

HEALTH FINANCING: DOMESTIC RESOURCE MOBILIZATION

OVERVIEW

Health financing is a recurrent item on the agenda of the GFF Investors Group. At the second Investors Group meeting, the financing discussion focused on issues related to health financing transitions and on trends in development assistance for health and for RMNCAH, while at the third Investors Group meeting a number of partners shared their experiences with providing complementary financing.

This time the focus is on domestic resource mobilization (DRM). Section 1 of the paper will briefly summarize the objectives of DRM as described in the Business Plan for the GFF. Section 2 then turns towards a review of where the 16 GFF countries stand in terms of Smart, Scaled and Sustainable financing and in terms of RMNCAH spending. Section 3 makes some projections about the feasibility of raising additional domestic funds for health in these countries and the final section reflects on the implications of the analysis for the health financing work under the GFF drawing on the experience to date in GFF countries.

The paper draws on two sources of publicly available data to explore these questions. Data on Gross Domestic Product (GDP) per capita, an indicator of national income, and economic growth rates are taken from the WBG's World Development Indicators. Health expenditure data are taken from the Global Health Expenditure database of WHO, numbers that are also reported in World Development Indicators.

ACTION REQUESTED

This paper is for information only.

SMART, SCALED AND SUSTAINABLE FINANCING

The Business Plan of the GFF estimated that the gap of \$33.3 billion between resource needs and availability for RMNCAH in all GFF eligible countries in 2015 could be reduced to only \$7.4 billion by 2030 through a combination of domestic economic growth (which would automatically increase the resources available for health even without any special attention by governments to DRM provided that governments maintain their current share of the budget allocated to the health sector), increased domestic resource mobilization beyond that linked to economic growth, increased development assistance for health and improved efficiency in health expenditure. Actions by GFF country governments to generate domestic resources beyond those associated with economic growth, and to improve efficiency in resource use, were seen as critical to the success of the GFF strategy, contributing to the production of smart, scaled and sustainable financing as key drivers of the RMNCAH results agenda (Box 1).

Box 1: Smart, Scaled and 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 & RMNCAH funding benefits from economic growth, and addresses the challenges faced by countries transitioning from low- to middle-income status.

Source: GFF Business Plan

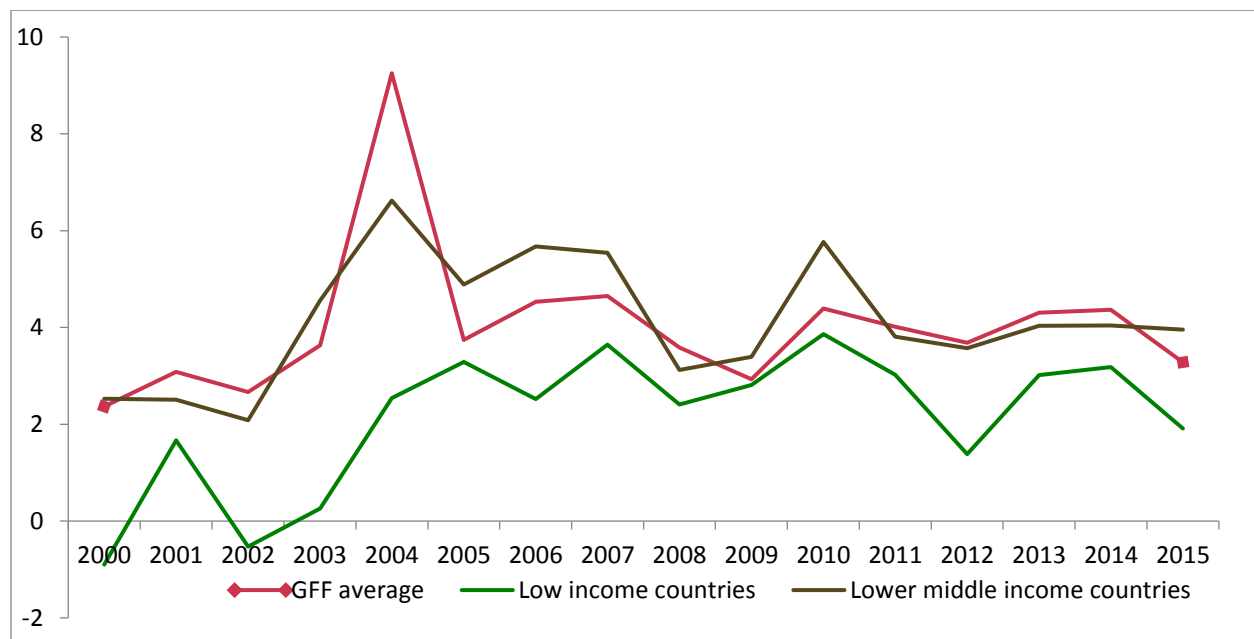
HEALTH FINANCING IN THE GFF COUNTRIES

Relatively low GDPs per capita but strong economic growth until recently. Eight of the current GFF countries (DRC, Ethiopia, Guinea, Liberia, Mozambique, Sierra Leone, Tanzania, Uganda) are classified as low-income in the World Bank Group (WBG) classification, and the remaining 8 are lower-middle income (Bangladesh, Cameroon, Guatemala, Kenya, Myanmar, Nigeria, Senegal, Vietnam). GDP per capita in 2015 (current prices) ranged from \$456 in DRC to \$3904 in Guatemala.¹ The countries funded by the GFF are, in general, poorer than countries in their respective income groupings – low and lower-middle income.

However, real (inflation adjusted) economic growth has been relatively strong in the GFF countries as a group since 2000, seemingly offering good potential for DRM. Growth in the GFF countries exceeded that in the low-income countries in all years, and was on a par with that in the lower-middle income countries.

¹ Source: WBG, World Development Indicators.

Figure 1: Real per capita growth in GDP 2000 to 2015



Source: World Development Indicators, World Bank Group

The average series presented in many of the figures in this paper hide considerable heterogeneity across countries. Moreover, recent falls in oil and commodity prices have taken their toll on both economic growth and government revenues (discussed subsequently) in a number of the GFF countries, something that is shown in Figure 1 with the decline in the rate of economic growth in 2015. Nigeria, for example, actually suffered a decrease in GDP per capita in 2015, following a decade of high economic growth (averaging 6% per year) linked to the decline in oil prices. Sierra Leone also experienced a dramatic decline in GDP per capita of 22% in 2015 due to the Ebola crisis and a decline in iron ore prices. Guinea also suffered a decline in GDP per capita in 2015, although of a much smaller magnitude compared to Sierra Leone (-2.54%). All the countries where natural resources compose a substantial part of GDP have also suffered declines in government revenues, something that is taken up in a later section.

National health expenditures per capita have grown rapidly, but remain low in most GFF countries. The most recent year for which data on total health expenditures is available is 2014.² Total health expenditure per capita also grew solidly from 2000 to 2014 in the GFF countries as a group, reaching \$67.6 per capita on average (weighted, current prices) in 2014. It ranged from \$19 in DRC to \$233 in Guatemala. In 12 of the 16 GFF countries, health expenditures grew noticeably more rapidly than GDP (Figure 2). On the other hand, it grew more slowly than GDP in Cameroon and Uganda, and at the same rate in the Democratic Republic of Congo (DRC) and in Senegal.

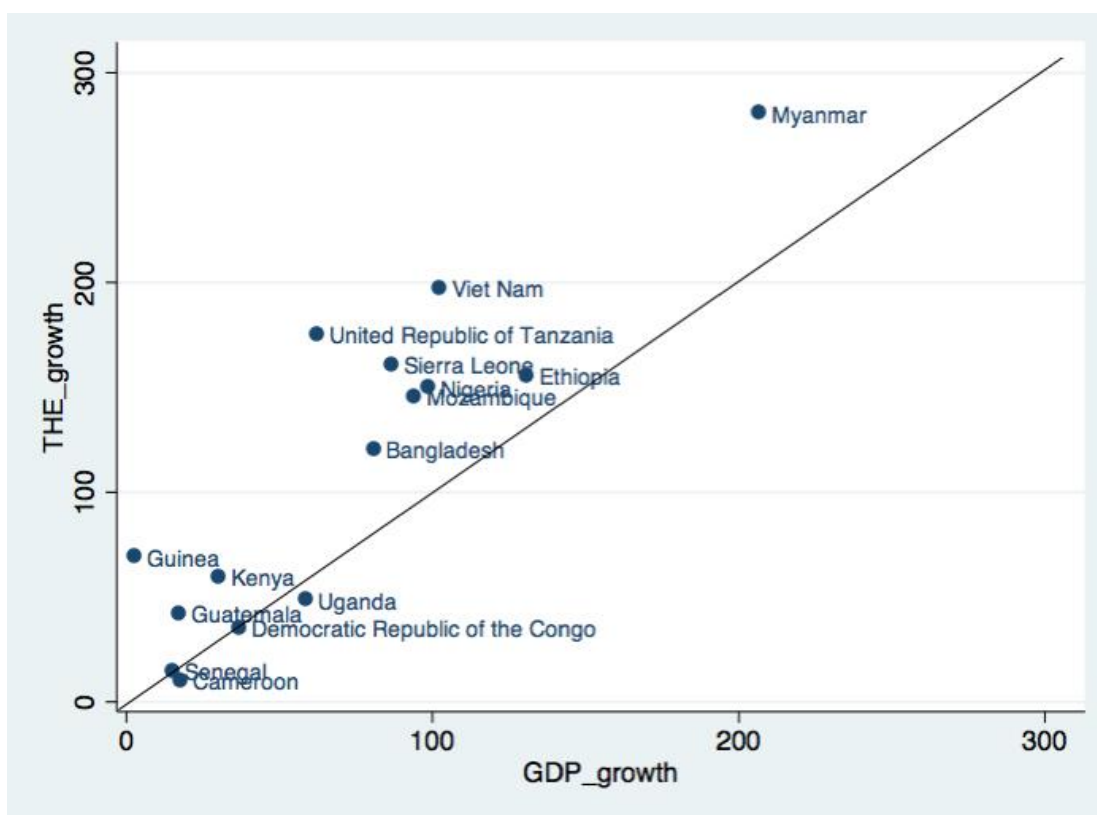
Despite this growth, in 12 GFF countries health spending was still too low to allow coverage for the entire

² As stated in the overview, the health expenditure data used in this paper are taken from the Global Health Expenditure database of WHO. World Development Indicators published by the WBG report the same numbers, although there can be some differences because WHO updates the database in real time whereas the WBG uploads new data once a year.

population with even a basic set of needed health services, estimated to cost \$89 per capita for 2014.³ Although four countries (Guatemala, Nigeria, Sierra Leone and Vietnam) spent more than \$89 per capita, a high proportion of this came from direct out-of-pocket spending paid by households at the time they need services, a requirement that prevents the poor and most vulnerable people from accessing needed services (see subsequent sections). Moreover, these countries continue to struggle to improve the range and quality of health services available to their populations, improve equity and increase or maintain levels of financial protection.

Data are not yet available on total health spending for 2015, but a number of countries report apparent declines in government budgets for health as a result of the declining economic output described above.⁴ This makes it more difficult for ministries of health to argue for more money for health and for RMNCAH in the current economic climate in many of the GFF countries.

Figure 2: Rate of growth of health expenditure (per capita) versus GDP (per capita), 2000-2014



Source: WHO Global Health Expenditure Database.

Note: Liberia is an outlier that does not fit easily on the graph. It had negative economic growth over the period but very high increases in health expenditure due in part to recent increases in development assistance for health.

³McIntyre D & F Meheus 2014. "Domestic funding of health and other social services". Chatham House, Centre on Global Health Security, Working Group on Financing, paper 5. https://www.chathamhouse.org/sites/files/chathamhouse/home/chatham/public_html/sites/default/files/20140300DomesticFundingHealthMcIntyreMeheus.pdf

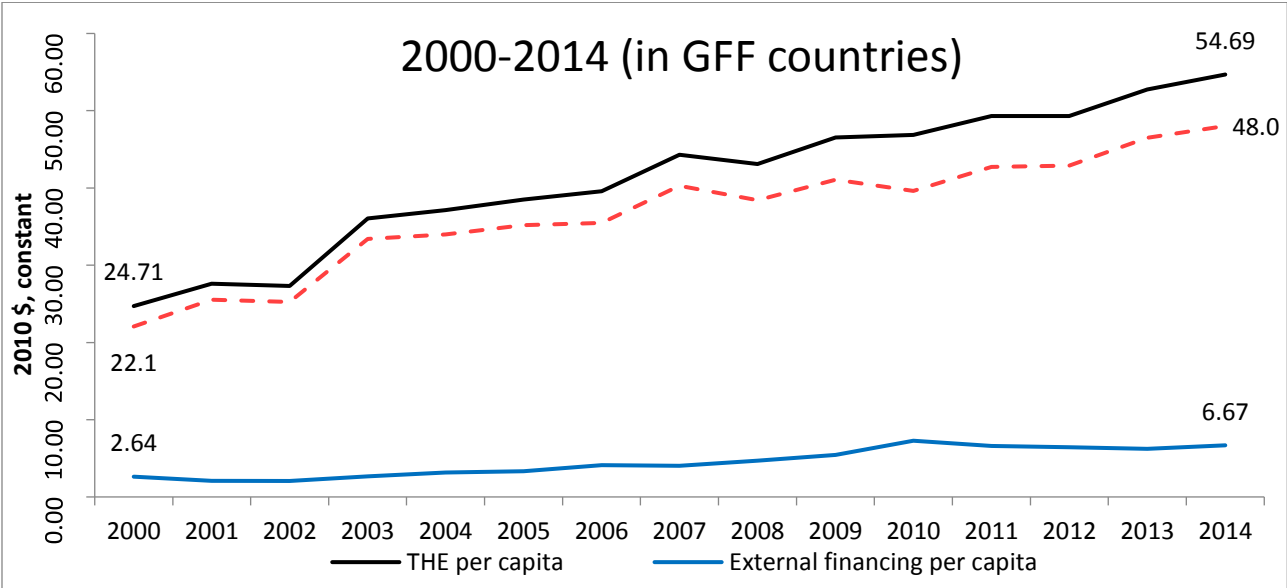
⁴ Some documentary evidence can be found in the WBG publication at http://siteresources.worldbank.org/EXTPREMNET/Resources/C11TDAT_193-206.pdf

Development assistance for health grew rapidly but domestically sourced funding provided the major part of the increased health expenditures. National health expenditures can be divided into expenditures from external sources (development assistance for health (DAH)) or from domestically generated sources. Here, we explore the extent to which the observed rapid increases in health expenditures in GFF countries was caused more by growth in DAH or in domestically sourced expenditures. In subsequent sections, we consider the components of domestically sourced expenditures.

In 12 of the 16 GFF countries, real (inflation adjusted) development assistance for health (DAH) per capita grew very rapidly from 2000-2014 – by over 100% in the 12, and by more than 400% in 6 of them. However, it grew by only 3% and 43% in Nigeria and Senegal respectively, and fell in both Guatemala and Guinea.

Despite the rapid rises in DAH per capita in most of the GFF countries, the bulk of the increase in country health expenditures was driven by increases in domestic resources taking the GFF countries as a group. Figure 3 reports the growth in total health expenditures, expenditures financed from DAH, and expenditures financed from domestic sources (total minus DAH). All figures are in per capita terms, inflation adjusted (2010 prices), and the weighted average of the GFF countries is reported. Almost 88% of the weighted total health expenditure per capita was derived from domestic resources in 2014, only a small decline from 2001 (89.4%) despite the growth in DAH. Although real DAH grew rapidly, it grew from a low base. It provided only \$4.08 of the additional health expenditures, while domestically generated resourced provided an extra \$25.90.

Figure 3: Growth in total health expenditure per capita and its components – DAH and domestically generated expenditures. Constant 2010 prices, weighted average

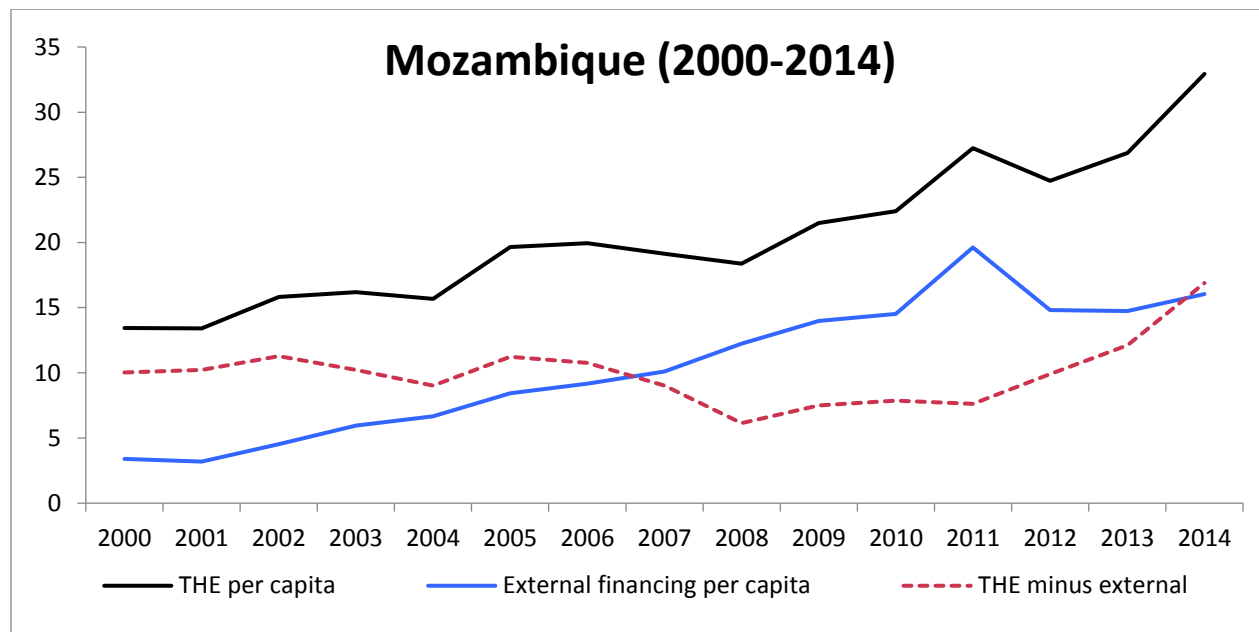


Source: WHO Global Health Expenditure Database

This weighted average again hides considerable heterogeneity across countries. For example, Nigeria, one of the most populous countries (so having a relatively large weight in the reported GFF average), received relatively little DAH compared to the other countries – DAH accounted for only 5% of its national

health spending in 2014 compared to 30% in countries like Ethiopia and Liberia. The relationship between domestic resource mobilization and DAH also varied considerably across countries. An interesting pattern in Mozambique is reported in Figure 4, showing that DRM fell in some years that DAH rose, but rose with increases in DAH in other years. This highlights that the complexity of trends and relationships between the various components of health expenditure can be lost if the focus is only on the start and end year of the analysis.

Figure 4: Total health expenditure per capita and its components: DAH and domestically generated spending. Mozambique. Constant \$2010



Out-of-pocket payments (OOPs) provide over 50% of total health expenditures. Despite falling as a share of total expenditure, they have risen in per capita terms. Another breakdown available from country health accounts is private versus public expenditures. Private is then divided into OOPs and other private expenditures, while public – called General Government Health Expenditure (GGHE)⁵ - includes expenditure from all compulsory, prepaid sources including the government itself and compulsory health insurance. Mostly, it is not possible to separate out the DAH that flows through GGHE or through private expenditures.

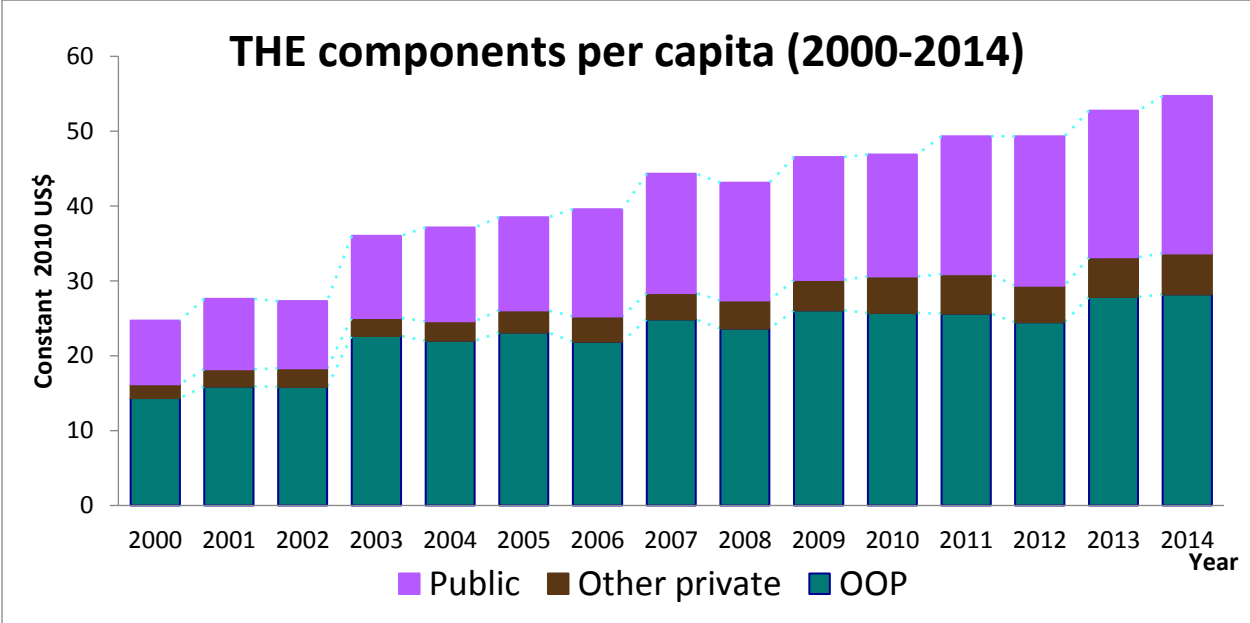
The bulk of spending in the GFF countries as a group continues to come from direct out of pocket health payments (OOPs) made by households to health service providers. These payments not only deter people from obtaining the health services they need but also result in financial catastrophe and impoverishment for many who use services. Although the average share of OOPs in total health spending has fallen since 2000, a good sign, it remains at over 51%. The incidence of severe financial hardship associated with OOPs falls to negligible levels only when the share is lower than about 15-20% - the inverse is that compulsory prepaid and pooled funds need to be around 80% to protect people against financial catastrophe as a result of OOPs.⁶

⁵ This terminology will change when the Global Health Expenditure Database is updated to the new System of Health Accounts methodology shortly (SHA2011).

⁶ WHO, 2000. The World Health Report 2000. Health Systems Performance Assessment. WHO, Geneva, 2000

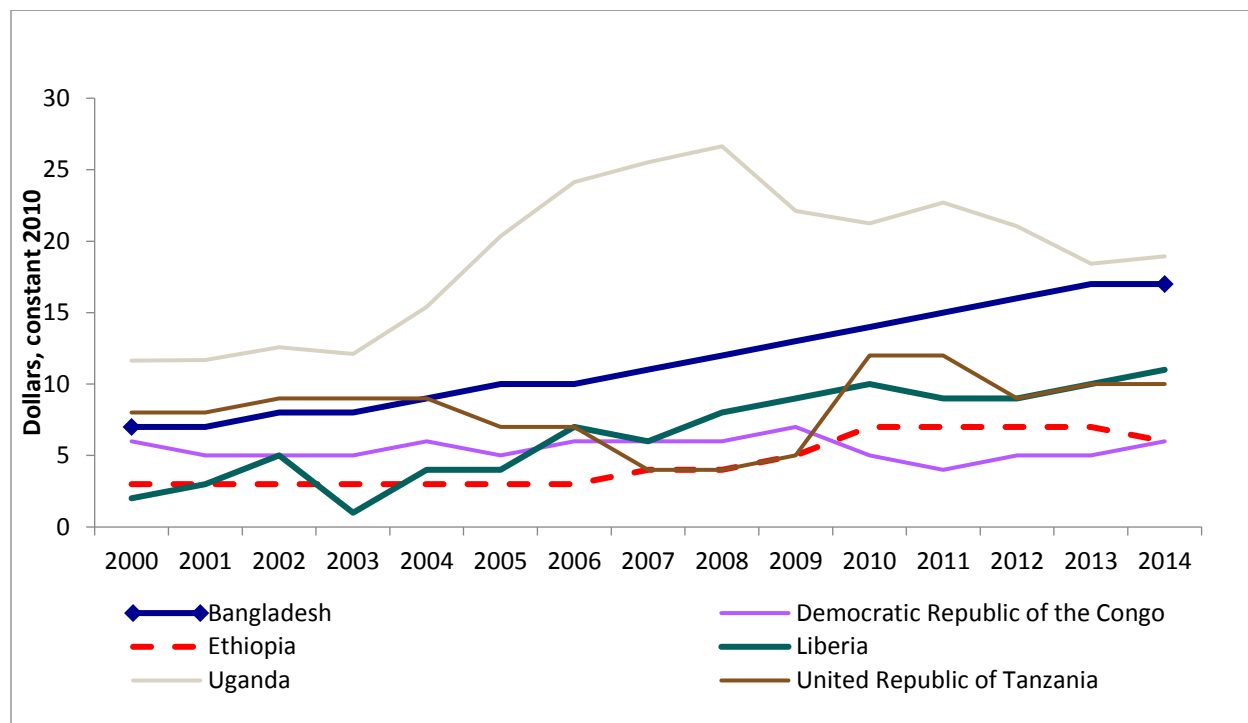
The rate at which the share of OOPs in total domestic health expenditures has declined has also been slower on average than the increase in total health spending. The result is that per capita out of pocket health payments increased over the period (Figure 5 illustrates). It shows the components of domestically generated health spending, in constant 2010 prices, for the period 2000-2014. The share of public (i.e. compulsory prepaid and pooled) expenditures rose, but the level of real OOPs per capita increased, indicating that households, on average, carry an increasing financing burden in GFF countries.

Figure 5: Components of domestically generated health expenditures per capita. 2010 constant prices. Weighted average GFF countries



Not surprisingly, given the considerable variation in health financing strategies followed in many of the GFF countries since 2000, there is again considerable variation in trends in OOPs per capita and the relative share provided by public funds (public fund capture government expenditures plus expenditures from compulsory prepaid and pooled funding sources such as compulsory insurance). Figure 6 illustrates for OOPs per capita in selected GFF countries. Most of the GFF countries show increases in real OOPs per capita over the period, but there are also some complex changes during the period. Uganda, for example, shows a substantial increase in real OOPs per capita from 2003 to 2008, although user fees in public health centres and hospitals were abolished in 2001, but a substantial fall thereafter.

Figure 6: Heterogeneity in real OOPs/capita, selected GFF countries



Box 1: What do we know about RMNCAH expenditures?

Only limited information exists on RMNCAH expenditures in the GFF countries. WHO, in collaboration with partners including those funded by USAID, began to support countries to develop disease specific expenditure accounts using the full distributive matrix as part of the work supported by the Commission on Information and Accountability for Women’s and Children’s Health. The advantage of using the full distributive matrix for disease accounts is that analysts are forced to ensure that the sum of expenditures across diseases does not exceed total expenditure, a discipline that is not required when disease-specific expenditure estimates are produced in isolation. However, the breakdown for RMNCAH is complicated as it requires disease-specific accounts as well as age-specific accounts.

WHO reports that to date 34 countries (most GFF eligible) have produced disease-specific accounts.⁷ Most of these have reproductive health accounts (RH: including expenditures linked to pregnancy and child birth) and some have child health (CH) accounts. Adolescent health was not included. Of the current GFF countries, data are publicly available for Cameroon, DRC, Ethiopia, Sierra Leone, Tanzania and Uganda for both reproductive health and child health expenditures, and for Liberia on reproductive health. Other countries – e.g. Kenya, Mozambique, Vietnam – have produced disease-specific accounts but they are not yet publicly available. Only a few countries have undertaken multiple exercises which allow an analysis of how these expenditures have changed over time – only DRC and Uganda among the current GFF countries.

⁷ <http://apps.who.int/nha/database/DocumentationCentre/Index/en>

Across all the countries (GFF and non-GFF) for which data are available, the share of health expenditures allocated to reproductive health ranged from approximately 5% to just over 30%, while for child health the range was from 5% to 40%. Child health expenditures exceeded those on reproductive health in 8 of the 12 countries for which both are available, while in the other 4, reproductive health expenditures are reported to exceed those of child health. Experience, however, suggests that the quality of these data improve over time as country teams get more experience in allocating expenditures by disease – certainly the share of total health expenditures that they are able to allocate to the different diseases increases over time. WHO recently called a meeting with agencies working on health expenditures as part of a process to decide the future of its work in this area, including in disease-specific expenditure tracking.

Source: WHO

Summary: Smart, Scaled and Sustainable Financing. This review of the current status of health financing in the GFF countries is based on publicly available data from national accounts and health accounts. Little can be said from these data about **smart** financing with its efficiency and equity components where more detailed analysis using data from sources such as household surveys and facility surveys is required.

In terms of **scaled** financing, total health expenditures have increased since 2010 in both real and nominal terms. While the rate of increase in DAH exceeded that of domestically sourced health expenditures, the bulk of the increase in spending came from domestic sources. Despite that, in 12 of the 16 countries there are simply insufficient financial resources, from domestic and external sources combined, to assure universal access to even a very minimum set of needed health services at an affordable price. Out of pocket health payments continued to provide the largest share of domestic expenditures although they have been declining as a share of total domestically sourced spending in most countries. On the other hand, per capita OOPs actually rose during the period 2000-2014, suggesting the average financial burden on households has increased. Other sources of private expenditure (e.g. private health insurance, NGOs) remain very small in the GFF countries.

The trends in **sustainable** financing have been positive to the extent that health expenditures have risen faster than GDP since 2000. Domestically sourced health expenditures have also been rising faster than GDP in most settings. However, the heterogeneity across countries in most of these variables means that the general situation described here might not apply in any given setting, and policy options in health financing need to be tailored to each country.

THE POTENTIAL FOR DOMESTIC RESOURCE MOBILIZATION

The estimates made in this section are based on 2014 data, the latest year for which information on health expenditures is available. Subsequently, the impact of the current slowdown in economic growth will be discussed.

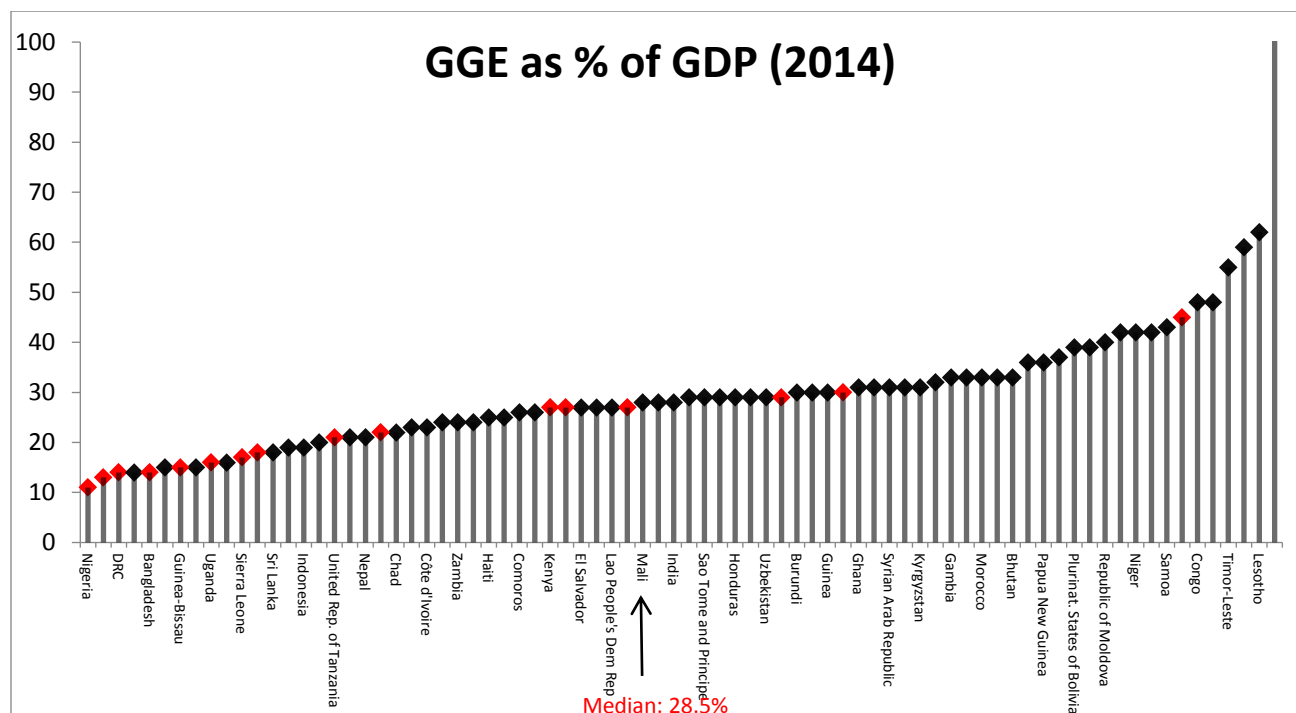
Traditionally, raising additional domestic funding for health (sometimes called increased fiscal space for health) is seen to come from three sources: raising more domestic revenues from which some flows to health; giving more priority to health in the budget; and increased efficiency.⁸ The first two are discussed here, while it has been proposed that efficiency is so important that it should be discussed at the next

⁸ Tandon A. & C. Cashin 2010. "Assessing public expenditure on health from a fiscal space perspective". World Bank Group, Health, Nutrition and Population Working Paper. <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/AssesingPublicExpenditureFiscalSpace.pdf>

Investor Group meeting. A fourth possibility is also discussed briefly here – improved budget performance.

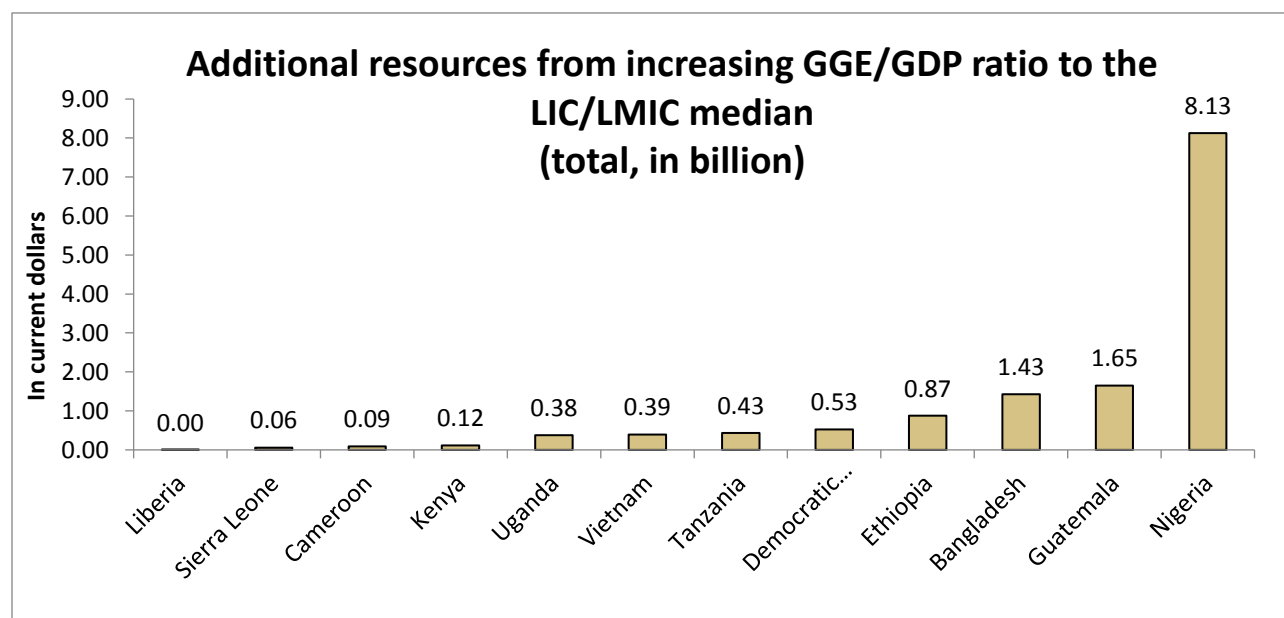
Raising more domestic revenue can substantially increase health expenditures. Given that increasing OOPs is not desirable in these countries, this section focuses on government revenues. The share of overall government expenditure in GDP for low and lower-middle income countries is shown in Figure 7. Although there is no firm yardstick, many low and middle income countries are able to raise at least 30% of GDP in government revenues, and a number also raise 40% suggesting this target might also be feasible. Interestingly, 12 of the 16 GFF countries fall below the median level of 28.5% for low and lower-middle income countries.

Figure 7: General Government Expenditure (GGE) as a share of GDP, 2014



More domestic resources can be raised through a combination of three options: increasing the efficiency of collection for the current taxes and charges (e.g. reducing tax avoidance or simply collecting more effectively), increasing the tax base (more people or companies must pay taxes or other charges) and introducing additional types of taxes and charges (e.g., value-added taxes, “sin” taxes, natural resource extraction levies, various types of financial transaction levies). Figure 8 reports the results of calculations showing how much additional funding each of the 12 GFF countries below the median could raise for health if they increased revenue mobilization to the median. The assumption here is that each country would allocate the same share of government revenues to health as they do currently, an assumption that is relaxed subsequently.

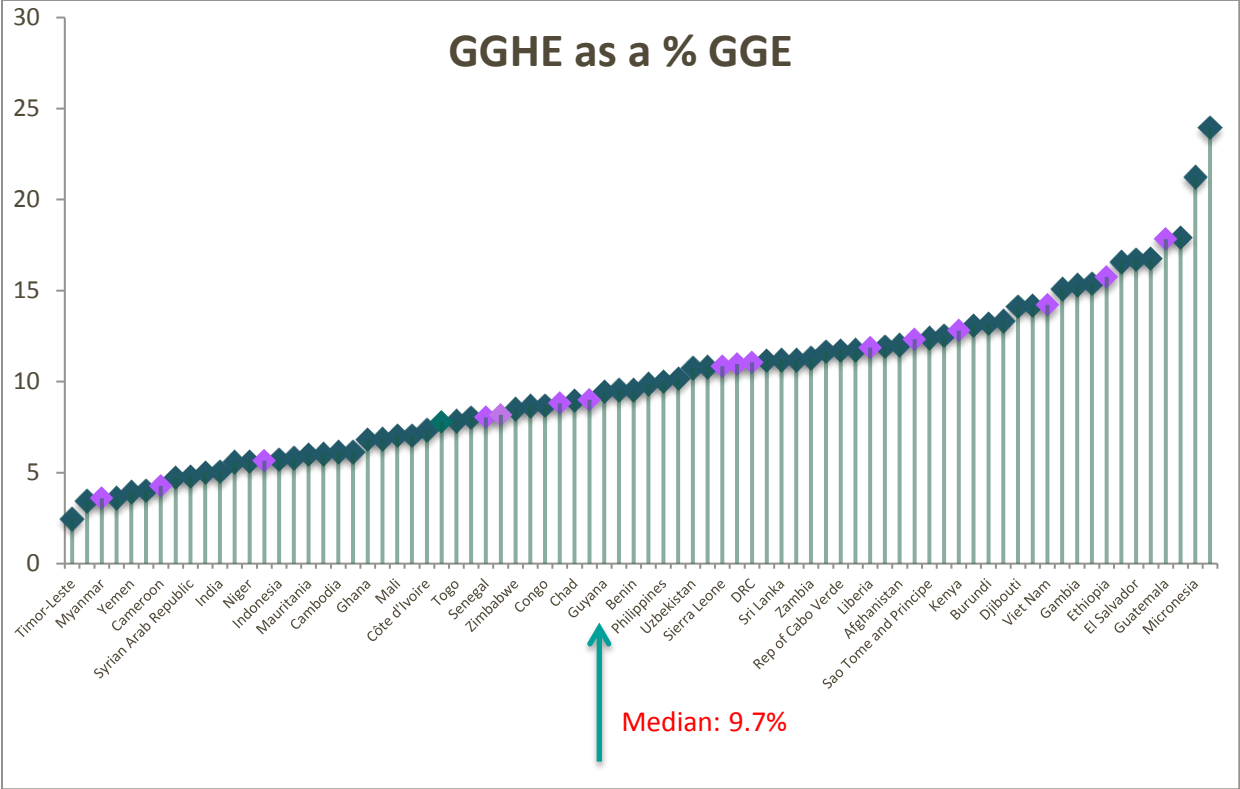
Figure 8: Additional resources for health from increasing the share of government expenditures in GDP to the LIC/LMIC median in the 12 GFF countries below the median, \$US billions, 2014



The 12 countries below the median could raise an additional \$14.1 billion for health between them, although the largest impacts are for Ethiopia, Bangladesh, Guatemala and Nigeria.

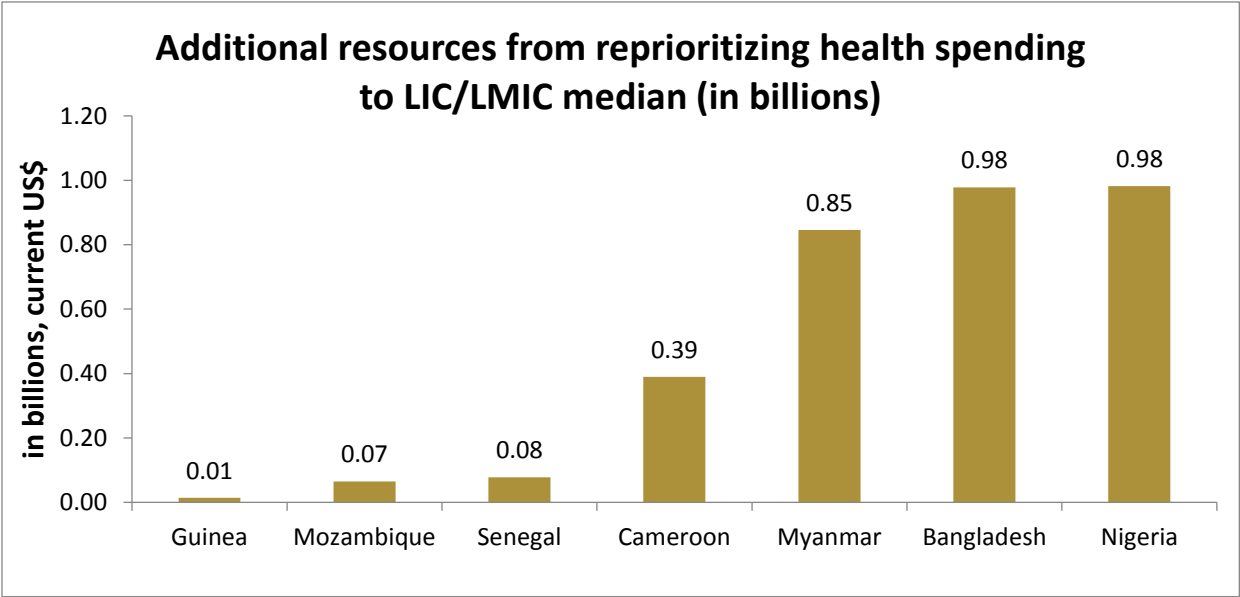
Increasing priority to health can also increase health spending, but in most GFF countries this raises less money than the focus on increased government revenues. Here the assumption is that the share of government expenditure in GDP remains as in 2014, but the countries below the median level increase the priority for health in government expenditures to the median. Figure 9 shows interestingly that while 12 of the GFF countries were below the median in terms of the share of government expenditures in GDP, only 7 are below the median in terms of priority for health in overall government expenditures (Cameroon, Bangladesh, Senegal, Nigeria, Mozambique, Guinea, Myanmar).

Figure 9: Share of health in overall government expenditures (general government health expenditures (GGHE) as a share of general government expenditures (GGE))



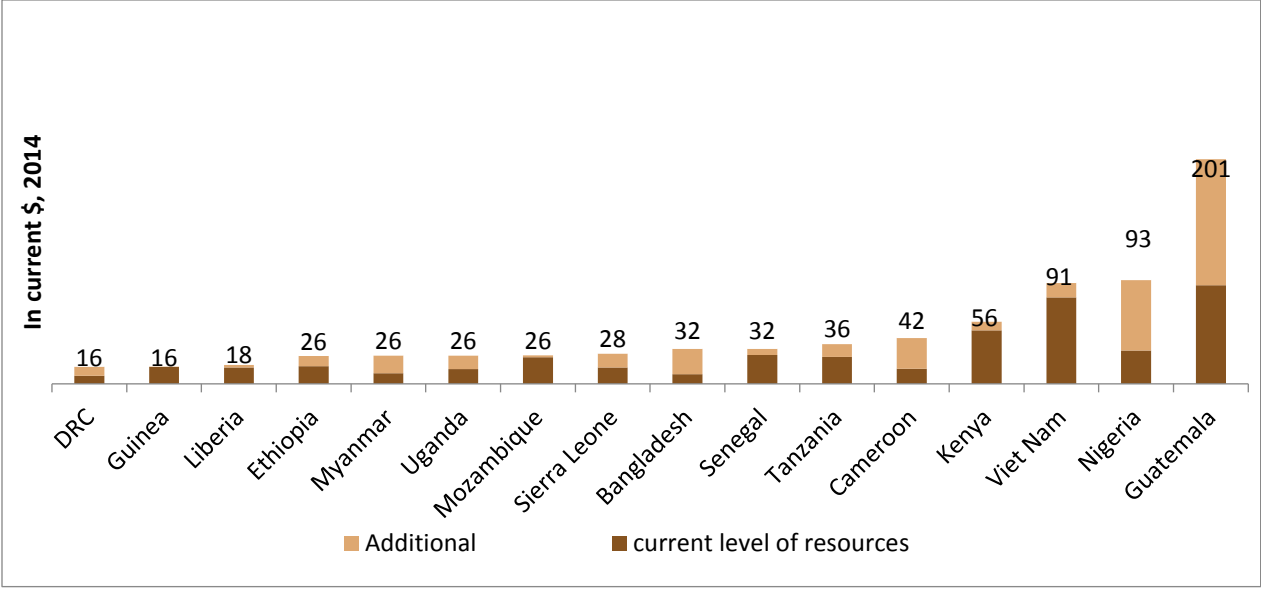
The 7 countries would raise additional \$3.36 billion for health in this manner (Figure 10) with Myanmar, Bangladesh and Nigeria showing the biggest gains.

Figure 10: Additional resources gained by increasing the share of health in total government expenditures to the LIC/LMIC median in GFF countries below the median level, \$US billions, 2014.



Increasing both tax efficiency and the priority given to health together raises more than \$23 billion. We now estimate how general government health expenditures could change with a more ambitious agenda on DRM, where both tax efficiency and priority to the health sector increase. Here we assume that countries first increase the share of GGE in GDP, then increase the share of health in GGE. The assumptions are optimistic in that if countries are greater than one percentage point below the median level of priority for health (share of GGHE in GGE), they increase to the median. All other countries increase the share of health in total government expenditures by one percentage point, except Ethiopia and Guatemala who already allocated more than 15% in 2014. Figure 11 shows current GGHE and potential GGHE in 2014, this time in per capita terms. All 16 countries benefit, to the tune of an additional \$23.03 billion, with the per capita increases ranging from \$1.20 in Guinea to almost \$113.1 in Guatemala.

Figure 11: Current per capita government health expenditure and potential government health expenditure from an ambitious agenda on domestic resource mobilization, 2014



In Guinea, the gains are relatively small compared to current levels of general government health spending – an increase of 8%. Similarly, this ambitious type of DRM would allow general government health expenditures to increase by only 11% in Mozambique; by less than 20% in Kenya and Vietnam; and by less than 25% in Liberia and Senegal. While these gains are worth generating, they are much greater in the other countries, and per capita government health expenditures could more than double in Bangladesh, Cameroon, DRC, Ethiopia, Guatemala, Myanmar, Nigeria and Uganda. The estimates presented here are only for 2014. They are repeated each subsequent year: indeed, with economic growth they increase year on year.

Improving budget performance can also increase expenditures. The health financing work to date in GFF countries has shown another possible way to increase domestic health expenditure (as opposed to revenue). A recent analysis of public expenditure reviews suggests that some GFF countries have not fully executed their budgets – DRC (2013) executed just over 40% of its health budget; Guinea (2014) under 70%; Ethiopia (2013) under 80%; while Mozambique (2014) executed over 90% (WHO2016).⁹ The reasons for low/high budget execution rates can be complex. For example, sometimes budgets are not fully disbursed by the Ministry of Finance, or are disbursed so late that the funds cannot be spent in time. Frequently budgets are allocated by line item (e.g. salaries, medicines, equipment), and do not allow flexibility to switch across items. Where salaries account for the bulk of the budget, if public service rules make hiring difficult, or part of the salary budget is to fill posts in outlying areas where it is difficult to recruit, part of the salary budget might remain unspent with no options to shift the funds to other areas. However, this area is currently being explored as another possible way to increase health expenditures in GFF countries.

⁹ WHO, 2016. Public Financing for Health in Africa: from Abuja to the SDGs. WHO, Geneva, 2016. <http://apps.who.int/iris/bitstream/10665/249527/1/WHO-HIS-HGF-Tech.Report-16.2-eng.pdf?ua=1>

GFF SUPPORTS COUNTRIES TO IMPROVE DOMESTIC RESOURCE MOBILIZATION

The previous sections showed a number of patterns and trends in health financing indicators since 2000, but also heterogeneity across countries re-enforcing the fact that policy options in health financing need to be tailored to each country. The GFF work on health financing supports countries to:

1. **Assess** the best options for addressing the DRM agenda – for example, by conducting fiscal space analysis or estimating the revenue generation potential of different options for raising additional resources (such as through “sin” taxes);
2. **Develop strategies** for increasing domestic resources for health through the support of the preparation of health financing strategies (HFSs). This may involve ensuring that DRM is a key component of the HFS and supporting the Government to commit to indicators related to increasing public financing for health;
3. **Provide implementation support** of key DRM strategies. This may involve translation of high-level strategic directions on DRM to implementation plans with actionable steps and support to the implementation of the chosen policies through a combination of technical assistance, financing, capacity building and institutional strengthening.

In all three areas, facilitating dialogue with the Ministry of Finance is critical, something to which close attention is paid in the GFF financing work.

The GFF countries are aware of the need for DRM, although the heterogeneity across countries means that their focuses vary. Bangladesh and Mozambique have, for example, noted the need for increased DRM and Bangladesh is beginning work on this. In Kenya, the health financing work as part of the GFF is linking with the parts of the WBG that work with the Ministry of Finance to support fiscal policy to explore options for either fiscal space increases or greater priority to health.

In some of the countries where economic growth and government revenues have slowed (e.g. DRC, Nigeria, Mozambique), it is proving difficult to argue for increased funds for health in the short run either by raising more government revenues or by greater priority to health. In those circumstances, the GFF will focus initially on other strategies; for example, improving efficiency and budget execution.

While the focus of the health financing work in each GFF country is still evolving, Table 1 provides a short overview of the current state of affairs (the four new countries are not included since it is too early to say what the health financing work will focus on).

Table 1: Summary of ongoing work on health financing supported by the GFF by country

Country	Main focus of HF support
Bangladesh	Health Financing Strategy (HFS) exists and implementation support program is currently being defined. It will likely focus on dialogue with the MOF to re-prioritize the budget in favor of health (DRM), improve PFM and enhance the targeting function of health-related safety net programs.
Cameroon	Background studies (fiscal space analysis, political economy analysis, PFM assessment) are currently being finalized to inform the HFS process. A Health Financing System Assessment (HFSA) will be undertaken and support will be provided to develop a HFS. The role of DRM will emerge from this, while the PFM sets the scene for greater efficiency in the use of resources.
DRC	The HFS is being finalized and implementation support is likely to focus on increasing fiscal space for health by improving efficiency in domestic health spending through PFM reforms. A PFM assessment will be completed in November and inform the MOH on key PFM steps to be taken to improve the domestic health budget execution. Additionally, the recent implementation of a single contract between donors and provincial health authorities in a few provinces ¹⁰ will yield efficiency gains in external spending. Capitalizing on this experience, the HFS is proposing to roll out this approach in several provinces. The HFS also seeks to improve advocacy for DRM and to draw on lessons from a WB governance and tax reform program from which more concrete actions in DRM will be developed.
Ethiopia	The HFS has been completed and is under review. GFF works closely USAID and the Bill and Melinda Gates Foundation with support focused on technical assistance and capacity building in the MOH and national insurance agency, operational and policy implementation analysis (e.g. on ways to improve efficiency), facilitation of knowledge exchange and policy dialogue.
Kenya	The HFS has been completed and is under review. An implementation support program will involve DRM, including an assessment of the feasibility of generating resources from sin taxes, levies and health insurance contributions, improving the efficiency of public spending, institutionalizing expenditure tracking and analyzing equity of public spending and transition issues of vertical programs. Support will also include capacity building in health financing at county and national levels.
Liberia	Support is provided to develop a focused HFS. Implementation support will likely focus on a DRM policy dialogue between the MOF and MOH. This will be informed by GFF support to: a fiscal space analysis; an assessment of the feasibility of sin taxes; the development of a new resource allocation formula for allocating funds to sub-national levels; a public expenditure review; and development of strategies to align external financing to improve efficiency in health spending.
Mozambique	The HFS is being finalized, implementation support is being defined and will likely focus on improving efficiency in health spending, strengthening public financial management, reducing fragmentation of external financing and advocacy to re-prioritize the budget in favor of health (DRM).
Nigeria	A HFS and HFSA are under development. Support is provided to the HFS process. The focus of subsequent implementation support is yet to be determined.

¹⁰ In some provinces, several donors have signed a memorandum of understanding with Provincial Health Authorities to fund and implement an operational plan at provincial level agreed by donors and provincial health authorities.

Senegal	A HFS is under development and the process and associated background studies are being supported by the GFF. Capacity strengthening on health financing will also be supported. The focus of subsequent implementation support will be determined once this work is completed.
Tanzania	The HFS has been completed and is under parliamentary review. The implementation support program is being prepared in the meantime, and subject to the review process, and will likely focus on: developing a Public Expenditure Review to assess performance and efficiency in the health financing system; supporting the transition to a single national insurance provider; promoting pro-poor coverage of services through establishing of targeting-mechanism linked to financing.
Uganda	A HFS has been completed and is under review. GFF support focuses on: the development of an implementation strategy for the HFS; an assessment of the sources of inefficiency and options for reducing them; analysis and an assessment of options for DRM; and long-term capacity building to the results-based financing/purchasing unit.
Vietnam	A draft HFS exists and an implementation support program is being defined. At the moment, the suggested focus for GFF support is on provider payment reforms, improving efficiency of health spending and other questions related to financial sustainability.

CONCLUSIONS AND GFF HEALTH FINANCING RESPONSES

Increased domestic resource mobilization, not from out of pocket payments but from forms of prepaid and pooled financing (captured in health accounts under the heading of general government health expenditures at the moment), is important to all GFF countries. It is particularly important in the countries with an absolute shortage of funds compared to estimates of need, to those which rely heavily on out of pocket payments to finance health, and to those facing the transition from Gavi and Global Fund grants in the near future.

There is room in all GFF countries for increased DRM, although the potential varies substantially across them. In half of them, government spending could more than double under the optimistic scenario described earlier and while the relative size of the potential increases is lower in the other countries, the benefits of the increases in spending in terms of improved health would still be important. In general, improving tax collection and efficiency will raise more for health than giving more priority to health in subsequent government spending, although this is not true for Guinea, Mozambique, Myanmar and Senegal where government expenditures as a share of GDP are already relatively high and increasing the priority to health in overall government expenditures offers the best option. In Cameroon both options can contribute, but increasing the priority to health will raise more for health than moving to the median share are GGE in GDP.

Guinea and Mozambique, however, pose some challenges for DRM. Their potential to substantially increase domestic revenues for health is smaller than the other countries, and their current levels of spending per capita are still too low to allow universal coverage with a minimum set of interventions at an affordable price. Securing sufficient DAH is still important for them, combined with the measures to make better use of the money that are discussed subsequently.

In most of the GFF countries, a complementary quick win is to focus on ensuring that the ministry of health fully executes its budget and on solving any problems in public financial management that make this difficult. This is one part of the overall efficiency agenda that all GFF countries recognize will allow them to achieve more with the available funds. Ministries of Finance also frequently argue that health ministries should not request additional resources until they show they can spend them, and spend them better, so the focus on efficiency improvements in GFF countries might also result in increased allocations from the Ministry of Finance.



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