Domestic Resource Mobilization: Status and Prospects of GFF countries

GLOBAL FINANCING FACILITY

SUPPORTED BY WORLD BANK GROUP

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FOURTH INVESTORS GROUP MEETING

Introduction

Topic: Domestic resource mobilization (DRM)

- Part 1: Progress towards Smart, Scaled and Sustainable financing in GFF countries, including RMNCAH spending
- Part 2: Prospects for additional DRM
- Part 3: Lessons from experience to date with GFF countries

Data sources

- Global Health Expenditure Database of WHO, replicated in World Development Indicators of the WBG
- World Development Indicators for economic growth

Part 1: Progress towards Smart, Scaled and Sustainable financing in GFF countries, including RMNCAH spending

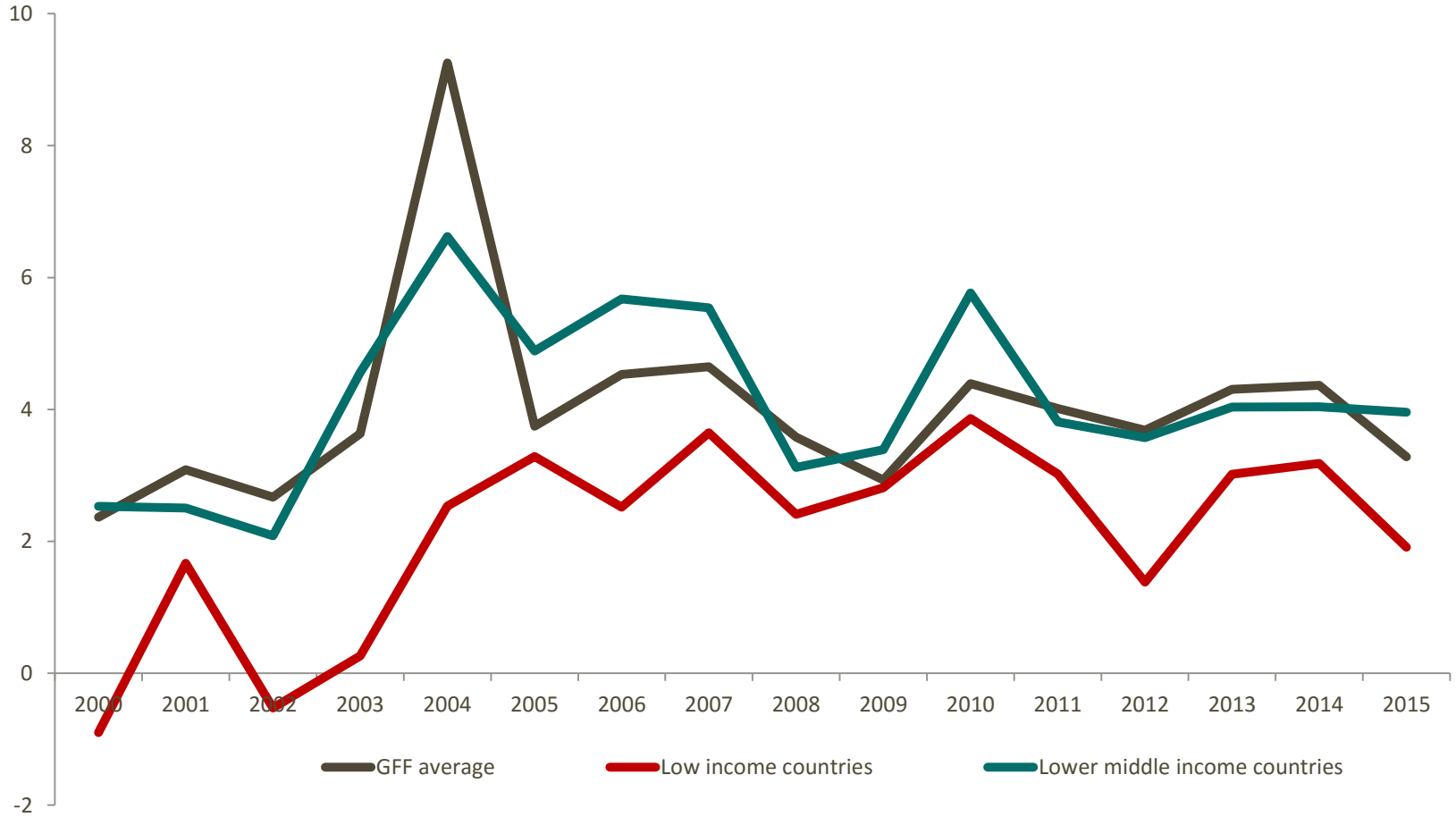
Smart, Scaled, Sustainable Financing

- **Smart financing**: interventions proven to have a high impact are prioritized and delivered in an efficient and results-focused way, while seeking to reduce inequities in coverage.
- **Scaled financing**: mobilizing the additional resources necessary from domestic and international (public and private) sources, while reducing reliance on direct out-of-pocket payments (OOPs)
- **Sustainable financing**: ensuring that health and RMNCAH funding benefits from economic growth, and addresses the challenges faced by “transition” countries

National income for GFF countries

- 8 low income (LIC): DRC, Ethiopia, **Guinea**, Liberia, Mozambique, **Sierra Leone**, Tanzania, Uganda
- 8 lower middle income (LMIC): Bangladesh, Cameroon, **Guatemala**, Kenya, **Myanmar**, Nigeria, Senegal, Vietnam
- GDP per capita in 2015 (current prices) ranged from $456 in DRC to $3904 in Guatemala
- In general, the countries are poorer than the average for LICs and LMICs respectively:
  - Among LICs, only Tanzania and Uganda have GDP/cap above the mean for LICs
  - Among LMICs, only Guatemala and Nigeria

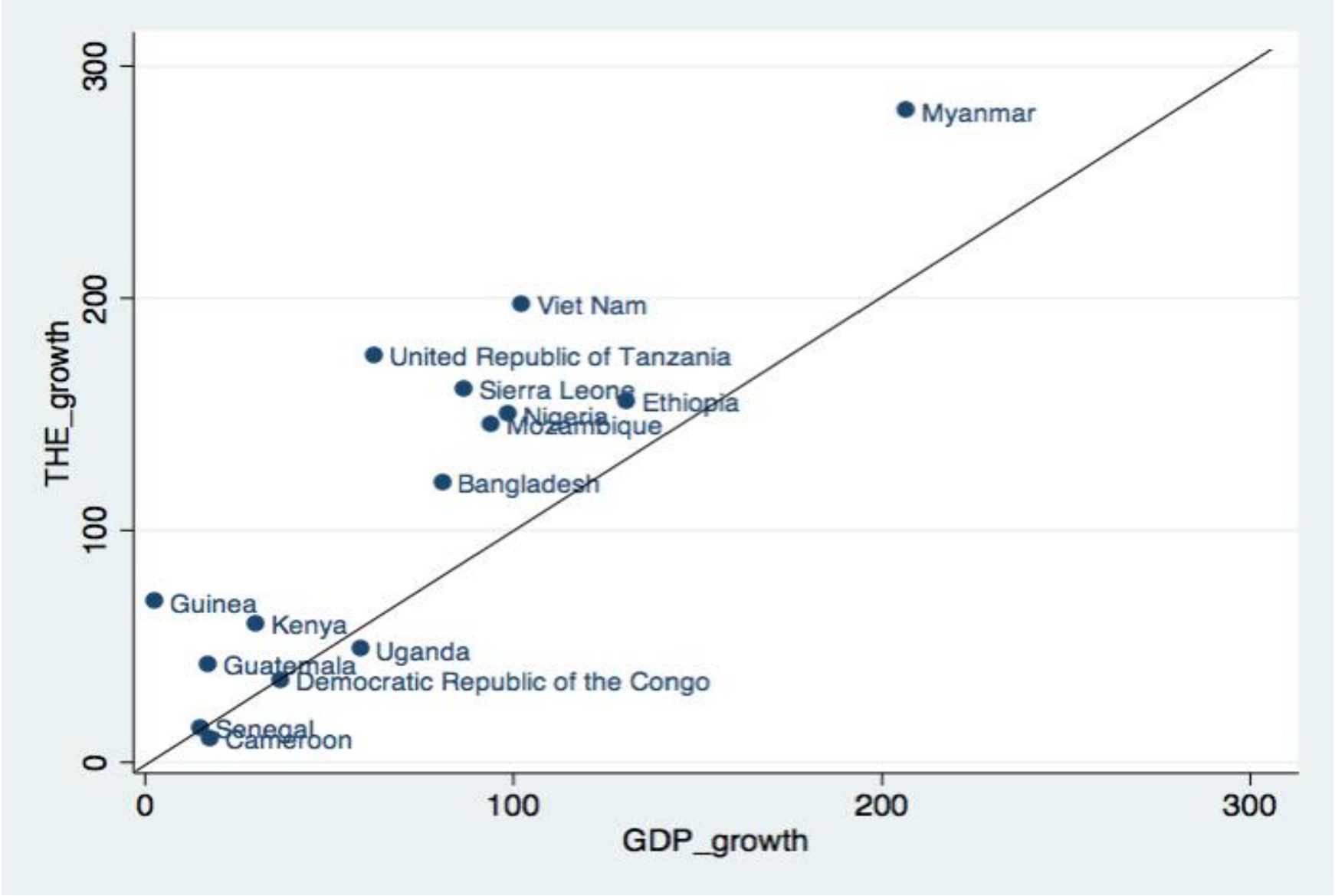
Real growth in GDP per capita: GFF, LICs, LMICs (weighted average)



Total Health Expenditure (THE) per capita-

- Health expenditure data available to 2014
- Total health expenditure per capita grew 2000-2014 in GFF countries as a group, reaching $67.6 per capita on average (weighted, current prices) in 2014
- Heterogeneity: range from $19 in DRC to $233 in Guatemala
- McIntryre and Meheus: estimated $89 per capita needed in 2014
  - 12 countries: too little to assure a basic set of health services
  - 4 countries (Guatemala, Nigeria, Sierra Leone and Vietnam) spent more than $89 per capita but a high proportion from direct out-of-pocket spending – need to increase prepaid and pooled funding

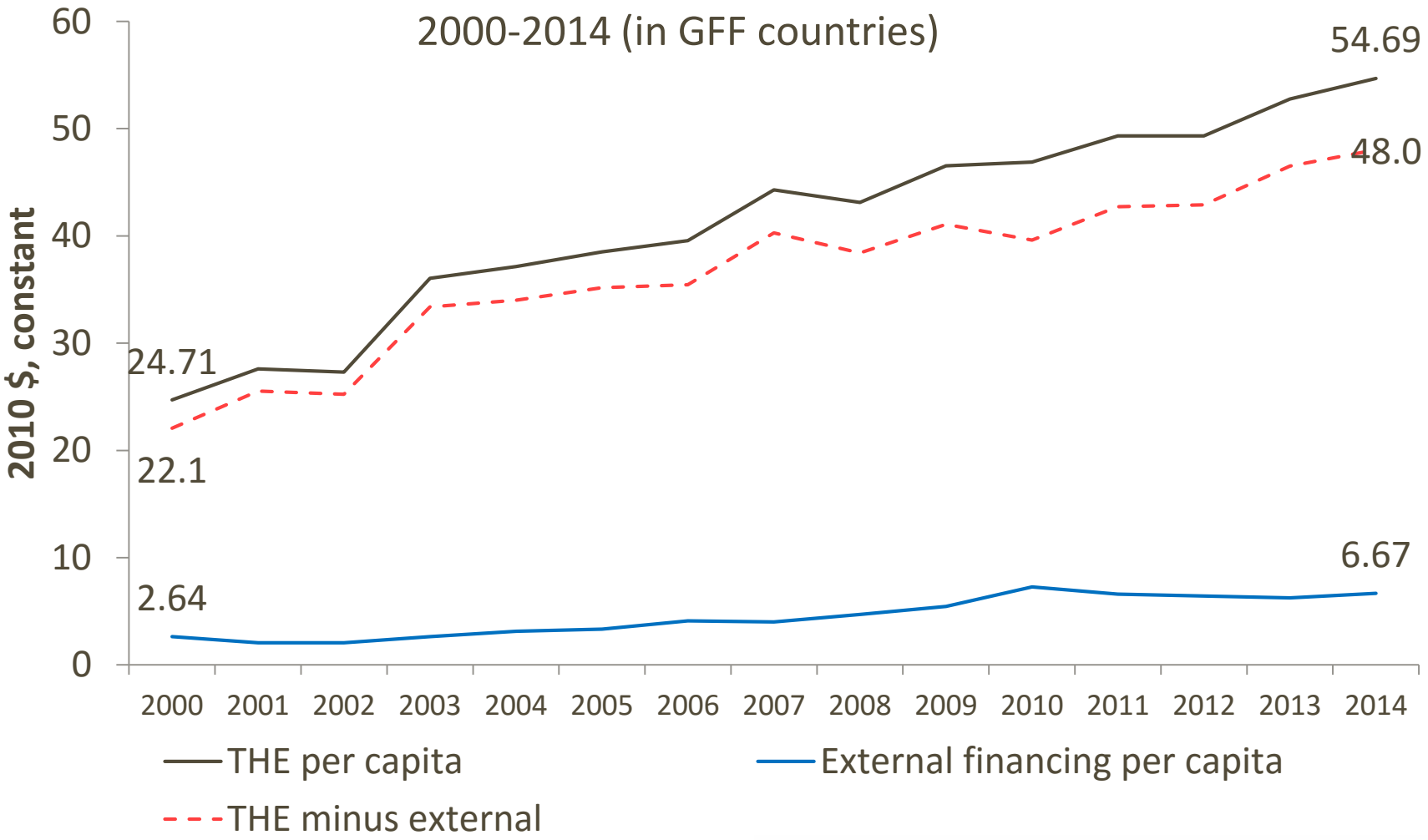
Growth rates of THE/capita vs GDP/capita 2000-14



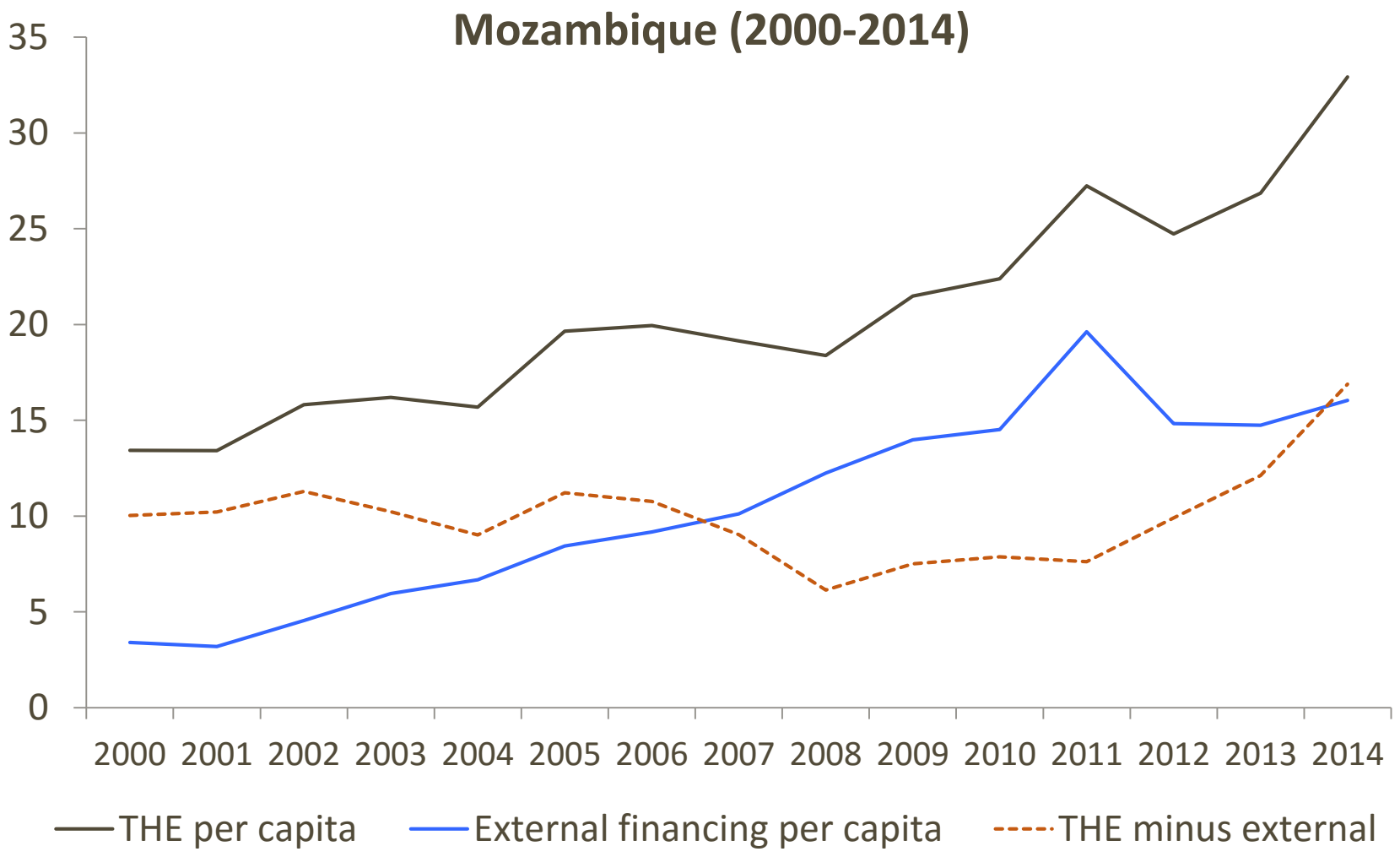
Components of health expenditure growth

- Total health expenditure per capita can be broken into expenditure from external sources (development assistance for health [DAH]) and expenditure from domestic sources
- We initially consider DAH versus external expenditure growth

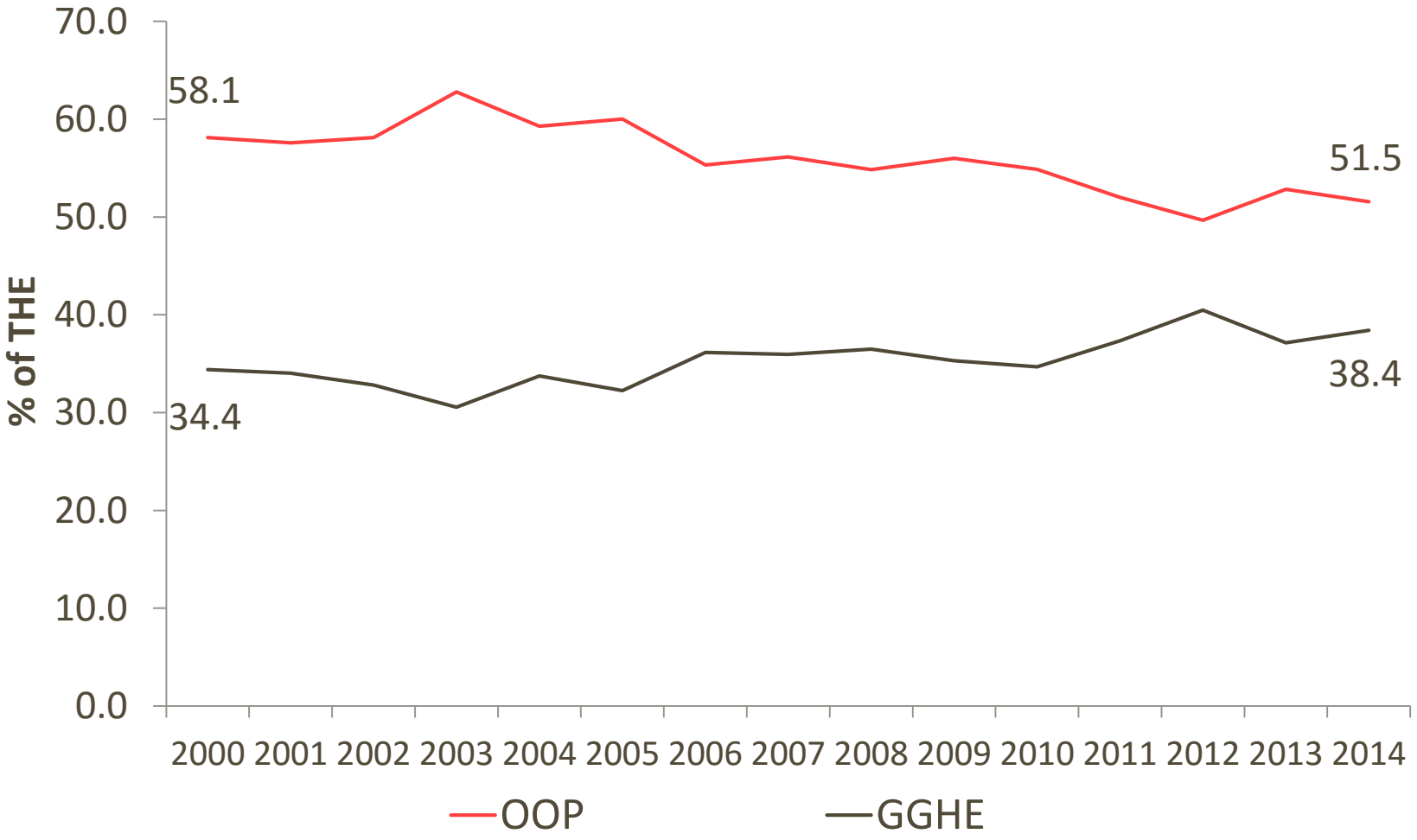
Components of real THE/capita growth: domestic versus external financing



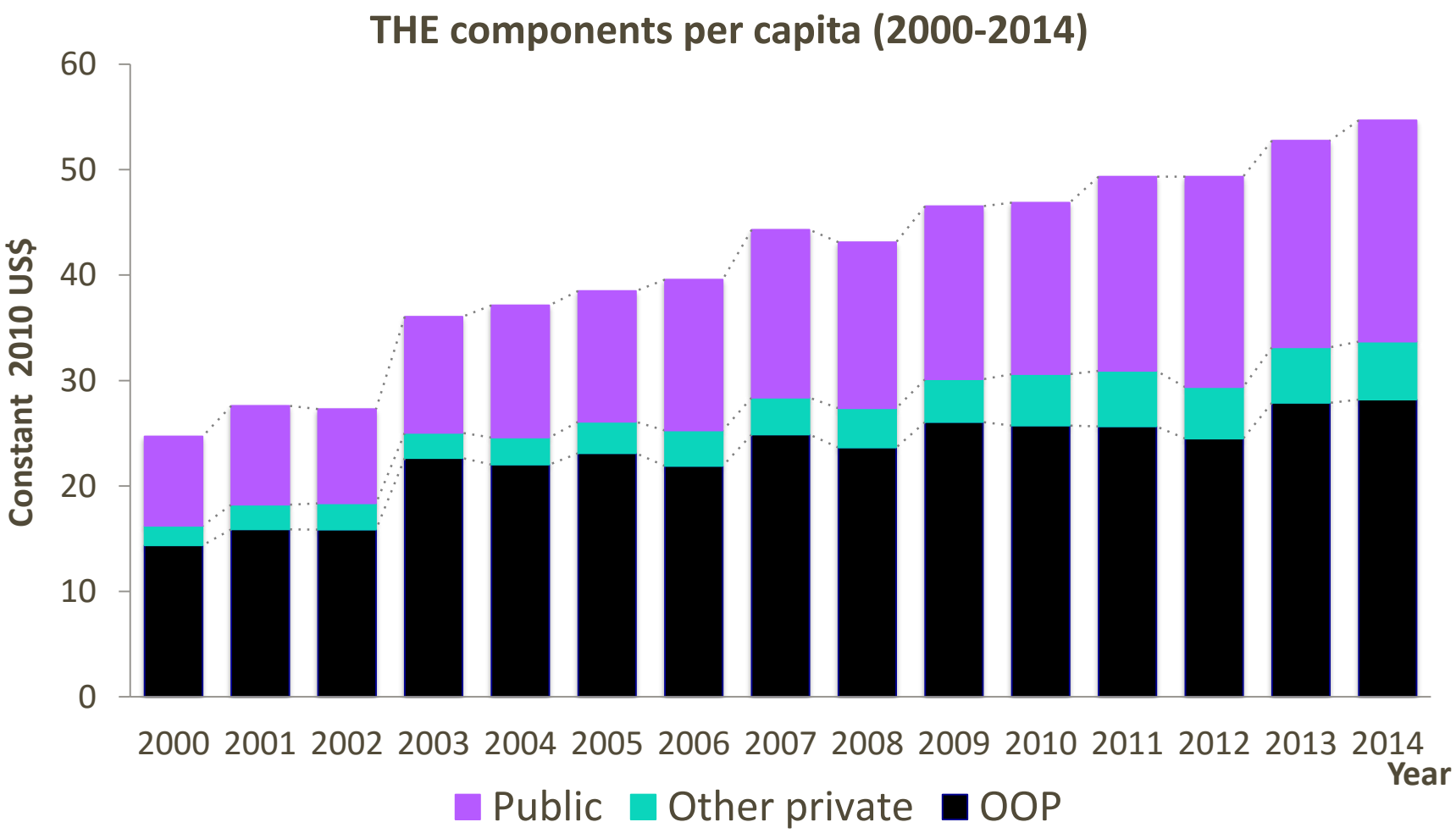
Heterogeneity in domestic versus external financing



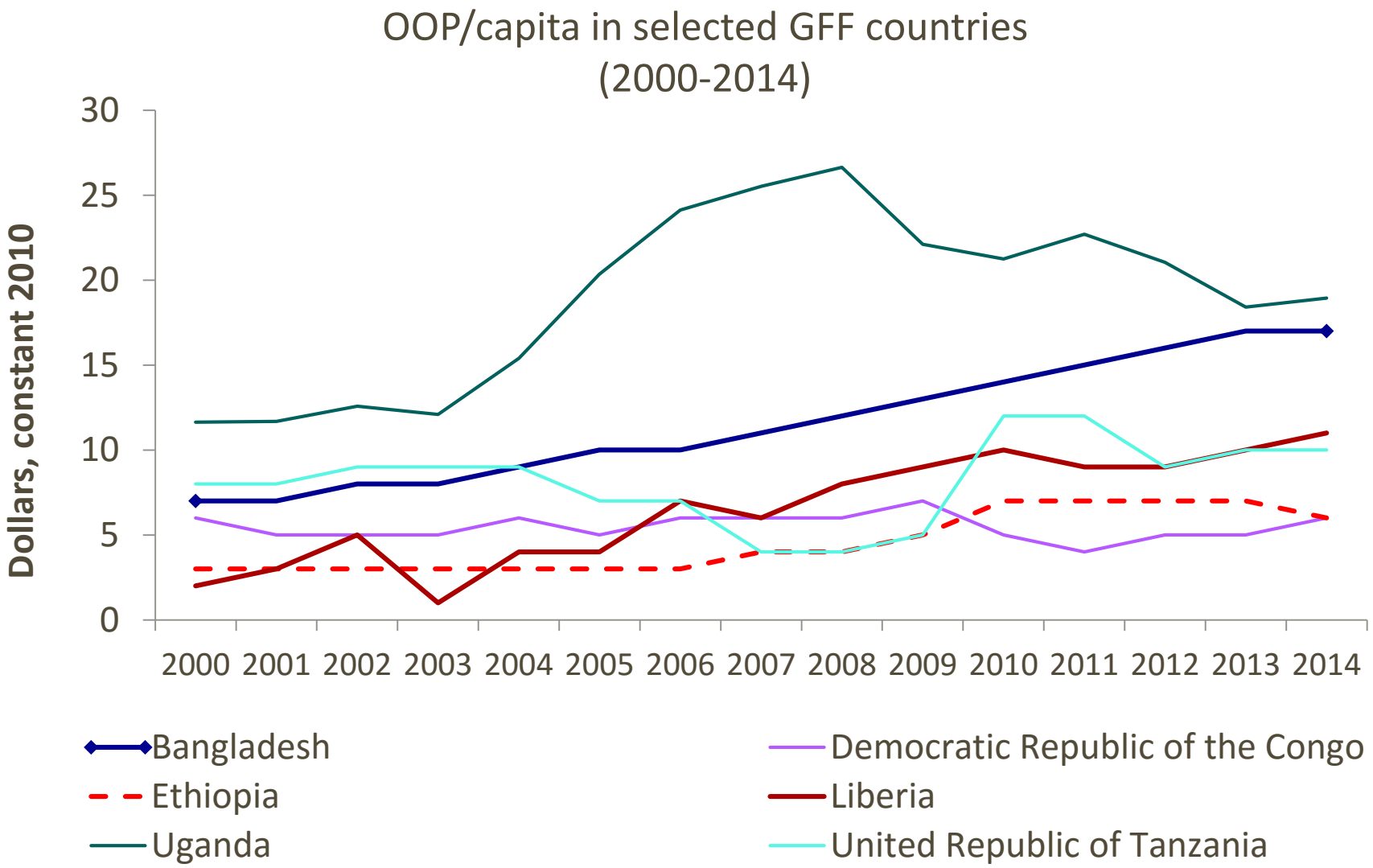
OOPs has fallen and GGHE risen as a share of THE



Real OOPs per capita has risen



Heterogeneity in OOPs per capita



What about RMNCAH-related expenditures?

- 34 countries have produced disease-specific accounts – almost always included Reproductive Health (RH) but not always Child Health (CH) (WHO website)
- No information on A (Adolescents)
- GFF countries:
  - Public data on both RH and CH expenditures in 6 of 16 GFF countries (Cameroon, DRC, Ethiopia, Sierra Leone, Tanzania, Uganda)
  - 3 have done this but data not available yet (Kenya, Mozambique, Vietnam)
  - 4 in process (Bangladesh, Liberia, Nigeria, Senegal)
  - Only 3 have at least 2 years (DRC, Ethiopia, Uganda) not necessarily the same years

Share of THE for RH and CH expenditures?

- Share of health expenditures:
  - Reproductive health (RH): ranged from ~5% to >30%
  - Child health (CH): ranged from 5% to 40%
- 12 countries (GFF and non-GFF) with both RH and CH:
  - CH > RH in 8 countries
  - RH > CH in 4 countries
- Indicator of quality of data improves over time as countries get more experience in allocating expenditures by disease
  - Share of total health expenditures that they are able to allocate to the different diseases increases

Smart, scaled, sustainable financing: Summary

1. Enormous heterogeneity across countries – implications for policy
2. Smart: Current levels of spending too low to ensure an essential package
   - Not much available from these data in terms of efficiency
   - Little in terms of equity: need to dig deeper
   - RH and Child account for a substantial share of national expenditures on health: but data lacking for many countries
3. Scaled:
   - THE/capita increasing in real terms
   - OOPs declining as a share of THE – but real OOPs/capita increasing except in a few countries
   - Other sources of private expenditure still very low
4. Sustainable:
   - Good economic growth
   - THE rising faster than GDP overall, though not in all countries
   - DAH has risen faster since 2000 than domestically sourced health expenditure, but patterns very heterogeneous; in the long run, transition means that domestically sourced financing rises faster than DAH (or DAH declines)

PART 2: The potential for DRM in GFF countries

Importance of Domestic Resource Mobilization (DRM)

- Health expenditure per capita still too low in 12 GFF countries to assure universal coverage with a core package of needed health services, including for RNMCAH
- In the other 4, OOPs is a high share of THE
- Exacerbated by DAH commitments and disbursements falling since 2012 (OECD)
- Transition strategies of Gavi and Global Fund on top of traditional WBG shift when countries move to middle income from low income make DRM more important in those countries

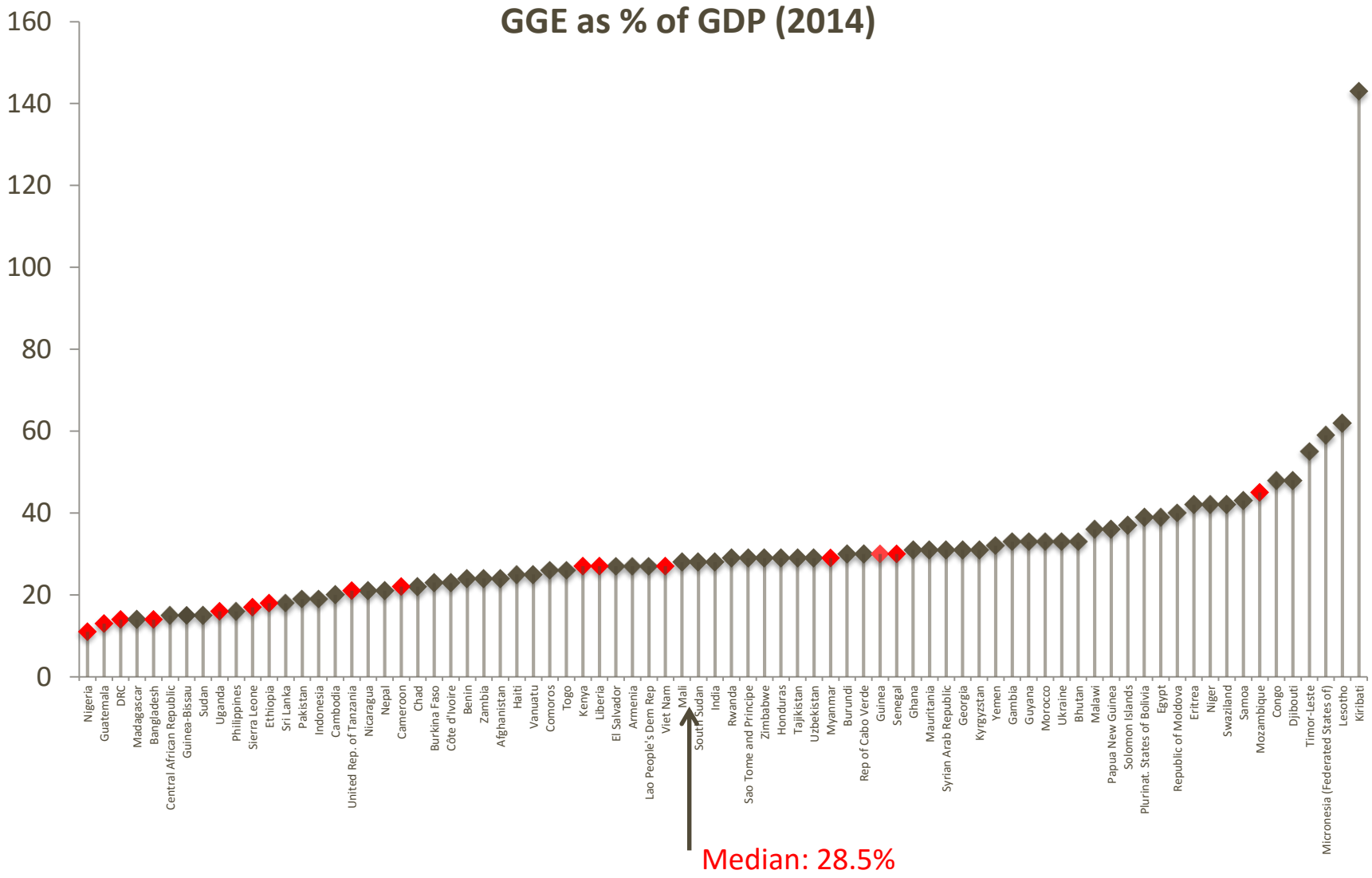
BUT

- Good growth predicted (although IMF economic growth projections have been revised down): for non-high income countries 4.1% 2016; 4.7% 2017 (*heterogeneity*)

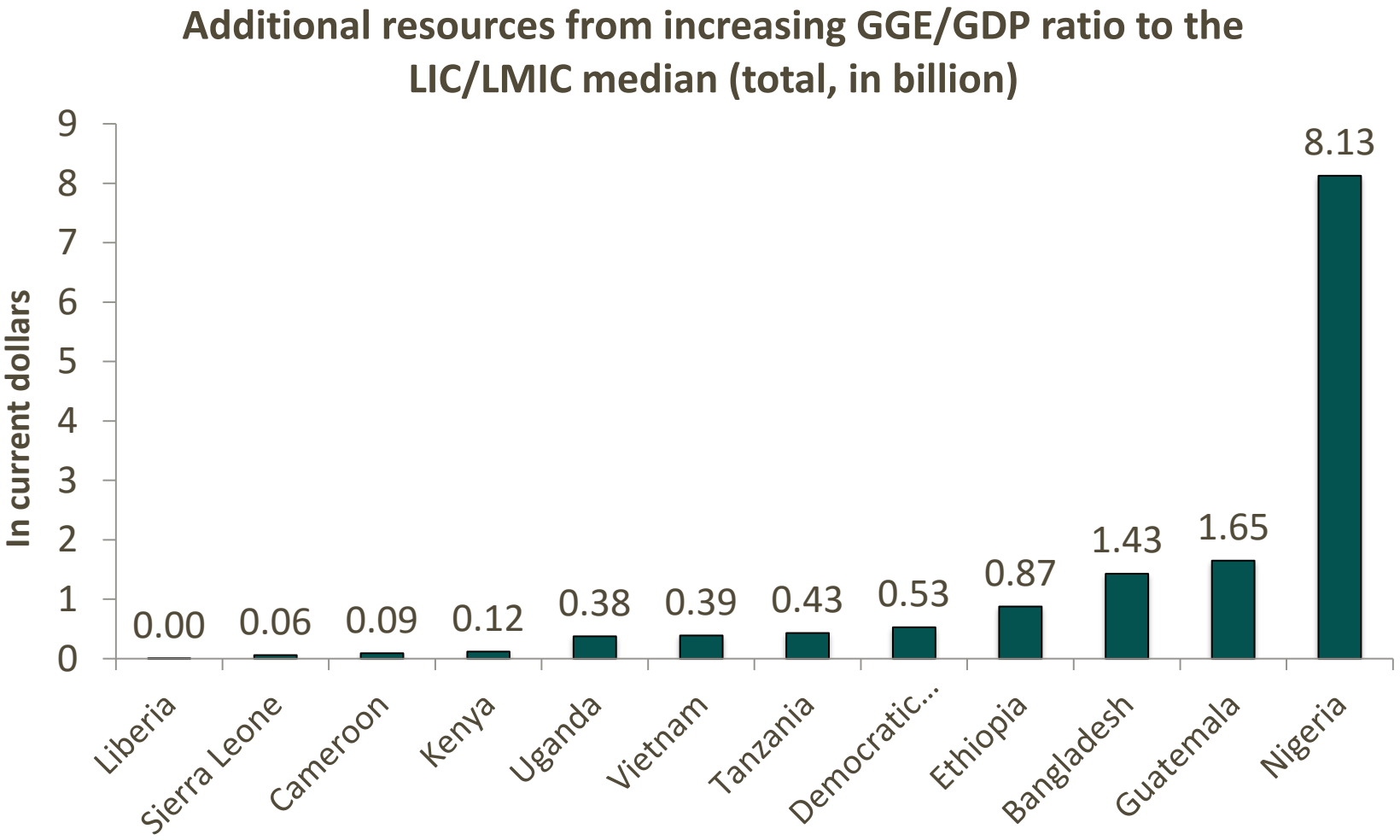
Mechanisms of DRM

1. Raising more – focus on GGHE (compulsory prepaid and pooled) as we do not want OOPs to increase
2. Giving higher priority for health in government expenditure
3. Greater efficiency or value for money
   - Efficiency proposed focus for next IG meeting
   - Role of private sector also worth discussing in the future
   - More recently: budget performance is also seen as a source of increased expenditure, though not revenue

Government expenditure as a share of GDP: LICs and LMICs

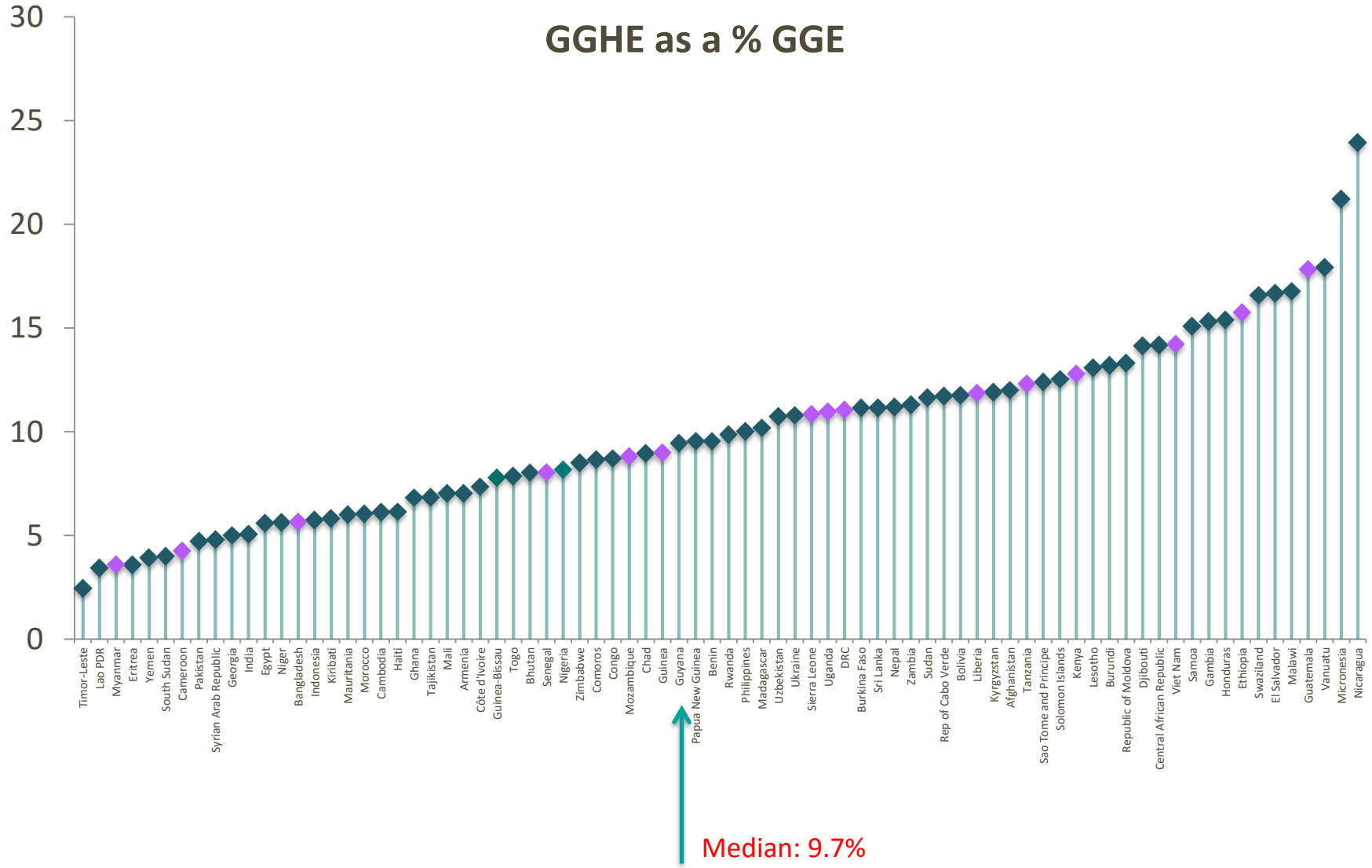


What would happen if GGE/GDP was increased to the median?

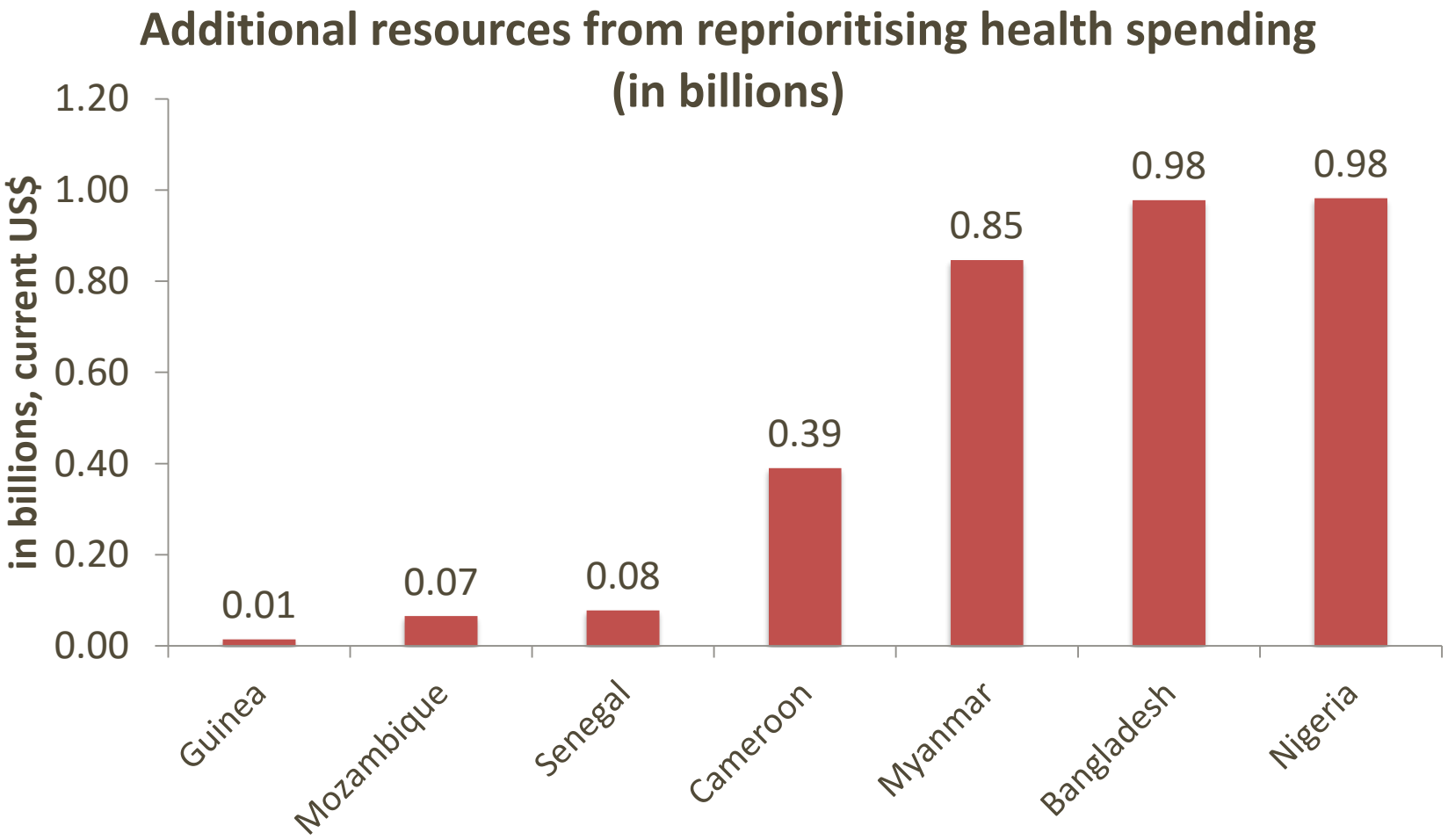


Total of $14.1 billion additional funding raised annually

Government priority to health: GGHE/GGE

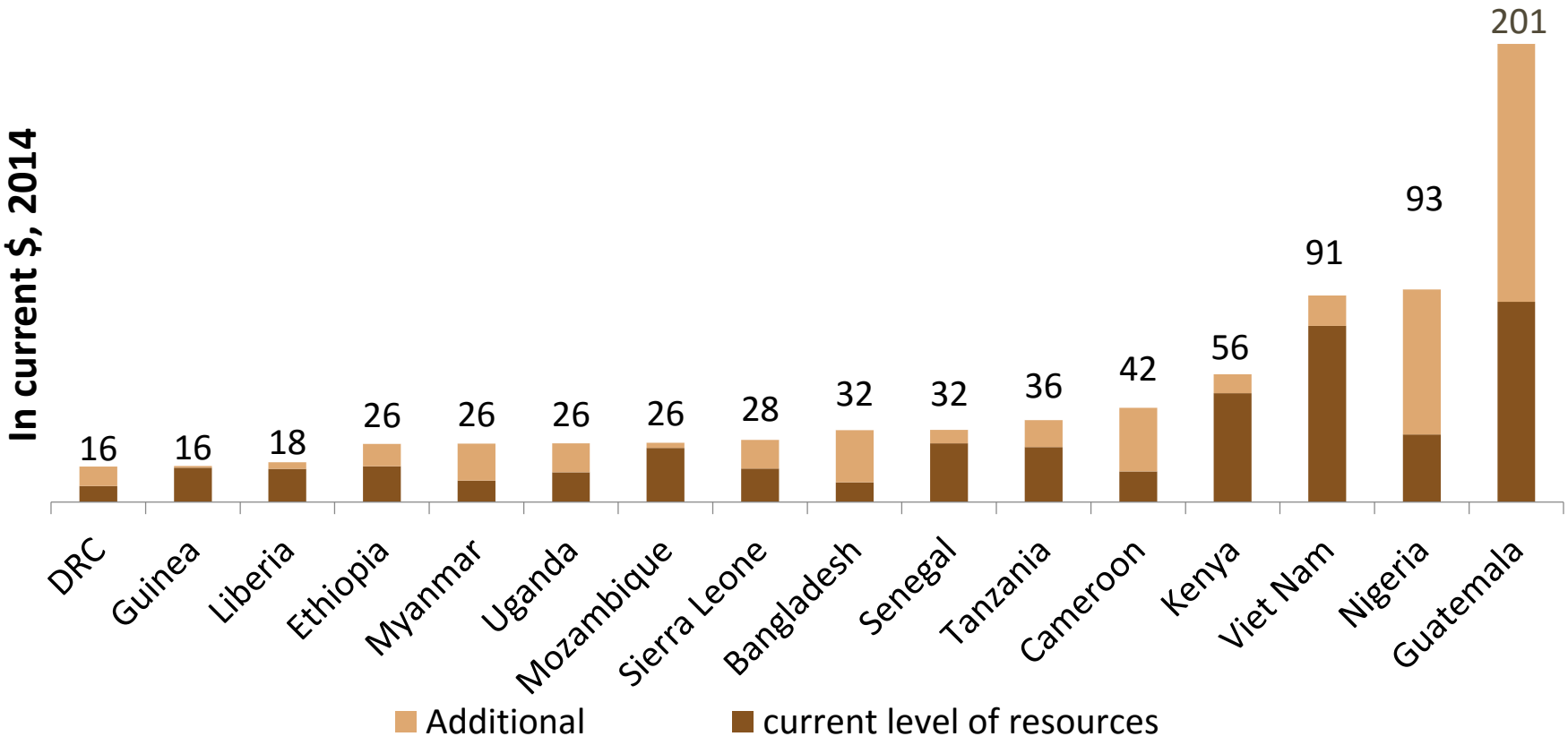


Government priority to health: increasing GGHE/GGE to median



Total of $3.36 billion additional funding generated annually

Let's get ambitious: current + additional $/capita



1. Countries increase GGE/GDP to 30% where below
2. Then, countries more than one percentage point below the median GGHE/GGE increase to the median
3. Others except Ethiopia and Guatemala (already high) increase by 1 percentage point.

Budget performance & public financial management

- A recent WHO report, using World Bank Public Expenditure Reviews, highlighted that a number of GFF countries have not fully implemented their health budgets in selected recent years:
  - DRC (2013) executed just over 40%
  - Guinea (2014) under 70%
  - Ethiopia (2013) under 80%
  - Mozambique (2014) 90%
- Complex reasons, but better financial performance could effectively increase expenditures in some countries

PART 3: Experience from GFF countries and conclusions

GFF support to domestic resource mobilization

- Significant heterogeneity → need for tailored approaches
- Three main types of support:
  - **Assess** the best options for DRM: conducting fiscal space analyses, estimating revenue generation potential for different options for raising resources
  - **Develop approaches** for DRM: supporting government to prepare health financing strategies, supporting development and tracking of indicators related to public financing
  - Provide **implementation support**: translating high-level strategies into implementation plans, supporting reform efforts through TA, capacity building, institutional strengthening, and financing
- Partnership and dialogue with **Ministry of Finance and sometimes IMF** critical

In Kenya the GFF in collaboration with external partners…

- Contributed to energizing the HFS process by
  - Working with GoK to set-up HFS coordination structure that ensured buy-in from key players and good dialogue with MOF
  - Providing intense TA to develop specific sections of HFS
  - Offering multiple rounds of comments on proposed strategic directions resulting in stronger focus on domestic resource mobilization and improving efficiency of health expenditure
- Will provide implementation support, focused on:
  - DRM: assessing the feasibility of generating health resources from sin taxes, levies and health insurance contributions in collaboration with the macroeconomic experts, MOH, MOF
  - Transition challenges: assess institutional and financial sustainability of programs funded off-budget
  - Efficiency: expenditure tracking at country level to analyze the efficiency, effectiveness and equity of public spending and development of actions to improve

In DRC, the GFF in collaboration with external partners…

- Contributed to energizing the health financing strategy (HFS) process by:
  - **Supporting the WB and development partners to assist Govt with a health financing system assessment feeding the preparation of the health financing strategy.**
  - **Supported the finalization of the HFS** led by the Ministry of Health

- Will provide implementation support, focused on:
  - **Efficiency reforms**: the Investment Case of DRC is capitalizing on "quick wins" recently implemented in DRC with support of WB and others donors: 1) The "single contract" at provincial level which is to reduce donors fragmentation; 2) The PBF approach which is to enhance management capacity at all levels of the health system; 3) Recommendations to come from a PFM study to improve the health budget execution.
  - **DRM reforms:** The action plan of the health financing strategy is to examine better tax compliance in collaboration with macroeconomic experts, MOF and the WB governance project.

Summary: the state of the world

- THE risen faster than GDP in most GFF countries
- DAH risen faster than domestic sources, but domestic financing has provided the bulk of the increase in real terms
- OOPs has fallen (& GGHE risen) as a share of THE, BUT OOPs per capita increased in most

Summary: DRM

- Considerable potential for DRM in most GFF countries, mostly through GGE/GDP, but also more priority to health in some
  - Guinea and Mozambique less room for this
- Recent falls in economic growth and government revenues are a concern
- Some potential for increased spending through budget efficiency

GFF Health financing lessons and challenges

Key lessons learned

- **Very different starting points** among countries
- Shift underway from emphasizing strategy to **implementation of reforms**
- Good analytical work does not automatically lead to reforms - politics
- Engagement of and with ministries of finance has been **uneven**
- GFF can **reenergize agenda** with intense support: financing, TA, peer-to-peer learning, capacity building, convening partners including MOF

Ongoing challenges

- GFF has given significant boost to process in many countries, but change is political and takes time
- Stronger experience and expertise on analytical work than on implementing reforms
- Syncing up the timing of the health financing work across all partners can be complex
- Dialogue with MOF (and IMF) difficult with the economic slowdown

Learn more

www.globalfinancingfacility.org

GFF@worldbank.org

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