Advancing Health Systems Podcast Series, Episode 1 - Full Transcript

Domestic Resource Mobilization

Kirby Crider (Host): This is episode one of the Advancing Health Systems in low- and middle-income countries podcast. My name is Kirby Crider. I work on the HFG project and I'll be your host for this episode. If you haven't listened to our very short first episode, episode zero, I suggest that you go back to that, especially if you're not that familiar with what health finance and governance is. And by the way, the HFG project is the Health Finance and Governance project. HFG is a six-year, USAID-funded project that's working on strengthening health systems in low- and middle-income countries around the world.

For this first episode, we're going to divide the podcast up into three sections and we're going to focus on three questions in each of the sections. The first question will be, "What is it?" Second, we'll look at, "Why does it matter and why does it matter now?" And finally, for the third question we'll talk about some lessons learned from the HFG project, which is coming to an end. And we'll think about how some of those lessons learned might apply to other sectors in international development, even outside of global public health specifically.

Let's get started with that first question. What is domestic resource mobilization?

Cheryl Cashin: Domestic resource mobilization is a fancy way of saying that the government needs to make money available to fund its priorities. You're generating funding from domestic sources, mainly general tax revenue, that is sufficient to meet your objectives for your health system. There are limits to what a given country can fund, but you're going to at least set some priorities and make the resources available from your domestic sources to meet those priorities.

Kirby Crider: That voice was Dr. Cheryl Cashin. She's a senior project director and health economist working for Results for Development, a partner on the HFG project. I think she did a great job of providing a simple definition of DRM. But you might be asking yourself, "How are health services paid for generally and what are the domestic resources that she's talking about?" Dr. Carlos Avila is a senior health economist on the HFG project, and he describes two of these sources, one of which is something we'd like to limit or even avoid when we work on DRM. Here he is.

Carlos Avila: The typical domestic source of money, there are two major ones: from general taxes and also from out-of-pocket from households. Out-of-pocket -- really, in some countries, some households are pushed into poverty. So, you have a tax system that is progressive, meaning those who earn higher amounts of money pay a little bit more of taxes.

Kirby Crider: Dr. Avila talked about two sources of money for health services in a country. One is out-of-pocket spending, where people pay for health services, for example when they go to a clinic. The other is government spending, and that spending might come from taxation or may come from changes to budgets, for example. So, when we think of DRM generally, the goal is to limit the out-of-pocket spending because, as Dr. Avila said, many families are pushed into poverty from this kind of spending.

Even in the U.S., medical debt from health care costs is actually the number one cause of bankruptcy. You can imagine it could be much worse in low- and middle-income countries where some people may not have credit cards or bank accounts, and they have to sell everything, even things that are productive assets or things that they use to make a living, in order to pay for the health care needs of a family member. That could even just be for malaria treatment or delivering a baby, these basic health services. What we're talking about here is equity, fairness, and justice in the way that people are treated, and that's a key part of DRM. It will come up in a couple different places later in the episode.

So, how can we increase domestic resources for health care? One way is to have higher tax rates on the population. You could also have higher tax revenues because maybe a country is experiencing economic growth. You could also move money around inside of the government's budget so that health spending gets a bigger piece of the pie. There's another way to make sure that there's more resources for health, and it's the concept of efficiency. Steve Musau is a public financial administration advisor on the HFG project, and he has an example and a clear explanation of this concept of efficiency. Here he is.

Steve Musau: We are working with the Ministry of Health in Botswana to look at the efficiency with which the HIV/AIDS program is being implemented. The National AIDS Coordinating Agency is doing some particular interventions and activities within the program, while the same interventions and the same kinds of activities and programs are being carried out by the Ministry of Health. They could save quite a bit of money just by coordinating and just by bringing together these parallel programs.

When people talk about domestic resource mobilization, they tend to focus more on how to raise more revenue and how to get more money into their health sector, but one of the issues that tends to get ignored is the fact that not only do we need more money, we also need to be able to get more out of what we already have. That's where the issue of efficiency comes in. How well are we making use of the revenue that we have already to produce more services to the consumers and have more impact without necessarily spending more?

Kirby Crider: I think with the help of these experts, we've identified the key elements of DRM. It's about finding money within a country to pay for health services through tax revenue and through budgeting. It's also about limiting the inequity with high out-of-pocket payments, which are especially tough on people who are poor, marginalized, or vulnerable. To that point, I heard from a number of these experts that if you focus your attention on these populations, you can improve the entire system for everyone, but that doesn't necessarily work in reverse. And finally, DRM involves looking at ways to improve the efficiency with which health services are delivered by looking for ways to avoid unnecessary duplication or by purchasing drugs and medical equipment in a more competitive way.

All right, listeners, we got through the first question. Congratulations! I hope you have a better idea of what domestic resource mobilization is. For the second question, I would like to ask, “Why does it matter and why does it matter now?” And to answer that, I want to take us back to 2013 and listen to a really short clip from Voice of America news.

> ***Voice of America:*** *Like other federal agencies, the U.S. Agency for International Development has to cut its budget as a result of sequestration. The 4 percent USAID must cut will reduce its foreign assistance.*

Kirby Crider: So, the budget sequestration was a mandatory, across-the-board cut for all agencies and departments in the U.S. government. And it might seem like old news, but I think it really illustrates how foreign assistance, as well as the countries that foreign assistance is going to, can't always rely on the big donors like they have in the past. Let's jump ahead to 2017. You're about to hear a short clip from Mick Mulvaney, the director of the Office of Management and Budget, talking about cuts to foreign aid.

> ***Mick Mulvaney:*** *We're absolutely reducing funding to the U.N. and to the various foreign aid programs, including those run by the U.N. and other agencies. That should come as a surprise to no one who watched the [Trump] campaign. The president said specifically, hundreds of times, you covered him, "I'm going to spend less money on people overseas and more money on people back home." And that's exactly what we're doing with this budget. Yes ma'am.*

Kirby Crider: So, I know both of those examples were U.S.-centric, but it is a trend around the world. Let's hear from one more of our experts, Sharon Nakhimovsky from the HFG project. She's going to talk about these reasons and also some other reasons why we're talking about this right now in this moment in time.

Sharon Nakhimovsky: The cost of health care -- this is in the U.S. and Europe as well as developing countries -- is rising, and there's a lot of reasons for that. There are technology advances, lots of new tempting things that you could use if you wanted them, and also just more people who are living longer. So, there's a growing burden of noncommunicable diseases while we're still tackling some of the infectious diseases, like malaria and HIV that are still just so important and that have turned to become chronic. So that's part of it. And then donor appetite for continuing to increase or even maintain support is growing uncertain. So countries, especially middle-income countries, where traditionally they've had money that would come in and support health programs, if that disappears, it will really change the equation.

How do you see that money go and yet maintain the improvements or progress that they've made over the last decades or more? And actually, they have become even more ambitious. So, the goal of universal health coverage, which has [inaudible] recently in the United Nations Sustainable Development Goals, it's big, it's thinking big. How do you reach more people? How do you reduce inequity and bring the poor up? So, all of these big dreams, rising costs, exiting donors -- I'd say that summarizes why domestic resource mobilization is a hot topic right now.

Kirby Crider: I think Sharon did a nice job of summarizing why we're talking about this right now, so I won't add much more to what she said. But you may have heard her mention the Sustainable Development Goals and a little later in the episode, you'll hear a really awesome rap song about the Sustainable Development Goals. One other thing she referenced was an increasing demand for services from people, and in my mind this increasing demand is actually a really good thing. People have an expectation for and are asking for health services that will improve their lives. So, on one side demand is growing and the costs are rising, and on the other side the plans from big donors, like the United States, are becoming increasingly more uncertain.

I'd like to introduce you to Elaine Baruwa, also a health economist on the HFG project, who will dig a little more into these reasons. Listen to her talk about this increasing demand and increasing expectation for all services, among some other reasons. Here she is.

Elaine Baruwa: As people demand more health care and that health care gets more expensive to deliver, we have to balance that expectation and meet those expectations. In many of the countries that HFG works in, many of the countries I work in, that expectation if you call it, say, universal health care coverage or that objective -- for example, access to a basic package of services so children under five should get immunizations and treatment for infections, women should have access to family planning methods, malaria should be treated for everyone particularly in endemic countries -- all of those things need to be paid for.

If you look at how much money it requires to meet all of those needs in most of the countries we work in and you look at what governments are spending, you'll see there's a huge discrepancy. Governments are not spending enough money to meet what we are more and more beginning to consider as the basic essential services that people should expect as a human right. So, because there is that gap in those low- and middle-income countries, domestic resource mobilization is about filling that gap.

Kirby Crider: So, there's a demand for more and more health services in countries and that creates greater expectations, but countries are still facing a big gap in being able to fund even basic health services for all the reasons you've just heard. And we're talking about DRM because it's a way to fill that gap. So, before we close out this question, I want to share with you one more global reason why DRM is being talked about now. Here's Cheryl Cashin again.

Cheryl Cashin: I think that this idea of domestic resource mobilization hasn't only come to the forefront because of the conversations around donor plans. On the other side, there's this really unprecedented global commitment to universal health coverage.

> ***Rap song:*** *Seventeen Sustainable Development Goals, let's get to them because the more you know, look, there's some corners of the world today, people are living on a dollar a day. It's not how it ought to be, so goal one, eliminate poverty. And goal two, root out hunger across the globe, there's 800 million people hungry if you want to know. Number three is health and well-being, and getting people the health care that they needing, learning in school…*

Kirby Crider: I hope you enjoyed that little musical interlude to close out this question. That was provided to us by U.N. Web TV and the organization that made it was Flocabulary. You can find the full version on U.N. Web TV's YouTube channel.

So, we've made it through the first two questions. For the third question, I want to focus on just a few key lessons learned. So, what lessons can we take from the HFG project that could apply to other sectors within international development, again even outside of global health? And as you might imagine, it often comes down to people and it comes down to relationships. Dr. Carlos Avila, again, is going to talk to you about those.

Carlos Avila: You really need to have a relationship with government. You need to have conversations with many stakeholders, the main players -- individual conversations. You also need to bring all of them to the table to discuss the issues. Making some things that are implicit, try to make those explicit. It's a

very important process in understanding why these resources are needed. Talk to the main players and stakeholders. Sometimes they realize, when they start looking at the data, they are the main problem of mobilizing resources. So, it's that kind of work. We are talking about analytical work and also the process. It's a process of providing the evidence. It's making the case. It's being very clear about communications -- you need to have a message. In terms of resource mobilization, it is always very important that we are talking not only about more money, but better use of the resources.

Kirby Crider: I think Dr. Avila, in that clip, described how to do communication and this relationship-building well. It's about being strategic about how you reach out to stakeholders. It's tailoring the message, but also having a clear message to share with them. And it's about backing up all of the messages with data that is solid and convincing. And I like how he described that sometimes stakeholders will even take on the messages that you've given them and it will be even more powerful because it's coming out of their mouths. Here's Elaine Baruwa again to add to this.

Elaine Baruwa: Donors who have supported these countries historically have tended to focus their support on many of these same basic services -- so immunization, family planning, treatment of malaria, those kinds of things. And what's happened is that those government have sort of thought to themselves, "OK if a donor is addressing this, I'm going to build secondary hospitals or I'm going to build tertiary hospitals," which makes sense. It's rational: Why should we all be providing the same thing when we still have needs elsewhere?

That sort of exacerbated over the last 15 years because we've had this huge flow of resources to global health that have gone from donors -- wealthy countries to low-income countries -- for very specific things, like HIV, malaria, and TB. And it will never go away, because in every country you're going to have a large population of vulnerable people that need to be taken care of, and the only way to take care of them is for government to pay. There isn't any magic tree that is going to give us money to pay for care for the vulnerable. If we talk about universal health coverage and we say that's our goal as a country, basically it's implicit there: Governments have to spend money to ensure that the vulnerable receive care.

Kirby Crider: So, I want to pause here and just reiterate what Elaine is saying, because she's saying a lot. She describes how historically countries have relied on donor funds to address the core, the basic health services, and they've been able to spend their resources that would go to those basic services elsewhere. So now things are changing, and unless the governments of these low- and middle-income countries fill in these gaps, the poor are going to be hit hard. Back to Elaine.

Elaine Baruwa: There's no magic bullet. There's no one option. It has to be a lot of options because what's politically in fashion now is out tomorrow, what's economically feasible now is out in a recession. And so you have to make your DRM plan political-proof because there will be elections, and economic-proof because there will be ups and downs. If you're reliant on something that moves a lot with ups and downs, that's a problem. We don't train. For those of us who did MPHs or PhDs, there wasn't really a class on political economy, and here is how you talk to people outside of health. If you don't engage, if you say politics is beyond us, then basically you can only look for domestic resources in the budget that you have, and you will never get a larger budget because you have to do that engagement. It is not just, "Let's do some math on the back of envelope working out how much we need and where the gaps are."

Kirby Crider: I think that's a key lesson from the HFG project. DRM is fundamentally political, and it can't just be desk work and great analyses of problems. We have to be in the thick of it and we have to be talking with ministries, with stakeholders, with people.

Elaine Baruwa: And it's not even just how do we fill them, because there's a lot of information out there on how we fill them right. People have great ideas. We'll do the airline tax, or we'll do sin taxes on alcohol, or we'll do social health insurance and deduct [from] people's salaries. The options are known, but how do you do that and which option? We can't be doing assessments all the time. The assessment and the gap analysis part -- what do we need and what do we have? -- they're important, but they're really the tip of the iceberg but not the whole iceberg. That is the start of a much larger process. And that process is to some extent, I've got to say, is not sexy. It's not putting pills in people's mouths. It's like public financial management: It's not shiny and it's not going to make senators' eyes light up, but it's absolutely critical if we're going to get countries to be able to stand on their own two feet.

The things that could make a huge difference -- treatment for diarrhea, basic antibiotics for respiratory tract infections that kill so many children -- all of these things are cheap. We need to get governments to take over those things so that they own them. We have to work out how we spend more and more effectively, on systems strengthening, and enabling ministries of health to do this domestic resource mobilization themselves.

Kirby Crider: So there's no magic bullet, there's no magic tree that's producing money. But as Elaine says, there are a lot of options. She makes the point that your DRM plan should look at all of these options and choose the right mix for the particular country and political context, and make it political-proof when possible. I'd like to bring back Steve Musau from earlier in the episode again because I think he can elaborate on what Elaine just said about the political economy side of things, especially as it relates to efficiencies and identifying inefficiencies.

Steve Musau: It is not good enough to have a good money-saving idea -- that doesn't always work. Things that we've seen in our work include being able to identify those areas where these inefficiencies exist. Then, having identified inefficiencies, deciding what is doable. You may identify a particular inefficiency but then in order to be able to resolve it, it may require a lot of effort or a lot of buy-in by key stakeholders. There may be very many interests involved. Until you understand who is driving the inefficiency, you may actually not to get very far. So, there is all of that engagement that one needs to have with all the different stakeholders within the Ministry of Health.

Kirby Crider: OK, so political engagement, relationship-building, communication, messages. What does all this look like in practice? Dr. Inyang Asibong is the health commissioner for Cross River State in Nigeria. In September 2016, that state passed a state health insurance scheme, and they passed the bill with a unanimous vote. It even got a nickname, which I really like, AyadeCare, named after the Cross River State Governor, Professor Ben Ayade. As you'll hear, it was not easy to do this. But Dr. Asibong describes some of the key things that they did and key things that happened as they worked to pass the bill.

Inyang Asibong: It started with an HFG and USAID meeting. They were telling us they were seeing the little we were trying to do with limited resources, so they actually said, "OK, let's have a meeting." We are very busy people, so trying to get the chairman of the House Committee on Health to sit down in one place for like five days is not easy. They got all key stakeholders. The chairman was there, I was

there, the permanent secretary, and everybody that was supposed to be there was there. Even the State Planning Commission had a representative and the Ministry of Finance had a representative. So it was packed.

It made my advocacy very easy because following that meeting, we were all on the same page. Because we were having stakeholder engagements, the Obong of Calabar – he's one of the eight recognized traditional rulers in Nigeria -- because he had seen what we had been doing. And that you can see doesn't come easy, you have to have earned it, and HFG actually earned it. It's something that if the head of HFG in Nigeria, Dr. Gafar Alawode, if he says, "Commissioner, please, I need to see the governor, we need to move ahead" or that HFG wants to meet, it is that easy. This is because he has a relationship with HFG and USAID already, and he has seen the tremendous support that HFG is giving to the health insurance scheme in the state.

Working together, it was very easy to get that bill passed and get it signed into law. There is something the governor did that was very special, and no other governor has done that. When he signed the bill into law, he launched the bill. The day of the signing was a very big event where all the political stakeholders and religious leaders were there, and he launched it by actually saying, "Let us have a pool for this fund, everybody should contribute," so people donated a lot of money.

From the beginning, we wanted to have it as a culture and for people to know that they need to pay for it to be sustainable. Before now, we have had a stint with free medical care, so many times that is the sole responsibility of government to fund health insurance. So that's why we're trying to do a lot of awareness to tell people that they need to contribute this little money so that they also have a sense of ownership, because we are also going to take care of vulnerable groups like pregnant women, children, the elderly and the handicapped. In Africa, we rear the culture of taking care of our brothers and leaning on your bother. So, it is about the rich paying for the poor, the healthy paying for the sick, and the young paying for the old. We try to talk to their hearts and not just their brain and tell them that this is about your brother; it's about being your brother's keeper.

Kirby Crider: OK, we did it. We got through all three questions. Congratulations, listeners! So question one was: What is it? DRM is a process for finding resources -- that is, money -- from within a country to address health care needs. It's about equity, about limiting out-of-pocket payments, which are especially hard on poor and vulnerable people, and also about improving the efficiency with which services are delivered in a country so that existing resources go farther in keeping people healthy.

So, question two: Why does it matter and why are we talking about it now? DRM matters because donor plans are changing and they're uncertain, and because there's a greater demand and also expectation for health services from people within countries. We saw that in things like the Sustainable Development Goals on a global level, in plans with these low- and middle-income countries themselves, and in improvements in technology that mean people know that we can better address diseases and they expect it and demand it.

And finally, question three: How do we do it and what are the lessons learned from the HFG project? Of course, DRM involves the analytical work of looking closely at health systems in a country. But perhaps more importantly, it's about developing relationships with various ministries, stakeholders, and people, and communicating a clear, compelling message about the need for DRM and the benefits it can bring. There's a key political element here. Understanding the political economy and political landscape in a

country is critical to DRM being effective in the long term. So don't shy away from getting political, even if it seems challenging, because you have to. Here in the U.S., we've lived through 10 or more years of complex debate about health care, and the importance of politics and understanding a complex political environment is very clear here, and of course other countries have complex political environments, too.

One last thank you for listening to this episode, and I really hope it was interesting and useful for you. Thanks to everyone who is on this episode and everyone on the HFG project, and a special thanks to Jen Leopold. Also, thanks to Blue Dot Sessions for our theme music and to Flocabulary -- that's the company that put together the rap song about the Sustainable Development Goals for the U.N. And finally, a thanks to USAID for funding the HFG project, which is led by Abt Associates.

About the Advancing Health Systems Podcast Series

The Advancing Health Systems podcast series explores fundamental issues involved in expanding people's access to health care in low- and middle-income countries. The podcasts were produced by the USAID-funded Health Finance and Governance (HFG) project, which ran from 2012-2018. They were recorded in 2018.