# The uncertainty of co-financing

## Introduction

Government co-financing is important because it enables countries to access the maximum support available from the Global Fund; at the same time it encourages countries to strengthen their own investment in health and the national responses.  Over time, steadily increasing the level of co-financing will be necessary for countries to achieve sustainable universal health coverage. But that is in the future. This article reviews the present situation.

## Background

Four years ago, article 7 in GFO Issue 348 was about co-financing being applied differently in different countries; and it called for harmonisation in implementing the Global Fund's co-financing policy.  Has that happened?

At the time, the article's author was able to access the grant performance evaluation reports for the three sample countries. Today, it is no longer possible to access grant performance evaluation reports; and the Global Fund does not publish any data relating to actual co-financing.  However, the topic remains important. As this article explains, it is difficult to understand how some countries will meet co-financing requirements; and the increased complexity of co-financing commitment requirements could delay funding request submissions in the forthcoming allocation period 2023-2025.

## Global Fund Co-financing Policy

The Global Fund's co-financing policy is set out in the Global Fund's Sustainability, Transition and Co-financing (STC) Policy.  However, it is better to focus on the Guidance Note on STC that relates to the

allocation period 2023-2025.

The Guidance Note makes clear that there are two core co-financing requirements that apply to all countries regardless of their income status:

1. They must show progressive government expenditure on health; and
2. They must show progressive absorption of key program costs.

Similarly, on the Global Fund webpage on co-financing, it states that "To access a Global Fund allocation, countries should show progressive government expenditure on health and show progressive uptake of key program costs, including those supported by the Global Fund."

That may be the intention but, as we shall see, it is unlikely to be applied.

Co-financing Incentive

Before we look at what the co-financing has achieved, we need also to note that the STC policy describes the co-financing incentive: "In order to encourage additional domestic investments, a co-financing incentive is included as part of the allocation for each country component. The 'co-financing incentive' is at least 15 percent of the Global Fund allocation (as specified in the Allocation Letter). In order to access the co-financing incentive, countries must: (1) provide commitments of additional domestic investments to the relevant disease programs and/or related Resilient and Sustainable Systems for Health (RSSH) over the implementation period of the grant arising from the allocation, as per the requirements in the STC policy; and (2) demonstrate realization of such commitments." It goes on to explain that "To access the co-financing incentive for each relevant disease component, the additional domestic investments must be:

1. More than the domestic investments made in the corresponding implementation period of the grants arising from the prior allocation period by at least: (i) 50 percent of the co-financing incentive for low-income countries; (ii) 100 percent of the co-financing incentive for middle income countries; and
2. Invested in priority areas of national strategic plans, in line with the investment guidance developed with partners (including region specific guidance, as applicable); and
3. Evidenced through allocations to specific budget lines, or other agreed assurance mechanisms."

Reporting on co-financing

As already mentioned, there is no reporting on co-financing that is available publicly. However, an advisory report on domestic financing for health issued by the Office of the Inspector General (OIG) in July 2022 includes a section on co-financing in which it states that "The GF's current co-financing policy is set forth in the Sustainability, Transition and Co-financing (STC) Policy, implemented for the first time during the 2017-2019 funding cycle." Other than the total co-financing commitments for respective allocation periods, the report does not provide any information on actual co-financing; but we can review government expenditure on health in the 2017-2019 period.

Government Spending on Health

In the Operational Policy Note on co-financing there is a footnote (218) that defines low government spending on health as being less than 8% of total government expenditure. Of the Global Fund's 2023 country Eligibility List, there are 56 countries (for which expenditure data are available) where governments spent less than 8% on health in 2019; 39 of those countries were in the lower lower-middle

income and low-income categories.

Look at Table 1, which sets out government expenditure on health in many of the countries in sub-Sahara Africa over recent years:

Table 1. Government expenditure on health as a percentage of total expenditure 2014-2019

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | Progressive? |
|---|---|---|---|---|---|---|---|
| Angola | 3.6 | 4.6 | 5.4 | 5.4 | ? | ? | ? |
| Benin | 4.0 | 3.2 | 3.7 | 4.6 | 3.0 | 3.7 | No |
| Burkina Faso | 7.8 | 7.2 | 11.0 | 10.0 | 8.8 | 9.6 | No |
| Burundi | 9.8 | 10.4 | 8.5 | ? | ? | ? | ? |
| Cameroon | 2.9 | 1.8 | 1.8 | 0.7 | 1.1 | 0.6 | No |
| Central African Rep. | 3.9 | 3.3 | 4.9 | 5.3 | 3.9 | 4.8 | No |
| Chad | 5.6 | 5.2 | 5.7 | 4.7 | 5.2 | ? | No |
| Congo | 1.9 | 2.7 | 2.9 | 3.4 | 3.5 | ? | Perhaps |
| Côte d'Ivoire | 5.1 | 4.9 | 4.9 | 5.2 | 5.1 | 5.5 | No |
| Dem. Rep. of Congo | 3.0 | 3.8 | 3.8 | 4.0 | 4.5 | 4.4 | ? |
| Eritrea | | | | | | | No data |
| Eswatini | 8.5 | 8.6 | 8.2 | 10.0 | ? | ? | ? |
| Ethiopia | 4.1 | 5.6 | 5.0 | 4.8 | ? | ? | No |
| Gabon | 6.4 | 7.0 | 9.2 | 9.7 | 9.4 | 9.6 | ? |
| Gambia | 5.8 | 5.1 | 6.6 | 4.4 | 5.1 | 4.4 | No |
| Ghana | 6.7 | 8.6 | 6.5 | 6.0 | 6.4 | 6.5 | No |
| Guinea | 3.0 | 2.0 | 4.1 | 3.5 | 3.9 | 6.1 | ? |
| Kenya | 7.5 | 7.8 | 8.0 | 6.8 | 7.3 | 8.3 | ? |
| Lesotho | 9.8 | 10.3 | 9.4 | 10.8 | 9.4 | 8.8 | No |
| Liberia | 2.5 | 3.3 | 3.9 | 4.2 | 5.3 | 4.1 | ? |
| Madagascar | 13.9 | 15.3 | 17.5 | 15.0 | 10.5 | 8.0 | No |
| Malawi | 8.6 | 9.7 | 9.7 | 8.2 | 8.7 | ? | No |
| Mali | 4.5 | 4.4 | 5.4 | 5.1 | 5.7 | ? | No |
| Mauritania | 5.2 | 5.5 | 5.8 | 6.1 | 7.0 | ? | Yes |
| Mozambique | 4.3 | 5.6 | ? | ? | ? | ? | ? |
| Niger | 5.4 | 4.6 | 5.7 | 9.7 | 8.3 | 9.4 | Perhaps |
| Nigeria | 3.3 | 5.3 | 4.9 | 4.4 | 3.9 | 3.8 | No |
| Rwanda | 8.0 | 7.9 | 8.9 | ? | ? | ? | ? |
| Senegal | 4.9 | 4.7 | 4.5 | 4.3 | ? | ? | No |
| Sierra Leone | 7.6 | 7.9 | 7.9 | 3.6 | 3.6 | 5.8 | No |
| South Africa | 14.9 | 15.2 | 15.2 | ? | ? | ? | ? |
| South Sudan | n/a | n/a | n/a | 2.1 | ? | ? | ? |
| Tanzania | 6.9 | 7.3 | 9.5 | ? | 9.4 | 9.6 | ? |
| Togo | 5.1 | 4.2 | 4.3 | 6.5 | 5.5 | 5.4 | No |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Uganda | 7.0 | 5.1 | 4.9 | 4.1 | 4.2 | 3.1 | No |
| Zambia | 7.7 | 7.4 | 7.0 | ? | ? | ? | No |
| Zimbabwe | 13.4 | 7.6 | ? | 6.4 | 8.7 | ? | No |

Source: World Bank online database

Health expenditure data for 2020 are not yet available; but, when they are, the picture will be clouded by the impact of COVID-19. In view of this, it is better to use the health expenditure data up to 2019 in the discussion on co-financing.

Table 1 shows that:

1. there is only one country, Mauritania, where the government progressively increased its expenditure on health year on year as a percentage of total expenditure;
2. expenditure reporting is becoming delayed or less transparent, with many not reporting recent data;
3. in only nine of the 35 listed countries did expenditure on health increase as a percentage of total government expenditure between 2016 (when the STC policy was established) and 2019; and
4. the majority of governments have not progressively increased the expenditure percentage on health.

From Table 1, one can only infer that, in general, the co-financing policy has not resulted in an increase government spending on health.

The problem with using the Table 1 data is that government revenues may fluctuate; and expenditure is largely determined by revenues. That can affect health expenditure, which may then be restricted but not by choice. What about the actual amounts spent by governments on health? That would provide a comparison of progression if the population remained constant, which it does not. Table 2 therefore shows the reported government expenditure per capita over the same period for the same countries as in Table 1:

Table 2: Government Expenditure per Capita on Health (US$ million)

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | Progressive? |
|---|---|---|---|---|---|---|---|
| Angola | 71.3 | 51.4 | 42.0 | 52.9 | 36.7 | 29.4 | No |
| Benin | 7.4 | 6.3 | 6.3 | 9.3 | 6.1 | 6.6 | No |
| Burkina Faso | 12.9 | 9.5 | 16.4 | 19.3 | 17.1 | 17.4 | No |
| Burundi | 7.7 | 7.4 | 5.4 | 6.0 | 6.2 | 6.9 | No |
| Cameroon | 9.8 | 5.0 | 5.2 | 2.1 | 3.2 | 1.8 | No |
| Central African Rep. | 3.0 | 1.7 | 2.4 | 3.3 | 3.4 | 3.9 | Yes |
| Chad | 12.6 | 7.5 | 5.8 | 4.7 | 5.0 | 5.2 | No |
| Congo | 35.8 | 27.4 | 24.6 | 21.0 | 17.5 | 18.3 | No |
| Côte d'Ivoire | 16.8 | 15.9 | 17.3 | 20.0 | 21.0 | 21.8 | Yes |
| Dem. Rep. of Congo | 2.7 | 3.3 | 3.0 | 1.9 | 2.8 | 3.3 | No |
| Eritrea | | | | | | | No data |
| Eswatini | 110.7 | 108.4 | 97.5 | 138.7 | 144.3 | 134.0 | No |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Ethiopia | 3.9 | 6.0 | 6.3 | 6.2 | 5.7 | 6.1 | No |
| Gabon | 146.6 | 115.6 | 140.4 | 127.2 | 128.0 | 129.7 | No |
| Gambia | 6.6 | 6.6 | 8.9 | 7.2 | 7.8 | 8.1 | No |
| Ghana | 28.3 | 28.3 | 25.6 | 22.0 | 30.3 | 30.3 | No |
| Guinea | 4.8 | 3.3 | 4.9 | 5.1 | 5.9 | 9.7 | Yes |
| Kenya | 26.9 | 28.2 | 31.0 | 30.0 | 31.7 | 38.4 | Perhaps |
| Lesotho | 60.9 | 61.5 | 51.9 | 61.1 | 58.8 | 54.1 | No |
| Liberia | 5.8 | 8.3 | 9.9 | 9.8 | 11.4 | 8.5 | No |
| Madagascar | 9.3 | 9.3 | 11.3 | 11.6 | 7.9 | 6.4 | No |
| Malawi | 8.2 | 10.2 | 8.6 | 8.7 | 9.1 | 9.9 | Perhaps |
| Mali | 7.6 | 6.9 | 9.4 | 9.8 | 10.3 | 11.5 | Yes |
| Mauritania | 21.0 | 21.6 | 18.4 | 19.6 | 22.5 | 21.7 | No |
| Mozambique | 11.7 | 10.7 | 7.0 | 7.7 | 9.1 | 8.4 | No |
| Niger | 7.2 | 5.4 | 5.5 | 9.8 | 10.1 | 11.2 | Yes |
| Nigeria | 14.4 | 16.1 | 10.3 | 10.5 | 10.7 | 11.4 | No |
| Rwanda | 16.3 | 15.8 | 16.6 | 17.2 | 18.4 | 20.5 | Yes |
| Senegal | 15.1 | 13.1 | 13.6 | 13.0 | 14.0 | 14.8 | No |
| Sierra Leone | 9.6 | 9.7 | 9.7 | 4.2 | 4.1 | 6.5 | No |
| South Africa | 305.4 | 287.5 | 263.3 | 305.2 | 323.4 | 321.2 | No |
| South Sudan | n/a | n/a | n/a | 2.2 | 2.9 | 3.7 | Yes |
| Tanzania | 12.0 | 11.6 | 15.1 | 15.4 | 15.8 | 16.5 | Yes |
| Togo | 8.9 | 7.3 | 7.9 | 8.7 | 9.2 | 7.7 | No |
| Uganda | 9.0 | 6.0 | 6.0 | 4.9 | 5.4 | 4.9 | No |
| Zambia | 33.4 | 28.0 | 22.0 | 27.1 | 29.8 | 27.8 | No |
| Zimbabwe | 39.2 | 22.4 | 26.2 | 27.8 | 45.3 | 18.2 | No |

Source: World Bank online database

Table 2 provides a very different picture to Table 1; and the trends are clearer:

1. In half the countries, government expenditure per capita on health declined between 2014 and 2019; so the STC Policy clearly did not work; and
2. Of the 34 countries listed and for which health expenditure data are available, 26 countries do not show a progressive trend of government expenditure on health.

Implications for grant approvals

That raises a stark question concerning the 2023-2025 allocations: How can countries access their allocation if they have not met the core requirement of progressive government expenditure on health? The Global Fund is not going to refuse a host of grant allocations on the basis of the non-fulfilment of co-financing commitments or non-compliance. So, the Policy will have to be overlooked.

Required government co-financing commitments

In its determination to encourage increased co-financing, the Global Fund has issued the template of a Commitment Letter that it expects the Ministry of Finance to complete, setting out the government co-financing commitment to Global Fund supported national responses. The template for the letter has very detailed information requirements on co-financing in the 2023-2025 allocation period including:

- Overall health spending commitments, which must grow at a stated rate.
- HIV, TB, malaria and RSSH commitments (which must be set out in a table).
- Specific programmatic commitments (also to be set out in a table).

The template letter also requires the government to commit to providing the Global Fund with verifiable and reliable documentation and evidence on the expenditure of domestic funds or, where spending figures are not yet available, the latest budgeted amounts, for past spending and for future planned spending.

Allocation letters to countries refer to the Commitment Letter and also note that: “Failure to realize previous co-financing commitments from the 2020-2022 allocation may result in the Global Fund reducing funds from existing grants and/or reducing the 2023-2025 allocation. (The country) should submit evidence of the realization of previous commitments, including budget execution evidence, when submitting its funding request.”

While the Commitment Letter may represent the ideal approach for formulating co-financing commitments and setting out a reporting format to monitor compliance, its preparation may well present challenges. It requires details that are not available within a Ministry of Finance alone but which will have to be obtained from various sources. Obtaining the necessary information from several government ministries and disease programs will prove difficult and time consuming. It also assumes that the necessary information systems are in place and functioning, which is not the case in many countries. The process of preparing this letter is going to prove burdensome for all applicants, some of whom may well require technical assistance for this.

We can therefore expect that the commitment letter may: (a) have to be simplified and commitments lowered to what is feasible (see below); or (b) result in being concocted to appear to meet the Global Fund’s requirements (using different approaches as shown in the previous GFO article) and reporting only budget figures, not actuals.

In some countries it may be possible to use the supreme audit institution (SAI) to provide assurance as to the co-financing commitment in approved funding requests by appointing the SAI to monitor and report on actual government co-financing every year to both parliamentarians and the Country Coordinating Mechanism. See our article here .

The harsh realities

The period 2020-2022 has shown deteriorating global economic conditions with increasing inflation, poverty, food shortages and fears of debt distress in poor countries. As a recent World Bank report states: “Public debt will further reduce spending capacities. Interest per capita payments are projected to rise on average in all country income groups through 2027, thereby increasing liabilities that are set aside before the remaining funds can be allocated to other priorities, including health.” It goes on to concludes that “Universal health coverage goals and future pandemic preparedness are now at risk.”

From the discussion in the same report, we can see that 30 countries in the Global Fund’s eligibility list

are projected to see a drop in their government spending capacity through 2027, with per capita government expenditure in 2027 remaining below pre-COVID-19 levels. The countries are: LICs: Liberia, Mozambique, South Sudan, Sudan; LMICs: Algeria, Angola, Belize, Comoros, Republic of Congo, Eswatini, Kiribati, Lesotho, Federated States of Micronesia, Papua New Guinea, Solomon Islands, Timor-Leste, Vanuatu, Zambia; UMICs: Belarus, Botswana, Brazil, Costa Rica, Equatorial-Guinea, Fiji, Iraq, Jamaica, Malaysia, Namibia, Surinam, Turkmenistan.

A second group of 47 eligible countries are expected to have positive, but relatively slow growth in government expenditure per capita over the period (i.e. the average annual rate of growth from 2019 to 2027 is projected to be below the average growth rate of countries in its income group in the ten years before COVID-19). The countries are: LICs: Burkina Faso, Burundi, Central African Republic, Chad, Eritrea, the Gambia, Malawi, Mali, Rwanda, Sierra Leone; LMICs: Bolivia, Cap Verde, Cameroon, Djibouti, Egypt, Haiti, Honduras, Kenya, Kyrgyzstan, Lao People's Democratic Republic, Mauritania, Morocco, Myanmar, Nicaragua, Nigeria, Pakistan, Samoa, Sao Tome and Principe, Sri Lanka, Tajikistan; UMICs: Azerbaijan, Colombia, Dominica, Gabon, Guatemala, Jordan, Kazakhstan, Maldives, Marshall Islands, Mauritius, Montenegro, Paraguay, Peru, Russian Federation, South Africa, St. Lucia, St. Vincent and the Grenadines.

With that background – and, incidentally, the report notes that the projections may be optimistic – it is very unlikely, even with the best will in the world, that governments are going to be able to progressively increase expenditure on health. Some may well be forced to reduce health expenditure.

The allocation letters for the 2023-2025 period refer to this. The Global Fund states that it recognizes the macroeconomic and fiscal challenges facing many countries that could limit the fiscal space for domestic financial investments in health during the allocation period and has taken these into account in proposing co-financing requirements.

The need for pragmatism

Given the harsh realities, it may still be necessary to be more pragmatic. First, the Global Fund should consider dropping the general co-financing commitment relating to government expenditure on health and focus solely on the government co-financing of the disease programs supported by Global Fund grants.

Second – and in line with the Global Fund's new Strategy – place more emphasis on maximising the efficient use of available funds, including: (a) greater clarity as to priorities (in terms of capital investments, commodities, services and locations); and (b) the timely sourcing and use of funds according to approved plans.

Third, the Secretariat should develop a definition of the cost elements that are considered applicable for assessing co-financing. Then this would facilitate reporting on actual government program co-financing in a more standard and comparable format.

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