

RESOURCE MOBILIZATION

TOPICS

The Challenge of Funding Your Organization's Mission

Alternative Sources of Resources

Practical Ways to Plan Resource Mobilization

In an era of changing levels and forms of financial support, this section targets ways for governing bodies to establish strategies and structures for the continuous procurement of local, national, and international political and financial support for the work of their health services organizations.

THE CHALLENGE

The Ministry of Health has just enacted regulations that will enable your public hospital to participate in performance-based financing (PBF) and earn donations for capital improvements of your facilities and equipment. Who would you engage and how would you engage them in planning a campaign for earning and wisely using new revenues?

THE CHALLENGE OF FUNDING YOUR ORGANIZATION'S MISSION

Health sector leaders remain concerned that the burden of communicable and noncommunicable disease in low-income countries is measured not just in disturbing numbers of lives lost, but in crippling patient costs that are inequitably shared between those who live in urban areas and those who live in rural areas, and between people who have resources and the poor. See the example in Box 20.1. The

agendas of governing bodies, at all levels of these countries, must address this funding problem.

BOX 20.1 The cost of treating one case of tuberculosis

Five presentations made at the 44th World Conference on Lung Health of the International Union against Tuberculosis and Lung Disease, held in Paris in 2013, found that diagnosis and treatment of tuberculosis (TB) represent a catastrophic health expenditure for many patients, in countries as diverse as Bangladesh, Nigeria, and Peru—even when treatment is supposed to be free. For example, a review of eight studies from 11 countries found that “total mean expenditure for TB care was equivalent to 16% of annual household income.”

Source: I. Alabu, et al. “Economic Burden of Tuberculosis at Household Level: Highlight [sic] of the Research and Policy Gaps,” *Abstract Book*, 44th World Conference on Lung Health of the International Union against Tuberculosis and Lung Disease, p. S46 (Nov. 2, 2013). Available at: http://www.theunion.org/what-we-do/journals/ijtld/body/ABSTRACT_BOOK_2013_Web.pdf

How can we do more with less? Our costs are exploding, and our sources of funding are at best flat.

How can we make governing decisions that allow us to simultaneously expand access to good services, recruit staff, purchase essential medicines, and pay for basic health facilities and electricity when our budgets are squeezed and user fees cannot be collected?

Even if the government funds social health insurance, how can we afford to prepare for the costs and complications of billing and collecting these payments?

Managing this health financing challenge is made more difficult because few of the members of our governing bodies and management teams have the knowledge and expertise needed to develop and oversee the policies to find, secure, and manage the funding levels we expect to need in the coming years.

ALTERNATIVE SOURCES OF RESOURCES

The top priority for governing body education needs to be the twin challenges of: (1) being able to forecast the amounts and types of resources we need to secure each month and each year for the coming era of change; and (2) identifying potential sources of funding that can meet these spending requirements under terms that are manageable. In both arenas, however, governing body leaders must be ready to advocate for national policy changes from new collaborations between the national ministries of health and finance. Then, leaders must advocate for such funds to flow equitably to the provincial, district, and community levels.

Use of Funds

Compared to the resources needed, governing bodies find it comparatively easier to define the types of expenditures needed for their type of health services organization. Whether a facility is an urban hospital, a storefront drug re-seller, a family planning clinic, or a rural health post, 60%-70% of its budget is usually used to pay wages and some modest benefits for health workers, including basic housing and food. Essential medicines and electricity follow close behind.

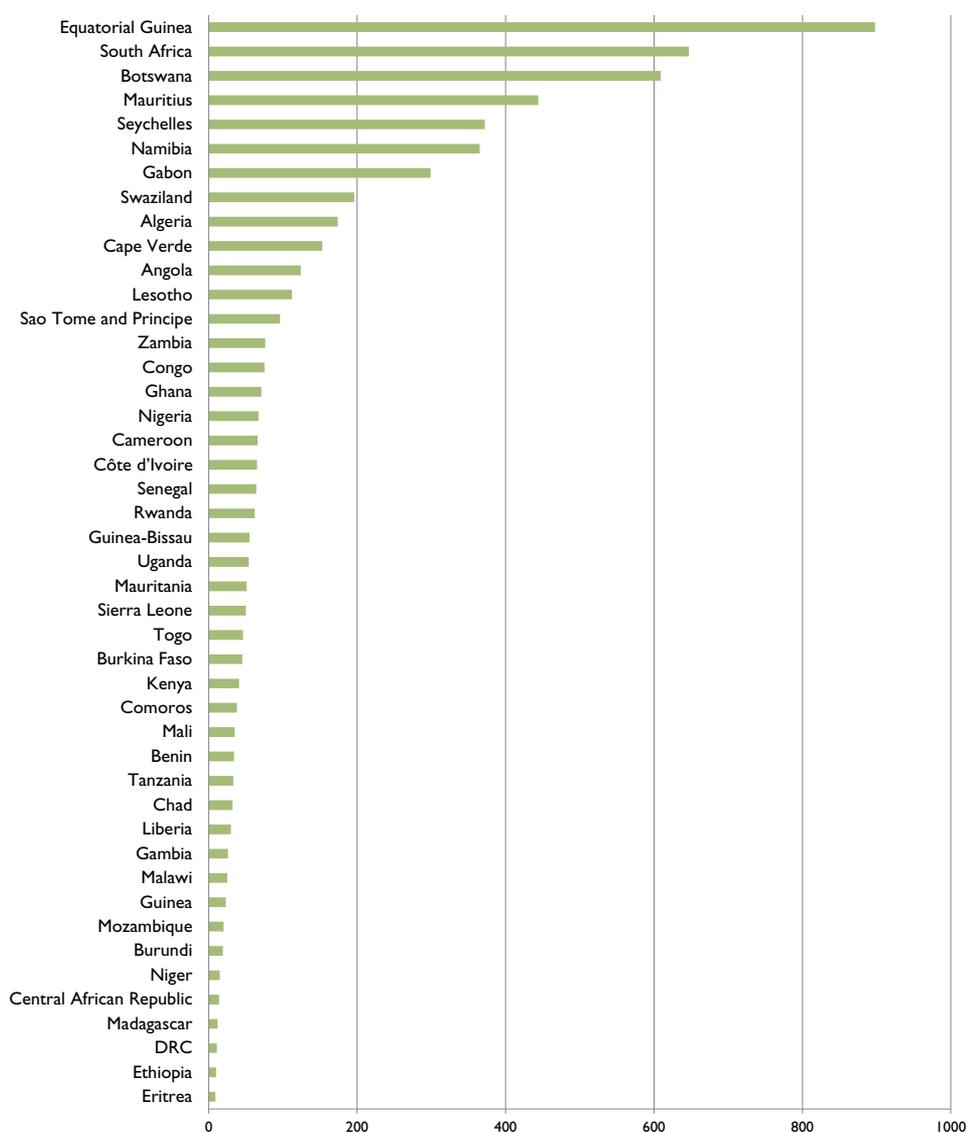
Governing bodies should have briefing sessions at least twice per year from their managers about the amounts, trends, and patterns of budget spending for their type of health program, facility, or system. Figure 20.1 on the next page shows the dramatic differences in health spending per person in African countries. Governing body leaders should advocate for additional spending for their programs and ask for explanations for gaps in their levels compared to other comparable districts or provinces.

Building Africa's health leadership capacity: Tackling the root causes of weak health systems

The main reason for Africa's weak healthcare systems is neither a shortage of policies, nor road maps, nor even funding. Lack of leadership capacity, reflected in corruption and flawed policy implementation, must be addressed, argues Dr. Margaret Mungherera, immediate past president of the World Medical Association.

Cited from "The Future of Healthcare in Africa: Progress, Challenges and Opportunities," *The Economist Intelligence Unit*, 2014, p. 10.

FIGURE 20.1 Total health expenditure per capita in the African region in US\$ (2010). Examining larger trends can help members of governing bodies compare their institution against the broader field and advocate for changes accordingly.



Source: World Health Organization (WHO), Regional Office for Africa, *State of Health Financing in the African Region* (Brazzaville: WHO Regional Office for Africa, 2013). Available at: <http://www.afro.who.int/en/clusters-a-programmes/hss/health-financing-a-social-protection/hfs-publications.html>

Sources of Funding

Health is increasingly recognized as a key aspect of human and economic development in Africa, and countries are increasing investment in actions and reforms to improve health outcomes and accelerate progress toward meeting the health Millennium Development Goals and Sustainable Development Goals.

Low-income countries will increasingly be expected to become more self-sufficient in meeting their health sector funding needs. Economic growth in the broader society is, of course, a prerequisite for this to happen.¹ In Africa, the more than 1 million community leaders serving on governing bodies must lend their voices to this call for investment in their health systems.

The political will of national leaders to put health in the forefront of development has been reiterated at the continental level through actions such as the Abuja Declaration of 2001 on increasing government funding for health, the Addis-Ababa Declaration of 2006 on community health in the African Region, and the 2008 Ouagadougou Declaration on primary health care and health systems in Africa. Health systems financing is one of the key areas that offer important opportunities to translate these commitments and this political will into results.²

Key health care financing patterns in sub-Saharan Africa include the following.³

- The current level of health care funding from government tax revenue is relatively low in most African countries, particularly in relation to the target of 15% of total government expenditure being devoted to the health sectors agreed to by the African heads of state in Abuja in 2001. In the majority of countries (about 60%), the health sector share of total government expenditure is below 10%. Achieving the 15% target would reflect government commitment to some degree of health sector prioritization in expenditure. It does not imply that this level of funding would be adequate to meet national health needs, even at a most basic level.
- There is still a reasonably high level of reliance on donor funding in African countries. Donor funding accounts for more than a quarter of total health care funding in about 35% of countries, with 5% of countries having more than half of all health care funding coming from external sources.
- There is limited insurance coverage in African countries, especially in relation to mandatory health insurance. However, community prepayment schemes have been on the increase in recent years.
- One of the single largest sources of financing is that of out-of-pocket payments, which exceed 25% of total health care expenditure in more than three-quarters of sub-Saharan African countries. Out-of-pocket payments include user fees at public sector facilities as well as direct payments to private providers, both nonprofit providers (e.g., missions) and for-profit providers (ranging from doctors working in private practice to informal drug sellers and traditional healers).

1. Sheila Dinotshe Tlou, "Self-Sufficiency of African Healthcare Systems," *The Economist*, Nov. 3, 2014. Available at: <http://www.economistinsights.com/healthcare/opinion/self-sufficiency-african-healthcare-systems>

2. See the many studies of resources on the Health WHO Financing website (Geneva: WHO, 2015). Available at: http://www.who.int/topics/health_economics/en/

3. Di McIntyre, Lucy Gilson, and Vimbayi Mutyambizi, *Promoting Equitable Health Care Financing in the African Context: Current Challenges and Future Prospects*, EQUINET Discussion Paper No. 27 (Harare, Zimbabwe: Regional Network on Equity in Health in Southern Africa [EQUINET], 2005). Available at: <http://www.equinetafrica.org/bibl/docs/DIS27fin.pdf>

The governing body should reach agreement with its managers on specific targets for financial vitality for the program or organization that everyone can work to achieve. Examples might be:

- Increase budget allocations from the Ministry of Health by 5% during each of the next three years.
- Save 5% of medicine costs by arranging for more stable procurement and storage arrangements to avoid stock-outs and waste from expired drugs.
- Generate new programs for revenues and/or in-kind resources from extractive industries, internal donors, and local philanthropists.⁴
- Develop contracts with private sector employers to earn funding from special diagnostic or testing services.
- Decrease reliance on out-of-pocket user fees for maternal and infant care services.

Governing body members must realize, however, that to decrease reliance on out-of-pocket payments, their countries and provinces will need to find ways to increase health funds that come from prepaid sources and are subsequently pooled. The potential to identify new sources of tax revenue, such as sales taxes and currency transaction fees, exists. Ghana, for example, has funded its national health insurance scheme partly by increasing the value-added tax by 2.5%. A review of 22 low-income countries showed that they could collectively raise US\$1.42 billion through a 50% increase in tobacco tax. Innovative resource mobilization instruments, including public-private partnerships and multisectoral engagements, could help reduce the funding gap and serve as good mechanisms for lobbying the state to increase the health budget.

Table 20.1 shows some innovative health financing mechanisms from several African countries. There are good practices in the region as well, for example, in Gabon (Box 20.2) and Ghana (Box 20.3).

TABLE 20.1 Innovative health financing mechanisms in some African countries

Country	Special levy on large profitable companies	Levy on currency and other financial transactions	Tobacco and alcohol excise tax	Other taxes earmarked for health
Cape Verde			✓	
Comoros			✓	
Gabon	✓	✓		
Ghana				✓
Guinea				✓
Zimbabwe	✓			

Source: WHO Regional Office for Africa, *State of Health Financing in the African Region*, 2013

4. For an example from the extractive industries, see Chile Hidalgo, Kyle Peterson, Dane Smith, and Hugh Foley, *Extracting with Purpose: Creating Shared Value in the Oil and Gas and Mining Sectors' Companies and Communities* (Boston, MA: FSG, Oct. 2014). Available at: <http://www.fsg.org/publications/extracting-purpose>

BOX 20.2 Innovative financing mechanisms in Gabon to augment health funds

In 2009 Gabon introduced new taxes to raise additional funds to subsidize health care for low-income groups. One was a tax on money transfers whereby a 1.5% levy on the post-tax of profits was imposed on companies that handle remittances. The second was a 10% tax on mobile phone operators in the country. The two taxes raised an equivalent of US\$30 million for health in 2009. These funds are used to protect low-income groups against financial risks and to reduce barriers to accessing health care. They support enrollment of the low-income population in national health insurance and social security schemes. This mechanism of raising funds for health for low-income groups is an example that can be emulated by other countries in the African Region.

Source: WHO Regional Office for Africa, *State of Health Financing in the African Region*, 2013

BOX 20.3 Organizing prepayment and pooling through the National Health Insurance scheme in Ghana

In order to improve access to health services, Ghana embarked on a health financing reform process in the late 1990s. This development, which ultimately led to the establishment of the Ghana National Health Insurance Scheme (NHIS), was pushed forward by strong political will that has since survived democratic transitions in political power.

The NHIS implementation process relied on existing mutual health insurance organizations (MHOs) established in the early 1990s, often with the help of international donors and agencies. The voluntary community-based MHOs started out at the local level, pooling risk for a limited number of people, often not more than 1,000. The NHIS process brought together these fragmented units into building blocks (which became the districtwide mutual health insurance schemes [DMHIS]) of a national system that was formalized through the National Health Insurance Act (Act 650) in 2003 and that was effectively rolled out from 2005.

The NHIS is built as a health financing pooling mechanism into which funds from multiple sources are channeled. Most of the NHIS funds come from a value-added tax (VAT) levy, a 2.5% part of the regular VAT that is earmarked directly for NHIS. Another source is the redirection of 2.5% of the payroll tax from the Ghana pension scheme for formal sector workers. The contributions of NHIS members represent only a small fraction of the total revenue of NHIS, and these contributions often stay at the DMHIS level and are not accounted for at the national level. NHIS aims at supporting revenue progressivity by cross-subsidies from the formal sector payroll tax and by VAT exemptions on some primary necessity products.

NHIS coverage was revised to 34.7% in 2011 against the 60% estimated in 2009. Since the inception of the scheme, those exempted from premium payments constitute more than 50% of the total members, with children under 18 years forming the biggest part of that group. The number of exempted indigents and pensioners is very low. Paying members from both the formal and informal economic sectors constitute less than 10% and about 20% of the membership, respectively. The current government has stated its commitment to introduce a one-time premium payment, which will further change the dynamics of NHIS revenue collection.

Source: WHO Regional Office for Africa, *State of Health Financing in the African Region*, 2013

PRACTICAL WAYS TO PLAN RESOURCE MOBILIZATION

Governing bodies need a blueprint to follow as they seek to mobilize additional resources for their organization's vitality. This “roadmap for resource mobilization”⁵ should have these characteristics:

- It is driven to meet tangible funding requirements defined by careful program planning and financial analyses for each program and institution.
- It contains a very clear “case for support” that defines the importance of how the funding will be used to yield tangible gains in lives saved, services provided, health services utilized, and quality of care delivered.
- It is targeted for specific amounts from each source of funding, including:
 - budget requests from local, district, provincial, and national agencies;
 - in-kind resources from international donors and local businesses, such as for:
 - water and utilities
 - medical supplies, equipment, and furnishings
 - housing and food for staff and volunteer community health workers
 - medicines
 - building and land maintenance
 - equipment maintenance
 - support for micro-enterprise development for co-ventures with local banks, hotels, caterers, security, or cleaning services
 - technical assistance for quality improvement, service excellence training for staff, and administrative system enhancements
 - revenues earned by contracting out services to other government offices, faith-based organizations, or private companies;
 - fundraising from local community groups, foundations, faith-based organizations, wealthy families, or corporations eager to support your health programs;⁶
 - support from international NGOs and global foundations such as Gates, Rockefeller, and those engaged in health systems strengthening and humanitarian assistance.⁷

5. There are many examples of planning for new resources. Explore these documents: Suresh N. Shende, *Improving Financial Resources Mobilization in Developing Countries and Economies in Transition* (New York: United Nations, 2002). Available at: <http://unpan1.un.org/intradoc/groups/public/documents/UN/UNPAN006235.pdf>. See also Mercy Corps, *Guide to Community Mobilization Programming* (Portland, OR: Mercy Corps, no date). Available at: <http://www.mercy-corps.org/sites/default/files/CoMobProgrammingGd.pdf>. Also WHO Regional Office for Africa, *Resources Mobilization Strategy 2009-2013* (Brazzaville, Republic of the Congo: WHO Regional Office for Africa, 2008). Available at: http://www.afro.who.int/en/downloads/doc_download/5421-resource-mobilization-strategy-2009-2013.html
6. Karin Stenberg et al., *Responding to the Challenge of Resource Mobilization: Mechanisms for Raising Additional Domestic Resources for Health*, World Health Report (2010) Background Paper 13 (Geneva: WHO, 2010). Available at: <http://www.who.int/healthsystems/topics/financing/healthreport/13Innovativedomfinancing.pdf>. See also Fundsnet Services, “International Grants and Funders.” Available at: <http://www.fundsnet.com/searchresult/30/International-Grants-&-Funders.html>
7. See the website of the Foundation Center, “Global Philanthropy: Health” (New York: Foundation Center, 2015). Available at: <http://foundationcenter.org/gpf/health/>

- It has a detailed action plan with leadership assigned to specific members of the governing body, leadership team, and local community civic, religious, and business leaders outside the governing body.
- It includes a calendar to guide follow-up. There should be monitoring and reporting on progress against the plan at each meeting of the governing body. Receipt of funding, such as a donation or new grant, should be openly celebrated in the service area to encourage supporters to sustain their work and support going forward.

The members of the governing body need to inspire and sometimes lead the development of these types of resource mobilization plans. A special taskforce or committee should be formed with a written charge, work plan, and staff support to be successful. This committee should plan openly with participation from community leaders. Broader engagement will not only yield more creative ideas, but also motivate people to help implement the plan and participate in the appeal to various governmental, donor, and private sector sources of support.