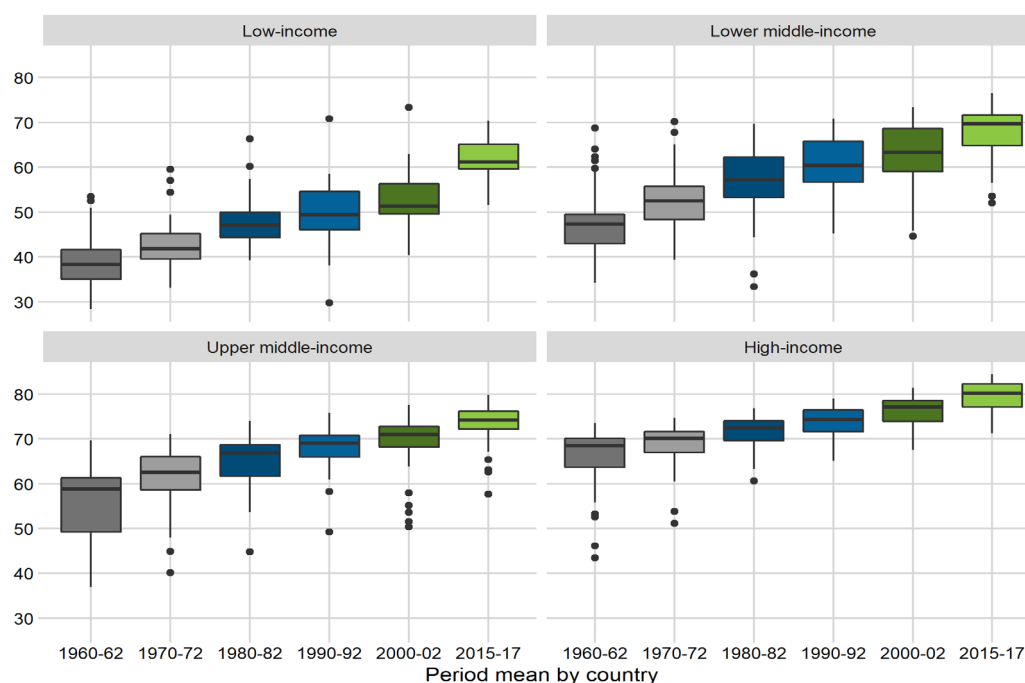
1. Health progress so far and remaining challenges

1.1. Health is at the heart of sustainable development

Countries across all income and regional groups achieved great improvements in health outcomes over the past decades. Figure 1.1 shows the increase in life expectancy, a summary measure of a population's health, across all income groups between 1960 and 2017. All countries have achieved significant gains in life expectancy since the mid-20th century thanks to a rapid expansion of medical knowledge and technology (Cutler, Deaton and Lleras-Muney, 2006^[1]; Weil, 2014^[2]). In parallel, inequality in life expectancy between countries has decreased (Peltzman, 2009^[3]).

Figure 1.1. Life expectancy has increased and converged across income groups

Life expectancy in years by income group between 1960 and 2017



Note: The bold middle line represents the median life expectancy. Income groups according to the World Bank in early 2020.

Source: Authors' illustration based on World Bank (2020^[4]), World Development Indicators (database),


<https://datacatalog.worldbank.org/dataset/world-development-indicators>.

Great progress was made towards most of the health-related Millennium Development Goals, notably Goals 4 (reduce child mortality), 5 (improve maternal health) and 6 (combat HIV/AIDS, malaria and other diseases).

- Globally, the number of deaths of children under five years of age fell from 12.7 million in 1990 to 5.3 million in 2018. The under-five mortality rate declined from 93 per 1 000 live births in 1990 to 39 per 1 000 live births in 2018 (WHO, 2020^[5]).
- In low- and middle-income countries, the percentage of underweight children under five years old dropped from about 28% in 1990 to 15% in 2017 (World Bank, 2020^[4]).
- Globally, new HIV infections fell by 37% between 2000 and 2018 while HIV-related deaths declined by 45% (WHO, 2019^[6]).

Building on the success of the Millennium Development Agenda, the 2030 Agenda includes health as an integral part of international development. SDG 3 aims for healthy lives and well-being for all at all ages. Graphic 1.1 outlines the nine primary (3.1 to 3.9) and four additional targets (3.a to 3.d) of SDG 3. For example, the Goal seeks to combat maternal mortality, preventable deaths of newborns and children under the age of five, infectious diseases, and non-communicable diseases.

Infographic 1.1. Targets of SDG 3 on health and well-being

	Targets	Means of implementation
	3.1. Maternal mortality	3.a. Tobacco control
	3.2. Neonatal and child mortality	3.b. Medicines and vaccines
	3.3. Infectious diseases	3.c. Health financing and workforce
	3.4. Non-communicable diseases	3.d. Emergency preparedness
	3.5. Substance abuse	
	3.6. Road traffic	
	3.7. Sexual and reproductive health	
	3.8. Universal health coverage	
	3.9. Environmental health	

Compared to its MDG predecessors, SDG 3 significantly expands the health-related agenda, for example by calling for universal health coverage (3.8). This includes (i) the coverage of essential health services and (ii) the reduction of household expenditures on health (financial hardship). Another target (3.c) directly relates to financing, calling for increased financing of the health workforce in developing countries.

Unlike the health-related MDGs that focused on communicable diseases, SDG Target 3.4 addresses the four major non-communicable diseases, namely cancers, cardiovascular diseases, chronic respiratory diseases, and diabetes, which are the leading cause of death globally and a challenge for sustainable development in the 21st century. Furthermore, SDG Target 3.d concerns the capacity of countries to respond to national and global health risks such as rapid and widespread virus outbreaks (e.g. SARS-CoV-2), a topic that has become particularly relevant in light of the COVID-19 outbreak.

What further distinguishes the 2030 Agenda is the explicit acknowledgement of interlinkages between different sustainable development goals. According to the World Health Organisation (WHO), at least 10 Goals beyond SDG 3 and more than 50 SDG indicators relate to health outcomes, determinants or service provision (WHO, 2018^[7]). One simple reason for this are the many factors beyond healthcare that affect health: nutrition, gender equality, air quality and conflicts, to name just a few, are all determinants of overall population health.

1.2. The challenges to reach SDG 3 by 2030 are large and call for more financing

Despite considerable progress, the international health agenda is far from finished. Countries are not on track to meet the majority of the SDG targets on health. The WHO reports that despite progress in 24 health-related SDG indicators, global improvements in health outcomes are only fast enough to reach the two of the nine targets with explicit objectives in 2030, namely on reducing under-five mortality and neonatal mortality (WHO, 2018^[7]).

Health sector capacities and health coverage lag behind in low- and lower middle-income countries. According to the WHO, at least one-half of the world's population does not have full coverage of essential health services yet (WHO, 2018^[7]). That is, countries at the lower end of the income spectrum have less physicians, nurses and midwives per population than in other countries. These countries are also facing challenges to ensure sufficient and affordable supply of quality medicines and are lagging behind in introducing newly recommended vaccines (e.g. rotavirus and pneumococcal-conjugated vaccine).

As recognised in SDG 3, non-communicable diseases present a growing threat to developing countries and developed countries alike. The share of deaths caused by non-communicable diseases (NCDs) has increased across all income groups between 2000 and 2016 (Table 1.1). The main four non-communicable diseases are cardiovascular disease, cancer, chronic respiratory disease, and diabetes.

While responsible for 23.1% of all deaths in low-income countries in 2000, the share of non-communicable diseases (NCD)-caused deaths increased to 36.8% among the respective countries by 2016. This increase for low-income countries is due to (i) an increase in the total number of deaths caused by NCDs and (ii) a large reduction in deaths caused by communicable, maternal, perinatal and nutritional conditions with declines from around 990 deaths per 100 000 population to 425 deaths per 100 000 population between 2000 and 2016.

Similarly, lower middle-income countries experienced an increase in deaths related to NCDs and a decrease in deaths caused by other diseases. In 2016, about 61 in 100 deaths were caused by NCDs in lower middle-income countries up from around 46 in 100 deaths in 2000. The share of NCD-related deaths also rose among upper middle-income and high-income countries, although levels had already been high in 2000.

Table 1.1. The share of deaths caused by non-communicable diseases increased across all income groups between 2000 and 2016

Causes of deaths by income groups in 2000 and 2016

		Population (thousands)		All Causes	Communicable, maternal, perinatal and nutritional conditions	Non-communicable diseases	Injuries
2000	LICs	425,130	Deaths (000s)	6,096	4,210	1,405	481
			% of total deaths	100.0	69.1	23.1	7.9
			CDR*	1,433.9	990.3	330.5	113.2
	LMICs	2,339,912	Deaths (000s)	20,953	9,424	9,704	1,825
			% of total deaths	100.0	45.0	46.3	8.7
			CDR*	895.5	402.7	414.7	78.0
	UMICs	2,314,471	Deaths (000s)	16,274	1,897	12,680	1,697
			% of total deaths	100.0	11.7	77.9	10.4
			CDR*	703.1	82.0	547.8	73.3

2016	HICs	1,061,277	Deaths (000s)	8,985	592	7,842	550
			% of total deaths	100.0	6.6	87.3	6.1
			CDR*	846.6	55.8	738.9	51.8
	LICs	659,273	Deaths (000s)	5,357	2,804	1,970	584
			% of total deaths	100.0	52.3	36.8	10.9
			CDR*	812.6	425.3	298.8	88.6
	LMICs	3,012,430	Deaths (000s)	22,134	6,537	13,439	2,158
			% of total deaths	100.0	29.5	60.7	9.8
			CDR*	734.7	217.0	446.1	71.6
UMICs	2,614,256	Deaths (000s)	19,106	1,418	16,118	1,570	
		% of total deaths	100.0	7.4	84.4	8.2	
		CDR*	730.8	54.2	616.5	60.1	
HICs	1,175,926	Deaths (000s)	10,277	687	9,019	571	
		% of total deaths	100.0	6.7	87.8	5.6	
		CDR*	874.0	58.4	766.9	48.6	

Note: * CDR = crude death rate (per 100 000 population)

Source: WHO (2018_[8]): Global Health Estimates 2016: Deaths by Cause, Age, Sex, by Country and by Region, https://www.who.int/healthinfo/global_burden_disease/estimates/en/

Low and lower middle-income countries thus face a double burden in disease related deaths. While communicable, maternal, perinatal and nutritional conditions cause fewer deaths in upper middle-income and high-income countries, they still account for a large share of deaths among low- and lower middle-income countries. In LICs, infectious and parasitic diseases caused 28% of total deaths compared to 15% in LMICs and 3% in UMICs. Neonatal conditions were responsible for more than 10% of deaths in LICs in 2016 compared to around 7% and 1% in LMICs and UMICs respectively.¹

The countries in the lower income and in the lower middle-income spectrum thus face at least a dual challenge to decrease morbidity and mortality of infectious and non-communicable diseases (in addition to reproductive and maternal health). Despite the importance and shift towards NCDs, countries should also remain prepared to respond to outbreaks of new or the reemergence of old infectious diseases which can spread quickly turning into epidemics or potentially global pandemics (see next on global health challenges).

Global health challenges are putting additional stress on health systems. As evident in recent development related to the COVID-19 outbreak, epidemics and pandemics continue to threaten health and lives, and its negative impacts on individuals and spillovers on societies and economies could become more immense.

Between 2011 and 2017, the WHO recorded at least 1307 epidemic events around the world (WHO, 2018_[9]). The major disease outbreaks since the early 2000s include among other the:

- SARS epidemic in 2003/04;
- Novel influenza virus (H1N1) pandemic which started to spread in 2009;
- MERS epidemic in the Middle East in 2012/13;
- Ebola epidemic in 2014 which affected Guinea, Liberia and Sierra Leone most strongly;

¹ Based on WHO (2018_[8]) Global Health Estimates 2016: Deaths by Cause, Age, Sex, by Country and by Region, 2000-2016, https://www.who.int/healthinfo/global_burden_disease/estimates/en/

- ZIKA virus that spread to over 70 countries from Brazil in 2015;
- Novel coronavirus (COVID-19) pandemic in 2020 (ongoing).

The WHO notes that epidemics in the 21st century are spreading faster and more widely than before (WHO, 2018^[9]). The interlinked, globalised nature of the world economy and individual travel and tourism can cause an infectious disease to spread from one country or continent to another in very short time. The disruptive (but often necessary) nature of the countermeasures (e.g. social distancing to reduce human-to-human transmission) have large consequences on individuals and economies.

Addressing these challenges calls for stronger global and national health system capacity including better public health surveillance and crisis preparedness. In the short-term, however, these epidemics and pandemics can create an overwhelming burden on health systems. While the emergency demands can exceed the capacity also in well-equipped health systems, the stress on under-resourced health sectors is amplified. For example, in systems with a small number of medical personnel and equipment only, combatting the epidemic likely diverts critical resources from other, important health services.

Further improving health outcomes and achieve universal health coverage requires more spending on health. Existing estimates point towards the need to increase *spending* on the health sector for countries to achieve SDG 3 by 2030. Chapter 2 discusses the various sources of health *financing* that could contribute to this increase.

Directly comparing the following spending targets is difficult due to different SDG areas covered, country samples and methodologies. Still, this non-exhaustive list provides an order of magnitude of the additional spending (and thus financing) needs estimated to achieve SDG 3 on health and well-being:

- UNCTAD (2014^[10]) estimates that annual spending needs in health in developing countries amount to USD 210 billion. An annual financing gap of USD 140 billion results at current funding levels.
- Schmidt-Traub (2015^[11]) estimates that low-income and lower middle-income countries, together, require an incremental additional spending in health between USD 69-89 billion annually between 2015 and 2030.²
- Considering health and education together, the IMF (Gaspar et al., 2019^[12]) estimates that low-income developing countries (LIDCs) require additional spending of USD 284 billion in the year 2030, equivalent to 8.3% of these countries' projected GDP.³ Emerging markets would require USD 1.1 trillion additionally for health and education in 2030. No figure is available for health individually. Spending would have to increase annually to meet the estimated level by 2030.⁴

² Low-income countries would require between USD 25-29 billion and lower-middle income countries between USD 44-60 billion incremental annual investment (Schmidt-Traub, 2015^[11]).

³ The IMF (Gaspar et al., 2019^[12]) estimates additional spending required to reach the SDGs by 2030 for five SDG areas (education, health, roads, electricity, water and sanitation). It considers 121 countries and projects additional spending needs of USD 2.6 trillion in 2030, or 2.5% of the world's projected GDP in 2030. This number rests on substantially increasing the efficiency of spending, too. The IMF estimate for the health sector considers a SDG 3 index that comprises fourteen health variables. The functional form to estimate the additional spending required is based on the number of health care workers, wages and controls for projected changes in demographics and GDP per capita.

⁴ Schmidt-Traub: Incremental annual investment needs in the education sector, for comparability with IMF figures, are estimated at USD 194 billion.

- The WHO (2019^[13]) suggests that an additional USD 370 billion per year for primary health care and universal health coverage (UHC) would be sufficient to reach the SDG's UHC targets in low- and middle-income countries.⁵

Yet, incorporating financing and spending needs for responding to health crises is difficult and, thus, the numbers above could underestimate the total needs when adding (health sector specific) responses to global pandemics.

Beyond the general tendency that health service coverage increases with the level of (public) health spending, it should be noted that the estimates outlined above should not undermine the need to improve public spending efficiency on health. Further, the great variety in health service coverage among countries with low spending levels suggests that countries can also improve health outcomes at least to some extent at a lower spending level for instance by improving the overall organisation of a country's health system (see for example Jowett et al, (2016^[14])).

⁵ Can be decomposed into USD 200 billion for primary health care and USD 170 billion for other services to reach universal health coverage.

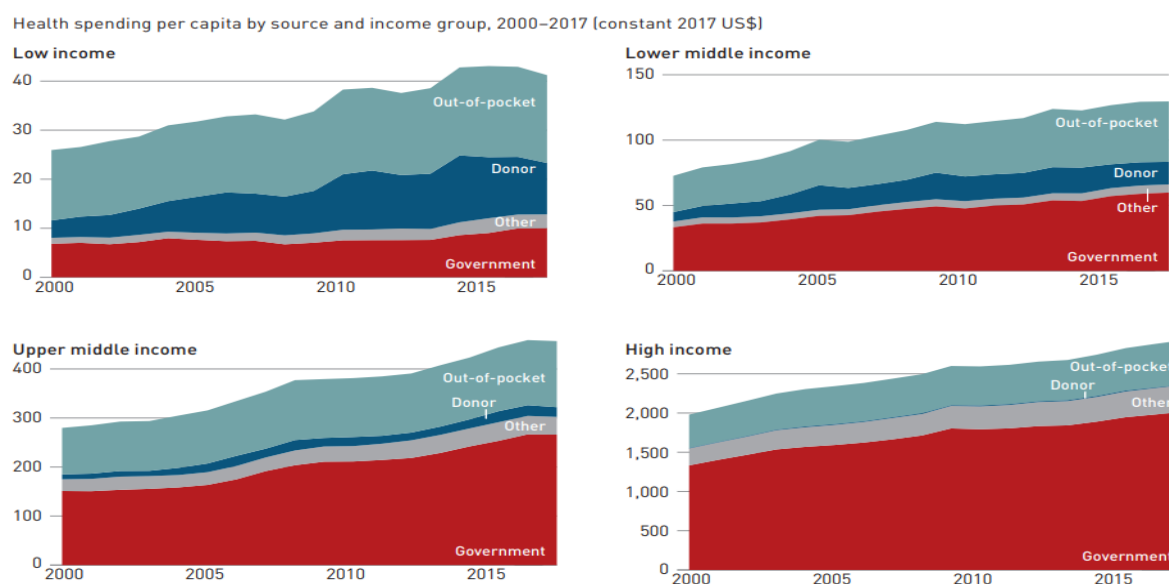
2. Health financing is in transition

2.1 The health financing mix is diverse and has dynamically evolved over the years

With ten years until the 2030 SDG horizon, total spending on health in developing countries has considerably increased, and reached USD 7.8 trillion in 2017, or about 10% of the world's gross domestic product (WHO, 2019_[13]). The increase in health spending has outpaced global economic growth. Between 2000 and 2017, global health spending (including in high-income countries) grew by an annual 3.9% in real terms while global GDP grew at 3.0%. In middle-income countries, health spending rose 6.3% a year between 2000 and 2017 while health spending in low-income countries rose 7.8% a year (WHO, 2019_[13]).

Domestic public resources constitute the largest part of global health expenditures. Domestic public spending has grown consistently, both in level and as a share in total health spending, as shown in Figure 2.1 About 60% of global spending on health in 2017 was public spending, up from 56% in 2000. Globally, domestic public spending on health grew at 4.3% a year between 2000 and 2017 (WHO, 2019_[13]).

Figure 2.1. Across all income groups health spending has increased, and the share of development finance has decreased



Source: WHO, (2019_[15]), World Health Statistics 2019: Monitoring health for the SDGs, sustainable development goals, https://www.who.int/gho/publications/world_health_statistics/2019/en/

This was especially driven by a rise in public spending in upper middle-income countries. In the recent period from 2015 to 2017, public health spending expanded also in low-income and lower middle-income countries. Despite this expansion, domestic public resources account for only one quarter of health

expenditure in low-income countries, while in lower middle-income countries they present 44% of total spending (WHO, 2019_[13]).

The health financing mix consists of diverse resources

Apart from domestic public resources, there is a variety of resources that are part of the health financing mix. These include the following:

Out-of-pocket (OOP) expenditures are direct payments made by individuals to health care providers at the time of service use. OOPs can take the form of user fees and co-payments. They can be an effective means to mobilise revenue, rationalise the use of health services, contain health system costs or improve health system efficiency and service quality. However, in the case of poor households, OOP can have significant negative impacts.

When out-of-pocket spending is not sufficiently supplemented by other means of financing, health emergencies can result in people borrowing, selling assets, not getting needed care, and engaging in other coping mechanisms. According to a recent report by WHO and the World Bank, about 100 million people are pushed into extreme poverty due to their health expenditures (WHO/World Bank, 2017_[16]).

While out-of-pocket spending increased globally between 2000 and 2017, the increase was slower than that of government spending. As a result, the share of out-of-pocket expenditure in overall health spending has been consistently declining across all income groups since 2000. However, OOP still represents an especially large share in low-income and lower middle-income countries, where it amounts to 41% and 44%.

Private health insurance here refers to voluntary, for-profit commercial coverage, which needs to be distinguished from mandatory and publicly funded health schemes that are implemented by private sector companies (Savodoff and Sekhri, 2004_[17]).

In higher income countries, private insurance is often complementary or supplementary to publicly funded schemes. For example, private coverage can include patient co-payments and may cover additional services and/or faster access to care where waiting lists are an issue.

In lower- and middle-income countries, where publicly funded health systems tend to be weaker, private coverage often takes the form of community-based health insurance schemes.

Private insurance can help to move towards prepayment and risk pooling until publicly funded coverage can expand sufficiently (Savodoff and Sekhri, 2004_[17]). The social insurance systems of several OECD countries evolved from voluntary private health insurance schemes based on professional guilds or communities.

With the emergence of a middle-class in lower and middle-income countries, private health insurance schemes play an increasing role. In these cases, the existence of private insurance can allow policy makers to target limited public resources towards the most vulnerable groups, while those who can afford it can contribute to their medical costs (Savodoff and Sekhri, 2004_[17]).

How far are we from reaching universal health coverage

Universal health coverage (UHC) is the goal to ensure that everyone has access to quality health services without suffering financial hardship. With its inclusion in the 2030 Sustainable Development Goals (SDG target 3.8), universal health coverage has emerged in recent years as a central health imperative. About 75 countries have enacted UHC legislation, and many countries – including Kenya, India, Indonesia and South Africa – have developed policy frameworks and committed new resources to expanding health services.

The UHC service-coverage index (SCI) provides a way to track progress on obtaining universal health coverage. This index focuses on four categories of health indicators: reproductive, maternal, and child health; infectious disease control; non-communicable diseases; and service capacity and access. The SCI global average increased from 45 (of 100) in 2000 to 66 in 2017, with gains recorded in all regions and income groups.

But significant barriers and gaps remain to achieving UHC:

- While rapid improvements in the coverage of infectious diseases contributed to gains in the UHC SCI, relatively little progress has been made on non-communicable disease and service capacity, particularly in low-income countries.
- While the absolute number of people covered by health services in the SDG era is expected to increase, the trend is offset by population growth. If current trends continue to 2030, the share of the global population covered by essential health services will rise only slowly.
- Data gaps on service coverage limit countries' ability to monitor progress on the ground. From 2013 to 2017, countries had data on only 40% of 14 tracer indicators, data on non-communicable diseases among the main challenges.

Moreover, the financial cost of massively expanding access to health care is a formidable barrier to achieving UHC, and financial protection is deteriorating:

- The additional cost of reaching the UHC standard for utilisation in 2016 was 106% of current spending for low-income countries, 130% for lower middle-income countries, 24% for upper middle-income countries, and 5% for high-income countries. (Moses et al., 2019^[18])
- The incidence of catastrophic health expenditure (SDG indicator 3.8.2), defined as large out-of-pocket spending in relation to household consumption or income, increased continuously between 2000 and 2015. The proportion of the population with out-of-pocket spending exceeding 10% of their household budget rose from 9.4% to 12.7%.
- The percentage of the population impoverished by out-of-pocket health spending increased from 1.8% in 2000 to 2.5% in 2015

Continued focus on the UHC agenda is especially important in the current context, as efforts to fight the COVID-19 pandemic risk diverting funds away from wider health services.

- Disruptions to immunisation campaigns could mean that as many as 117 million children worldwide could miss out on measles vaccinations.
- Suspension of distribution campaigns for insecticide-treated nets and malaria treatment could lead to 225 million additional malaria cases across sub-Saharan Africa in 2020.

Source: WHO (2019^[13]), Global spending on health: a world in transition, <https://apps.who.int/iris/bitstream/handle/10665/330357/WHO-HIS-HGF-HF-WorkingPaper-19.4-eng.pdf?ua=1>; Krubiner et al. (2020^[19]) Balancing the COVID-19 Response with Wider Health Needs:

Key Decision-Making Considerations for Low- and Middle-Income Countries, <https://www.cgdev.org/publication/balancing-covid-19-response-wider-health-needs-key-decision-making-considerations-low>

Development finance refers to external support for health including official development assistance and other official flows from DAC and non-DAC countries as well as private philanthropic funds. These funds can be extended in the form of grants, loans and aid in kind from bilateral, multilateral or private foundations.

Development finance steadily increased in absolute volumes since 2000. (Figure 2.1) However, due to the rise in other sources, especially domestic public funding and OOP, it has been decreasing as a share of overall health spending. At the aggregate level, development finance is a small share (less than 1%) of global health spending.

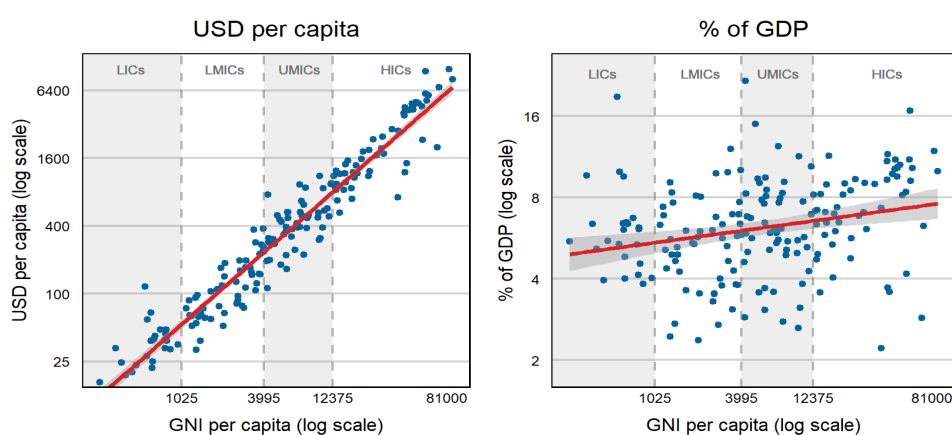
However, health-related development finance is still important in many low and lower middle-income countries. In 2017, more than 140 countries across all income groups received external funding for health. In 2017, aid represented 29% of the health spending in low income countries and 12% in lower middle-income countries (WHO, 2019^[13]). Income-dependent changes in the health financing mix can give rise to transition challenges

Development finance becomes less important as countries move to higher income levels

The per capita income level of a country is a key determinant of its total spending on health spending. As seen in Figure 2.2 income levels are positively correlated with per capita healthcare expenditure. This relationship remains after accounting for additional factors, such as country-specific demographic characteristics (Ke, Saksena and Holly, 2011^[20])⁶.

Figure 2.2. Total health expenditure and income per capita

Total health expenditure, logarithmic scale and linear fit, country average 2014-17



Note: Graph includes developing countries and high-income countries. The WB indicators shown are SH.XPD.CHEX.PC.CD (left-hand side) and SH.XPD.CHEX.PC.CD (right-hand side). Left-hand graph adj. R² = 0.52 and beta-coefficient = 909.0 (significant at 0.0001 level). Right-hand graph adj. R² = 0.056 and beta-coefficient = 0.074 (significant at 0.0001 level).

Source: World Bank (2020^[4]), World Development Indicators, <https://datacatalog.worldbank.org/dataset/world-development-indicators>

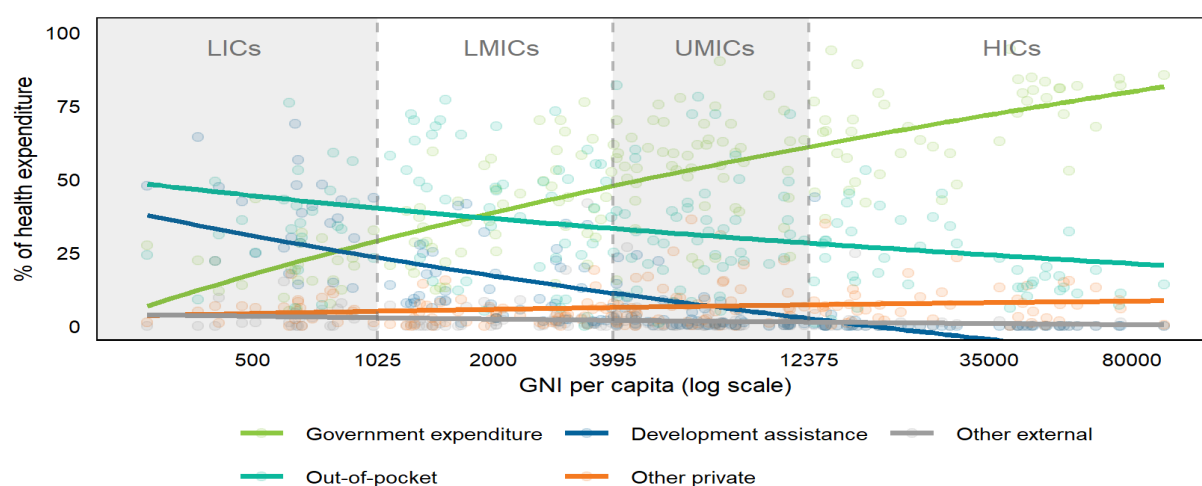
⁶ The income elasticity was less than 1 for low-middle and upper-middle income countries, while it was around 1 in low and high income countries.

The composition of health expenditure transitions with a country's income level as well. At low levels of income, external development finance is a relatively important source for health financing, but as per capita income increases to the middle-income level, it is replaced by other sources. At the same time, the share of out-of-pocket payments decreases, while the share of government spending increases.

However, Figure 2.3 shows that out-of-pocket payments and development finance decline at different rates. On average, external development finance starts to decrease at a lower income level, and does so more steeply than OOP.

Figure 2.3. The financing mix transitions with the income trajectory of a country

Share in total health expenditure, country average 2014-2018



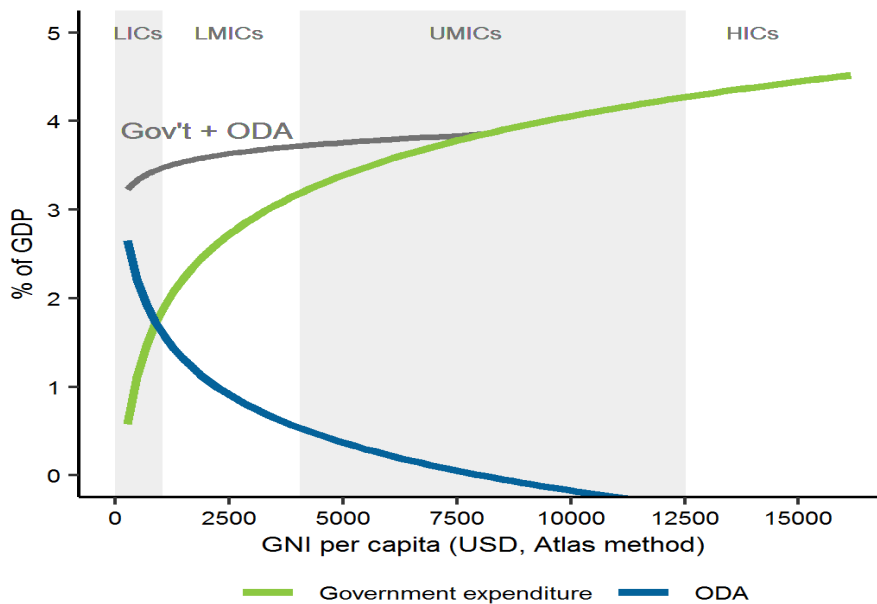
Note: Logarithmic fit including low-, middle- and high-income countries. Detailed methodology in the methodological annex.

Source: Authors based on World Bank (2020^[4]), World Development Indicators (database), <https://datacatalog.worldbank.org/dataset/world-development-indicators> (World Bank data is based on WHO Global Health Expenditure database); OECD (2020^[21]), Creditor Reporting System (database), <https://stats.oecd.org/Index.aspx?DataSetCode=crs>

This steep decline in development finance for health can cause concerns about potential transition finance gaps. A transition finance gap is defined as the occurrence of a net loss in the total amount of development finance available for a certain sector, as countries move towards higher levels of per capita income (Piemonte et al., 2019^[22]). According to this definition, the health sector is particularly prone to such a transition finance gap. Countries continue to depend on official development assistance (ODA), even after they move to different sources, notably other official flows from DAC countries, for the financing of other sectors. But once ODA starts to decline it does so sharply (Piemonte et al., 2019^[23]).

Extending the analysis to include domestic government expenditure, there is no longer a net loss in total health financing, on average. As external development finance, consisting of ODA and OOF as well as private philanthropic flows, declines, government expenditures tend to grow enough to cover the fall-out in external assistance (Figure 2.4).

Figure 2.4. Government expenditure rises to cover the decline in development finance



Note: Right-hand graph: Adj. R2 for gov't expenditure = 0.19 and beta-coefficient = 0.96 and for ODA adj. R2 for ODA = 0.39 and beta-coefficient = -0.78.

Source: OECD (2020^[21]), Creditor Reporting System (database), <https://stats.oecd.org/Index.aspx?DataSetCode=crs> for ODA and World Bank (2020^[4]), World Development Indicators (database), <https://datacatalog.worldbank.org/dataset/world-development-indicators> for general government expenditure on health.

2.2 Transition in the health financing mix comes with growing pains

The transition in the financing mix, however, is not automatic nor necessarily smooth. Even if, on average, government expenditures rise sufficiently to cover for the decline in external assistance, this is not always the case. A WHO study (2019^[13]) finds that in 17 out of 42 countries, that have experienced transition in their income status, either from low-income to lower middle, or from lower middle to upper middle-income level, government spending on health as a share of health spending fell, while the share of OOP increased.

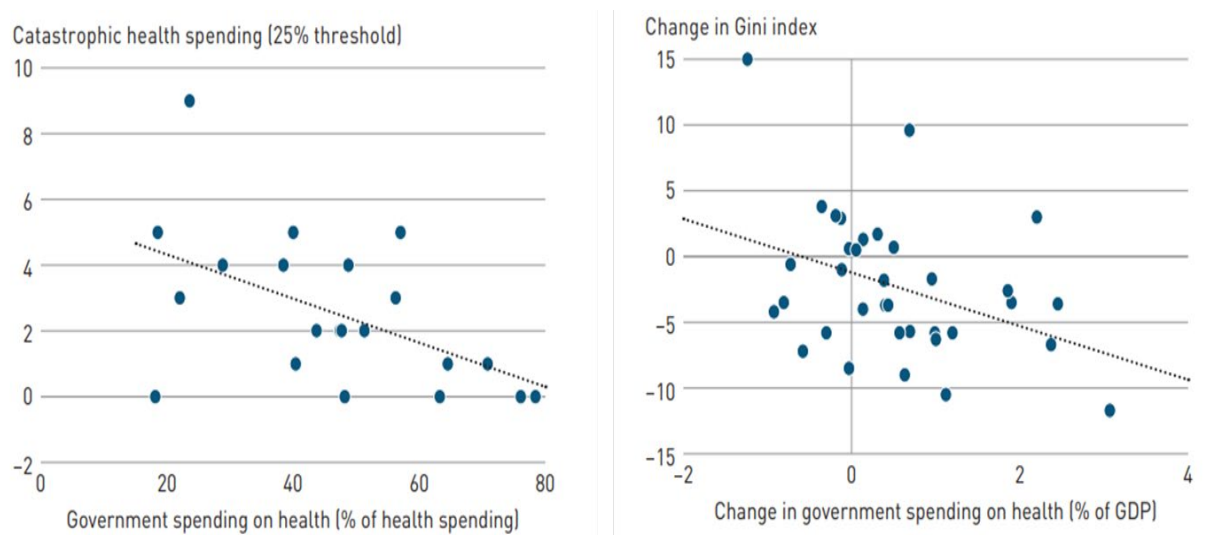
Even with greater government spending, there is a continued reliance on out-of-pocket payments. In light of increasing prices and evolving health needs in middle-income countries, total health expenditures rise more quickly than government expenditures can cover. Before government-supported health systems become well-functioning and efficient, private households continue to rely on OOP. As seen in Figure 2.3 the share of OOP in total health expenditure decreases with rising income levels but it decreases at a slower pace than external assistance. Well over the threshold level for lower middle-income status, OOP remains the most dominant source in the financing mix.

These out-of-pocket payments can be prohibitively costly for large segments of the population. Often, these people are left without means to address newly evolving health risks, which require costly treatments. They are exposed to the risk of catastrophic health expenditure, which is defined as health expenditure in excess of 10% or 25% of a household's total income. Between 2000 and 2015, the proportion of the global population facing catastrophic health expenditure, based on the 10% threshold, rose from 9.4% to 12.7% (WHO, 2019^[13]).

Where government expenditure rises fast enough, the occurrence of catastrophic health expenditure tends to be less frequent and inequality tends to be lower. According to the WHO study

(2019^[13]) the government share of health spending is negatively correlated with catastrophic expenditure, which here is defined as health spending in excess of 25% of the household budget. (Figure 2.5, left) Moreover, higher government spending on health as a share of GDP is negatively associated with inequality, as measured with the Gini coefficient (Figure 2.5, right).

Figure 2.5. Government spending on health can play a role fighting health inequity



Source: WHO, (2019^[15]), World Health Statistics 2019: Monitoring health for the SDGs, sustainable development goals, https://www.who.int/gho/publications/world_health_statistics/2019/en/

For development partners, the relative portion of OOP and government expenditure in a partner country could be a useful indicator to help design and time their phase-outs and exits. In light of the importance of the role of the domestic public expenditure, a planned phase-out in health support can also provide an impetus to consider ways to support domestic resource mobilisation.

Even where government health spending is increasing sufficiently, the decline in external assistance can leave transition gaps in specific areas, especially infectious disease control. The notion of a transition gap is especially pertinent in the fight against epidemics, which have been the primary areas of focus for external development finance in health. These are the control of HIV/AIDS, malaria and tuberculosis, where great progress has been made over the years (Institute for Health Metrics and Evaluation (IHME), 2018^[24]). There is a risk that important health gains made on this front can be reversed as countries become wealthier and development finance providers phase out their support. For example, in some countries transitioning from Gavi support such as the Republic of Congo and Angola, the government was slow to step up and replace declining Gavi funding for vaccines with its own health ministry budget (Hecht and Bennett, 2016^[25]).

Moreover, there can be large gains in health outcomes by improving the efficiency of public health spending. This can be done through cost-saving measures such as investment in preventive health care, particularly in the context of the growing burden of non-communicable diseases (NCDs) as well as minimising costly overseas medical referrals, which risk exacerbating health inequalities.

Development partners need to ensure a smooth transition of the programmes, effectively transferring responsibilities and capacities to domestic institutions to ensure continued progress, a topic that will be explored in more detail in the following section.

3. Re-shaping the role of development partners

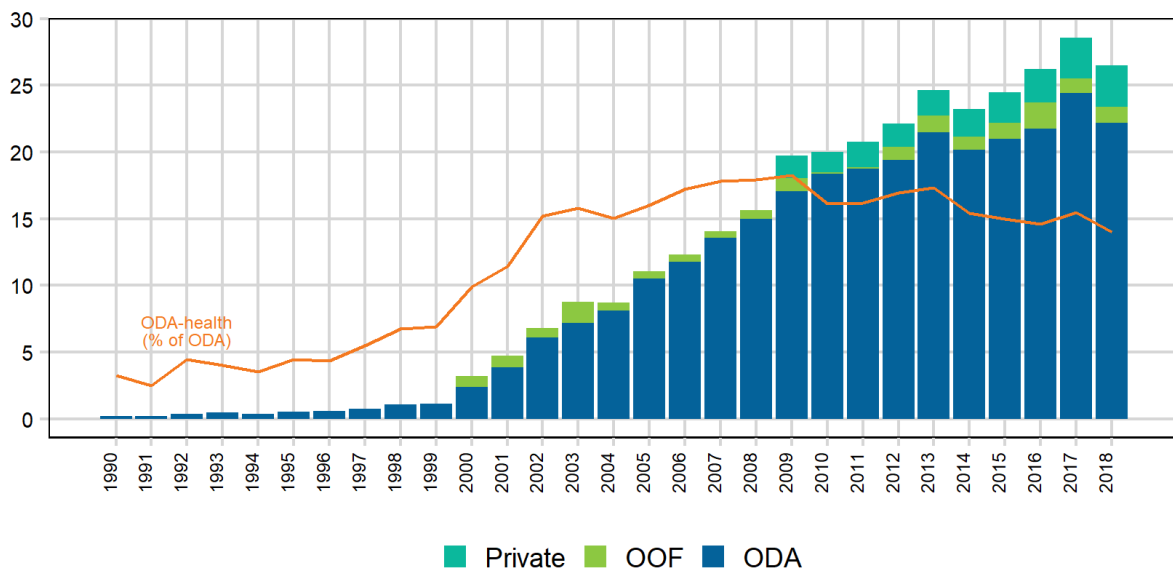
3.1 Development partners remain committed to the health needs of the most vulnerable countries

Despite the proliferation of actors, development finance for health remains highly concentrated

The health sector has played an important role in the field of development co-operation. The early 2000s saw a steep increase in interest from development partners. The portion of total official development assistance that was devoted to the health sector more than doubled from less than 7% in 2000 to 15% in 2003, after which it has remained relatively stable (Figure 3.1).

Figure 3.1. Development flows to health have increased largely since the early 2000s

Disbursements to health in USD billion constant 2017 (bars) and as share of total (line), 1990-2018

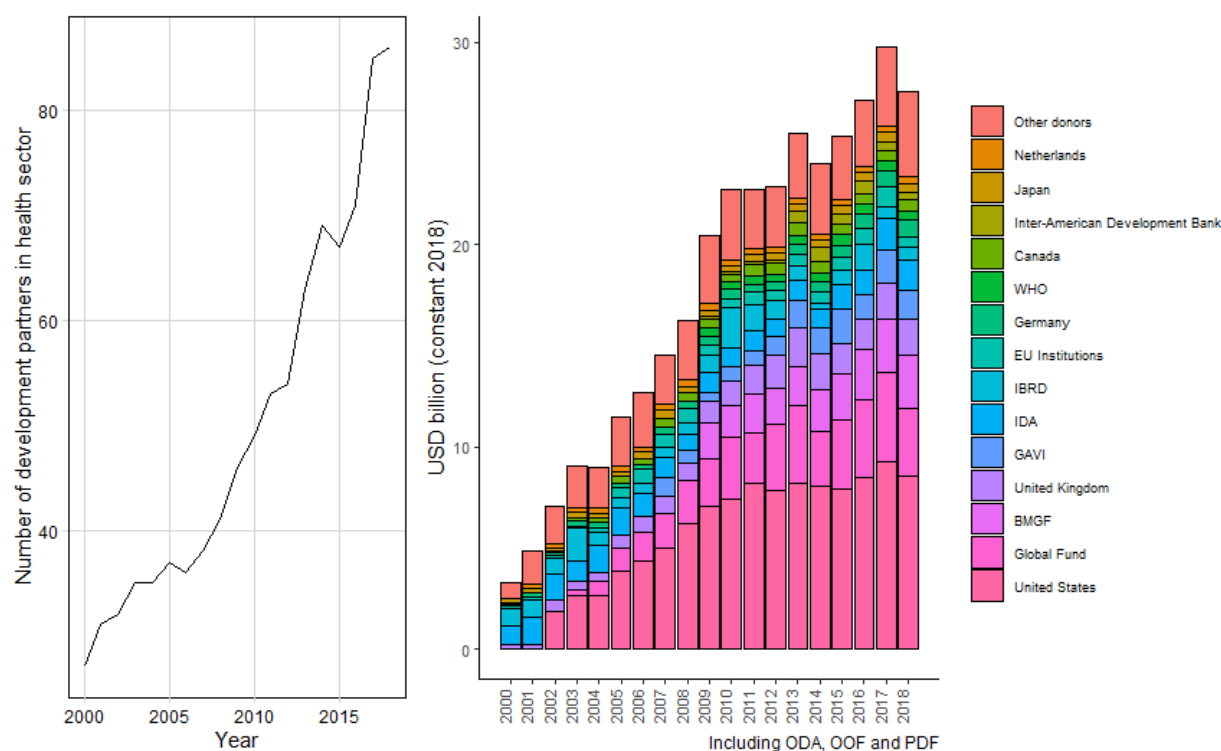


Note: Bilateral allocable aid only (see methodological annex). Inclusion of development flows to health and population policies and programmes. Source: OECD (2020^[21]), Creditor Reporting System (database), <https://stats.oecd.org/Index.aspx?DataSetCode=crs>.

While there has been an increase in the number of players active in health, the bulk of the financing comes from a relatively limited number of large players. The number of development partners active in the health sector has steeply increased. The number of entities reporting their health-related

disbursements to the OECD Creditor Reporting System (CRS), for example, has grown from 27 in 2000 to 86 in 2018 (Figure 3.2). This trend has raised concerns about over-crowdedness and inefficiencies due to redundancies and fragmentation.

Figure 3.2. More and more actors provide health-related development finance



Source: Authors' calculations based on OECD (2020^[21]), Creditor Reporting System (database), <https://stats.oecd.org/Index.aspx?DataSetCode=crs>

However, in terms of financing amounts, a small number of development partners dominate the landscape. In 2018, the top three partners (United States, Global Fund, Bill and Melinda Gates Foundation) provided more than half (53%) of all development finance for health (Figure 3.2, right).

Among the key players are DAC members such as the United States and the United Kingdom, but also private philanthropic foundations, notably the Bill and Melinda Gates Foundation (BMGF), as well as a number of global programmes designed to target specific health issues and diseases. These global programmes include the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the Global Alliance for Vaccines and Immunisation.

DAC members are strong supporters of these vertical funds. Between 2016 and 2018, DAC members contributed an annual average of USD 129.5 million in health development finance to vertical funds. The largest bilateral development partner, the United States, also channels a large part of its health development finance through its own vertical fund, namely the President's Emergency Plan for AIDS Relief (PEPFAR).

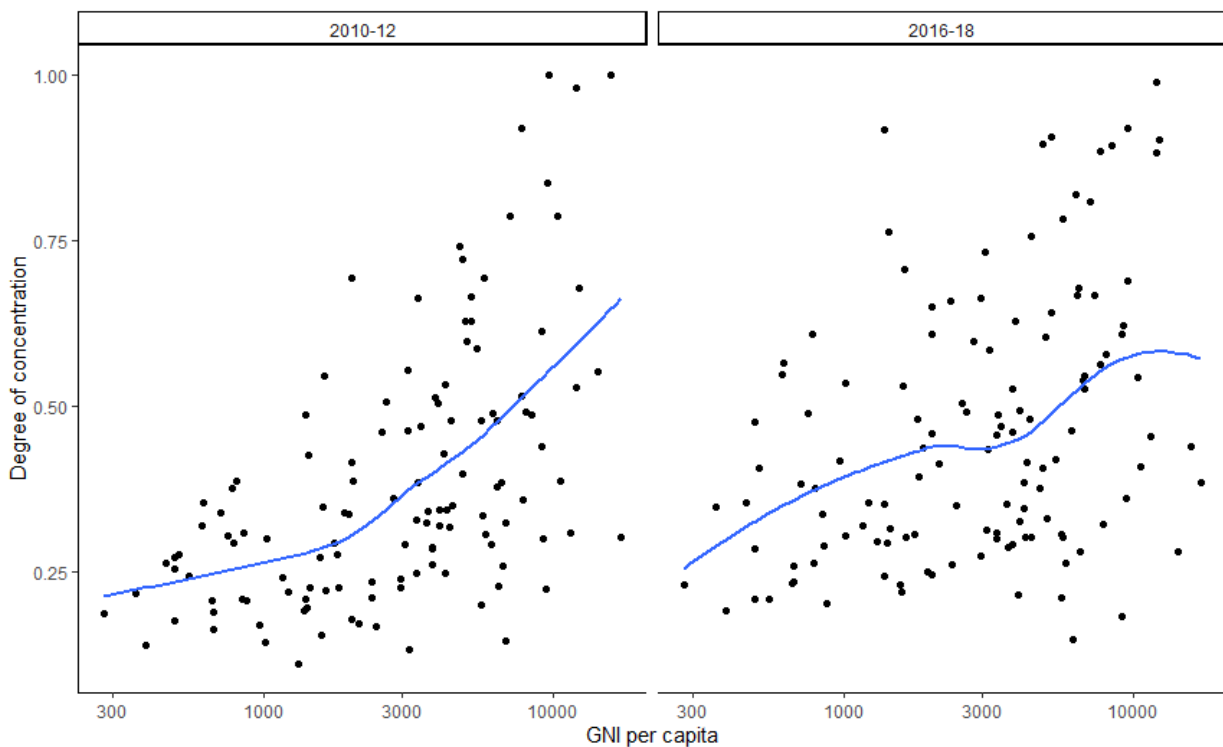
The proliferation of health actors does not necessarily lead to overcrowded health financing landscapes within countries.

Crowdedness in the health sector can be measured by way of a concentration index, which shows how much of health financing is concentrated in the hands of few development partners. The index value is

lower and approaches '0' if health financing is provided by a multitude of similarly influential actors, and closer to '1' if it is predominantly concentrated among few larger providers. Comparing the degree of concentration of development partners within countries in the early and late 2010s, it does not seem that the increased number of actors engaged in the health sector led to a fragmentation of health financing in countries (Figure 3.3).

If at all, the comparison indicates that external health financing has become slightly more concentrated for countries that are at a relatively lower level of per capita income (i.e. 1 000 – 3 000), as suggested by the higher trend curve in 2016-18.

Figure 3.3. Despite the proliferation of actors, health financing within countries is not more fragmented than before

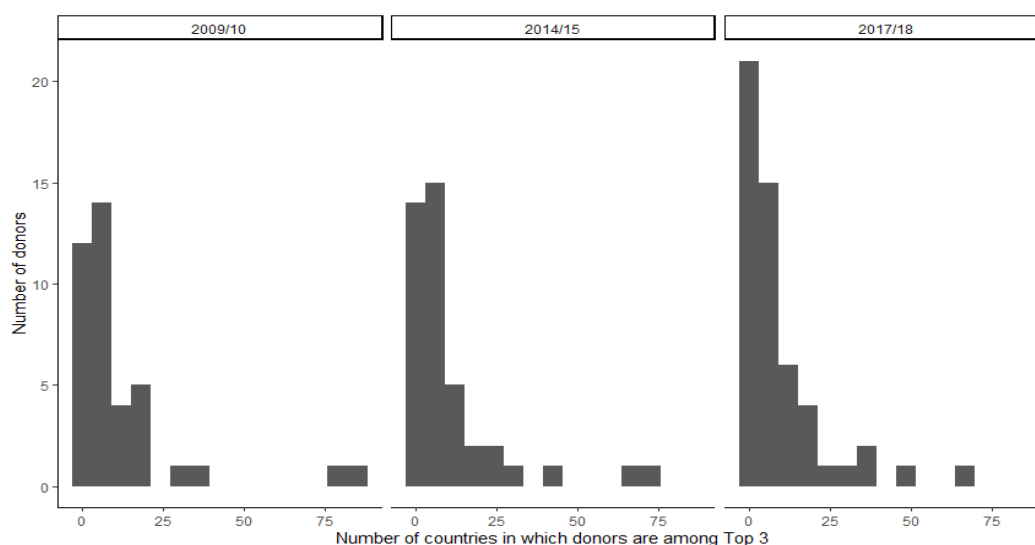


Note: The degree of concentration was calculated using the Herfindahl-Hirschman Index which sums the square of the relative contribution of each development partner in the health development finance mix in a country.

Source: Authors' calculations based on OECD (2020^[21]), Creditor Reporting System (database), <https://stats.oecd.org/Index.aspx?DataSetCode=crs>

One reason for this phenomenon is that development partners have adjusted their strategies to the increasing crowdedness in the health sector by focusing on selected countries, where they have a larger influence. Figure 3.4 shows that the number of development partners that focus on a few countries has significantly increased over the years. In the figure, there has been a steep increase in development partners that pick up to five countries where they are among the top three providers, while the number of partners retaining a large influence in more than ten countries has stayed relatively stagnant.

Figure 3.4. More development partners focus on few countries where they retain a large influence

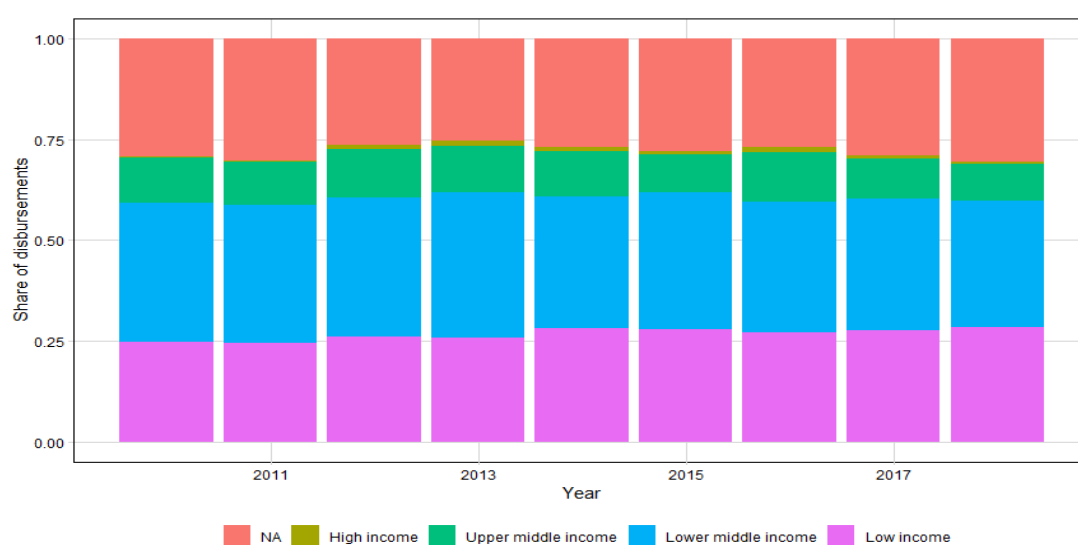


Source: Authors' calculations based on OECD (2020^[21]), Creditor Reporting System (database), <https://stats.oecd.org/Index.aspx?DataSetCode=crs>

Development finance for health remains focused on the most vulnerable countries and infectious disease control

In terms of their target recipients, however, development partners seem to have maintained a consistent approach, with a strong focus on low-income and lower middle-income countries. Since 2010, the portion of health-related development finance targeting low-income and lower middle-income countries has stayed the same at about 25% and about 30% (Figure 3.5).

Figure 3.5. Development partners continue to focus on low-income and lower middle-income countries

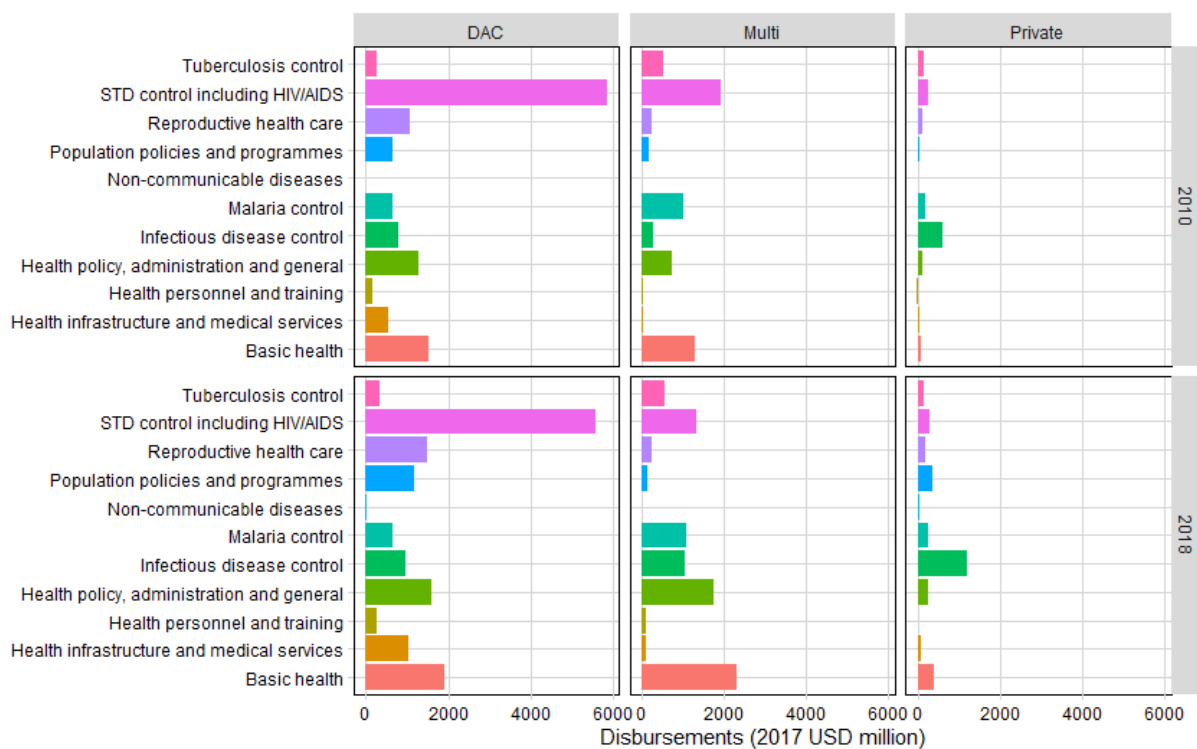


Source: Authors' calculations based on OECD (2020^[21]), Creditor Reporting System (database), <https://stats.oecd.org/Index.aspx?DataSetCode=crs>

Similarly, the thematic focus of development partners has remained the same, with HIV/AIDS and sexually transmitted infections (STI) control being the largest target area of development interventions. Between 2014 and 2017, 53.2% of ODA commitments targeted the control of HIV/AIDS and STI, infectious disease control, malaria and tuberculosis (TB) control. STD control alone accounted for 30.7% of ODA commitments (Figure 3.6).

Infectious diseases, as mentioned above in Chapter 1, continue to put a considerable burden on developing countries, presenting 52.3% and 29.1% of deaths in LICs and LMICs, respectively. The engagement of development co-operation in these areas is therefore necessary and welcome. However, development partners have been less responsive to the rise in other health threats such as NCDs, which account for an increasing share of deaths in developing countries.

Figure 3.6. HIV/AIDS and STI control remains a primary focus area for development partners



Source: Authors' calculations based on OECD (2020^[21]), Creditor Reporting System (database), <https://stats.oecd.org/Index.aspx?DataSetCode=crs>

It should be noted, though, that there is some variation depending on the types of actors. While bilateral partners have a strong focus on infectious disease control, multilateral development partners including the WHO and the World Bank, invest sizable portions of overall financing in more upstream areas such as basic health as well as health policy and administration.

3.2 To ensure continued progress on infectious diseases, development partners need to facilitate smooth transition

Graduation from external support for infectious diseases can entail transition setbacks

The consistent commitment of development partners has contributed to an increase in financing and co-ordinated action in fighting infectious diseases. During the past two decades, the massive international response to HIV, tuberculosis (TB) and malaria has markedly reduced global case incidence and mortality rates. For example new HIV infection decreased from 3 million per year in 2000 to 2 million in 2015. Global malaria deaths decreased from 839 700 in 2000 to 438 000 in 2015.

As a result of this success, many global programmes or vertical funds specifically designed for the purpose of addressing these diseases are ceasing or planning to end their support. For example, the Global Polio Eradication Initiative (GPEI), which has been paramount in the near-eradication of wild polio, ceased most of its operations except in the three countries (Afghanistan and Pakistan) where polio is still endemic. Others are still operating globally, but have exited countries, especially if they have seen substantial growth in their per capita income levels. Since 2014, more than a dozen countries have seen their funding from Gavi end and over ten countries have had financial support from the Global Fund come to a halt (Silverman, 2018^[26]).

However, despite the considerable success, significant challenges remain, and countries that are graduating from vertical funds often have to tackle these challenges by themselves. Immunisation rates are highly variable, while vaccine refusal is growing in many countries. Due to fragile and weak immunisation systems, only 7% of children in the world's 73 poorest countries are being fully immunised (Kerr, 2017^[27]). The poor remain disproportionately affected by infectious diseases and their consequences. The end of HIV/Aids, TB and malaria, which constitutes SDG Target 3.3, is not in sight with the number of deaths related to HIV/AIDS, TB and malaria being 770 000, 1.5 million and 405 000, respectively, in 2018.

Transition setbacks are likely to disproportionately affect vulnerable and marginalised populations. Even in cases where the fiscal impact of development finance phase-out is negligible, the health financing transition can entail high risk of health setbacks to vulnerable populations. For example, in the context of graduation from the Global Fund and PEPFAR, there is an acute risk of HIV re-emerging among “key populations” such as sex workers, men who have sex with men, people who inject drugs, transgender populations, and prisoners (Hecht et al., 2018^[28]). Romania saw a rapid rise in the HIV prevalence among persons who inject drugs (PWID) after graduating from the Global Fund in 2010. The HIV prevalence among PWID, estimated at 1.1% in 2009 increased to 6.9% in 2012 and spiked at 53% in 2013 (ICASO, 2016^[29]).

This is especially true in countries where the government's engagement with civil society is limited. Civil society organisations often deliver critical preventive care, and support services, especially for HIV programmes, often with the budgetary support of external development partners. In the absence of “social contracting” mechanisms, through which governments fund non-governmental entities to provide public services to the local population, there is a risk that important health services will be disrupted (Gotsadze et al., 2019^[30]).

Refugees and populations in conflict-affected regions can be disproportionately affected from the health financing transition. Middle-income countries that are ineligible for support from Gavi, host almost half of the world's 18 million refugees. Under current policies, Gavi cannot extend immunisation support to refugees in ineligible countries, even if the refugees have fled from countries that would otherwise meet Gavi eligibility criteria. Although polio eradication efforts have been successful across the world, polio is still endemic in two countries, namely Pakistan and Afghanistan, which is due to wide-spread immunisation gaps in conflict-affected areas such as on the border between Afghanistan and Pakistan.

Development partners can help to ensure sustained support for vulnerable populations

Recent OECD work on health financing in Morocco after graduation from the Global Fund discusses the need to put in place a framework to collaborate with civil society organisations (CSOs), for example by establishing "social contracts" between these organisations and the Ministry of Health. It further suggests to use existing resources and mechanisms to ensure continued financing of health programmes for vulnerable criminalised populations such as sex workers, men who have sex with men, and people who use drugs (OECD, 2020 forthcoming^[31]).

Another area that needs particular attention in the context of transition is family planning and sexual and reproductive health commodities and medicines. Countries in the Asia Pacific region are especially affected, experiencing the highest levels of unmet need for family planning globally and growing adolescent birth rates. Pacific Island countries, in particular, are heavily reliant on UNFPA Supplies that procures and distributes an estimated 95% of all family planning commodities for PICs and close to 100% in PNG and Timor-Leste.

Development partners have become more engaged in transition preparation

The challenges of transition have recently received considerable attention and measures have followed to ease the transition burden. For example, the WHO's 2019 Global Health Expenditure Report (WHO, 2019^[13]) was centred around the issues of transition, adding to existing research on the health financing challenges involved in the transition from low-income towards middle-income status (Yamey, Ogbuoji and Nonvignon, 2019^[32]).

Some vertical funds have adopted eligibility and transition frameworks laying out criteria under which countries will lose eligibility for their support, as well as a gradual timeframe to phase out external financing. Often, these criteria are linked to the income level of a country as well as the disease burden.

As part of these transition policies and with the aim to promote country ownership, the governments of partner countries need to meet varying degrees of co-financing requirements for the implementation of programmes that depend on their status in the transition policies (Table 1.1).

Countries accessing support from the Global Fund, for example, are required to co-finance programmes. At least 15% of a country's allocation takes the form of a co-financing incentive, which is made available if countries make and eventually realise additional domestic investments to share the implementation costs of the programme. The amount of these additional co-financing investments are determined by a country's income classification and country context.

Table 3.1. The transition frameworks of GAVI and the Global Fund help countries prepare for eventual graduation

	Gavi	Global Fund
Eligibility criteria	GNI per capita over three-year period	GNI per capita over previous three-year period <ul style="list-style-type: none"> • Membership in OECD DAC / G20 • Disease burden for HIV, TB, and malaria; malaria elimination status • Small island nation status
Summary of eligibility policy	Countries below LIC threshold: eligible, in "initial self-financing," co-financing at USD 0.20 per dose	Eligibility determined by disease component (HIV, TB, Malaria) and the income category, which is

	<p>Countries above LIC threshold, below Gavi GNI per capita threshold (USD 1,580 as of 2018): eligible in "preparatory transition," cofinancing increases by 15% per year</p> <p>Countries with GNI per capita, averaged over previous three years, above USD 1,580 threshold: enter five-year "accelerated transition" period in which funding phases out. After end of five-year "accelerated transition" period, countries become fully self-financing</p>	<p>determined by the three-year rolling average of GNI per capita using World Bank thresholds.</p> <p>LIC: eligible for all components; to access co-financing incentive (at least 15% of allocation), must increase co-financing by at least 50% of incentive amount</p> <p>LMIC: eligible for all components; to access co-financing incentive (at least 15% of allocation), must increase co-financing by at least 100% of incentive amount</p> <p>UMICs: eligible for components where disease burden is "high"; to access cofinancing incentive (at least 15% of allocation), must increase co-financing by at least 100% of incentive amount • If a UMIC becomes ineligible based on disease burden, it may still receive an allocation for a single three-year "transition" period.</p> <p>HICs and members of the OECD Development Assistance Committee: ineligible</p> <p>Exceptions: Malaria-free countries are not eligible for malaria grants UMICs who are members of the G20 and were in eligible under previous policy remain ineligible except via NGO rule (below)</p> <p>Exceptions possible for "challenging operating environments" Countries that are not listed as ODA-eligible by the Development Assistance Committee cannot receive HIV funding unless there are "demonstrated barriers to providing funding for interventions for key populations, as supported by the country's epidemiology," in which case only NGOs can receive funding</p>
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Source: Silverman, R. (2018^[26]), Projected health financing transition, <https://www.cqdev.org/sites/default/files/projected-health-financing-transitions-timeline-and-magnitude.pdf>

There are also a number of additional measures taken by vertical funds to facilitate transition. Gavi's eligibility and transition policy, for example, include early assessments of country readiness and special grants to countries to ease transition. The policy allows to flexibly adjust the number of years in which countries have to transition out of Gavi support and includes mechanisms to secure affordable prices for vaccines for countries for several years after their graduation. The Global Fund has also commissioned a series of evaluations of national transitions in ten countries that ended their Global Fund support in 2014-15, in order to learn lessons that can be applied in the future.

However, countries that meet the same sets of criteria can vary in terms of their readiness to face graduation. One important factor to consider, for example, is the relative magnitude of external support vis-à-vis domestic government expenditure. There is wide variation in the composition of the financing mix among countries at a similar stage of transition. The impact of graduation from vertical funds, however, can be expected to be more serious in countries that have a higher reliance on external assistance. Even where health expenditures are financed predominantly by domestic resources, the effects of graduation on the population will be more detrimental in countries with a high share of out-of-pocket payments.

Following this reasoning, it is possible to identify countries that are more vulnerable to the effects of transition including graduation from vertical funds. In eight countries that are preparing transition

from GAVI, the share of external assistance exceeds 20% of the entire health financing mix. Among these countries, Zambia, which is in the GAVI preparatory transition stage, has the highest share of over 40%. The share of external assistance constitutes more than one third of the health financing mix of Sao Tome and Principe and Solomon Islands, which are both in the accelerated GAVI transition phase.

Table 3.2. Countries with high dependence on external assistance can be more vulnerable to transition setbacks

Share of external assistance in health financing mix for countries undergoing transition from vertical funds

Country	Share of external assistance	Income category	Transition group
Zambia	42.62	Lower middle income	GAVI prep
Sao Tome and Principe	38.95	Lower middle income	GAVI accelerated
Solomon Islands	35.19	Lower middle income	GAVI accelerated
Lesotho	28.1	Lower middle income	GAVI prep
Kenya	23.01	Lower middle income	GAVI prep
Kiribati	21.84	Lower middle income	GAVI prep
Djibouti	20.94	Lower middle income	GAVI prep
Papua New Guinea	20.14	Lower middle income	GAVI accelerated

Source: Authors' calculations based on methodological annex

There can be added vulnerabilities for countries where a small number of development partners provide the bulk of the external assistance. This notion of concentration has already been mentioned in the preceding section, which found that in-country concentration of health assistance has increased as development partners pick and choose countries where they have greater influence.

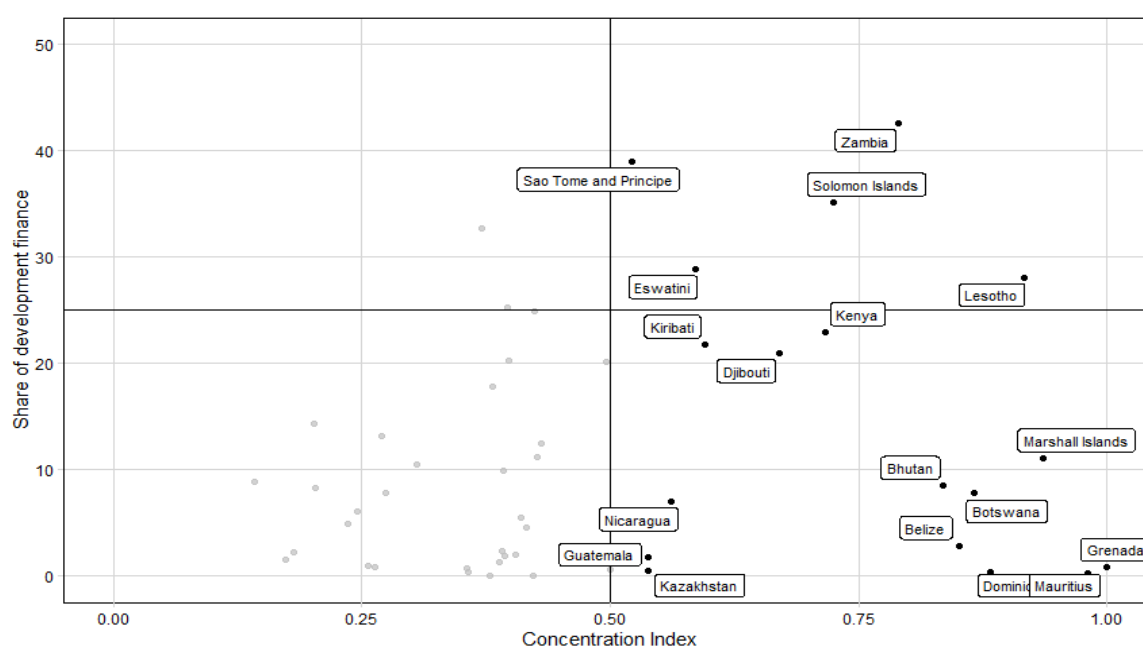
This trend can have a number of different effects on countries' ability to transition. On the one hand, it may be easier to co-ordinate the gradual withdrawal and eventual graduation from health assistance if there are only few development partners on the ground. On the other hand, the impact of the action of one single development partner can be more severe.

It seems that countries with a high share of external assistance in health financing tend to have a concentrated development partner base, calling for special attention in the design of the transition.

Most of the countries with a relatively share of development finance (Table 3.2) are found on the right hand side of Figure 3.7, which denotes countries that have a fairly concentrated development partner base. These countries include Zambia, Solomon Islands, Sao Tome and Principe, Lesotho, Kenya, Kiribati and Djibouti. They can be broken down into countries with a high incidence of specific diseases such as HIV/AIDS and TB as in the case of Zambia, Kenya and Lesotho and, and small countries that rely on relatively large contributions from bilateral partners with special historical, geographic, and other ties. Examples for the latter are the Solomon Islands, which receives significant health assistance from Japan and Australia or Sao Tome and Principe, where Portugal and Spain are the largest development partners.

This suggests that factors such as the degree of concentration of health assistance and its composition need to be carefully explored and addressed in managing the transition process.

Figure 3.7. Countries with high dependence on development finance also tend to have a concentrated partner base



Source: Authors' illustration based on OECD (2020_[21]), Creditor Reporting System (database), <https://stats.oecd.org/Index.aspx?DataSetCode=crs>.

Beyond the funding shortfall, transition can have long-term impacts on health system capacities.

Even where the exit of external health assistance has only a limited fiscal impact, development partners withdrawing from a country can leave a gap in technical capacities and procurement cost advantages. For example, Gavi provides a broad range of technical assistance including for immunisation planning, surveillance, communication, as well as effective vaccine management programmes. Once Gavi support ends, the gains made from such technical assistance can be reversed, unless local advocacy efforts are intensified and national technical skills are strengthened.

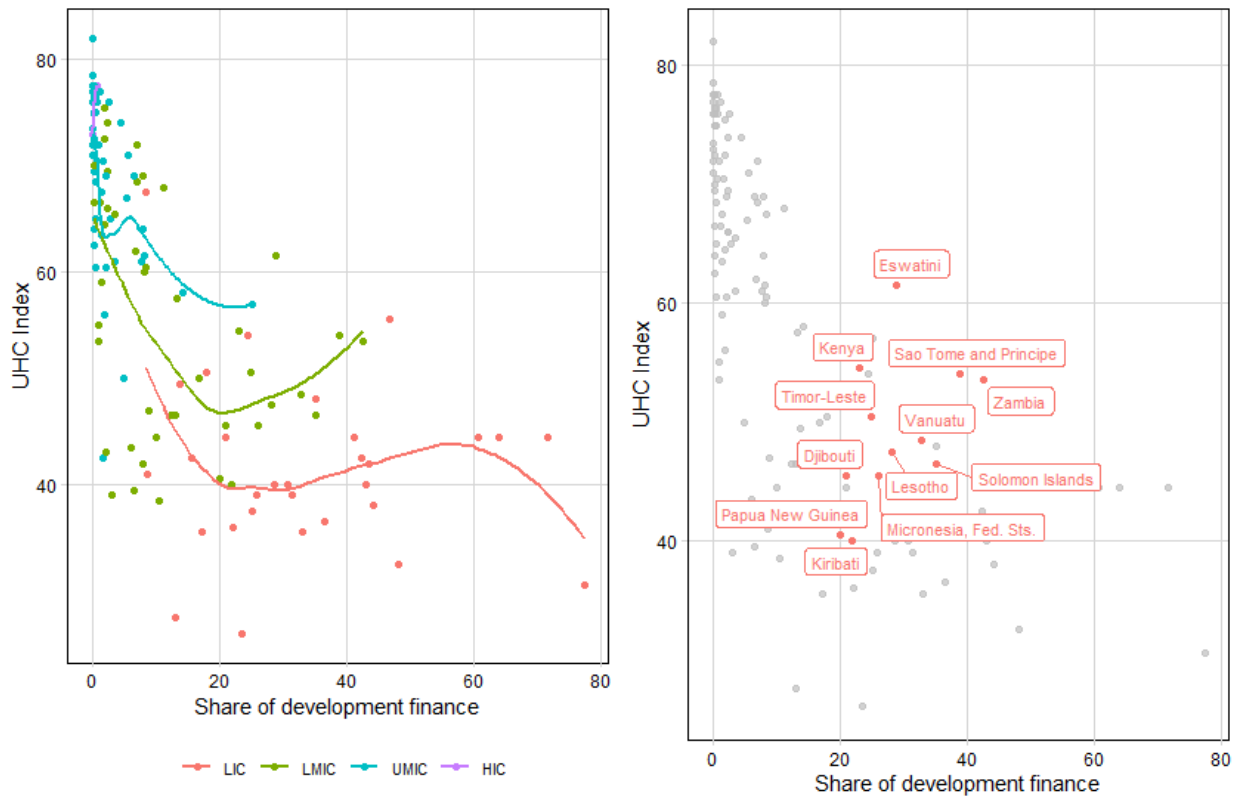
Despite relatively high levels of income, countries that have never been eligible for GAVI support, show weaknesses in priority setting of immunisation programmes, product selection, and procurement processes, which result in high vaccine prices and slow vaccine adoption. There is a risk that countries graduating from GAVI support will face similar problems (Silverman and Glassman, 2019_[33]).

Apart from tackling specific infectious diseases, development finance can play a role in advancing health systems. For lower middle-income countries, in particular, high reliance on development finance in the financing mix is associated with a higher coverage of general medical services, as measured by the Universal Health Coverage Index (Figure 3.8) This stands in contrast with low-income countries, where there is no clear relationship between the share of development finance in the health financing mix and health coverage, as well as with upper middle-income countries, where high reliance on development finance is rather correlated with lower UHC index values.

This is all the more important as countries in the lower middle income bracket, are typically the ones that are preparing for graduation from some of the vertical funds. There is considerable overlap between the countries highlighted in Figure 3.8 among those LMIC countries where health coverage seems to be positively correlated with the share of development finance in the health financing mix, and the group of countries which have been previously identified as facing potential transition risks due to a high reliance on external assistance as well as a concentrated development partner base.

A withdrawal of external health financing that does not take into account potential links between the role of development finance and health coverage, risks amplifying shocks to the domestic health systems.

Figure 3.8. For some LMICs high reliance on development finance is associated with better health coverage



Source: Authors' illustration based on OECD (2020^[21]), Creditor Reporting System (database), <https://stats.oecd.org/Index.aspx?DataSetCode=crs> and World Development Indicators (database), <https://datacatalog.worldbank.org/dataset/world-development-indicators>

3.3 Development partners can play a catalytic role in mobilising support for non-communicable diseases

Non-communicable diseases present a growing burden for countries in transition

While the problem of non-communicable diseases (NCDs) continues to increase in all regions of the world, it has an especially high toll on countries undergoing or preparing for the health financing transition. As remarked in Chapter 1, the global disease burden is shifting towards non-communicable diseases. However, this shift is especially burdensome for low and lower middle-income countries. In 2016, NCDs accounted for 73% of global deaths (40 million people), of which 75% (30 million) were in low-income and middle-income countries (Hatefi and Allen, 2018^[34]).

This is worrying because health systems in LICs and LMICs often lack adequate funding and were not designed to manage chronic conditions, as they were primarily aimed at fighting infectious diseases. Therefore, the financial burden of health care costs fall on individuals, families, communities (Allotey, Davey and Reidpath, 2014^[35]).

A failure to meet NCD-related financing needs with public resources can exacerbate socio-economic vulnerabilities. For countries in transition that rely to a large extent on OOP, NCDs can be a huge threat to households, as they require ongoing treatment with expensive medication. The chronic nature of NCDs and the high costs of diagnosis and treatment impose heavy financial burdens on impoverished households. Socioeconomic inequalities are exacerbated, families are pushed further into poverty and many simply go without care in settings where out-of-pocket payment is the major source of financing (Allen, 2017^[36]).

But financing for NCDs lags behind needs

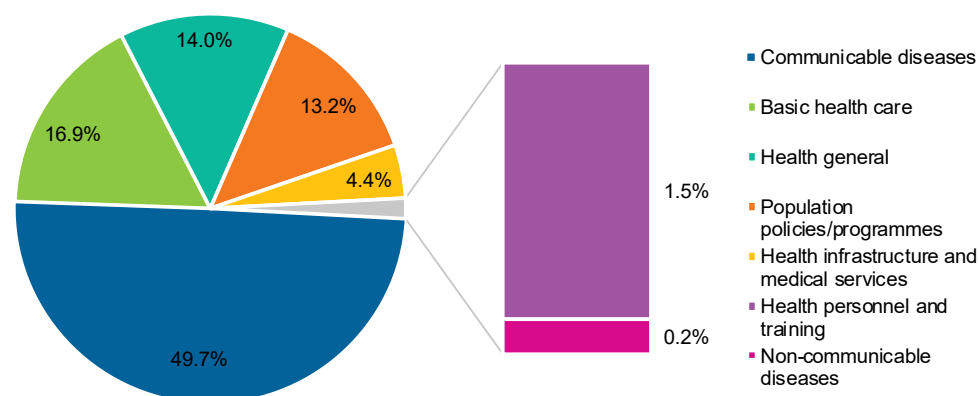
Due to these enormous human and economic costs, NCD response has started to receive more attention from the international health community. In 2011, the United Nations (UN) High-Level Meeting on NCDs addressed this financing gap by committing to 'explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms' (Allen, 2017^[36]). Moreover, the 2030 Agenda for Sustainable Development recognised NCDs as a major challenge for sustainable development. As part of the Agenda, Heads of State and Government made the commitment to develop ambitious national responses for the overall implementation, including SDG targets 3.4, 3.5, 3.8, 3.a and 3.b.

Despite these efforts, funding for NCDs is far from meeting the needs. According to the WHO, addressing NCDs in all low- and middle-income countries will cost an estimated USD 11.4 billion per year⁷ (an overall cost of USD 170 billion over the period 2011-2025). By comparison, total development assistance in health to all developing countries amounts to USD 26 billion per year.

NCDs attract only a limited amount of external resources. In 2018, support for NCDs presented a mere 0.21% (0.31%) of health-related development finance disbursements (commitments) (Figure 3.9).

Figure 3.9. Non-communicable diseases receive only little development assistance to health

Share in total disbursements from development finance from official and philanthropic providers, 2018



Note: Aggregation of CRS purpose codes according to methodological annex.

Source: Authors' illustration based on OECD (2020^[21]), Creditor Reporting System (database), <https://stats.oecd.org/Index.aspx?DataSetCode=crs>

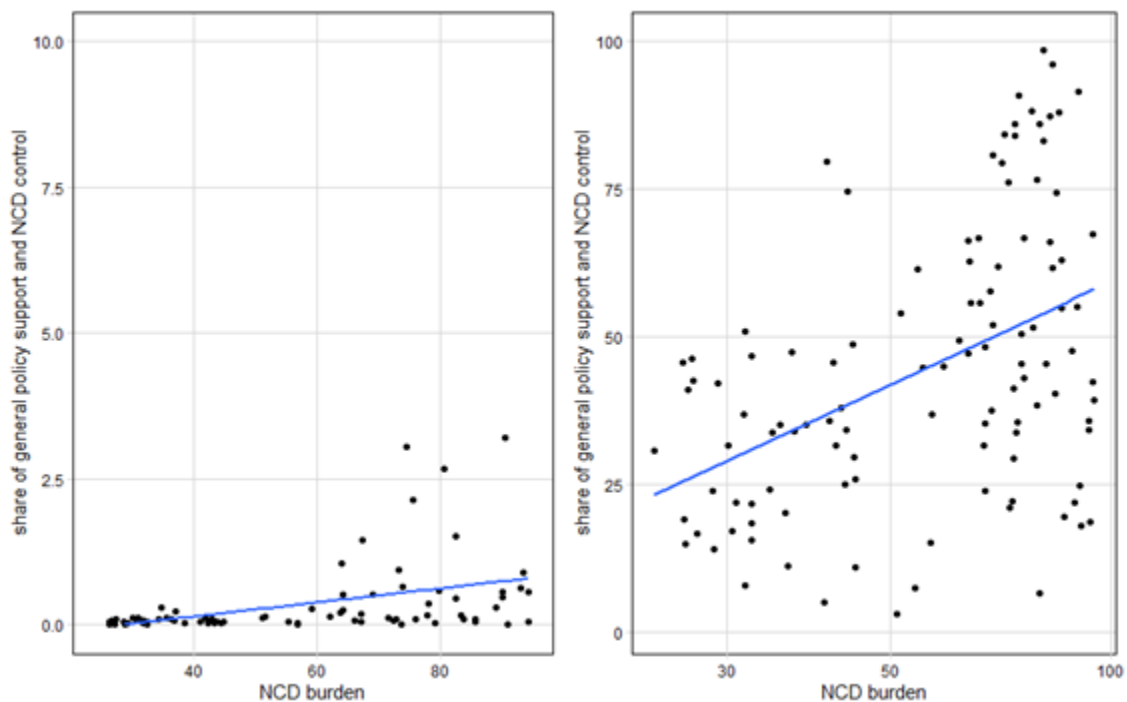
⁷ These measures do not include surgical and in-patient treatment costs.

It should be noted that these figures are prone to underestimate the amount of NCD funding. NCD support has only become a separate reporting item in the OECD Creditor Reporting System in 2016. A significant portion of funding that potentially addresses NCDs is likely categorised as ‘health sector support’ and ‘other’.

However, even accounting for such underestimation, NCDs are a largely neglected area in development finance for health. In 2018, the categories “general health” and “other basic health”, which include funding specifically or indirectly addressing NCDs, made up 14% and 16.9% of development assistance for health. In comparison, HIV/AIDS and STI control made up 26.5% of health-related development finance disbursements.

Development finance is responsive to the epidemiological transition in partner countries, but only to a limited extent. Figure 3.10 illustrates that support explicitly targeting NCDs increases with the NCD burden, or the relative share of deaths caused by NCDs in a country. However, even for countries where NCDs cause more than 80% of deaths, support for NCDs remain a fraction of health-related development finance. A growing NCD burden is also associated with a shift towards support for general health, basic health and overall health policies. This suggests that as the relative importance of NCDs increase in countries, development partners generally shift their attention towards more general and upstream areas of support, which can comprise direct and indirect measures to support the prevention and treatment of NCDs. But there is a wide variation among countries.

Figure 3.10. Development partners increase direct and indirect support for NCDs as countries undergo the epidemiological transition



Source: Authors' illustration based on OECD (2020^[21]), Creditor Reporting System (database), <https://stats.oecd.org/Index.aspx?DataSetCode=crs> and World Development Indicators (database), <https://datacatalog.worldbank.org/dataset/world-development-indicators>

Mobilising more domestic public resources is crucial for countries undergoing the health financing and epidemiological transition. As described earlier in this chapter, domestic resources constitute the

majority of overall health spending especially as countries move from the low to the middle-income level. In light of the lack of external assistance for NCDs, domestic funds are also the key funding source for the prevention and treatment of NCD.

This requires an increase in tax revenues that allow for sufficient public health spending. Some taxes (through their influence on consumer behaviour) have stronger links to the health sector than others. They can incentivise behaviour that contributes to the prevention of some NCDs. For example, taxing the consumption of alcohol, tobacco or high sugar-containing beverages can indirectly lead to healthier lifestyles that are less prone to cancers and diabetes. By raising tax revenues, these taxes can also play a role in increasing health financing.

The OECD study on mobilising tax revenues to finance the health system in Morocco, for example, suggested to increase the use of such taxes for health financing and to give more prominence to environmental taxation. In addition to the positive health impacts it has on the general population, it could be used as a way to diversify and broaden the tax base, which is currently too reliant on the VAT as well as personal and corporate income taxes (OECD, 2020 forthcoming^[31]).

In parallel, domestic health systems are at the centre of efforts to tackle the growing NCD burden.

Currently, the health systems in low-income and lower middle-income countries tend to focus on the prevention and control of infectious diseases such as HIV, tuberculosis, and neglected tropical diseases. Often characterised by fragmented health services, weak primary healthcare services and significant access barriers, domestic health systems are ill prepared to provide long-term care and risk management for people affected by NCDs (Atun et al., 2013^[37]).

Whereas most of NCD-related health services are provided by primary care in high-income countries, primary care facilities in poorer settings are not equipped to detect and treat NCDs. Surveys by the World Health Organisation find that only 6% of low-income countries compared with 85% of high income countries have the necessary equipment generally available to undertake six essential measurements: height, weight, blood glucose, blood pressure, total cholesterol, and urine albumin (WHO, 2017^[38]).

There is a need to strengthen domestic health systems, particularly by equipping primary healthcare facilities to detect and treat NCDs, thereby allowing for an integrated approach that includes prevention, diagnosis, treatment, and palliative care for all conditions and over time (Varghese, Onakpoya and Barkley, 2019^[39]). This should go hand in hand with cost-effective interventions aimed at the prevention of NCDs through population-level policy measures. The WHO, for example, has compiled a list of recommendable best-buy measures that address the four key risk factors for NCDs (tobacco, harmful use of alcohol, unhealthy diet and physical inactivity) and the four disease areas (cardiovascular diseases, diabetes, cancer and chronic respiratory diseases) (WHO, 2017^[40]).

Development partners can complement and support domestic efforts to fight NCDs

While development partners will not shift their focus from infectious to non-communicable diseases, they can design their interventions to have positive spill-over effects conducive to the fight against NCDs. For the fight against infectious diseases to continue unabated, existing efforts of development partners should be maintained. However, they can design their programmes and interventions in a way to have a positive spill-over effect that can support the fight against NCDs.

Support for system strengthening and capacity building for the health sector, in general, can be an effective way to indirectly address NCDs. Providing equipment and training for primary healthcare providers, for example, can increase the likelihood that an NCD is diagnosed and cured early, and measures to expand the access to primary healthcare can allow more people to benefit from these improvements.

Even in the case of vertical interventions that target specific infectious diseases, there is a possibility to create synergies with NCDs. This is especially relevant for HIV and tuberculosis which substantially benefit

from international financing. Increasingly, development partners seek to use existing HIV and TB infrastructure as an opportunity to address NCDs and their risk factors, and successful cases suggest that there are considerable benefits from integration (Hyle et al., 2014^[41]).

For example, HIV/AIDS services in several countries in Southeast Asia have been integrated with hypertension and diabetes programmes, while in sub-Saharan Africa they have been used as platforms to introduce NCD screening programmes such as for the detection of cervical cancer. Similarly, tuberculosis programmes have been used for the management of chronic respiratory diseases and other NCDs (Atun et al., 2013^[37]).

Where external assistance can be mobilised to address NCDs, it should target the poor and vulnerable segments of the population. Whereas the growing middle-class in low-income and lower middle-income countries has increasing access to healthcare coverage through corporate and private insurance, uninsured and hard-to-reach households, for example in poor and rural areas, are most likely to face gaps in financing the therapeutic care and treatment of NCDs (Dutta and Ly, 2018^[42]). Therefore, development partners engaging in NCD support can prioritise detecting these populations and understanding their specific prevention and specialised therapeutic, chronic care needs. This will ensure alignment with the development mandate of these actors, and allocate scarce development finance to address the greatest financing gaps.

Moreover, development partners can support medical and health policy research for example on the causes and mitigating factors for non-communicable diseases. Such research will help to identify affordable policy options to enhance prevention efforts. Bilateral development partners also have a key role to play in integrating low-income and middle-income country concerns into the health-research agenda of OECD countries, for example by supporting the search for cost-effective means of diagnosing and treating NCDs. Development partners can also foster exchange of information on lessons learned and best practices. The role of South-South and triangular co-operation with non-DAC partners including BRICS countries (Brazil, Russia, India, China, South Africa) and the Gulf States, can be especially important in providing experience of low-cost approaches to managing NCDs.

Furthermore, development partners can support research about interlinkages between health and various other sustainable development goals, for example between environmental goals and health. (see Box) Development partners already design programmes with the explicit intention to target multiple goals. But more research and evidence about interlinkages will inform their own development co-operation strategies and increase the effectiveness of their programmes by allowing to leverage synergies and manage trade-offs. A rich evidence base on interlinkages between health and other policy areas will also serve countries to develop and implement coherent policies.

Support for health can have close interlinkages with other SDGs

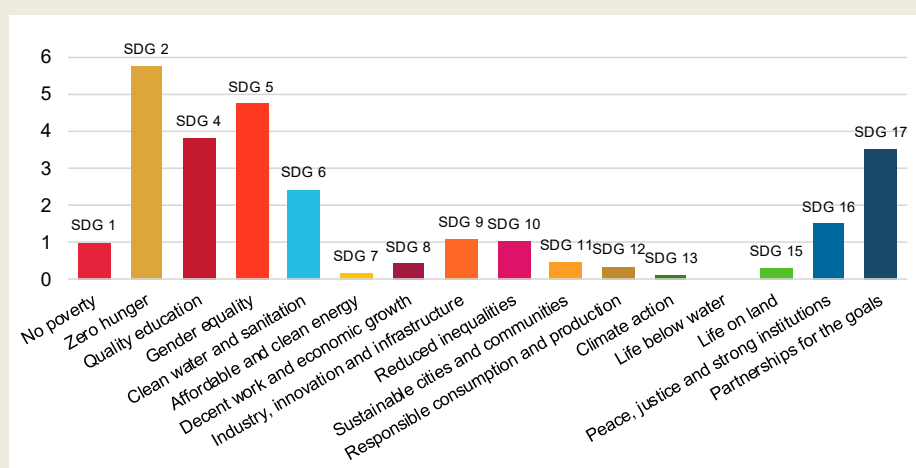
According to OECD estimates, around three in ten US Dollars of official development finance projects targeting SDG 3 also target other Goals. Using text-based descriptions of development projects, the OECD SDG Financing Lab maps official development financing to the SDGs: using machine learning, it can ascribe one or several SDGs to projects contained in the OECD Creditor Reporting System (CRS) (OECD, 2019^[43]). When it finds several SDG labels related to one project, it also allows to uncover interdependences between the 17 Goals. A total of USD 91.5 billion in official development finance targeted SDG 3 on good health and well-being between 2012 and 2017.⁸ Of this financing, about 29 % also targeted additional Goals.

Figure 3.11 represents the interlinkages between official development finance to SDG 3 and the other sixteen Goals. The largest interlinkages are observed with SDG 2 Zero Hunger (USD 5.7 billion or 6.2%), SDG 5 Gender Equality (USD 4.7 billion or 5.1%) and SDG 4 Quality Education (USD 3.8 billion or 4.2%). Other sizable links include SDG 17 Partnerships (USD 3.5 billion or 3.8%), SDG 6 Clean Water and Sanitation (USD 2.4 billion or 2.6%), and SDG 16 Peace and Justice (USD 1.5 billion or 1.6%).

More evidence on the interlinkages between health and other SDGs can inform strategic funding patterns that allow to target multiple goals at the same time, thereby leveraging DAC members' engagement in the health sector and maximizing potential synergies.

Figure 3.11. Health related SDG financing links strongest with SDGs on zero hunger, gender equality, quality education and partnerships for the goals

Estimated financial interlinkages of official development finance to SDG 3 with other SDGs between 2012-2017 USD billion, constant 2017



Note: Estimates include official development assistance (ODA) and other official flows (OFF). Total flows targeting SDG 3 between 2012 and 2017 are estimated at USD 91.493 billion. An estimated USD 64.9 targeted SDG 3 solely. Flows in disbursements for all DAC members to all recipients including unallocated flows.

Source: (OECD, 2019^[43]), OECD SDG Financing Lab, <https://sdg-financing-lab.oecd.org/>

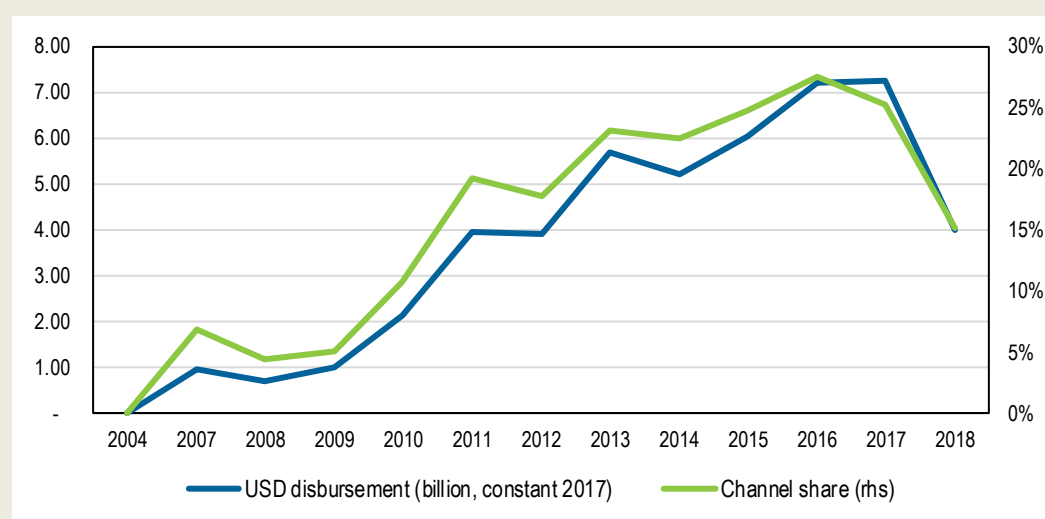
It is important that development partners give attention to building institutional capacities within government systems, at an early stage, to ensure the long-term programmatic sustainability of health programs as countries graduate. Externally-financed programs often face institutional challenges for integration that may put at risk not only continued progress of improving outcomes, but also sustaining hard-won achievements. It is also important for development partners to avoid taking an approach, often driven by the need to achieve rapid progress in weak institutional capacity settings, of establishing multiple, parallel systems for financial management, health information, supply chains, and incentives to staff and consultants. Combined, these various pathways of support pose significant programmatic sustainability challenges. There are also potential cost saving measures for countries in avoiding significant administrative costs of parallel systems.

Often, health-related development finance is not channelled through the domestic public sector

Rather, development finance is often disbursed directly by development partners for example through contracting non-governmental organisations or other providers. The share of health development finance channelled through domestic governments has peaked at around 25% in 2016, after which it declined rapidly to 15%.

Figure 3.12. Health development finance channelled through recipient governments

Recipient government as channel of development finance for health in USD (lhs) and as % of total (rhs)



Note: Bilateral allocable aid only. Figure includes bilateral DAC and non-DAC donors, multilateral donors, and philanthropic donors. Source: OECD (2020^[21]), Creditor Reporting System (database), <https://stats.oecd.org/Index.aspx?DataSetCode=crs>

This approach has proven effective by tightly focusing researches and clearly defined targets and priorities. Another reason behind the choice of non-governmental and development partner channels are weak levels of governance, low public sector capacities, as well as lack of transparency.

However, this approach has also been criticised of possibly bypassing and therefore undermining domestic public institutions, and, in the event of phase-out of development finance, the transition and smooth handover of programmes can be difficult.

Development partners can especially help strengthen capacities for efficient public financial management in the health sector. For example, strengthening budget execution practices to ensure the predictable and timely release of funds can reduce the level of unused revenues and increase spending efficiency in the health sector (Barroy and Gupta, 2020^[44]). For domestic institutions that are supposed to take over functions and programmes from development partners, a key skill will be analytical capacities and the ability to assess budgetary needs. This will ensure need-based allocation of resources within the sector. In the case of Morocco, an OECD recommendation was to update and strengthen analytical capacities of staff in the Ministry of Health to be better prepared for technical discussions with the Ministry of Finance and other counterparts. The rationale was that evidence-based discussions will increase

negotiating power during budget trade-offs, and facilitate access to funds granted in the form of budget support by donors (OECD, 2020 forthcoming^[31]).

World Bank Advance UHC multi-donor trust fund

In 2015, the World Bank and the Australian Government established the Advance UHC trust fund to support the equitable expansion of Universal Health Coverage (UHC) in 13 countries across Southeast Asia and the Pacific.

The Advance UHC trust fund has a focus on supporting countries manage their transition from externally-financed health programs to domestic health financing and service delivery systems. Since its inception, it has mobilised additional funding from Gavi, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the Bill and Melinda Gates Foundation to a total contribution of USD 117 million to date. It now supports more than 30 countries in Asia, Pacific, Africa, the Caribbean and Central-Asia regions.

Ensuring the long-term financial and programmatic sustainability of health programs that have been traditionally funded by development partners is critical, particularly at a time when the COVID-19 crisis is placing unprecedented stress on health systems and the economic impacts are threatening to reverse progress towards achieving UHC.

Advance UHC draws on the World Bank's distinct comparative advantage in working with Ministries of Health and Ministries of Finance to increase the overall share of public expenditure going to health, where relevant, as well as increasing the efficiency and effectiveness of health spending. It also supports governments to reduce their reliance on impoverishing out-of-pocket payments for health care, while addressing the rising burden of non-communicable diseases that is placing additional pressure on public finances.

Advance UHC is paving the way for innovative financing and effective donor co-ordination to support countries sustain adequate health financing and delivery of essential health services. The World Bank's analytical and advisory support includes the preparation of country health financing systems assessments (eg Lao PDR and Indonesia). This work has supported partner governments to strengthen their health systems, including integrating individual disease programs within public financing and management platforms. For example:

- In Kiribati, the World Bank, DFAT, UNICEF and Gavi are reviewing how the government's own resources can be used to develop a more sustainable immunisation program.
- In Laos, the US\$36 million Health and Nutrition Services Access Project 'HANSA' aims to increase access to quality health care and strengthen health systems. HANSA is co-financed by the World Bank, the Global Fund and the Australian Government, and demonstrates harmonised support across multiple agencies for the Government of Laos to reach its goal of achieving UHC by 2025.

Advance UHC provides an effective framework to ensure strong health and development outcomes in the context of the global UHC agenda and progress towards SDG3 by 2030. Building on experiences with infectious disease programs, the Advance UHC model offers the potential to strengthen financial transition plans for other areas of health sector support traditionally reliant on donors, such as family planning and sexual and reproductive health commodities and services.

Development partners can play a role in strengthening international co-operation for resource mobilisation. Development partners can use scarce resources in a way to catalyse other funding options

that could be effective in addressing NCDs. By supporting the development of government and private health insurance schemes, development co-operation can also support and facilitate the creation of an ecosystem that offers diverse financing solutions to cover the financial risks involved in the epidemiological transition. Increasingly, development partners explore and experiment with innovative financing solutions that seek to mobilise domestic resources for health financing. One notable example is the Global Financing Facility.

The Global Financing Facility aims to catalyse domestic resources for financing under-invested areas of health

Established in 2015, the Global Financing Facility (GFF) is a multi-stakeholder partnership bringing together governments and partners around a country-led plan, prioritizing high-impact but underinvested areas in health such as sexual and reproductive health and rights, new-born survival, adolescent health, nutrition – and in the health systems needed to deliver at scale and sustain impact.

The GFF Trust Fund acts as a catalyst for financing, with countries using modest GFF Trust Fund grants to significantly increase their domestic resources alongside the World Bank's IDA and IBRD financing, aligned external financing, and private sector resources. Each relatively small external investment is multiplied by countries' own commitments – generating a large return on investment, contributing to lives saved and improved.

Apart from assistance for the health sector, support for domestic resource mobilisation, in general, will be an important complement to development co-operation efforts to facilitate the health financing transition. The availability of tax revenues is critical especially in low-income countries and in contexts with weak health financing systems.

DAC members can help to create greater opportunities to strengthen partnerships and co-ordination with the domestic public sector. One possible way is to increase the portion of funding that is directly channelled through domestic governments. Another way is to increase government ownership in the transition process, for example by supporting the creation of bodies that oversee and co-ordinate the development co-operation efforts in the health sector.

In the case of Cote d'Ivoire, the Health Systems Strengthening Accelerator, an initiative funded by USAID and the Bill & Melinda Gates Foundation, provided technical and financial support for a National Dialogue on Health Financing, organised by the Ivorian Ministry of Health and Public Hygiene. The National Dialogue brought together government, partner, civil society, and private sector stakeholders and led to the launch of the National Health Financing Coordination Platform, where members discuss improved health financing strategies. As part of the process, development partners agreed to harmonise procedures, ensure the alignment of external funding with national priorities, and support the government of Côte d'Ivoire in preparing for the best possible transition. Similarly, the government notably pledged to increase the annual health budget, invest in infrastructure improvements, and implement the key structural reforms needed for greater efficiency in the health system such as decentralisation, performance-based financing, and the hospital reform (Health Systems Strengthening Accelerator, 2019^[45]).

Annex A. Methodology

Data source, donor coverage and considered type of aid

The source for data on official development finance and finance from philanthropic foundations is the OECD Creditor Reporting System (CRS). Unless specified, all donors are used: bilateral DAC and non-DAC donors, multilateral donors and private philanthropic foundations. Unless noted otherwise, disbursements (and not commitments) are used. Sums are expressed in USD constant 2017 terms unless specified otherwise.

The data shown only includes so-called “bilateral allocable aid”, i.e. funding for which the provider can control the sectoral allocation and deployment of the financing extended. For example, general budget support is excluded since by definition it supports the recipient government’s budget rather than a specific expenditure. In contrast, sectoral budget support is budget support earmarked for a specific purpose and is included. Bilateral allocable aid is obtained by only including the following type of aid from the CRS: A02, B01, B03, B04, C01, D01, D02 and E01.

Purpose code mapping

In Figure 3.6 several purpose codes are grouped into broader targeted areas. These are mapped according to CRS purpose code entry:

- Basic health care: 122, 12220, 12240, 12261
- Communicable diseases: 12250, 12262, 13040, 12263
- Health general: 120, 121, 12110, 12191
- Health infrastructure and medical services: 12182, 12230
- Health personnel and training: 12181, 12281, 13081
- Non-communicable diseases: 123, 12310, 12320, 12330, 12340, 12350, 12382
- Population policies and programmes: 130, 13010, 13020, 13030

Details to Figure 2.3 on the health financing transition mix

Data sources

The data for Figure 2.3 is derived through the World Bank World Development Indicators (WDI) and the OECD Creditor Reporter System (CRS). The data on health expenditure – while downloaded from WDI – is based on the WHO Global Health Expenditure Database.

More specific, the following variables for 2014–2018 are used to calculate the final variables:

Table A.1. Data sources of health financing transition mix

Variable	Indicator	Downloaded from
GNI per capita (current USD, Atlas method)	NY.GNP.PCAP.CD	WB WDI
GDP deflator (series of USA in particular)	NY.GDP.DEFL.ZS.AD	WB WDI
Population	SP.POP.TOTL	WB WDI
Government health expenditure (current USD, per capita)	SH.XPD.GHED.PC.CD	WB WDI
External health expenditure (current USD, per capita)	SH.XPD.EHEX.PC.CD	WB WDI
Out-of-pocket health expenditure (current USD, per capita)	SH.XPD.OOPC.PC.CD	WB WDI
Domestic private health expenditure (current USD, per capita)	SH.XPD.PVTD.PC.CD	WB WDI
Total current health expenditure (current USD, per capita)	SH.XPD.CHEX.PC.CD	WB WDI
Development assistance to health (Disbursements, current USD)	ODA and OOF from DAC and non-DAC donors + financing from philanthropic donors; disbursements to purpose codes 12XXX and 13XXX.	OECD CRS

Note: Health expenditure variables downloaded from WB WDI are based on WHO Global Health Expenditure Database.

Source: Authors' overview

Deflation

When nominal values are used in the calculation, all values are deflated to USD constant 2017. The US GDP deflator series is used for all countries and flows, i.e. one common global deflator is applied. For a flow in current USD in year t and country i , the following is applied:

$$USD_{t,i,constant\ 2017} = USD_{t,i,current} \frac{US\ GDP\ deflator_{2017}}{US\ GDP\ deflator_t}$$

The deflator is applied to the GNI per capita and health expenditure per capita data (both in current USD) but also to the CRS values for disbursements expressed in current USD. Note that this differs from the CRS values expressed in constant USD as contained in the source data due to differences in the applied deflator. Still, applying a common deflator to all financing flows – especially since they are taking into relation of each other – is deemed more consistent.

Data manipulation

The health expenditure data on a per capita basis are transformed into total expenditure by multiplying with population size.

A few specific adjustments to the data are made:

- Development finance for health in the form of sectoral budget support is subtracted from government health expenditure. Development finance for health sectoral budget support is identified through the aid type “A02”. This is done to correct for double counting otherwise.
- The variable on “Other domestic private expenditure” is the difference in SH.XPD.PVTD.PC.CD and SH.XPD.OOPC.PC.CD.
- The variable “External other” is the difference in total external health expenditure (SH.XPD.OOPC.PC.CD * SP.POP.TOTL) and development assistance to health (DAH) disbursements. In few cases, development finance for health exceeds external expenditure and for such cases “External other” is set to 0. The rationale is that based on CRS data more external health expenditure could be identified.

The total health expenditure which forms the denominator for individual shares is defined by the sum of: Government expenditure to health, out of pocket expenditure, other domestic private expenditure, development assistance to health and other external expenditure. Shares are calculated by dividing the specific expenditure type in year t by the total expenditure in year t , for each country respectively.

The final data represents the unweighted mean per country and expenditure share (and GNI per capita) over 2014-2018 including. When an expenditure type is not available (e.g. no development finance for health) it is regarded as "0" in order to be reflected when calculating the trendlines. Taking averages is the final step, i.e. all previous calculations were made for year-specific country data.

Statistical properties of trendlines

All trendlines are based on simple logarithmic regressions described by:

$$\text{Predicted value} = \text{Health expenditure type} \sim \log(\text{GNI per capita})$$

The properties of these one-variate regressions are as follows:

- Government expenditure: Adj. R2 = 0.5578, beta coefficient = 11.8389***
- Development assistance to health: Adj. R2 = 0.4969, beta coefficient = -7.3330***
- Other external expenditure: Adj. R2 = 0.02368, beta coefficient = -0.6486*
- Out-of-pocket expenditure: Adj. R2 = 0.1337, beta coefficient = -5.1054***
- Other domestic private expenditure: Adj. R2 = 0.04771, beta coefficient = 1.2639**

Where *** statistically significant to 0.001 level, ** 0.01 level and * to 0.05 level.

Countries transitioning from Gavi and Global Fund

Countries (ISO codes) as shown in Figure 3.7 by transition group:

- Gavi preparatory: BGD, CIV, CMR, DJI, GHA, KEN, KHM, KIR, LSO, MMR, MRT, PAK, SDN, ZMB
- Gavi accelerated: IND, LAO, NGA, NIC, PNG, SLB, STP, UZB, VNM
- Global Fund transition 2017-19: ALB, BLZ, BWA, DOM, DZA, LKA, PAN, PRY
- Global Fund transition 2020-22: ARM, GTM, GUY

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