Aidspan
Independent observer of the Global Fund

Determining, analysing and increasing domestic financing for health

I was critical about the report published by the Office of the Inspector General (OIG) (Advisory Report on the Global Fund's Role and Approach to Domestic Financing for Health (DFH) because the report lacked DFH data and discussion on the different forms of DFH and displayed a lack of understanding of the complexities of the subject. For those who are interested in DFH, this article describes the main forms of DFH, explains some of the difficulties in examining the subject and suggests how the Global Fund might promote increased DFH in the countries in its portfolio.

Lack of complete, consistent and reliable data

The first major difficulty is the lack of complete, consistent and reliable national data. Most persons are likely to first go to the World Health Organization (WHO) website; but, for those of us outside WHO, accessing its database on health financing is near impossible. If you are persistent and lucky enough to access the database, it is extremely difficult and time consuming to navigate and it is limited in content. So, for ease of access, I use the World Bank online database that, for every country, provides the following data for each year:

Current health expenditure (% of GDP)

Current health expenditure per capita (current US$)

Current health expenditure per capita, PPP (current international $)

Domestic general government health expenditure (% of current health expenditure)

Domestic general government health expenditure (% of GDP)

Domestic general government health expenditure (% of general government expenditure)

Domestic general government health expenditure per capita (current US$)

Domestic general government health expenditure pr capita, PPP (current international $)

Domestic private health expenditure (% of current health expenditure)

Domestic private health expenditure per capita (current US$)

Domestic private health expenditure per capita, PPP (current international $)

Out-of-pocket expenditure (% of current health expenditure)

Out-of-pocket expenditure per capita (current US$)

Out-of-pocket expenditure per capita, PPP (current international $)

Population, total

From these annual data it is possible to calculate the estimated totals of: (a) current health expenditure; (b) donor contributions; and (c) the three components of DFH: government, out-of-pocket payments (OPPs) and other types of non-government health expenditure.

These data are useful for comparative purposes over time; but, as explained below, they are neither complete nor accurate. They should therefore be treated with caution.

Some relevant WHO data

Given my above criticism of the WHO health financing database, I should in fairness state that WHO publishes an informative annual report on global health expenditure. On the subject of DFH, it is interesting to note some of the key messages in WHO's 2021 report on global expenditure on health. It states that, in the period 2000-2019:

- Health spending in low-income countries was financed primarily by out-of-pocket spending (44%) and external aid (29%).
- External aid rose considerably over the past two decades. In countries that are highly dependent on external aid, health priority in government spending fell in line with the increased aid.
- In low and middle-income countries, an average of two-thirds of external aid for health went to infectious diseases, while government health spending was evenly split between infectious and noncommunicable diseases.
- Nearly half of both primary health care (PHC) and non-PHC spending in low and middle-income countries was funded by private sources. In low-income countries, the rest was funded by external aid (one-third of total PHC spending and one-fifth of total non-PHC spending) and government sources (one-fifth of total PHC spending and one-third of total non-PHC spending).

The same WHO report also notes that the share of health spending in total general government expenditure decreased in 2020 in 15 of 22 countries with available data.

Capital v. current expenditure

You will note in the above listed World Bank health finance indicators the use of the adjective ‘current’. This relates to government accounting which normally separates ‘current’ from ‘capital’ expenditure. In relation to health, I define these types of expenditure as follows:

- Current expenditure relates to financial outgoings for operational purposes on personnel, medicines, other goods, and services consumed within the current year and which need to be made recurrently to sustain the production and delivery of health services.
- Capital expenditure relates to financial outgoings to acquire, upgrade and, in some cases, maintain physical assets such as property, buildings, laboratories, ambulances and major medical equipment. Those outgoings are not expensed against income in the year they are incurred; instead, they are recorded (or ‘capitalised’) on the balance sheet and the value is expensed over the useful lifetimes of the different categories of fixed assets.

Apologies for the accounting-speak; but I am trying to be clear and precise.

Government departments are normally required to prepare two sets of budgets: one for current expenditure and one for capital expenditure. Assuming that there were no changes at all in economic, social or health circumstances and a government had fully expensed its current health budget in one year, then its current expenditure budget for the next year would likely be the same. However, the capital expenditure budget would vary because the asset acquisition, upgrading and major maintenance requirements vary from year to year.

The difficulty for most governments is that they do not have the financial resources to meet all the capital expenditure requirements across all sectors; and many struggle to meet current expenditure needs; and social and political pressure means that current expenditure is given priority. That is why much capital expenditure is often deferred; and, in the health sector, this has implications for the scope of services that health facilities can offer and for the development of the sector. Insufficient attention is paid to reporting on health capital expenditure and the outstanding requirements.

Focus on actual expenditure not budgets

If you have read articles and reports on health financing you may have noted the tendency for many of them to refer to government budgets. In most cases, actual government expenditure on health is below – and sometimes well below – budget. Current expenditure, which has to cover staff costs utilities and other running costs, is likely to be close to budget unless salaries are paid late. However, capital expenditure has to wait until a government has the funds either through tax collection or loans.

Another issue is that Government expenditure on health is not always incurred by/through the Ministry of Health (MOH). Other ministries may operate their own medical facilities (for example, the Ministry of Defence) and ministry budgets may have health items such as insurance contributions. As a result, it is rarely clear whether reported government expenditure on health covers all ministries or refers only to the MOH.

My advice is that you ignore budget figures, except to compare with actual expenditure, and focus on actuals. That said, it is sometimes difficult to obtain actual data, especially on capital expenditure.

Types of DFH and scope of reporting

The different components of DFH are not always fully understood, reported on or taken properly into account. Here are some examples:

Government expenditure should refer to what government has financed. However, donor financing is treated differently in different countries. Some take care to report donor funded health expenditure separately; others include donor funding in government expenditure when that funding has been channelled through the government. In the latter case, the government element of DFH is accordingly overstated.

Governments sometimes use loans from external sources to fund health expenditure. Loans may be for specific health projects/programs or economic support loans (such as from the international Monetary Fund) obtained to meet general government expenditure. It could be argued that all external loans should all be treated as borrowing; but it can also be argued that loans specific to a sector should be treated as external financing for that sector, not simply overall government borrowing.

In time, loans have to be repaid. Ultimately, it is the population who will pay the taxes that will be used to make repayments. For this reason, it could be argued that loans represent a temporary form of DFH. That may appear logical but it is not entirely sound. First, if external loans are drawn down and those funds are applied in a particular financial period to meet health expenditure, then those loans represent a form of external financing and not DFH in that period. It is in later periods that the loans, together with associated interest and administration charges, are repaid; and governments then treat those repayments as debt servicing. Also, the future is uncertain; and it may be that a government defaults on a loan or is granted some debt relief. Ultimately, the case for not treating external loans received as a form of DFH is that, if they are, then the repayments should be treated as negative DFH (which, of course, is not going to happen).

OPPs are often understated; and the reasons vary from one place to another. Weaknesses in health management and accounting systems can result in the non-recording and/or reporting on OPPs. However, a common reason is the incidence of corrupt practices including: health user charges that go unreported, overcharging, and service providers charging patients for services and medicines that should be free. Such practices are difficult to deal with where they have become embedded and/or when medical and other staff are underpaid or not receiving their salaries on time. If you are familiar with the health system in a particular country, you will know if the reported OOPs are – or are not – likely to be materially understated.

If, using the World Bank data, we deduct OPPs from total domestic private health expenditure on health, we are left with ‘other’ forms of DFH. These ‘other’ forms of DFH and their importance again vary considerably from one country to another.

In many countries it is unclear if insurance premiums are considered to be OPPs or if they are included in ‘other’ DFH. We tend to assume the latter but that may be an incorrect assumption. It would be helpful if the estimated total value of insurance premiums were reported and how much of ‘other’ was by the insurance companies.

There is also a need to distinguish between government-sponsored compulsory insurance schemes and private voluntary health insurance.

Uncertainty also prevails about expenditure in the private health sector. Some countries have a system that regulates the private sector; but there are countries where regulation is weak and/or not exercised so that data on the income and expenditure of private facilities is incomplete. Traditional medicine is not regulated and expenditure in that sector is not reported.

We rarely see mention of employers; yet they also play variable roles in health financing. To help hire and retain capable staff in countries with low living standards, some employers may decide to pay for medical insurance or meet the medical costs incurred by their employees and, possibly, their families. In countries where the health system has been weak, some larger employers provide and finance their own medical clinics. Again, it is often unclear whether that expenditure is included in DFH.

Finally, donations by and/or the cost of services provided by local and national non-government organizations (NGOs) may or may not be included in reported DFH.

To summarise, DFH comprises:

Government	Out-of-pocket payments	Private sector – hospitals and clinics	Employers – support for employees and families	Local and national NGOs
Recurrent expenditure on health	Private insurance premiums	Ambulance services	Contributions to private/public health insurance schemes	Contributions to health programs / projects / funds
Capital expenditure on health	National health scheme contributions	Pharmacies	Staff health costs reimbursed	Hospitals and clinics
Contributions to national health scheme(s)	Official health services charges	Traditional practitioners	Own operated internal clinics	
	Unofficial health services charges	Individual donations to public health programs		
		Donations to public health programs		

In relation to reporting on DFH, I should mention the Africa Scorecard on Domestic Financing for Health. This is an advocacy tool for member states to use in financial planning and expenditure tracking. However, it is a tool only used to or measure AIDS, TB and malaria spending and is intended to measure only the Abuja Declaration of health target of 15% of total government expenditure.

Accounting year differences

If you look at donors' reports of their grants to countries and you compare the reported amounts with government reports on donor contributions to health, you will rarely be able to reconcile the two. A key factor for this is that different organisations have different accounting years, often not coinciding with the calendar year. This is an added complication when attempting to compile data and it disguises errors, particularly omissions.

The need for annual health accounts

Much greater clarity is needed about the sources of health financing. WHO developed and published “A System of Health Accounts 2011” which provides an integrated and comprehensive methodology for tracking health expenditure through a set of uniform accounts comparable across countries. The framework, which focuses on final consumption, tracks resource flows through the health system: from its sources (funding sources, financial arrangements), patterns of provision (providers and factors of provision), and through to its use (health care functions, diseases/programs). It is a pity that most of the countries supported by the Global Fund do not apply this methodology and routinely prepare and publish annual health accounts. Were they to do so, they would be employing a common methodology and reporting format which might relieve the burden of multiple reporting to various donors.

Increasing DFH

The general trend in DFH is not positive, especially when looking at year on year health expenditure per capita. I can confidently predict that universal health coverage (UHC) will not be achieved unless and until there is a significant increase in DFH per capita.

The question then is: what should the Global Fund do to encourage an increase in DFH?

The Global Fund’s interest in DFH is primarily to ensure that the governments of recipient countries are contributing to financing HIV, TB and malaria programs and that, to the extent that they are able, they gradually take over full funding responsibility. At the same time, the Global Fund works with other partners in the health sector to promote and monitor DFH. For this purpose, the Global Fund and its partners should encourage countries to produce national health accounts as a matter of routine. This would deliver three important results. First, it would provide much better information on both the sources of financing and how and where the money was spent. Second, it would help relate the expenditure data to changes in health indicators, thus giving better assurance as to appropriate and efficient use of available financing. Third, and most important, it would help strengthen governance and accountability.

Increased government investment in health is what is required. To help convince governments of the importance of increasing their investment in health, the Global Fund and its partners should take every opportunity to explain the return on investment and the importance of health to economic and social development. More research is required on the benefits of investment in health and the results should be disseminated through media that will reach politicians and local community leaders and build a broad consensus for increasing government health financing.

A word of caution

I have to conclude on a word of caution because I know that some observers will suggest that designing and adopting new financial mechanisms and promoting the development of the private sector provide opportunies to increase DFH. That may well be true; but the result would be increased inequity; and that would mean saying goodbye to the aim of achieving UHC.

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