# Beyond fiscal space: what does state capacity mean for health financing?

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The achievement of universal health coverage (UHC) is usually framed as a financing problem in terms of how much governments are willing to spend on care. Our research showed that this framing is incomplete. Whether healthcare systems are adequately and equitably financed depends not only on the volume of financial resources, but equally on the underlying capacity of the state to raise, allocate and manage these resources. This is known in the politics and governance literature as state capacity – the power of governments and associated agencies to implement and execute policies effectively and efficiently. State capacity is a much broader concept than financial capacity and encompasses the administrative, legal and coercive functions of the state.

Around 4.5 billion people worldwide still lack full access to essential health services, and out-of-pocket (OOP) payments push tens of millions into poverty each year. Health-financing reform sits at the heart of the UHC agenda, but such reforms depend crucially on the capacities that institutions can actually deliver: bureaucracies that execute budgets, courts that uphold contracts, systems that limit wasteful loss or siphoning away of resources from their intended use. In fragile and low-income

settings these institutions are often the binding constraint, yet they rarely feature in mainstream health-financing debates.

Our research considered seven dimensions of state capacity which we examined individually and also combined into an aggregate index: bureaucratic quality, control of corruption, rule of law, civilian control of government, government effectiveness, property rights and state fragility. We used data for 141 countries, 49 of which were low- and middle-income countries (LMICs), over the period 2000–2020, including well-established governance and health-financing datasets (ICRG-PRS, V-Dem, Quality of Government, WHO's Global Health Expenditure Database and the World Development Indicators). We developed models to analyse the relationship between these state capacity parameters and government health expenditure per capita and the household OOP share of current health spending. Our methods took account of a range of other factors that could influence spending and OOP shares to isolate the effect of state capacity, as well as ensuring that we were not capturing any effects working in the opposite direction, whereby higher spending may strengthen state capacity.

We found that stronger state capacity goes hand in hand with higher public health investment and better financial protection. A one-standard-deviation improvement in rule of law, government effectiveness or property rights was associated with 13–31% higher government health expenditure per capita, and with a 1.6–2.8 percentage-point reduction in the OOP share. State fragility works powerfully in the opposite direction: a comparable rise in fragility is linked to roughly a third less public spending on health. Associations were larger in LMICs, and the steepest gains appeared as countries move from low to moderate state capacity.

Our findings reemphasise that progress toward UHC is not only a fiscal challenge, but equally, a system-wide governance challenge. In LMICs, sequencing matters too: strengthening bureaucratic professionalism, procurement systems and legal accountability may be a necessary precursor to improving financial performance, so that additional resources actually translate into better care and lower household financial burdens. Decision-makers need to pay attention to key aspects of state capacity if they wish to ensure that financial resources for healthcare will deliver the desired population health gains.

**Read the full paper, funding sources and disclaimers in BMJ Global Health.**

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