

2025 | Background Brief 0.2

Justice Financing Framework

A Guide to Budgeting and Financing for
People-Centered Justice for the Justice Sector





BACKGROUND BRIEF 0.2

0.2 Lessons for Justice Financing from the Health Sector



Introduction

The Justice Financing Framework suggests countries might want to explore lessons from the health sector, as this is one of the sectors that has successfully scaled up front line services to millions of people in the last twenty-five years. Three key elements to this transformation were: having a clear ambition for universal coverage; prioritizing spending on primary services; and delivering innovative approaches to service provision (such as community health workers).

There are obviously significant differences between health and justice. The scientific evidence base for health is much more developed. The frequency of health interventions is greater: outpatient visits are on average one for every person each year, whereas a non-trivial core legal need occurs once every eight years. However, many of the principles remain the same and the core issue of how to make the best use of available resources is a fundamental concern in both sectors.

This background brief draws on an ODI Global [Working Paper on financing](#) lessons the justice sector can learn from the health sector in lower-income countries:

- **More Money for Health:** How the sector has increased financial resources, including through user fees.
- **More Health for the Money:** How the health sector improved the quality of spending, including through prioritizing primary health care.

1. More Money for Health

This section looks at lessons for the justice sector from the health sector on how to increase funding. It considers:

- **User fees:** Lessons from the initial rise—and then fall—of user fees in the health sector.
- **Government funding:** Lessons on how the health sector achieved increased domestic funding for primary front line services.

1.1 User fees have largely been abandoned for primary health services

[Background Brief 2.3](#) explores the potential for contributions to costs by beneficiaries and users of the justice sector to boost resources. The experience of user fees in the health sector provides useful lessons.

User fees for primary health services were introduced in lower-income countries in the 1980s during a period of low growth and high debt. Fiscal constraints resulted in insufficient resources reaching front line services, exacerbated by budgets often biased toward hospitals in larger cities. In the 2000s the trend reversed, and user fees were largely removed when evidence of their negative impact on access to services became overwhelming. A review of user fees (focused on the highest quality studies) found that the introduction of charges led to a 28–50 percent fall in service use, while their removal resulted in a 30–50 percent increase. The impact of the removal of user fees was most evident in children and lower-income populations. See Box 1 below for more detail.

Box 1: The Rise and Fall of User Fees in the Health Sector in Lower-Income Countries

In 1987, African health ministers met in Bamako and endorsed user fees for primary health care to help ensure that the entire population could access good quality care at an affordable price. Moves to user fees were also supported by international organizations, including the World Bank. 1987 saw the publication of an influential World Bank report, *Financing health services in developing countries: an agenda for reform*. This first set out the challenges to existing health spending in the form of poorly allocated budgets with insufficient spending on cost-effective activities, inefficiently delivered public health programs by underfunding non-salary recurrent expenditures, and inequity in the distribution of benefits from this spending. The report stated that “slow economic growth and record budget deficits in the 1980s have forced reductions in public spending ... A case certainly could be made for more public spending on health in developing countries ... But in most countries the general budget stringency makes it difficult to argue for more public spending.”

In the absence of increased spending, the World Bank report laid out a four-fold agenda to address these challenges: charging users of government health facilities; introducing health insurance to protect against the costs of expensive curative care; encouraging provision by nongovernmental organizations (NGOs) of health services for which households were willing to pay; and decentralization of services. User fees were thus intended to be part of a broader reform strategy. The report also noted the need to protect the poor through lower or zero charges in clinics in urban slums and in rural areas.

The results of these policy shifts were that by the mid-1990s, most African countries had some form of fee system for government facilities and the World Bank continued to make similar recommendations for health financing in this period. However, evidence began to accumulate that user fees had negative effects: they deterred the poor from accessing services, and did not provide the benefits expected. Moreover, they raised less revenue than expected, and did not lead to the degree of community participation that was originally envisaged.

South Africa abolished user fees when it transitioned to democracy in 1994, followed by a wave of fee abolitions in the 2000s: Uganda in 2001 was followed by Ghana, Zambia, Burundi, Niger, Senegal, Liberia, Kenya, Lesotho, Sudan, and Sierra Leone. The World Bank had also ended its support for this policy by the late 1990s. The 2004 World Development Report, *Making Services Work for Poor People*, an important marker, stated that the World Bank no longer had a blanket policy on user fees. Instead, the focus was on maximizing prepaid financing of health through tax or insurance.

1.2 Increases in health spending have largely been driven by economic growth

The JFF stresses the importance of planning for people-centered justice on the basis of a realistic resource envelope, particularly realism about the prospects of increased government funding (see [Background Brief 5.1](#)). This section considers lessons from government spending on health.

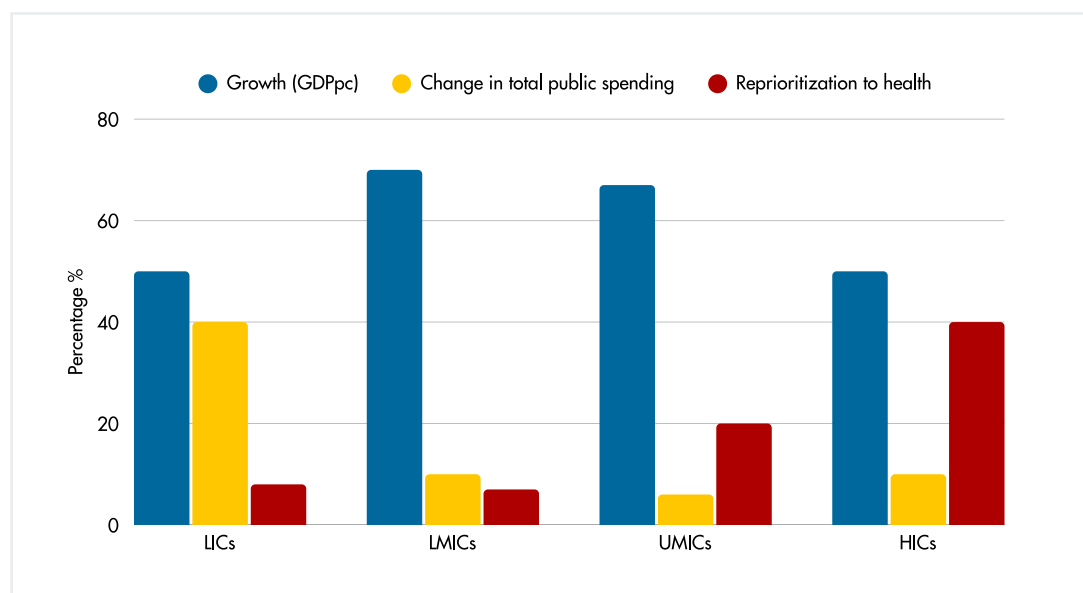
Changes in government spending per person in a given sector can come from three possible sources:

1. Growth (the change in gross domestic product [GDP] per person).
2. The change in overall public spending (government expenditure as a proportion of GDP).
3. The sector's share of government expenditure.

Evidence from the health sector shows that increased funds for primary front line services have largely come from 1) and 2), rather than by re-allocating funds from other sectors to health. Figure 1 below shows increases in health spending before the pandemic (2000–2017) in different country income groups. It can be seen that:

- In low-income countries, increases have been driven by **growth** and by the **increase in overall government spending** as a proportion of GDP.
- In middle-income countries, increases have been driven predominantly by **growth**.
- Only in high-income countries has **reprioritization to the health sector** from other sectors played a major role.

Figure 1: Reprioritization to the Health Sector Has Played Little Role in the Growth of Health Spending in Low- and Middle-Income Countries⁵



These findings are not surprising when put in the context of broader research on budgetary changes. Budgets mostly change incrementally, with only small movements from year to year. Research across a number of European and North American countries has found a pattern of ‘punctuated equilibrium’ in the evolution of budgets: little or no change in most years, with occasional large increases or decreases. Similar patterns have been documented for middle-income countries such as Brazil, Russia, and Turkey. The research shows that large changes happen when a policy area gets onto the political agenda, and the extent of those changes is related to institutional constraints on budgetary decision making, such as executive strength, the degree of federalism or decentralization, the parliamentary system, and how authoritarian or democratic the overall political system is.

The implications are that policies and budgets will usually be stable, apart from periods when they are being reformulated. This also suggests that, in most circumstances, outside of these rare policy windows, there should be a focus on improving the effectiveness of existing levels of spending, rather than seeking to increase the sector’s share of government resources.

⁵ Ajay Tandon et al. “From Universal Health Coverage services packages: From slippery slopes to steep hills: Contrasting landscapes of economic growth and public spending for health,” *Social Science and Medicine* 259 (June 2020), <https://doi.org/10.1016/j.socscimed.2020.113171>.

2. More Health for the Money: Improving the Quality of Spending

This section looks at lessons from the health sector on how countries can improve the effectiveness of their spending. There have been significant international efforts to identify good practices for improving population's health. The key findings consider the importance of:

- Focusing on high-level, people-centered outcomes (addressing people's health problems) rather than on institutions.
- Prioritizing spending on primary services.
- Focusing on cost effectiveness.
- Developing and applying indicators to guide spending.
- Recognizing the need for both political commitment and effective bureaucracies able to innovate, learn lessons, and adapt.

The rest of this section explores these issues, including by drawing on the experience in particular of Thailand, Ethiopia, and Rwanda—three countries that have made huge strides in improving health outcomes and the coverage and effectiveness of primary health services. Annex A provides brief case studies for further elaboration.

2.1 Focusing on high-level people-centered outcomes

The JFF recommends setting high-level outcomes for people-centered justice related to the resolution of people's most pressing justice problems. (See [Background Brief 1.1](#)).

In the health sector, the 2000 Millenium Development Goals (MDGs) focused the health sector's attention on two key health outcomes (reducing child and maternal mortality rates) and reversing the spread of three key diseases (HIV/AIDS, malaria, and tuberculosis). Remarkable progress was made by 2015, with global child and maternal rates falling by half (compared to the MDG baseline of 1990). In 2015, the health MDGs were extended and expanded in the health Sustainable Development Goals (SDGs).

2.2 Prioritizing spending on primary services

The JFF recommends a financing ambition (#2) for spending on primary front line services. (See [Background Brief 3.2](#)).

Financing Ambition #2 draws on the experience in the health sector. A key reason for the global progress in health outcomes was a growing focus on prioritizing primary health care that had developed since the late 1970s (see Box 2 below). The result was the scaling up of primary health care services such as primary health posts, which in turn was associated with a rapid growth in the coverage of key interventions like immunization. Measles vaccination rates rose from less than 20 percent in the early 2000s to over 70 percent by the mid-2020s. Vaccinations alone are estimated to have reduced infant mortality by 40 percent in the last 50 years.

Box 2: The International Process for Focusing Spending on Primary Health Services

In 1978, primary health care was set as a global priority in the Alma-Ata declaration. In 1993, the World Bank focused the World Development Report on health for the first time ever. A key recommendation of Investing in Health was that government spending on health should prioritize cost-effective programs that help the poor, such as the control and treatment of infectious diseases and malnutrition. The report argued that improved prioritization of spending could lead to large reductions in the disease burden in low- and middle-income countries.

After the Millenium Development Goals were adopted in 2000, the World Health Organization (WHO) convened a Global Commission on Macroeconomics and Health which identified essential interventions needed to deliver the MDGs. The Commission noted that most of these could be delivered through primary health care posts and outreach from these posts. The Commission also costed the interventions and estimated the minimum per capita spend required to deliver them.

The MDGs were extended and expanded in the 2015 Sustainable Development Goals. It was estimated that up to 75 percent of the projected health gains in the SDGs could be achieved through primary health care.

Both the World Bank and WHO have developed costing estimates for providing an essential set of universal care health interventions, and WHO has also identified required levels of primary health care spending. These have prompted proposals by an independent commission for a minimum health spend per person.

A key aspect of this approach has been an ongoing evolution at the international level of the definition of what such 'primary' or basic services should look like (see Box 3 below).

Box 3: Ongoing Evolution of the International Definition of Primary Health Services

The process of achieving a global definition of primary health care has continued to evolve over the past forty years:

- The Alma-Ata declaration on primary health care encompassed contributions from other sectors to address social determinants of health (such as education, water, and sanitation).

- WHO's Global Commission for Health in 2001 identified the most essential interventions needed to deliver the Millenium Development Goals, nearly all of which were primary health care interventions.
- When the Sustainable Development Goals were agreed to in 2015, the concept of an essential health package was developed with WHO researchers. It identified 200 specific health interventions, 91 percent of which would be delivered by primary health care services, including public health mass media, community health workers and services, and local health posts and centers.
- Despite the focus on primary health care, there is still no global consensus on the definition. Neither the globally recognized System of Health Accounts nor the collective United Nations (UN)/Organisation for Economic Co-operation and Development (OECD)/International Monetary Fund (IMF) has agreed upon classifications of government functions to define "primary health care." The OECD and WHO have different definitions, the key differences being the extent to which hospital-based treatments are included (e.g., outpatient services) and whether part of the overall administrative costs should be included.

Building on this experience, the JFF recommends a financing ambition for minimum spending on primary front line justice services, based on an agreed high-level definition of what comprises these services (see **Background Briefs 3.1** and **3.2**).

The experience of the health sector demonstrates that in addition to increasing budget allocations to primary services, active measures need to be taken to ensure these resources reach the front lines and are well spent. More visibility in budgetary allocations, in tandem with a clear and context-specific operational definition of primary services, can improve tracking and enable accountability. Other measures include service delivery arrangements, such as explicit service standards. In some countries, new cadres of front line primary health providers have enabled more resources to be directed to primary health care. Finally, as institutional responsibility can be fragmented across central ministries and subnational governments, there needs to be clarity for where budgeting and planning responsibility lies in the Ministry of Health (see **Background Brief 5.2** for broader discussion of the importance of transparency and accountability).

2.3 Focusing on cost-effectiveness

There is a growing international focus on cost-effectiveness in health sector interventions. In 1993, alongside the World Bank's World Development Report Investing in Health, the first edition of Disease Control Priorities was the first systematic attempt to assess the cost-effectiveness of different interventions against the major diseases in low- and middle-income countries. The Report has been updated in 2006, 2017, and 2025. Building on this, the **essential health package** concept defines a set of cost-effective health interventions. However, challenges remain in the health sector in many countries where essential health packages have been developed with no attention to budget constraints. In these contexts, the cost of providing the package routinely exceeds available resources.

The achievements of Ethiopia and Rwanda in scaling up access to primary healthcare services is strongly linked to their focus on cost-effective 'task shifting,' i.e., delegating tasks to new cadres of community health workers. This approach improves population health by expanding service coverage, while the added efficiency improves the overall productivity of the health system.

As retired chief justice of the Supreme Court of Texas W.B. Jefferson has noted, there are direct parallels here between expanding access to health services and expanding access to justice:

Time and again, the profession has rejected reform efforts in the name of protecting core value. But as commentators have asked: '[W]hat good are the profession's core values to those who do not make it through the lawyer's office door?' Many of these reforms echo those experienced by the medical profession. Just as that model has moved away from services provided by physicians and toward those given by physician's assistants and nurse practitioners, we could similarly rely more on trained non lawyers to provide many of the services for which a lawyer is now required. Perhaps, '[a]s the medical profession has learned, it may be necessary to live with the ethical tension of encroachments on professional autonomy in order to make professional services available to a wider class of society.'⁶

Cost-effectiveness for people-centered justice is discussed in [Background Brief 3.4](#).

2.4 Developing and applying indicators to guide spending

The use of outcome targets and coverage indicators is central to the health SDGs, with the WHO index being the core coverage indicator (SDG3.8.1). The WHO index combines data on coverage and access of services addressing reproductive, maternal, newborn and child health; infectious diseases; and noncommunicable diseases. Effective coverage is defined as the proportion of people in need of services who receive services of sufficient quality to obtain potential health gains.

⁶ Commonwealth of Australia. "Liberty and Justice For Some: How the Legal System Falls Short in Protecting Basic Rights." *New York University Law Review* 88, no. 6 (2013), 1979–1980. Cited in the Australian Government Productivity Commission, "Access to Justice Arrangements: Overview Inquiry Report No. 72," September 2014, <https://www.pc.gov.au/inquiries/completed/access-justice/report/access-justice-overview.pdf>.

Such outcome targets and coverage indicators also help countries identify where additional spending is required, with Thailand a clear example of the impact this can have (see the Annex for details). In addition, output and input indicators also help identify gaps in access and equality, such as:

- Percentage of population living within ten kilometers of a primary health care center.
- Ratio of health workers to population.
- How the health worker ratio varies across the country.

Indicators for people-centered justice are discussed in [Background Brief 1.1](#).

2.5 Recognizing the need for both political commitment and effective bureaucracies able to innovate, learn lessons, and adapt

In 1985, the Rockefeller Foundation published *Good Health at Low Cost* to understand why four countries/regions then seen as success stories—China, Costa Rica, Sri Lanka, and the Indian state of Kerala—had achieved better health outcomes than other countries at similar income levels. Revisiting the publication twenty-five years later with the addition of a further five countries (Bangladesh, Ethiopia, Kyrgyzstan, the Indian state of Tamil Nadu, and Thailand) demonstrated that attributes of success included “good governance and political commitment, effective bureaucracies that preserve institutional memory and can learn from experience, and the ability to innovate and adapt to resource limitations.”⁷

The successes achieved in Thailand, Ethiopia, and in expanding access to health care and improving outcomes was linked to their respective governments’ effective use of evidence to focus on expanding the most cost-effective services. A clear lesson can be drawn from the importance of strong political will for change, providing the authorizing environment for talented technocrats to use the best evidence available to design effective programs.

7 Balabanova et al., “Good Health at Low Cost 25 years on: lessons for the future of health systems strengthening,” *The Lancet*, 381, no. 9883 (2013): 2118–2133, [https://doi.org/10.1016/S0140-6736\(12\)62000-5](https://doi.org/10.1016/S0140-6736(12)62000-5).

Annex: Country examples

Thailand

Thailand has been seen as a pioneer of universal health coverage since the introduction of its universal coverage scheme (UCS) in 2001. This reform was accompanied by two important health financing reforms:

1. To ensure that the scheme was properly funded, it was accompanied by changes in how the health budget was set.

Instead of the usual bilateral negotiation between the finance and health ministries, an annual budget request is now made using a formula to estimate the financing needs of the UCS. These are estimated on a per capita basis. The three parameters used to reach this estimate (use rate, unit cost, and target population) are peer-reviewed and agreed to based on consensus by a multistakeholder budgeting subcommittee appointed by the National Health Security Board. This has resulted in improved budgeting transparency: rather than just a bilateral process, the Bureau of Budget is just one among many stakeholders who verify evidence and approve estimates. The process also provides greater evidence to use in guiding budget allocations.

2. Thailand instituted an evidence-based, systematic process for determining which services would be included in the UCS coverage package based on cost-effectiveness, budget impact, and other criteria.

Thai officials created a Health Intervention and Technology Assessment Program (HITAP), which is now an autonomous research institute in Thailand. Known for its expertise in health technology assessment (HTA), HITAP provides evidence to support Thailand's universal coverage benefits package for medicines, health services, programs and procedures, and vaccines through collaborations with policymakers such as the National Health Security Office and the Thai Ministry of Public Health. HITAP has a proven track record in HTA research, especially economic evaluations, continuously impacting Thai public health policy. HITAP is widely regarded as a "star in the east." It is important to note that the establishment of HITAP followed, rather than preceded, the Universal Coverage Scheme. The UCS's enormous additional costs and implications for public expenditure—health spending increased by around USD 1 billion, or a 38 percent increase, when the scheme was introduced in 2002—led to the demand for evidence that could help control costs, as well as price negotiations with suppliers of pharmaceuticals and other medical supplies.

New Zealand

In the early 2000s, the New Zealand government introduced a new primary health care strategy centered on a shift away from funding based on fee for service to funding based on population:

The government established a new type of not-for-profit entity which enlisted primary health care providers on a voluntary basis. This allowed the health system to shift to universal weighted capitation at the primary health organization level. The shift ensured that all citizens could receive subsidized care in a way that accounted for need. The move to capitation was also designed to control government expenditure on primary health care and expand the range of services that could be delivered by nurses. Large decreases in unmet need for general practitioner services were observed in the first five years.⁸

Brazil

The Family Health System in Brazil scaled up the provision of primary health care over the last twenty years through multidisciplinary teams which provided community-based services in a geographical area.⁹ This move transformed the way health care services are delivered in Brazil, and was financed through a direct transfer from the federal level to municipalities, known as 'Floor for Basic Care.' The transfer was calculated at a fixed per-capita amount based on municipal population, with allowance for more funds to be allocated to more deprived municipalities. The number of Family Health System teams grew from 2,000 to 43,000 between 1998 and 2020, covering two thirds of the population. A number of studies have pointed to the effectiveness of these health services in improving health outcomes, improving access to health services, and reducing health inequalities.

Ethiopia

Ethiopia's health extension program has been hailed for providing "good health at low cost." A key component of this has been the recruitment of over 30,000 community health extension workers and the construction of more than 2,500 health centers and 15,000 village health posts. Expanded service coverage and improved health practices has been led to significant improvements in maternal and child health, communicable diseases, and hygiene and sanitation.

8 Kara Hanson et al., "The Lancet Global Health Commission on financing primary health care: putting people at the center," *The Lancet Global Health* 10, no. 5 (2022), e715–e772, [https://doi.org/10.1016/S2214-109X\(22\)00005-5](https://doi.org/10.1016/S2214-109X(22)00005-5).

9 Ibid.

Rwanda

Rwanda has made rapid progress on reducing child and maternal mortality by focusing on rapidly scaling up cost-effective interventions such as vaccinations, treatment of childhood illnesses, maternal care, and malaria and HIV/AIDS control programs. This was achieved through a combination of the shift to payment by results, the expansion of community-based health insurance, the provision of services at relatively local health centers, and the recruitment of 45,000 community health workers.



Appendix of Background Briefs

Introduction and Purpose

0.1 Justice Financing Framework: Introduction and Purpose

0.2 Lessons for Justice Financing from the Health Sector

People-Centered Culture and Purpose

1 Setting High-Level People-Centered Justice Objectives

1.1 Outcomes Focused on the Resolution of People's Justice Problems

"More Money for Justice"

2 Assessing the Scope for Increasing Resources

2.1 Financing Ambition #1: Justice Sector Share of Total Government Expenditure

2.2 Judicial System Share of Total Government Expenditure

2.3 Contributions to Costs by Beneficiaries

2.4 Private Sector Investment in Justice

2.5 Financing Ambition for Countries in Receipt of Significant External Development Support

"More Justice for the Money:" More Justice Outcomes from Available Resources

3 Setting Spending Priorities in Line with People-Centered Justice Objectives

3.1 Defining Primary Front Line Justice Services

3.2 Financing Ambition #2: Primary Front Line Justice Services

3.3 Financing Ambition #3: Information, Advice, Assistance, and Informal Dispute Resolution

3.4 Scalable Best Value-for-Money Activities

4 Improving Efficiency and Effectiveness of Spending

4.1 Governance and Regulation of Justice Services

4.2 Financing Ambition #4: Research, Development, Governance, Evidence-Based Practice, and Continuous Improvement

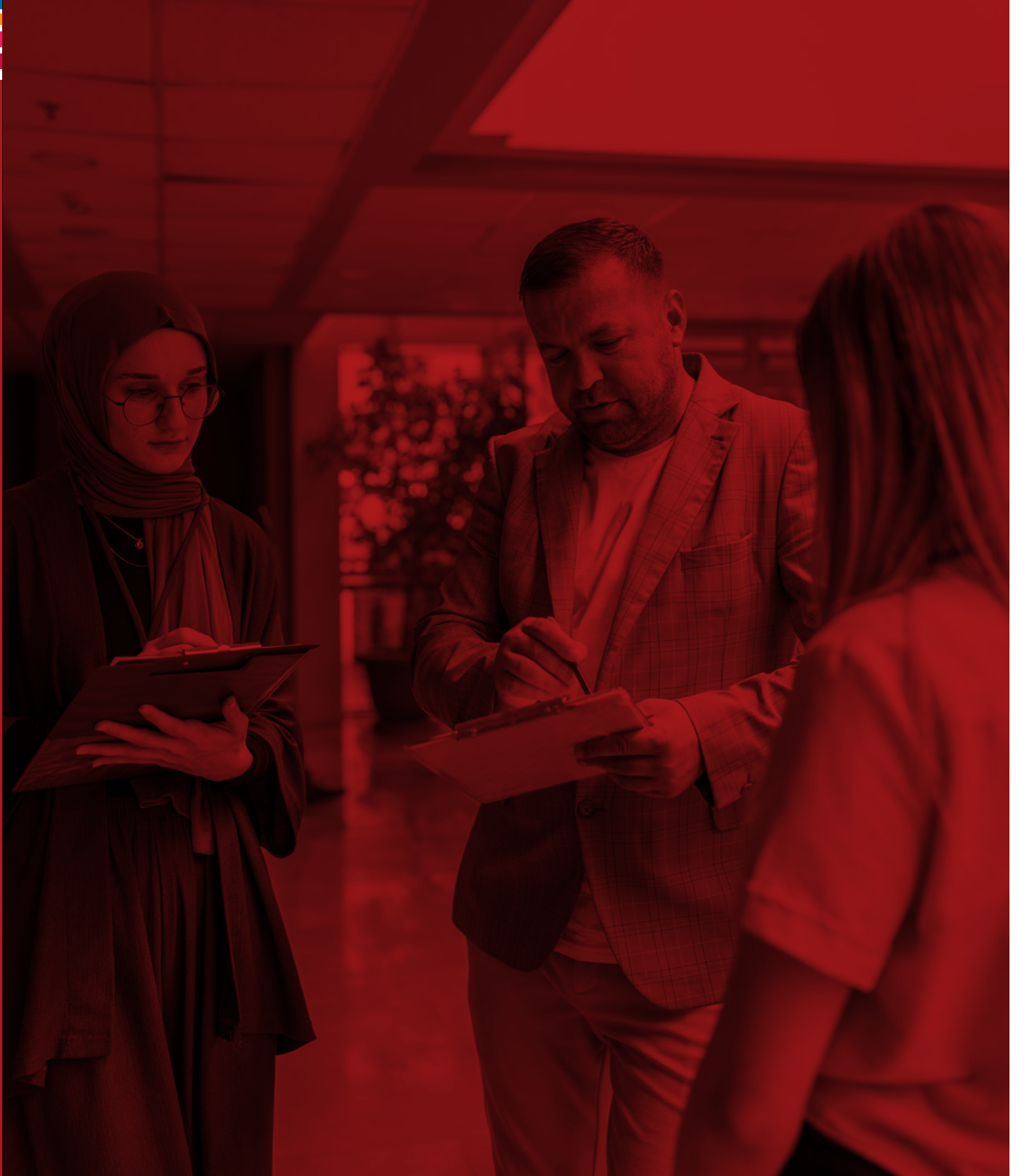
4.3 Systematic Efficiency and Effectiveness Expenditure Reviews

Implementation

5 Developing Achievable, Costed, Prioritized, Transparent, and Accountable Plans

5.1 Achievability, Costing, and Prioritization

5.2 Transparency and Accountability



This Background Brief is an excerpt from the Justice Action Coalition Workstream IV, "Justice Financing Framework," November 2025. For more information, see www.sdg16.plus/justice-financing-framework.