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# Securing Domestic Financing

for Universal Health Coverage:  
Lessons in Process

**HFG Series:**  
**Advances in Health  
Finance & Governance**

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## About the Health Finance and Governance Project

The Health Finance and Governance (HFG) Project works to address some of the greatest challenges facing health systems today. Drawing on the latest research, the project implements strategies to help countries increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The project also assists countries in developing robust governance systems to ensure that financial investments for health achieve their intended results.

With activities in more than 40 countries, HFG collaborates with health stakeholders to protect families from catastrophic health care costs, expand access to priority services – such as maternal and child health care – and ensure equitable population coverage through:

- Improving financing by mobilizing domestic resources, reducing financial barriers, expanding health insurance, and implementing provider payment systems;
- Enhancing governance for better health system management and greater accountability and transparency;
- Improving management and operations systems to advance the delivery and effectiveness of health care, for example, through mobile money and public financial management; and
- Advancing techniques to measure progress in health systems performance, especially around universal health coverage.

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To learn more, visit [www.hfgproject.org](http://www.hfgproject.org)

## About this series

HFG's Advances in Health Finance & Governance series is designed to highlight learning and lessons from the HFG project in nine core areas: domestic resource mobilization, strategic health purchasing, health financing strategies, expanding coverage through health insurance, financial data for decision making, governance, institutional capacity building, workforce and efficiency, and building understanding for universal health coverage.

***Securing Domestic Financing for Universal Health Coverage: Lessons in Process***, is the first report in the 2018 series.

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# Securing Domestic Financing for Universal Health Coverage: Lessons in Process

## Executive Summary

Demand for health care is growing and external support is becoming more uncertain. Consequently, domestic resource mobilization (DRM) for health has emerged as an important topic in low- and middle-income countries (LMICs). This brief articulates the lessons learned by USAID's Health Finance and Governance (HFG) project in its efforts to support ministries of health (MOH) and their partners as they organize their work on and realize opportunities for DRM.

### Key Lessons\*

- 1 USE POLITICAL ECONOMY ANALYSIS (PEA) FOR EFFECTIVE DRM STAKEHOLDER ENGAGEMENT:** An analysis of the relationship between politics and the economy can help MOHs engage in inclusive processes for successfully planning for, advocating for, and implementing DRM options. In particular, it can help MOHs craft nuanced communications that convince and enable actors in power-holding positions to make the case for health.
- 2 PLAN AND IMPLEMENT OPTIONS FOR INCREASING DRM IN A STRATEGIC PROCESS:** The process should produce an up-to-date mix of DRM options accounting for political and economic cycles, projections for continually increasing demand, and opportunities to secure new money and spend better.
- 3 STRENGTHEN TRANSPARENCY AND COMMUNICATION IN RELATIONSHIPS ACROSS PUBLIC SECTOR MINISTRIES:** This will improve budget formulation, execution, and monitoring, effectively advocate for increases in government resources, and mitigate challenges when cash releases fall short.
- 4 ALIGN DRM PLANNING AND ADVOCACY WITH OVERALL HEALTH, RATHER THAN DISEASE-SPECIFIC GOALS:** This can help use findings from lesson 1, achieve effective planning processes from lesson 2, and ensure decision-makers outside of the health sector are responsive to sector-wide needs.
- 5 ENSURE QUALIFIED STAFF ARE TASKED WITH AND HELD RESPONSIBLE FOR THE DAY-TO-DAY BUSINESS OF DRM:** Only then will an MOH be able to take ownership over DRM as an ongoing process.

\*Lessons are not ranked in order of importance



# Introduction

DRM for health has emerged as an important topic in LMICs in the context of growing demand for health care, rising costs of those services, and increasing uncertainty about donor commitments. Demand for health care is growing amid the continuing fight against communicable diseases, the need to improve maternal and child health outcomes, the growing burden of non-communicable disease, the threat of pandemics in a globalized society, and new risks arising from a changing climate (*United Nations 2015; Frenk et al 2013*). Globally, growing demand for services has spurred growth in the health sector exceeding that in the overall economy between 2000 and 2015 (*WHO 2017*). Demand for services has also shaped national and global commitments to universal health coverage (UHC).

At the same time, LMICs are less able to count on predictable donor support over the long term. Many LMICs are outgrowing the income-based criteria for receiving some aid. For example, GAVI supports only those countries with a three-year average per capita gross domestic product under \$1,580 (*Ottersen et al. 2017*). Also, after tremendous growth in development assistance for health in the 2000s, donor agencies are facing a post-2008 recession geopolitical landscape, where the case for spending on aid, particularly for middle-income countries, has become less convincing to larger numbers of vocal constituents. In response,

**To achieve UHC, the poor in LMICs will need support. While focused on raising the financial resources needed, DRM also is about ensuring that methods to raise money are not overly burdensome on the poor and that the poor actually benefit from the resources raised.**

donor agencies are emphasizing doing more with less (*PEPFAR 2014*). In countries with stronger economies, donors seek to transition the disease-specific primary health care programs they built and supported over the last two decades to local public and private organizations, which have varying degrees of ownership over these programs. This situation leaves the poor and vulnerable at risk of resurgent epidemics and with inadequate support to address new health challenges.

Through experimentation and research, the global health community has accumulated knowledge about financing a sustainable path toward UHC in LMICs in light of these challenges (*World Bank 2016, Pablos-Mendez et al 2016, Meheus and McIntyre 2017*). Though it may be seen as a public and private joint venture, UHC will require increased government investment to reduce reliance on household out-of-pocket spending, especially among the poor, where disease burden is often heaviest (*WHO 2010*). Increasing the allocation of government general revenue to health and improving the efficiency of existing health spending are two of the most viable options for DRM in LMICs (*Barroy et al 2017*). These options are more promising than earmarking revenue—that is, designating a specific revenue source for health—a mechanism that often has a mixed overall impact on DRM for health (*Cashin et al 2017a*). Improving DRM also involves governance reform, with particular attention to strengthened public financial management (PFM) systems (*Runde and Savoy 2016*). In addition to these insights, stewards of the health system in LMICs must understand the capacity and organizational requirements needed to turn these insights into DRM gains.

Over its six years of implementation experience, HFG helped LMIC governments understand these requirements. This brief presents five lessons the HFG project learned through this experience and draws from them recommendations for LMIC governments and their development partners.



## HFG's work in DRM

To understand DRM capacity and organizational requirements, HFG provided **operational support** to 10 LMIC governments and regional institutions on a bilateral basis, as part of a series of regional workshops, or by developing global guidance.

### This support included:

1. Facilitation for developing a strategic process for DRM with broad stakeholder engagement
2. Tools and technical assistance to build the capacity of MOHs to advocate for health and engage with key stakeholders

HFG also provided **analytical support**, though not always as part of a larger operational support agenda. Analytic support included resource-need estimation, modeling gaps and DRM options, political economy analysis, resource tracking, costing of implementation plans, economic evaluation, and institutional assessments of PFM systems.

In addition, HFG has worked toward deepening the understanding of DRM generally by conducting multi-country analytical studies answering questions such as:

- Does increased tax collection result in more money spent on health?
- To what extent will LMICs be able to afford a basic package of services, given the withdrawal of donor support?
- How can donor transitions be structured to help lead to increased ownership by governments in LMICs?

### HFG's support for DRM, 2012–2018

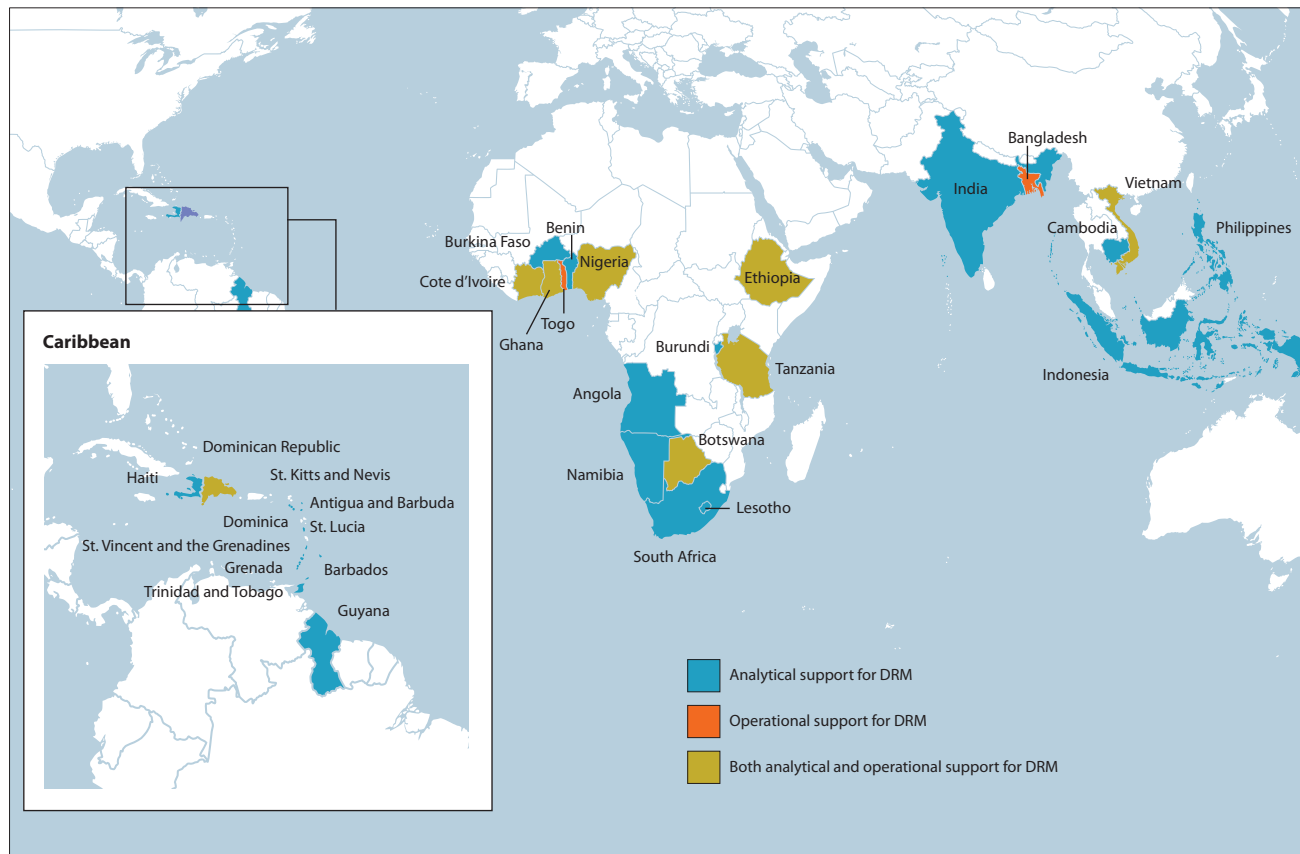






Photo: © Md. Akram Ali. Courtesy of Photoshare

Though several steps removed from the delivery of effective care, increasing domestic resources for health can help ensure this baby remains healthy for a lifetime.



## Lessons learned in DRM

### Lesson 1

#### Use PEA for Effective DRM Stakeholder Engagement

PEA seeks to understand the relationship between politics and economics (*Hoogvelt 2001 in Bump and Reich 2013*). It asks why political figures decide to raise and distribute resources in the way they do. It seeks to understand the actors who try to influence the cycle of policy development, their interests, and how they attempt to influence decisions. It seeks to understand the clientele and constituents whose needs, including in health, these governmental figures serve to maintain power. And it considers how contextual factors such as election cycles and macro-fiscal trends shape the motivations and decisions of those individuals.

Understanding these factors can help MOHs enact reform in support of DRM. In Ethiopia, MOH and Regional Health Bureaus<sup>1</sup> (RHB) considered these

factors carefully in their successful bid to change a finance law that required public health facilities to remit all revenue generated to the treasury (*Ze/elew 2012*). The reform sought to allow facilities to retain and use the revenue collected (in addition to their government budget) to improve quality of service and fund operational expenses.

In three regions, the RHB strategically engaged key actors whose support would be essential, including the respective regional finance bureaus, the regional president's legal advisors, and members of the regional parliaments. The RHB also worked closely with the regional finance and civil service bureaus to put in place the necessary personnel and systems for strengthening the facility-level PFM system needed to implement the change. This approach realized new revenue for health beginning in 2005. Capitalizing on these lessons, HFG supported the Government of Ethiopia in expanding the reform to other regions and federal-level facilities (HFG 2018). As of 2015/16, almost all public health centers

<sup>1</sup> In Ethiopia, laws (proclamations) are passed by the parliament and accompanying regulations that expand on the law are passed by the cabinets. Ethiopia's decentralized system then gives regional governments discretion to implement DRM reforms within the established legal and regulatory structure.

(3,244) and hospitals (225) were able to retain an additional 43-153 percent of their non-salary operational budgets (*Alebachew et al. 2015*).

Asking PEA questions can help health sector stewards of DRM collaborate with decision-making institutions and articulate arguments for health sector investment when and where it counts. In Nigeria, HFG identified the health committees within state and national legislatures as institutions with the political stature to advance arguments for investment in health. With the MOH, HFG helped determine what message would resonate with these committees and their counterparts in the legislature. Using this analysis, HFG helped catalyze momentum for policies the health committees championed. The committees were equipped with tailored information from the MOH to make their arguments. As a result of these efforts, the Senate Committee on health launched and now leads the Legislative Network for UHC, which has become a vocal proponent both on the legislature floor and in the media for increased funding for health.

The media also can help shape debate around investment in health. Reporting can help raise awareness of and build broad support for reforms leading to DRM for health, which in turn can help influence decision-makers. Reporting also can elevate health needs of the poor and vulnerable in the discussion, drawing the attention of political figures who advocate for equity or whose power is dependent on support from the poor and vulnerable.

In many countries, however, governments and development partners need to do more to communicate key arguments about the need for DRM with the media and civil society organizations to ensure they are empowered to enter the conversation. Such interventions can make a difference. In support of this approach, HFG developed a briefing kit to help journalists and editors ask probing questions and tell important stories about financing health priorities in their countries, including on topics such as sustainability, equity, and efficiency (*Meline et al 2015*). Two days after piloting the tool in Kenya, one participant reported and aired a news story on health financing on two national radio stations and scheduled a related radio broadcast for a longer feature story.

## Lesson 2

### Plan and Implement Options for Increasing DRM in a Strategic Process

In their efforts to increase or sustain DRM, government health stewards should engage in a planning and implementation process that is comprehensive in the types of DRM options considered, implemented, and monitored. The reality is different: HFG has observed a tendency among health system stakeholders to expend focus and political capital on “magic bullets” – Social Health Insurance! Alcohol Tax! Trust Funds! Private sector! – rather than consider a strategic mix.

Relying on single options for DRM reduces the ability of health programs to smooth revenue across the economic and political cycles of each option. As HFG observed in Nigeria, debt forgiveness helped fund a program to provide free primary health care, but the program simply ended when this funding ran out as there was no DRM plan identifying other options. Similarly, earmarking extractive industry taxes produces revenue when

#### A STRATEGIC PLANNING AND IMPLEMENTATION PROCESS FOR INCREASING DRM SHOULD:

1. **Account for economic and political cycles and the risks over time of each option**
2. **Consider options for increasing new money for health and improving efficiency of existing resources**
3. **Recognize that health resource needs will continue to grow in many LMICs as demand continues to grow, costs continue to rise, and donors continue to transition away from program support**

commodity markets are booming, but overreliance can be devastating in a downturn.

Relying on a single option may also not be sufficient in the face of an almost certain growth in health resource needs in LMICs. In Ghana, the National Health Insurance Scheme has been in deficit since 2009, when need outstripped revenue growth from the value added tax. HFG's PEA suggests that other options, particularly related to improving efficiency, are needed since the earmarked value added tax, which currently funds about 75 percent of the National Health Insurance Scheme, has proven inadequate to fund the growing demand for health (*Ghana Center for Democratic Development and HFG. 2018*).

In other cases, local and international actors suggest that better engagement of private investors may help fill the financing gap. However, HFG's review of domestic DRM options found that none of the private options (excluding household out-of-pocket spending) have the potential to contribute significant revenue to health (*Nakhimovsky et al. 2014*). This is confirmed in multiple Health Accounts, conducted with HFG support, which show that private spending on health (excluding household out-of-pocket spending) amounts to only small percentages of total current health expenditure (*Haryana State Health Resource Center 2016; Le Tuan 2016*). Health programs financed by the private sector have critical value for the people who directly benefit from them but will not substantively add to the resources needed to make progress on a pro-poor pathway toward UHC.

**DRM health stewards may want to consider innovative options for raising new money in planning and implementing activities to increase DRM but shouldn't forget opportunities for improving efficiency.**

More generally, planning and implementation for DRM should not ignore the importance of improving value for money in health spending. Along with allocation of general revenue, improving efficiency is considered the other most viable and sustainable strategy for DRM (*WHO 2010; Barroy et al 2017*).

HFG's work demonstrated the potential of realizing efficiency savings in pharmaceutical and supply systems. In Vietnam, HFG worked on building the capacity of the local HIV and AIDS commission to conduct procurement for antiretroviral therapy. That unit was able to procure commodities at a lower price than anticipated during the planning process and thus purchase more drugs with available resources.

Working on efficiency can also help address a problem of perception. In the process of working on DRM for HIV, HFG has repeatedly heard the issue of the inefficiency of the health sector mentioned. It prevented serious consideration of increased budgets from stakeholders outside the health sector. In Uganda, the perceived inefficiency of the health sector made the Ministry of Finance (MOF) unwilling to consider increased funding for HIV without demonstrable (i.e., tracked) improvements in efficiency in health overall. Strong PFM that demonstrates progress in quantitative terms may help MOHs address this problem. DRM health stewards may want to consider innovative options for raising new money in planning and implementing activities to increase DRM but shouldn't forget opportunities for improving efficiency.

## Lesson 3

### Strengthen Transparency and Communication in Relationships Across Public Sector Ministries

HFG's dialogue with stakeholders and analytic work reveal the importance of strengthening MOH relationships with MOFs for effective DRM (*Baldrige et al. 2016; HFG 2017; Soe-Lin et al 2015*). During a series of workshops facilitated by HFG intended to strengthen MOF-MOH dialogue and increase health's slice of the pie, MOFs pointed out that MOHs often have a weak record of financial reporting in PFM systems, making it hard for them to defend themselves against the accusation of inefficiency, much less mount convincing arguments for increased budgets (*Krusell et al 2017*). The problem is not just a matter of perception. In several Nigerian states, HFG found that budget allocations were often higher than cash releases, which rely on sporadic revenue flows and for which other ministries were better at jockeying. In one state, for example, a 300 percent budget increase for health



was never released because the state did not have the revenue to fund the budget.

One large component of improving this relationship comes with better communication and transparency through the PFM processes of budget formulation, execution, and monitoring. HFG found that one helpful way the MOH can act to improve communication between the ministries is by preparing the right data in the right way. At the workshops mentioned above, multiple country teams began using an MOF-MOH dossier, a collection of key data about the health sector that corresponds to the interests and expectations of an MOF audience. After the workshop, the Bangladesh MOH developed a robust dossier, including country comparisons to help give more meaning to the data. The MOH then used the dossier to increase health sector budget from 4.3 percent to 5.1 percent of the national budget.

Having good, transparent data and external credibility can facilitate DRM outside of the routine budgeting processes. For example, in Vietnam, the Vietnam Administration of HIV and AIDS Control (VAAC) needed to build a strong case for including HIV services in the social health insurance (SHI) benefit plan. The case had to be credible and rigorous to convince the Department of Planning and Finance at MOH, which was in charge of defining the SHI benefit package, to add HIV services to the plan. With support from HFG, VAAC presented and got approval for a costed list of services for inclusion in the benefit plan. This was part of an effort to clarify the request and corresponding financing implications. A study on the financial liability of an SHI package for HIV also was introduced to the Vietnam Social Security agency, which was in charge of disbursing funds for SHI payments. The study enjoyed widespread acceptance as credible evidence about the affordability of the HIV package.

MOHs can strengthen their case by building platforms for routine, productive dialogue. In Nigeria, to help MOHs equalize access to the MOF's cash releases, HFG strengthened the capacity of state MOHs to implement effective advocacy and communication approaches. They included regular advocacy visits to executives such as the governor or deputy governor and regular communication with the state house committees for appropriations and for health. Similarly, after the first HFG-facilitated MOH-MOF workshop, the team from Côte d'Ivoire

**Good relations with the MOF in part rely on improving MOH processes for transparent and adequate budget planning, execution, and monitoring, and creating a platform for ongoing communication.**

drafted an order establishing an inter-ministerial committee on DRM. It included the MOH, Ministry of Planning and Development, Prime Minister's Budget Office, and Ministry of Economy and Finance. The MOH continues to push for this official platform to facilitate better exchange.

## Lesson 4

### Align DRM Planning and Advocacy With Overall Health, Rather Than Disease-Specific Goals

Aligning DRM planning with overall health, rather than disease-specific goals is necessary to realize the type of technically sound and iterative strategic planning process argued for in lesson 2. By estimating resource needs and assessing options to fill gaps across the entire health sector, planners can ensure that the mix of options is reliable and can weather economic and political cycles. Planners also can monitor the effectiveness of the options jointly and over time make adjustments.

In some cases, this type of alignment can enable health stewards to act on learning from PEA (lesson 1) and craft messages aligned with the interests and perspectives of key political and executive actors responsible for allocating resources. HFG found in multiple countries that the idea of more money for health has substantially broader appeal than messages about one disease or health area. In Vietnam, HFG worked with VAAC to develop a message that linked HIV and AIDS financing with the attainment of UHC. HFG and VAAC knew that this would resonate with the provincial People's Committee, which might then support the purchase of insurance cards for people living with HIV and AIDS with provincial-level funds.

Without this alignment, successful disease-specific advocacy may end up securing needed funding for some priorities, while leaving external stakeholders weary or wary of additional requests from health. This possibility is ever more likely given the proliferation of priorities on the one hand and a tight fiscal landscape on the other (*Glassman and Chalkidou 2012*). And if DRM helps fund some services needed by the poor while ignoring others, it could impede processes for setting explicit priorities that would lead to more efficient and fair health-resource allocations.

In the course of its technical assistance activities, HFG observed health officials take active steps to address this problem. For example, one Nigerian state's commissioner complained that, having negotiated that state government's commitment toward co-funding routine immunization, it was then difficult to request health budget increases for primary health care more broadly. Subsequently, a health financing unit estimated infrastructure needs for primary health care facilities that deliver routine immunization while rallying support for national-level funding earmarked for state-level health system strengthening. By facilitating engagement between the government and routine immunization donors, the unit secured a proportion of the routine immunization money for primary health care infrastructure development.

## Lesson 5

### Ensure Qualified Staff are Tasked With and Held Responsible for the Day-to-Day Business of DRM

HFG has observed that when its program of work started in a country, DRM for health was not often the MOH's priority despite widespread belief that inadequate resources hampered its ability to function, but rather a by-product of the planning and budgeting unit. In fact, MOHs tend to identify a focal person only when donors ask HFG or other partners to support the development of a DRM strategy. With their legacy of significant donor financing, some HIV and AIDS units have a DRM focal point.

Given the first four lessons above, it is clear that a single focal point is inadequate. Instead, MOHs need to recognize that DRM is one of its fundamental functions and that individuals of wide-ranging

skillsets must be assigned the task of and held accountable for doing the day-to-day work needed to accomplish it. Some of their tasks include:

- Asking PEA questions in the context of DRM to identify a broader range of stakeholders inside and outside the MOH, understanding their motivations, and crafting nuanced messages and dissemination strategies for effective advocacy
- Leading the process for strategically selecting and updating DRM options to pursue, with strong stakeholder engagement
- Creating and costing a plan for all individuals within and outside the MOH who have a role to play in pursuing the DRM options identified in the planning processes. This plan should include clearly defined roles and responsibilities and monitoring processes with defined targets. DRM staff and units or individuals providing oversight should then use the plan and monitoring framework to monitor performance
- Monitoring performance on efficiency and PFM interventions that support DRM, even if other actors are responsible for implementing those efficiency improvements
- Conducting or at least having ownership over the technical analyses needed to inform the DRM strategy. This would include gap analysis and assessments of options, including their political and economic cycles
- Managing and planning for donor transitions. Each donor cannot be expected to be aware of every other donor's strategic moves to transition their programs. Only an MOH can be a unified voice for donors and interact with the rest of government to prioritize DRM for health
- Recruiting for and training staff to accomplish these tasks

HFG worked with several MOHs involved in creating institutional structures dedicated to DRM. For example, after the HFG-facilitated MOH-MOF workshop, the Ghana Health Service established a separate unit focused on DRM. Similarly, in Ethiopia, the MOH established a Resources Mobilization Directorate, separate from the Planning Directorate. While MOHs may choose to organize these individuals in multiple ways, the key point is to ensure that the MOH has individuals with the right qualifications to fulfill and monitor progress toward increasing DRM for health.

Making health systems more sustainable and efficient can help ensure a steady supply of life-saving antiretrovirals for people living with HIV and AIDs.



## Conclusion and Recommendations

LMIC governments and their donor partners are conducting numerous analytical and advocacy efforts to mobilize the substantial domestic resources that will be required to meet ambitious goals such as UHC. As USAID's HFG project has provided support to many of these countries, several lessons have been learned that are important for both LMICs and donors to consider as the DRM push continues.

First and foremost, quantitative analytics such as gap/needs analysis and financial modeling of DRM options are a necessary starting point for DRM planning and advocacy, but they are not sufficient. Instead, MOHs should plan for DRM through a comprehensive, strategic, politically savvy process with accountability and oversight. Such processes should cover all the resources required by health, including priority diseases, and account for economic and political cycles and risks over time of each option. The processes also should identify all possible sources of funds such as efficiency gains, rather than focus on single ones (private sector, sin taxes) that are popular in the moment. MOHs should also think long term,

asking such questions as: Does an earmarked tax today lead to lower budget allocations tomorrow?

In pursuing DRM options, stakeholders should ensure that disease-specific advocacy does not “crowd out” DRM for other health priorities. To achieve this objective, MOHs can consider whether they can re-design disease-specific options to include broader health system needs and thus align their communications and advocacy efforts with health system objectives such as UHC.

Capturing the breadth of potential resources also requires countries to focus on PFM and efficiency in practice—a conclusion in alignment with a growing body of literature. It is not enough to have budgets and policies passed. MOHs need to improve their PFM practices to ensure that they get the resources budgeted, spend them, account for them, and demonstrate that they have been spent well, i.e., completely and efficiently and with the desired results. Weak practices in this regard hamper many MOHs and cast them in a poor light

with MOFs and the broader government, thus impeding their ability to obtain increased budgets.

Donors have a role to play in DRM as well. Given time and flexible resources, donors and implementing partners can earn the trust of MOH leaders and help them to build relationships outside of health (finance, media, legislature) that are critical for taking the DRM analytics further toward realizing DRM. Donors can invest in capacity building for improving efficiency and PFM processes that directly contribute to and support DRM. It is also worthwhile making the additional investment in the capacity building of external actors. This could include the oversight and accountability capacity of the legislature or the messaging and accountability capacity of the media. Finally, donors can support country-led, integrated DRM efforts and avoid using political influence at high

levels of government to push for disease specific DRM, which could sabotage the broader DRM effort.

Beyond these considerations, DRM itself is a fundamental function of the MOH because resource needs for health will continue to increase, and ambitious health impact goals need resources to achieve them. Thus, there needs to be a group of people for whom it is a priority, and not a second or third responsibility, regardless of where in the ministry they sit. Collectively, this group needs to have a broad set of skills. Such skills would not just include quantitative skills such as budgeting and modeling, but also include coordination, communication, and lobbying skills. These skills are critical to identifying and engaging the powers outside of health that can advocate for a re-prioritization of health and its funding within a government's agenda.





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