Towards Greater Domestic Resources for Health and Family Planning

ATTAINING SUSTAINABLE FINANCING FOR FAMILY PLANNING IN SUB-SAHARAN AFRICA

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Dr. Chris Atim, HFG/Ghana

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Objectives of the session

- Understand DRM and its importance
- Discuss DRM options and their feasibility to country contexts
- Learn from country experiences on DRM
- Discuss and analyze main DRM Dilemmas

Outline of the Session:

Plenary Presentation:

- Technical deep-dive into DRM

Panel:

- Country experiences with various DRM approaches

Facilitated discussion:

- How to address most common DRM dilemmas?

Outline of the Presentation

- Introducing DRM – what is it and why is it so important?
- Outline of traditional and non-traditional methods for mobilizing resources
- Factors that influence DRM and need to be accounted for
- Tools available to guide DRM initiatives and decision making processes

What is DRM? And why is it so important?

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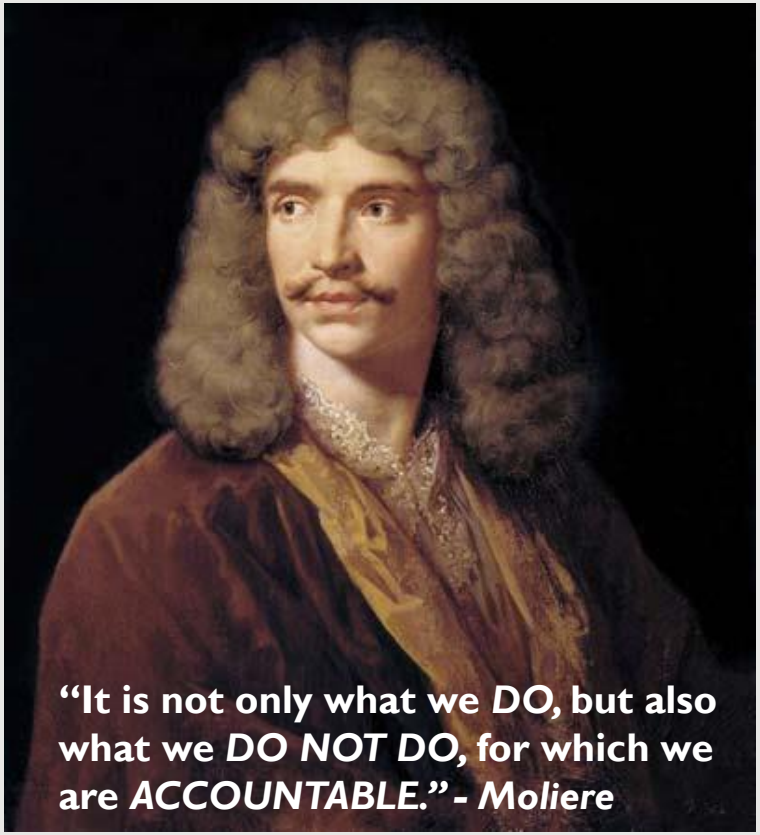
What is DRM?

- Domestic Resource Mobilization refers to the process by which countries raise and spend their own funds to provide health care for their people.
- Domestic Resources Include:
  - Public funds mobilized through "traditional" methods
  - Public funds mobilized through "innovative" methods
  - Private sector investments
  - User fees
  - Other methods for internal revenue generation

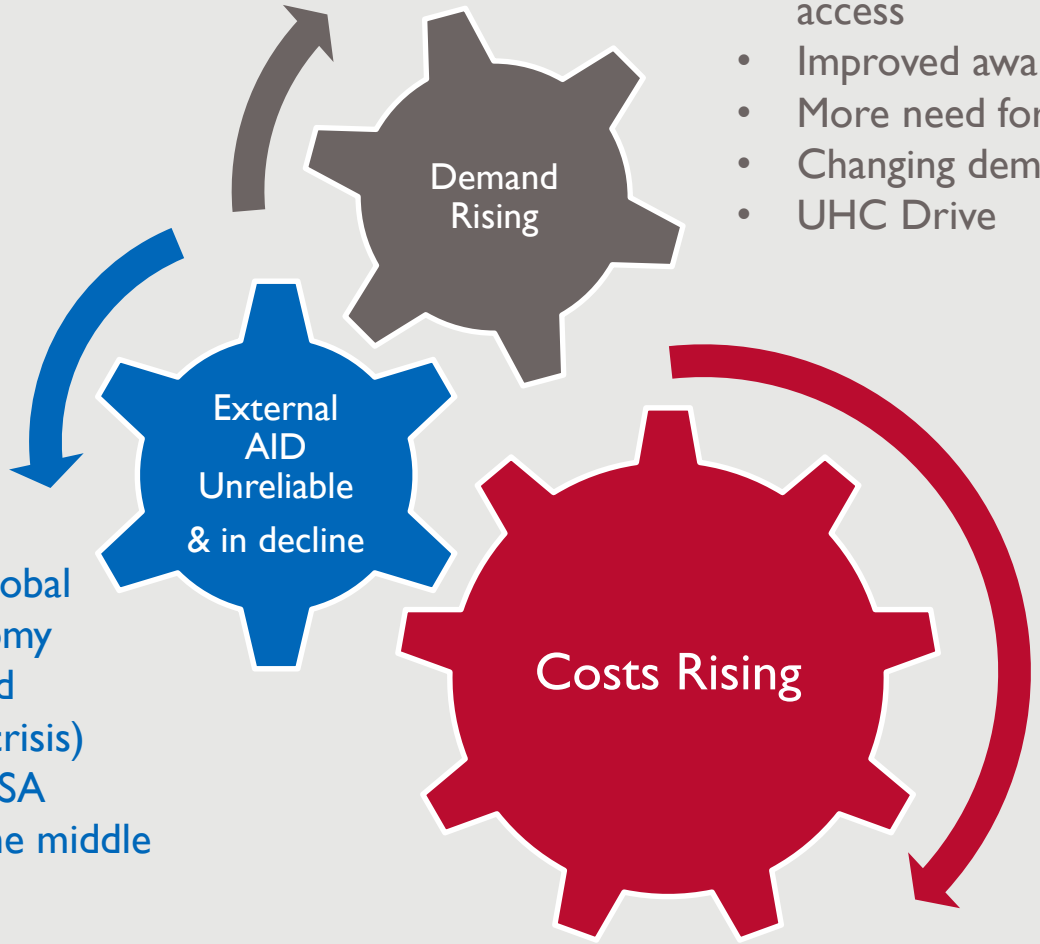
Why is DRM so important?

- DRM promotes and demonstrates ***country ownership*** of healthcare policy
- Generating domestic resources is the ***long-term, sustainable*** option to health financing initiatives
- Health is increasingly considered a basic human right – premise of the global UHC movement
- From that perspective, governments ***ARE responsible*** for providing funding for health for their populations:
    - In 2010, an estimated 97 million people (1.4% of world's population) were impoverished on health care at the 2011 PPP $ 1.90-a-day poverty line in 2010; rates were highest in Africa and Asia



Healthcare investments need to grow

- Increased supply and access
- Improved awareness
- More need for health
- Changing demographics
- UHC Drive



- Depends on global political economy (recessions and humanitarian crisis)
- Countries in SSA approaching the middle income status

- Advanced technology
- Rising labor costs
- Aging population
- Non-communicable diseases globally
- Dual burden of disease in SAA

And the projections are even more alarming…

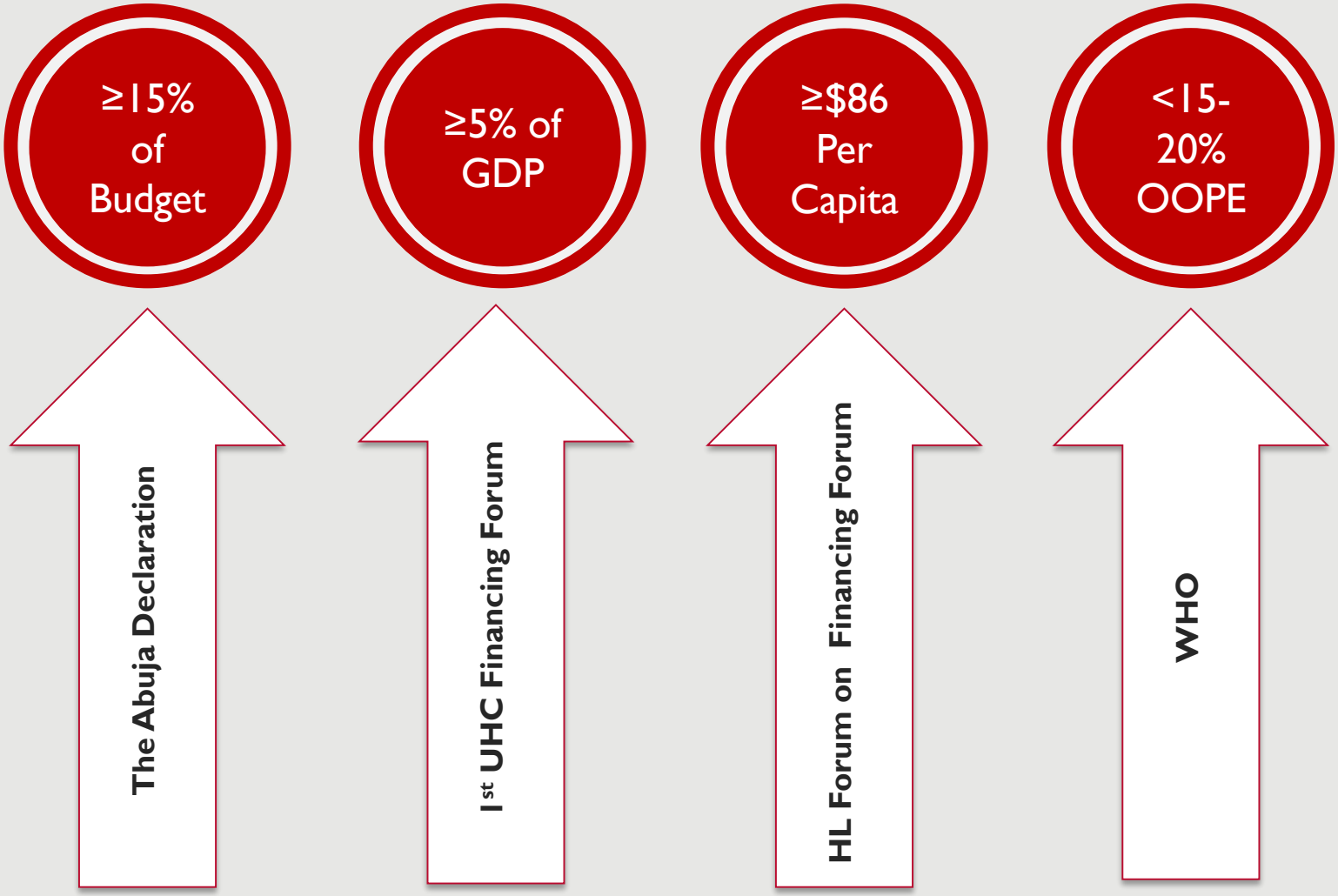
- Global Healthcare Expenditure projected to increase to **$8.7 trillion in 2020**, from $7 trillion in 2015
  - About 50% will be spent on three leading causes of death: **cardiovascular diseases, cancer and respiratory diseases**
- Aging population (over 65 years old) projected to increase by **8%** (from 559 million in 2015 to 604 million in 2020).
- No "magic bullet" for health financing has been discovered to date, no matter the system

Source for 1,2 and 3: Global Healthcare Outlook 2017; Deloitte

How much should we mobilize and spend for health?

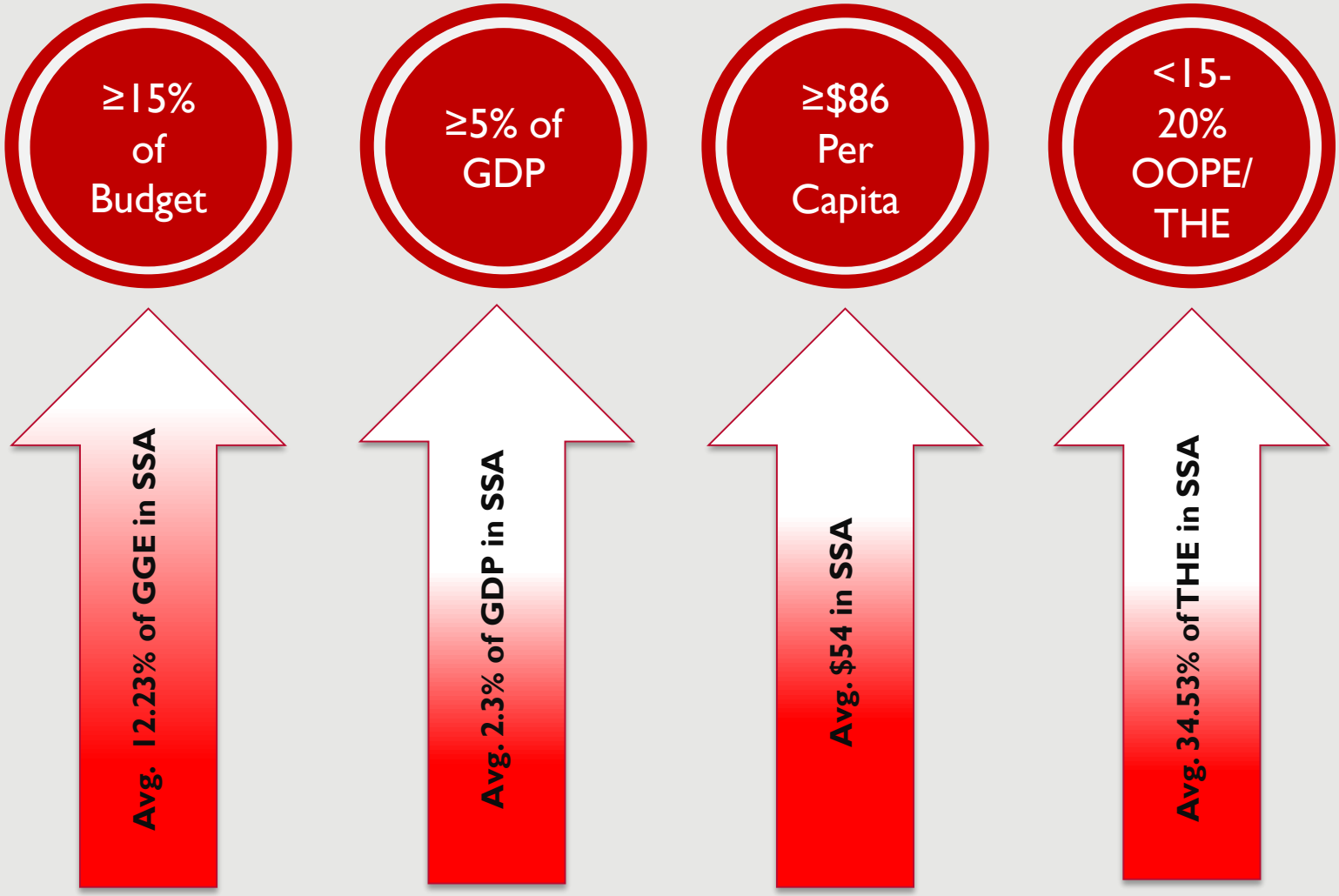
No magic number!..

…just some normative benchmarks



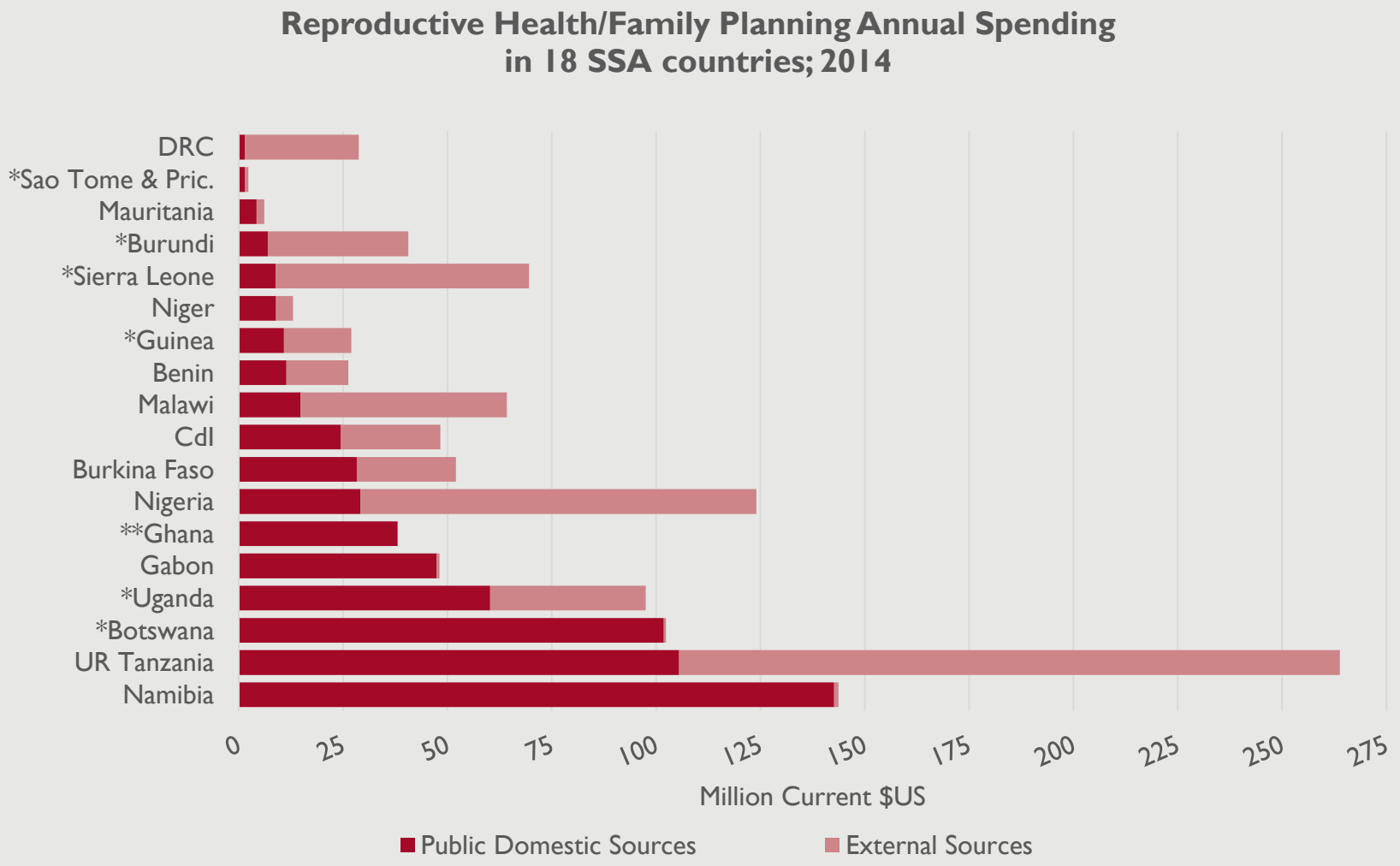
Sources: Abuja Declaration, Raising Funds for Health – Background Paper, 1st UHC Financing Forum; "How much should countries spend on health" – Discussion Paper, WHO

How well has SSA region been doing?



Sources: World Data Bank, WHO Global Health Expenditure Database; 2013

How much do SSA governments spend on Family Planning?



Source: WHO World Expenditure Database, Accessed January 10th, 2018
* 2013 Data
** Data on funding from external sources not available

Strategic planning for DRM: What are the options?

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Key characteristics to consider

- Is the approach progressive – is it pro-poor enough to ensure equity in contributions?
- Is it sustainable over time?
- How burdensome is it to administer? Will the admin burden outweigh the benefit?
- Does it enable prioritization of spending for health?
- How much revenue can it generate?

Cross-comparison of DRM mechanisms for health: What has history taught us so far?

DRM Mechanism	Pro-Poor	Sustainability	Admin Burden	How Easy to Prioritize	Revenue Generation
General Taxation	***	***	*	*	***
Earmarking	**	**	**	***	**
Mandatory Contribution Schemes	**	**	*	***	**
CBHI / Voluntary Health Insurance	**	*	***	***	*

*relatively low; **medium; ***high

‘Innovative’ Mechanisms for DRM for Health

Type	Application	Example(s)
	EXPANDING THE GENERAL TAX BASE – PUBLIC SECTOR*	
Heritage taxes and taxes on large companies and windfall profits	• Companies in mining, oil, gas, other natural resources/ extraction industries • Tourism • Mobile phone companies	- PNG’s PNGSDP - $180m from biggest copper mine in 2 years - Lao’s PDR : $30m/yr from hydroelectric project - Gabon (pop. 1.6m) - 10% mobile company income ($25m in 2009) - Nigeria NHA: 1% of FGN rev. or $250m/yr
Taxes on goods, services	• VAT • Excise taxes including “sin” taxes (alcohol/tobacco), salt, sugar, fats • *More impact studies needed	- Ghana’s National Health Insurance Levy (NHIL, 2.5% of VAT) - $160m in 2013 - Philippines – alcohol and tobacco taxes to enroll poorest in PhilHealth scheme, huge increase in members
Currency and financial transactions	• Foreign exchange transactions • Interest on savings /deposit accounts • Remittances	- Gabon – foreign exchange transactions (1.5% on transactions, c.$8m in 2009) - Zambia Medical Levy: $3.9m 2009 - Brazil’s special tax on financial inst’ns
Debt financing	• Debt relief • Loan buy-downs • Diaspora bonds	- Polio incentives in Nigeria - HIPC e.g. Nigeria’s MDGs MCH program

Critical Look at 'Innovative Mechanisms'

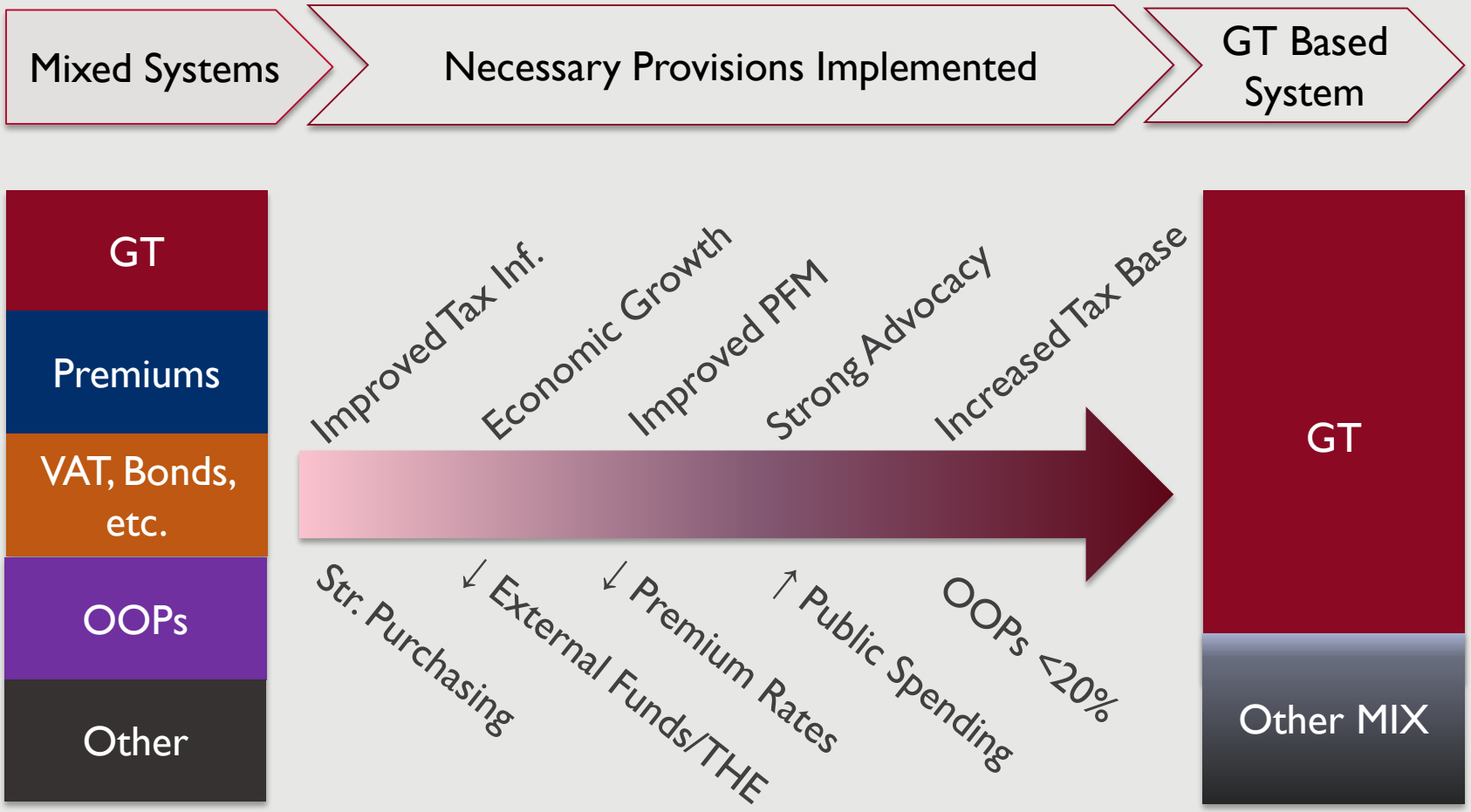
- What is "innovative" about 'innovative mechanisms'?
- How much money can these mechanisms generate?
- Would there be implications for other health funds?
- Is VAT progressive? What to exempt, and how to implement "luxury" taxes?
- Are mobile phones solely "consumables" or have they turned into social goods (m-Health implications)?
- Will generated funds be prioritized for health? Or RMNCH? Or FP?
- Is the potential of sin taxes widely misunderstood? What are the equity implications?
- What "innovations" can be used to extend the tax bracket to people working in the informal sector?
- Can these mechanisms replace regular funds?
- Better to speak of **'smart' financing**?

What can we consider "Smart" Financing?

- GLOBAL EVIDENCE SUGGESTS GENERAL TAXATION (GT):
  - The most straightforward public spending
  - The most potential to be pro-poor and equitable
  - The most sustainable (according to WHO)
  - Facilitates strategic purchasing
  - Majority of UHC lead countries rely on GT as a dominant source
- BUT
  - Tax base in SSA is low
  - Tax infrastructure in SSA is weak
  - How to prioritize for health?
- AND HENCE…

Roadmap to "Smart Financing"

… Countries can start with mixed methods, with a targeted effort towards General Taxation (GT).



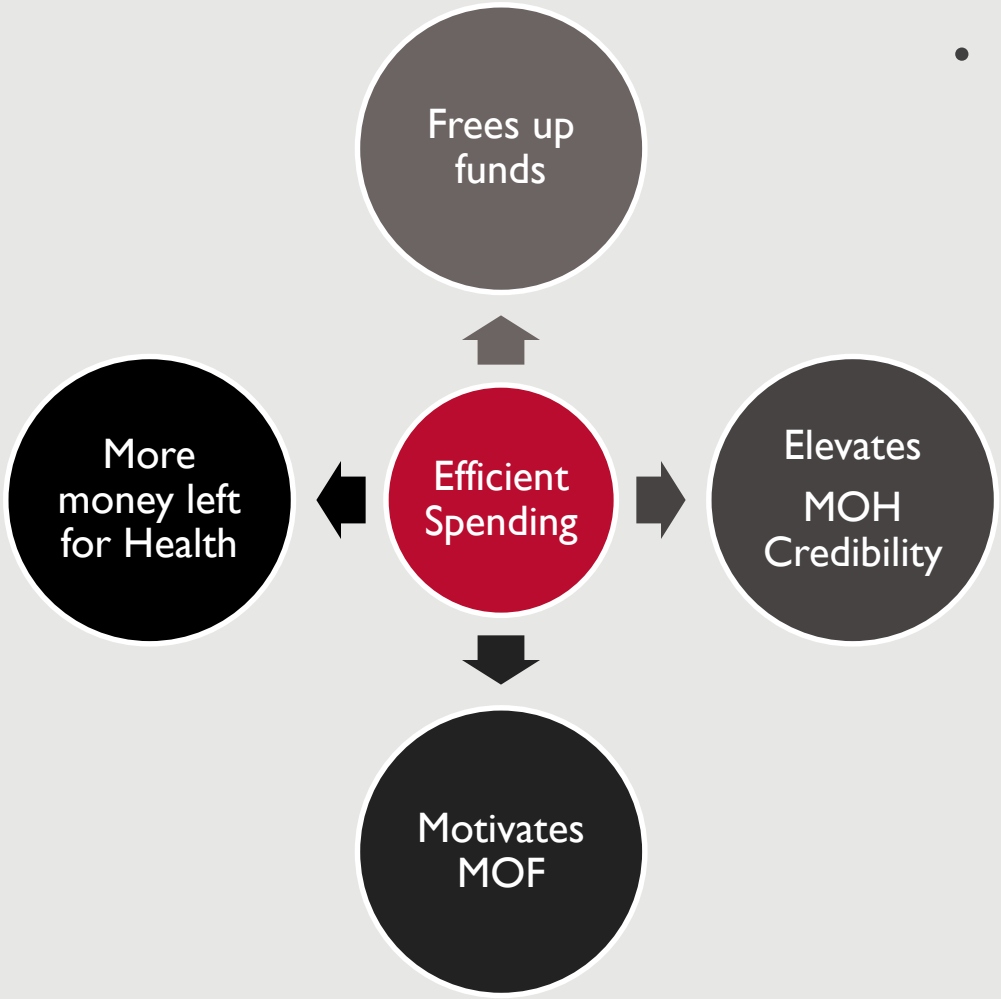
How to guarantee that health investments are prioritized?

- Mobilizing domestic resources for health's "slice of the pie" to achieve country health objectives is often a ***complex and political process***
- **BUT,** there is good evidence that where there's will, there's a way!
- Identify "shared values" with MOF and work together to advance these:
  - Poverty reduction
  - Healthy and productive work force
  - Healthy and ready-to-learn children attending school (investment in future work force productivity)
  - Lowered costs
  - Documented evidence of efficient spending, with minimal corruption

How to prioritize health investments for FP?

- Government commitment is a good first step
  - Commit to integrate a MoH budget line to increase resources allocated for FP/RH (Haiti)
  - Commit to inter-ministerial committee focused on FP/RH (Haiti)
  - National framework that integrates advocacy and resource mobilization for demographic dividend (includes right to FP access) (Chad)
  - Line items in national budgets - has it been successful?
- Methods to elevate FP on the national agenda:
  - Use advocacy tools to demonstrate impact (population-related models); build evidence base to include FP in UHC schemes
  - Collaborate with partners to integrate FP into PBI/RBF in country to ensure consistent inclusion of FP at country level

Efficient use of limited resources will generate even more!



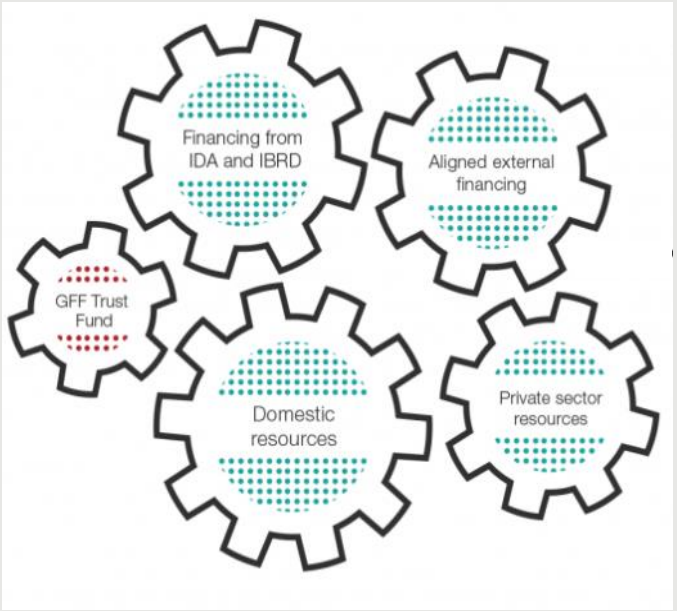
- **Efficiency Efforts:**
  - Establishing output-based payment systems
  - Strategic purchasing focused on health/FP priorities
  - Accounting for efficient use of funds; monitoring & reporting

Tools, resources and partnerships for DRM/FP

- Peer learning opportunities
- Analytical Tools and Toolkits (e.g. HFG DRM Toolkit)
- Strategic Communications Resources (e.g. Repositioning FP Advocacy Tools)
- Country and partner consortiums (FP 2020, Ouagadougou Partnership)
- Costed Implementation Plans for FP
- Country coordination platforms – GFF for RMNCH

GFF: A Pathfinder for DRM

- New financing model, with the country in the driver's seat
- Uses available resources *catalytically* and enables *"smart"* spending to achieve SDG goals (especially those related to RMNCAH)
- GFF trust fund is established to catalyze and channel external and internal (public and private) investments for priority services



- Currently working in 26 countries; many more are eligible
  - Afghanistan, Bangladesh, Burkina Faso, Cambodia, Cameroon, CAR, CdI, DRC, Ethiopia, Guatemala, Guinea, Haiti, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mozambique, Myanmar, Nigeria, Rwanda, Senegal, Sierra Leone, Tanzania, Uganda, Vietnam

Recap of key messages -1

- Demand for health is rising, and so are the costs. External AID, at the same time, is diminishing and unpredictable
- DRM enables countries to take ownership of their own healthcare costs and ensure sustainability of health funding
- There are numerous ways to mobilize domestic resources – the "best" options depend on the political economy of the country
- Efficient spending and prioritization are key considerations for DRM
- There are 'smart' financing mechanisms to *complement* health budgets, but not to replace it
- Global community provides tools and resources to support DRM efforts, but nothing can move the needle without the political will within the country

Recap of key messages -2

- Administrative costs of collecting taxes
- Equity, or regressive nature of some taxes
- Predictability and sustainability
- Economic growth as major driver of higher health spending
- **Meeting unmet needs for FP can lead to virtuous cycle: better health, more productivity, educated healthier children/mothers, higher per capita income, etc.**

HFG/Ghana team

Dr. Chris Atim – catim@r4d.org

Tamara Chikhradze – tchikhradze@r4d.org

Meera Suresh – msuresh@r4d.org

Andrew Won - andrew_won@abtassoc.com

PANEL PRESENTATIONS & DISCUSSION

Moderated by:
Akua Kwateng-Addo
Health Office Director, USAID/Ghana

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CHANGE COMES FROM WITHIN: MOBILIZING RESOURCES FOR FP IN GHANA

MOH/Ghana

MINISTRY OF HEALTH
REPUBLIC OF GHANA

- Establishment of a Resource Mobilization Unit within the Ministry of Health, in line with the President's "Beyond Aid" mandate
- Increased thoughtfulness regarding engagement with the private sector (in line with principles of the Health Sector Act) and other non-state actors
- Strategic planning for donor transition
- Strengthened advocacy for inclusion of family planning clinical methods in the National Health Insurance Scheme (NHIS) benefits package
- Creation of budget line for family planning commodities using statutory funds (in line with FP2020 obligations, already committed as of 2018)

GHANA NHIS EXPERIENCE ON MOBILIZING DOMESTIC RESOURCES FOR HEALTH

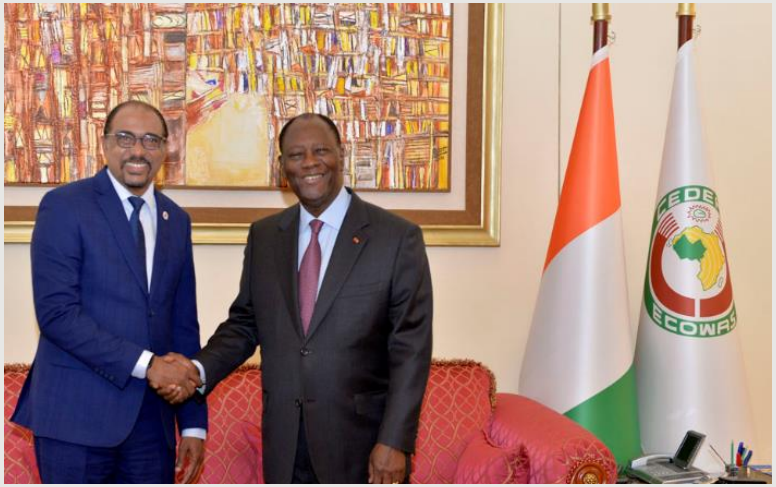
NHIS/Ghana

- VAT is dominant revenue source for Ghanaian NHIS
- VAT has proven to be sustainable, equitable, and efficient method for DRM
- Premium contributions have raised far less revenue than consumption tax – as is typical in developing countries
- Other sources to consider: mining, oil, sin taxes, and other profit-generating industries that produce health externalities
- KEY LESSONS LEARNED:
  - **Political processes important to consider** when implementing VAT; initiative should be legislated
  - **Low incomes, and unavailability of reliable data** on household income, makes it difficult to set market-based premiums
  - **Efficiency is key:** system must be "liquid" and money must flow to the right place at the right time → delayed releases and payments may negatively impact quality of care

INCREASING DOMESTIC RESOURCES FOR HIV AND AIDS: EXPERIENCE FROM COTE D'IVOIRE

HFG/Cote d'Ivoire

- **What was achieved:** Domestic resources for HIV response increased by 400%



- **Factors contributing to success:**

  Advocacy for DRM led by MoH:

  – Established interministerial committee

  – Engaged international "champions"

- **Ongoing challenges:**

  – Sustaining dialogue between MoH, other ministries

  – Including other national priorities on DRM committee agenda (i.e. Ebola, maternal health)

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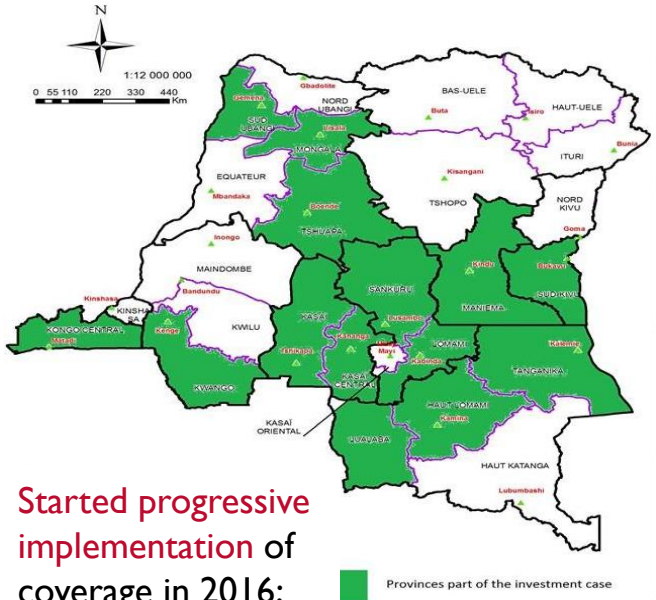
GFF INVESTMENT CASE: EXPERIENCE OF DRC

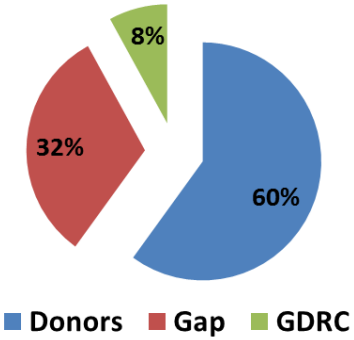
MOH/DRC



Started progressive implementation of coverage in 2016;

6 out of 14 provinces included to date

Budget: $2,645,980,389 for 5 yrs



- FP not isolated in health system; integrated into the RMNCAH package of services at Primary Health Center level
- GFF Investment Case (IC) channels strategic purchasing of RMNCAH package using RBF mechanisms
  - Induces innovative ways to do business: reinforcing institutions, strengthening people, using standardized/ unified tools (National health strategy, unique contracts...)
  - Offers opportunity to improve efficiency and public financial management in health sector and prioritize FP in state budget
  - First step toward Universal Health Coverage and catalytic fund for GDRC's investment in health (RMNCAH project in Kinshasa)

Challenges:

- Additional resource needed to fill the gap
- Extend coverage to entire country

DISCUSSION AND Q&A

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