

Public Financing for Health in Africa: from Abuja to the SDGs



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Foreword

Leaders of the African region have demonstrated their continued commitment to making resources available in support of stronger health systems and better health results – from declarations made in Abuja (2001), Ouagadougou (2009), Tunis (2012) and Luanda (2014). Their decisions have generally been followed and put into effect at country-level, reflecting national commitments to the sector. In particular, the share of public resources allocated to health has increased over time in a majority of African countries.

With the adoption of the new Sustainable Development Goals (SDGs), the year 2015 marked a shift in the global and regional discourse on health. Universal Health Coverage (UHC) is now acknowledged as a core target for all nations and offers a powerful framework with system-wide implications across the full spectrum of health services, presenting a unique opportunity to drive progress toward better health results in the region.

The challenge is now to transform domestic investments in health into actual progress toward UHC. Increasing reliance on public funds to finance coverage expansion has proven to be successful in other settings to reduce out-of-pocket (OOP) spending and therefore to improve financial protection. However, the way in which public funding is allocated and used matters. Too often, public resources are fragmented, poorly distributed, and inefficiently used. As a result, they do not benefit the people who need them most. Bolstered by UHC-related principles enshrined in SDG target 3.8, the countries of the region are presented with a unique opportunity to embrace UHC as a driver of social equality, and are therefore encouraged to reform their systems of public financing for health.

At the same time, external assistance must increasingly support and catalyse sustainable health system performance, transitioning away from the sometimes volatile and fragmented approaches of the past. At the 2015 Addis Ababa conference, WHO urged the international community to strengthen cooperation with low- and lower-middle income countries of the region to combine domestic and external funding in order to provide sufficient resources to build robust health systems. Strong, adequately-financed health systems are essential to ensure both individual and global public health security, a truth that was thrown into sharp relief by last year's Ebola crisis in West Africa. UHC presents a unique opportunity to promote a comprehensive and coherent approach to health, beyond the treatment of specific diseases, to focus on how the health system as a whole delivers integrated, people-centred health services.

We call upon Ministers of Health, Ministers of Finance, other Department Ministers, Parliamentarians and all stakeholders involved in health financing and systems to use the evidence published in this document to advocate for change and take the urgently needed decisions regarding public policies, strategies and reforms. By doing this they will ensure that resources invested in health are used in the most relevant, effective and efficient manner so as to benefit the people who need them most.

We thank you very much. Your commitment makes all the difference.



A handwritten signature in black ink, appearing to read 'M Kieny'.

Dr Marie-Paule Kieny
WHO Assistant
Director-General,
Health Systems and
Innovation



A handwritten signature in black ink, appearing to read 'M Moeti'.

Dr Matshidiso Moeti
WHO Regional Director
for Africa

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Introduction

In 2001, African Union heads of state pledged to allocate at least 15% of annual expenditure to health under the Abuja Declaration.¹ They also urged donor countries to fulfil the yet-to-be-met target of Overseas Development Assistance (ODA) to developing countries equivalent to 0.7% of Gross National Income (GNI). This commitment acknowledged the key role played by public funding to ensure sustainable and equitable health coverage. The alignment of high level African leaders on pro-health commitments was an important first step in the Millennium Development Goals (MDGs) era and remains a unique initiative in the history of financing health and social goals.

Fifteen years later, most African governments have increased the proportion of total public expenditure allocated to health. In addition, the average level of per capita public spending on health rose from about US\$70 in the early 2000s to more than US\$160 in 2014 (Parity Purchasing Power, PPP). Health is predominantly financed by domestic resources in Africa, with an average 76% in 2014, while external aid has increased from 13% to 24% of total health expenditure over the same period.

But it is too early to declare victory. Moving towards spending targets, though important, is not enough. Indeed, by focusing too much attention on reaching certain expenditure levels, policy makers may actually lose sight of other challenges, such as improving the way existing resources are allocated and used in the health sector. The adoption of the Addis Ababa Action Agenda on Financing for Development and of the new Sustainable Development Goals (SDGs) in the second half of 2015 has been accompanied by a growing recognition of the need to explore the nature of the resources available and the use to which they are put, rather than focusing solely on the volume of resources required to make progress toward UHC. In particular, how public monies are allocated, spent and used has a direct impact on the level of coverage and financial protection, as well as on equity.

Countries' experiences in reforming public finance systems to support progress toward UHC indicate that success depends on more than simply increasing levels of public budgets; it requires:

- **Appropriately targeted health budget allocations** (public resources for health are not optimally distributed among the population and often fail to target priority areas, notably the health services required to cover the needs of the most vulnerable populations);
- **Complete execution of health's public budgets** (annual health's public budgets are not systematically or fully disbursed due to public financial management deficiencies, resulting in missed opportunities for better health results);
- **Improved efficiency in the use of public resources for health** (for the same level of public spending, outputs vary considerably across African countries; there is often scope to move toward more equitable service coverage and financial protection without significant increases in expenditure if public money is spent differently).

This report takes stock of the main public financing for health trends in the past fifteen years in the region, and highlights opportunities for accelerated progress toward UHC in Africa based on better informed budget planning and utilization decisions. Presenting new evidence on the critical role played by domestic public financial management systems on the level, effectiveness and quality of public spending on health in Africa, the report argues that public expenditure management needs to be re-considered if countries are to close the gap between the current rules, conditions and practices of health expenditure and what is required to move towards UHC.

The remainder is composed of three sections. The first section is articulated around three policy highlights:

- 1) [Aligning budget resources and health priorities;](#)
- 2) [Closing the gap between health budget allocation and expenditure; and](#)
- 3) [Maximizing UHC performance with the money available.](#)

Section 2 is dedicated to providing detailed health financing information on countries of the region and specifically includes 48 country profiles focused on key health financing trends. The last section includes information on progress toward the development of health financing strategies in the region, as well as regional and country benchmarks on key health financing indicators.

Key recommendations

Progress toward UHC depends on strengthened revenue collection efforts and improved allocation of existing public resources toward health in most African countries;

- Tax capacity has to be strengthened to allow “fair space” for financing health and social sectors, even at a constant budget share;
- As national income and domestic revenues increase, the allocation of public, compulsory funds to health should be better prioritized within existing multi-year and annual fiscal frameworks;
- High-level leadership is required to encourage greater engagement between health and finance authorities in determining the level and allocation of health’s public budgets, and to ensure the relevance and fitness-for-purpose of public funding for health;
- Beyond budget prioritization, improved predictability in both domestic and external resources is key to allowing effective planning and implementation of sector activities;
- Better documenting the use and benefits of public funds committed to health across socio-economic groups should be prioritized to make all levels of health financing systems more accountable and transparent as a part of ensuring that “no one is left behind” is not just a slogan;
- Defining a package of essential services to be purchased in alignment with adequately designed providers’ incentives could help direct public financing into more effective delivery of priority health services to priority populations.

Reducing health budget underspends is crucial to maximizing the benefits of existing public resources allocated to the sector;

- Strengthening alignment between multi-year expenditure frameworks, parliament-authorized annual budget allocations and actual spending is required in most countries to increase the predictability and stability of sector financing;
- Improving realization of the allocated envelope depends in part on limiting sector de-prioritization in mid-year budget re-allocations and reducing leakages due to deficiencies in health expenditure management;
- The identification of country-specific public financial management bottlenecks that affect the effectiveness and efficiency of public financing on health should be an urgent inter-ministerial priority;
- A comprehensive review of the full public expenditure on health cycle should be undertaken in the region, focusing on the way health policy-based budgeting is undertaken, how cash is made available to ministries of health, and how health budgets are effectively executed and accounted for; any gaps identified should be the focus of urgent policy action;
- Better articulating the development and implementation of health financing strategies with ongoing Public Financial Management (PFM) reforms, in close collaboration with regional entities that lead the production of PFM regulation, is a must for all countries of the region, as well as for development partners, to ensure that money effectively goes where it is needed.

Supporting and evaluating the transformation of public resources into actual progress for equitable service coverage and financial protection is at the core of the SDG agenda;

- Transitioning toward predominant reliance on public, pre-paid, compulsory sources of funds is necessary to ensure progress toward UHC, and in particular to reduce dependence on OOP payment; effective allocation of these funds to priority services and populations is essential to provide sufficient protection for the poorest;
- Effective, parallel monitoring and evaluation of the effects of public financing for health reforms on both financial protection and service coverage is crucial to making the adjustments needed to achieve the UHC targets;
- Particular attention to increasingly prevalent catastrophic expenditure among the poorest, as coverage expands, should motivate future reforms targeted at pro-actively protecting people from financial hardship or from foregoing services.

Note: in this report, the authors use “Africa” to refer to countries in the WHO African Region, which includes: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cabo Verde, Central African Republic, Chad, Comoros, Congo, Côte d’Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, and Zimbabwe. <http://www.afro.who.int/>

Note: unless otherwise stated, the report uses the latest data available produced by the World Health Organization under the Global Health Expenditure Database (GHED), available on line at: <http://www.who.int/health-accounts/ghed/en/>. The System of Health Accounts (SHA) is an internationally accepted methodology, which serves as the global standard for summarizing, describing, and analysing the financing of health systems. Systematically tracking the flow of expenditures in the health system, SHA is critical for improving governance and accountability at the national and international levels of policymaking. First published in 2000 by the Organization for Economic Cooperation and Development (OECD), WHO subsequently produced an implementation guideline, in collaboration with USAID and the World Bank, for low- and middle-income countries. Recently, OECD, Eurostat, and WHO produced an updated version of the SHA called SHA 2011. It is important to note that in a few cases the data may differ from country-generated data, as the Global Health Expenditure Database publishes cross-country comparable information, which is the result of WHO reviewing country data and validating it against one global standard. At times this may require adjustments to the data published by countries.

1. Policy Highlights

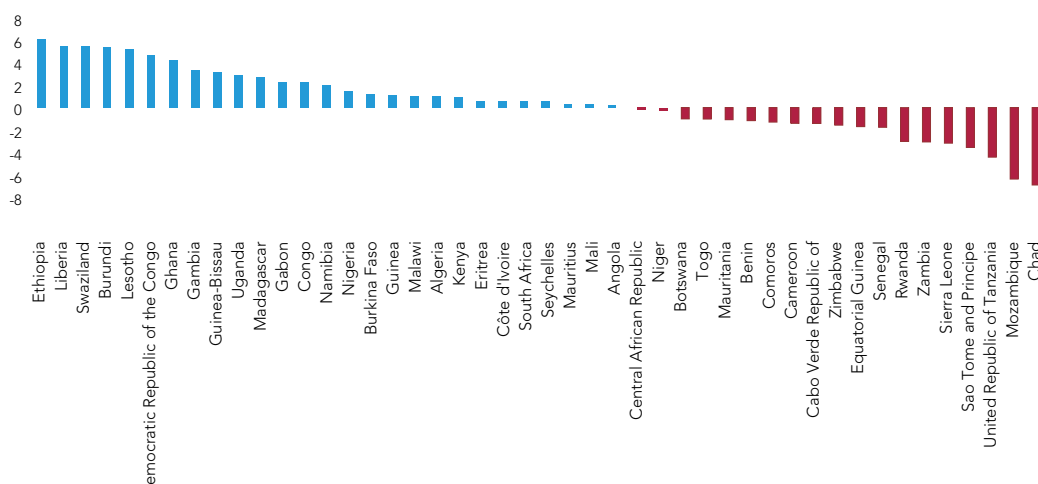
1. Aligning budget resources and health priorities

As state revenues grow and more resources become available to African Governments, health spending is sometimes being de-prioritized. Funding flows are characterized by extreme annual fluctuations, which limits the sector's capacity to effectively plan and implement. In addition, key populations and/or services are not being systematically prioritized in public spending. Governments are tending to allocate only limited public resources to primary and preventive care services, despite these being critical to achieving equitable and sustainable progress toward UHC.

1.1 Prioritizing health within budget: mixed trends, including de-prioritization

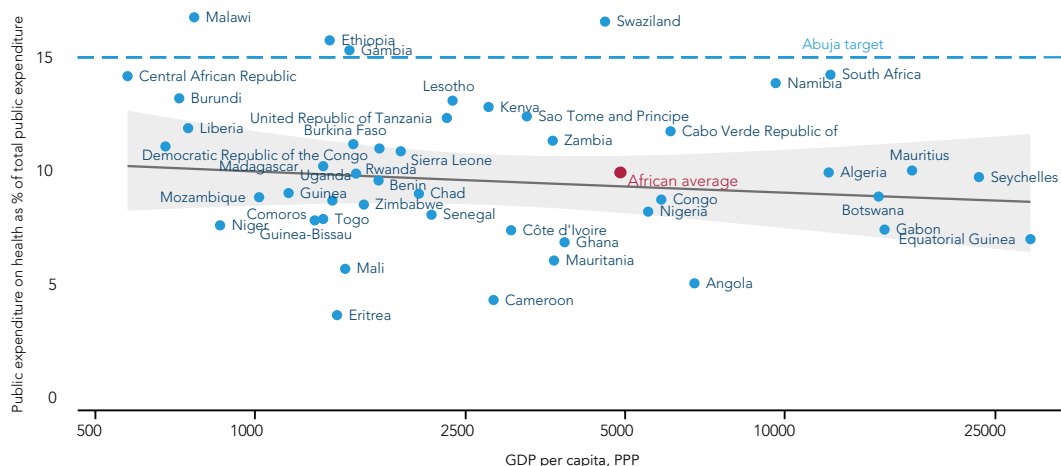
Most African countries have improved their budget allocations to health over the past 15 years, reflecting the Abuja Declaration calls for increased spending on health as a proportion of total public expenditure. The average annual public expenditure on health in the region is 10% of total public spending in 2014, ranging from 4% (Cameroon) to 17% (Swaziland).² However, while some countries have increasingly prioritized health spending over time (e.g. Ethiopia, Liberia, Swaziland, Burundi or Lesotho), in recent years nineteen of them have been spending less on health as a percentage of total public spending than was the case in the early 2000s (red bars - Figure 1).³

Figure 1: Change in government health prioritization, % point change of median values 2000-06 and 2007-14



Source: authors, from Global Health Expenditure Database, WHO, 2016

Figure 2: Government health prioritization and GDP per capita, 2014



Source: Global Health Expenditure Database, WHO, 2016

Government health prioritization does not seem to be associated with national income or level of government revenues in the African region (Figure 2). For example, higher per capita income countries do not systemically give higher priority to health in their public spending (i.e. countries above US\$ 10,000 per capita (PPP): Algeria, Botswana, Equatorial Guinea, Gabon, Mauritius, Seychelles and South Africa). In contrast, a few lower income countries allocate more than 15% of their public spending to the sector (Ethiopia, Gambia, and Malawi).

When states become richer, public spending on health as a proportion of total public expenditure does not systematically increase, and in most cases public expenditure on health is not responsive to increased state revenues. Despite increases in fiscal capacity, spending on health has been de-prioritized as governments strive to meet other obligations (Table 1-lower elasticity). In low-income settings, the de-prioritization of health in public expenditure tends to be associated with country-level fragility and political instability, poor governance⁴ and corruption.⁵

Table 1: Responsiveness of public expenditure on health to growth in state revenues, 2000-2014

Low elasticity (below 1)	Higher elasticity (above 1)
Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Central African Republic, Chad, Comoros, Equatorial Guinea, Ethiopia, Eritrea, Kenya, Gabon, Gambia, Ghana, Guinea Bissau, Lesotho, Liberia, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Republic of Congo, Rwanda, Sao Tome and Principe, Senegal, Seychelles, South Africa, Swaziland, Togo, Zambia	Cameroon, Guinea, Ivory Coast, Madagascar, Nigeria, Sierra Leone, Tanzania, Uganda

Note: Elasticity below 1 means that public expenditure on health increases less rapidly than revenues.

Source: authors, from Global Health Expenditure Database, WHO and World Economic Outlook database, IMF

Budget data analysis also reveals large annual fluctuations in both allocations and actual expenditure for health in most countries of the region, reflecting limited stability and predictability in the volume of public resources available for the sector. Uncertainty regarding resources hampers effective planning and implementation of sector activities. Multi-year budgeting tools should be more effectively used to provide more visibility and predictability of the “spending window” available for the sector within a three-to-five year period. Successful experiences tend to show that the more health authorities engage in the budgeting cycle from the early stages and collaborate with finance entities in determining allocations, the more health budgets are likely to be credible and aligned with health sector priorities, both in terms of level and quality.

Box 1

Re-prioritizing budget toward health: A fiscal space perspective

The concept of fiscal space for health has become increasingly prominent in global and national health policy discussions as countries strive to progress towards UHC. First defined by Heller in 2006 as the budgetary room that allows a government to provide resources for health without impairing fiscal solvency, the concept and subsequent frameworks derived from it have been used extensively in low-and middle-income countries (LMICs) to assess both the currently available and future potential space for spending on health.

Prioritizing health sector spending in government budgets is a key factor for expanding fiscal space for health in existing frameworks (Tandon & Cashin 2010, Mathonnat 2010). A 2016 WHO literature review of 27 fiscal space for health studies conducted in African countries shows that health re-prioritization is one the main drivers of fiscal space expansion. The size of expected change varies considerably across studies but gains are generally expected to be higher when the existing share of health within budget is lower.

In contexts characterized by low health sector prioritization, margins are expected to be significant. For example, a Tanzania study estimates that reaching the Abuja target (in Tanzania this would require an 11% increase from the 2014 level of public spending on health) would generate more than US\$700m extra on average every year for the sector. In the case of DRC, a reprioritization from the 2013 level of 5% to 8 and 10% could lead respectively to 0.3% and 0.6% point GDP increases – a relatively limited increase as a share of GDP due to the small size of the overall government/public resources, but a doubling in nominal volume for the sector.

Regardless of the existing level of public spending on health, several studies suggest that significant change in fiscal space for health in the short to medium term is unlikely. For examples, studies on Chad, Gabon and Uganda provide a relatively pessimistic prospect for increasing the health share of the budget in the foreseeable future, given political commitments to other sectors (i.e. infrastructure, education or agriculture/local development). In the case of Ghana, ongoing fiscal consolidation (2010-2011) is seen to be a key constraint to increased resource allocation for health.

Based on compelling empirical evidence, the key factors driving increased prioritization of spending on social and health sectors in the region include: sustained political commitments toward the sector; legal or constitutional mandates that support sector spending; effective marketing and domestic buy-in of sector results; active engagement of civil society; and empowered communities – both of which driving greater transparency and accountability. However, in general, the studies reviewed do not present substantive analysis of the political economy considerations that could potentially support fiscal space for health expansion, or budget re-prioritization, which is, above all, a political choice. This is likely to limit the applicability or feasibility of the studies’ recommendations and many questions remain as to how policy initiatives intended to support fiscal space expansion can actually translate into reality.

Source: Barroy H., Sparkes S., Dale E.: Projecting fiscal space for health: A review of the evidence, World Health Organization, Geneva (forthcoming)

In the low-income countries (LIC) of the region, where DAH most significantly increased over the past 15 years (from 1 to 2.4 % of GDP), there is no clear indication of any crowding out trend. While domestic financing increased less rapidly in some settings, suggesting possible crowding out of public resources allocated to the sector, in others, public and external sources increased at the same pace. Since 2010, however, the observed average decrease or flattening out in the level of external funding for African LIC has not been compensated for by an increase in domestic sources for the sector, which, on average, stagnated at 2.5% of GDP. Fluctuations in funding from foreign sources also have a significant impact on health expenditure. The lack of predictability of aid flows has severely deterred sector performance, particularly in countries where aid is a dominant source of health financing. Regardless of funding source (external or domestic) it is essential to move toward stable, multi-year planning horizons and to minimize instability in funding flows.

Apart from requiring a change in budget priorities, the shift to more domestic funding for health, where this occurs, has to be supported by strengthened revenue collection efforts. GDP growth of 5% in real terms over the past fifteen years has not been matched by comparable increases in state revenues, with an average tax-to-GDP ratio remaining relatively low at 17.9% in 2014.⁶ Apart from macro-economic enablers, policy measures such as strengthening tax compliance and administration, reforming tax structures and broadening bases of certain taxes that would enhance progressivity, can all help to mobilize increased tax revenues, and ultimately to finance the sector at constant budget share. Other useful policy objectives include reducing tax exemptions and tax evasion. Borrowing seems not to be a viable alternative for African countries seeking to expand their financial capacities, since deficit and debt levels, after significantly decreasing in the past decade, are projected to expand in the near future (2017-2021), according to IMF projections.⁷

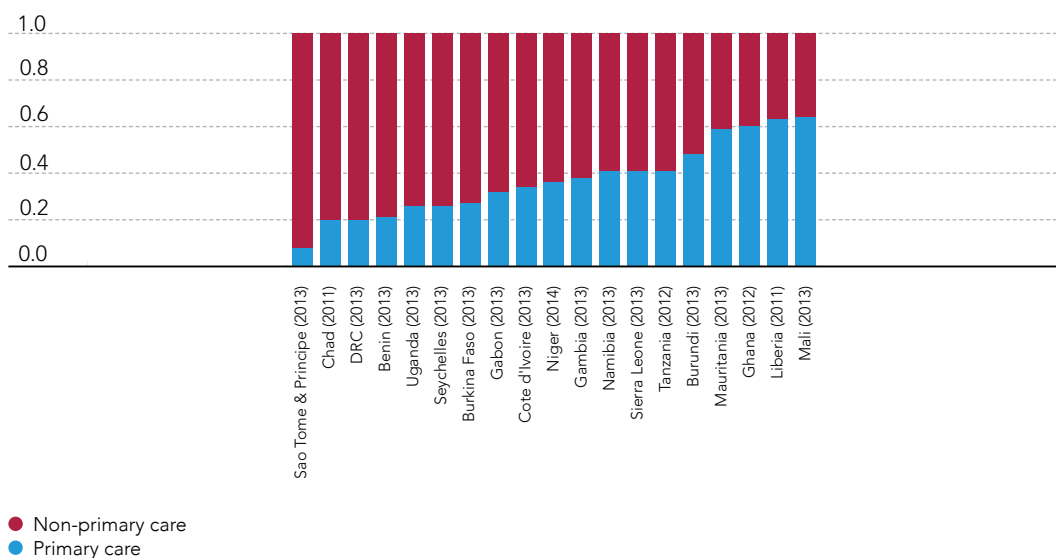
1.2 Resource allocation skewed towards high-end care

In a majority of African countries, public monies flow disproportionately to high-end care (i.e. secondary and tertiary levels, referral hospitals, capital facilities) and benefit those who use these facilities proportionally more, that is to say the richest members of society. Efficient and equitable health systems allocate a significant share of funds to primary care, while maintaining sufficient transfers to referral hospitals that are important for offering specialized care.

Available data, organized using the SHA 2011 classification, clearly indicates that significantly lower priority is given to primary care.⁸ With a few exceptions, a large number of African governments spends less than 40% of health service expenditure on primary care (Figure 3). Private and external funds continue to be the predominant source of finance for primary care in most settings, including OOP payment, a significant deterrent for the most vulnerable groups (Figure 4).

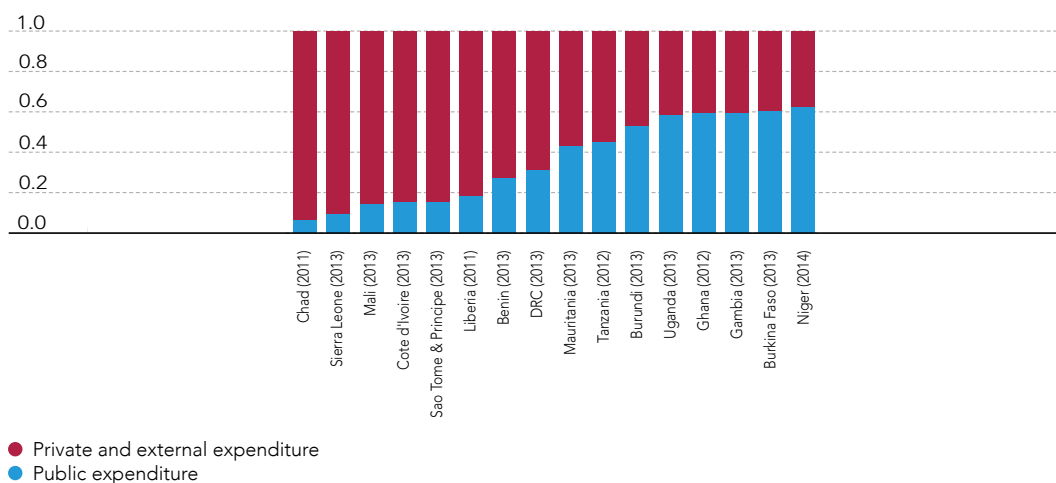
Conversely, within public curative care expenditure, hospitals are in general the biggest spending item (40-60%), while hospital service use remains extremely low⁹ and inequitable. According to the available data, per capita median public expenditure on non-primary care is up to 3 times higher than spending on primary and preventive services. This largely contributes to socio-economic inequalities in the actual benefit generated by public funds.

Figure 3: Primary and non-primary care expenditure, as a share of public expenditure on health services, %¹⁰



Source: authors' estimates, from National Health Accounts data

Figure 4: Public and non-public expenditure on primary care, %¹¹



Source: authors' estimates, from National Health Accounts data

The priority given to strengthening quality primary care is reflected in higher public expenditure ratios in several countries, including Ghana (60%), Liberia (63%), Mali (64%) or Mauritania (59%). Alternative payment systems for purchasing primary care services are also being explored in Ghana (capitation), Benin, Burundi, Cameroon, DRC or Rwanda (performance-based financing), as a way of improving the quality of services delivered, as well as managing public expenditure better (targeted, performance-oriented allocation to providers). Scaling up and institutionalizing alternative provider payment systems especially for primary care, should be a priority for these countries, and for the region as a whole.

Reprioritizing public expenditure within the health sector, while often a necessary exercise, is, generally speaking, a long, and technically cumbersome process involving a significant political component. One way to help shift sector spending toward identified priorities such as improved access to quality PHC services is to define (or re-define) an explicit benefit package of essential services and align it with appropriate provider payment mechanisms and incentives. Reducing fragmentation, and notably the use of separate funds to serve discrete policies or programmes, is another possible way of maximizing gains and reducing possible inequities in the use of public funding.

Box 2

Appropriate allocation of public funds for health through targeted budget transfers: The case of Gabon

Gabon introduced a non-contributory, fully subsidized programme for the "economically vulnerable" called the "Gabonais Economiquement Faibles" - GEF in 2007. Based on direct means-testing of individual income, the GEF scheme's target population is people with annual income below FCFA 80,000 (US\$152), and it covers dependents, as well as students, pupils and refugees.

Under the umbrella of the CNAMGS (the recently created national health insurance fund), the scheme is funded by newly introduced ear-marked taxes and general revenues. Ear-marked funds, originating from taxes on mobile phone company turnovers and on individual money transfers, cover more than two-thirds of the GEF fund expenditure.

The scheme has so far enrolled 90% of its target population and provides coverage of a standard benefit package of health services with no co-payments. The benefit package is comprehensive and covers outpatient, ambulatory, and inpatient services, as well as medicines. It is thus similar to the one offered to formal sector workers. Informal sector workers have yet to be enrolled in a separate scheme, but are still expected to be under the CNAMGS umbrella.

The ear-marked revenues used to fund GEF were recently found to be insufficient to cover the scheme's increasing expenditure which has been driven by increased enrollment and demand for health services, and led to the fund reporting a budget deficit in 2015. The GEF case is one more example of the need for general revenues to support such schemes even when ear-marked sources, such as indirect taxes or social contributions are helping bridge resource gaps. It also underlines the importance of strategic purchasing to better manage demand and expenditure, especially in fee-for-service environments, as exists, for example, in Gabon.

Source: adapted from Saleh K., Couttolenc B., Barroy H.: *Health financing in Gabon*, World Bank (2014); & Inoua A., Musango L.: *Assurance Maladie Obligatoire au Gabon : un atout pour le bien être de la population*, Background report, World Health Report 2010.

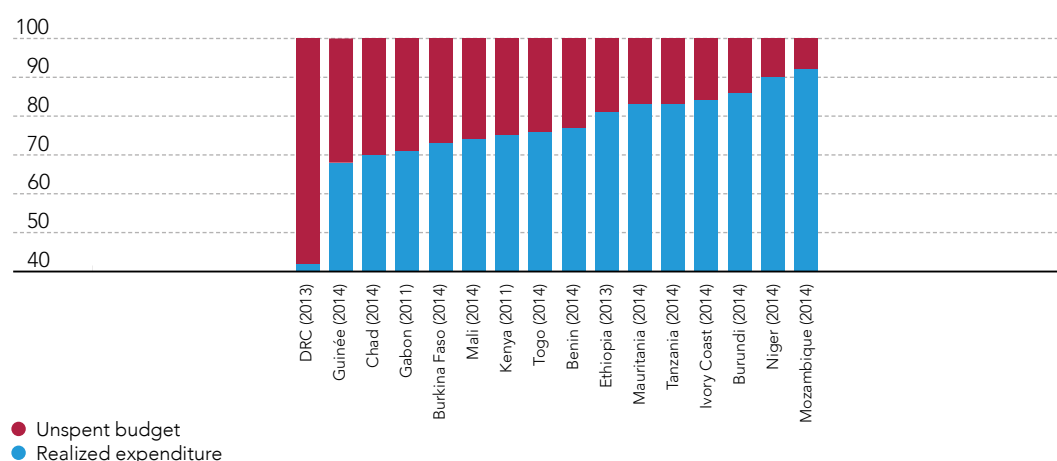
2. Closing the gap between health budget allocation and expenditure

Health budget allocations reflect political commitment to the sector, but allocating funds and actually spending them are two different things. In many cases, governments are unable to make full use of annual budgetary allocations, failing to do so for a variety of reasons, notable among which public financial management deficiencies. The failure to fully execute budgets constitutes a significant fiscal loss for the sector, with unused budgetary space ranging from US\$10 to 100 million across African countries. Addressing public financial management shortcomings is a priority if the effectiveness of public spending on health and overall sector results are to improve.

2.1 Underspending health budgets: opportunities lost

Failure to spend the entirety of financial resources budgeted is commonplace in the region, with most countries experiencing difficulties, particularly in regard to allocations for the health sector. The available data indicate that the proportion of unspent health budget ranges from 10 to 30% of authorized allocations in African countries, with some outliers (such as DRC) getting close to 60% unspent (Figure 5).

Figure 5: Share of health budget spent and unspent, % of total sector allocations



Source: authors' estimates, from Ministry of Finance (Benin, Burkina Faso, Burundi, Chad, Guinea, Ivory Coast, Mali, Mauritania, Niger, Senegal, Tanzania, and Togo), BOOST (Ethiopia, Kenya, and Mozambique), and World Bank (DRC, and Gabon) data.

From a fiscal space for health perspective, failing to spend the entirety of Parliament-authorized budgets entails a loss of financial resources for the sector and missed opportunities for improving overall service coverage and financial protection. Estimates show that significant loss of fiscal space for health due to low budget execution ranges from US\$10 to more than \$100 million per year, or US\$1-3.5 per capita across African countries (Table 2). Looking beyond annual budgets, gap analysis between multi-year expenditure frameworks (MTEF) and annual allocations also reveals that at least one third of planned expenditure for health is never realized in African countries, mostly because of reduction in revenues and/or inter-sectoral budget re-allocations.

Table 2: Loss of fiscal space for health due to underspends

	Unspent health budget (current million US\$)	Unused budgetary space per capita (current US\$)
Benin (2014)	33.5	3.31
DRC (2013)	119.8	1.52
Guinea (2014)	10.2	0.89
Ivory Coast (2014)	66.3	2.93
Mauritania (2014)	11.0	2.90
Togo (2014)	17.5	2.39

Source: authors' estimates, from Ministry of Finance and World Bank data

Low execution is particularly prevalent for non-discretionary expenditure, which is more vulnerable to inter-sectoral re-allocations, and is heavily dependent on appropriate planning and effective financial management systems. While personnel costs are, generally speaking, fully executed based on historical allocations, in general non-wage expenditure is largely underspent. In particular, capital expenditure planned for infrastructure investment, frequently dependent on donor funding channelled through the budget and subject to poor forecasting and execution mechanisms, is particularly affected by low execution rates (Table 3).

Table 3: Execution rates for discretionary and non-discretionary public expenditure on health, %

	Non-discretionary		Discretionary	
	Personnel	Subsidies and transfers	Goods and services	Capital
DRC (2011-2013)	94	45	40	36
Niger (2011-2014)	96	83	72	46

Source: Ministry of Finance (DRC); BOOST, World Bank (Niger)

While increasing budget allocations has become a political priority at both regional and global levels, the underspent budget issue has been largely ignored. It is however of fundamental importance, not least from the point of view of accountability, and needs to be addressed by all African governments and stakeholders in the domestic space.

Box 3

Role of Public Financial Management systems in health

Sub-optimal execution of budgets is above all a public financial management issue. Optimizing the way in which public funds for health are managed and flow through the health system is critical to achieving UHC objectives with the resources available.¹² PFM systems serve to optimise the level and allocation of public funding (budget preparation), but can also increase the effectiveness of spending (budget execution) and the flexibility with which funds are used (pooling, sub-national PFM arrangements, purchasing).

Understanding the guiding principles of budgeting as well as the political dynamics that enable the budget elaboration and approval process is essential to aligning allocations with priorities and maximizing opportunities for full execution. In many countries, health policy making, planning and budgeting take place independently of each other, leading to a misalignment between health sector priorities and funds ultimately allocated by MoF to health. How fund managers spend their money largely depends on how the budget is allocated. In other words, it is not just a question of the total budget amount, but how that total is structured, how it flows into the system and how it is employed to purchase the needed health services.¹³

Possible misalignments between PFM and health financing requirements are likely to emerge at various steps of the expenditure cycle, including: i) budget preparation (with misalignment between fiscal discipline and sector prioritization); ii) budget formulation, (with different perspectives and interests regarding budget structure); iii) execution, (with pooling and service purchasing vs passive line-based disbursements); iv) different management of costs savings and budget re-allocation.

As a result more policy action is needed to foster mutual understanding of PFM and health financing functions and rules, identify mutual benefits and determine joint areas of possible alignment with a view to progressing towards UHC. Several countries in the region have embarked on alternative health financing reforms that have been mutually beneficial for both the sector and public financial management as a whole. These include: the development of sectorial Medium-Term Expenditure Frameworks; the strengthening of domestic procurement mechanisms; sound management of domestic pooled funds, and the introduction of purchasing agents and strategic payment mechanisms as a measure to control expenditure and expand effective coverage at the same time. In that respect, health can be considered the “bridgehead” to leverage domestic PFM reform efforts in more African countries.

Source: authors

2.3 The root causes of health budget underspends

The main causes of health budget underspending are found up- and downstream of the budget elaboration process; they include:

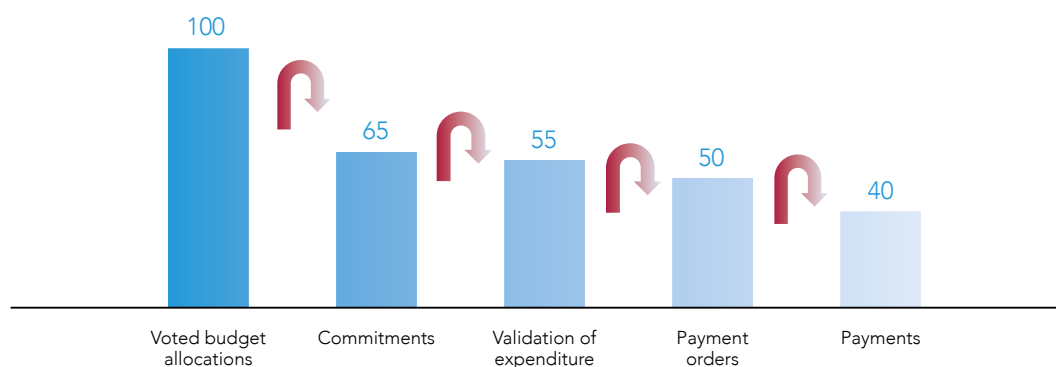
Unpredictable allocations: when actual revenues, whether domestic or external, do not match with multi-year and annual forecasts, annual allocations for health are subject to cuts; available revenues are commonly re-prioritized to non-social expenditure to meet other government obligations. As a result of such actions, revenues made available for the health sector fall short of the approved budget, resulting in suboptimal budget execution. While several African countries have recently introduced sector-specific, multi-year budgeting tools, uncertainties surrounding revenues and mid-year reallocations continue to hamper improvements in budget predictability;

Mismatch between policy and budget allocations: health budgets tend not to align with sector priorities such as those set out in national plans and regulatory frameworks, and generally follow historical cost estimates; the limited involvement of health authorities in the budgeting elaboration process poses significant challenges for full budget execution; political and technical windows of opportunity for health entities to influence or modify intra-sectoral allocations are also generally limited;

Inappropriate budget structures: the way health budgets are formed also has implications for the rate or level of execution ultimately achieved. Rigidities, such as line-item budgeting, and lack of responsiveness to sectoral specificities, for example, pooling requirements, or autonomy in funds management, make the budget realization process cumbersome and contribute to lowering execution rates; limited flexibility for the sector to pay health service providers in a way that secures quality and equity in service use, as well as efficiency in the use of public resources, also plays a role in underspending. Despite progress made with the introduction of program or performance budgeting in the health sector, there is still space to improve the way performance information is used to inform budget allocation decisions;

Under-performing execution systems in health: execution rules and practices directly affect the level of public spending in health; potential obstacles occur at each step of the execution process – from commitments to final payments (Figure 6); discretionary (non-wage) health expenditure is particularly vulnerable to under-performing expenditure management systems; limiting the use of extra-budgetary, exceptional procedures for executing health expenditure should also be at the core of this reform agenda.

Figure 6: Stylized illustration of possible budget underspends throughout the execution process



Source: authors

The key priorities for strengthening the relevance and execution of health budget allocations are: strengthening the use of multi-year revenue and expenditure frameworks, reinforcing policy-based fiscal strategy and budgeting, assessing challenges and opportunities associated with alternative budget structures, and undertaking screening exercises regarding execution management systems in health. Better articulating the development and implementation of health financing strategies with ongoing PFM reforms, in close collaboration with regional entities that lead the production of PFM regulation, is a must for all countries of the region, as well as for development partners.

Box 4

Understanding the root causes of low execution: The example of DRC

Despite recent changes, shortcomings in public finance management continue to undermine the volume and quality of government expenditure in DRC. The country launched a far-reaching public finance modernization campaign starting with the adoption of a vast program of public finance reforms via the establishment of COREF (2009), the adoption of a Strategic Public Finance Reform Plan (2010), the revision of the Public Procurement Code (2010), and the passing of a new Public Finance Act (the LOFIP) in 2011. These reforms cover the entire budgetary process as well as the administration and accounts management of expenditure. The main aim of the reforms is to decentralize the budget and finance ministry payment process, transferring responsibility to the line ministries, including health. The Administrative and Financial Divisions (AFDs), scheduled to be set up in each ministry in 2015, are the latest part of this reform.

Notwithstanding these reforms, budget preparation still shows little standardization or systematization. The introduction of general “steering” tools—the Medium-Term Fiscal Framework (MTFF) and budget preparation by program—has, to a certain extent, improved the predictability of the expected volume of revenue and expenditure and improved the budget’s clarity and credibility. The introduction of the Medium-Term Sector Expenditure Framework (MTSEF) for the sectors was also expected to improve the predictability of budget allocations in the priority sectors, including for health. Although the tool has been an effective training and information vehicle on budget preparation technique at the Ministry of Public Health (MoPH), it has done little to improve the predictability of budget allocations and choices; allocations are still far from being fully aligned with health sector priorities, and continue to challenge effective spending.

Although expenditure channels have been systematized, obstacles also hamper sound execution, especially for social and health sector allocations. The current execution procedure has been improved with four standard expenditure steps. The Budget Commitment Plans—introduced to keep expenditure in line with cash flow and restrict slippage (multitude of emergency procedures, overruns, and initiation from outside the expenditure chain)—have limitations in practice, including delays, no connection to the original allocation, unsuitable timeframes, and meager commitments. Although the actual transfers generally match these plans, expenditure validation and payment orders are more problematic. These two steps remain highly manual and, although lead-times have been reduced, overdue payments are still the norm and carryover transfers are frequent.

Expenditure steps	Responsible administration	Problems identified
Commitment	Budget	Delays issuing the quarterly Budget Commitment Plans. Disconnect between these plans and the sector budget. Limitation of sums available for commitment (liquidity)
	Ministry of health	Delays/errors in the preparation (departments; sub-managers), signature (Minister) and submission (sub-manager) of the commitment voucher in accordance with the Budget Commitment Plan.
Validation of expenditure	Budget	Delays in the signature (charged to the following quarter; loss of quarterly transfers for the MoH). Long processing delays/standstills. Highly manual procedures.
Payment order	Finance	Payment orders can take two to three months to be sign (loss of quarterly transfers). Carryover transfers. Manual procedure.
Payment	Treasury	Delays/errors in authorization for payment and the bank transfer. Significant lag between opening the dossier (requisition) and releasing the payment.

Source: Barroy H., Andre F., Mayaka S., Samaha H. (2016): *Investing in Universal Health Coverage: Opportunities and Challenges for the DRC, Results from a Health Public Expenditure Review*, World Bank

3. Maximizing UHC performance with the money available

One of the consequences of public money not being directed and spent where it should be is that financial protection has not significantly improved for the poorest in the region, despite increases in public spending for health over the past fifteen years. While service coverage has overall improved in the region over the past decade, utilization from the poor likely remains constrained by financial barriers. Monitoring and evaluating the effects of public financing reforms on financial protection and service coverage in parallel is necessary to ensure that “no one left behind” is more than just a slogan, and that better coverage is effectively associated with fewer inequalities and financial risks.

3.1 Misallocation of public money: the negative impact on financial protection

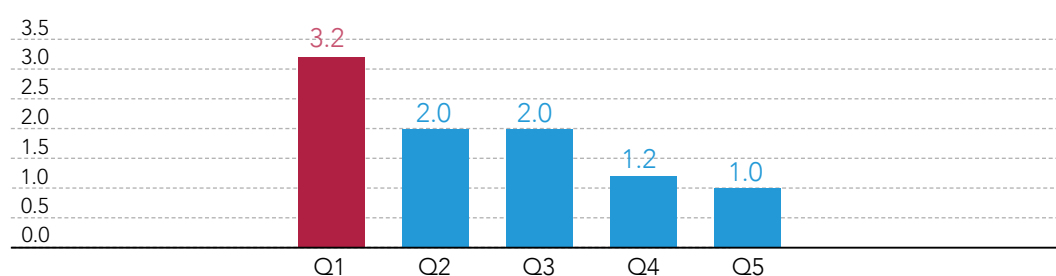
The misallocation of public resources directly impacts the benefits to be derived from public funding for health. As public money tends not to be systematically prioritized for primary care, or for more accessible services for the poor, it is the rich who benefit most from public funds for health – an estimated from 2 to 7 times more than the poorest in the region.¹⁴

Inequitable distribution and use in public funds for health also has repercussions on financial protection, especially for the poorest. Because access to essential services is for the most part financed by OOP expenditure and because public money is not appropriately targeted, the poor continue to face severe financial hardship.¹⁵ While countries in the region are relying less on OOP payments which have declined from a median 42% of total health expenditure in 2000 to 31 % in 2014, the level of OOP payment has worsened in a number of countries in the past 15 years.¹⁶ Indeed, twelve countries in the region increasingly rely on OOP payment to finance health coverage.

As a direct consequence, catastrophic spending is more prevalent among the poorest (3.2 % among quintile 1 compared to 1.0 % among quintile 5) (Figure 7) and the difference in the proportion of the poorest facing catastrophic spending can be up to 6 times higher than the proportion of the richest (Figure 8).

When public funds allocated to the sector increase, OOP expenditure is expected to decrease, as is catastrophic spending. This transition has not yet started in the region, where there are significant country variations in financial protection for the same level of public spending on health due to system inefficiencies, including poor funds allocation.¹⁷ Analysis shows that, for the same level of public spending, countries provide stronger financial protection where health financing systems have been effectively reformed. For example, Rwanda and Kenya's governments both cover 40% of total health expenditure, the former providing a relatively high level of financial protection (Rwanda has only 1% of catastrophic expenditure) following the introduction of a quasi-compulsory, nationally pooled insurance system, while in the latter, about 5% of the population experience catastrophic spending as a result of using health services, the funding of which relies only minimally on compulsory payments.

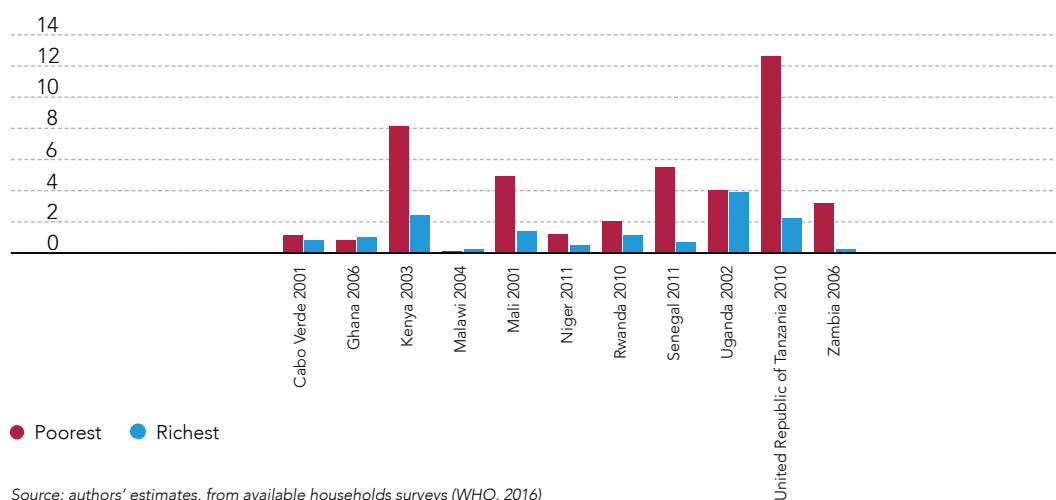
Figure 7: Catastrophic health expenditure, median headcount ratio by quintile



Catastrophic health expenditure is defined as when spending out-of-pocket on health is equal to or exceeds 40% of total expenditure net of a subsistence-level of food spending. WHO & World Bank (2015). Tracking universal health coverage: first global monitoring report. WHO.

Source: authors' estimates, from available households surveys (WHO, 2016)

Figure 8: Catastrophic health expenditure among poorest and richest quintiles



Source: authors' estimates, from available households surveys (WHO, 2016)

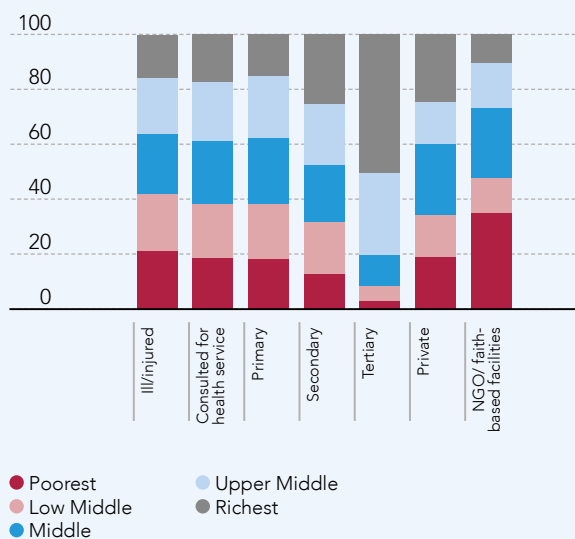
Box 5

Skewed allocation in a low income setting: The case of Chad

In Chad the tertiary sector is heavily subsidized with government funds, but is most frequented by the richest quintile (Figure A). The health budget is thus inequitably distributed. Two-thirds of hospital subsidies go to national hospitals (in the capital), while regional and district hospitals share 26%. A benefit incidence analysis of public financing for health based on ECOSIT 3 2011 data concluded that public expenditure does not reach the poorest, who receive only 6% of public subsidies, against 46.5% for the richest quintile (Figure B).

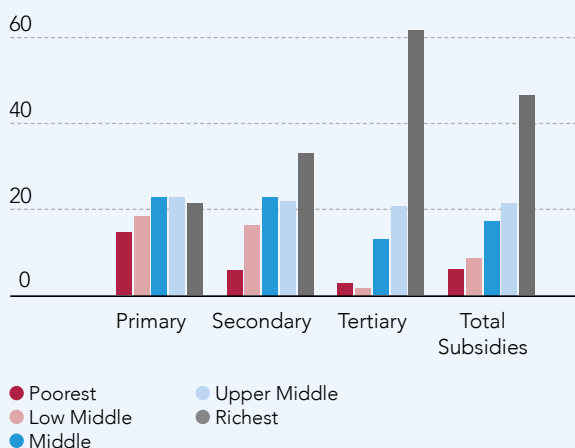
Earlier evidence from a Public Expenditure Tracking Survey (PETS), used to examine flows of public resources to healthcare facilities, revealed that only 18% of non-wage recurrent budget reached the regional level, while front-line providers received less than 1%. Systemic low allocation to health service delivery and provider systems, weaknesses in public financial management systems and significant leakages were among the main identified causes (Gauthier & Wane, 2005).

Figure A: Distribution of beneficiaries of health services by socio-economic quintiles, %



Source: ECOSIT 3, National Institute of Statistics/INSEED, Chad, 2011

Figure B: Government health subsidies by socio-economic quintiles, constant unit cost assumption, %



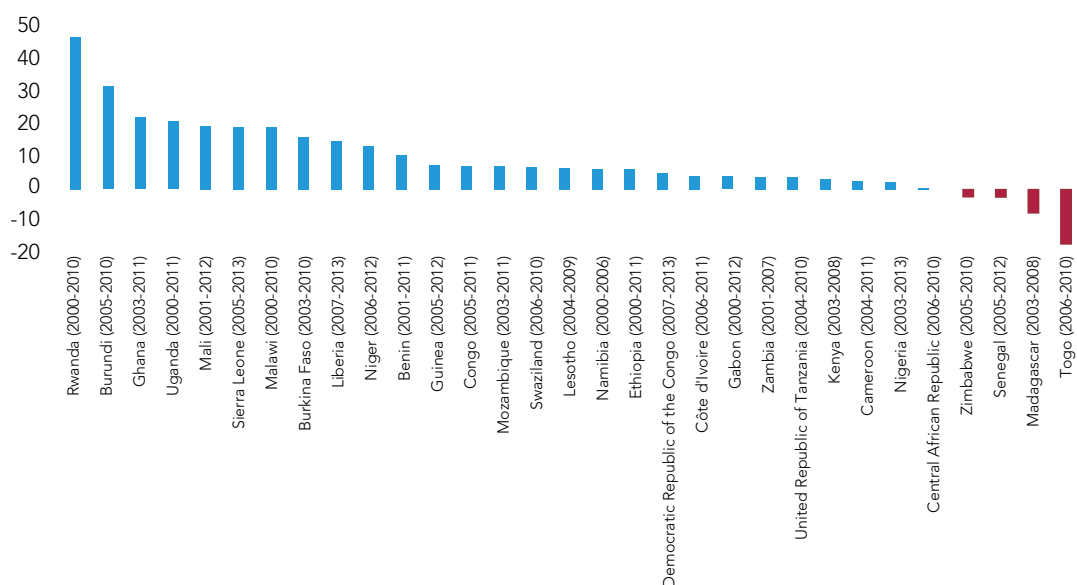
Source: ECOSIT 3, National Institute of Statistics/INSEED, Chad, 2011

3.2 No direct association between better service coverage, equity and financial protection

Regional evidence shows that overall health service coverage has progressed over the last decade in Africa, for all the most commonly used indicators.¹⁸ In particular, most countries in the region have made progress in covering more women and children with essential health services. For instance, coverage for skilled birth attendance increased in 27 out of 31 African countries over the past decade (Figure 9).¹⁹ Unfortunately, this progress has not benefited everyone in an equitable manner.

In a majority of African countries, households from richer socio-economic quintiles continue to have much greater access to skilled birth attendance (Figure 10). In addition, several countries have seen their coverage gap worsen over time. This is true of Cameroon, Ethiopia, Guinea, Kenya, Lesotho, Madagascar, Niger, Nigeria, Togo, Uganda, where the gap in coverage between the richest (Q5) and the poorest (Q1) quintiles (red bars) has significantly increased over the last decade (Figure 11).

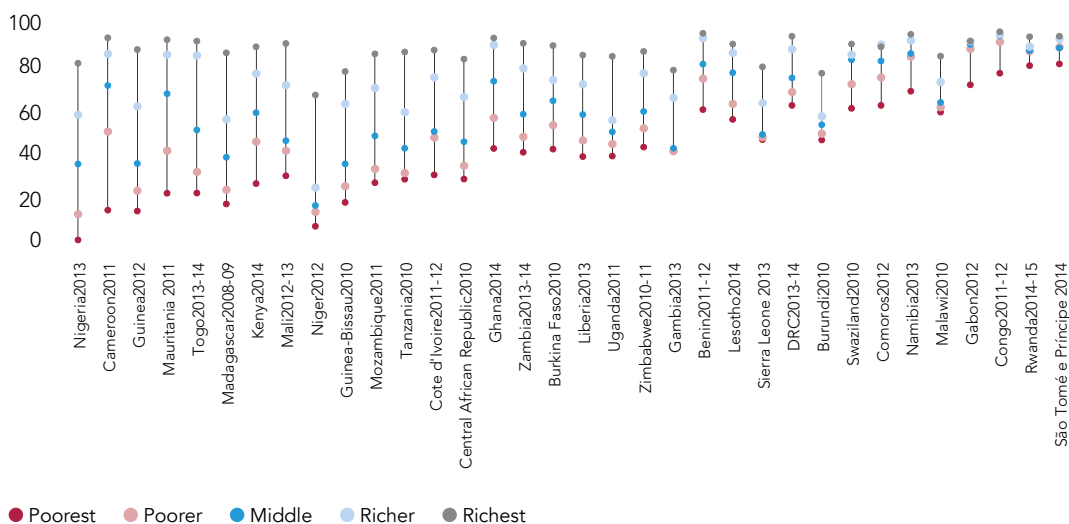
Figure 9: Change in coverage level, skilled birth attendance, % point change



Countries for which coverage data was available for more than two time periods

Health Equity Assessment Toolkit (HEAT): Software for exploring and comparing health inequalities in countries. Built-in database edition. Version 1.0. Geneva, World Health Organization, 2016.

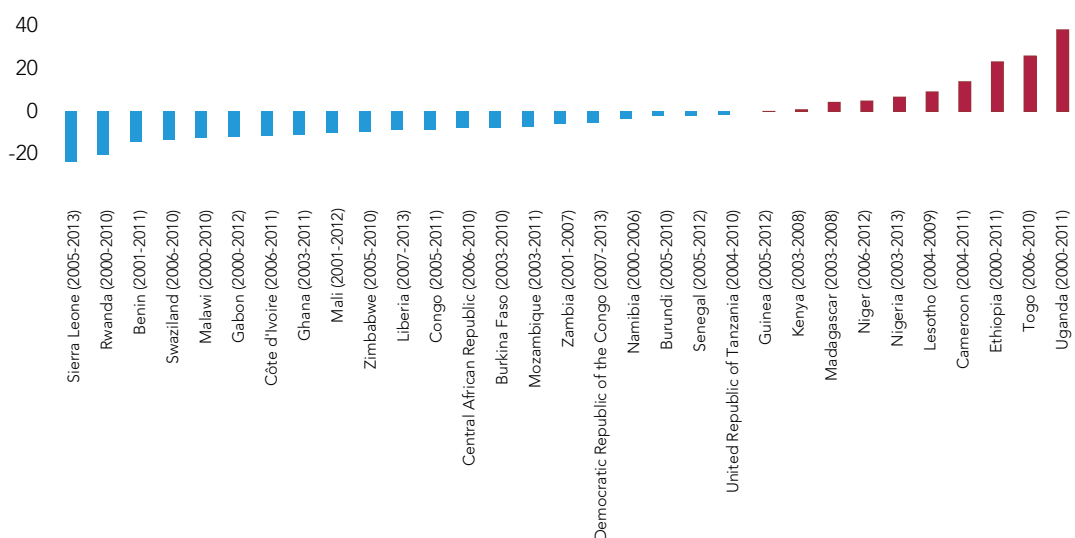
Figure 10: Coverage of skilled birth attendance by socio-economic status



Notes: countries are ranked in a descending order by the difference observed between the richest and poorest quintiles.

Source: authors' estimates, from most recent DHS and MICS data of each country, updated on May 2016. Results from more than ten years ago, i.e. before 2006, are not used for cross country comparison.

Figure 11: Change in coverage gap of skilled birth attendance between richest and poorest quintiles, % point change



Countries for which coverage data was available for more than two time periods

Health Equity Assessment Toolkit (HEAT): Software for exploring and comparing health inequalities in countries. Built-in database edition. Version 1.0. Geneva, World Health Organization, 2016.

Another characteristic of the region is that in several cases, where service coverage has increased, financial protection has worsened, signaling that even if people access services more, public policies are not effective enough to protect them against financial hardship. A limited number of countries (Burundi, Cabo Verde, Cameroon, Ethiopia, Eritrea, Liberia, Malawi, Mali, Mauritania, Senegal, Sierra Leone, South Sudan, and Swaziland) has seen a parallel increase in service coverage and financial protection, as indicated by the level of OOP payments relative to total health expenditure. This confirms the importance of monitoring and evaluating both dimensions of UHC at the same time and tracking their relationship to one another, following the introduction of public financing for health policy change in the region.

Box 6

Ghana: Reforming public financing for health for better coverage and financial protection

Ghana is often cited as one of the few countries in Africa to have made significant progress towards UHC, with a public financing system that has driven impressive increases in health service coverage, reduced reliance on OOP payments, and better health outcomes. Key to Ghana's success is the passage of legislation for national health insurance, significant expansion of enrolment in a national-level health insurance scheme, and financial support for the system based on the earmarking of substantial public financial resources. Nevertheless, as the country looks to sustain and build on the progress made thus far, it will need to address some efficiency and equity issues.

The health financing system in Ghana has evolved over the last eight decades. In the late 1960s, the system was based on general tax revenue providing free health services for its population, but this eventually faced sustainability and quality issues. In the 1980s, the system transitioned to a "cash and carry" system based on user fees, which negatively impacted access to services. Beginning in the 1990s, Ghana began to expand community-based insurance schemes which were initially limited in population coverage and in benefit package. These schemes eventually transitioned into the National Health Insurance Scheme (NHIS) which was established through a legislative act in 2003 to provide a broad range of health services supported by dedicated, compulsory, pre-paid resources.

Ghana's public financing for health system relies on a range of funds, pooled under the NHIS, most of which are compulsory and pre-paid. The largest source comes from an earmarked 2.5 % of a value-added tax on goods and services representing approximately 70 % of revenues. The NHIS is also supported by a dedicated portion of payroll taxes accounting for approximately 23 % of revenues. Other additional sources include individual contributions and other funds (e.g. donor support). A large portion of health system resources is also targeted to subsidise coverage for vulnerable groups.

The NHIS has improved financial access to health services, with coverage rates for key maternal health services improving over time. However, equity remains an issue. Although the service coverage gap between the richest and poorest quintiles decreased from 70.1 % in 2003 to 58.9 % in 2011, the gap still remains very wide. With regard to financial protection, catastrophic health expenditure in 2006 affected the poor face slightly less than the rich (0.8% compared to 1.0%), and, at the systems-level, OOP to total health expenditure decreased from 31.8% in 2000 to 26.8% in 2014, albeit with some fluctuations over that period.

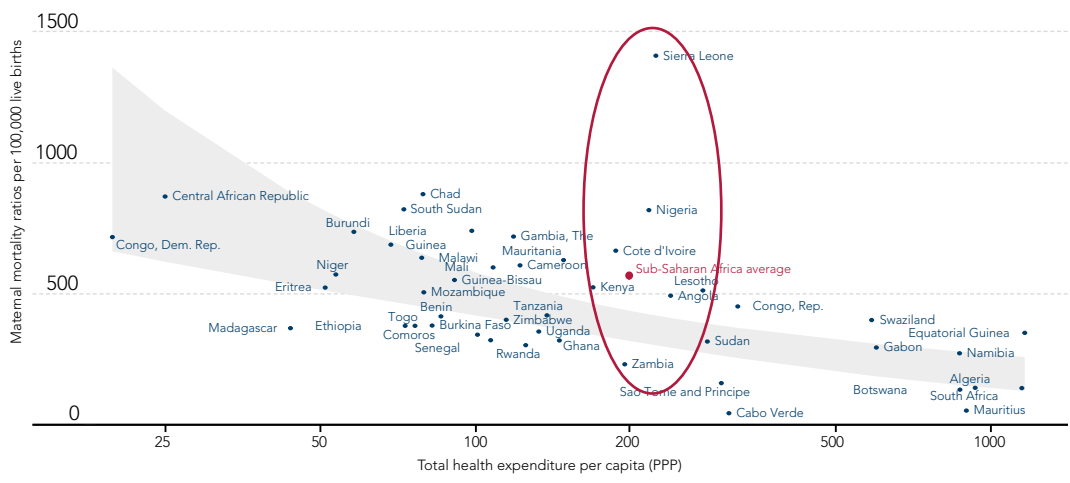
Maintaining and building on these achievements will not be easy, particularly in regard to efficiency. Problems arising as a result of public financial management of budgets and expenditures are well documented, notably with regard to the majority of resources being earmarked centrally to specific programmes so that local authorities have little control over their use. In addition, efficiency in the delivery system is hampered by a combination of: delays in releasing budgets; unplanned projects; difficulties with the procurement of health services equipment; and the lack of adequate payment systems. Despite the share of public expenditure on health in total government expenditure rapidly increasing from 7.8 % 2000 to 16.4 % in 2009 (albeit with some fluctuations), in recent years health has been de-prioritized following a contraction in overall state revenues. Improving use and efficiency of existing resources is thus imperative, and will need to include revised provider payment mechanisms to ensure appropriate use of public funds, in a context with unregulated growth of expenditure and limited opportunity to increase sector resources.

Source: authors, compiled and adapted from various sources including : Schieber G., Cashin C., Saleh K., and Lavado R. (2012): *Health Financing in Ghana*. Washington, DC: World Bank. & Blanchet NJ, Fink G, and Osei-Akoto I (2012). *The effect of Ghana's National Health Insurance Scheme on health care utilisation*. *Ghana Medical Journal*: 46(2).

3.3 No convergence in translating money into health results

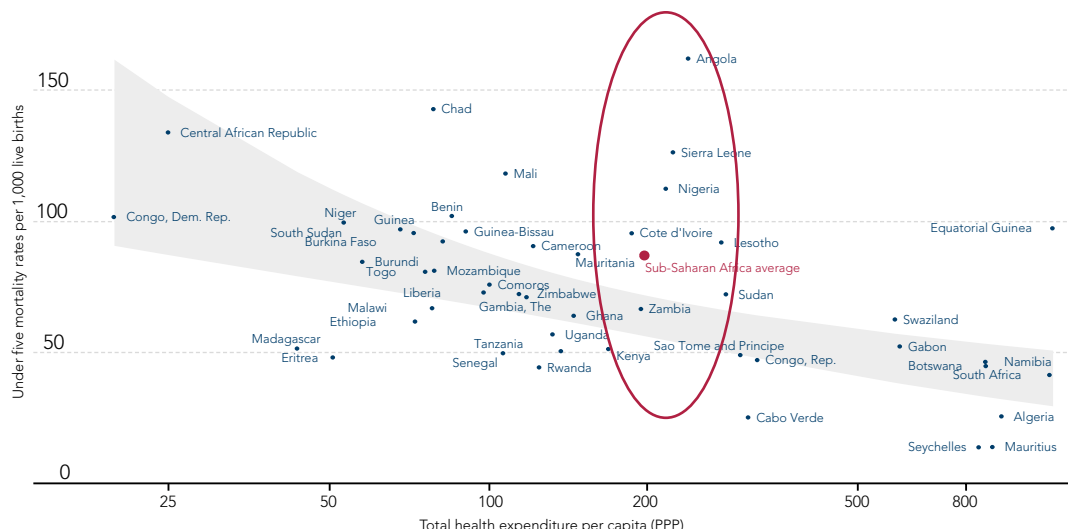
Even though a higher level of total health expenditure is associated with better outcomes, at the same level of spending, health results vary considerably across African countries due to major system inefficiencies. The evidence therefore suggests that there is significant room for improvement in the way money is spent and that progress towards UHC is possible without major increases in spending in some cases.¹⁷

Figure 12: Maternal mortality ratio and total health expenditure per capita in Africa, 2014



Note: x axis on log scale
Source: World Development Indicators

Figure 13: Under five mortality rate and total health expenditure per capita in Africa, 2014

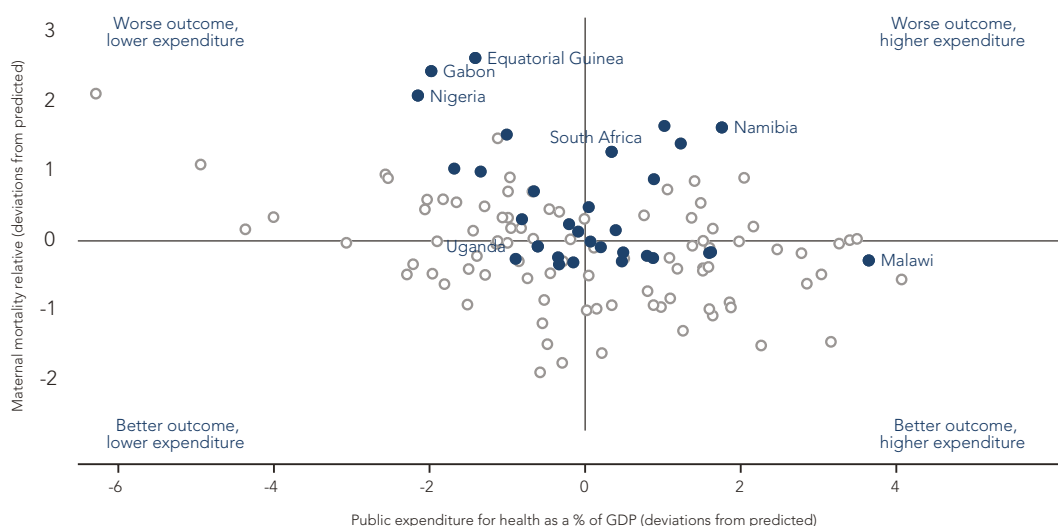


Note: x axis on log scale
Source: World Development Indicators

Regional average health expenditure of about US\$200 per capita is associated with 2014 maternal mortality ratios, ranging from below 250 per 100,000 live births in Zambia, to 500-1000 per 100,000 in Kenya, Cote d'Ivoire, and Nigeria, and close to 1,500 per 100,000 in Sierra Leone (Figure 12). This represents a 1 to 6 variation in results for comparable spending. Similarly, under five mortality (Figure 13) varies from 50 per 1,000 live births in Kenya, to 50-100 in Zambia, and Cote d'Ivoire, to above 100 per 1,000 live births in Nigeria, Sierra Leone, and Angola (which has the highest rate, above 150), for the same level of health spending. Figure 14 further provides evidence that there is room for efficiency gains in the way public money is spent in several countries. Most countries in the region (identified with blue dots) were found to have maternal mortality outcomes that were worse than might be expected given their income and the level of public spending on health.²⁰ Identifying and addressing the root causes of system inefficiencies is central to be able to transform domestic investments into better health (Box 7).

Despite these problems, many African countries have implemented reforms that were focused precisely on transforming money into outputs. Over the past 10 years, what has been called the performance-based financing movement has become part of the health system of more than twenty countries on the continent.²¹ The focus has been to link funds to outputs, and holding providers accountable for delivering these. While generally at a small scale so that it has not affected the aggregate figures presented above, its significance lies in bringing a results-oriented accountability mechanism into African health systems. It provides an

Figure 14: Maternal mortality and public expenditure on health, deviations from estimates based on per capita income (2011 PPP), 2014



International Monetary Fund, World Economic Outlook Database, April 2016. WHO, UNICEF, UNFPA, The World Bank, and the United Nations Population Division. Trends in Maternal Mortality: 1990 to 2015. Geneva, World Health Organization, 2015. All data extracted using wboendata in Stata

important illustration of how it is possible to link budgets to health results. Building on the “Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector”, signed by African Ministers of Finance and Health gathered in the Tunisian capital in 2012, a Value for Money program has also been developed by the African Development Bank, with contribution from multiple partners, to provide support to African stakeholders to ensure that public spending in the social sector in Africa has the most impact and generates the best results possible (Box 7).

Box 7

The Africa Value for Money, Accountability, and Sustainability Program

The Africa Value for Money, Accountability, and Sustainability Program hosted by the African Development Bank was established in response to a call of Ministers of Finance to address the challenges of ineffective and inefficient social spending in Africa. The program is a joint endeavour of the AfDB, WHO and World Bank together with GAVI and UN organizations (UNFPA, UNFEM and UNICEF). In July 2012, the AfDB hosted the Tunis Conference on VfM bringing together African Ministers of Finance and Health; heads of institutions and CSOs for a High-level dialogue culminating in the Tunis Declaration which calls for collaboration between the two ministries, development partners, parliamentarians and civil society to deliver equitable, efficient, and sustainable health services in Africa while ensuring accountability at all levels of the health system. To implement this program the AfDB partnered with NORAD and GAVI Alliance and set up a Trust Fund of about 6 million USD over 5 years. The VfM Programme accomplished the following:

- a. The Ministerial Forum on VfM Programme: Recognizing the critical role of political leadership in implementing the commitments of the Tunis Declaration, and particularly the strategic role of Ministers of Finance in ensuring value for money, the Bank and the Harvard School of Public Health developed an annual ministerial leadership in health program for serving African Ministers of Finance. The program has enhanced understanding of the importance of transformational political leadership in improving national health and health care, examined the importance of health for national economic development and poverty eradication and explored innovative health financing options.
- b. Capacity building for parliamentarians: Parliamentarians are key actors in decision making regarding social sectors financing, as they have final say on the public budget and also their key role in the design of legislations that impact social sectors. In collaboration with CABRI capacity building sessions for members of budget, social, health and education committees for ECOWAS and SADC Parliamentarians were organised to enable them play their roles effectively in enhancing VfM in health.
- c. Capacity building for Senior Officials and CSOs: One of the strategies of improving value for money is building the capacity of senior officials from the concerned ministries and institutions. To this end, senior officials from ministries of finance, health and education as well as CSOs and well as regional bodies such as EAC and SADEC have gained capacity to improve VfM in health.
- d. Generating evidence for policy formulation at country level. The VfM Programme has supported Tanzania in generating evidence on fiscal space and exploring innovative financing strategies towards UHC.
- e. Exploring the potential links between domestic public health expenditure and foreign direct investment: the VfM Programme in collaboration with the Global Fund have commissioned a study with a view to: 1) Building a business case for increased investment in health through the lens of the CEOs of private sector organizations, as well as the impact of FDI on improving health. 2) Developing a convincing case that will justify further health investment in low and middle-income countries (LMICs) on economic grounds. This study provided a tool for ministries of Health to advocate for greater funding on high impact interventions from ministries of Finance, and also from major private-sector organizations.

Source: African Development Bank, Value for Money, Briefing Note, June 2014

Conclusion: Making public funds work for UHC

For every US\$100 that goes into state coffers in Africa, on average US\$16 is allocated to health, only US\$10 is in effect spent, and less than US\$4 goes to the right health services. This failure to ensure that public financial resources reach the health services that need them has undoubtedly had a negative impact on health sector results in the fifteen years since Heads of State met in Abuja, compromising efforts to achieve equity in both financial protection and service coverage.

Four key areas are of particular concern.

First, the deprioritization of health in the context of increasing revenues. As this report shows, as government revenue has increased in the region (reaching an average of about 18% of GDP in 2014) in most part due to the rapid economic growth of the past decade, budget priorities have changed. In many countries, health has been deprioritized as GDP grew, compromising government capacity to sustain long-term progress. Going forward, it is essential that governments make the health sector a budget priority, especially if economic prospects are to deteriorate in the near future.

Second, funding inconsistency. The health sector's capacity for effective planning and implementation has been undermined by the lack of predictability in resource levels and flows, irrespective of whether the source is domestic governments or donors. Instability in resource flows affects sector-specific results, efficiency, financial accountability and overall transparency and governance. Lack of predictability contributes to perpetrate historical budgeting and possible skewed allocations, and hampers budget execution in health. Improving predictability could support sector budget planners to defining more adequately the level and the distribution of intra-sectoral allocations.

Third, budget underspends. Even where governments plan to give more to health, budget execution is poor. Budget underspends are estimated to represent between US\$10 and US\$100 million in unrealized expenditure. The evidence reported here suggests that weak links between health and public financial management explain underspending from the way revenues are planned; to the way annual health budget allocations are determined and structured; and to the way that public expenditure management systems work. Underspending health budgets not only affects public governance, it is a core determinant of sector performance. Accessing and making full use of budgeted resources should be a key goal for a strengthened collaboration between health and finance authorities within each level of public administration, as well as the core of a renewed social contract between governments and citizens in the context of their commitment to UHC.

Fourth, misallocation of resources. Much of the money that is spent goes to the "wrong" places. Overall, the report shows that primary care receives less than 40% of public spending on health services in most African countries. Access to the essential, first-contact services is generally financed through OOP expenditure, which has proved to negatively affect financial protection and equity. The available regional evidence shows that poor people tend to be

disproportionally affected by catastrophic spending - up to 6 times more than the richest. Increasing the level and effective use of public financing for health should ensure that “no one left behind” becomes more than just a slogan; in particular, governments must act to prioritize service coverage and protection for the poor.

It should be clear from the foregoing, that the reform of public financing for health to support progress toward UHC requires significant, country-level changes starting with greater collaboration between health and finance ministries in the budget planning process, leading to a better identified and stable resource envelope. The more explicit use of purchasing mechanisms as a policy instrument to strategically direct resources toward priority services should be part of any health financing reform toward UHC; incentivizing providers to deliver quality primary care as a first entry point of the system within an agreed envelope is a win-win option, with expected direct implications for equity and efficiency.

Progress towards UHC is a core objective of the SDGs. How we finance health will largely determine how much progress we make. As this report has shown, more direct alignment of public expenditure with the health services that people need is essential to success.

Endnotes

- 1 http://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1
- 2 In the remainder, and otherwise indicated differently, public expenditure for health refers to expenditure made by all public and semi-public entities (including social health insurance entities) from both domestic (i.e. tax and non-tax revenues) and foreign sources executed through the budget (grants and other forms of ODA).
- 3 Breaking down public health expenditure into domestic and foreign-sourced components offers a complementary perspective, especially for countries that are highly dependent on external aid to finance the sector such as Burundi, Central African Republic, DRC and Rwanda, where external funds are a dominant source of public health spending, taking the form of in-budget grants. Disaggregated analysis indeed reveals that a significantly lower share is actually being spent on health from purely domestic sources. This scenario is expected to characterise an increasing number of African countries as greater portions of ODA will transition from off-budget to in-budget aid in most settings at long term.
- 4 Good governance follows the World Bank's CPIA definition based on the policy and institutional framework. Performance refers to how conducive that framework is to fostering poverty reduction, sustainable growth, and the effective use of development assistance. <https://www.worldbank.org/ida/papers/CPIACriteria2011final.pdf>
- 5 Liang L.L., Mirelman A.: Why do some countries spend more on health? An assessment of socio-political determinants and international aid for government health expenditures, *Social Science & Medicine*, 2014, vol. 114, issue C, pages 161-168
- 6 Two thirds of African countries with available data have seen an increase (on average 4%) in tax revenue as a share of GDP in the last fifteen years. Lesotho has seen the biggest increase from 36.1% to 58.7%, while Angola has seen the biggest decrease from 39.7% to 17.3%. Although richer countries are collecting more tax in both absolute and relative terms, there are several exceptions. Nigeria (1.6%) and Republic of Congo (7.6%), for instance, have lower tax to GDP ratio than those with similar income; on the other hand, Lesotho (58.7%) and Algeria (37.2%) collect more tax than peers with comparable income.
- 7 Fiscal balance is expected to be persistently affected after 2016 (below 5%, compared to fiscal surplus observed in the early 2000s), as well as debt level which is projected to move from below 30% in the early 2000s to close to 40% by 2021 (regional average, *World Economic Outlook*, IMF, 2016).
- 8 In the remainder, « primary care » is understood as outpatient services delivered by Primary Health Care (PHC) and other health facilities.
- 9 12.65 admissions per 1,000 capita in 2012 in the region (World Bank), compared to an average 172 in OECD countries (OECD).
- 10 Estimates include, as numerator, public expenditure on outpatient care services delivered mostly by primary level facilities, and, as denominator, overall public expenditure on curative, preventive, long-term, rehabilitation and ancillary care services.
- 11 Public expenditure on primary care includes in-budget expenditure from foreign sources.
- 12 http://www.who.int/health_financing/topics/public-financial-management/montreux-meeting-2016/en/
- 13 Budgeting for Health, in *Strategizing National Health in the 21st Century: A handbook*, WHO World Health Organization, Geneva (2016, forthcoming)
- 14 Findings are based on available Benefit Incidence Analyses of the region that include Chad, DRC, Ivory Coast, Kenya, Ghana, Guinea, Madagascar, South Africa and Tanzania.
- 15 OOP payments for health cause individuals to incur catastrophic expenditures and/or push them into poverty. The two main financial protection indicators are catastrophic health expenditure and impoverishing health expenditure. Catastrophic health expenditure is defined as OOP spending equal to or exceeding 40% of total expenditure net of a subsistence-level of food spending. Subsistence-level food spending is estimated as the average food expenditure per adult equivalent across households in the 45th–55th %ile of the food budget share distribution. When actual food spending is below this amount, capacity-to-pay is defined as total expenditure net of actual food spending. http://apps.who.int/iris/bitstream/10665/69030/1/EIP_HSF_DP_05.2.pdf. A household is identified as facing impoverishing health expenditures when its out-of-pocket health expenditures push it below a defined poverty line.
- 16 Please note that the declining OOP share of total health expenditure is in large part due to growth in DAH in several settings. Also, the OOP measure only includes those who accessed health services.
- 17 Jowett M., Petro-Bunal M., Flores G., Cylus J. : Spending targets for health, no magic number, WHO, WHO/HIS/HGF/HFWorkingPaper/16.1, Geneva, 2016 (draft)
- 18 http://www.who.int/healthinfo/universal_health_coverage/report/2015/en/
- 19 In addition, most countries have seen an increase in DTP3 vaccination rate over the period, except for five countries (Benin, Botswana, Equatorial Guinea, Kenya and South Africa), among which Equatorial Guinea is the only one with a low starting point (a 35% coverage rate). In terms of the treatment success rate for new tuberculosis cases, again the majority of countries have seen an increase, except for seven countries (Angola, Botswana, Lesotho, Liberia, Mauritius, Sao Tome and Principe, and Seychelles). Where there have been declines, these have generally been relatively small. When it comes to antenatal care (at least one visit for pregnant women), only five countries have seen a decline namely Botswana, Ghana, Gambia, Togo and Zimbabwe.
- 20 The vertical axis in Figure 14 shows the deviation between actual and predicted maternal mortality ratios (MMR), where predicted MMR is obtained through a linear regression with income per capita adjusted by purchasing power. Positive [negative] deviations occur when the country's actual health outcomes were higher [lower] than predicted. Thus, countries in the lower half of the figure can be considered as good performers as they have lower rates of MMR than would be expected given their income. Similarly, countries in the upper half have higher rates of MMR than expected. In particular, Equatorial Guinea, Gabon, and Nigeria have MMR that is much higher than expected. The horizontal axis similarly shows the deviation between the actual and predicted shares of public health expenditure in GDP. Predictions were also estimated through a similar regression, again with the explanatory variable of income per capita income. The left [right] half thus show countries whose public health expenditures are lower [higher] than expected given its income. Uganda is spending less than expected while Malawi is spending much more than expected.
- 21 Meessen, B., Soucat, A., Sekabaraga, C. (2011). "Performance-based financing: just a donor fad or a catalyst towards comprehensive health-care reform?" *Bulletin of the World Health Organization* 89(2):153-156.

2. Health Financing Country Profiles

Algeria



Spending on health in current US\$, 2014

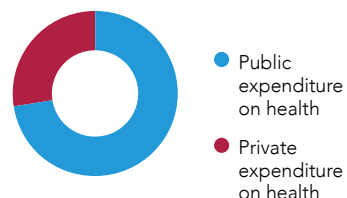
362

Per capita

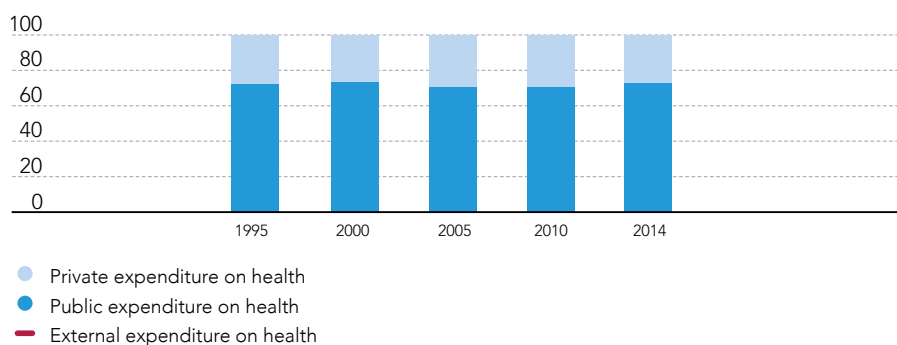
Who funds health, 2014



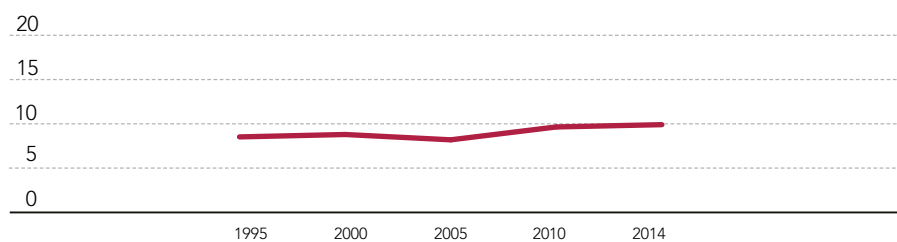
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
4318	29.1	-15.3	3.7	Upper middle

Angola

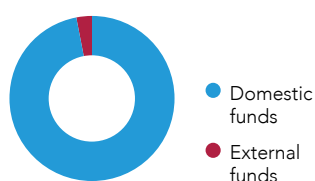


Spending on health
in current US\$, 2014

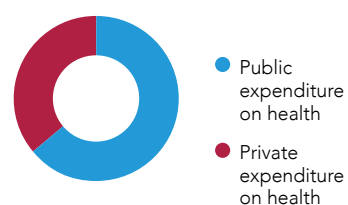
179

Per capita

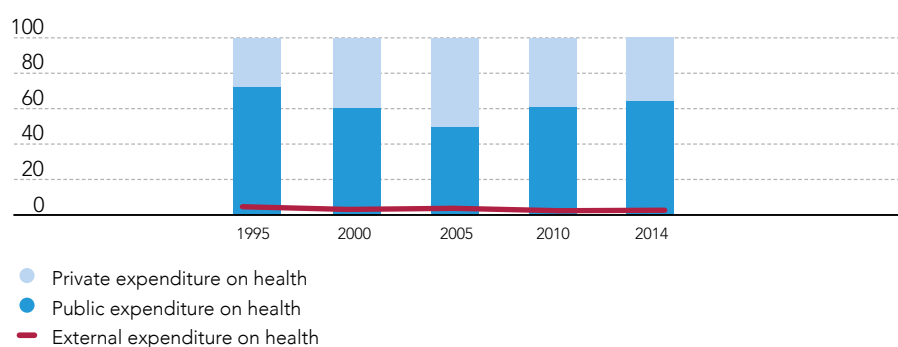
Who funds health, 2014



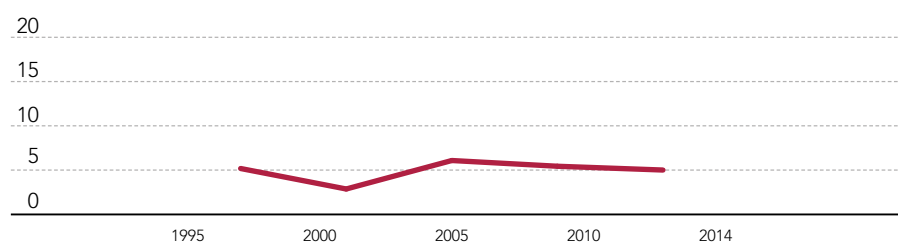
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
4100	24.8	-4.1	2.9	Upper middle

Benin

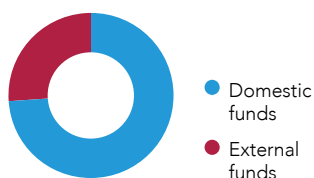


Spending on health in current US\$, 2014

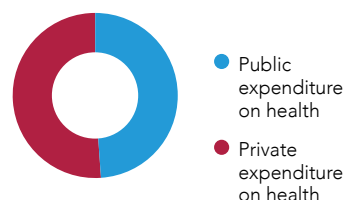
38

Per capita

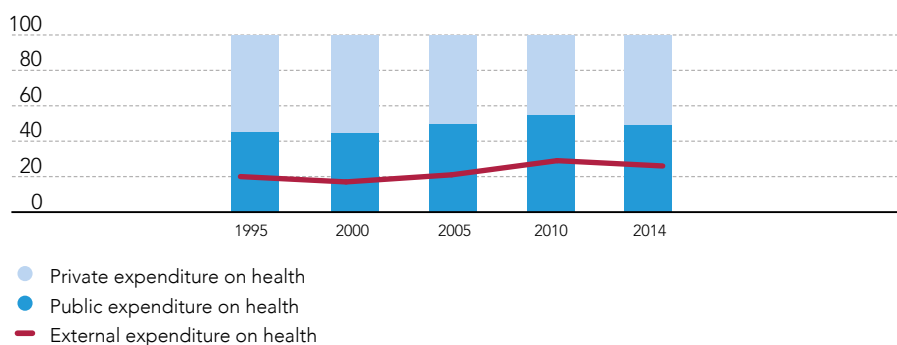
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
780	16.9	-7.9	5.208	Low

Botswana

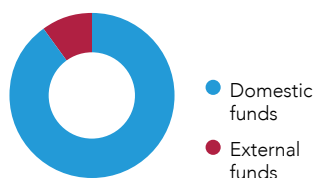


Spending on health
in current US\$, 2014

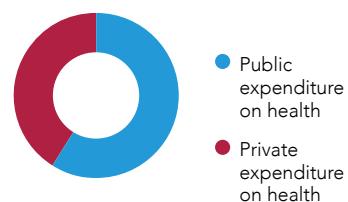
358

Per capita

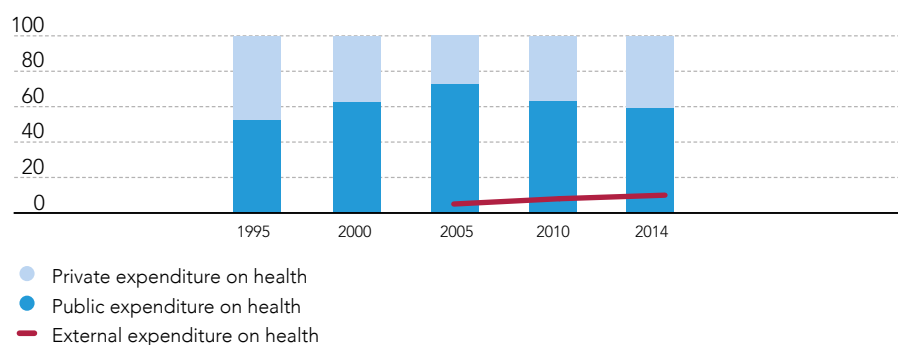
Who funds health, 2014



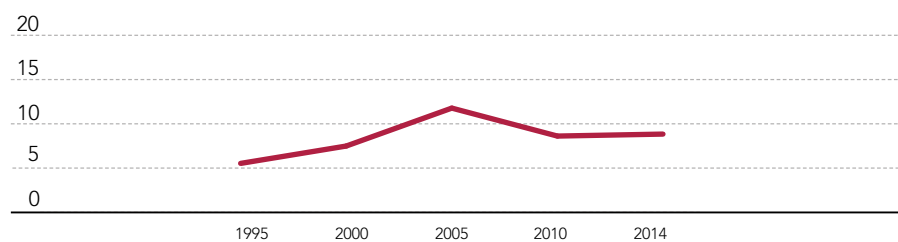
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
6041	38.2	-1.6	-0.3	Upper middle

Burkina Faso

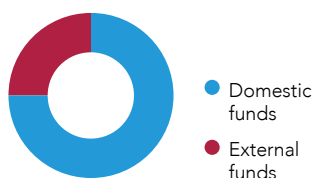


Spending on health in current US\$, 2014

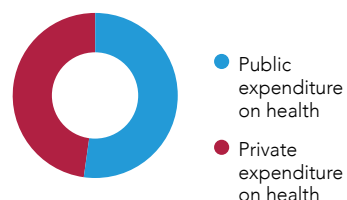
35

Per capita

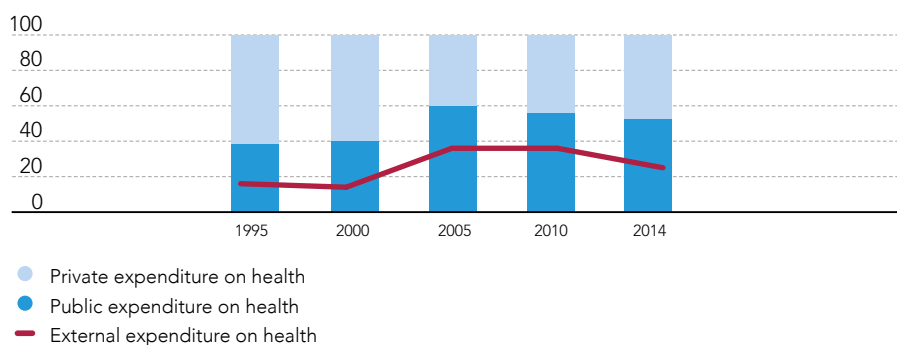
Who funds health, 2014



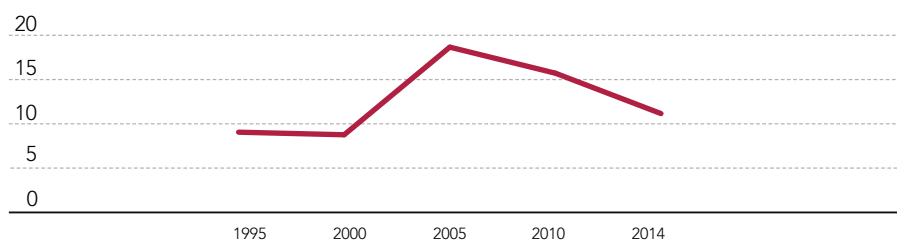
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
614.5	19.8	-1.5	4.0	Low

Burundi

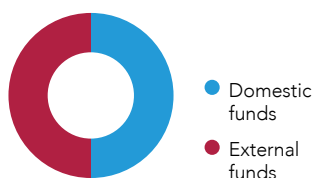


Spending on health in current US\$, 2014

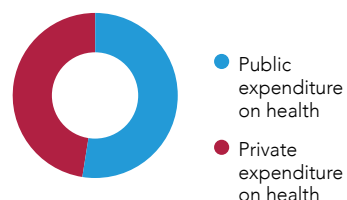
22

Per capita

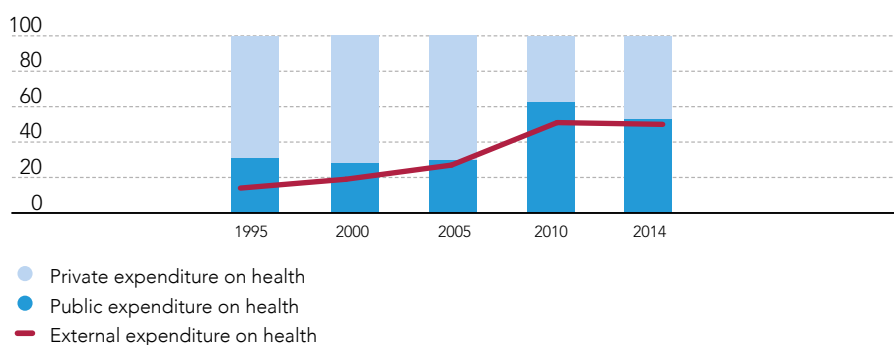
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
305.8	23	-6.9	-4.1	Low

Cameroon

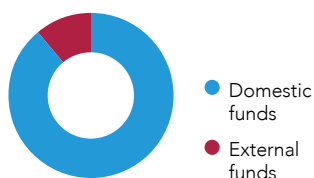


Spending on health in current US\$, 2014

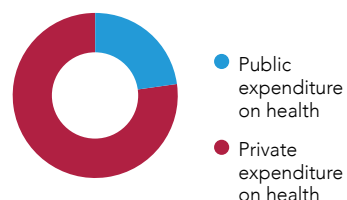
59

Per capita

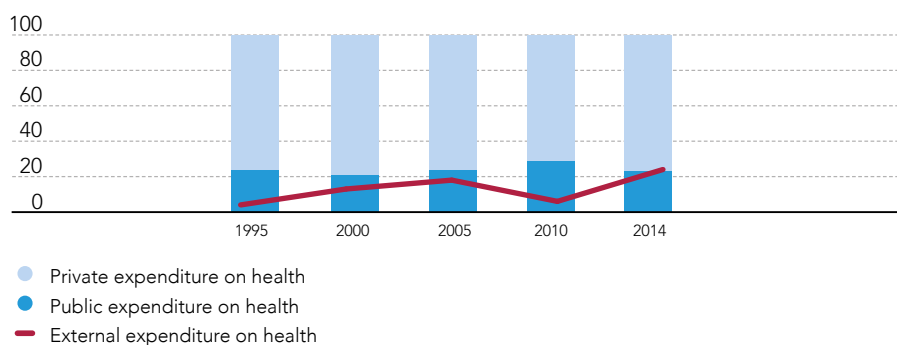
Who funds health, 2014



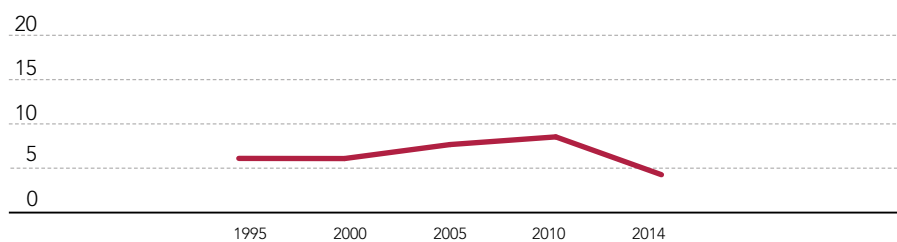
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
1232.4	17.8	-5.8	5.9	Lower middle

Central African Republic

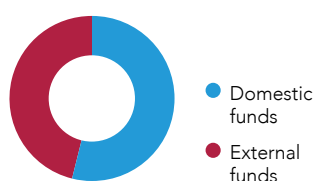


Spending on health in current US\$, 2014

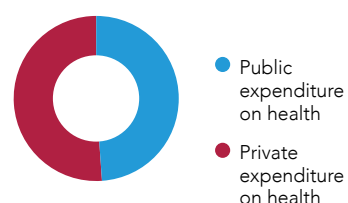
16

Per capita

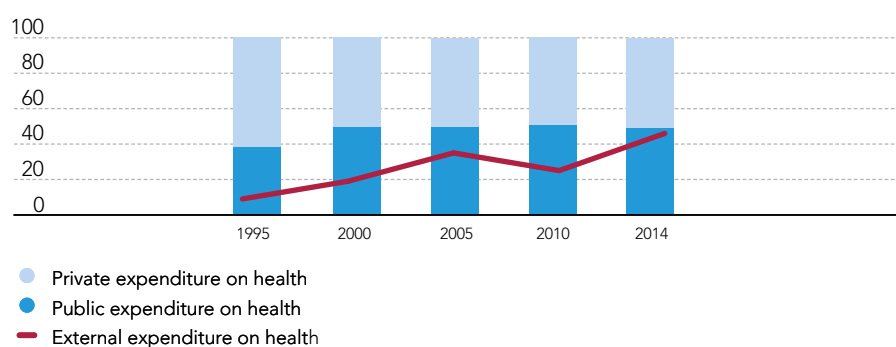
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
334.9	11.4	-3.1	4.3	Low

Cabo Verde Republic of

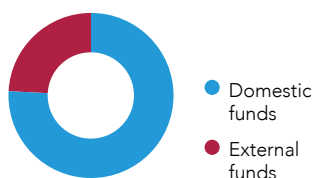


Spending on health in current US\$, 2014

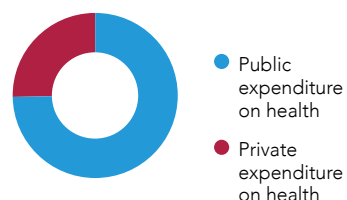
173

Per capita

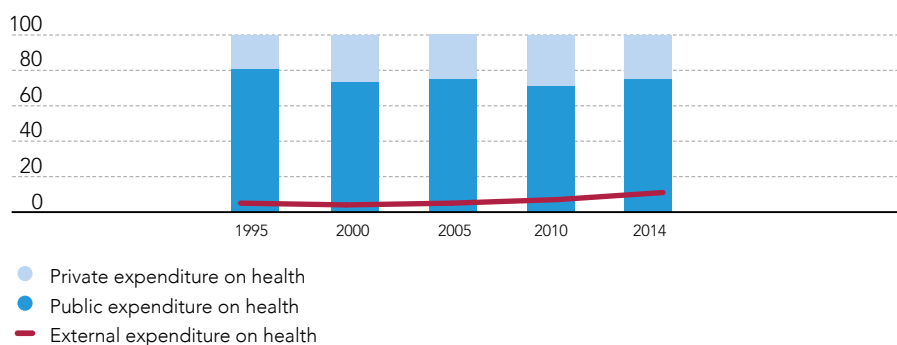
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
3038.5	25.1	-4.8	1.8	Lower middle

Chad

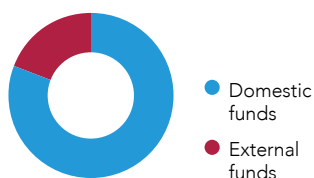


Spending on health in current US\$, 2014

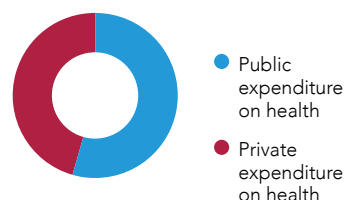
37

Per capita

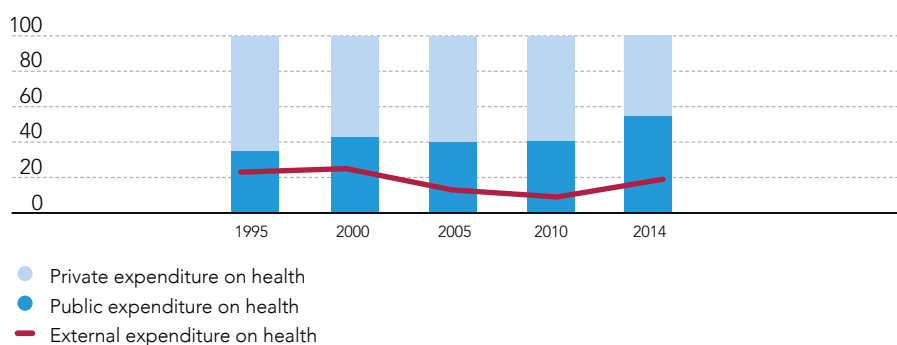
Who funds health, 2014



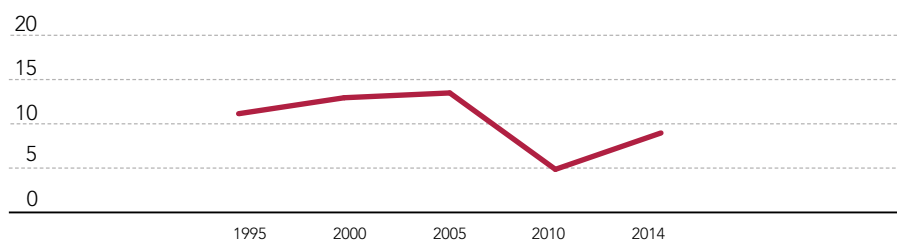
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
-	-	-	-	-

Comoros

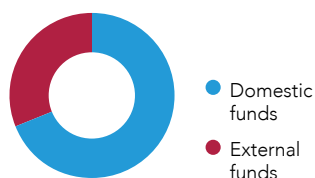


Spending on health in current US\$, 2014

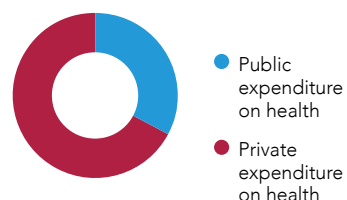
57

Per capita

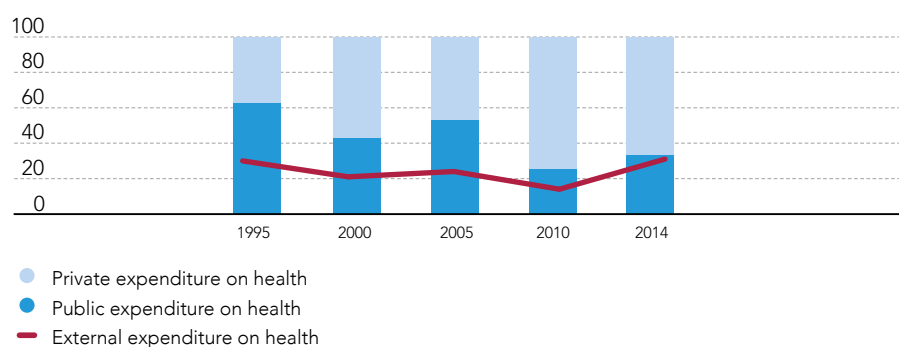
Who funds health, 2014



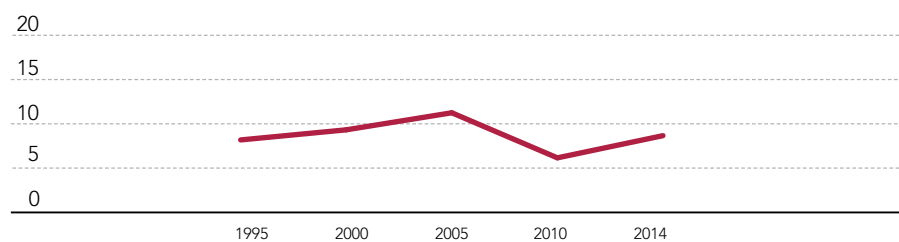
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
736.3	30.1	4.6	1.0	Low

Congo

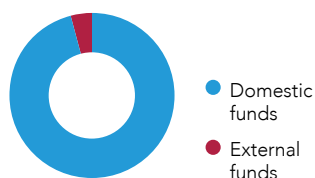


Spending on health
in current US\$, 2014

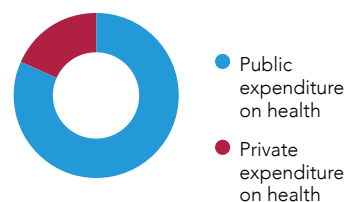
162

Per capita

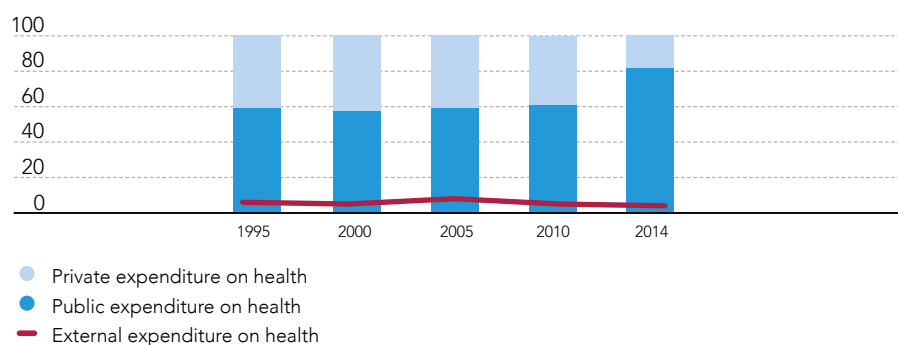
Who funds health, 2014



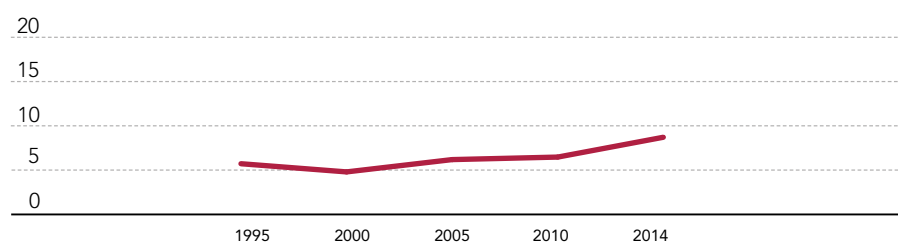
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
2032.3	27.7	-11.8	2.5	Lower middle

Côte d'Ivoire

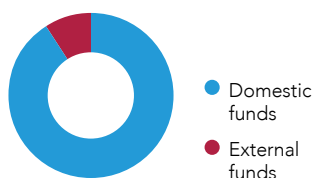


Spending on health in current US\$, 2014

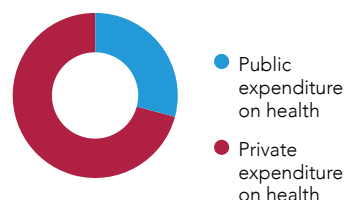
88

Per capita

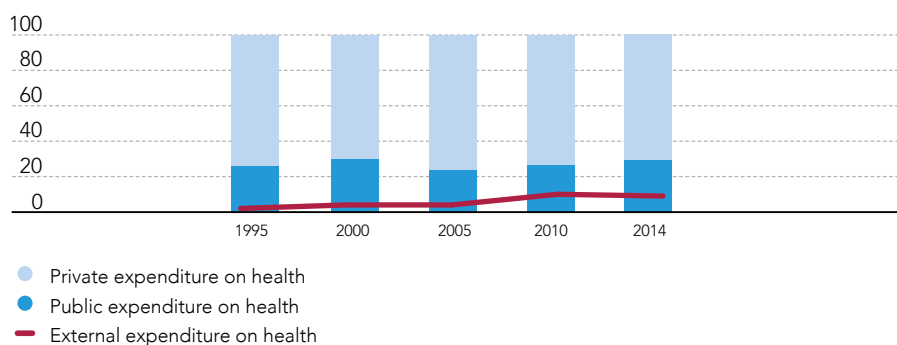
Who funds health, 2014



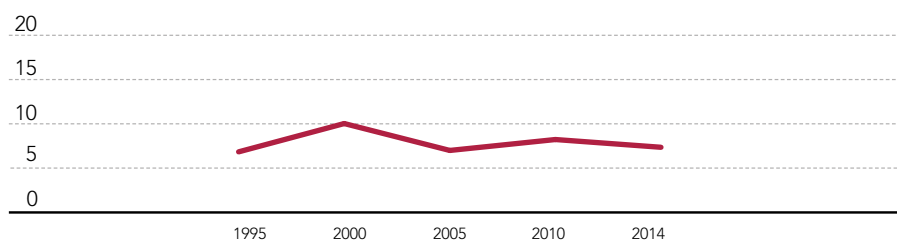
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
1314.7	19.5	-3.2	8.6	Lower middle

Democratic Republic of the Congo

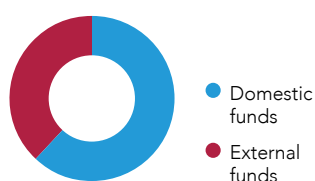


Spending on health in current US\$, 2014

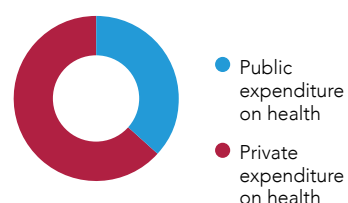
19

Per capita

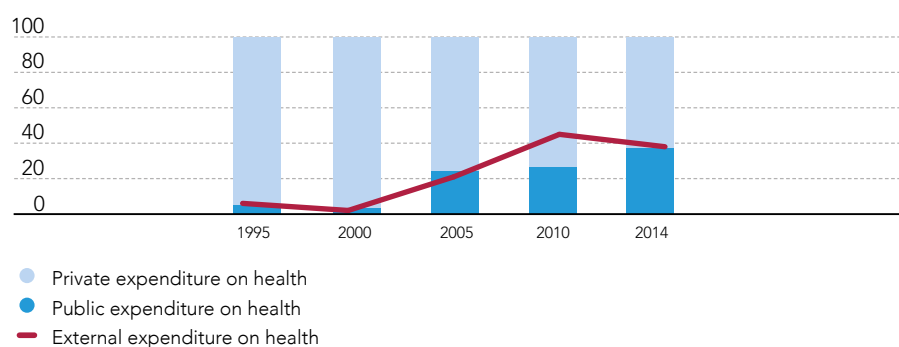
Who funds health, 2014



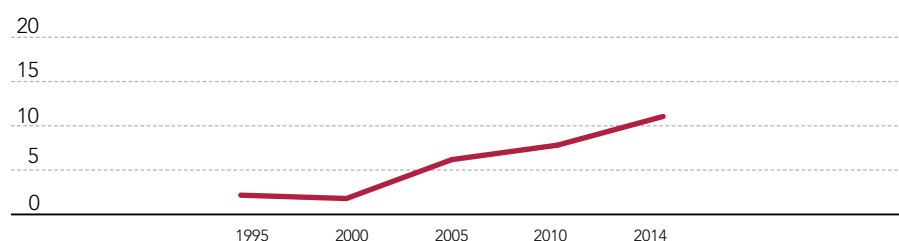
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
475.9	16.1	1.9	7.7	Low

Equatorial Guinea



Spending on health in current US\$, 2014

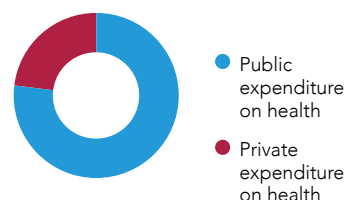
663

Per capita

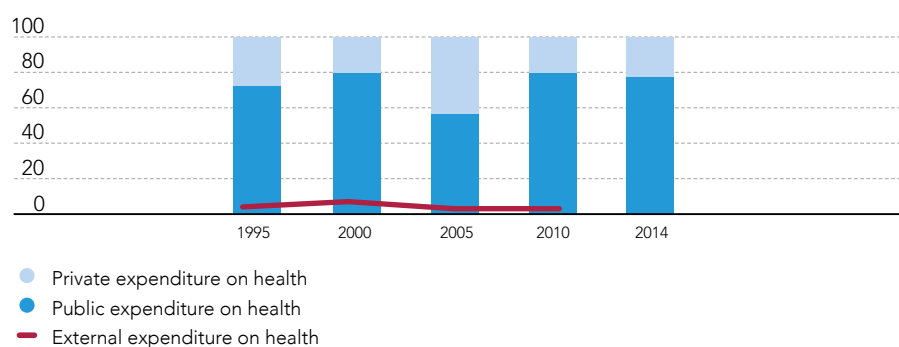
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
11762.4	35.2	-3.0	-12.2	Upper middle

Eritrea

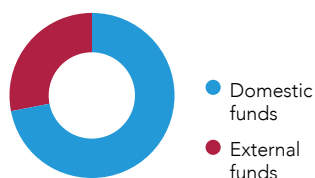


Spending on health
in current US\$, 2014

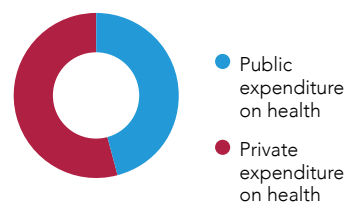
25

Per capita

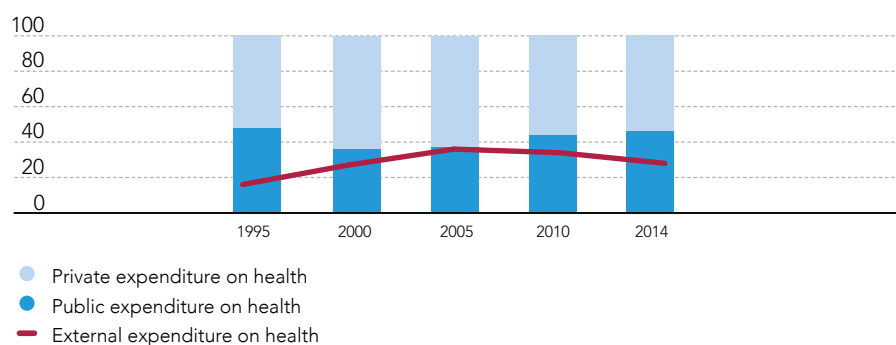
Who funds health, 2014



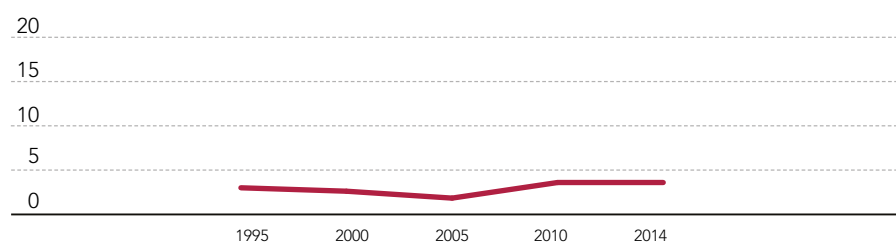
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
694.8	14.3	-14.2	4.8	Low

Ethiopia

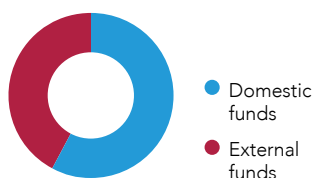


Spending on health in current US\$, 2014

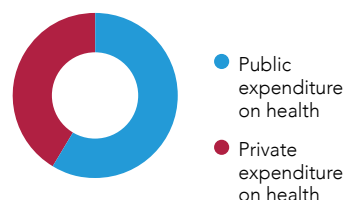
27

Per capita

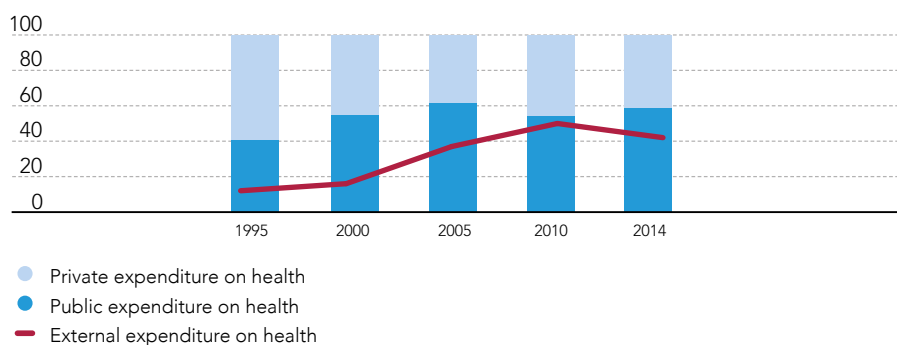
Who funds health, 2014



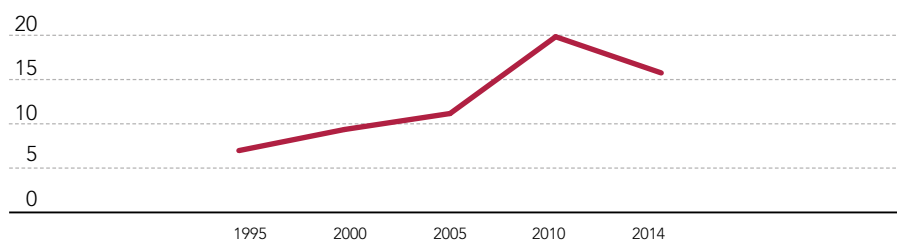
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
686.6	16.1	-2.5	10.2	Low

Gabon

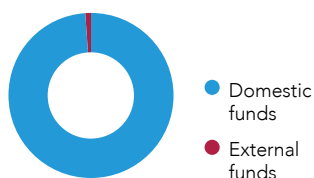


Spending on health in current US\$, 2014

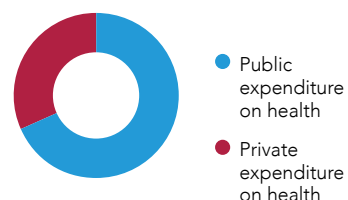
321

Per capita

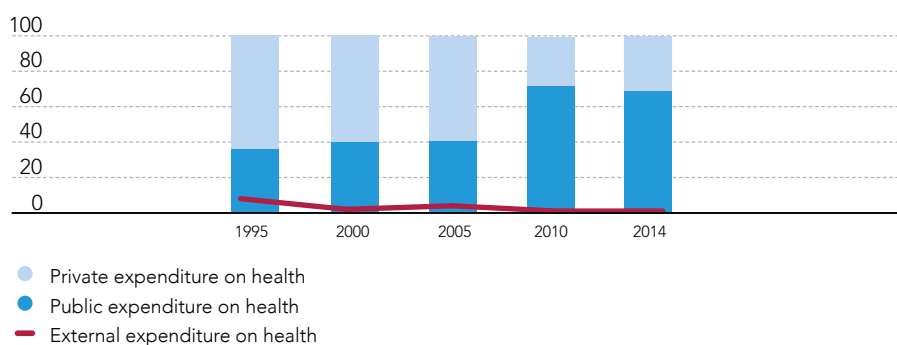
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
7735.9	21.4	-2.3	4.0	Upper middle

Gambia

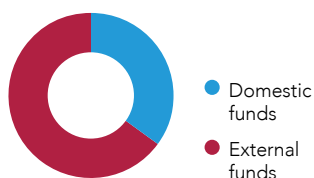


Spending on health in current US\$, 2014

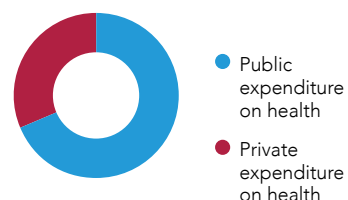
31

Per capita

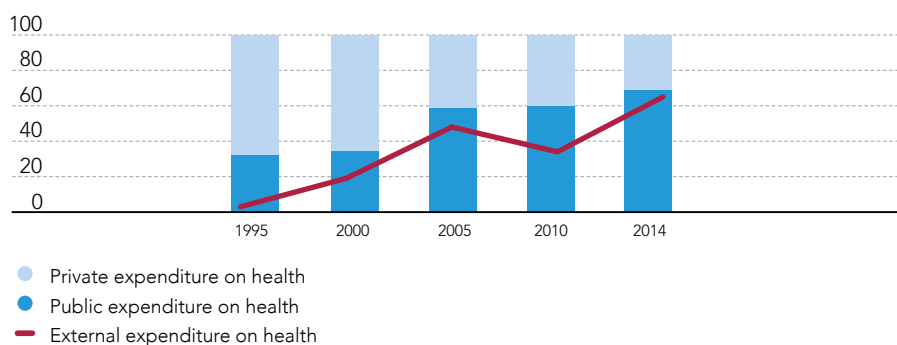
Who funds health, 2014



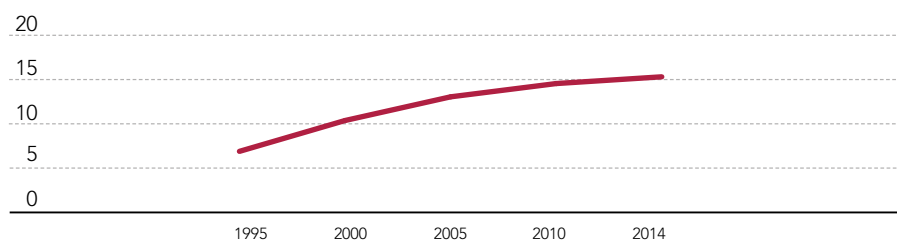
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
450.9	21.7	-6.5	4.4	Low

Ghana

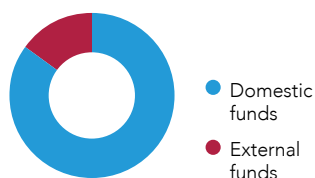


Spending on health
in current US\$, 2014

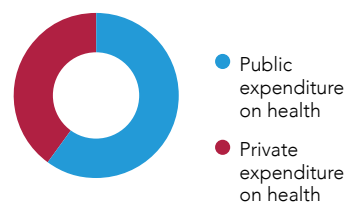
58

Per capita

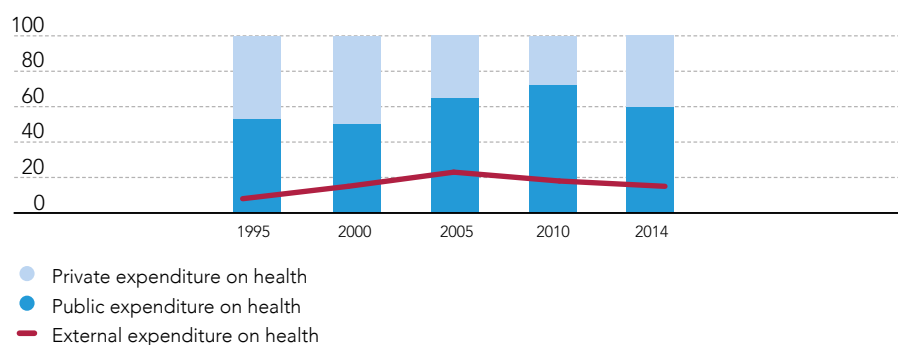
Who funds health, 2014



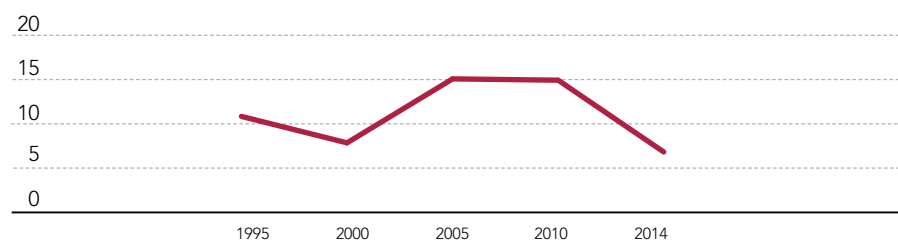
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
1340.4	19.3	-5.0	3.5	Lower middle

Guinea

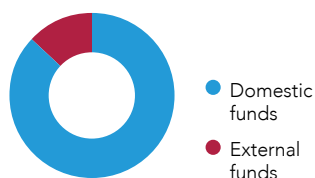


Spending on health in current US\$, 2014

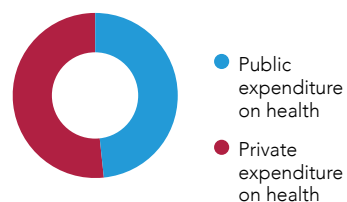
30

Per capita

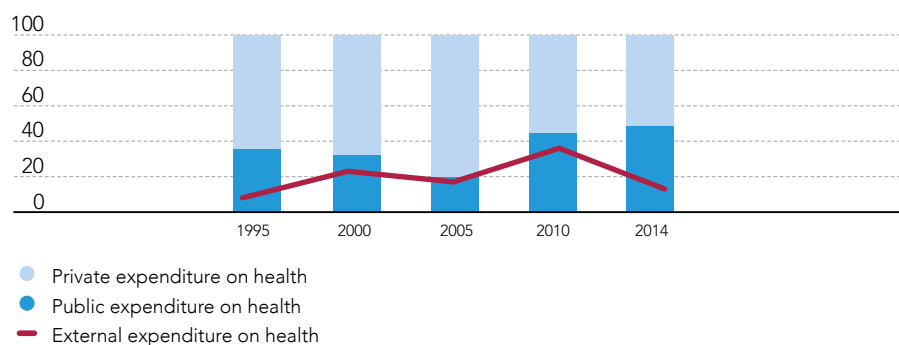
Who funds health, 2014



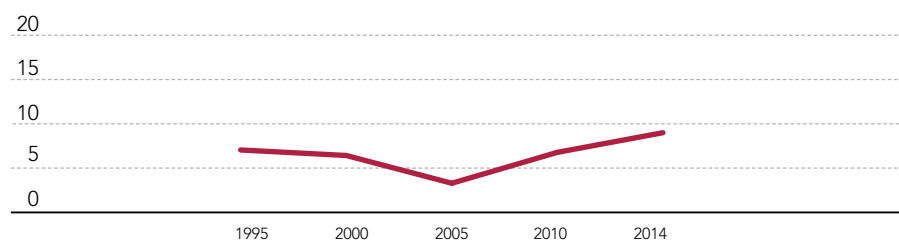
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
542.4	19.4	-9.0	0.1	Low

Guinea-Bissau

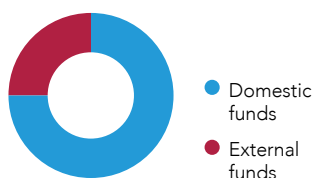


Spending on health in current US\$, 2014

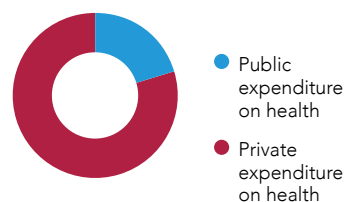
37

Per capita

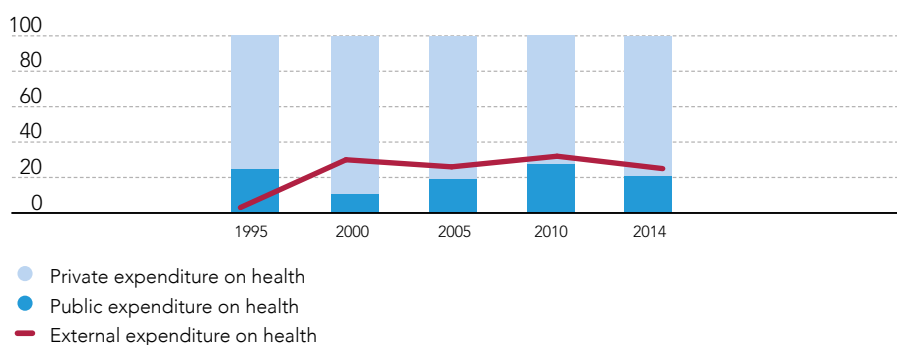
Who funds health, 2014



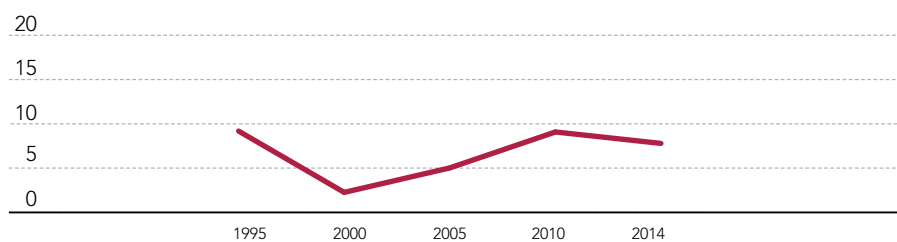
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
594.9	18.6	-6.8	4.8	Low

Kenya

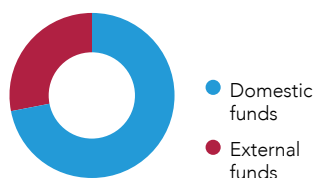


Spending on health in current US\$, 2014

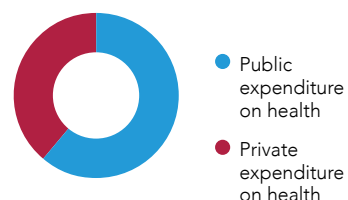
78

Per capita

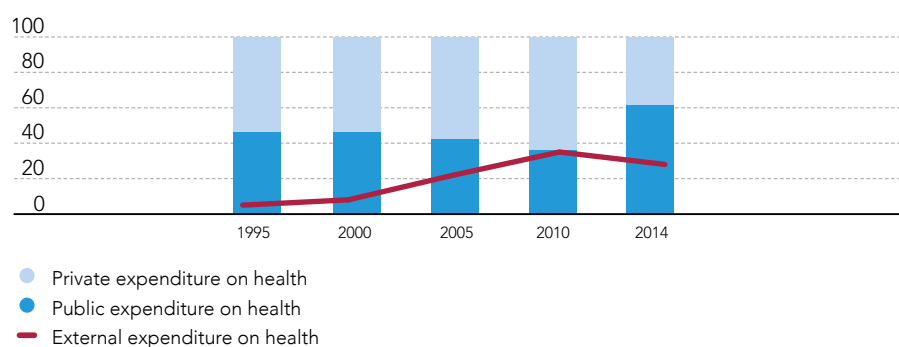
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
1388.5	20.2	-8.4	5.6	Lower middle

Lesotho

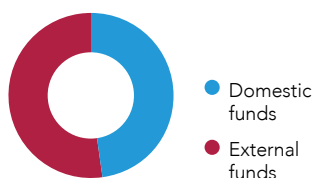


Spending on health in current US\$, 2014

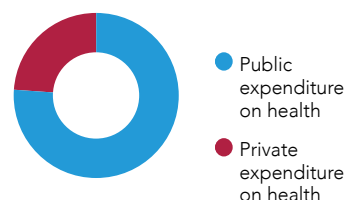
105

Per capita

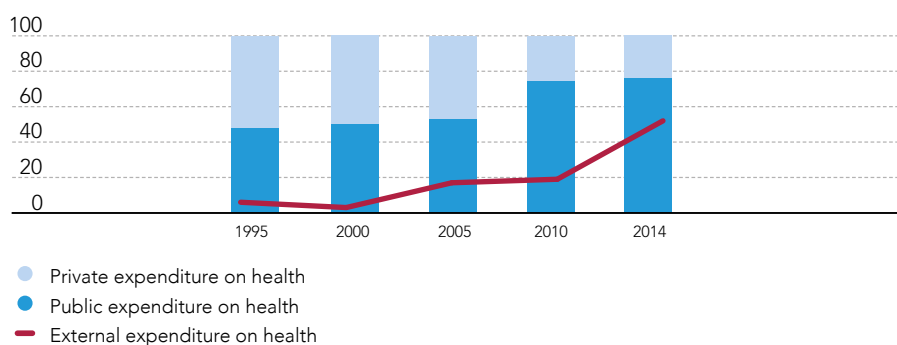
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
1051.6	59.4	0.1	2.5	Lower middle

Liberia

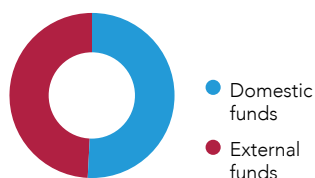


Spending on health in current US\$, 2014

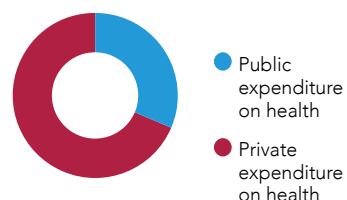
46

Per capita

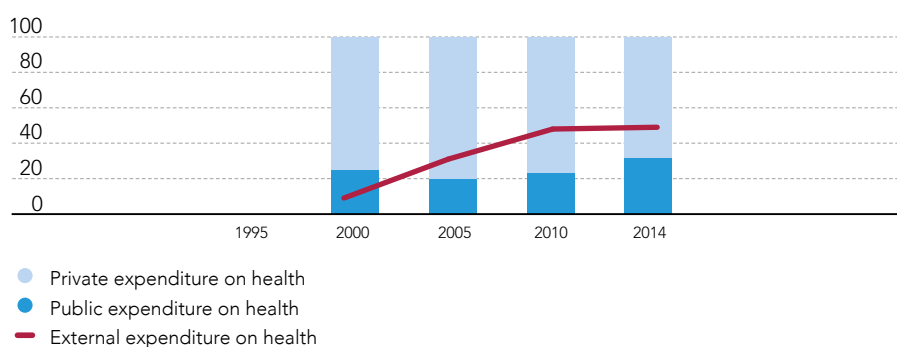
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
473.6	32.5	-12.0	0.0	Low

Madagascar

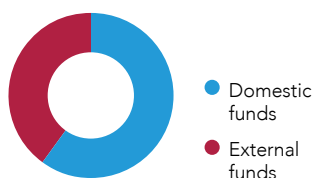


Spending on health in current US\$, 2014

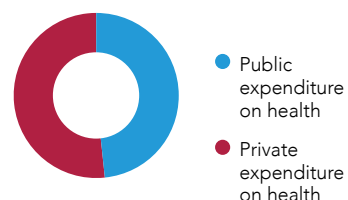
14

Per capita

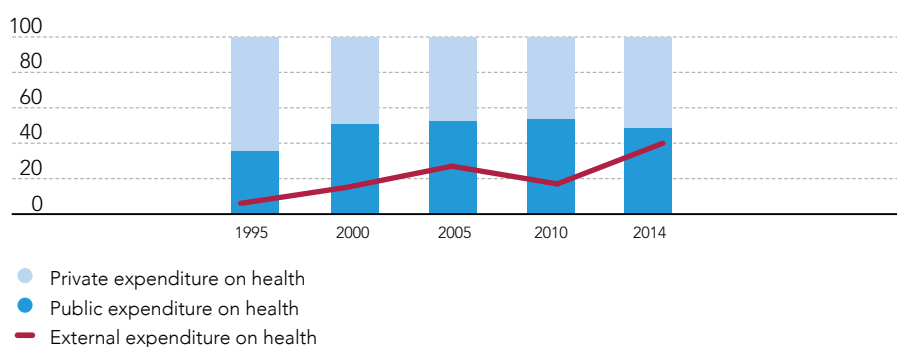
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
401.8	11.8	-3.7	3.0	Low

Malawi

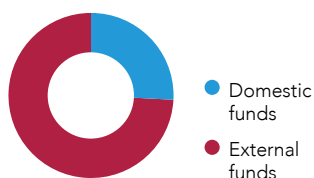


Spending on health in current US\$, 2014

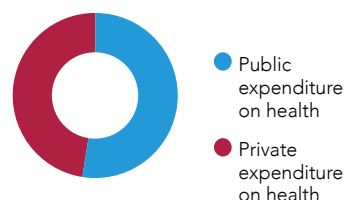
29

Per capita

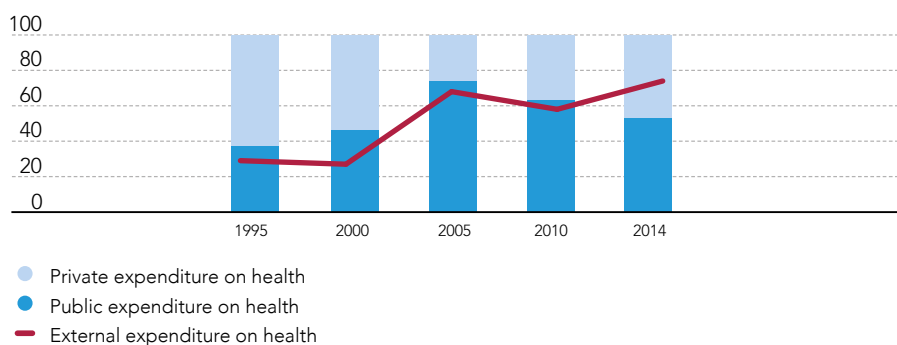
Who funds health, 2014



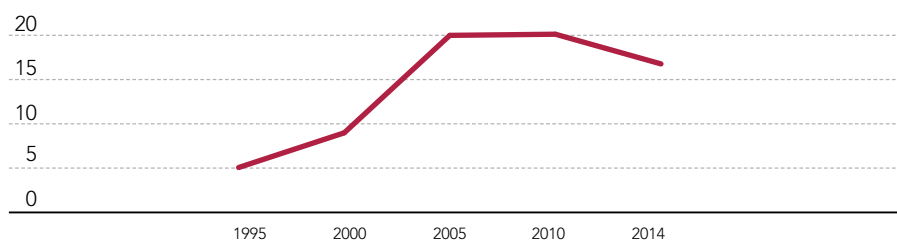
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
354.3	24.7	-5.9	3.0	Low

Mali

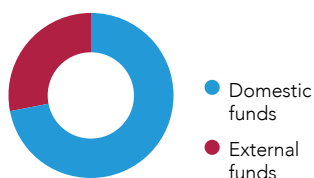


Spending on health in current US\$, 2014

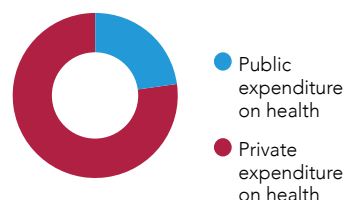
48

Per capita

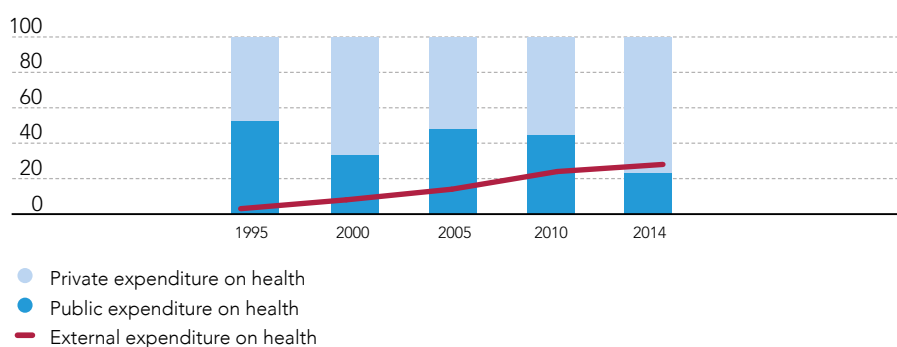
Who funds health, 2014



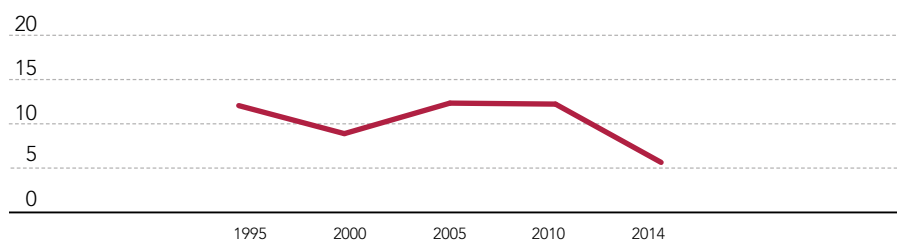
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
801.8	18.2	-2.1	6.1	Low

Mauritania

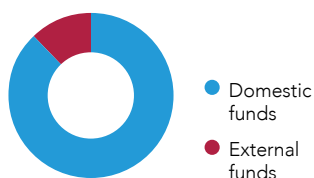


Spending on health in current US\$, 2014

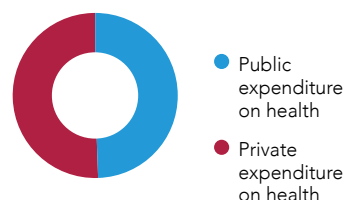
49

Per capita

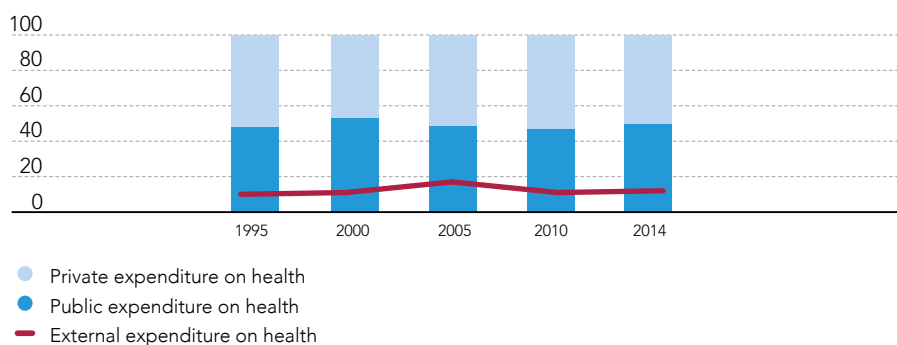
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
1282.3	29.9	-3.5	1.9	Lower middle

Mauritius

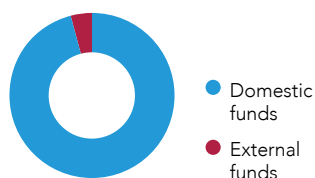


Spending on health in current US\$, 2014

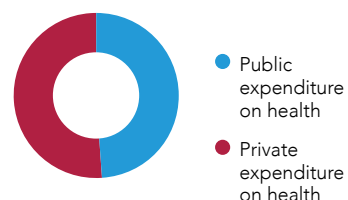
482

Per capita

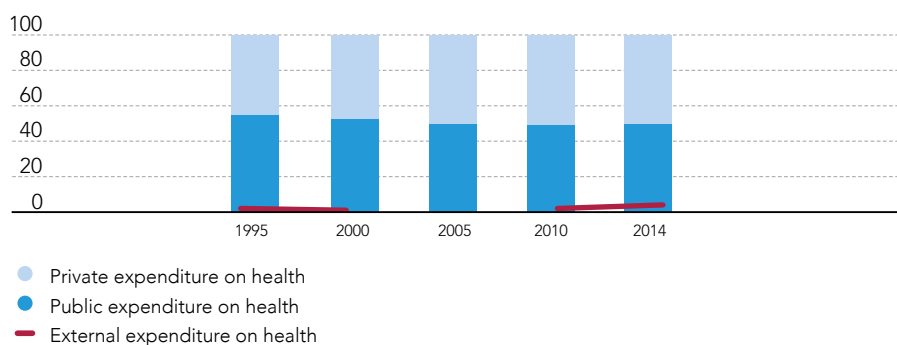
Who funds health, 2014



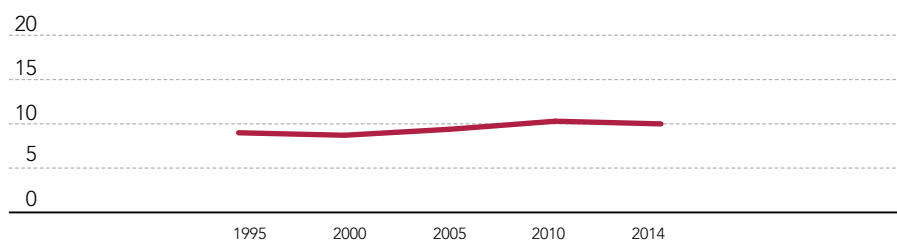
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
9218.4	22.5	-3.4	3.4	Upper middle

Mozambique

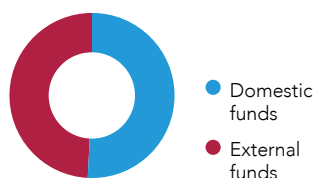


Spending on health in current US\$, 2014

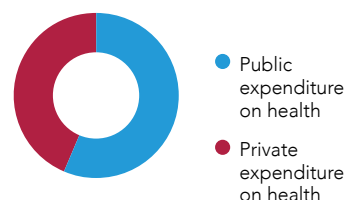
42

Per capita

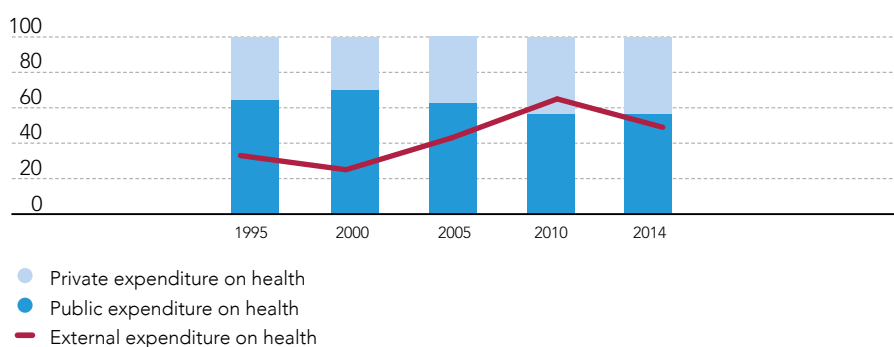
Who funds health, 2014



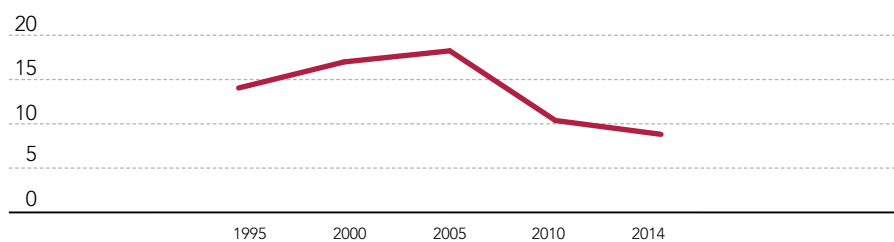
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
534.9	29.4	-6.0	6.3	Low

Namibia

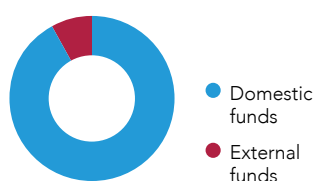


Spending on health in current US\$, 2014

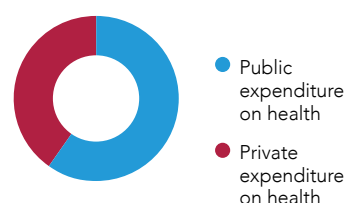
499

Per capita

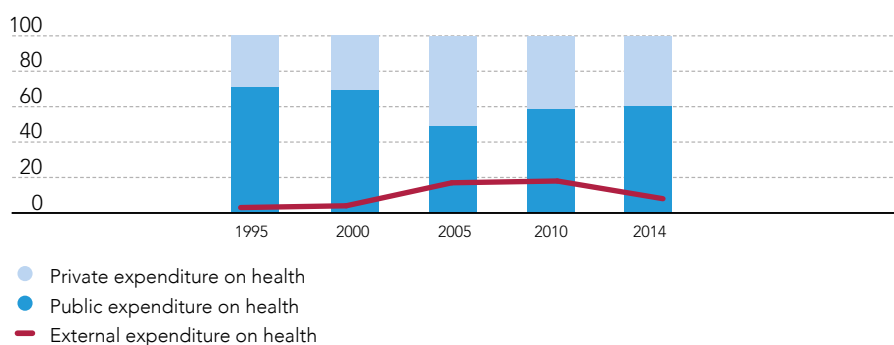
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
5776.9	33.7	-5.9	4.5	Upper middle

Niger

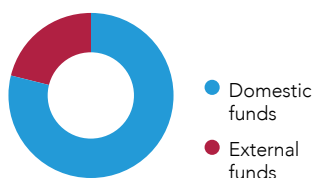


Spending on health in current US\$, 2014

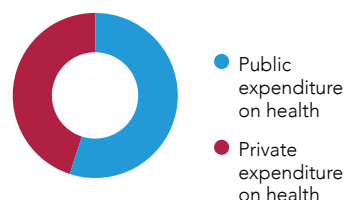
24

Per capita

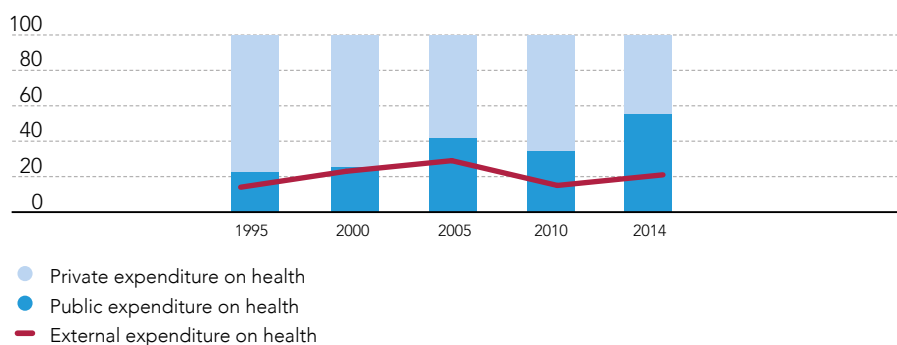
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
405.2	23.6	-7.4	4.0	Low

Nigeria

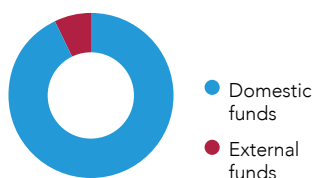


Spending on health in current US\$, 2014

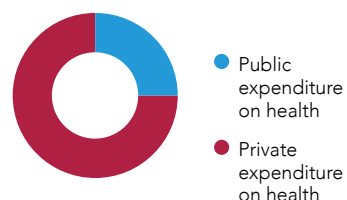
118

Per capita

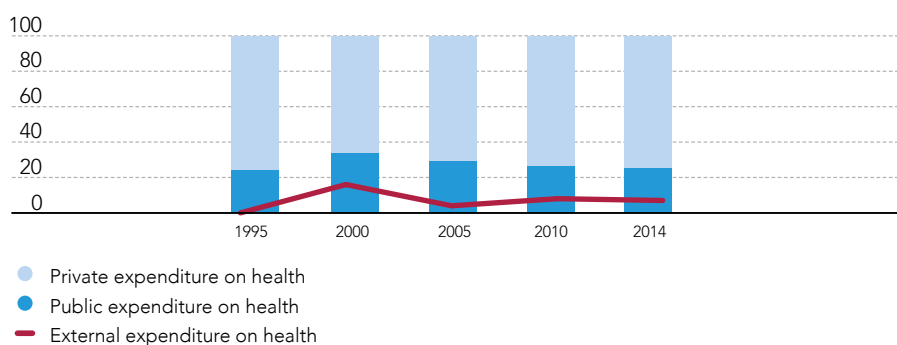
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
2742.9	7.8	-4.0	2.7	Lower middle

Rwanda

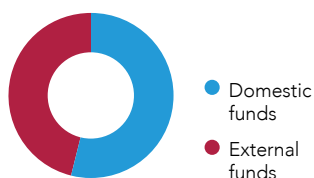


Spending on health in current US\$, 2014

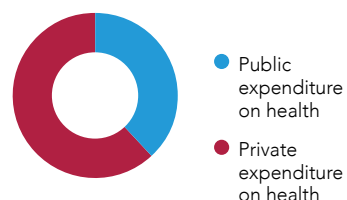
52

Per capita

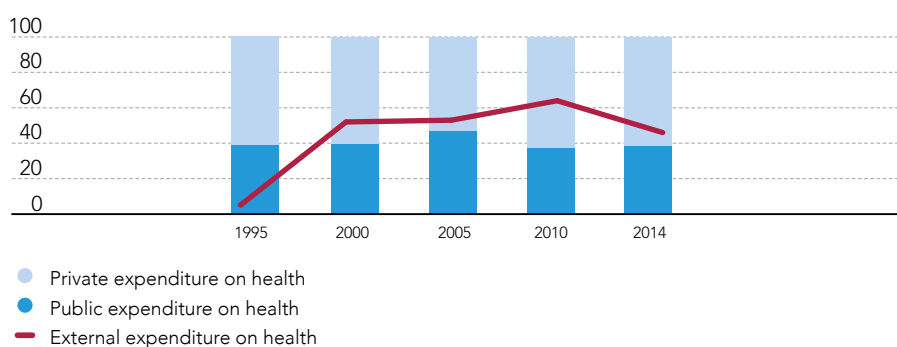
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
731.5	24.4	-2.8	6.9	Low

Sao Tome and Principe

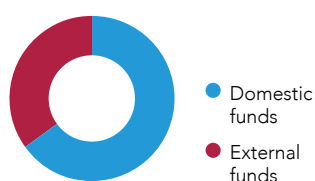


Spending on health
in current US\$, 2014

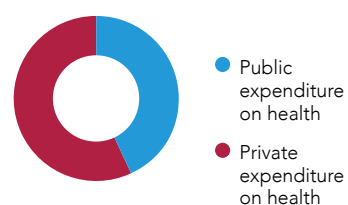
166

Per capita

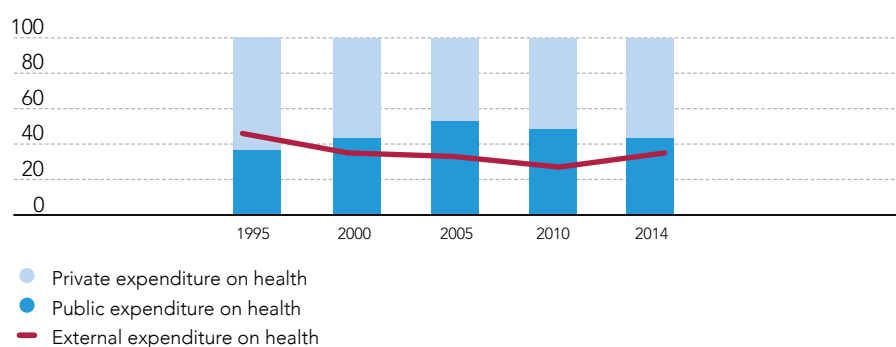
Who funds health, 2014



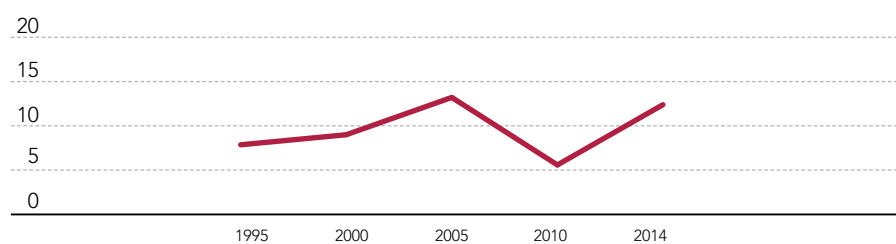
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
1569.0	28.4	-6.8	4.0	Lower middle

Senegal

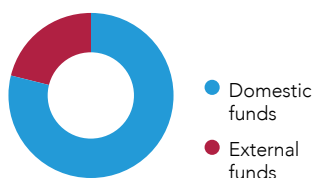


Spending on health in current US\$, 2014

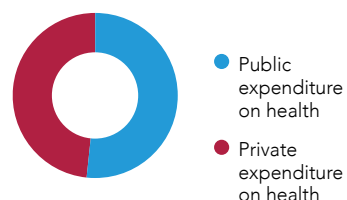
50

Per capita

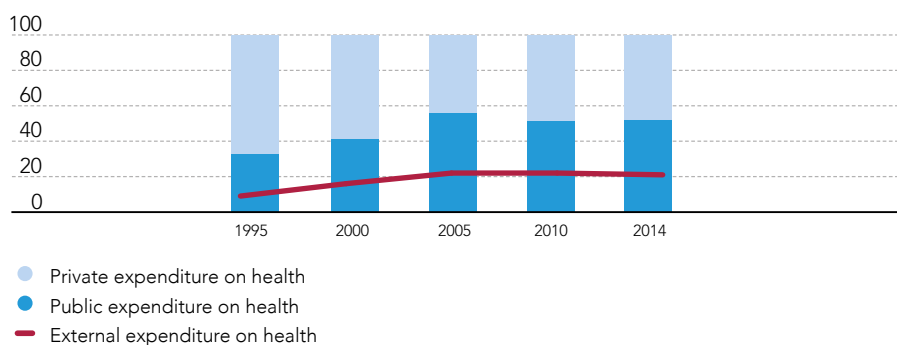
Who funds health, 2014



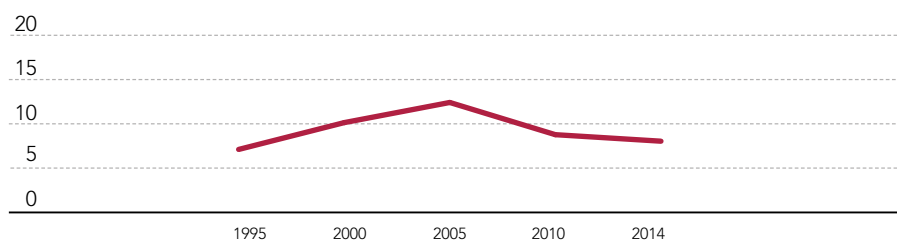
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
913.0	25.1	-4.8	6.5	Low

Seychelles

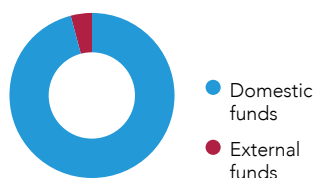


Spending on health
in current US\$, 2014

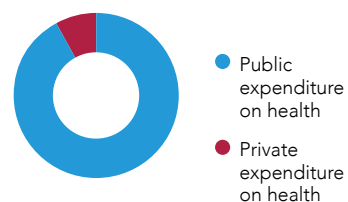
494

Per capita

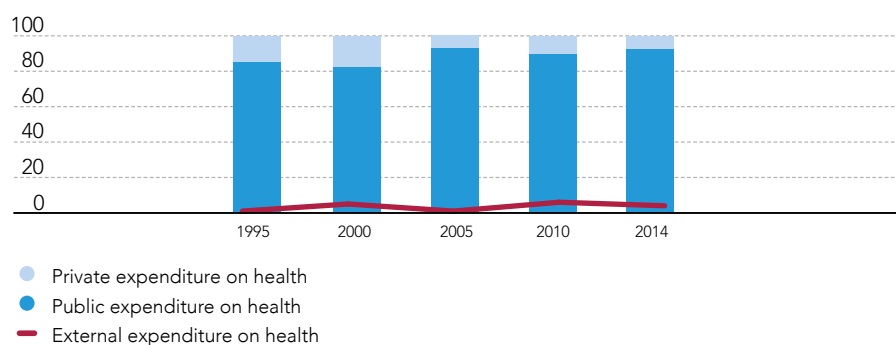
Who funds health, 2014



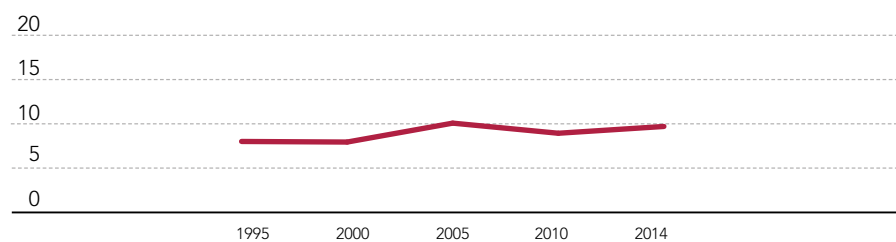
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
14940.7	34.3	2.0	4.4	High

Sierra Leone

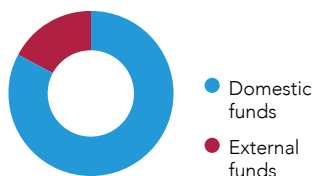


Spending on health in current US\$, 2014

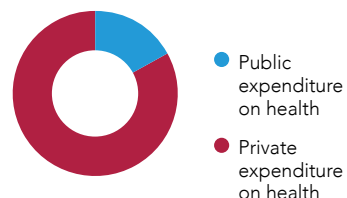
86

Per capita

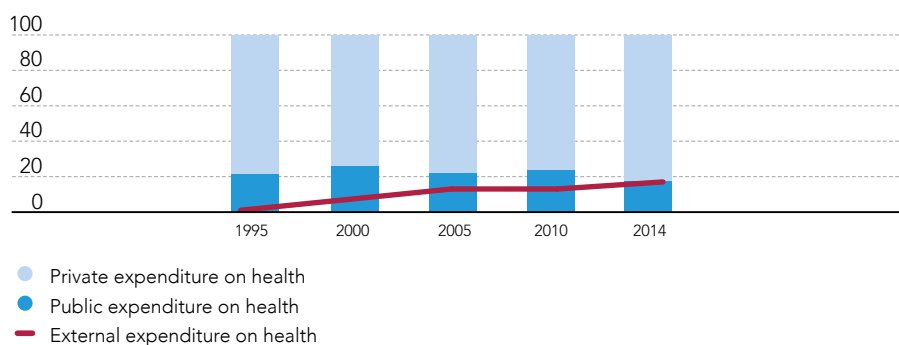
Who funds health, 2014



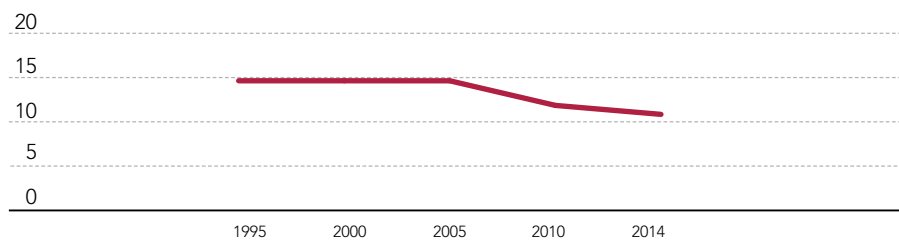
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
659.4	15.9	-4.4	-21.5	Low

South Africa

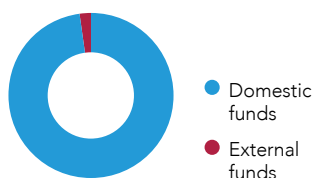


Spending on health in current US\$, 2014

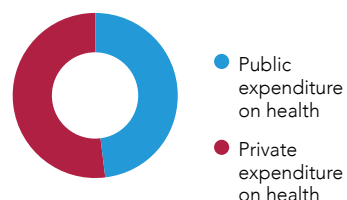
570

Per capita

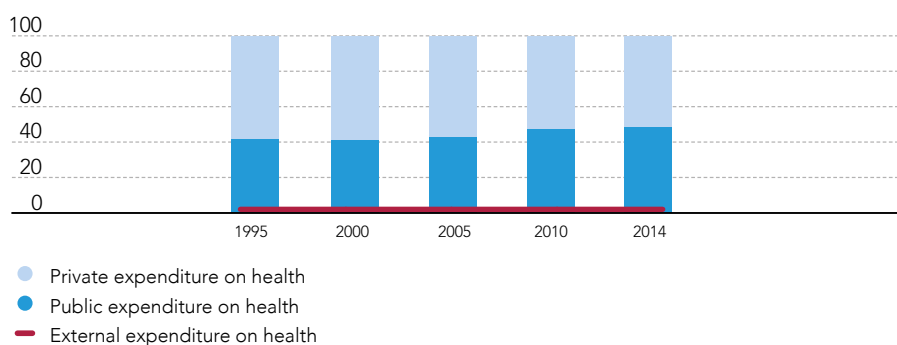
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
5694.6	29.7	-4.0	1.3	Upper middle

South Sudan

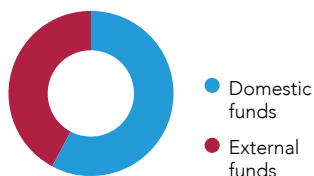


Spending on health in current US\$, 2014

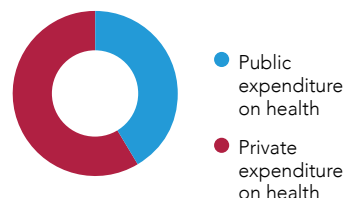
30

Per capita

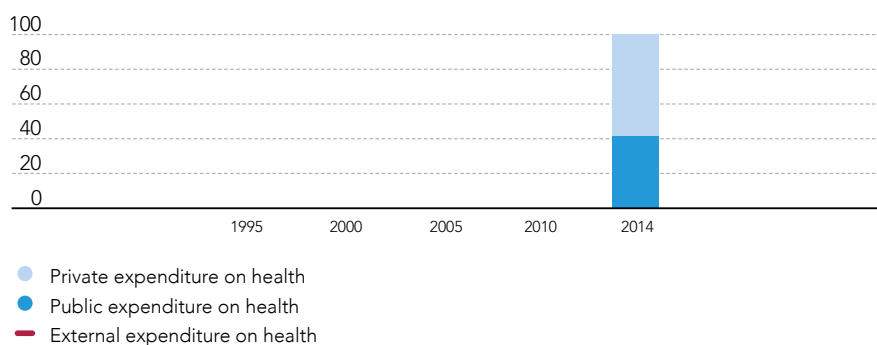
Who funds health, 2014



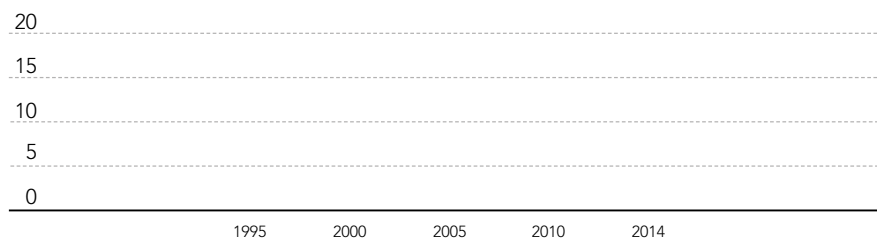
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
220.9	72.0	4.2	-0.2	Low

Swaziland

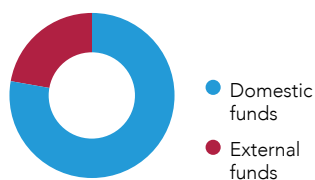


Spending on health
in current US\$, 2014

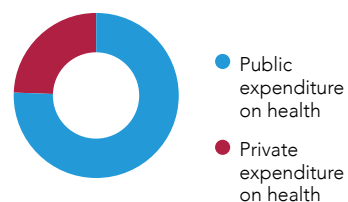
248

Per capita

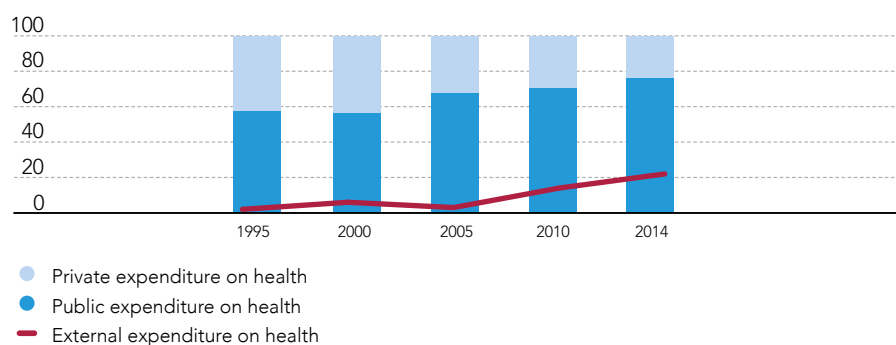
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
3139.7	27.6	-5.4	1.7	Lower middle

Togo

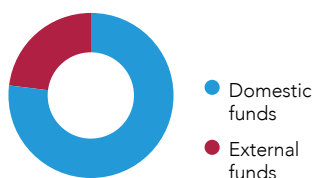


Spending on health in current US\$, 2014

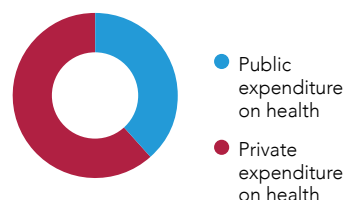
34

Per capita

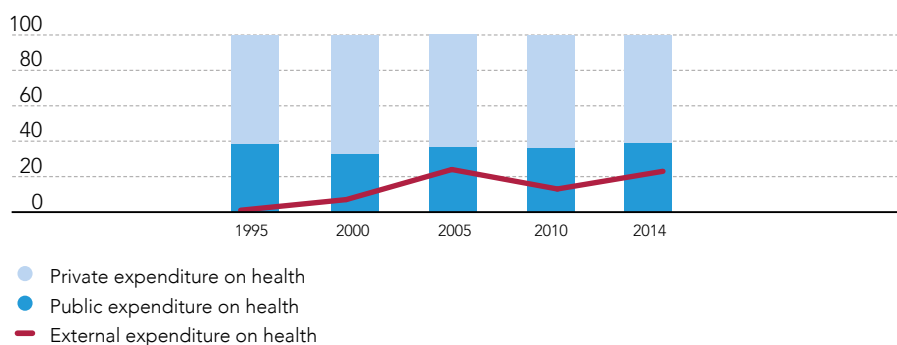
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
569.4	21.0	-6.4	5.3	Low

Uganda



Spending on health in current US\$, 2014

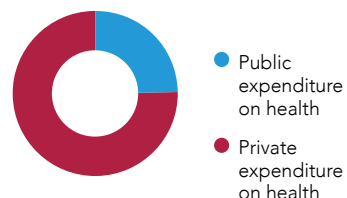
52

Per capita

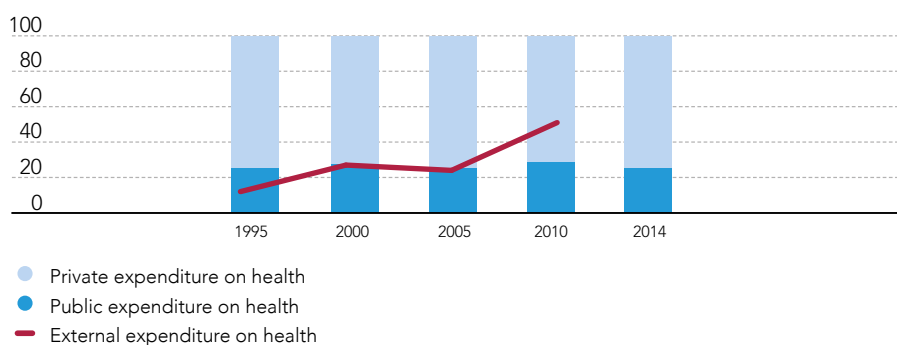
Who funds health, 2014



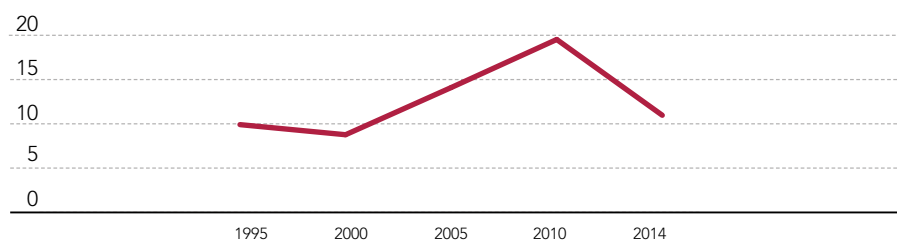
Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
620.2	15.1	-2.9	5.0	Low

United Republic of Tanzania

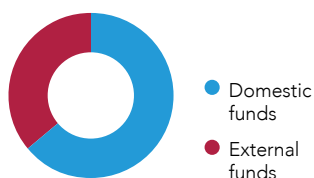


Spending on health in current US\$, 2014

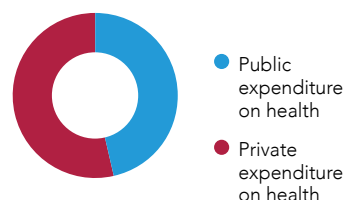
52

Per capita

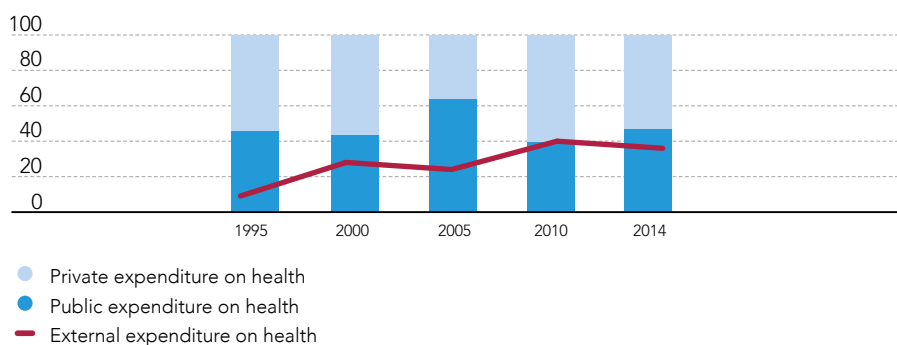
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
941.8	15.1	-3.7	7.0	Low

Zambia

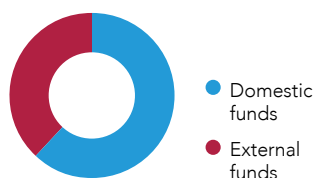


Spending on health
in current US\$, 2014

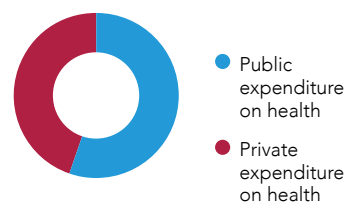
86

Per capita

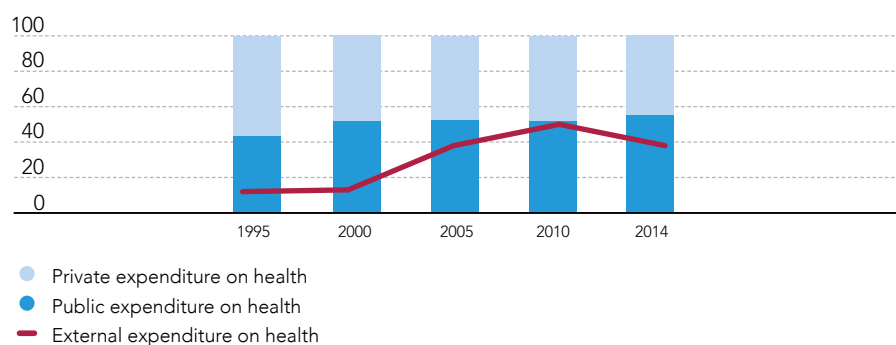
Who funds health, 2014



Who spends on health, 2014



Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
1350.2	17.5	-8.1	3.6	Lower middle

Zimbabwe



Spending on health in current US\$, 2014

58

Per capita

Who funds health, 2014

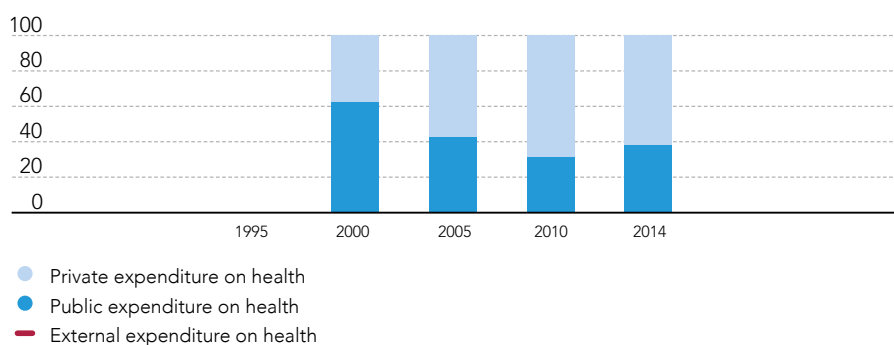
- Domestic funds
- External funds

Who spends on health, 2014

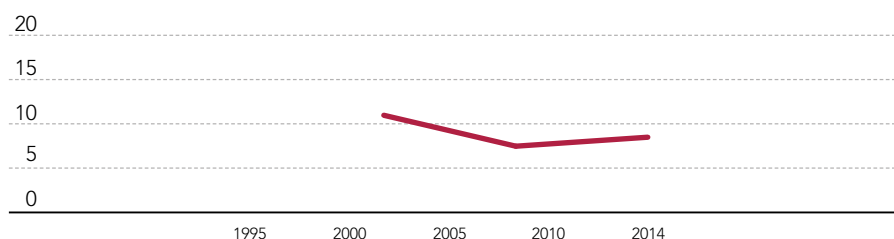


- Public expenditure on health
- Private expenditure on health

Public and private expenditure on health, and share externally funded (% total health expenditure), 1995–2014



Public expenditure on health as a share of overall public expenditure, 1995–2014



Macro-fiscal indicators, IMF 2015

Per capita GDP (in current \$US)	Government revenues as a % of GDP (in current \$US)	Fiscal balance as a % of GDP	GDP growth rate (%)	Income group
1064.4	27.3	-1.2	1.5	Low

3. Health Financing Strategies and Benchmarks

Elaboration of Health Financing Strategy in African Countries: Situation in June 2016

Countries	Not started	Started/In process	Finalized and approved
Algeria	●		
Angola	●		
Benin			●
Botswana		●	
Burkina Faso		●	
Burundi			●
Cameroon		● Analytical work in support of the development of a strategy is getting underway	
Cape Verde			●
Central African Republic	●		
Chad			●
Comoros	●		
Congo	●		
Cote d'Ivoire			●
Democratic Republic of the Congo		The government is leading the process of developing a health financing strategy for UHC with support from the World Bank and WHO	
Equatorial Guinea		● Situation analysis ongoing	
Eritrea	●		
Ethiopia			A health financing strategy is currently under government review and includes a focus on equity.
Gabon			Law on implementation of UHC elaborated and approved.
Gambia	●		
Ghana			● Adjustments are under government review
Guinea			●
Guinea-Bissau	●		
Kenya		A draft strategy is in its advanced stages with wide stakeholder consultation planned in the near future	
Lesotho	●		
Liberia		The development of a broad and prioritized medium-term health financing action plan is in progress	
Madagascar			National Health Strategy for UHC includes the strategy for health financing as a component
Malawi		● Under development	
Mali			●
Mauritania		● Situation analysis ongoing	

Mauritius	●		
Mozambique		Advanced draft produced for further consultation. Process for finalization to be harmonized in the context of Global Financing Facility Initiative.	
Namibia		●	
Niger			●
Nigeria		The process has started. Currently diagnostics are being conducted with support from partners including WHO and World Bank	
Rwanda			●
Sao Tome and Principe		Situation analysis ongoing	
Senegal		The strategy will integrate the universal health insurance programme (Couverture Maladie Universelle) that is currently under development	
Seychelles	●		
Sierra Leone	●		
South Africa		● National Health Insurance White Paper approved	
South Soudan	●		
Swaziland	●		
Tanzania			The health financing strategy is waiting for parliamentary approval
Togo		●	
Uganda			The health financing strategy has been approved by MOH senior management, and is awaiting review by the Cabinet
Zambia		●	
Zimbabwe		Started, final draft in circulation	

Key Health Financing Indicators: Regional and Country Benchmarks, unweighted averages, 2014 (in Parity Purchasing Power, PPP)

	Total health expenditure as a share of GDP	Public expenditure on health as a share of GDP	Public expenditure on health as a share of total health expenditure	Private expenditure on health as a share of total health expenditure	Public expenditure on health as a share of total public expenditure	External expenditure as a share of total health expenditure	Out-of-pocket expenditure as a share of total health expenditure	Private health insurance expenditure as a share of total health expenditure	Per capita total health expenditure	Per capita public health expenditure
African Region	6	3	51	49	10	24	32	4	274	164
Region of the Americas	7	4	57	43	14	3	32	8	1 327	774
South-East Asia Region	5	3	57	43	10	9	38	2	459	321
European Region	8	5	67	33	13	1	28	5	2 548	1 904
Eastern Mediterranean Region	6	3	56	44	9	3	38	5	1 082	741
Western Pacific Region	7	5	72	28	12	18	22	5	1 128	795
Total	7	4	60	40	12	10	31	6	1 308	912
Algeria	7	5	73	27	10	<	26	1	932	678
Angola	3	2	64	36	5	3	24	-	239	154
Benin	5	2	49	51	10	26	39	5	86	42
Botswana	5	3	59	41	9	10	5	33	871	514
Burkina Faso	5	3	52	48	11	25	39	2	82	43
Burundi	8	4	53	47	13	50	21	1	58	31
Cameroon	4	1	23	77	4	11	66	:	122	28
Cabo Verde Republic of	5	4	75	25	12	24	22	1	310	232
Central African Republic	4	2	49	51	14	46	46	1	25	12
Chad	4	2	55	45	9	19	39	4	79	43
Comoros	7	2	33	67	9	31	45	:	101	33
Congo	5	4	82	18	9	4	18	1	323	264
Côte d'Ivoire	6	2	29	71	7	9	51	3	187	55
Democratic Republic of the Congo	4	2	37	63	11	38	39	3	32	12
Equatorial Guinea	4	3	77	23	7	<	20	-	1 163	897
Eritrea	3	2	46	54	4	28	54	-	51	23
Ethiopia	5	3	59	41	16	42	32	<	73	43
Gabon	3	2	68	32	7	1	22	8	599	410
Gambia	7	5	69	31	15	65	17	2	118	81
Ghana	4	2	60	40	7	15	27	1	145	87
Guinea	6	3	48	52	9	13	45	1	68	33
Guinea-Bissau	6	1	20	80	8	25	49	-	91	19
Kenya	6	4	61	39	13	28	26	8	169	104
Lesotho	11	8	76	24	13	52	16	:	276	210
Liberia	10	3	31	69	12	49	31	4	98	31
Madagascar	3	1	48	52	10	40	41	5	44	21

Malawi	11	6	53	47	17	74	11	2	93	49
Mali	7	2	23	77	6	28	48	<	108	25
Mauritania	4	2	50	50	6	12	44	2	148	73
Mauritius	5	2	49	51	10	4	46	1	896	441
Mozambique	7	4	56	44	9	49	9	:	79	45
Namibia	9	5	60	40	14	8	7	24	869	522
Niger	6	3	55	45	8	21	34	4	54	30
Nigeria	4	1	25	75	8	7	72	2	217	55
Rwanda	8	3	38	62	10	46	28	5	125	48
Sao Tome and Principe	8	4	43	57	12	35	11	<	300	130
Senegal	5	2	52	48	8	21	37	10	107	55
Seychelles	3	3	92	8	10	4	2	<	844	779
Sierra Leone	11	2	17	83	11	17	61	<	224	38
South Africa	9	4	48	52	14	2	6	43	1 148	554
South Sudan	3	1	42	58	4	42	54	3	73	30
Swaziland	9	7	76	24	17	22	10	:	587	444
Togo	5	2	38	62	8	23	46	1	76	29
Uganda	7	2	25	75	11	:	41	2	133	33
United Republic of Tanzania	6	3	46	54	12	36	23	4	137	64
Zambia	5	3	55	45	11	38	30	2	195	108
Zimbabwe	6	2	38	62	8	:	36	10	115	44

Health expenditure series. Geneva: World Health Organization (latest updates and more information on countries are available at: <http://apps.who.int/nha/database/DataExplorerRegime.aspx>). All the indicators refer to expenditures by financing agent except external resources which is a financing source. WHO regional, income-group and global aggregates are calculated using absolute amounts in national currency units converted to Purchasing Power Parity (PPP) equivalents unless otherwise noted. In countries where the fiscal year begins in July, expenditure data have been allocated to the later calendar year (for example, 2011 data will cover the fiscal year 2010–11),

