The uncertainty of co-financing

This article is about the advisory report, published on 21 July 2022 by the Office of the Inspector General (OIG), on 'The Global Fund's Role and Approach to Domestic Financing for Health (DFH).'

This article was drafted in early September last year, but its publication has been delayed because it has proved to be somewhat controversial. The draft was widely circulated and commented upon. Some OIG and Global Fund Secretariat staff members feel that this article does not do justice to the work undertaken and the content of the report. However, they have found no errors in this article.

Perhaps the main reason this article cannot do justice to the content of the report is because of the length of the report and this article – itself already very long and beyond the GFO standard – focuses on what an independent reader gleans from the report rather than going through and discussing every part of it.

Interestingly, in view of the global economic climate today, the subject matter of the report has become all the more important. Unfortunately, in its published form, the report fails to deal adequately or appropriately with the topic for the reasons explained in this article.

Lack of clarity as to what DFH includes

It begins with an incomplete definition of DFH, phrased specifically for the report, which does not make clear that DFH is about the mobilization, allocation and deployment of financial resources for health from domestic sources and excludes financing from non-domestic donors and lenders. This is important because in some countries government expenditure on health includes donor funds and external loans channelled through government and DFH is accordingly overstated; a fact that has been ignored. (For more discussion on the inclusion or exclusion of external loans in DFH, see the accompanying explanatory article on DFH).

Given the size of the report (50 pages), it is surprising that it does not include an explanation of the different types of DFH. In addition to government funding, there are out-of-pocket payments (OOPs), funding provided by insurance payments (in turn financed by insurance premiums which may or may not be included in OOPs), public and/or private health services paid for by employers, health services provided internally by larger employers; and health services provided or supported by domestic NGOs. Even OOPs are of two types: standard/published charges for certain types of health services and charges decided and levied at the service provider level.

Despite the title of the report, its narrow focus on what it calls DFH means that this advisory is about the Global Fund's aims at influencing government financing for health and not the full ambit of domestic financing for health.

Lack of DFH data and on deep-dive and spotlight countries

DFH is about money mobilised and spent on health, yet the report provides no financial data on the different sources and recent trends of DFH.

This is all the more surprising because OIG went 'deep-diving' in eight countries and selected another five 'spotlight' countries but has failed to provide data on – and, therefore, any analysis of – the sources and amounts of DFH in those countries. The report has a footnote concerning the country selection parameters. Even so, the rationale for the country selection appears to be that they are the only examples of co-financing and blended finance, rather than any connection with DFH, which is the main topic reflected in the title of the report.

The DFH challenges that are reported would be more convincing if backed by supporting financial data.

Useful data for readers

For readers of this article, Tables 1 and 2 below (compiled by the article author) provide overviews of the most recent available data on health financing and expenditure in those thirteen 'deep-dive' and 'spotlight' countries.

Table 1: 2019 Health Expenditure in the OIG 'Deep-Dive' and 'Spotlight' Countries *

	Population	Health Expenditure Per Capita											Total Expenditure
		Government		Out-of-Pocket		Other		Total DFH		Donors		Total	
	million	US$	%	US$	%	US$	%	US$	%	US$	%	US$	US$ m.
Angola	31.8	29.4	41.2	26.7	37.5	13.0	18.1	69.1	96.8	2.2	3.2	71.3	2,270.0
Bangladesh	163.0	8.5	18.6	33.3	72.7	1.2	2.6	43.0	93.9	2.9	6.1	45.9	7,476.8
Chad	15.9	5.2	17.3	17.1	57.2	1.5	5.1	23.8	79.6	6.1	20.4	29.9	476.0
Congo (DR)	86.8	3.3	15.8	7.9	38.5	1.4	6.9	12.6	61.2	8.0	38.8	20.6	1,785.4
Côte d'Ivoire	25.7	21.8	29.1	28.0	37.3	13.8	18.4	63.6	84.8	11.5	15.2	75.1	1,931.0
Ghana	30.4	30.3	40.2	27.3	36.2	9.2	12.3	66.8	88.7	8.5	11.3	75.3	2,289.9
Haiti	11.3	6.3	11.0	24.7	43.3	3.0	5.2	34.0	59.5	23.0	40.5	57.0	641.9
Kenya	52.6	38.4	46.0	20.3	24.3	9.3	11.2	68.0	81.5	15.4	18.5	83.4	4,385.3
Lao (PDR)	7.2	25.2	36.9	28.5	41.8	-	-	53.7	78.7	14.5	21.3	68.2	489.1
Nigeria	201.0	11.4	15.9	50.4	70.5	0.6	0.8	62.4	87.2	9.1	12.8	71.5	14,362.0
Philippines	108.1	57.7	40.6	69.0	48.6	14.8	10.4	141.5	99.6	0.6	0.4	142.1	15,361.1
Uganda	44.3	4.9	15.1	12.4	38.3	1.5	4.6	18.8	58.0	13.6	42.0	32.4	1,434.7
Ukraine	44.4	111.1	44.8	126.8	51.1	8.5	3.4	246.4	99.3	1.7	0.7	248.1	11,013.7

* Source: World Bank online database.

Table 2: 2019 Domestic and Donor Health Financing in the OIG 'Deep-Dive' and 'Spotlight' Countries *

	Population	DFH		Global Fund		Other Donors		TOTAL
	(million)	US$ m.	%	US$ m.	%	US$ m.	%	US$ m.
Angola	31.8	2,198.0	96.8	18.3	0.8	53.7	2.4	2,270.0
Bangladesh	163.0	7,019.5	93.9	47.9	0.6	409.4	5.5	7,476.8
Chad	15.9	378.8	79.6	53.5	11.1	43.7	9.3	476.0
Congo (DR)	86.8	1,093.6	61.2	190.5	10.7	501.3	28.1	1,785.4
Côte d'Ivoire	25.7	1,638.8	84.8	81.1	4.2	213.1	11.0	1,931.0
Ghana	30.4	2,031.7	88.7	68.0	3.0	190.2	8.3	2,289.9
Haiti	11.3	382.2	59.5	29.8	4.6	229.9	35.9	641.9
Kenya	52.6	3,573.6	81.5	113.6	2.6	698.1	15.9	4,385.3
Lao (PDR)	7.2	385.4	78.7	3.6	0.7	100.1	20.6	489.1
Nigeria	201.0	12,530.9	87.2	213.5	1.5	1,617.6	11.3	14,362.0
Philippines	108.1	15,297.3	99.6	54.5	0.3	9.3	0.1	15,361.1
Uganda	44.3	831.8	58.0	129.4	9.0	473.5	33.0	1,434.7
Ukraine	44.4	10,938.9	99.3	47.8	0.4	25.0	0.3	11,013.7

* Sources: World Bank and Global Fund online databases.

Effects of COVID-19

The disruptions caused by the COVID-19 pandemic adversely affected all health services and programs. In response to the pandemic, health facilities and workers were reallocated to deal with COVID-19 cases and many governments were forced to allocate more financial resources to cope with the situation and meet and distribute vaccines. This means that, when 2020 and 2021 health expenditure data become available, comparisons with previous years will not be useful. We would expect expenditure to have increased but, surprisingly, in the most recent WHO report (Global expenditure on health: Public spending on the rise?), it informs us that, in 2020, government expenditure on health actually decreased in 15 of the

22 countries with available data.

Comparing countries

From the data in Tables 1 and 2, readers will note the stark differences between the countries in the levels of expenditure per capita and the percentages financed by governments, OOPs, other domestic sources and external donors. These are due to a range of factors; but their importance is that they indicate that general conclusions and recommendations on DFH are of very limited use. Each country has its own set of circumstances that determine the types and levels of its health financing needs, its approach to DFH and the financial capacity of the different sources.

Progress in increasing DFH

Another omission in the report is any idea of progress in increasing DFH, either globally, regionally or in the 'deep-dive' and 'spotlight' countries. To put the topic of DFH into context, it is important to understand if, in recent years, the various initiatives to stimulate an increase in DFH have had a material effect.

Table 3 (also compiled by me and which unfortunately does not include capital expenditure on health) compares the percentages of reported health financing between 2000 and 2019 in the OIG selected countries. It shows that over that period: (i) only four of those countries increased DFH as a percentage of total health financing while in nine countries the percentage of DFH decreased; and (ii) government financing of health as a percentage of the total DFH increased in only five of the thirteen countries. Readers can draw their own conclusions as to the progress achieved.

Table 3: Comparison of Changes in Health Financing in OIG Selected Countries 2000-2019*

	Year	Percentage of Health Financing				
		Government	Out-of-Pocket	Other	Total DFH	Donors
Angola	2000	58.2	27.3	14.0	99.5	0.5
	2019	41.2	37.5	18.1	96.8	3.2
Bangladesh	2000	28.7	61.1	2.3	91.1	8.9
	2019	18.6	72.7	2.6	93.9	6.1
Chad	2000	38.0	56.2	2.3	96.5	3.5
	2019	17.3	57.2	5.1	79.6	20.4
Congo (DR)	2000	4.0	51.1	19.2	74.3	25.7
	2019	15.8	38.5	6.9	61.2	38.8
Côte d'Ivoire	2000	9.6	73.1	10.2	92.7	7.1
	2019	21.8	37.3	18.4	84.8	15.2
Ghana	2000	27.8	52.6	7.6	88.0	12.0
	2019	40.2	36.2	12.3	88.7	11.3
Haiti	2000	21.8	44.4	2.3	68.5	31.5
	2019	11.0	43.3	5.2	59.5	40.5
Kenya	2000	28.6	47.1	11.9	87.6	12.4
	2019	46.0	24.3	11.2	81.5	18.5
Laos	2000	28.8	44.8	16.5	90.1	9.8
	2019	36.9	41.8	-	78.7	21.3
Nigeria	2000	18.3	60.2	4.5	83.0	17.0
	2019	15.9	70.5	0.8	87.2	12.8
Philippines	2000	44.4	41.2	10.9	96.5	v3.5
	2019	40.6	48.6	10.4	99.6	0.4
Uganda	2000	24.8	43.1	0.6	68.5	31.5
	2019	15.1	38.3	4.6	58.0	42.0
Ukraine	2000	47.3	48.4	4.1	99.8	0.2
	2019	44.8	51.1	3.4	99.3	0.7

*Sources: World Bank online database.

Some differences between the OIG ‘DFH space’ and reality

There is too much theory and insufficient attention to reality in the report. For example, the overview of ‘priority’ DFH challenges fails to mention three key factors:

(1) Security: Government ownership and prioritisation of health are affected by political stability, internally and/or externally. This is recognised by the Global Fund with its policies that deal with Challenging Operating Environments. (COEs). Is it even reasonable to expect such countries to increase DFH when they are facing major challenges (such as Ukraine)?

(2) Avoidance of unpopular measures: To be able to increase spending on health and in other sectors, a government needs to generate more income. This inevitably requires: (a) enforcing/improving tax collection; and, possibly, (b) raising taxes. Such measures are both unpopular and may also be politically risky; and, understandably, tend to be deferred.

(3) Corruption: The weaknesses in public financial management and health financing have prevailed for many years. Corruption is one of the key factors causing delays in resolving these weaknesses. One way to approach this problem is to put more pressure on accountability for performance and results. It is noticeable that the section on public financial management and heath financing data (which is the real substance of the DFH topic) does not mention accountability. Such a pity: as this section is the only convincing part of the report.

Understatement of out-of-pocket payments

Another example of inattention to reality: a fundamental problem with DFH data is that in many countries OOP expenditure on health is understated. In some instances, this is due to weak oversight of private sector health services. Sometimes, it may be the result of weaknesses in health accounting and management systems; but the more usual reason is the incidence of corrupt practices. These include health user charges that go unreported, overcharging, and service providers charging patients for services and medicines that should be free. In the estimated total, some allowance may be made for unreported OOP expenditure based on a survey but surveys are limited in scope and infrequent; and rarely is such allowance quoted.

Corruption

This is relevant to Annexes 1 and 2 of the report in which the first health financing outcome is “More Money for Health”. The strengthening components and interventions are fine but there is no mention here (or anywhere else in the report) of dealing with corruption. When more money becomes available, temptation increases. This calls for effective financial controls, transparency and full accountability.

More omissions

The third health finance outcome described in Annexes 1 and 2 (“Accessibility & Sustainability of Healthcare Systems”) is split into two: (i) increased orientation towards universal health coverage (UHC) in DFH policies; and (ii) enhanced sustainability of DFH.

With regard to UHC, the report fails to consider/mention that this will not be achieved in countries where DFH relies predominantly on OOP payments. Tables 1 and 3 above show the high dependence on OOP payments in the OIG selected countries.

As for “enhanced sustainability”, this would be clearer if it were to read: achievement of the required DFH to provide UHC. However: (a) there is a lack of data to show if, over the past 20 years, there has been any

overall progress towards achieving sustainability; and (b) the ability to increase DFH and sustain it depends on a country's economic performance and a continued absence of unforeseen occurrences (such as Russia's attack on Ukraine or the influx of refugees suffered by some countries), realities that are also overlooked in this report.

No reference to capital expenditure

Government budgets usually distinguish between capital and current expenditure; but this is not mentioned in the report. The health expenditure data that are generally reported – such as in the World Bank database and used in Tables 1, 2 and 3 above – refer to current expenditure. Data on actual capital health expenditure are not readily accessible; yet the coverage, capacity and condition of major health assets have a major bearing on the availability and usage of health services and, therefore, current expenditure.

Failure to differentiate between budget allocations and actual expenditure

The compilers of Annex 3 make the error of referring to budget allocations for health, HIV, TB and malaria. This is an error because governments go through the budget allocation process but actual spending on health (with the exceptions forced on some of them in 2020 by the COVID-19 pandemic) is often below – and sometimes well below – those allocations. Actual government current expenditure on health tends to be close to budget allocations because it has to meet the salaries and other staff costs, utilities and other running costs; although there are instances when governments delay paying staff salaries, resulting in a greater variance against budget. However, governments, particularly of low-income and lower middle-income countries, whose revenues are insufficient to meet expenditure demands, invariably scale down capital expenditure. The recurrent delays in capital investment means that the requirements accumulate while the health system deteriorates. Given this situation, budget allocations should be used for reference only; and, to gauge what is happening and assess results, it is important to use actual health financing and expenditure.

Over-emphasis on co-financing and joint and blended financing

In this report, too much emphasis is placed on co-financing and joint and blended financing. Note that only total commitments but no actual amounts are quoted for co-financing. However, readers may be interested in the remarks made in July 2022 by the firm who provided technical assistance to Angola (see pharosglobalhealth.com): "To date, Angola is the best and perhaps only example of a country accounting for each dollar of co-financing commitments agreed upon with the Global Fund in the NFM2 and NFM3 grants."

Twenty percent of the main report is devoted to joint and blended financing; but readers will note that: (a) the report does not provide overall amounts to gauge their significance to DFH; (b) even the total of co-financing commitments is not of great significance compared to the total of DFH; and (c) the examples provided (of Haiti and Laos) are about co-donor financing and have nothing at all to do with DFH.

Value for Money

While achieving value for money is important, the case for including value for money as a DFH lever is tenuous; and the recommendations are a concoction of phrases which mean – and are likely to result in – very little.

Lack of a full grasp of the subject

In the background section on the importance of DFH to the GF mandate there is a sentence that reads: "Translating these commitments into actual investments will require sustained political leadership and

rapid development of health financing mechanisms." On quick reading this may sound fine; but it is way off the mark. First, no commitments were previously mentioned; second, no account is taken of socio-economic factors and political stability; and third, health financing mechanisms are not what is needed. Anyone who has been working on the topic of DFH will know that time spent on developing financing mechanisms (which may or may not be implemented and work) is wasting a valuable asset when health financing mechanisms are not the issue: the problems are weak health management systems, weak governance and lack of accountability.

In the same section it goes on to read: "It is a key requirement of a country's ownership on health to support the country's ability to prioritize investments in health systems and ensure efficient spending and equitable access to healthcare." This sentence may appear to say what many want to hear but it fails to recognise that equitable access to healthcare is not yet universally accepted as an aim. And the next paragraph states that: "DFH is also key to ensuring a country's ability to successfully transition from donor support, …". That is only true of countries who need that support; but not all countries who are Global Fund grant recipients are reliant on donor support. Some countries have only a small level of donor support (below 5% of total health financing) and accept what is available for national disease responses; but they are not necessarily dependent on it. That is in contrast to other countries, especially those with 20% or more of their health financing coming from donors, who are reliant on that support because of their poor health infrastructure and various social and economic issues. Interestingly, Table 3 in this article shows that in nine of the thirteen OIG selected countries, dependence on donor funding support increased between 2000 and 2019 and increased significantly in seven of those countries.

The Global Fund remit

The framework for strengthening DFH set out on page 48 of the report is useful but surely extends beyond the remit of the Global Fund. Perhaps the role of the Global Fund in DFH is overstated. The Global Fund has a clear role in promoting increased domestic spending in fighting HIV, TB and malaria. However, while the Global Fund should clearly support investment in health more broadly, responsibility for promoting the other interventions in what the report calls the 'DFH Space' should be assumed by the other global 'actors'.

If Global Fund management wishes to proceed with the 72 recommendations in this report, there would have to be a significant increase in staff and budget for that purpose, a move that would probably not be supported by many stakeholders.

The ultimate omission

The COVID-19 pandemic drew attention to the under-investment in health worldwide; so, every country needs to increase its DFH. That said, politicians, who are assailed with requests for increased government investment from every direction, need to better understand the benefits of investing more in health. Speakers representing the Global Fund often quote research that showed that $1 invested in health yields $31 in health gains and economic returns. This is the most compelling selling point for the Global Fund and its global partners to repeat at every opportunity. It is therefore surprising that this most convincing argument for increasing DFH – used by the Global Fund in its work – is not mentioned in the report.

Back to 'Global Fundspeak'

I cannot resist pointing out that the authors of this report have reverted to the use of 'Global Fundspeak'. Readers of the report will be struck by, in addition to 'deep diving' and extensive over-use of exaggerated – and sometimes inappropriate – terms such as strategic' and 'critical', phrases and sentences that do not add substance to the subject.

OIG reaction to this article

A draft of this article was shared with the OIG. Their responses explain the content and some of the omissions in the report.

The OIG pointed out that:

- Advisory engagements are client-driven. In this case, the DFH advisory was sponsored by the Executive Director;
- As part of Advisory reviews, there is a usually a steering committee (steerco) made up of cross-functional teams from the Secretariat and OIG. The steerco looks at the detailed analysis behind the conclusions and recommendations, and requests additional clarifications when needed to inform further analysis as part of the advisory engagement. The steerco meets at defined intervals during the engagement; and
- Much of the detailed analysis shared with the steerco does not necessarily make it to the final report because it does not affect the conclusions and related recommendations.

These are important items of information. Why were they not mentioned in the advisory report? Importantly, nowhere is there any reference to the steering committee, what it reviewed and what it decided.

The OIG goes on to explain that “Some of the details (referred to in your article e.g., tables 1 and 2) in some cases are shared separately with the steering committee and sponsor of the advisory engagement. We could have easily produced report of 100 pages or more with some of those details, which frankly do not change the conclusions. Some of them are what we call ‘working papers’ and are not necessarily included in reports.” Are you convinced by this? Does this satisfactorily explain why a report on the subject of DFH – and published in the public domain – does not include a proper discussion of the topic and omits financial data? Surely these should have been included, if only in annexes.

In response to my comment that the recommendations are unconvincing and some may prove inappropriate, the OIG maintains that “the recommendations in the report were discussed with the sponsor, as indicated on page 4 of the report”. There is no reference to discussions of recommendations with the sponsor either on page 4 or elsewhere in the report; but, in any case, this does not make the recommendations any more convincing to external readers.

OIG maintains that the agreed scope has been fully addressed in the report. One of the stated objectives of the advisory was to “Identify priority DFH challenges at country level, understand their root causes and extrapolate the priority challenges to be tackled through DFH interventions.” However, to convince a reader that the scope has been fully addressed surely requires a clear explanation of DFH?

OIG stated that:

1. ”DFH as a topic could be broad and no single review could extensively cover every component.”
2. The topics … such as OOPs, government ownership, macro-economic factors, and trends were covered in detail during the Advisory review. These components were presented to the steerco as part of the engagement process.

That would have been fine had the report only been issued internally. As for (a), this article and the

accompanying article (Determining, Analysing and Increasing Domestic Financing for Health) on DFH provide adequate information in not that many pages. As for (b), that does not justify the omission in a report published in the public domain.

Responding to my comments on the progress in increasing DFH, OIG says that "As indicated above, and mentioned in the Global Fund's Focus on Domestic Financing for Health, co-financing is a key component of DFH." and goes on to say that "Our Advisory report on page 23 indicates "significant increases in domestic financing since the introduction of the counterpart financing" and includes a table illustrating this." That is not so. Page 23 of the report includes a table on co-financing which does show an increase. However: (a) that increase is only in line with the increase in Global Fund financing – so hardly that impressive; (b) the table is about the total of commitments but not the actual co-financing that has occurred; and (b) co-financing is insignificant in the total DFH picture.

OIG states that: "We are unable to comment on your table (Table 3) because our report already talks about the increase in co-financing across the Global Fund's portfolio (please refer to figure 4 on page 23)." OIG is not paying attention. Table 3 (above) has nothing at all to do with co-financing.

In response to my comment on the over-emphasis on co-financing and joint and blended financing, OIG replied that "The agreed scope was to look at what the Global Fund has done in the past and what lessons could be learned. Co-financing and joint and blended financing are the two areas the Global Fund has used significantly and we needed to cover those extensively." That is a reasonable explanation. However, to say that co-financing and blended financing have been used 'significantly' is an exaggeration. Just look at the size of the overall Global Fund portfolio over time.

Concluding Remarks

As noted in the introduction to this article, it has proved controversial. Other Global Fund Secretariat staff that we shared this article with stated:

"The Advisory was designed to support the Global Fund Secretariat to think through how they support countries to strengthen domestic financing, leveraging the tools and comparative advantage of the Global Fund and its position in the Global Health architecture.

The Advisory was a collaborative effort of the OIG and the Secretariat, and offers important recommendations across a wide variety of thematic areas, including how the Global Fund can further detail its approach to health financing, ensure its operating model positive influences domestic financing, how it can strengthen effective implementation of the co-financing policy, improve / scale efforts on joint financing and blended finance, improve value for money, better leverage partnerships to achieve domestic financing objectives, and strengthen public financial management and the generation / effective use of HF Data. These are key thematic areas for the Global Fund; and enhancing its focus and efforts on them is critical to achieving the goals of the 2023-2028 Strategy.

While the Domestic Financing Advisory does not cover every aspect of DFH or dive deeply into all technical areas of DFH, it offers important food for thought and recommendations for the Global Fund to consider continuing working to enhance our efforts to strengthen the DFH systems and national HIV, TB, and malaria responses."

As this article has shown, the advisory is not about DFH but only about government financing for health and what the Global Fund is trying to do to influence it. Even then, the report is unclear about how blended finance influences government financing for health and fails to mention that, in general, government financing for health per capita has not been increasing.

More thought should have been given to how this report would read in the public domain. The scope

exclusions, the lack of any DFH data and discussion on the various types of DFH, and the other omissions referred to in this article render this OIG report unconvincing to external readers. Lacking these essential elements, it would have been better not to have published the report in its present form. It would have been more appropriate to have focused only on co-financing and blended finance going forward and to have excluded DFH in the title.

Readers who wish to know more about the topic of DFH and co-financing should read the accompanying articles 4 and 6 Determining, analysing and increasing domestic financing for health and The uncertainty of co-financing.

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