Potential Avenues to Increase Government Investment in Health in Afghanistan

Fiscal Space Analysis

June 2017
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ACRONYMS

AFMIS Afghanistan Financial Management Information System
AFN Afghan Afghani (national currency unit)
AMS Afghanistan Mortality Survey
ANDS Afghanistan National Development Strategy
BHC Basic Health Center
BIA Benefit Incidence Analysis
BPHS Basic Package of Health Services
CHC Comprehensive Health Center
CHW Community Health Worker
CMS Central Medical Store
CPI Consumer Price Index
DHS Afghanistan Demographic and Health Survey
EMIS Expenditure Management Information System
EPHS Essential Package of Hospital Services
GDP Gross Domestic Product
GHE Government Health Expenditure
HMIS Health Management Information System
HRMIS Human Resources Management Information System
IMF International Monetary Fund
MDG Millennium Development Goal
MoF Ministry of Finance
MoJ Ministry of Justice
MoPH Ministry of Public Health
NCD Noncommunicable Disease
NGO Nongovernmental Organization
NHA National Health Accounts
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>OOP</td>
<td>Out-of-pocket (expenditure on health)</td>
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<td>PBF</td>
<td>Performance-based Financing</td>
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<td>PETS</td>
<td>Public Expenditure Tracking Survey</td>
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<td>PPP</td>
<td>Public-private Partnership</td>
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<td>SDG</td>
<td>Sustainable Development Goal</td>
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<tr>
<td>SEHAT</td>
<td>System Enhancement for Health Action in Transition</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UHC</td>
<td>Universal Health Coverage</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>USD</td>
<td>U.S. Dollar</td>
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<td>VAT</td>
<td>Value-added Tax</td>
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<td>WEO</td>
<td>World Economic Outlook</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>YLL</td>
<td>Years of Life Lost</td>
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Acknowledgements

This report on fiscal space analysis, produced for the first time in Afghanistan, assesses the potential avenues to increase investment in the health sector in Afghanistan. The development of the fiscal space analysis report was made possible through the intensive efforts from individuals and institutions.

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Minister of Public Health, Afghanistan
EXECUTIVE SUMMARY

Introduction

Afghanistan has made considerable progress in expanding access to health services and improving the health outcomes of its population. Despite these achievements, much remains to be done. Its maternal mortality rate is among the highest in the region, and life expectancy is low. Afghanistan is facing a double burden of disease; communicable diseases continue to account for a large share of the overall burden of disease while noncommunicable diseases (NCDs) are increasing rapidly. The population is growing quickly, which will put additional pressure on the financing and provision of health services.

The Afghanistan health system is severely underfunded, as reflected in shortages of health workers, drugs, and supplies. In 2014, total spending on health was U.S. dollars (USD) 70 per capita. Direct out-of-pocket (OOP) spending by households accounted for 72% of total spending on health, whereas donors contributed 23%, and the government financed 5%. Although donor financing appears stable in the short term, reductions are expected in the medium and long term. This expectation means that it is essential to increase government investment in health. Currently less than 5% of the total government budget is allocated to the health sector.

The Ministry of Public Health (MoPH) is exploring options for expanding the fiscal space for health. Additional domestic investment in health would allow the health system to build on its successes and address current policy and programming priorities. The analysis presented in this report is intended to inform a policy dialogue, strategic advocacy, and planning by identifying and assessing options for increasing investment in health through the expansion of fiscal space for health.

The specific objectives of this analysis are to (1) analyze the status of fiscal space for health; (2) estimate potential increases (or decreases) in fiscal space through quantitative projections under different scenarios; (3) make recommendations on how to prioritize and leverage potential opportunities; and (4) support efforts to advocate for increased allocation of government resources to the health sector.

Conceptual framework and data sources

Following a conceptual and analytical framework developed by the World Bank, this report structures the assessment of the potential to increase fiscal space for health under five “pillars” outlined below:

- **Macro economy**: How will macroeconomic conditions affect resource levels for health?
- **Re-prioritization of the health sector**: How much fiscal space could be generated by increasing the health sector’s share of the government budget?
- **Health sector-specific resources**: Can additional taxes and other revenue sources be implemented and earmarked for health?
- **Foreign aid**: How will future foreign aid flows affect the resource envelope for health?
- **Efficiency gains**: Can fiscal space for health be increased through more efficient use of current and future financial resources?
The analysis projected potential increases of fiscal space for health for 2017–2021 under three different scenarios, ranging from conservative to ambitious: low, medium, and high. It assigned an overall score of the potential for increases in fiscal space for health of 0–10 to each pillar. Two dimensions determined the score: the projections of potential increases in government health spending and the feasibility of realizing the potential increases as influenced by political economy factors and implementation capacity from 2017–2021. The analysis then translated the scores into three categories: limited (0–3), moderate (4–6), and significant (7–10). The scores are indicative, rather than definitive, and are meant to identify areas in which there may be potential for increases in the fiscal space.

The fiscal space analysis was informed by a desk review, quantitative analysis, and discussions with MoPH officials to validate assumptions, data sources, and emerging findings. It mainly relied on the following data sources: The Revenue Generation Strategic Framework; other government reports; international databases, including the World Economic Outlook (WEO); and unpublished data from the MoPH.

Key findings

Macro economy: overall score of 4 (moderate potential)

There is moderate potential to increase fiscal space through the macro economy, as economic growth and improvement in revenue collection capacity are expected to be modest in 2017–2021. Economic growth could generate USD 11.5 million of additional resources per year for the period 2017–2021. This growth would represent an increase of about 6% per year in that time. Improved revenue collection could translate into an additional USD 22.1 million per year, equal to an increase of about 10% per year. Prices on health goods and services are increasing more quickly than general inflation, justifying the need for increased government health spending because the health sector thus receives less for its money compared to other sectors.

Re-prioritization of the health sector: overall score of 7 (significant potential)

There is significant potential to increase fiscal space through re-prioritization of the health sector, as reflected in the government’s policy of increasing the allocation to health in its budget. Increasing government spending on health as a share of total government spending from the current level of 4.3% (2014) to 6.5% by 2021 could generate an additional USD 22.1 million per year over the period 2017–2021. This change would represent an increase of about 10% per year. An evidence-based effective advocacy plan tailored to key government actors is crucial in this regard. Further close collaboration with other sectors is also important to advocate for increased spending on the social sectors.

Health sector-specific resources: overall score of 5 (moderate potential)

There is moderate potential to increase fiscal space through health sector-specific resources. As estimated in the MoPH Revenue Generation Strategic Framework, implementing earmarked taxes for health could potentially generate an additional USD 84 million (tobacco tax USD 25 million; vehicle tax USD 27 million; and fuel tax USD 32 million) per year in 2017–2021. Similarly, the introduction of user fees and health insurance could potentially generate USD 62 million and USD 50 million per year, respectively. In the short term, the focus should be on an earmarked tobacco tax and the implementation of user fees, which are likely to be more feasible and fall more under the influence of the health sector. The development of a legal framework and implementation arrangements for user fees is underway, whereas the introduction of health insurance is likely to take more time.
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**Foreign aid: overall score of 3 (limited potential)**

There is limited potential to increase fiscal space for health through increases in foreign aid. Based on currently available data, donor financing appears to be stable in the short term; also, ongoing negotiations on donor financing are underway, which may inject additional funds. However, in the medium to long term, donor financing is expected to decrease, thus reducing fiscal space for health. This report recommends monitoring developments in this area and considering development of a fundraising strategy.

**Efficiency gains: overall score of 5 (moderate potential)**

There is moderate potential for increased fiscal space for health through improvements in efficiency. Increasing the execution rate of the total government budget to 86% could generate an additional USD 7.2 million per year over the period 2017–2021, representing an increase of about 3% per year. Potential areas for fiscal space gains include hospital autonomy, procurement, task shifting, and investment in preventive care. This approach requires further study, and international experience can help to inform strategies to increase fiscal space by addressing health systems inefficiencies.

**Figure ES.1. Summary of potential for fiscal space increases**
Recommendations

Actions designed to capitalize on these opportunities should be prioritized and sequenced accordingly. The focus should be on areas in which the health sector is well positioned to influence policy and resource allocation decisions, such as improving health systems efficiency and tapping new health sector-specific sources of revenue. This report makes the following specific recommendations:

- Prioritize earmarking of the tobacco tax by continuing evidence-based policy dialogue with the Ministry of Finance (MoF) and the Ministry of Justice (MoJ)
- Prioritize the implementation of user fees by developing operational guidelines, strengthening the financial systems of secondary and tertiary hospitals, and designing an exemption mechanism to ensure access by the poor to needed hospital services
- Improve absorption of the allocated budget through systematic monitoring of expenditure and support to low-performing programs and projects
- Expand efforts to increase hospital autonomy, supported by capacity building and strengthening of financial systems, to extract more from existing resources
- Establish an inter-ministry task force, supported by a technical team, to oversee the implementation of evidence-based advocacy activities strategically tailored to key decisionmakers
- Develop an investment case for health by packaging global evidence on the economic returns of investing in health
- Prepare a high-level briefing paper articulating the country's vision toward universal health coverage (UHC) for both improved access and financial protection
- Strengthen the decision-making and evaluation process to ensure that additional resources are deployed in the areas where they are most needed and can be spent most feasibly
1. INTRODUCTION

Afghanistan has made considerable progress in improving the health outcomes of its population. It achieved Millennium Development Goal (MDG) 4 (reduce child mortality): the under-five mortality rate was reduced from 257 deaths per 1,000 live births in 2002 to 55 in 2015 (target: 93) (UN, 2015). It almost achieved MDG 5 (improve maternal health): the maternal mortality ratio was reduced from 1,600 deaths per 100,000 live births in 2002 to 327 in 2015 (target: 315) (Bartlett et al., 2014; WHO et al., 2015; CSO et al., 2016). The health system in Afghanistan, operating in a difficult security environment, is likely to face increasing pressure due to population growth and a changing burden of disease. In addition, with the new Sustainable Development Goals (SDGs), there will be an increased focus on achieving universal health coverage (UHC), whereby all population groups have access to quality health services without the risk of financial hardship, thus requiring additional resources (UN, 2016a).

The Afghanistan health system is underfunded and largely relies on household out-of-pocket (OOP) spending (72%) and donor financing (23%), with only 5% coming from government revenues (MoPH, 2016a). The 2016 government budget for health was USD 317 million, equal to only 4.8% of the total budget of USD 6.6 billion (MoF, 2016b). Health facilities, particularly national and regional hospitals, are facing severe resource constraints to service delivery, such as shortages of drugs and supplies (MoPH, 2015a).

Health systems financing in Afghanistan is affected by the macroeconomic environment. In 2014, the gross domestic product (GDP) per capita was USD 763 (CSO, 2016). The economy is growing, but at a slow rate. After a period of strong growth in 2002–2013, GDP growth dropped to about 1% in 2014 (IMF, 2016a). Projections suggest that the economy will slowly get stronger, reaching about 4% annual growth by 2020 (IMF, 2016c). More than one-third (39%) of the population is poor (World Bank, 2016a).

Given the increasing pressures on the health system, and that donor financing may be decreased in the long term, the Ministry of Public Health (MoPH) is exploring options to generate additional domestic resources for health, which would allow the health system to build on its successes and address current financial constraints and policy priorities. The analysis presented in this report is intended to inform dialogue on options for increasing investment in health through the expansion of fiscal space for health.
2. PURPOSE AND OBJECTIVES

The purpose of the analysis is to assess possible options to increase fiscal space for health to support the Government of Afghanistan in building a sustainable health financing system. The specific objectives are as follows:

- Analyze the status of fiscal space for health in Afghanistan
- Estimate potential increases (or decreases) in fiscal space through quantitative projections under different scenarios
- Make recommendations on how to prioritize and leverage potential opportunities, considering feasibility and political economy factors
- Support efforts to advocate for increased allocation of government resources to the health sector

This report also contributes to identifying MoPH priorities in advocating for more resources for health, supporting MoPH medium-term planning by assessing the potential for increased resources, and identifying the need for further analytical work.
3. CONCEPTUAL FRAMEWORK, DATA SOURCES, AND LIMITATIONS

3.1 Conceptual framework

Fiscal space has been defined as the “capacity of government to provide additional budgetary resources for a desired purpose without any prejudice to the sustainability of its financial position” (Heller, 2006). An assessment of fiscal space generally includes an analysis of whether and how a government could increase its spending in health in the short to medium term while maintaining consistency with a country’s macroeconomic context. Fiscal space has been the subject of several cross-country analyses in recent years (Tandon and Cashin, 2010; Durairaj and Evans, 2010; PAHO, 2015).

Following an analytical framework developed by the World Bank, this report structures the assessment of the potential to increase fiscal space under five pillars, outlined below (Tandon and Cashin, 2010).

- **Macro economy:** How will macroeconomic conditions affect resource levels for health?
- **Re-prioritization of the health sector:** How much fiscal space could be generated by increasing the health sector’s share of the government budget?
- **Health sector-specific resources:** Can additional taxes and other revenue sources be implemented and earmarked for health?
- **Foreign aid:** How will future foreign aid flows affect the resource envelope for health?
- **Efficiency gains:** Can fiscal space for health be increased through more efficient use of current and future financial resources?

To increase the granularity of the analysis, the report also includes analysis of sub-pillars. For example, the macro economy pillar included four sub-pillars: economic growth, revenue collection capacity, debt and fiscal balance, and inflation.

The pillars are not mutually exclusive, and fiscal space can be found in just one pillar or in a combination of them. Changes in one of the pillars are likely to affect others. For example, if the budget execution rate in the health sector is increased, and if earmarked taxes for health and user fees are introduced, the aggregate increase in the allocation to health may not be as large as when they are projected separately.

The quantitative analysis conducted projections of potential increases in fiscal space for health under three different scenarios by varying certain parameters under the five pillars. For example, how many additional resources could be generated if the government meets its budget execution targets? What would be the potential revenues from earmarking different taxes for health? If government spending on health as a share of total government spending reached international recommendations, what would be the impact on fiscal space for health? If foreign aid decreased in the medium to long term, how would that trend affect fiscal space? Given the dynamic nature of the macroeconomic, political, and health sector environments, the analysis limited the projections to five years (2017–2021). The three scenarios ranged from conservative to ambitious:
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- Low-increase scenario: This analysis applied conservative assumptions to its parameters (e.g., the rate of economic growth in the macro economy pillar or the projected share of government spending for health in the “increased allocation to health” pillar).
- Medium-increase scenario: The assumptions were potentially the most realistic, and the results presented here mainly represent the medium scenario.
- High-increase scenario: This analysis applied more ambitious assumptions.

The analysis estimated the total additional government health expenditure (GHE) in 2017–2021 by deducting the projected expenditure in the baseline year 2016 from the projected expenditure in 2021. It then divided the total by the number of years to arrive at an estimated annual increase in fiscal space in USD terms and percentage increase.

The analysis assigned a score of 1–10 to each sub-pillar of the five pillars to reflect the potential to increase fiscal space for health. It then aggregated the scores assigned to each sub-pillar and assigned an overall score of 0–10 to each pillar.

The analysis considered two dimensions to determine the score:

- Results of financial projections: This part of the scoring was informed by quantitative projections of potential increases in fiscal space for health in financial terms (average annual USD million increase in 2017–2021), using the three scenarios described above.
- Feasibility: This part of the scoring considered factors that would influence the degree to which the potential fiscal space increases will be realized. These factors include political economy, receptiveness of key government stakeholders to arguments for increased prioritization of health, capacity to implement suggested earmarked taxes for health, and so on.

The scores are indicative, rather than definitive, and are meant to identify areas where there may be potential for increases in fiscal space. Broadly speaking, the scores may be interpreted as follows:

- 0–3: limited potential
- 4–6: moderate potential
- 7–10: significant potential

3.2 Data sources

The fiscal space analysis was informed by a desk review, quantitative analysis, and interviews with MoPH officials to validate assumptions, data sources, and emerging findings. The analysis mainly relied on the following data sources: the Revenue Generation Strategic Framework; government reports; published journal articles; grey literature; international databases with information on macroeconomic indicators, development outcomes, and expenditure on health; and qualitative information from MoPH officials and development partners (see the References for further details).

Projections of the potential increased fiscal space for health were informed by data from the MoPH on government budget, revenue, and expenditure; and the International Monetary Fund (IMF) World Economic Outlook (WEO) from April 2016 on GDP and inflation.
3.3 Limitations

This report has some limitations. First, some analyses, such as the potential for efficiency gains in the health sector, were constrained due to data limitations. The report therefore provides suggestions for additional analyses that could further inform the fiscal space policy dialogue. Second, given the magnitude of some of the parameters of the fiscal space projections, the results are sensitive to the assumptions applied. Third, because the fiscal space pillars are not mutually exclusive, there is a degree of overlap in the analysis. Finally, the assignment of a score of 0–10 is a basic measure but is indicative only and meant to suggest the relative potential to increase fiscal space in each of the five pillars.
4. Health outcomes and health systems context

To provide background for the fiscal space analysis, the analysis looked at the current situation of health outcomes and the health system. A summary of this analysis is provided below. Annex A provides further details and references underpinning the health systems context.

**Health outcomes and future health needs**

Afghanistan has made considerable progress in reducing child mortality and improving maternal health. The under-five mortality rate was reduced from 257 deaths per 1,000 live births in 2002 to 55 in 2015, surpassing the MDG target of 93 (UN, 2015). Less progress has been made on communicable diseases. The number of reported HIV cases increased between 2008 and 2012, and the prevalence rate of tuberculosis (TB) was well above the MDG target of 224 (National AIDS Control Program, 2014; WHO, 2015a). Afghanistan is facing a double burden of disease—communicable diseases continue to account for a large share of the burden of disease, whereas noncommunicable diseases (NCDs) are increasing rapidly (IHME, 2013). Also, the population is growing quickly, with a population pyramid dominated by youth (UN DESA, 2015). This growth will increase the pressure on the government to finance and provide social services.

**Health service delivery**

Afghanistan’s health system has progressed over the last 13 years, with increasing coverage of primary healthcare services (MoPH, 2016b). The MoPH operates health facilities in three provinces; the provision of health services in the remaining 31 provinces has been contracted out to nongovernmental organizations (NGOs) through implementation of the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS) (Blaakman and Lwin, 2013). Evidence suggests that the implementation of the BPHS contributes to increased access to primary healthcare services in rural areas (Newbrander et al., 2014). The private sector also plays a significant role in the delivery of health services. The for-profit sector provides a considerable share of services, particularly in urban areas and for outpatient care (Saeed et al., 2014).

There are still challenges regarding access and utilization of health services. About 60% of the population lives more than one hour away from a health facility that provides the BPHS (MoPH, 2014a). Also considerable inequalities exist in the utilization of health services. For example, only 24% of the births by women in the poorest quintile were attended by a skilled provider, compared to 85% of their peers in the richest quintile (CSO et al., 2016). Quality of care also remains a major concern. Evidence suggests that the quality of health services is often poor. Of all Basic Health Centers (BHCs), 17% were not able to provide even half of the required services recommended for maternal, newborn, and child health (WHO, 2015b). Similarly, approximately 19% of health facilities do not have the needed medical equipment available, and more than one-third of facility buildings do not meet quality requirements (WHO, 2015b). The MoPH is currently finalizing an assessment of health system quality.

**Health workforce**

There is both a shortage and uneven distribution of qualified health workers. Afghanistan had 7.3 physicians, nurses, and midwives per 10,000 people in 2010—considerably below the World Health Organization (WHO) recommendation of 23 (WHO, 2011; MoPH, 2011a). Only 28% of the health workforce is female, a concern in the context of a high maternal mortality rate and a country where women tend to be more comfortable with female staff. The workforce is also
distributed unequally between rural and urban areas. In 2010, there were more than twice the number of public health workers per 10,000 people in urban (36) versus rural (17) areas. There are also significant regional differences (MoPH, 2011a).

**Health information system**

The Health Management Information System (HMIS) unit at the MoPH manages the consolidation and reporting of data collected from the health system (AEHIN, 2016). An ongoing challenge is ensuring that data collected from facilities are complete, timely, and accurate, and used to inform program planning and implementation.

**Medicines**

A 2009 study found a significant variation in stockouts for primary health facilities (an average stockout of seven days per month) and hospitals (an average of nine days) (Green et al., 2009). As a result, patients are often forced to turn to the private sector for their drug needs. Purchases of pharmaceuticals and medical goods represent 57% of total household health expenditure (MoPH, 2016a). The evidence on drug prescription practices is mixed. A study by the United States Agency for International Development (USAID) found that generic drugs accounted for very high proportions of prescribed drugs in primary healthcare facilities and hospitals, and these facilities followed the national essential drugs list almost exclusively (Green et al., 2009). The study also identified overuse of antibiotics: 58% of patients received antibiotics in primary healthcare facilities (90% in hospitals). A WHO study of 35 countries found that an average of 45% (range 22%–77%) of patient visits included a drug prescription (WHO, 2004). The evidence on the quality of medicines is also mixed. A 2011 study of public and licensed private facilities found that 89% of drugs at public facilities and 92% at private facilities were compliant with international standards (Karwar et al., 2011). However, the fact that many individuals purchase drugs from unlicensed vendors is a significant problem because there is no quality control of drugs from those outlets (MoPH and WHO, 2011).

**Governance**

The governance structure is designed to promote a more inclusive system determined by local needs; however, capacity varies, leading to mixed results. Financial autonomy has been piloted in some facilities (USAID, 2015a), and stewardship of the health system is improving as capacity increases at the central level. The central government is focusing on increasing transparency and accountability, especially regarding management of financial resources, supported by tools like the Afghanistan Financial Management Information System (AFMIS) or the Expenditure Management Information System (EMIS).

The country’s unstable political situation affects the capacity to implement policy reforms and deliver social services. Despite progress, there are still considerable constraints to development due to political instability, which increases the difficulty of policy making, slows economic recovery and poverty reduction, and has contributed to increased emigration in recent years. The security situation also continues to be unstable, affecting the functioning of the state and the provision of social services. Frequent attacks and bombings occur, targeted at the general population, troops, politicians, and public service providers. A recent United Nations (UN) report estimated that 90,000 children have missed their immunizations due to the security situation (UN, 2016b).
5. **KEY FINDINGS**

5.1 Macro economy

5.1.1 Economic growth

Afghanistan experienced a robust growth rate during 2005–2013, but it has slowed down and is expected to stay at a moderate level until 2020. Annual GDP growth varied from 5% to 21% between 2005 and 2013 (IMF, 2016c). These are robust growth rates, but given their very low starting point, Afghanistan remains one of the poorest countries of the region, with a GDP per capita of USD 654 in 2014 (Figure 1). The level of GDP growth decreased each year from 2012 to 2014. The IMF suggests that this slowdown is due not only to the country’s highly uncertain security, political context, and weak institutions, but also unfavorable weather that has decreased agricultural outputs. The annual GDP growth is expected to show an increase from 2015 by 2% in 2016, with less than 4% average annual growth over the 2017–2020 period (IMF, 2016c). From 2022 on, however, higher growth rates are expected due to increased productivity and capacity to extract natural resources. The IMF suggests that the mining sector has the potential to attract foreign investment, increase revenues, and improve the economy (IMF, 2016a).

![Figure 1: Gross domestic product per capita, 2010–2020](source: IMF (2016c).)

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**Source:** IMF (2016c).
Significant expected population growth and low economic growth projections could put downward pressure on GDP per capita. The estimated population of Afghanistan in 2015 was 32.5 million. It is projected to increase to more than 50 million by 2040, with an estimated population average growth of 2.4% per year during the 2016–2020 period (UN DESA, 2015). However, GDP growth is not likely to overcome population growth in 2016 and 2017. To increase GDP per capita, economic growth needs to be higher than the projected annual population growth.

Projections conducted for this analysis suggests that the potential to increase fiscal space through economic growth is moderate. Using data on economic growth, based on the latest WEO published by the IMF in April 2016 (IMF, 2016c), the projections for this analysis assume GHEs equivalent to 1.2% of GDP (based on 2015) for three scenarios: low, medium, and high. The medium scenario is based on IMF projections of Afghanistan GDP growth until 2020, whereas the low scenario assumes a 1 percentage point lower GDP growth than IMF calculations, and the high scenario assumes a 1 percentage point higher GDP growth. Projections of improvements must be interpreted with caution because economic performance depends on a range of factors, including security, political and economic stability, governance, policy reforms, and agricultural and extractive industry productivity.

Assuming a constant share of GHE from GDP, economic growth would generate the following additional resources for health in 2017–2021:

- Low scenario: USD 45.5 million (USD 9.1 million per year)
- Medium scenario: USD 57.6 million (USD 11.5 million per year)
- High scenario: USD 70.2 million (USD 14.0 million per year)

These projections mean that in the medium scenario, economic growth could increase GHE by 29% in 2017–2021 (or about 6% on average per year). Figure 2 provides further details on the potential for increased government expenditure on health based on economic growth. The upper lines represent GDP in USD billions (measured on the left vertical axis). The lower lines correspond to GHEs in USD millions (measured on the right vertical axis). The decreases between 2014 and 2016 are due to exchange rate effects (there was no decrease in GDP in the national currency).

Assessment of fiscal space potential (4 out of 10): There is moderate potential for increased fiscal space from economic growth because of the projected slow growth of GDP in 2017–2021.
Figure 2: Potential increases in fiscal space from economic growth

<table>
<thead>
<tr>
<th>Year</th>
<th>GDP (USD billion)</th>
<th>GHE (USD million)</th>
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<tbody>
<tr>
<td>2011</td>
<td>148</td>
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</tr>
<tr>
<td>2012</td>
<td>129</td>
<td>19</td>
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<tr>
<td>2013</td>
<td>198</td>
<td>20</td>
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<tr>
<td>2014</td>
<td>256</td>
<td>20</td>
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<tr>
<td>2015</td>
<td>269</td>
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<td>2016</td>
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<td>17</td>
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<tr>
<td>2017</td>
<td>203</td>
<td>17</td>
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<tr>
<td>2018</td>
<td>215</td>
<td>18</td>
</tr>
<tr>
<td>2019</td>
<td>244</td>
<td>20</td>
</tr>
<tr>
<td>2020</td>
<td>256</td>
<td>21</td>
</tr>
<tr>
<td>2021</td>
<td>259</td>
<td>22</td>
</tr>
</tbody>
</table>

Source: IMF 2016c, Ministry of Finance expenditure data.

5.1.2 Revenue collection capacity

Domestic revenues increased by 22% in 2015, but still account for only a small share of the financing of the national budget. Domestic revenues increased from 8.7% of GDP in 2014 to 10.4% of GDP in 2015, largely driven by improved tax policy reforms, arrears collection, and administration (World Bank, 2016a). The share of domestic revenue is still at the lower range for low-income countries (typically 10–20% of GDP) (Gottret and Schieber, 2006). Tax revenues increased by 14% and customs duties by 17% in 2015, whereas non-tax revenues increased by 46% (World Bank, 2016a). Taxes accounted for 48.7% of domestic revenues in 2015, followed by non-tax revenues (26.5%) and customs duties (24.9%) (World Bank, 2016a). The introduction of a value-added tax (VAT) has been postponed because government authorities and the IMF are working to strengthen revenue administration and governance before introducing it (IMF, 2016b).

There may be some potential for increases in fiscal space in 2017–2021 due to improved government revenue collection capacity. Government revenues are expected to increase by USD 1.6 billion by 2020 (IMF 2016c). Based on the third Afghanistan National Health Accounts (NHA) from 2016, projections were conducted similarly to those for potential fiscal space increases from economic growth. The analysis used three scenarios: low, medium, and high. The medium scenario is based on IMF projections of Afghanistan government revenue
as a share of GDP, with the low scenario assuming a 1 percentage point lower share than IMF calculations and the high scenario assuming a 1 percentage point higher share.

Assuming everything else equal, improved revenue collection would generate the following additional resources for health in 2017–2021:

- **Low scenario:** USD 100.7 million (USD 20.1 million per year)
- **Medium scenario:** USD 110.3 million (USD 22.1 million per year)
- **High scenario:** USD 119.8 million (USD 24.0 million per year)

This analysis means that in the medium scenario, improved revenue collection capacity could increase GHE by 51% during 2017–2021 (or about 10% on average per year). Figure 3 provides further details on the potential generation of fiscal space for health in Afghanistan due to increased government revenue collection. The upper lines represent government expenditure in USD millions (measured on the left vertical axis). The lower lines correspond to GHE in USD millions (measured on the right vertical axis).

**Assessment of fiscal space potential** (5 out of 10): There is moderate potential for increased fiscal space through improved revenue collection, given current trends of increased government capacity to collect taxes and other revenue.

**Figure 3: Potential increases in fiscal space from increased government revenue collection**

Source: IMF 2016c, Ministry of Finance expenditure data.
5.1.3 Debt and fiscal balance

The government debt-to-GDP ratio is low and is projected to increase slightly until 2020. The government debt-to-GDP ratio is one factor influencing the likelihood that a country can obtain concessional loans (the lower the debt-to-GDP ratio, the stronger the likelihood of a loan), which would increase fiscal space. The government debt-to-GDP ratio is currently 6% and is projected to increase to 10% in 2020—still a low ratio (IMF, 2016c).

Increasing the fiscal deficit may represent a potential source of increased fiscal space for health in Afghanistan. Reforms of revenue collection and expenditure have significantly improved the country’s fiscal position. The fiscal deficit was 1.3% of GDP in 2015 (World Bank, 2016a). The World Bank 2016 Afghanistan Development Update suggests that a deficit of this order of magnitude is not a cause for concern, being due mostly to the use of a cash-based accounting system in preparing the budget. Increasing the fiscal deficit may therefore be explored as a tool to increase fiscal space for health.

Assessment of fiscal space potential (4 out of 10): There is moderate potential to increase fiscal space for health by leveraging Afghanistan’s low level of current debt-to-GDP ratio and fiscal deficit, but further monitoring of domestic revenues and development of donor financing are needed. The fiscal deficit, excluding donor grants, is forecasted to increase from 16.7% of GDP in 2015 to 22% by 2018; the World Bank therefore suggests that “if donor grants are not forthcoming to cover this gap, more aggressive expenditure consolidation efforts will need to be implemented, which would compromise development prospects and undermine measures to improve social outcomes” (World Bank, 2016a).

5.1.4 Inflation

The prices of healthcare goods and services are increasing more quickly than the prices of other goods and services. General inflation, as measured by the consumer price index (CPI), decreased significantly between 2003 and 2014 (Figure 4) (IMF, 2016c). In 2015, the country faced negative inflation. In 2016, the CPI was estimated to return to a positive but low level, consistent with the recent slow economic recovery. In contrast to general inflation, the inflation for healthcare goods and services has been relatively steady in recent years. The health sector CPI has increased between 5% and 10% per year since 2012 (IMF, 2016b). Health contributed more to CPI than other sectors, such as transportation, housing, and electricity. The effect of a general inflation lower than the inflation rate for healthcare goods and services should be a decrease of the fiscal space for health in the national currency, all else being equal, because the central government will not be able to buy the same amount of health goods and services with the same amount of money. Just to maintain the current level of real government spending in the health sector, fiscal space for health would need to expand because the prices of health goods and services are expected to increase at a higher rate than general inflation for the foreseeable future.

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1 The Afghanistan Development Update 2016 states: “Unlike the accrual approach, the cash-based accounting system records receivables and expenditures at the time when they are actually received and paid. These can occur with some delays with respect to the time of commitments/obligations. Since there is often a time lag between donor grant commitments and the actual receipt of the associated funds, the budget could show a deficit towards the end of the year before fiscal accounts are closed” (World Bank, 2016a, p. 7).
Assessment of fiscal space potential (0 out of 10): There is limited potential for increased financial space for health through inflation effects because the prices of healthcare goods and services are increasing more quickly than those of other goods and services.

Figure 4: Consumer price index (% year-on-year change), 2002–2019

Source: IMF 2016c.

5.1.5 Overall score

The potential for increases in fiscal space due to the macro economy pillar received an overall score of 4 out of 10 (moderate potential). Macroeconomic conditions are not particularly favorable, given that economic growth is projected to increase at a low rate during 2017–2021. There is moderate potential for increased resources through the government’s improved capacity for revenue collection and leveraging the low debt-to-GDP ratio and moderate fiscal deficit.

5.2 Re-prioritization of the health sector

Government spending on health is low. Afghanistan’s first poverty reduction strategy, the Afghanistan National Development Strategy (ANDS) 2008–2013, included health as a political priority (Islamic Republic of Afghanistan, 2010). However, this strategy is not reflected in the level of government allocation to the health sector. The NHA estimate that government spending on health in 2014 was USD 3.5 per capita, representing 4.3% of total government expenditure, 0.5% of GDP, and 4.9% of total health expenditure (MoPH, 2016a). Government health spending as a share of total government spending is significantly lower than international benchmarks and recommendations. The Afghanistan figure of 4.3% as a share of total
government expenditure is considerably below the Abuja declaration of 15% (OAS, 2001), the 10% target presented in the MoPH Revenue Generation Strategic Framework (MoPH, 2014a), or the 8% recommendation by the WHO Eastern Mediterranean region (WHO, 2010a).

Government spending on health as a share of GDP is lower than in Pakistan (0.9%), Turkmenistan (1.3%), Tajikistan (2.0%), Kazakhstan (2.4%), Iran (2.8%), Uzbekistan (3.1%), or Kyrgyzstan (3.6%) (WHO, 2016a). The level of GHE is far below the threshold of 5% of GDP, which has been found to be the level at which catastrophic health expenditure is significantly reduced (Xu et al., 2010). Table 1 compares Afghanistan to the averages of other countries in the region, as well as low-income and lower-middle income countries.

Table 1: Government spending on health in Afghanistan and other countries, 2014

<table>
<thead>
<tr>
<th>Government spending on health</th>
<th>Afghanistan</th>
<th>Average WHO Eastern Mediterranean region</th>
<th>Average low-income countries</th>
<th>Average lower middle-income countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>As share of total government expenditure</td>
<td>4.30%</td>
<td>7.86%</td>
<td>10.27%</td>
<td>6.71%</td>
</tr>
<tr>
<td>As share of GDP</td>
<td>0.46%</td>
<td>2.70%</td>
<td>2.37%</td>
<td>1.61%</td>
</tr>
</tbody>
</table>

Sources: MoPH, 2016a; WHO, 2016a.

Currently, more than half of the government budget is allocated to security and infrastructure. The government budget consists of operational and development budgets. The total national budget amounts to USD 6.6 billion for March 20, 2016 to March 20, 2017, made up of a USD 4.1 billion (62%) operating budget and a USD 2.5 billion (38%) development budget (MoF, 2016b). International donors financed 67% of the 2016 total budget (55% of the operating budget and 87% of the development budget) (MoF, 2016b). The distribution of the total budget in 2016 is shown in Figure 5. The security sector accounted for the largest share (40%) of the total budget, followed by infrastructure (20%) and education (13%) (MoF, 2016b). Health accounted for 4.8% of the total budget. Annex B provides more information on the distribution by sector for the operating and development budgets.
Fiscal space for the health sector could be expanded significantly by increasing the health sector’s share in government spending. To explore the potential for generating more fiscal space for health in 2017–2021 from a re-prioritization of the health sector, the analysis conducted projections for three different scenarios. In the low scenario, government spending on health as a share of total government spending was assumed to increase linearly from 4.3% in 2015 to reach 5% by 2021. In the medium scenario, the share increased linearly to reach 6.5% by 2021. In the high scenario, the share increased linearly to reach 8% by 2021 (WHO Eastern Mediterranean region recommendation). Assuming everything else equal, the scenarios would generate the following additional resources in 2017–2021:

- Low scenario: USD 35.1 million (USD 7.0 million per year)
- Medium scenario: USD 110.3 million (USD 22.1 million per year)
- High scenario: USD 185.6 million (USD 37.1 million per year)

This analysis means that in the medium scenario, an increased allocation of the government budget to the health sector could increase GHE by 51% in 2017–2021 (or about 10% per year) (Figure 6). However, increasing the share of the government’s expenditure on health also depends on changes in the budget execution rate for the health sector.

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2 The MoPH Revenue Generation Strategic Framework states a target of 10% by 2020 (MoPH, 2014a). However, given that the share has been below 5% since 2010, the analysis used 8% as the high scenario (even this number is an ambitious target in such a short timeframe).
Assessment of fiscal space potential (7 out of 10): There appears to be significant potential to increase fiscal space for health from re-prioritization of the health sector. Government spending on health is currently low; hence, even modest increases in health spending as a share of total government spending would generate significant additional resources for the health sector.

Figure 6: Potential increases in fiscal space from re-prioritization of the health sector

Source: MoPH, 2016a; IMF, 2016c.

5.3 Health sector-specific resources

Another potential source of increased fiscal space for health is the introduction of health sector-specific domestic revenue sources, including earmarked taxes, user fees, and health insurance. To explore which types of earmarked taxes would be most viable and beneficial, the Health Economics and Financing Directorate within the MoPH prepared a Revenue Generation Strategic Framework in 2014 (MoPH, 2014a). Table 2 summarizes the proposed earmarked taxes and potential revenue. In the strategy, MoPH proposed the following uses of any additional health sector-specific resources: improving the overall quality of secondary and tertiary public healthcare, establishing a treatment and research center for cancer and control treatment centers for NCDs and injuries, training highly qualified clinical staff, and equipping and modernizing the hospital sector to meet international standards.
## Table 2: Summary of findings of the MoPH Revenue Generation Strategic Framework

<table>
<thead>
<tr>
<th>Policy</th>
<th>Proposed Intervention</th>
<th>Estimated annual revenue (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco tax</td>
<td>Excise tax of 50% levied on all imported tobacco products</td>
<td>25 million</td>
</tr>
<tr>
<td>Vehicle tax</td>
<td>Phase 1: Specific tax of AFN 12,500 (USD 223) levied on imported vehicles</td>
<td>Phase 1 = 2.2 million</td>
</tr>
<tr>
<td></td>
<td>Phase 2: Road permit tax of AFN 1,750 (USD 31)</td>
<td>Phase 2 = 25 million</td>
</tr>
<tr>
<td>Fuel tax</td>
<td>AFN 1 tax levied per liter of gasoline, with 100% allocated to health</td>
<td>32 million</td>
</tr>
<tr>
<td>User fees</td>
<td>Introducing user fees (payment structure to be determined)</td>
<td>62 million</td>
</tr>
<tr>
<td>Health insurance</td>
<td>Introducing health insurance (approach and implementation arrangements to be determined)</td>
<td>50 million</td>
</tr>
</tbody>
</table>

Source: MoPH (2014).

In addition to generating revenue, earmarked taxes benefit public health by discouraging the consumption of harmful products. Evidence from countries at all income levels has shown that increasing taxes is a highly cost-effective intervention to reduce the demand for and consumption of products harmful to health, such as tobacco and alcohol (not applicable in the Afghanistan context). Such taxes are often referred to as “sin taxes.” WHO estimates that, on average, a 10% price increase on cigarettes reduces demand by about 5% in low- and middle-income countries (and even more for children and adolescents) (WHO, 2011). Sin taxes have been successfully implemented in the Philippines and Thailand. The Philippines uses revenues from tobacco taxes (USD 1 billion per year) to finance UHC initiatives; Thailand uses revenues from alcohol and tobacco taxes (USD 120 million per year) to finance preventive care and public health research through the Thai Health Promotion Foundation (WHO, 2015c; Thailand Health Promotion Foundation, 2016). Ghana is financing part of its health insurance system though an earmarked VAT tax and is considering the introduction of sin taxes (Akazili et al., 2011; Republic of Ghana, 2015).

### 5.3.1 Earmarked tobacco tax

The MoPH Revenue Generation Strategic Framework estimated that a 50% tax on all imported tobacco products could generate up to USD 25 million in additional annual revenues. A total of USD 98 million worth of cigarettes are imported into the country annually. A 2014 survey estimated that the average price of one cigarette pack in Kabul was AFN 36.4 (MoPH, 2014a). Estimates from various Asian countries suggest that the short-run price elasticity for tobacco products ranges from −0.2 to −0.8, whereas long-run estimates range from −0.4 to −0.9 (WHO, 2009). With an assumed price elasticity of −0.5, the MoPH estimated that increasing the tax on imported tobacco products to 50% would generate an additional USD 25 million per year in revenue (MoPH, 2014a).

The tax on imported tobacco products has already been increased, but there is some uncertainty regarding the percentage change. Following a newly endorsed Tobacco Law, the MoF increased the tax on imported tobacco by 50%, from 14% to 21%. However, it requires additional efforts to earmark tobacco tax for health.

Assessment of fiscal space potential (7 out of 10): There appears to be considerable potential for increased fiscal space for health through an earmarked tax on tobacco. The MoPH
has estimated the potential revenues that could be generated, and strong public health arguments can be made for advocacy (tobacco taxes have shown a significant negative impact on smoking).

5.3.2 Earmarked vehicle tax

The MoPH estimates that an earmarked vehicle tax could generate more than USD 27 million in annual revenues. Road construction, coupled with limited legislation on road safety and vehicle standards, has contributed to a sharp rise in motor vehicle accidents, particularly among people between ages 15–49. The traffic department in Afghanistan estimates that there are currently 820,000 registered vehicles in the country. Furthermore, more than 10,000 cars are imported annually (MoPH, 2014a). On average, costs range from USD 3,000 to USD 120,000, depending on the model and year of the vehicle. Currently, Afghanistan levels a municipality charge of 1% per vehicle and a customs duty ranging from 2.5% to 30% based on the characteristics of the car (MoF, 2014). The global average for custom duties levied on imported vehicles is 16.8%, suggesting that an increased customs duty could be introduced for many of the cars entering the country and remain within a globally accepted level (Pitney Bowes, 2016). The MoPH has estimated that the proposed earmarked tax of USD 223 per imported vehicle and a flat fee of USD 31 for road permit renewal could generate more than USD 27 million per year.

Assessment of fiscal space potential (4 out of 10): There appears to be limited potential for increased fiscal space for health through an earmarked tax on vehicles. The MoPH has demonstrated the potential revenues that could be generated, and there are strong public health arguments because the increased tax should reduce the increase in the number of cars and healthcare costs associated with the high number of traffic-related injuries. However, discussion of its potential implementation has not yet begun, so the reform may take time to be implemented.

5.3.3 Earmarked fuel tax

The MoPH estimates that a fuel tax could generate 32 million USD in annual revenue. In 2012, Afghanistan imported 1.8 million liters of fuel. It is estimated that imports will increase by 8% to 10% each year. The MoPH has proposed levying a tax of AFN 1 per liter of fuel and estimates that as much as 32 million USD could be raised annually. A fuel tax would also contribute to curbing air pollution and associated respiratory diseases. The number of cases of pulmonary diseases increased from 11,340 in 2009 to 12,350 in 2010. Although several factors contribute to cardiovascular and respiratory illnesses, studies show that pollution emitted from fuels has an adverse effect on health. A recent study published by the United States Institute of Medicine found that an increase of air particles from 2.5 to 10 micrograms per cubic meter is associated with a 3% increased risk of death from all causes and a 10% increase in the risk of death from heart disease (Hayes et al., 2015).

Assessment of fiscal space potential (4 out of 10): There appears to be limited potential for increased fiscal space for health through an earmarked tax on fuel. The MoPH has demonstrated the potential revenues that could be generated. However, opposition by the population and the transportation industry may compromise the feasibility of introducing any such tax.

5.3.4 User fees

The implementation of user fees could generate USD 62 million in annual revenues. The introduction of user fees has legal backing under an amendment to the second article of the Health Law. The amendment stipulates that a process for exempting the poor must
be established before charging user fees. The MoPH has drafted a user fees regulation and submitted it to the MoJ for approval. The Revenue Generation Strategic Framework envisions a flat fee for outpatient and inpatient services, and estimates that as much as USD 62 million could be raised annually. This figure will change depending on the exact amount of fees to be charged. Further, the MoPH plans to implement user fees in a phased manner, beginning with a pilot in a few national hospitals.

Beyond being a source of revenue, user fees at hospitals can potentially be an effective mechanism to rationalize the use of care. The introduction of user fees at hospitals will require that the population pay more attention to their primary care options. Some international experience suggests that user fees, in combination with an effective referral mechanism, can encourage the use of more appropriate, less expensive primary care health facilities, when appropriate (Akashi et al., 2004).

User fees can create financial barriers to accessing care; therefore, mitigating measures must be put in place. The introduction of user fees must be complemented by a system for identifying and exempting the poor, backed by sufficient financial resources to compensate health facilities (MoPH, 2013a).

Assessment of fiscal space potential (7 out of 10): There appears to be significant potential for increased fiscal space for health through user fees; the MoPH is working toward the development of a legal framework for implementing such fees.

### 5.3.5 Health insurance

A recent feasibility study assessed the benefits of and drawbacks to Afghanistan of different health insurance models, as well as the political and legal factors that would affect the introduction of public health insurance (Health Policy Project, 2015). It found that clear guidance on setting up, implementing, and managing public health insurance needs to be developed, that the quality of healthcare facilities needs to be improved to ensure public buy-in, and that the general idea of pooled payment will need to be promoted.

Assessment of fiscal space potential (4 out of 10): There appears to be moderate potential for the introduction of health insurance in Afghanistan. Some analytical work has been conducted to inform policy dialogue, and health insurance is clearly within the sphere of influence of the MoPH and the health sector. However, it should be acknowledged that managing health insurance requires considerable investment in staff, training and management, and IT systems. Implementation of health insurance is likely to take a relatively long time, however, thus affecting the actual generation of revenue in the short term.

### 5.3.6 Overall score

The potential for increases in fiscal space through implementation of health-specific resources received an overall score of 5 out of 10. The MoPH has calculated the significant additional revenues they could generate. Not all new potential resources have the same probability of being legally endorsed, which influenced the overall score.

### 5.4 Foreign aid

International assistance for health is expected to be sustained in the short term, but reductions are expected in the medium to long term. Afghanistan is one of the world’s largest recipients of international aid. The country received USD 148 per capita in international aid in 2014 (World Bank, 2016b). The Afghanistan Development Update suggests
that whereas long-term donor financing is expected to decrease, total on-budget donor grants for all sectors are expected to increase from USD 2.7 billion (15% of GDP) in 2015 to USD 4.5 billion (21.0% of GDP) in 2018 (World Bank, 2016a). As in other sectors, external resources are the main source of public financing of health expenditures. The largest program financed by donors is the System Enhancement for Health Action in Transition (SEHAT), which amounts to USD 654 million over five years (2013–2018). The program comprises three components: financing and improving the BPHS and EPHS, building the stewardship capacity of the MoPH, and strengthening system development and program management. SEHAT represents more than half (54%) of on-budget aid for health (MoPH, 2015b). Although international assistance appears stable in the short term, it is expected to decrease in the medium to long term.

**Assessment of fiscal space potential** (3 out of 10): There appears to be limited scope for increased fiscal space through foreign aid, based on anticipated medium- to long-term reductions in international assistance for health. Future commitments from donors are difficult to predict and may evolve based on the situation in Afghanistan and political economy factors in donor countries. For example, negotiations about donor financing in the short term are currently taking place, and there may be an injection of funds during the 2017–2021 period.

### 5.5 Efficiency

**There is potential to increase fiscal space for health by reducing inefficiencies in the health system.** Efficiency in the health sector has been defined as “extracting the greatest health gains from a set of inputs” (WHO, 2001). Technical efficiency relates to “doing things right”: getting the maximum health outputs possible for a given level of inputs to reduce waste. Allocative efficiency refers to “doing the right things”: achieving an optimal distribution of resources to achieve the best health outcomes and maximize the social benefits of investments. Technical efficiency gains can be realized by generating increased outputs at the same level of inputs (human resources, infrastructure, equipment, drugs, etc.) or getting the same level of outputs from reduced inputs. Allocative efficiency can be improved by making sure that resources are allocated where they can generate the most benefits in addressing the burden of disease, ensuring that services are provided at an appropriate level of the health system, and making sure that vulnerable populations such as the poor receive the services they need. The World Health Report 2010 estimated that 20–40% of all health spending is wasted through inefficiencies (WHO, 2010b). It identified 10 major causes of inefficiency in the health sector (Table 3).

<table>
<thead>
<tr>
<th>No</th>
<th>Area</th>
<th>Source of Inefficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medicines</td>
<td>Underuse of generics, higher-than-necessary prices for medicines</td>
</tr>
<tr>
<td>2</td>
<td>Medicines</td>
<td>Use of substandard and counterfeit medicines</td>
</tr>
<tr>
<td>3</td>
<td>Medicines</td>
<td>Inappropriate and ineffective use</td>
</tr>
<tr>
<td>4</td>
<td>Healthcare products and services</td>
<td>Overuse/oversupply of equipment, investigations, and procedures</td>
</tr>
<tr>
<td>5</td>
<td>Health workers</td>
<td>Inappropriate or costly staff mix; unmotivated workers</td>
</tr>
<tr>
<td>6</td>
<td>Healthcare services</td>
<td>Inappropriate hospital admissions and lengths of stay</td>
</tr>
<tr>
<td>7</td>
<td>Healthcare services</td>
<td>Inappropriate hospital size (low use of infrastructure)</td>
</tr>
<tr>
<td>8</td>
<td>Healthcare services</td>
<td>Medical errors and suboptimal quality of care</td>
</tr>
</tbody>
</table>
Potential Avenues to Increase Government Investment in Health in Afghanistan: Fiscal Space Analysis

<table>
<thead>
<tr>
<th>No</th>
<th>Area</th>
<th>Source of inefficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Health system leakages</td>
<td>Waste, corruption, and fraud</td>
</tr>
<tr>
<td>10</td>
<td>Health interventions</td>
<td>Inefficient mix/inappropriate level of strategies</td>
</tr>
</tbody>
</table>


5.5.1 Transparency and accountability

Efficiency could be increased by strengthening transparency and accountability. More than three-quarters (77%) of the population believes that corruption is a major problem in Afghanistan, and more than one-quarter (26%) identifies it as one of the top four problems facing the country (Rade et al., 2014). It is estimated that half of the population makes informal payments to obtain public services (Integrity Watch Afghanistan and Transparency International, 2016). Audits and performance-based monitoring can increase accountability and transparency (Azfar and Gurgur, 2001). The government has taken steps to implement new technological tools to track disbursements, procurements, and expenditures. The AFMIS was installed in all provinces by 2010 with the aim of promoting transparency, increasing budget execution, improving revenue collection, and making more timely payments. The system has been implemented only in provincial centers, however, and does not collect data from service delivery points. In addition, the MoPH introduced the EMIS to track expenditure at the facility level and is advocating for national-level implementation. Sophisticated systems for monitoring the budget and expenditures such as the AFMIS and EMIS are too complex for many facilities, however.

Assessment of fiscal space potential (5 out of 10): There is moderate potential to increase fiscal space for health by improving transparency and accountability, but it is a complex issue and potential measures should be considered carefully. Improving transparency and changing practices may take time.

5.5.2 Budget execution

Budget execution within the health sector is a priority within the MoPH. The health sector’s budget execution rate for the operational budget is almost 100% because it mainly consists of staff salaries. The health sector’s execution rate for the development budget increased from 62% in 2011 to 69% in 2015 (MoF, 2016a). Only the agriculture sector is doing better, with a development budget execution rate of 74% (MoF, 2016a). Nevertheless, the budget execution rate could be further improved both by addressing factors within the control of the MoPH, such as poor planning, low absorption capacity, cumbersome and lengthy procurement processes, and inadequate delegation of authority (which in turn reduces the capacity at the subnational level), and constraints that are mainly outside of the control of MoPH. Constraints include the security situation, weak overall budget planning and autonomy, unpredictable and late disbursement of funds, rigid procurement rules, and inflexibility in shifting budgets to different line items. This situation suggests that there is significant scope for increasing fiscal space by addressing several factors that lead to a low budget execution rate.

The results of projections suggest a moderate scope for increased fiscal space through increased budget execution rates. This analysis conducted projections for three scenarios to estimate how much GHE would be increased by improving the budget execution rate. In all three scenarios, the budget execution rate for the health sector was assumed to increase from the 2015 level of 75% to 80% (government target) in 2017 (IMF, 2016b). The three scenarios would then increase to 83% (low), 86% (medium), and 90% (high) by 2021. The
analysis then multiplied the budget execution rates of each scenario by the anticipated government budget for health for the same period to estimate GHE in 2017–2021.

**The results suggest that improvement of the budget execution rate in the health sector can create moderate fiscal space.** Assuming everything else equal, the scenarios would generate the following additional resources in 2017–2021 (Figure 7):

- Low scenario: USD 26.4 million (USD 5.3 million per year)
- Medium scenario: USD 36.2 million (USD 7.2 million per year)
- High scenario: USD 49.3 million (USD 9.9 million per year)

This analysis means that in the medium scenario, an increased allocation by the government budget to the health sector could increase GHE by 15% in 2017–2021 (about 3% on average per year).

**Figure 7: Potential increases in fiscal space from improved budget execution rates**

Source: Ministry of Finance (2016).

**Assessment of fiscal space potential** (6 out of 10): There appears to be moderate scope for increased fiscal space from increased budget execution. Its feasibility rests on various factors, not all of which are under the control of the MoPH. For example, transparency of the overall budget execution is essential to its achievement. What MoPH can control is the quality of financial management and budget monitoring systems to identify bottlenecks.
The development budget execution rate of the health sector (69% in 2015) is the second highest among all ministries. Only the agriculture sector is doing better, with a development budget execution rate of 74% (MoF, 2016a). This relatively high rate compared to other sectors can serve as a powerful advocacy argument by demonstrating a high absorption capacity in the health sector.

5.5.3 Technical efficiency

Strengthening strategic purchasing through health insurance and contracting represent potential avenues to increase the efficiency of health service delivery. Most health services provided through the BPHS and EPHS has been contracted out to NGOs. Evidence suggests that the contracting-out approach may have contributed to an increase in access to primary healthcare services in rural areas (Newbrander et al., 2014). Strategic purchasing could also contribute to increasing the efficiency of health resources. In the Revenue Generation Strategic Framework, the MoPH recommended the introduction of health insurance (MoPH, 2014a). The primary goal of (public) health insurance is to increase financial protection for the population against excessive healthcare spending, but it can also contribute to increasing efficiency. When the health system is predominantly financed by OOP expenditure, there is a tendency to delay treatment, leaving conditions to worsen over time and making them costlier to treat. Prepayment such as health insurance can help address this issue. In addition, health insurance can also influence efficiency through its purchasing function, particularly as the scheme grows and purchasing power increases.

There is mixed evidence on the efficiency of hospitals. Hospitals accounted for 40% of total health expenditure in 2014 – a significant increase compared to 2009 (29%) and 2012 (24%) (MoPH, 2016a). The bed occupancy rate in 2015 was quite high for provincial hospitals (90%), followed by regional/national and specialty hospitals (86% and 76%, respectively). However, other data suggest that there may be potential for efficiency gains. One study conducted in 2012 estimated that 56%–59% of health facilities were inefficient (Osmani, 2013). A 2015 study of costs in national hospitals found that there were two doctors for every nurse and one doctor for every bed (MoPH, 2015a). Both these ratios have risen since the 2013 study, despite MoPH recommendations of one doctor for every two nurses and four beds. The average length of stay in a national hospital was 11.8 days – well over MoPH recommendations of three days, or the average length of stay in Asian countries (6.4 days) (OECD and WHO, 2012). The costing study identified improvements in some areas. For example, costs per visit have dropped. An outpatient visit fell from USD 3.56 in 2012 to USD 3.16 in 2014 (MoPH, 2015a).

Increased autonomy for hospitals presents an opportunity for increased efficiency if financial and operational capacity is improved at the facility level. Health facilities in Afghanistan have limited autonomy. Funds are disbursed from the central level per the line-item budget. Hospitals generally do not have control over hiring and firing staff, monitoring and adjusting hospital budgets, purchasing equipment, adding or discontinuing clinical services or programs, or deciding revenue accrual methods (MoPH et al., 2013). This lack of power often results in budgets and staffing arrangements unaligned with local needs. Afghanistan has begun experimenting with greater autonomy for health facilities, giving financial autonomy to 15 of the 16 national hospitals in Kabul in accordance with the National Hospital Strategy (MoPH, 2011b). This autonomy allows hospitals to procure their own equipment and drugs. A recent Public Expenditure Tracking Survey (PETS) of national hospitals found that allowing national

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3 Even without outliers, the average stay was more than four days, which is above the MoPH recommendation.
hospitals to procure drugs and services directly made the process more efficient, reduced wastage, and more closely linked drug procurement to local demand (MoPH, 2012a).

**Task shifting is one of the potential options for enhancing technical efficiency in the health sector.** Task shifting (or task sharing) aims to reduce health service delivery costs by training and enabling mid-level and “lay” health workers to perform interventions otherwise provided only by health professions with longer experience (and sometimes more specialized) (WHO, 2016b). Ethiopia strengthened its human resources for health in 2007 by developing a cadre of health extension workers to work in community health posts. By the end of 2012, more than 35,000 health extension workers had been trained and deployed, which improved the ratio from one health worker per 63,785 in 2007 to one per 17,128 in 2012. Consequently, the rate of contraception use increased from 23% to 62%, use of antenatal care doubled, and women using skilled health workers for deliveries increased by 7 percentage points (Yip and Hafez, 2015). Uganda also found success in expanding its HIV/AIDS health programming by shifting some tasks from doctors to nurses, and from nurses to community health workers (WHO, 2007).

**Issues with the available skill mix of health workers persist.** Not only are human resources low in numbers at all levels of medical staff, but several skills are especially hard to find or are missing entirely from the country. Medical technologists specializing in laboratory science, radiography, blood bank services, and anesthetics are needed. Although there are many laboratory technicians in the public sector, they are under-skilled. Also, the country currently has no biomedical engineering program, which has resulted in an absence of qualified biomedical engineers. Facilities must either send medical equipment overseas for repair or invite external experts from other countries. The national sanitarian training program, which produces professionals to oversee health programs, has been discontinued. There is a significant shortage of psychosocial counselors (MoPH, 2011a).

**Procurement remains an issue for public facilities.** Procurement processes and general hospital management require training and a level of capacity not available at many facilities. A lack of knowledge regarding tendering and contract awarding, quality control, and monitoring of supply chains prevents many facilities from independently handling procurements (MoPH, 2012a). The absence of a system to track procurements across the country in a transparent way also prevents the MoPH from decentralizing further. For these reasons, the MoPH is responsible for or conducts final approval for procurements at public facilities outside of the 15 national hospitals. The limited number of suppliers of drugs and equipment, along with minimal regulation and quality control, affects efficient procurement in Afghanistan. To scale up a model of facility-based fiscal autonomy, a high level of capacity building is necessary, with an oversight committee kept in place to verify vendors and help with tenders.

**There may be potential for public-private partnerships (PPPs).** A significant part of the population seeks care in the private sector. In 2011–2012, more than half (61.8%) of OOP expenditures went to private facilities (MoPH, 2012b). The MoPH has explored the potential for small-scale pilot PPPs to increase efficiency and access.

**Assessment of fiscal space potential** (5 out of 10): There is moderate potential to increase fiscal space by improving technical efficiency, particularly through strategic purchasing and increased autonomy. Strategic purchasing could be strengthened by enhancing the current contracting approach and introducing health insurance. The MoPH is carefully considering how to improve hospital autonomy, and a strategy has been developed to promote the increased financial autonomy of national hospitals. In addition, the “Strengthening Mechanism” contracting-in approach used in the three provinces where MoPH is responsible for delivering services gives greater autonomy to public providers (Cashin et al., 2015). There seems to be
potential to improve efficiency through more localized drug procurement, but it will require significant capacity building, training, and oversight.

5.5.4 Allocative efficiency

Allocative efficiency refers to an optimal distribution of resources – that is, focusing resources where they will be most useful. Examples include deciding the geographic distribution of health facilities, the balance of primary and tertiary care facilities, and the distribution of health workers.

Assessment of alignment of expenditure with burden of disease was inconclusive. The most recent NHA data from 2014 indicate the following distribution of health expenditure by disease or condition:

- Child health (including acute respiratory infection, diarrhea, and malnutrition): 25.2%
- Reproductive health (including family planning and maternal health): 17.1%
- Immunization: 3.1%
- Infectious diseases (including HIV, TB, and malaria): 2.2%
- Other: 52.4%

The “other” category constitutes more than half of total health expenditure, which makes it difficult to draw any conclusions on how spending is aligned with the burden of disease. For example, NCDs (which account for a considerable share of the burden of disease) would be covered in this category, but there is no way of knowing the level of NCD spending based on available health expenditure data.

Spending on preventive care is low. Preventive care accounted for 5% of total health expenditure in 2009, increasing to 6.9% in 2014 (MoPH, 2016a). Although there is no international benchmark for preventive care spending, Afghanistan’s share is still low compared to the global average (7.7%) and the average of low-income countries (24.6%) (WHO, 2016a). Afghanistan thus could increase its investment in preventive care to reduce costs related to curative care and improve health outcomes. Curative services, including inpatient and outpatient care, accounted for 33%, and pharmaceuticals accounted for 42% of total health expenditure in 2014 (MoPH, 2016a). Public funding for preventive care is critical, given the positive externalities nature of many preventive interventions, meaning that individuals and households will not invest enough in preventive care from a societal perspective.

The distribution of public health facilities suggests a concentration among primary care facilities. Public health facilities were distributed as follows in 2014: basic health centers (35.6%), sub-health centers (23.6%), comprehensive health centers (CHCs) (17.4%), mobile clinics (5.2%), district hospitals (3.4%), provincial hospitals (1.2%), drug addiction treatment centers (1.2%), specialized hospitals (1.1%), regional/national hospitals (0.3%), and other (11.0%) (MoPH, 2014b).

There are considerable geographic differences in the distribution of health workers. There are more than twice as many public health workers in urban compared to rural areas, although only 23% of the population lives in urban areas (MoPH, 2011a). Qualified private health workers also tend to be based in urban areas, which may be due partly to the location of hospitals. Nevertheless, the imbalance is likely to contribute to underutilization and hence efficiency losses of health facilities in some rural areas.
Assessment of fiscal space potential (5 out of 10): There appears to be moderate potential to increase fiscal space by improving allocative efficiency, particularly by increasing the budget execution rate, spending on preventive care, improving the health workforce distribution and skill mix, and potentially exploring task shifting. The recent increase of spending on preventive care is encouraging but still not high enough. It should be reasonably straightforward to increase spending on preventive care via increasing fiscal space through improvements in allocative efficiency, although it would involve advocacy. However, increasing fiscal space gains through a more balanced health workforce distribution and skill mix will require considerable planning and implementation efforts.

5.5.5 Overall score

The potential for increases in fiscal space through efficiency gains received an overall score of 5 out of 10 (moderate potential), given identified opportunities to increase the spending rate of the health budget and improve technical and allocative efficiency.
6. CONCLUSIONS AND RECOMMENDATIONS

The overall scores reflecting the potential for increased fiscal space for health under each of the five pillars are presented visually in a spider web diagram in Figure 8. The scores in the diagram are indicative of potential areas for increased fiscal space; definitive conclusions should be interpreted with caution.

Figure 8: Summary of scoring of potential for fiscal space increases

There is moderate potential to increase fiscal space through the macro economy. Economic growth is projected to be modest in 2017–2021, and revenue collection capacity is improving at a moderate pace. Prices on health goods and services are increasing more quickly than general inflation, which justifies the need for increased government health spending. There is significant potential to increase fiscal space through re-prioritization of the health sector, as reflected in increased allocations of the government budget to health. There is moderate potential to increase fiscal space through health sector-specific resources. Although significant resources could be generated through earmarked taxes for health and the introduction of user fees and health insurance, their full-fledged implementation may take several years.

There is limited potential to increase fiscal space for health through increases in foreign aid. Based on currently available data, donor financing appears to be stable in the short term but is expected to decrease in the medium to long term. There is moderate potential for increased fiscal space for health through improvements in efficiency. Potential areas for fiscal space
gains include improved budget execution, hospital autonomy, task shifting, and increased investment in preventive care. One of the MoPH’s key objectives is to reduce the burden of healthcare expenditures on the population (MoPH, 2014a). An analysis of the effect of fiscal space increases on OOP expenditure thus was conducted based on Afghanistan’s NHA data. Assuming that any fiscal space increases would directly replace OOP expenditure, expansion in the fiscal space would reduce OOP expenditure by 9% in 2021. In addition to generating additional revenues for health, cost-containment measures should be prioritized to further reduce OOP expenditure, such as through promoting the rational use of drugs.

Actions designed to capitalize on these opportunities should be prioritized and sequenced. Efforts should focus on areas in which the health sector is well positioned to influence policy and resource allocation decisions, such as improving health systems efficiency and tapping new health sector-specific sources of revenue. The prospects of success will also be determined by understanding the political economy factors that influence resource allocation and the health sector’s ability to strengthen its implementation capacity, including planning and financial management.

The report makes the following specific recommendations:

- **Prioritize earmarking of the tobacco tax by continuing an evidence-based policy dialogue with the MoF and MoJ, informed by lessons learned by other countries that have successfully leveraged tobacco taxes to promote public health and mobilize additional government resources.**

- **Prioritize the implementation of user fees by developing operational guidelines, strengthening the financial systems of secondary and tertiary hospitals, and designing an exemption mechanism to ensure access by the poor to needed hospital services. In parallel, continue preparations for introducing health insurance based on the findings of the health insurance feasibility study.**

- **Improve absorption of the allocated budget through systematic monitoring of expenditure and support to low-performing programs and projects to strengthen areas such as procurement and financial planning and management.**

- **Expand efforts to increase hospital autonomy, supported by capacity building and strengthening of financial systems, and explore other areas for efficiency gains to extract more from existing resources.**

- **Establish an inter-ministry task force, supported by a technical team, to oversee the implementation of evidence-based advocacy activities. The activities should be strategically targeted to key decision-makers based on actor analysis and the development of tailored messaging and delivery platforms, such as ministerial and parliamentary briefings, and leveraging civil society and media resources. Consider potential allies, such as the Ministry of Education, with which to jointly advocate for earmarked taxes for social sectors.**

- **Develop an investment case for health by packaging global evidence on the returns of investing in that sector, especially emphasizing economic returns though improved productivity, lower absenteeism rates, and reduced dependency ratios,**

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4 The dependency ratio is the number of household members (usually defined as children 0–14 years and those 65 and older) divided by the number of those working (usually defined as those ages 15–64 years), which means that in Afghanistan one person of working age supports about 0.9 persons of non-working age.
arguments for increased government health resources that resonate with the MoF (Box 1).

- Prepare a high-level briefing paper articulating the country’s vision toward UHC through the design and implementation of health financing policies and mechanisms to improve access, quality, and financial protection. This document will contribute to aligning health sector actors in making a credible, coherent, and coordinated case for increased government investment in health.

- Further analyze the scope for efficiency gains in health facilities, including the effects of contracting on efficiency and management of health providers, and the potential of expanding PPPs to increase efficiency and access.

- Establish a decision-making and evaluation process to ensure that additional resources are deployed where they are most needed and can be spent most feasibly, based on an analysis of burden-of-disease and health systems capacity. This process will strengthen absorption capacity and improve budget execution rates. Promote on-budget rather than off-budget support to provide more flexibility for allocating resources where they are needed.

**Box 1: A robust international body of evidence exists regarding the economic returns of investing in health.** The Lancet Commission on Health estimated that in 2000–2011, the value of annual increases in life expectancy was equal to a 1.8% annual increase in GDP – a very large return on investing in health (Jamison et al., 2013). Another recent study found that increasing health expenditure by as little as USD 5 per person per year until 2015 in 74 high-burden countries could yield up to nine times that value in economic and social benefits (Stenberg et al., 2014). Despite the need for spending in other sectors, healthcare expenditures and a population with improved health status can benefit all sectors. These include macro-level returns (increased economic growth, increased productivity, lower dependency ratio, lower unemployment, etc.) and micro-level returns (increased school attendance and performance, increased wages, etc.). Improved health and nutrition in children has been found to yield returns in the form of furthered education, increased wages, improved cognitive development, and even increased self-confidence and social participation (IMF, 2004). Better health can positively affect other sectors, such as education, agriculture, and infrastructure. A healthy workforce produces better outputs and reduces sick days by 2.3 days each year (Cutler and Lleras-Muney, 2007). The benefits are reinforcing: better education leads to healthier behaviors and improved health outputs. Increased levels of education can lower the risk of heart disease by 2.2 percentage points (base level 31%) and that of diabetes by 1.3 percentage points (base level 7%), a real benefit for a country with a growing NCD burden (Cutler and Lleras-Muney, 2007).
ANNEX A. SUMMARY OF HEALTH STATUS AND HEALTH SYSTEMS ANALYSIS

A1. Health outcomes and future health needs

**Afghanistan has made considerable progress on the MDGs of reducing child mortality and improving maternal health.** The under-five mortality rate was reduced from 257 deaths per 1,000 live births in 2002 to 55 in 2015, surpassing the MDG target of 93 (Table 4) (UN, 2015). The maternal mortality ratio was reduced from 1,600 deaths per 100,000 live births in 2002 to 396 in 2010, slightly short of the MDG target (315) (Afghan Public Health Institute et al., 2011).

**Progress on communicable disease was less promising.** The number of reported HIV cases increased from 489 in 2008 to 1,529 in 2012, partly due to improved case detection, but also to a low level of knowledge and inconsistent use of condoms (National AIDS Control Program, 2014; Todd et al., 2011). The prevalence rate of TB was 340 per 100,000 people in 2014, well above the target of 224 (WHO, 2015a). The incidence rate of malaria decreased slightly, from 1.48% in 2000 to 0.79% in 2013, close to the MDG target of 0.7% (WHO, 2015d).

**Table 4: Progress on the health Millennium Development Goals**

<table>
<thead>
<tr>
<th>Goal</th>
<th>MDG baseline value</th>
<th>2015 value</th>
<th>2015 MDG target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 4: Reduce Child Mortality</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under-five mortality rate (per 1,000 live births)</td>
<td>257 (MoPH, 2002)</td>
<td>55</td>
<td>93</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>165 (MoPH, 2002)</td>
<td>45</td>
<td>46</td>
</tr>
<tr>
<td>Measles immunization, children under 12 months</td>
<td>35%</td>
<td>75%</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Goal 5: Improve Maternal Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100,000 live births)</td>
<td>1,600 (MoPH, 2002)</td>
<td>396</td>
<td>315</td>
</tr>
<tr>
<td>Proportion of births delivered by a skilled provider</td>
<td>6.0%</td>
<td>50.5%</td>
<td>43%</td>
</tr>
<tr>
<td>Fertility rate (live births per woman)</td>
<td>6.2</td>
<td>5.3</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>Goal 6: Combat HIV/AIDS, Malaria, TB, etc.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>10%</td>
<td>22.5%</td>
<td>50%</td>
</tr>
<tr>
<td>Incidence rates of malaria</td>
<td>1.48%</td>
<td>1.53% (2012)</td>
<td>0.7%</td>
</tr>
<tr>
<td>Prevalence rates of TB (per 100,000 population)</td>
<td>671</td>
<td>340</td>
<td>224</td>
</tr>
</tbody>
</table>

Sources: CSO et al., 2016; UN, 2015; WHO et al., 2015; World Bank, 2016b.

**Afghanistan is facing a double burden of disease.** Communicable diseases continue to account for a large share of the burden of disease in Afghanistan, but NCDs are increasing rapidly. The Global Burden of Disease Study found that communicable diseases accounted for nine out of the 10 leading causes of years of life lost (YLLs) in 1990 and four in 2013 (IHME,
However, NCDs such as heart disease and cerebrovascular diseases increased significantly between 1990 and 2013, which means that the health system will need to complement a traditional focus on communicable diseases with investment in the health system for prevention and treatment aimed at the growing burden of NCDs.

Other social sectors have seen improvements in the last decade. Access to improved water sources increased from 40.8% in 2006 to 55.3% in 2015 (World Bank, 2016b). More than three-quarters (77%) of children attend primary school, and 64% reach their final year in primary school, which contributed to an increase in the literacy rate of 15- to 24-year-olds to 47% in 2011 (MoE, 2013). These improvements suggest that investment in the social sectors in Afghanistan can engender progress.

The population is growing quickly, and the population pyramid is dominated by youth, which will increase the pressure on the health system. The estimated population of Afghanistan in 2015 was 32.5 million (UN DESA, 2015). It is projected to increase to more than 50 million by 2040 (UN DESA, 2015). Afghanistan has a life expectancy of 61 years. The country’s population is very young; 44% of the population is under the age of 15, and only 2% is 65 or older (World Bank, 2016b). Afghanistan’s dependency ratio of 87% in 2015 was among the highest of countries in the region: Nepal (64%), Iraq (79%), India (53%), Iran (40%), and Pakistan (66%) (World Bank, 2016b). Demographic changes can affect fiscal space in different ways. A high dependency ratio puts pressure on the government to contribute to the financing and provision of social services. On the other hand, a low dependency ratio is a key driver of economic growth (Bloom and Williamson, 1997; Bloom et al., 2010).

A2. Health service delivery

Afghanistan’s health system has progressed over the last 13 years, with increasing coverage of primary healthcare services. The public health system of Afghanistan consists of 15,171 health posts, 579 sub-health centers, 147 mobile health teams, 834 BHCs, 405 CHCs, 80 district hospitals, 28 provincial hospitals, and six regional and 29 specialized/national hospitals (Figure 9) (MoPH, 2016b). The MoPH operates health facilities in Kapisa, Panjsher, and Parwan provinces. Provision of health services in the remaining 31 provinces has been contracted out to NGOs through implementation of the BPHS, starting in 2003, and the EPHS, starting in 2005 (Blakman and Lwin, 2013). Evidence suggests that implementation of the BPHS has contributed to an increase in access to primary healthcare services in rural areas (Newbrander et al., 2014).
The private sector plays a significant role in the delivery of health services. As described above, NGOs have been contracted to deliver the BPHS and EPHS. There is also a considerable for-profit sector, particularly in urban areas. The 2010 Afghanistan Mortality Survey (AMS) found that private providers accounted for 1.6 outpatient visits per person per year on average—double the number of outpatient visits to public facilities, at 0.8 (Saeed et al., 2014). The public sector was used more frequently for inpatient care (0.4 visits per year on average) than private providers (0.1). The population often consults private providers who operate in the informal sector—for example, drug sellers; thus, many individuals and households purchase health services and goods in an unregulated market.

There are still challenges in access and utilization of health services. A large proportion of the population still does not have close access to a health facility. About 60% of the population lives more than one hour away from a health facility with BPHS (MoPH, 2014a). The Afghanistan Demographic and Health Survey (DHS) 2015 found that 58.5% of children have received all of their basic vaccinations, which means there is a need to increase such efforts (CSO et al., 2016). Only 23% of currently married women are using any family planning method. Only 59% of women who gave birth in the last five years received antenatal care from a skilled provider, and only 18% of women had the recommended four antenatal checkups.
There are considerable inequalities in the utilization of health services. Only 38.4% of children under five in the poorest quintile had received all basic vaccinations, compared to 55.5% in the richest quintile (CSO et al., 2016). The inequalities in maternal healthcare are even more pronounced; only 24.0% of the births of women in the poorest quintile were attended by a skilled provider, compared to 85.2% of women in the richest quintile. For 2012–13, the Afghanistan Health Sector Balanced Scorecard found that outpatient visits were slightly pro-poor and client satisfaction was neither pro-poor nor pro-rich (MoPH et al., 2013). However, these findings may reflect very different expectations among the poor and the rich. There were no significant changes in equity performance compared to the 2011–12 scorecard.

Quality of care remains a major concern. Evidence suggests that the quality of health services is often poor. Of all BHCs, only 83% provide at least half of the required services recommended for maternal, newborn, and child health (WHO, 2015b). Only 81% of health facilities possess the necessary medical equipment available and more than one-third of facility buildings do not meet quality requirements. Additionally, blood transfusions are available in less than half of all district hospital CHCs. The proportion of provinces meeting the lower benchmarks for the quality score of the Afghanistan Health Sector Balanced Scorecard decreased from 82% in 2012 to 65% in 2013 (MoPH et al., 2013).

The government has made efforts to improve quality of care. In 2011, the MoPH launched the Afghanistan National Strategy for Improving Quality in Health Care to improve patient safety, strengthen the data recording and reporting system, improve clinical practices, and build the system’s capacity to improve continuously (MoPH, 2011c). The MoPH is currently finalizing an assessment of health system quality.

A3. Health workforce

There is a shortage and uneven distribution of qualified health workers. Afghanistan had 7.3 physicians, nurses, and midwives per 10,000 people in 2010 – considerably below the WHO recommendation of 23 (MoPH, 2011a; WHO, 2014). Despite a considerable increase in the training of nurses and midwives scheduled in 2011–2015, the ratio was expected to increase to only 9.1 in 2015 (MoPH, 2011a). Women are important resources for health facilities, especially in a country with such a high maternal mortality rate and where women tend to be more comfortable with female doctors. In Afghanistan, only 28% of the total health workforce is female, suggesting that the share of female doctors and nurses is very low. The workforce is also distributed unequally between rural and urban areas. In 2010, there were 16.7 public health workers (including unqualified support staff) per 10,000 people in rural areas, compared to 36 per 10,000 in urban areas. More qualified health workers work in private facilities, which are mostly located in urban areas. There are also significant regional differences. Of the country’s seven regions, the Central Region has a ratio of four times as many health workers to population as the South Region. Degree courses for dentists, pharmacists, nurses, and technicians are offered only in Kabul (MoPH, 2011a).

A4. Health financing

The largest share of total health expenditure comes from OOP expenditure, followed by donors and the government. The latest NHA estimate that total health expenditure was USD 1.9 billion in 2014, equivalent to USD 70.9 per capita and 9.5% of GDP (MoPH, 2016a). OOP expenditure accounted for 71.8% of total health expenditure, whereas external donors contributed 23% and the government 5%. The shares of the three main financing sources remained relatively stable in 2009–2014 (Figure 10). Government spending on health accounted for 4.3% of total government expenditure and 0.48% of GDP (MoPH,
Potential Avenues to Increase Government Investment in Health in Afghanistan: Fiscal Space Analysis

2016a). OOP expenditure was distributed as follows in 2014: 25% on curative and rehabilitative care, 17% on ancillary care (almost exclusively on patient transportation), and 58% on medical goods (primarily pharmaceuticals). OOP expenditure in Afghanistan is considerably higher than in other countries in the region (WHO, 2016a).

**Figure 10: Main health financing sources, 2009–2014**

![Graph showing main health financing sources, 2009–2014](image)

Source: MoPH, 2016a.

**OOP expenditure on healthcare is a significant problem for a large share of the population.** The 2015 DHS found that the second most common reason for not seeking care outside of the home was that services were too expensive (24.1%) (CSO et al., 2016). About 48.2% of those hospitalized in the 12 months before the survey reported some form of distress financing, and 12.3% reported some form of severe distress financing to pay for these costs.

**In addition to low government financing of healthcare, the high rate of OOP expenditure is a result of the lack of risk pooling and prepayment mechanisms.** No financial risk protection system currently exists in Afghanistan, and there is an urgent need for increased government financing and other forms of risk pooling and prepayment mechanisms (MoPH, 2014a). However, there are plans to introduce health insurance, and a feasibility study was published recently (Health Policy Project, 2015). The feasibility study examined various national and community-based schemes to identify the benefits and drawbacks of different models, as well as the political and legal realities of introducing public health insurance. It found that clear guidance on setting up, implementing, and managing public health insurance needs to be developed, the quality of healthcare facilities needs to be improved to ensure public buy-in, and the general idea of pooled payment will need to be promoted.

**There is limited strategic purchasing of health services, but the MoPH is studying the potential use of global budgeting for hospitals.** The current payment mechanism in
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national hospitals in Afghanistan is based on a line-item budget. Implementing this payment system is relatively simple, but there is no link between outputs and the payment mechanism (inputs). The line-item budget can be adjusted slightly each year but is usually determined based on historical budgets and execution rates. Providers have limited flexibility to transfer funds across line items, and often there is no space for introducing initiatives for better performance and quality improvement under this mechanism. To address these limitations, the MoPH is considering a global budget payment mechanism pilot. Services in the BPHS and EPHS are delivered through performance-based financing (PBF) contracts with NGOs. The PBF approach includes an intensive data verification process, focusing on both the quantity and quality of delivered services to ensure that providers reach performance thresholds and disburse performance payments (Cashin et al., 2015).

**Hospitals account for the largest share of total health expenditure.** In 2014, the largest share of total health expenditure by provider was incurred in hospitals (40%), followed by outpatient care centers (25.5%) and retailers, such as pharmacies and informal drug sellers (24.9%) (MoPH, 2016a). Administration of public health programs and general health administration made up 4.3% and 4.4%, respectively.

**Inequalities exist in public spending on healthcare at the tertiary hospital level, but spending on primary care is pro-poor.** A benefit incidence analysis (BIA) conducted in 2013 found that overall public spending was mildly pro-poor, as reflected in a concentration index of -0.0515 (MoPH, 2013a). However, public spending was significantly pro-rich in national, regional, and provincial hospitals, accounting for 40% of total public spending by health facility level. For example, the share of public spending benefiting the poorest quintile is only 5.9% in national hospitals, compared to 35.0% for the richest quintile, thus implying that spending on inpatient care in hospitals greatly favors those financially better off. Spending at district hospitals, health centers, and health posts was pro-poor because a disproportionate share of the poor utilizes those services.

**Medicines account for almost half of total health expenditure.** In 2014, pharmaceuticals accounted for the largest share of total health expenditure by inputs, at 42.5%. This number represents a significant increase from 2009 (28.0%) and 2012 (26.0%) (MoPH, 2016a).

**A5. Health management information system**

**Health data are reported using a comprehensive bottom-up system.** The MoPH uses a variety of tools to track health information. HMIS data from health posts, BHCs, CHCs, and district hospitals (DHs) are consolidated at the provincial level, where reports are monitored for completeness. Health facilities are contacted for missing reports and errors. Reports are then forwarded to the central HMIS Unit of the MoPH each month. In 2005, the HMIS was updated and now includes provincial data collected by NGOs (MoPH, 2006). The inclusion of a PBF scheme in the provision of healthcare in Afghanistan required some work on strengthening the HMIS to ensure that reported figures were accessible and could be verified (MoPH, 2010). In 2010, the HMIS unit was given oversight of all health information and is now responsible for

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5 The concentration index is a summary measure of inequalities in health. The index takes a negative value when there is a disproportionate concentration of the health variable among the poor. Regarding the BIA analysis, it means that spending on national, regional, and provincial hospitals disproportionately benefits those financially better off, whereas spending in other levels of the health system benefits the poor. For a detailed discussion of the concentration index and other health inequality measures, see O'Donnell et al., 2008.
managing all data coming into the central level, including the EMIS, and the human resources management information system (HRMIS) (AeHIN, 2016). An ongoing challenge is ensuring that data collected from facilities are complete, timely, accurate, and used to inform program planning and implementation.

The implementation of a web-based health information system is constrained by uneven internet access. The MoPH has started implementing a web-based reporting system. If internet access is available, data are entered into the computer at the provincial level and forwarded electronically. This level of integration allows the central government to receive the most up-to-date information available and provides implementing agencies with updated analysis of health trends and outputs (MoPH, 2006). However, due to lack of internet coverage in some areas, data are still submitted to the central level in hard copy form (MoPH, 2006).

A6. Medicines

Afghanistan is dependent on imports to meet its needs for drugs. Less than 5% of drugs sold in Afghanistan are produced domestically (MoPH, 2014c). Afghanistan therefore imports drugs from several countries, including Pakistan (24%), India (20%), Iran (17%), and China (11%) (Karwar et al., 2011), suggesting it is sensitive to changes in the international prices of drugs, as sudden increases would reduce what the country can purchase with its health sector resources.6

Drug stockouts are a considerable problem in the public sector and tend to push patients to the private sector. Medicines, instruments, equipment, and health supplies (mainly financed by donors) are stored in the Central Medical Store (CMS) at the national level and then distributed to the specified hospitals throughout Afghanistan via 35 public warehouses in the secondary tier of the public sector’s distribution network (MoPH, 2013b). A 2011 study found that the percentage of availability of key medicines at the CMS is 80% (MoPH and WHO, 2011). A 2009 USAID study of drug prescription and use in 14 primary healthcare facilities and 14 hospitals in five provinces found a significant variation in stockouts for primary health facilities, with an average stockout of 6.6 days per month for 15 key medicines (Green et al., 2009). Hospitals experienced an average stockout of 8.7 days per month. As a result of such stockouts, patients are forced to turn to the private sector to meet their needs for medicines, including both formal private sector facilities and informal providers, such as grocery stores or street stalls. Purchase of pharmaceuticals and medical goods represent 57% of total household health expenditure (MoPH, 2016a).

The evidence on drug prescription practices is mixed. A study by USAID found that generic drugs accounted for very high proportions of prescribed drugs in primary healthcare facilities (96%) and hospitals (88%), and the national essential drugs list was followed almost exclusively (98%) in primary healthcare facilities (Green et al., 2009). However, the study also identified significant overuse of antibiotics in primary healthcare facilities. The average percentage of patients receiving antibiotics was 58% (range 39–80%) in primary healthcare facilities and 90% in hospitals – relatively high based on international comparisons. A WHO study of 35 countries found that an average of 45% (range 22–77%) of patient visits included a prescription for drugs (WHO, 2004). The high use of antibiotics in Afghanistan is due to poor knowledge about antimicrobial resistance; incentives to health workers; and pressure from the population to prescribe drugs, including antibiotics, during visits to health facilities.

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6 Analysis of the potential vulnerability of this dependence on drug imports is outside the scope of this report.
The evidence on the quality of medicines is mixed. A 2011 study of 348 pharmaceutical samples from public and licensed private facilities found that 89% of drugs in public facilities and 92% of drugs in private facilities were compliant with International Pharmacopeia standards (Karwar et al., 2011). However, the fact that many individuals procure drugs from unlicensed vendors, such as local street stalls, is a significant problem because there is no quality control of drugs in those outlets (MoPH and WHO, 2011).

A7. Governance

The governance structure is designed to promote a more inclusive system determined by local needs, but capacity varies, leading to mixed results. Community health workers (CHWs) work closely with CHCs, BHCs, and DHs to ensure coordination of their common goals and activities. CHCs, BHCs, and DHs are governed by provincial offices, which, in return, report to the central government. This bottom-up approach to local healthcare needs is informed by the HMIS. Provincial health offices hold quarterly meetings with facility managers to determine needed services and resources, and synchronize activities. However, capacity varies between provinces and facilities. Financial autonomy has been piloted in some facilities (USAID, 2015a).

Stewardship of the health system is improving as capacity is increased at the central level. There is a continued focus on strengthening the governance capacity of MoPH staff and health workers. Governance guidelines were developed and distributed under the USAID Leadership, Management, and Governance Project in 2014, offering direction to the managers at provincial and district levels that focuses on effectiveness, efficiency, transparency, and accountability (USAID, 2015b). The central government is focusing on increasing transparency and accountability, especially on management of financial resources, supported by tools like AFMIS or EMIS.

The political situation is unstable, which affects the capacity to implement policy reforms and deliver social services. After years of conflict and civil war, Afghanistan began rebuilding in 2002 with the support of large aid flows. A new constitution was approved in 2004, and the effort to build democratic institutions began. Despite significant progress, there are still considerable constraints to development due to political instability, which makes policy making harder, slows economic recovery and poverty reduction, and in recent years has contributed to increased emigration.

Security constraints affect the functioning of the state and the provision of social services. The security situation continues to be extremely unstable in Afghanistan. Frequent attacks and bombings occur, targeted at the general population, troops, politicians, and public service providers. A recent UN report estimated that 90,000 children have missed their immunizations due to the security situation (UN, 2016b).
ANNEX B. DISTRIBUTION OF NATIONAL BUDGET BY SECTOR

As illustrated in Figure 11, the security sector accounted for nearly two-thirds (63.6%) of the government’s operating budget in 2016, followed by education (13.6%) and social protection (7.7%) (MoF, 2016b). The health sector received only 1.1% of the operating budget. As illustrated in Figure 12, infrastructure accounted for the largest share (50.1%) of the development budget in 2016, followed by agriculture (16.1%), education (12.5%), and health (10.8%).

Figure 11: Operating budget by sector, 2016

Source: Ministry of Finance, 2016a.
Figure 12: Development budget by sector, 2016

- Infrastructure, 50.1%
- Agriculture and rural development, 16.1%
- Education, 12.5%
- Health, 10.8%
- Economic governance, 5.3%
- Social protection, 1.1%
- Contingency budget, 1.3%
- Security, 0.9%
- Governance, 1.8%

Source: Ministry of Finance, 2016a.
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