GFF Country Workshop, January 28 – February 1, 2018

Domestic Resource Mobilization
How the GFF drives results

1. **Prioritizing**
   - Identifying priority investments to achieve RMNCAH outcomes
   - Identifying priority health financing reforms

2. **Coordinated**
   - Coordinated implementation
   - Reforming financing systems:
     - Complementary financing
     - Efficiency
     - Domestic resources
     - Private sector resources

3. **Learning**
   - Strengthening systems to track progress, learn, and course-correct

Accelerate progress now on the health and wellbeing of women, children, and adolescents

Drive longer-term, transformational changes to health systems, particularly on financing
Results

- Better sustainable RMNCAH-N outcomes
  - Strengthening systems to sustain RMNCAH-N outcomes

- Increased value-for-money and total volume of financing from:
  - Domestic resources
  - Financing from IDA and IBRD
  - External Financing
  - Private sector resources

- Impoverishment prevented in case of illness
I. Importance of Domestic Resource Mobilization
Importance of Domestic Resource Mobilization (DRM)

Health expenditure per capita is still too low to ensure universal coverage with a core package of needed health services, including RNMCAH – N services

- McIntryre and Meheus estimated $89 per capita needed in 2014

![Graph showing total health expenditure per capita 2014 (constant 2010 US$)]

Source: WHO GHED 2015

![Bar chart showing sources of total health expenditures 2014]

Source: WHO GHED 2015
DAH constitute a small part of total health expenditure overall, although it varies across countries: lower income countries tend to have a large share.

Source: WHO GHED (2017)
Domestic resources tend to be more predictable, less volatile than external aid, and promotes debt sustainability.

**Domestic health expenditure per capita, in constant (2010) US$**

- Afghanistan
- Burkina Faso
- Cambodia
- Central African Republic
- Côte d’Ivoire
- Haiti
- Indonesia
- Madagascar
- Malawi
- Rwanda

**Development assistance per capita, in constant (2010) US$**

- Afghanistan
- Burkina Faso
- Cambodia
- Central African Republic
- Côte d’Ivoire
- Haiti
- Indonesia
- Madagascar
- Malawi
- Rwanda

Source: WHO GHED (2017)
As countries grow, the composition of finance changes with a shift away from DAH and out-of-pocket to domestic, prepaid and pooled financing.

Notice the following graph illustrating the shift in financing composition with increasing GNI per capita. The shaded areas represent different income levels (Low Income, Lower Middle Income, Upper Middle Income, High Income), and the lines indicate the transition from external resources to prepaid and pooled (domestic) resources. The red triangle highlights that implementation of right HF reforms is needed for high-income countries, as indicated by the text "NOT AUTOMATIC! IMPLEMENTATION OF RIGHT HF REFORMS NEEDED."
II. DRM an Important part of Fiscal Space for Health

the following slides are from Ajay Tandon et al. from JLN DRM collaborative
Fiscal Space “…room in a government’s budget that allows it to provide resources for a desired purpose without jeopardizing the sustainability of its financial position or the stability of the economy.” [Heller (IMF, 2005)]

Domestic resource mobilization (DRM) refers to public financing from domestic resources.

DRM is a sub-component of fiscal space.
Mathematics of Public Spending on Health

GDP per Capita
Mathematics of Public Spending on Health

Public Expenditure Share of GDP $\times$ GDP per Capita
Mathematics of Public Spending on Health

Health Share of Public Expenditure \times \text{Public Expenditure Share of GDP} \times \text{GDP per Capita}
Health Share of Public Expenditure \times \text{Public Expenditure Share of GDP} \times \text{GDP per Capita} = \text{Public Expenditure on Health per Capita}
Mathematics of Public Spending on Health

Example from Vietnam
14% × 27% × US$2,050 = US$74
I. Conducive Macroeconomic Conditions

► Sustained Economic Growth

► Increases in General Government Expenditure
  ▪ New Taxes and Revenue Sources
  ▪ Increasing the revenue base of these taxes
  ▪ Improving the effectiveness of tax collection
Conducive Macroeconomic Conditions

\[
\text{Public Expenditure on Health per Capita} = \text{Health Share of Public Expenditure} \times \text{Public Expenditure Share of GDP} \times \text{GDP per Capita}
\]

**Example from Vietnam**

14% × 27% × US$2,050 = US$74
14% × 27% × US$4,000 = US$151
GDP Per Capita, 1995-2015

GDP per Capita (Constant 2010 US$) in Lower middle income countries

- Côte d'Ivoire
- Indonesia
- Cambodia

Source: WDI 2017

GDP per Capita (Constant 2010 US$) in Low-income countries

- Afghanistan
- Burkina Faso
- Haiti
- Madagascar
- Malawi
- Central African Republic
- Rwanda

Source: WDI 2017
“Direct” taxes (generally more progressive)
- Personal income taxes.
- Corporate taxes.
- Property/wealth taxes.

“Indirect” taxes (generally less progressive)
- Sales/excise taxes.
- Value-added taxes.
- Import/export taxes.

Other sources of government revenue
- Natural resources.
- Grants (e.g., foreign aid).
- Public enterprises.

<table>
<thead>
<tr>
<th>Income classification</th>
<th>Total revenue</th>
<th>Direct taxes</th>
<th>Indirect taxes</th>
<th>Grants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low income</td>
<td>21%</td>
<td>7%</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>Lower middle income</td>
<td>30%</td>
<td>9%</td>
<td>12%</td>
<td>2%</td>
</tr>
<tr>
<td>Upper middle income</td>
<td>32%</td>
<td>10%</td>
<td>12%</td>
<td>2%</td>
</tr>
<tr>
<td>High income</td>
<td>39%</td>
<td>19%</td>
<td>12%</td>
<td>0.2%</td>
</tr>
</tbody>
</table>
Government expenditure as a share of GDP

GGE as % of GDP (2014)

Median: 28.5%
Conducive Macroeconomic Conditions

Health Share of Public Expenditure \times Public Expenditure Share of GDP \times GDP per Capita = Public Expenditure on Health per Capita

Example from Vietnam
14\% \times 27\% \times US\$2,050 = US\$74
14\% \times 27\% \times US\$4,000 = US\$151
14\% \times 35\% \times US\$4,000 = US\$196

Health Outputs and Outcomes
Five Pillars of Fiscal Space for Health

1. Conducive macroeconomic conditions
2. Efficiency
3. Reprioritization
4. Sector-specific domestic revenue sources
5. External sources
II. Reprioritizing Health

- Increasing the share of government expenditures on health -- often a key signal of overall government commitment to health – can be key for fiscal space.

- Pits health against competing priorities: e.g., other sectors such as education, infrastructure, agriculture, etc.

- Key challenge being that health is often perceived by ministries of finance/planning as being inefficient and non-productive.
Government priority to health: GGHE/GGE – a few GFF countries spend less than the median in LMICs

GGHE as a % GGE in 2014

Median: 9.7%
Reprioritization

Health Share of Public Expenditure \( \times \) Public Expenditure Share of GDP \( \times \) GDP per Capita = Public Expenditure on Health per Capita

Example from Vietnam

- \( 14\% \times 27\% \times \$2,050 = \$74 \)
- \( 14\% \times 27\% \times \$4,000 = \$151 \)
- \( 14\% \times 35\% \times \$4,000 = \$196 \)
- \( 20\% \times 35\% \times \$4,000 = \$280 \)
Five Pillars of Fiscal Space for Health

Conducive macroeconomic conditions

Efficiency

Reprioritization

External sources

Sector-specific domestic revenue sources
Sector-Specific Revenue Sources for Fiscal Space

Government expenditure share of GDP

Public expenditure on health per capita

Sector-specific earmarks

GDP per capita

GDP per capita
Social health insurance (SHI) often introduced as a way to collect additional revenues for health, especially from employers.

Increasing contribution rates from formal sector often a key fiscal space question.

Challenge in implementing mandates and collecting contributions in economies with large levels of informality.

Interplay: social health insurance and informality.

<table>
<thead>
<tr>
<th>Social health insurance share of total health spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monaco</td>
</tr>
<tr>
<td>Czech Republic</td>
</tr>
<tr>
<td>Croatia</td>
</tr>
<tr>
<td>Netherlands</td>
</tr>
<tr>
<td>Japan</td>
</tr>
<tr>
<td>France</td>
</tr>
<tr>
<td>Estonia</td>
</tr>
<tr>
<td>Slovenia</td>
</tr>
<tr>
<td>Luxemburg</td>
</tr>
<tr>
<td>Germany</td>
</tr>
</tbody>
</table>
Use of “sin taxes” on tobacco and alcohol increasingly prevalent for financing health.

Justified often both from a health and fiscal perspective, despite being regressive.

Other forms of innovative “financing”: earmarking of other taxes such as VAT; natural resource revenue earmarks, etc.

Impact on revenues can vary, dependent on “elasticity” of response.

Impact on revenues can vary, dependent on “elasticity” of response, including impact on smuggling.

Not clear what is behind growing trend towards earmarking revenues, especially in health sector; earmarking revenues to reprioritize sector?

Most forms of earmarking unpopular with ministries of finance: introduces rigidities in allocations across sectors.
### Examples of “Innovative Financing”

<table>
<thead>
<tr>
<th>Option</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax on remittances</td>
<td>Mexico, Kenya</td>
</tr>
<tr>
<td>Financial transaction tax</td>
<td>Argentina, Brazil, Zambia</td>
</tr>
<tr>
<td>Value-added tax</td>
<td>Ghana</td>
</tr>
<tr>
<td>Turnover tax on mobile phones</td>
<td>Gabon</td>
</tr>
<tr>
<td>Airline ticket levy</td>
<td>Cameroon, Congo, Madagascar, Mali, Mauritius, Niger</td>
</tr>
<tr>
<td>Excise tax on extractive industries</td>
<td>Botswana (mining)</td>
</tr>
<tr>
<td>Sin taxes</td>
<td>Philippines, Thailand,</td>
</tr>
</tbody>
</table>
III. Potential for DRM in your Country
Potential for DRM in your Country

Sources of Current health expenditure

Source: WHO GHED (2017)
Potential for DRM in your Country

Côte d’Ivoire

Sources of Current health expenditure

Source: WHO GHED (2017)

Afghanistan

Sources of Current health expenditure

Source: WHO GHED (2017)
Potential for DRM in your Country

Sources of Current health expenditure

Source: WHO GHED (2017)
Potential for DRM in your Country

Haiti

Indonesia

Sources of Current health expenditure

Source: WHO GHED (2017)
Where might there be room to increase the public budget? – 5 minute discussion in your table

- Raise more government revenue?
- Allocate more of the government budget to health?
- Ask people to contribute?
- Get more health out of the existing resources?
IV. Examples in other GFF Supported Countries
Reforms that Prioritize Health in the Budget

- DLIs or funded activities in GFF/World Bank IDA projects linked to maintaining and increasing share of government budget allocated to health:
  - **Mozambique**: Domestic health expenditures as a percentage of total domestic government expenditures (stable first 3 years, then increasing).
  - **Tanzania**: Recipients have achieved all of the Program annual 6 results in institutional strengthening at all levels (national, regional, LGA and facilities).
    - Share of health in total government budget
  - **Kenya**: Counties receive resources from the project if the share of the county budget allocation (for Year 2) and expenditure (for Years 3–5) for health (excluding conditional grants for health) is higher than the previous year, but no less than 20 percent.

- Use of buy-down resources for health:
  - **Guatemala**: Government doubling buy-down amount (US$9M) and committed to invest this amount (US$18M) in Conditional Cash Transfer program
Development of health financing strategies and implementation plans:

- Cameroon
- Senegal
- Kenya
- Uganda
- Ethiopia (including customized regional versions)
- Myanmar
- Sierra Leone