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GETTING HEALTH'S SLICE OF THE PIE: DOMESTIC RESOURCE MOBILIZATION FOR HEALTH

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The Health Finance and Governance Project
USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The five-year, $209 million global project is intended to increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG supports countries as they navigate the economic transitions needed to achieve universal health care.

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GETTING HEALTH'S SLICE OF THE PIE: DOMESTIC RESOURCE MOBILIZATION FOR HEALTH

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ACRONYMS

DRM	domestic resource mobilization
EOI	expression of interest
GDP	gross domestic product
GGE	general government expenditure
GGHE	general government health expenditure
JLN	Joint Learning Network for Universal Health Coverage
MOF	Ministry of Finance
MOH	Ministry of Health
PFM	public financial management
R4D	Results for Development
SDGs	Sustainable Development Goals
UHC	universal health coverage
UN	United Nations
USAID	United States Agency for International Development
WHO	World Health Organization

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1. INTRODUCTION

Many low- and middle-income countries have experienced strong economic growth in recent years, resulting in increased capacity for social sector spending. Net energy importers have further benefited from falling fossil fuel prices. At the same time donors are preparing to scale back development assistance, including support for global health initiatives.

In this context, sustaining health gains will require countries to mobilize more domestic resources for health. Heads of state and government have recognized that "significant additional domestic public resources...will be critical to realizing sustainable development" as part of the Addis Ababa Action Agenda (UN, 2015). International donors and countries alike have endorsed the concept of domestic resource mobilization (DRM) through their participation in efforts like the Addis Tax Initiative, which aims to strengthen technical cooperation around DRM and taxation and improve the fairness, transparency, efficiency, and effectiveness of tax systems.

DRM for health means increasing the share of public resources allocated to health—or put simply, getting an adequate "slice of the pie" to achieve a country's health objectives. However, mobilizing domestic resources for health is often a complex and political process. Much of the current literature on DRM focuses on generating more government revenue through improved tax systems. While evidence shows that added tax revenue is associated with increased health spending, other sectors tend to capture a larger slice of the pie compared to health (Tamarappoo et al., 2016). Increased government revenue is therefore necessary but not sufficient for robust and sustained spending on health.

Responding to a lack of practical guidance on how countries can mobilize more domestic resources for the health sector, the Health Finance and Governance (HFG) project organized a series of joint learning workshops to promote knowledge exchange, share new and existing resources, and support countries in a DRM-for-health action planning process. Two in-person workshops and one virtual meeting were held between September 2016 and May 2017, including delegates of health and finance agencies from five countries: Bangladesh, Cote d'Ivoire, Ghana, Tanzania, and Togo. In addition to peer learning, participants also had the opportunity to engage with the former Minister of Health of Peru, Midori de Habich, who successfully worked with Peru's Ministry of Finance (MOF) during her tenure to increase the health sector budget.

This report summarizes the workshop proceedings and outputs, and provides templates, links, and tips for countries endeavoring to sustain and accelerate progress toward health objectives through the mobilization of domestic resources.

2. WHAT IS DOMESTIC RESOURCE MOBILIZATION FOR HEALTH?

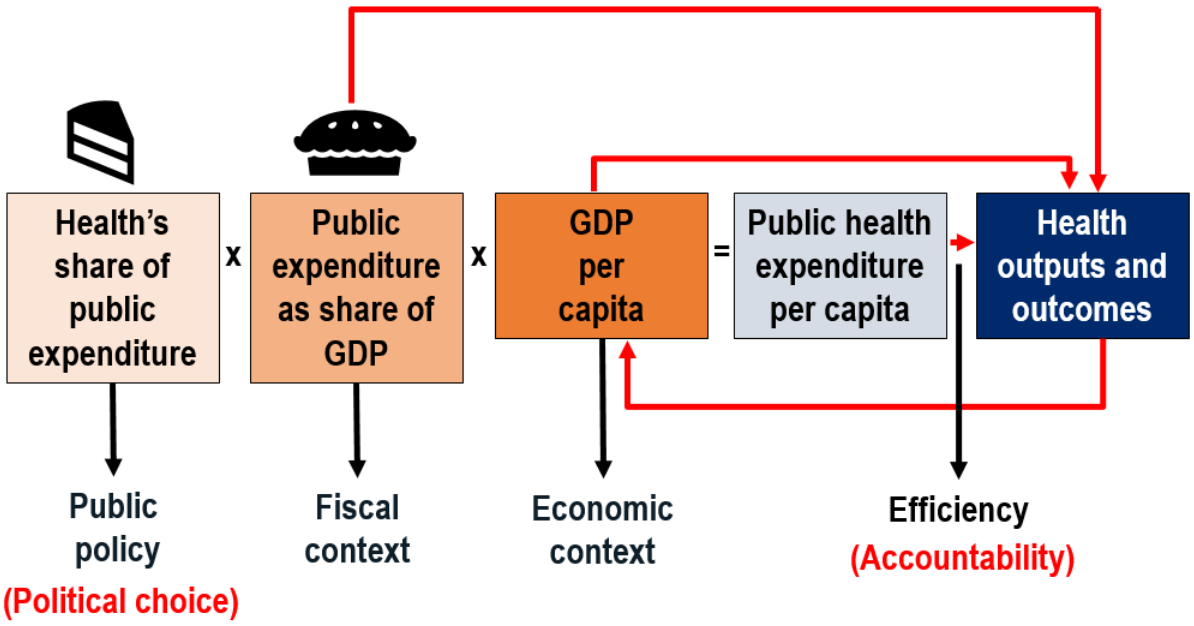
Domestic resource mobilization is "the process through which countries raise and spend their own funds to provide for their people" (U.S. Agency for International Development [USAID], 2017). Domestic funds can come from both public and private sources.

In the context of health, private resources consist of out-of-pocket spending, private investments in health system infrastructure, and private insurance. Public resources on the other hand include general tax revenue, taxes earmarked for health, mandatory health insurance contributions, and natural resource revenues, among others. To achieve universal health coverage (UHC), there is wide agreement that out-of-pocket payments should be minimized in favor of mandatory prepayment mechanisms that draw on public sources of funding (World Health Organization [WHO], 2010).

With donors planning to reduce their support for global health initiatives over the coming years, many low- and middle-income countries recognize the need to increase their public expenditure on health (Rodríguez et al., 2016). Many are also experiencing macroeconomic growth and benefiting from the recent decline in fossil fuel prices. These trends provide countries with the fiscal space or "budgetary room" to devote increased resources to health and other sectors. In simple terms, they are facing decisions about how to slice their growing pie of government resources.

However, experience shows that increased government resources do not automatically translate to increased government expenditure on health. For example, a recent analysis of tax revenue and social sector spending found that while added tax revenue is associated with increases in health spending, especially in low-income countries, other sectors tend to capture a larger slice of the pie (Tamarappoo et al., 2016). This trend is explained in part by the politically complex nature of decisions about health sector spending, represented in Figure 1.

Figure 1: Decisions about Government Health Expenditure Are Situated in a Broader Political, Economic, and Fiscal Context.



Source: Midori de Habich

To ensure a fair slice of the pie is allocated to the health sector, countries must employ a three-pronged strategy:

- Allocating sufficient public funding to health
- Ensuring that the health budget is released and spent efficiently
- Sustaining investments for continued improvements in health outcomes

The literature describes several factors that are correlated with allocations to health, such as national political priority for health, tax funds specifically for health, earmarking of tax revenues for health, and decentralized spending (Soe-Lin et al., 2015). However, countries endeavoring to sustain and accelerate progress toward health objectives using domestic resources would also benefit from additional guidance and practical tools to do so.

3. HFG'S JOINT LEARNING WORKSHOPS

Responding to this need, the USAID-funded Health Finance and Governance (HFG) project led two multi-country workshops and one virtual meeting. The workshops convened policymakers from both health and finance agencies from five countries to engage in collaborative learning, to share new and existing tools and resources, and to develop feasible and sustainable DRM for health action plans.

The workshops used peer-to-peer joint learning methods to promote knowledge exchange within and across countries, and co-generation of solutions. The workshops were conducted by technical facilitators from HFG and the Joint Learning Network for Universal Health Coverage (JLN),[1] and featured guidance and insights from former Minister of Health (MOH) of Peru, Ms. Midori de Habich, based on her experiences working with the MOF to increase the health sector budget.

3.1 Landscape Analysis

To refine the scope of the workshops, HFG conducted a landscape analysis of planned, ongoing, and past global activities focused on DRM for health. Through a desk review the team identified 24 activities taking place between 2010 and 2017, including high-level panels, workshops, conferences studies, reports, policy briefings, and blog posts. Analysis of these activities revealed several patterns:

1. The majority of DRM technical support activities are taking place in Africa, with limited activity in Asia, Latin America, and the Caribbean.
2. Many activities focus on "growing the pie" or generating more public revenue through tax policy reform and curbing illicit financial flows. Less attention is paid to how countries can get health's "slice of the pie," or allocate more of public resources to health, whatever the size of the total "pie."
3. Few activities provide concrete recommendations or tools, instead producing research on what has happened in the past, or providing fora for discussion.

Based on the results of the landscape analysis, HFG designed its workshops to increase awareness of existing tools and guidance for increasing government expenditure on health, and to share newly developed resources. The workshops were not primarily concerned with how countries can increase general government revenue (e.g., improving tax compliance). Nor did the workshops address what the optimal "slice" is for the health sector—a decision shaped by the macroeconomic, fiscal, and political context in each country, as well as a country's specific health objectives.[2]

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[1] The JLN is a network that facilitates practitioner-to-practitioner learning to help countries design stronger, more equitable and efficient primary health care-focused systems to achieve UHC. The JLN's innovative collaborative learning approach goes beyond sharing of experiences. Member countries work together to set the agenda and to translate their knowledge into practical tools and guides on how to address various implementation challenges in the pursuit of UHC.

[2] Several targets for public expenditure on health have been proposed, including relative targets like 15% of general government expenditure as articulated in the 2001 Abuja Declaration, or at least 5% of GDP (WHO 2011; McIntyre et al., 2017). Absolute per capita targets (including all sources) for covering core PHC services have also been proposed, including $54 and most recently $86 per capita (HLTF, 2009; McIntyre et al., 2017).

3.2 Country Participants

The landscape analysis also helped HFG articulate the desired profile for participant countries, including the following criteria:

- A recognized need to mobilize additional domestic resources for health
- Strong economic growth and/or falling energy bill
- Relatively low public expenditure on health.

The intended audience for this activity therefore included health (MOH, national insurance authority, or other health stewardship institution) and finance agency (MOF, Treasury, Budget Office or other financial stewardship institution) staff whose responsibilities include budgeting for the health sector, in countries deciding how to slice their growing pie of government resources—a concept also known as allocation of fiscal space.

Participant countries were identified through a two-step process. First, HFG reviewed 28 quantitative indicators for 52 countries. Indicators covered macroeconomic, health expenditure, and development assistance trends, as well as health outcomes. Nine target countries were identified, meeting the following criteria:

- HFG-supported country or JLN member country
- Gross domestic product (GDP) growth >5% (2011 – 2014)
- General government health expenditure (GGHE) < 4% of GDP (2013)
- Net energy importer.

Second, HFG issued a call for expressions of interest (EOI), targeting in particular the 9 countries identified through quantitative analysis. The call for EOIs requested that each country describe: 1) how DRM for health is of high relevance in the country's current policy agenda; 2) why the country is well-positioned to mobilize additional government resources for health; 3) specific successes or challenges to date; and 4) additional tools and approaches that are needed to make further progress. The call for EOIs also asked each country to identify a delegation of four people representing a range of stakeholders including the Ministry of Health, Ministry of Finance, health insurance authority, academia, or equivalent institutions. Four country delegations were ultimately accepted to participate: Bangladesh, Cote d'Ivoire, Ghana, and Tanzania. In addition, representatives from Togo submitted an EOI and participated in the final workshop.

3.3 Joint Learning

3.3.1 Abidjan workshop (September 2016)

The first joint learning workshop was held in September 2016 in Abidjan, Cote d'Ivoire and attended by health and finance representatives from Bangladesh, Cote d'Ivoire, Ghana, and Tanzania. The workshop began with an exercise to identify areas of agreement and disconnect between MOHs and MOFs, followed by sessions that introduced available tools and resources for improving dialogue between the two agencies and making a case for increased health spending. The workshop concluded with a planning activity, in which each country delegation incorporated insights and tools into action plans to vet, adapt, and implement over the coming year. Participants also benefitted from guidance from Ms. Midori de

Habich, former Minister of Health of Peru, who shared insights from her own experience working with her counterparts at the MOF to increase the national budget for health.

3.3.2 Webinar (November 2016)

In November 2016 participants reconvened through a virtual meeting to provide updates on adaptation and implementation of their action plans, and to collectively troubleshoot challenges. Delegations reported on the stakeholder meetings they had held to further develop their action plans, and presented draft versions of their discussion dossiers—a tool presented during the Abidjan workshop. They also identified topics for discussion at the next in-person workshop.

3.3.3 Accra workshop (May 2017)

In May 2017, a second workshop was held in Accra, Ghana. The workshop provided a venue for participants to: (1) report progress and outcomes to date, (2) brainstorm solutions to challenges they had faced in implementing their action plans, and (3) learn about additional topics and resources that were not covered in the first workshop such as earmarking specific tax revenues for health. Again, participants were able to draw on the expertise of former Minister de Habich, who shared specific tips addressing the three components of a DRM strategy: increasing allocations to the health sector, ensuring health budgets are released and spent efficiently, and sustaining investments over the long term.

The following sections of this report describe in detail the content of the workshops, including common challenges, ingredients for a successful MOH-MOF dialogue, tools and resources, and guidance on action planning.

4. WORKSHOP LEARNINGS

Workshop Learnings 1: Common Challenges in the MOH-MOF Relationship

Dialogue and decisions about public expenditure on health are politically complex, and they play out primarily in the relationship between MOHs and MOFs, or equivalent government institutions.

Contrasting MOH and MOF perspectives

MOHs are typically responsible for using scarce government resources to improve the health of the population. Meanwhile**,** MOFs are typically responsible for allocating government's scarce resources across all public sectors, and holding institutions and agencies accountable for their efficient use.

Table 1: Roles of the MOH and MOF in Health Systems.

MOH Roles	MOF Roles
Develop sector-wide strategies	Provide instruction for annual budget request process and budget ceilings
Set health sector priorities	Evaluate economic return on government investment across sectors
Assess annual and multi-year budget requirements	Assess and finalize annual and multi-year budget plans for all ministries, including health
Prepare annual budget requests and advocate for funding levels	Release funds according to approved budget
Oversee or directly manage the delivery of health services	Oversee compliance with government expenditure regulations
Track and document health outcomes and impact	Ensure accounting, reporting, and final outturns are consistent between central system and ministries
Account for health expenditures, and ensure internal controls	Ensure internal financial control throughout government
Set sector standards for and control agencies	Ensure budget requests are consistent with national and sector objectives
Ensure proper control over all sector revenues	Assess cost-effectiveness

Source: Kanthor et al, 2013

In many contexts, the MOH-MOF relationship is a challenging one. To address common concerns head-on, the workshop series began with an activity in which health and finance representatives listed their complaints about the MOH-MOF relationship.

MOH representatives tended to say that:

- Allocations to health do not align with stated national health strategies and priorities
- The health sector receives inadequate resources to meet population health needs
- There are delays in the disbursement of funds

Meanwhile, MOF delegates frequently noted that:

- The health sector cannot demonstrate that money has been spent efficiently
- The health sector has weak internal financial controls
- The health sector has difficulty spending its budget by the end of the fiscal year, so cannot justify increased allocations

Unique features of the health sector

One challenge that impedes MOH-MOF dialogue is that the health sector has important differences from other sectors, which make budgeting and planning particularly difficult. First, it can be difficult to demonstrate efficiency in spending when health is a somewhat subjective state of being, and not a good or service that is easily measured or monetized. In addition, because healthcare needs vary across populations, time, and geographic areas, health sector financial planning involves high levels of uncertainty, especially at the local level. Moreover, the most expensive healthcare needs are often concentrated in a small number of people, making it necessary to mitigate risk across the population by pooling resources. Finally, provider and patient decisions can significantly impact the cost and quality of care, such as doctors prescribing unnecessary tests or drugs, or patients bypassing primary healthcare facilities in favor of hospitals (Cashin et al., 2017a).

Finding a common language and shared objectives

Another challenge impeding dialogue between MOHs and MOFs is that each agency is staffed by individuals with different educational backgrounds and specialties, different priority concerns, varying key stakeholders, and different technical jargon—illustrated in the table below. These differences impede the ability of budget and finance agencies to interpret requests from the health sector, and likewise hinder health agencies in responding to questions and concerns from their counterparts in the Ministry of Finance.

Table 2: Illustrative Differences between Health and Finance Agencies, which Often Impeded Productive Dialogue

	Ministries of Health	Ministries of Finance
Staffed by	• Doctors • Nurses • Public health specialists	• Economists • MBAs • Accountants
Priority concerns	• Health outcomes • Unexpected events that impact health (e.g., famine, natural disasters, epidemics)	• Sources of revenue • Budget execution • Efficiency
Priority stakeholders	• Patients • Providers	• Cabinet and Parliament • Auditors
Technical jargon	• Morbidity and mortality • Primary, secondary, tertiary care • Epidemiology • IMCI, BEmONC, CEmONC	• Costs and benefits • Productivity • Return on investment • Zero-based budgeting • MTEFs

But there are more shared objectives than generally recognized, as participants of HFG's joint learning workshops came to realize through group work exercises. In fact, both entities prioritize:

- Poverty reduction
- Healthy and productive workers and students
- Reduced costs
- Efficient and effective use of resources
- Improved financial management.

These shared objectives can serve as a foundation for dialogue and collaboration to improve health financing and outcomes.

Workshop Learnings 2: Ingredients for a Successful MOH-MOF Dialogue

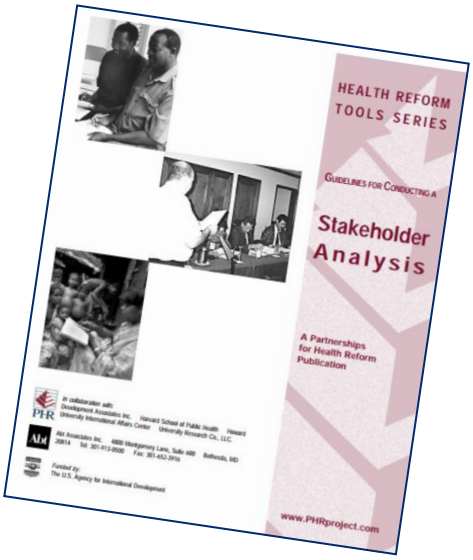
Insights from the former Minister of Health of Peru

In addition to peer learning approaches, the workshops provided participants an opportunity to engage with former Minister of Health of Peru, Ms. Midori de Habich. During her tenure as Minister, Ms. de Habich worked successfully with the MOF to increase the government budget for health. Based on this experience, she served as a resource to the country delegations and provided five key pieces of guidance for improving the MOH-MOF relationship.

- **Institutionalize a regular consultative process between health and finance agencies among both senior and mid-level staff**. This process should supplement formal budget negotiations with more frequent meetings, and can help to build rapport and understanding.
- **Invest in personnel in both MOHs and MOFs who are well-versed in the technical terms of both institutions**—hire them, train them, and retain them. Combined with a regular consultative process, this can help to sustain dialogue during periods of leadership transition.
- **Support negotiations with good-quality, shared information on value**. Value is a function of outcomes over cost, and therefore it is important to present data on both health outcomes and expenditures. A "discussion dossier" is one format for presenting this data in support of health sector budget negotiations.
- **Adopt a dual focus on short-term wins and mid-term planning.** For example, executing the health sector budget and improving financial controls in the near term can help increase the MOF's willingness to engage in three-year budgeting exercises that provide increased flexibility in health spending. This is because MOFs view sector spending as a mechanism for stimulating economic growth, and are therefore concerned about the macroeconomic impacts of underspent budgets.
- **Engage with a wide range of stakeholders when making a case for increasing public expenditure on health.** Seek input on proposed policies from other social sectors like nutrition and WASH, donors, private sector providers, NGOs, citizens, and the media. When they trust that their voices have been heard, these constituencies may form coalitions to bring political pressure to bear in favor of health sector spending.

Workshop Learnings 3: Practical Tools and Resources

Conducting a stakeholder analysis



There are many tools available to help improve MOH-MOF dialogue and "make the case" for increased budgetary allocations to health.

The first is stakeholder analysis, which helps advocates to assess the perspectives, interests, and influences to consider when developing or implementing a policy or program—in this case increasing government expenditure on health. By understanding who the decision makers are and what their interest are, advocates can more effectively frame the discussion, incorporate feedback, and generate support for proposed changes.

To put into practice the steps they learned during the workshop, participants conducted a stakeholder analysis exercise for their own contexts using a template (see **Annex A**) derived from Guidelines for Conducting a Stakeholder Analysis authored by Kammi Schmeer.

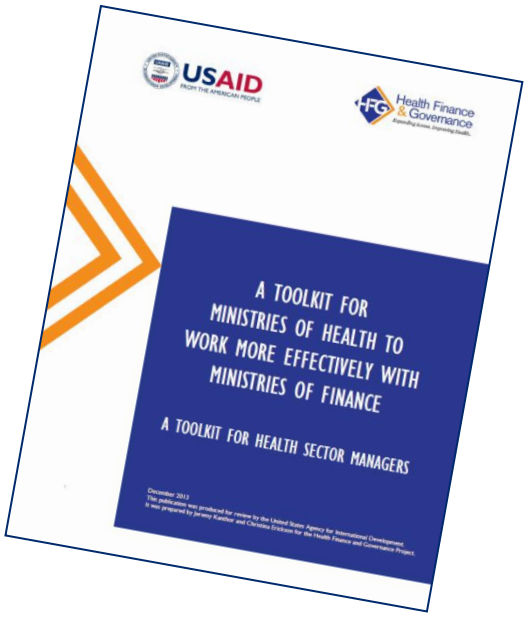
Developing a MOH-MOF discussion dossier

Once advocates understand who the key stakeholders are and what their interests are, the next step is to develop messages that make a case for increasing health's "slice of the pie," relying on high-quality data. These messages and data should respond to the concerns and priorities of all parties.

The MOH-MOF discussion dossier, developed by HFG workshop facilitators, is one set of resources available to support countries in preparing for health sector budget discussions. The tools consist of (1) a sample list of key data categories (see **Annex B**) and an example presentation format for adaptation based on available data and stakeholder priorities (see **Annex C**. The sample presentation begins by describing national health policy objectives, and then proceeds to highlight key data (macroeconomic, health expenditure, health outcomes) and trends with comparisons to peer countries when relevant.

This concept resonated strongly with workshop participants, and country teams from both Ghana and Bangladesh have since developed robust dossiers. Ghana noted that the dossier presents several opportunities for collaboration across the MOH and MOF, including joint preparation of the dossier and presentation of the dossier to a wider stakeholder group.

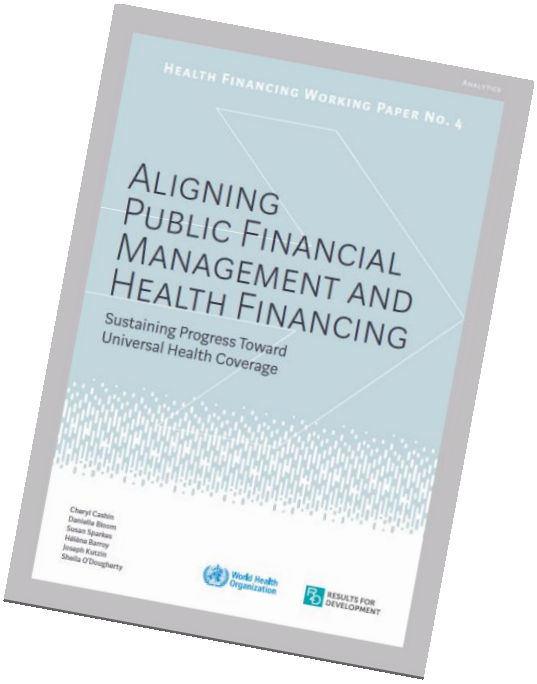
Toolkit to Improve Dialogue between Ministries of Health and Ministries of Finance



To further support MOF-MOF dialogue, workshop facilitators shared with participants a set of resources developed by the HFG project to help MOHs better manage their own financial and information resources and in turn to communicate more effectively with MOFs. A Toolkit for Ministries of Health to Work More Effectively with Ministries of Finance includes four tools:

- **Guided Self-Assessment of Public Financial Management (PFM) Performance**—To identify and address misalignments between budget and spending cycles, to better support health financing needs
- **Developing Key Performance Indicators (KPIs)**—To track and demonstrate outputs and impact of health spending
- **Self-Assessment of Internal Control**—To improve and demonstrate financial accountability and compliance
- **Data for Efficiency Tool**—To organize data in a way that demonstrates value for money

Aligning Public Financial Management and Health Financing: Sustaining Progress toward Universal Health Coverage



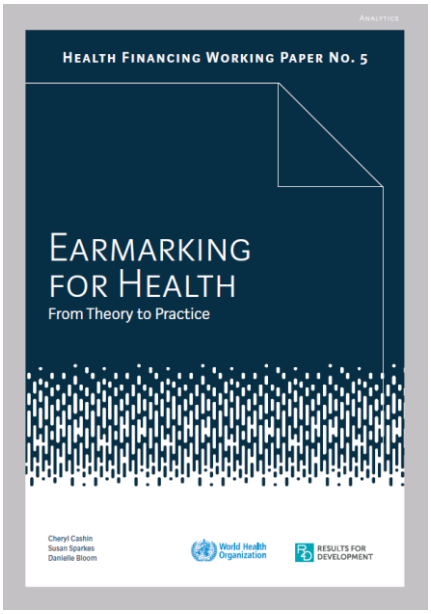
Several country teams expressed interest in improving health sector efficiency by strengthening sub-national financial management. In addition to HFG's Guide Self-Assessment of PFM Performance, workshop facilitators shared a working paper that was recently published by the WHO and Results for Development (R4D). Aligning Public Financial Management and Health Financing: Sustaining Progress Toward Universal Health Coverage provides a framework and guidance for aligning PFM processes and health financing systems**,** which can lead to:

- More predictable budget allocations
- Reduced fragmentation in revenue streams and funding flows
- Timely budget execution
- Better financial accountability and transparency

A complementary process guide is forthcoming.

Earmarking for Health: From Theory to Practice

Responding to participant requests, the workshop series included a session on innovative health financing. The session began by defining what "innovative" means in the context of DRM. Five to ten years ago, "innovative financing" referred mostly to methods for channeling external donor funds toward health. Today, health financing discourse focuses increasing on the role of domestic resources. Since tax policy and administration are the key levers for increasing domestic resources, innovations involve non-traditional ways of channeling tax revenue toward the health sector.



Levers for generating increased tax revenue for health include direct taxes on income, profits, and assets, such as payroll taxes in many countries, including for instance, Indonesia, that fund social health insurance for formal sector workers. Other levers are indirect taxes on goods, services, and transactions, such as in Ghana where a portion of the value-added tax (VAT) is allocated to the National Health Insurance Fund. Other examples of indirect taxes are: taxes on natural resource extraction (for example, Nigeria's SURE-P) and financial transactions, trade tariffs, mobile phone taxes (for example, in Gabon), and sin taxes on alcohol and tobacco. Sin taxes in particular are an increasingly popular revenue source. For example, in 2014 taxes on alcohol and tobacco funded over 35% of government health expenditure in the Philippines.

Earmarking is a common mechanism for directing tax revenue to the health sector. Earmarking involves setting aside a specific portion of revenue for a dedicated purpose. It is often politically popular, and can help to improve accountability in government spending. However, there are also drawbacks such as fragmentation of the national budgeting process. Given its many pros and cons, there are several criteria for analyzing whether earmarking is appropriate in a given country context. One factor to consider is to what extent a revenue source may be regressive or progressive—that is, the extent to which it disproportionately burdens the poor or generates its revenue from the richer.

Additional information and guidance on earmarking can be found in a new resource produced by the WHO and R4D—Earmarking for Health: From Theory to Practice. The paper discusses both the theoretical foundation and country experiences with earmarking, including a **typology** of earmarking policies, country **case studies**, and a **checklist** of key considerations for countries considering earmarking.

5. ACTION PLANNING

Building on group discussions, guidance from Minister de Habich, and the tools and resources presented, the workshops culminated in an action planning process. Facilitators provided planning prompts and templates (**Annexes D and E**) to country teams, who then drafted "living" action plans meant to be vetted with a wide range of stakeholders, revised based on feedback and country context, implemented, and periodically re-evaluated and adapted.

Figure 2: Action Planning Process

Workshop participants drafted phase I action plans in September 2016. Two months later, they reconvened for a virtual meeting where they reported on progress in sharing and adapting their phase I action plans with key players in the MOH, MOF, and other institutions. In May 2017, country teams reported on implementation of their phase I action plans, including progress, challenges, and outcomes. Then, they developed phase II action plans that incorporated new resources and lessons learned during the concluding workshop. Phase II action plans include new activities and continue activities from phase I that are still in process. The results of this process are summarized in Table 3.

Table 3: Implementation and Adaptation of DRM for Health Action Plans

Country	Phase I Action Plan Developed September 2016	Interim Progress September 2016 – May 2017	Phase II Action Plan Developed May 2017
Bangladesh	• Develop discussion dossier and convene a coordination meeting between the Ministry of Health and Social Welfare (MOHSW) and MOF	• Co-developed robust discussion dossier and used it (particularly country comparisons) to increase health sector budget from 4.3% to 5.1% of national budget	• Hold a joint seminar on increasing private sector investments in health to achieve UHC
Côte d'Ivoire	• Develop institutional framework for DRM, including subnational levels of health system • Strengthen budgeting and planning capabilities within MOH	• Phase I action plan adopted by MOH, but not yet MOF • Order establishing inter-ministerial committee on DRM drafted	• Train 75% of staff on budgeting and planning with support of HFG • Set up inter-ministerial committee on DRM

Country	Phase I Action Plan Developed September 2016	Interim Progress September 2016 – May 2017	Phase II Action Plan Developed May 2017
Ghana	• Develop discussion dossier • Establish multi-agency steering committee on DRM for health	• Ghana Health Service (GHS) and MOF co-developed robust discussion dossier • Established unit within GHS focused on DRM	• In post-election context, re-engage key stakeholders through joint meetings • Finalize and present discussion dossier
Tanzania	• Improve financial controls and reporting at sub-national levels	• Implementing new facility-level accounting system (FFARS)	N/A
Togo	• Establish a framework for MOF-MOF dialogue • Establish a partnership framework for private sector participation in health	N/A	N/A

6. CONCLUSIONS

In the context of declining donor support, there is consensus that DRM represents "the long-term path to sustainable development finance" (USAID 2017). Much of the current literature on DRM focuses on generating more government revenue through improved tax systems. However, increased government revenue is necessary but not sufficient for robust and sustained investments in health. Unproductive communications, mistrust, and misunderstandings between Ministries of Health and Finance contribute to bottlenecks in allocating needed resources to the health sector.

Responding to a lack of practical guidance on how countries can better channel domestic resources to the health sector, HFG's series of joint learning workshops promoted improved MOH-MOF dialogue through peer-to-peer knowledge exchange. The workshops also provided practical tools and approaches for:

- Identifying shared objectives between MOHs and MOFs that can serve as the basis for more productive dialogue about health sector spending
- Increasing domestic resources for health directly by improving the effectiveness, efficiency, and equity of health spending, strengthening internal controls, and
- Jointly creating and implementing action plans that can help MOHs and MOFs clarify, build deeper working relationships, and commit to next steps for "getting's health's slice of the pie."

ANNEX A: STAKEHOLDER ANALYSIS TEMPLATE

Below are several questions and prompts to stimulate stakeholder analysis related to DRM.

- Key stakeholders
  - Who are the main stakeholders (groups, individuals) in the MOH and MOF?
  - Who are the key stakeholders beyond MOH and MOF (e.g., legislature, decentralized governments such as district councils, president/cabinet, civil society, media)?
- Interest and position
  - What are the interests and concerns of each stakeholder, relative to DRM?
  - Is the stakeholder a supporter, neutral, or an opponent of the proposed change?
- Influence
  - How much power or influence does the stakeholder have over development and execution of the health budget?
- Engagement and messaging
  - Which stakeholders should be engaged directly?
  - What key messages would respond effectively to the interests of high-priority stakeholders?
  - What types of communications materials and channels might be useful/effective?
  - What are some approaches to building trust (e.g., frequency of interaction, secondment of staff)?

Key Stakeholders	**Interest in the Issue** *(top objectives and concerns)*	**Position** *(supporter, neutral, opponent)*	**Influence Over the Issue** *(high, medium, low)*	**Engagement Priority Based on Position and Influence** *(high, medium, low)*	**Key messages and Approaches that Respond to Interests**

ANNEX B: MOH-MOF DISCUSSION DOSSIER —SAMPLE LIST OF KEY INFORMATION

By compiling and presenting the types of data below, Ministries of Health can address and respond to issues raised by Ministries of Finance during past budget negotiations, such as:

- Relating spending to outputs/outcomes
- Questions about efficiency
- Questions about spending of allocations
- Concerns about declining external support, etc.

National Policies and Strategies:

- National strategies and plans:
  - Focusing on how health is emphasized relative to other sectors
- Health sector strategy/policy:
  - Main objectives
  - Cost estimates (absolute, relative to past spending and projected spending)
  - Focus on any content related to financing, efficiency, investments v. operating costs

Macroeconomic and Fiscal Indicators (for last five years, if available):

- Economic growth rate:
  - Last 5 years
  - Projections for the next 3 – 5 years
- Tax capture:
  - As share of GDP
  - Last 5 years
  - Projections for the next 3 – 5 years

Health Expenditure Data (for last five years, if available):

- Government Health Expenditure (GHE):
  - Absolute amount
  - Relative to General Government Expenditure (GGE)
  - Relative to Gross Domestic Product (GDP)
  - Relative to GDP per capita
  - Compared to peer countries (neighbors, income per capita group, and region)

- Out-of-Pocket Expenditure (OOPE):
  - Absolute amount
  - As a share of Total Health Expenditure (THE)
  - As a share of THE per capita
  - By income quintile
  - Compared to peers (neighbors, income per capita group, and region)
- Spending of allocated resources:
  - GHE compared to budgeted/allocated amounts
- Total Health Expenditure (THE):
  - Absolute amount
  - Relative to GDP
  - Relative to GDP per capita
  - Compared to peers (neighbors, income per capita group, and region)

External Assistance for Health (for last five years, if available):

- Historical amounts:
  - Broken out between grants and loans
  - How funds are restricted (e.g., for HIV, for family planning)
  - Relative to GHE
  - Per capita
  - Compared to peers (neighbors, income per capita group, and region)
- Spending of external assistance:
  - Absolute amounts for operations v. investment/external TA
- Projected amounts:
  - Next 3-5 years
  - How restricted (e.g., losing eligibility for Global Fund, PEPFAR, GAVI assistance, World Bank IDA lending and/or secular decline)

Health Indicators (for last five years, if available):

- Infant Mortality Rate (IMR)
- Maternal Mortality Ratio (MMR)
- Under-Five Mortality (U5M)
- Immunization coverage
- By income quintile
- Compared to peers (neighbors, income per capita group, and region)

ANNEX C: MOH-MOF DISCUSSION DOSSIER ——SAMPLE PRESENTATION FORMAT

https://www.hfgproject.org/sample-drm-health-dossier-jasmania/

ANNEX D: ACTION PLANNING TEMPLATE—PHASE I

- Objective
  - To set a clear partnership agenda among the representatives of health and finance sectors for a bigger slice of the pie for health
- Outcomes
  - To identify key challenges, potential solutions, priority actions, and resources needed to improve dialogue between health and finances agencies
- Planning Prompts
  - Problem specification and root cause analysis
    - What specific domestic resource mobilization (DRM) problem(s) are you trying to solve?
    - What are the root causes leading to each of these problems? Where are the key bottlenecks?
    - Where are there gaps in perception between MOF and MOH?
  - Potential solutions, processes, and strategies
    - What specific actions could be taken to address each of these root causes?
    - What stakeholders must be engaged?
    - What tools might be helpful to inform these actions?
  - Data/information assembly, analysis, and packaging
    - What additional information and analyses are needed to make the case for investing in health?
    - What key indicators does MOF need?
    - What key indicators would help MOH make a stronger argument?
    - How, when, and to whom should the information be packaged and presented?
    - Are there possibilities for MOH-MOF collaboration on information generation, analysis, and packaging?
  - Next steps
    - Which actions are most important? Which can you implement in the near-term?
    - What human, financial, and physical resources do you need to implement these next steps?
    - What output will you have ready to share in six weeks? Six months?

Specific DRM Challenges	Root Causes	Specific Actions to Address Challenges	Information and Analyses Needed	Stakeholders to Engage	Tools to Apply	Next Steps	Resources Needed	Outputs to Share

ANNEX E: ACTION PLANNING TEMPLATE—PHASE II

- Objective
  - To set a clear partnership agenda among the representatives of health and finance sectors for a bigger slice of the pie for health
- Outcomes
  - To set a specific goal, output, and priority actions towards the partnership agenda
  - To take stock of progress made on existing action plans and make necessary amendments to accelerate progress towards the goal
- Step 1: Define a goal for improving the MOH-MOF relationship and obtaining a bigger slice of the pie for health
  - Be context-specific—goal should be based on your country's political economy, inter-ministerial relationship, and policy priorities
  - Include pioneering ideas—increased DRM for health may require breaking barriers and changing communication paradigms
  - Consider various formats—an initiative, a coordination platform, a partnership document, etc.
- Step 2: List an output that could demonstrate the partnership described in Step 2
  - What could be tangibly achieved by the partnership in the near-, mid-, and long-term?
- Step 3: Describe priority activities that will help to achieve the output (listed in step 2) over the next six months
  - Refer to Phase I Action Plans to select continuing activities and add new activities as needed
  - Indicate which institutions will undertake the activities (e.g. MoH, MoF, Joint)
  - List main stakeholders to engage in the activity
  - Refer to the tools and resources discussed during the workshops

Step 1: Define a goal for improving the MOH-MOF relationship and obtaining a bigger slice of the pie for health			
Step 2: List an output that could demonstrate the partnership described in Step 2			
Step 3: Describe priority activities that will help to achieve the output (listed in step 2) over the next six months			
Activity 1: Description *Can include both new and continuing activities*	**Responsible sector** *(MOH, MOF, Joint)*	**Stakeholders to engage**	**Tools to apply**
Activity 2: Description	**Responsible sector**	**Stakeholders to engage**	**Tools to apply**
Activity 3: Description	**Responsible sector**	**Stakeholders to engage**	**Tools to apply**

ANNEX F: REFERENCES

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