USAID FROM THE AMERICAN PEOPLE

PROPEL Health

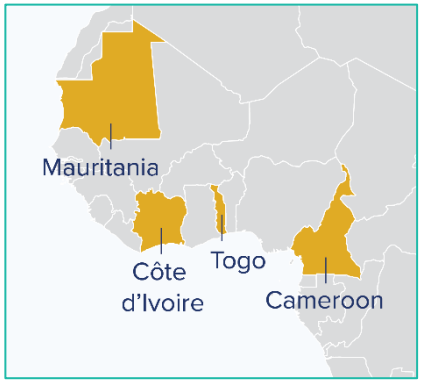
PROPEL Health: Policy Brief

June 2024

Domestic Resource Mobilization for Primary Healthcare in West Africa

By Robert Kolesar, Modibo Maiga, Eduardo Gonzalez-Pier, and Simplice Kamdem

Cameroon, Côte d'Ivoire, Mauritania, and Togo face many health financing and domestic resource mobilization (DRM) challenges when it comes to primary healthcare. Country actors commonly focus on the need for increased budget allocation (i.e., reprioritization of health within the national budget). However, there are other potential "lower hanging fruit" opportunities, such as improved health budget execution and technical efficiency, that can increase resource optimization. Moreover, such options are primarily under the management control of the Ministry of Health and can strengthen their position to argue for increased budget allocation more effectively.



Within this context, the U.S. Agency for International Development (USAID)-funded PROPEL Health project developed a Health Financing Gap and Deductive Domestic Resource Mobilization Modeling Tool to help country stakeholders quickly quantify the financing gaps and resource mobilization potential to reach their respective Abuja targets by 2028. Six key domestic resource mobilization and optimization approaches were modeled: budget execution, efficiency, health taxes, economic growth, social health insurance, and reprioritization. This exercise aims to catalyze dialogue for the strategic development or revision of DRM agendas and action plans and reinvigorate their implementation.

This brief presents an overview of the context, highlights from stakeholder engagement, health expenditure benchmarking methods and results, DRM modeling methods and results, and conclusions to inform priority-setting and action in Cameroon, Côte d'Ivoire, Mauritania, and Togo.

Context

The West Africa region's growing and aging population will increase healthcare demand, exerting greater pressure on already strained health systems. By 2030, the population of the Economic Community of West African States (ECOWAS)[1] is projected to grow to 600 million. Additionally, rapid youth population growth will continue for the foreseeable future. This presents an opportunity to harness the economic growth that comes as a result of the population's age structure (known as the demographic dividend) as well as a threat to healthcare if adequate financing and appropriate policies

[1] The 15 members of ECOWAS are Benin, Burkina Faso, Cabo Verde, Cote d'Ivoire, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, and Togo.

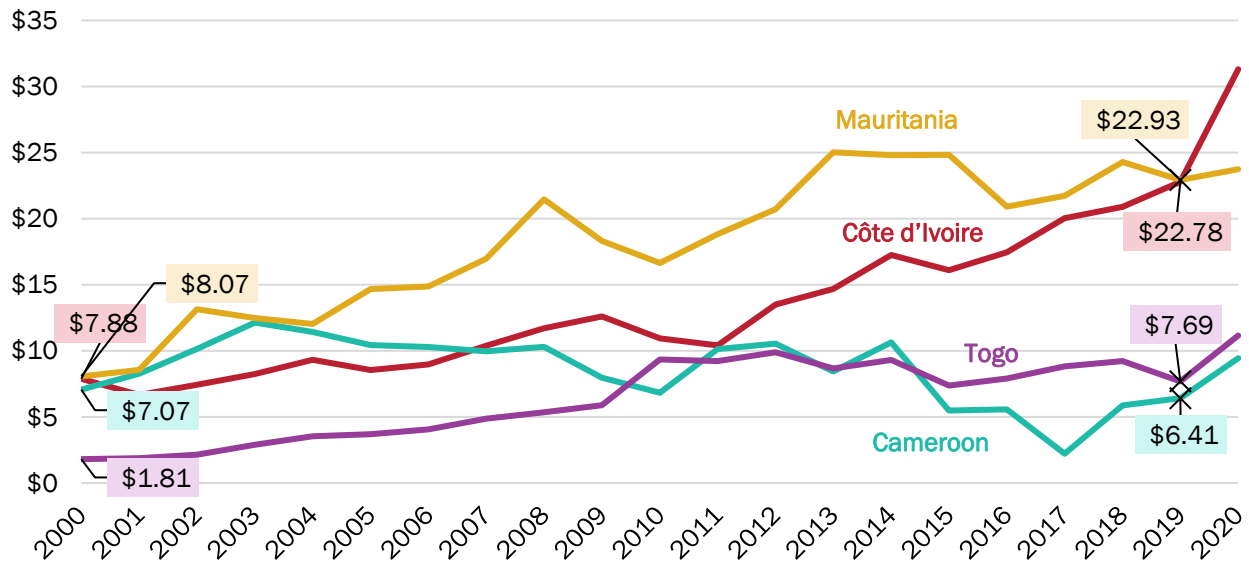
are not implemented. Despite the existence of national gender policies and action plans in almost every country in West Africa, serious gender equality gaps persist, with women experiencing inferior outcomes in education, income, and health. Female genital mutilation or cutting, intimate partner violence, and child marriage are prevalent. Most women marry in their teens and the median age at first sexual encounter is also in the teens, while only 3.6 percent of men in the region are married by age 18.

West African countries face various challenges to improving health, economic, and gender outcomes, including a limited capacity to optimize resources within the health sector; political instability and terrorism threats that disrupt healthcare services in many countries; low domestic funding and high donor dependence and out-of-pocket spending for health; inefficient coordination across sectors; weak governance and accountability for health systems; and inconsistent implementation of legal and health political frameworks, policies, and resolutions. However, there is also unprecedented momentum to strengthen the public health response, which can be leveraged to enhance progress toward better overall health in the region. In turn, this will contribute to other human capital outcomes to drive economic growth and reduce poverty rates.

Togo is a low-income economy with a gross domestic product (GDP) per capita of $2,602 (international dollars). Cameroon, Côte d'Ivoire, and Mauritania are lower-middle-income economies with a GDP per capita of $3,398, $6,540, and $6,296, respectively for 2022. Cameroon and Togo have high out-of-pocket expenditures for health, 68.3 percent and 61.5 percent, respectively, while Mauritania and Côte d'Ivoire have notably lower out-of-pocket health expenditures, 46.6 percent and 32.0 percent, respectively (World Bank, 2024).

Figure 1 shows domestic government health expenditure in real U.S. dollars from 2000–2020. We focus on 2019 data as increased expenditures in 2020 are attributed to COVID-19 (Kurowski et al., 2023). Côte d'Ivoire and Mauritania have increased real domestic government health expenditure over the past two decades (2000–2019) from $7.88 to $22.78 and $8.07 to $22.93 per capita, respectively. Togo's domestic government health expenditure increased five-fold from $1.81 to $7.69 per capita, and Cameroon's spending decreased from $7.07 to $6.41 (World Bank, 2024).

Figure 1. Domestic Government Health Expenditure in Real USD per Capita from 2000–2020



Data Source: World Bank, 2024

Stakeholder Engagement

PROPEL Health is engaging national-level universal health coverage and health financing working groups alongside government and civil society actors in Cameroon, Côte d'Ivoire, Mauritania, and Togo to identify priority health financing needs and strategic opportunities, and to generate evidence to mobilize and optimize health resources. Key stakeholder priorities were identified during the 2023 West and Central Africa Health Financing Forum in Abidjan, co-creation workshops in each of the focus countries, and numerous virtual and in-country follow-up meetings. Stakeholders include representatives from the ministries of health and finance; USAID; multilateral donors including UNICEF, the United Nations Population Fund (UNFPA), and the World Health Organization (WHO); the World Bank Global Financing Facility; and many civil society and international organizations.

The 2023 West and Central Africa Health Financing Forum identified four priority areas: (1) enhancing the efficiency, equity, and effectiveness of primary healthcare spending; (2) ensuring regular monitoring and measurement of primary healthcare services and spending; (3) increasing investment in primary healthcare services; and (4) establishing and maintaining an enabling environment for increased investment in health with a focus on primary healthcare services.

Priorities identified through country level co-creation events and follow-up meetings included: (1) identifying resource optimization opportunities; (2) strengthening monitoring and evaluation capacity and mechanisms, including data quality and interoperable systems; (3) strengthening government resource mobilization including transparency and accountability; (4) engaging existing coordination platforms to develop or update strategic documents including financing strategies and domestic resource mobilization plans; and (5) generating evidence for free postpartum family planning for two years to support birth spacing.

Benchmarking Government Health Expenditure

Methods

Four international benchmarks were used to assess the health financing gap in Cameroon, Côte d'Ivoire, Mauritania, and Togo (Table 1). World Bank data was used to calculate where each country falls in relation to each benchmark.

The per capita target of US$86 for low-income countries is based on an initial estimate of the required level of public health expenditure prepared by the High Level Taskforce on Innovative International Financing for Health Systems (McCoy, 2009). Subsequently, this figure has been independently reviewed and validated (Mcintyre et al., 2017). This is the only benchmark that represents adequate resources based on population healthcare need. However, it is not adjusted for inflation.

The 5 percent of GDP indicator was first proposed in the WHO's *World Health Report 2010*. Subsequent analysis has reaffirmed that governments should aim to spend at

Table 1. Health Financing Benchmarks

Benchmark	Supporting Explanation
$86 per capita	Estimate of required level of public health expenditure to meet population healthcare need
5% of GDP	Percentage governments should progressively move toward for spending on health
Abuja Target 15% of government budget	Pledge to allocate at least 15% of the annual budget to the health sector (Abuja Declaration)
Actual 8.3% of government budget	Average share of government health expenditure among middle-income economies

least 5 percent of GDP on health and progressively move toward this target (Mcintyre et al., 2017; Røttingen et al., 2014). Broadly speaking, this benchmark can be used as a measure of a government's prioritization of health. However, there are several challenges. GDP is not linked to healthcare need nor is it under the direct sphere of influence of health budget policymakers in government. In addition, it is susceptible to external shocks and possible austerity measures when government financing for healthcare and social services should normally increase. It is also dependent on effective tax policy and collection systems.

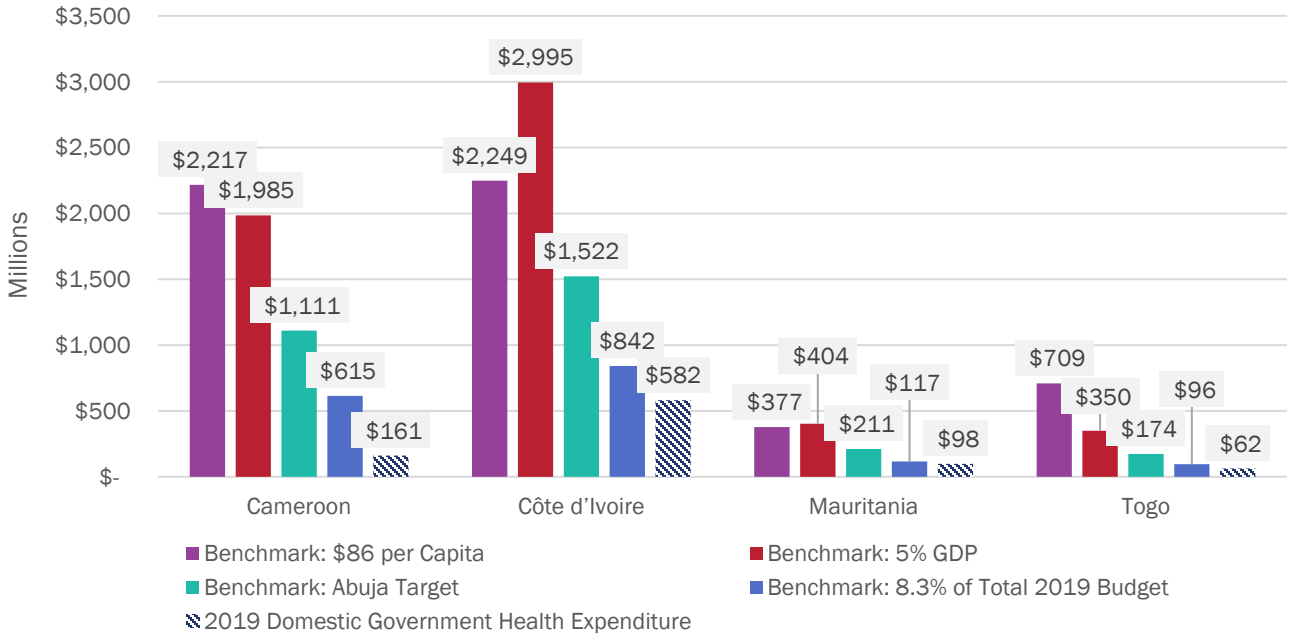
With the 2001 Abuja Declaration, governments committed to the efficient and effective use of resources and the progressive realization of allocating 15 percent of their national budgets to the health sector (African Union, 2001). The 15 percent Abuja target is the most cited health financing benchmark, particularly in sub-Saharan Africa. It represents the government's prioritization of health relative to the total budget, which is or should be within the sphere of influence of health budget policy makers. As a relative measure of progress toward the Abuja Declaration target, a country's government health expenditure can also be compared with the average share of general government health expenditure among low- and middle-income economies, which is 6.8 percent and 8.3 percent, respectively (Xu et al., 2018).

Results

All four countries have important health financing gaps. Figure 2 illustrates 2019 domestic health expenditure compared to each of the four benchmarks. Using 2019 population figures, the US$86 per capita target equates to about US$2.22 billion for Cameroon, which is nearly 14 times the current 2019 government health expenditure. To attain the US$86 per capita target, Côte d'Ivoire would require a nearly fourfold budget increase. Likewise, Mauritania and Togo would need to increase government health expenditure by a factor of 3.8 and 11.4, respectively.

The Abuja Declaration target is comparatively more attainable. To have achieved that target in 2019, Cameroon's government health expenditure would have needed to have increased nearly sevenfold, Côte d'Ivoire's and Togo's nearly threefold, and Mauritania's more than twice.

Figure 2. Estimated Health Financing Gaps in Current USD (2019)



Domestic Resource Mobilization Modeling

Methods

There are four key dimensions to domestic fiscal space: (1) macroeconomic conditions, (2) efficiency, (3) sector-specific revenue sources, and (4) reprioritization (Table 2). Applied deductive modeling can illustrate the relative resource potential of each dimension. For example, under the first dimension, as national budgets are typically linked directly to macroeconomic growth, we can use International Monetary Fund data to project health budget changes through 2028.

In relation to efficiency (the second dimension), the most recent public expenditure and financial accountability assessments allow estimations of health budget efficiency (i.e., budget execution) to calculate the unexpended health budget. Likewise, technical efficiency is estimated using bias-corrected data envelopment analysis. The input variable is total health expenditure per capita and the output variable is WHO's universal health coverage service coverage index. The latter is a summary measure that captures both service coverage and financial protection.

Table 2. Fiscal Space for Health (Domestic Resources Opportunities)

Dimension	Supporting Explanation
Macroeconomic conditions	Projecting future domestic health budget allocations from a country's overall macroeconomic growth
Efficiency	Improving the efficiency of existing and/or new sector outlays
Sector-specific domestic revenue sources	Examining sector-specific means to raise additional revenue (earmarked income, consumption and health taxes, social health insurance, etc.)
Reprioritization	Focusing on the extent to which health may be reprioritized within the government budget

Sector-specific domestic revenue (third dimension) includes health taxes, such as those collected from tobacco, alcohol, and sugar-sweetened beverages, as well as social health insurance contributions.[2] Domestic government health expenditure (2019) base levels are assumed to include health tax earmarks. Health taxes are estimated to raise about 0.6 percent of GDP for Cameroon, Côte d'Ivoire, and Togo, or about double the current health tax revenue as these countries are well below the WHO recommended targets. For Mauritania, a more moderate but still significant 0.15 percent increase is estimated as the sale of alcohol is not legal. Per capita social health insurance contributions can be estimated for each country based on the proportion of the formal sector labor force, total projected 2028 labor force population, social health insurance contribution rate, and mean annual earnings divided by the total 2028 population projection.

Under the fourth dimension, reprioritization is the balance or gap of per capita financing necessary to reach each country's respective Abuja Declaration target.

Results

Figures 3 through 6 summarize the results from the deductive DRM modeling for each country to reach its Abuja Declaration target (the most attainable and commonly cited target) by 2028. The first segment in the figures represents the 2019 base USD per capita domestic government health expenditure. For example, Cameroon's current (2019) domestic government health expenditure is US$6.26 per capita, which equates to 11 percent of the total needed to reach the 2028 target (Figure

[2] Means-tested user fees and community-based health insurance contributions are not included as there are no reliable, externally valid metrics to use in the model.

3). By contrast, Mauritania's current (2019) domestic government health expenditure of US$22.40 per capita, represents 38 percent of the total amount required (Figure 5).

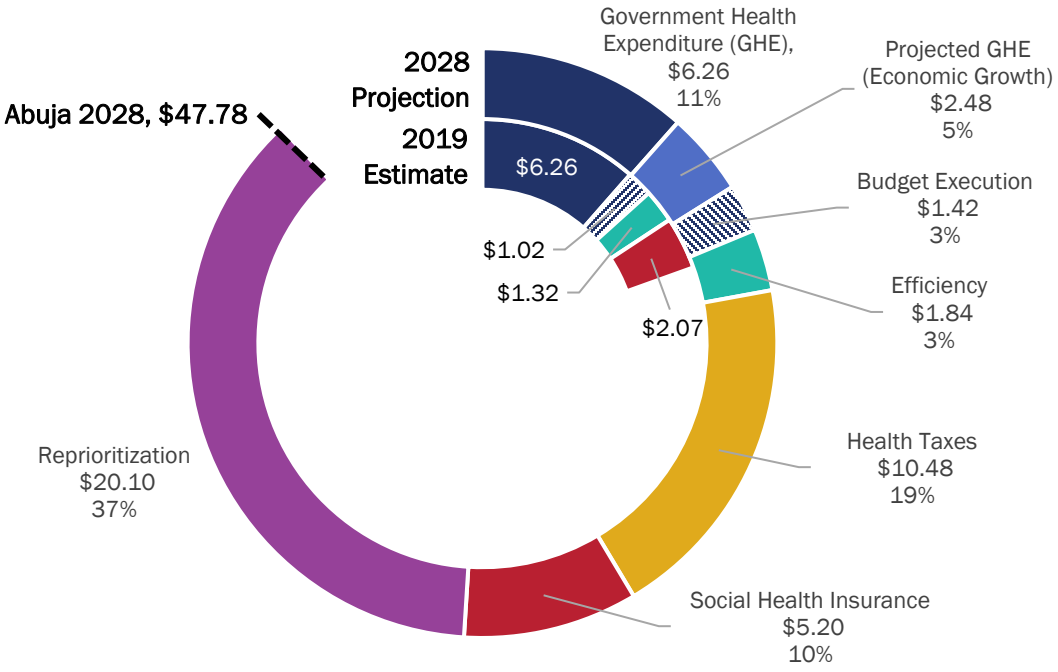
The second segment represents the projected increase in government health expenditure (GHE), assuming projected economic growth will increase domestic health budgets proportionally. This presents significant potential health budget growth by 2028, increasing Cameroon's health budget by 39.7 percent; Côte d'Ivoire by 67.2 percent; Mauritania by 38.6 percent; and Togo by 57.0 percent (not shown). If addressed, unspent health budget (labeled as budget execution) represents 3 percent in Cameroon, 6 percent in Côte d'Ivoire, 3 percent in Mauritania, and 10 percent in Togo of the total estimated resources needed by 2028 to reach Abuja targets. By 2028, technical efficiency gains represent a potential budget equivalent of 3 percent in Cameroon, 10 percent in Côte d'Ivoire, 13 percent in Mauritania, and 7 percent in Togo.

Health taxes are another important potential revenue source,[3] estimated between 6 percent (Mauritania) and 21 percent (Côte d'Ivoire). The potential for social health insurance is highly variable, ranging from 1 percent in Côte d'Ivoire, where there is low formal employment and low contribution rates, to 18 percent in Togo.

Finally, reprioritization refers to increasing the proportion of the total government budget committed to health needed to attain each country's Abuja target in 2028. This metric is highly variable as well, with Cameroon at 37 percent and Côte d'Ivoire at 15 percent. Mauritania and Togo could reach their Abuja targets without reprioritization if other resource optimization strategies are fully realized.

Notably, each country's per capita domestic expenditure target is different as it is relative to the total projected, nominal domestic budget and total population in 2028: Cameroon US$47.78, Côte d'Ivoire US$77.98, Mauritania US$52.76, and Togo US$26.97.

Figure 3. Cameroon Modeled Domestic Sources Estimates to Achieve Abuja Target by 2028 in Current US$ Expenditure per Capita



[3] New or increased health tax revenue is assumed to be earmarked for health however it is context specific.

Figure 4. Côte d'Ivoire Modeled Domestic Sources Estimates to Achieve Abuja Target by 2028 in Current US$ Expenditure per Capita

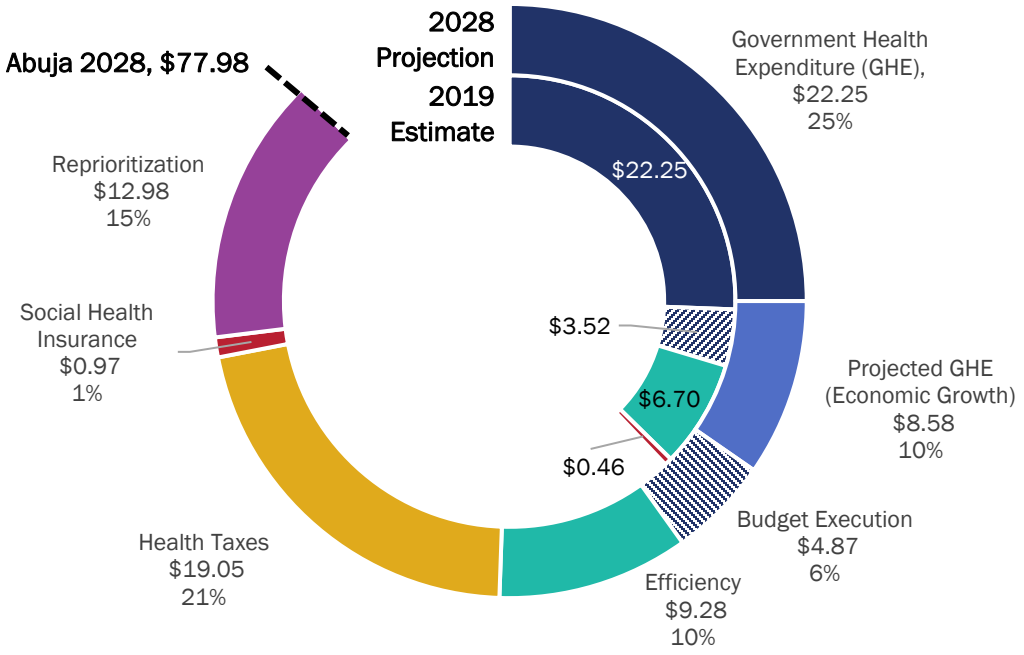


Figure 5. Mauritania Modeled Domestic Sources Estimates to Achieve Abuja Target by 2028 in Current US$ Expenditure per Capita

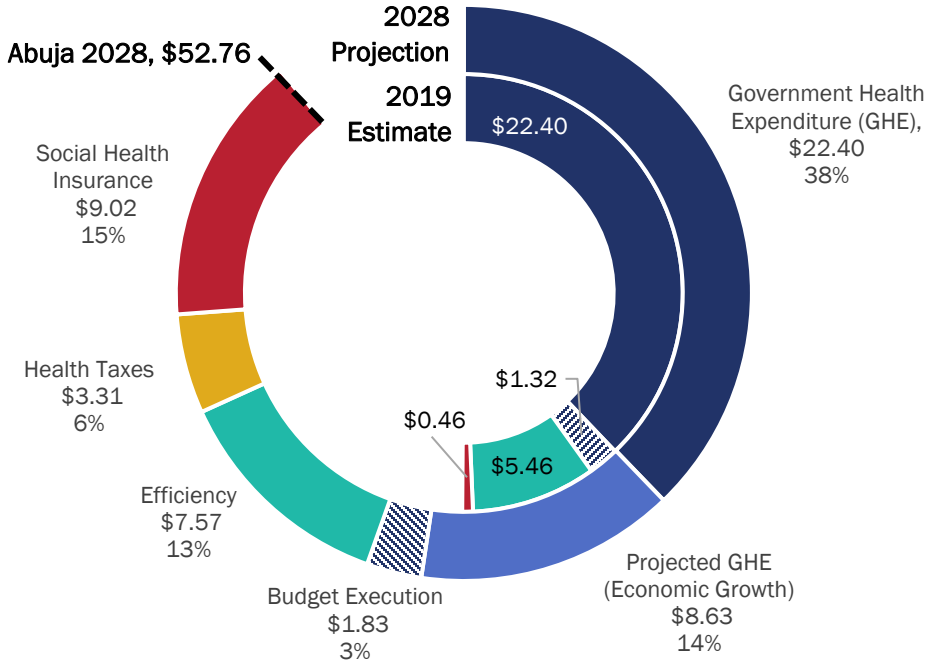
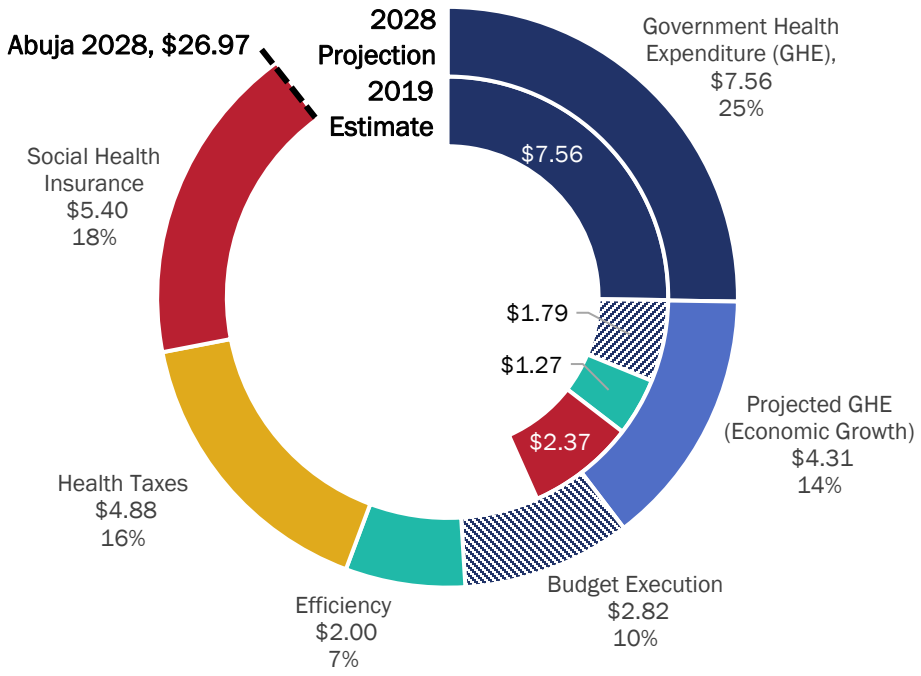


Figure 6. Togo Modeled Domestic Sources Estimates to Achieve Abuja Target by 2028 in Current US$ Expenditure per Capita



Conclusions

PROPEL Health developed the Health Financing Gap and Deductive DRM Tool to estimate financing gaps and the potential fiscal space opportunities to achieve Abuja Declaration targets by 2028. The tool was applied to inform DRM strategic priority-setting in Cameroon, Côte d'Ivoire, Mauritania, and Togo.

Most health expenditure is out-of-pocket in all four countries, posing challenges for financial risk protection. With the exception of Cameroon, real government health expenditure has increased over the past two decades; however, serious health financing gaps remain. Government health financing is far from all benchmark targets and more work is needed to mobilize and optimize domestic resources for health. Budget execution and efficiency are the most important short-term opportunities to increase fiscal space, particularly as they are presumably under the government's management control. Funds flow analysis can support decisionmakers to pinpoint bottlenecks, preventive measures, and mitigating actions. Likewise, applied efficiency analysis can empower managers to identify context-specific solutions while increasing accountability. Perhaps more importantly, addressing budget and technical efficiency issues can position the Ministry of Health to advocate for increased budget allocation more credibly and effectively.

Health taxes and insurance resources are important sources of health sector revenue in many countries. These sources can be enhanced through policy adjustments. For example, social health insurance contribution caps can be increased or even removed to increase revenue and equity. However, these mechanisms also have political dimensions, are dependent on effective collection mechanisms, and can be limited by underlying labor dynamics such as the proportion of the formal workforce. Therefore, these can be considered longer-term solutions toward reaching Abuja targets.

There is evidence showing that economic growth is the most important source of increased health sector revenue for low- and middle-income countries (Soucat et al., 2023). This modeling estimates it to increase focus country health budgets by between 38–68 percent. However, even these large increases are insufficient to reach the Abuja targets. Moreover, reprioritization could multiply the effects of increased revenue resulting from economic growth.

Each country has a different context and path to reaching its Abuja targets. However, a strategic focus on budget execution and efficiency is the most practical priority area. Concurrently, countries can advance longer-term efforts to strengthen health taxes, insurance, and reprioritization. Overall, an increased country focus on the "best buys," most notably primary healthcare, would yield a greater health benefit and value for money.

References

African Union. 2001. *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases.* Abuja: African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, African Union. https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf.

Kurowski, C., A. Kumar, M. Schmidt, and D.V. Silfverberg. 2023. "Health Financing in a Time of Global Shocks: Strong Advance, Early Retreat." *World Bank Blogs,* June 7, 2023. https://blogs.worldbank.org/en/health/health-financing-time-global-shocks-strong-advance-early-retreat.

McCoy, D. 2009. "The High Level Taskforce on Innovative International Financing for Health Systems." *Health Policy and Planning* 24(5): 321–323. https://doi.org/10.1093/heapol/czp033.

Mcintyre, D., F. Meheus, and J. Røttingen. 2017. "What Level of Domestic Government Health Expenditure Should We Aspire to for Universal Health Coverage?" *Health Economics, Policy and Law* 12(2): 125–37. https://doi.org/10.1017/S1744133116000414.

Røttingen, J., T. Ottersen, A. Ablo, D. Arhin-Tenkorang, C. Benn, et al. 2014. *Shared Responsibilities for Health: A Coherent Global Framework for Health Financing.* London: The Royal Institute of International Affairs, Chatham House, Centre on Global Health Security Working Group on Health Financing. https://www.chathamhouse.org/sites/default/files/field/field_document/20140521HealthFinancing.pdf.

Soucat, A., A. Tandon, and E. Gonzales Pier. 2023. "From Universal Health Coverage Services Packages to Budget Appropriation: The Long Journey to Implementation." *BMJ Global Health* 8: e010755. https://doi.org/10.1136/bmjgh-2022-010755.

World Bank. 2024. "World Bank Open Data." https://data.worldbank.org/.

World Health Organization (WHO). 2010. *The World Health Report 2010: Health Financing: The Path to Universal Coverage.* Geneva: WHO. https://iris.who.int/bitstream/handle/10665/44371/9789241564021_eng.pdf?sequence=1.

Xu, K., A. Soucat, J. Kutzin, C. Brindley, N. Vande Maele, et al. 2018. *Public Spending on Health: A Closer Look at Global Trends.* Geneva: World Health Organization. https://iris.who.int/bitstream/handle/10665/276728/WHO-HIS-HGF-HF-WorkingPaper-18.3-eng.pdf.

Promoting Results and Outcomes through Policy and Economic Levers (PROPEL) Health is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. 7200AA22CA00023, beginning September 23, 2022. PROPEL Health is implemented by Palladium in collaboration with African Economic Research Consortium, Avenir Health, Population Reference Bureau, RTI International, Samasha Medical Foundation, and the White Ribbon Alliance.

Learn more at: propelhealth.thepalladiumgroup.com

Palladium
MAKE IT POSSIBLE