

Context and Overview

This private dinner will assemble a small group of finance ministers, hosted by Dr. Ngozi Okonjo-Iweala, Gavi, the Vaccine Alliance Board Chair and Bill Gates to discuss sustainable budgeting for health, and health financing transitions and how best to prepare for them, and to share experiences around ensuring adequate funding for key health priorities like immunization.

Sustainably funding health services is always a challenge in the face of many competing claims on the public purse. In recent years, governments and development partners have made significant progress in addressing the funding needs required to cover immunization and other essential health services in low income countries. The successful mobilization of targeted and concessional financing for health contributed to improvements in health outcomes across the developing world. Between 2000 and 2015 global infant mortality rates declined by 50%, while under-5 mortality rates declined by 44% in low income countries. This was in part enabled by improvements in immunization coverage rates, for example with the third dose of DPT (diphtheria, pertussis, and tetanus) coverage increasing from 50% to 81% during the same period. Developing countries have benefitted greatly from these improvements. Healthier citizens can live better lives, and contribute more to growth and development than ever before.

But with economic growth comes a new set of challenges, because the external financing environment changes. Countries tend to spend more of their public resources on health as they become richer, both in terms of share of GDP and budget. In 2015, middle income countries spent an average of 9.4% of their public expenditure on health, while low income countries spent 5.8% on average. However, lower-middle income countries face particular challenges as they lose access to IDA, and other sources of concessional financing, such as Gavi the Vaccine Alliance, Global Fund for AIDS, Tuberculosis and Malaria, PEPFAR, UNFPA, and Global Polio Eradication Initiative that support critical parts of the health sector.

Simultaneous transition from Gavi and other sources of concessional financing can present considerable risk even if there is not a major impact on fiscal space. For most countries entering Gavi transition, current vaccine costs represent less than 0.1% of public spending which does not significantly limit fiscal space. However, the budgetary reality is often more complex. The cost of vaccines may represent a disproportionate share of health capital expenditures, requiring increases in domestically-funded allocations to make up for decreases in concessional funding. Concessional financing sources can show up very differently on plan, on budget, on treasury and on accounting. Although public funds are fungible in theory, the practicalities of concessional finance often mean that many governments treat them more like hypothecated revenue streams – if the revenue drops, so may the expenditure.

Every minister of finance should be concerned with the risk of gaps in immunization coverage. Immunization spending represents very high value for money in public health. For every US\$1 invested, an estimated US\$16 in lost productivity and medical costs can be avoided. Incorporating the value that people place on living better and longer, this figure increases to US\$44 return over a ten-year period on every US\$1 invested. Immunization is a low-cost investment with great impact, on people's lives, but also on growth and economic transformation. Vaccines have a large potential for poverty reduction by reducing the incidence of medical impoverishment.

Drops in immunization coverage reduce the quality of spending across the entire health sector. Vaccine commodities leverage a whole range of outputs that the government will continue to provide, such as the salary cost of nurses and health systems. Immunization programs need to reach every new birth cohort every year. Attaining high coverage rates is a testimony to an enormous amount of effort to

GEORGIA COUNTRY BRIEF

provide life-saving vaccines to the remotest populations. Vaccines don't deliver themselves but require a robust primary health care system. Sustainable financing of immunization requires adequate operating costs for Primary Health Care (PHC). Disrupting delivery by dropping funding in only one year creates vastly disproportionate harm.

Ministries of finance and ministries of health cannot solve the challenges of sustainable budgeting for health in isolation. Budgeting and fiscal policy are always works of coordination. But in practice, a lack of coordination and planning, including from donors, often exacerbates the scarcity of resources. But in working together through the budget process, both ministries can minimize any operational risk. So far, 16 countries have successfully transitioned from Gavi. None of these countries have dropped their vaccines, or significantly reduced coverage. Sri Lanka, for instance, was one of the first countries to transition from Gavi in 2016 and has maintained DTP3 coverage at 99%.

Committing more domestic resources because of transition does not need to create indefinite liabilities. The UNICEF price of the pentavalent vaccine (diphtheria, pertussis, tetanus, hepatitis B and Haemophilus influenzae type B) has come down significantly since 2000 (84%) from USD3.65 per dose to USD0.60 per dose, depending upon manufacturer. Cost increases in the vaccine budget are more often driven by the introduction of new vaccines and increases in coverage. Adding new vaccines to the mix creates future opportunities for ministries of finance and health to exert proper scrutiny over value for money. Careful deliberation and strategic budgetary choice, not unanticipated or unplanned for changes in concessional financing, should drive country priorities.

The challenges of Gavi transition are emblematic of larger issues in fiscal policy. Achieving middle-income status is not easy and should be celebrated, and quite quickly domestic revenues will replace concessional financing many times over. However, this change creates multiple challenges for ministries of finance. We understand that fiscal policy needs to keep pace with new citizens' demands and the requirements of a transforming economy. In many middle-income countries, this has prompted policy discussions between finance and spending ministries in countries as varied as South Africa, Chile and Vietnam. Vietnam used a transition strategy paper to advocate IDA for a longer transition period in 2015. Developing a transition strategy that can drive budget decisions in finance and in health can be a model for allocative and operational efficiency.

We know that ministries of finance are concerned with fiscal discipline, as well as allocative and operational efficiency across all sectors. This engagement is not primarily about levels of funding, but also the way to plan, budget and ensure quality of spending. We are eager to hear ministers' views about perceived bottlenecks and potential ways forward in dialogue with ministers of health and finance.

We look forward to a robust and open dinner discussion covering the following questions:

- **Your experience in budgeting sustainably for health.** What are the challenges you face, how do you ensure sustainable social sector and health expenditures over time and how do you make choices about tradeoffs?
- **Your perspective on health financing transition.** What is your experience in managing through financing transitions, and how did that affect the health sector?
- **How could the development community help manage this process most effectively with you?**

GEORGIA COUNTRY BRIEF

Health Financing Transitions in Georgia ¹

Between 2000 and 2015, Georgia's economy grew at an average of 5.5% per annum. During this period, GNI per capita expanded from \$750 to \$4,120 and Georgia transitioned from LIC to LMIC to UMIC although reversing to LMIC in 2017. Still, as a middle-income country, Georgia has gradually taken on more financial responsibility for its development programs with a resultant decline in volume and concessionality of donor funding. Since becoming an LMIC, ODA volumes have declined by about a third from its peak in 2008. In addition, proportion of grants and concessional loans to total development funding have declined to 70% from 90% a decade ago.

In 2013, Georgia transitioned from the World Bank's more concessional IDA window to the IBRD. This transition came with a shift in resource allocations and notably a 50% reduction in average disbursements to the health sector under IBRD than in IDA. More of these types of transitions and graduations are expected in the coming years. Georgia recently transitioned from Gavi support, and financing from the Global Fund is projected to decline in the next 3 years. In 2015, combined resources from these programs channeled to the health sector amounted to \$10.5 million or 58% of total development assistance for health.

Although small in comparison to total public health expenditure, these resources are typically concentrated on specific priority health programs, magnifying their relative importance. Proper budgetary planning through these transitions is essential to ensure that there are no disruptions in financing or the provision of services and to sustain and build on Georgia's gains in improving health outcomes.

Gavi Transition and Immunization Financing ²

Gavi, The Vaccine Alliance has provided support to Georgia since 2002, disbursing \$6.38 million in vaccine commodities and systems strengthening support. Through Gavi support, Georgia has introduced vaccines that prevent pneumonia, diarrheal disease, liver cancer, measles, tetanus, pertussis, diphtheria, influenza, and cervical cancer. Vaccines are a small share of government expenditures (around 0.01%), representing a small percentage of government health spending.

Since the beginning of Gavi, self-sufficiency in country immunization programs has been a goal. Countries co-finance new vaccines, and as their economies grow, are expected to finance an increasing share until they are self-financing. As of January 2018, Georgia successfully transitioned from Gavi and is now in the post-transition phase.

Between 2011 and 2015, government accounted for 64% of the total expenditures for routine immunization, with the balance financed by Gavi and other external partners. By 2018, Georgia is financing 100% of its program. The introduction of hexavalent vaccine (DTP+HebB+Hib+IPV) in December 2015 was fully financed by the government.

¹ Sources: IMF World Economic Outlook, 2017; OECD CRS, 2017; WHO National Health Accounts, 2017.

² Sources: Gavi Secretariat; WHO-UNICEF Joint Reporting Form.

GEORGIA COUNTRY BRIEF

Figure 1: Georgia Co-financing as % of vaccines introduced with Gavi³

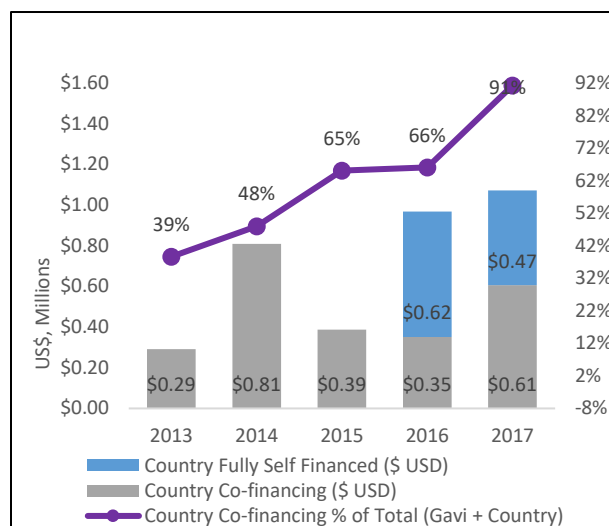
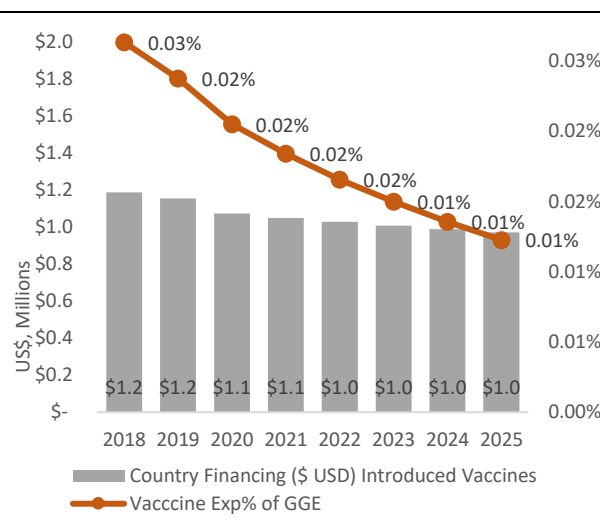


Figure 2: Projections - Government of Georgia financing for current and future vaccines introduced with Gavi as % of GGE⁴



Despite the complexity of adding new vaccines, Georgia has maintained strong coverage rates for most of the 12 antigens in its national program and coverage has been consistently increasing (98% DPT3). However, there are some pockets of low coverage that still require technical support and assistance with vaccination. Continued investments in the program are needed to maintain coverage, particularly in view of vaccine refusals and rising anti-vaccine movements like other countries in the EURO region. Having a specific budget allocation for operational activities to cover costs for surveillance and maintenance will be important.

Georgia's experiences and lessons from the transition process will be useful to discuss at this dinner. Georgia is a member of the Gavi Learning Network for Countries in Transition (LNCT) which aims to support countries through transition with peer learning. We would welcome a representative from the Ministry of Finance be part of the group.

Health Financing Trends in Georgia

The Government of Georgia has committed to the Sustainable Development Goals (SDGs) and introduced Universal Health Coverage (UHC) in 2013 through a public-private partnership. Georgia has recently increased its allocations to the health sector from 6% in 2000 to 10% by 2015. Per capita public health expenditure has increased as a result, from \$4 to \$109 during the same period and is now almost twice the amount that other LMICs are spending.

Today, private companies provide most immunization and medical services, with financing from the government and patients. While access to the health system has improved, concerns still exist about

³ Source: Gavi Secretariat

⁴ Source: Gavi Secretariat

GEORGIA COUNTRY BRIEF

rising expenditures, growing out-of-pocket payments, and coordination between the government and private companies. The Institute for Health Metrics and Evaluations projects that at current trends, public health expenditure per capita will rise to \$145 by 2030. But a potential slowdown in economic growth in Georgia may limit further expansion of the health budget with downward pressure on immunization financing.

Figure 3: Government Health Expenditure per capita⁵

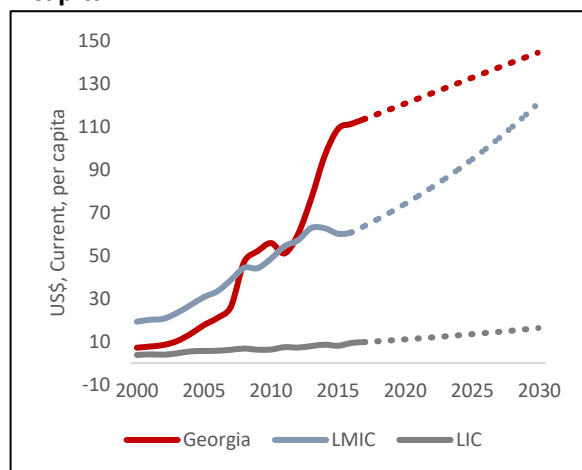
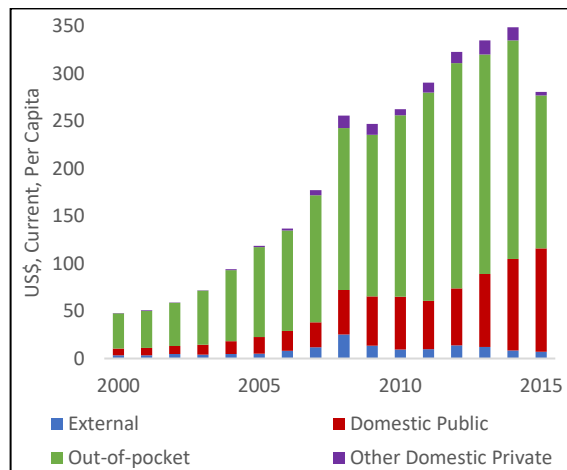


Figure 4: Total Health Expenditures by Sources⁶



For more information or to follow up on Gavi related transition issues, please contact Santiago Cornejo, Director for Immunization Financing and Sustainability, Gavi, at scorejo@gavi.org

5 Source: WHO National Health Accounts and IHME

6 Source: WHO National Health Accounts

ANNEX 1: PROJECTED HEALTH TRANSITIONS AND FISCAL IMPACT

	ANGOLA	BANGLADESH	GEORGIA	GHANA	INDONESIA	KENYA	PAKISTAN	SUDAN
Projected IDA Transition								
Projected GPEI Transition								
Projected PEPFAR Transition								
Projected Gavi Transition								
Projected Global Fund Transition								
All Projected Transitions in Next 10 Years	GPEI, PEPFAR, Gavi	Gavi, GPEI	Gavi, GF Malaria	PEPFAR, Gavi	GPEI, PEPFAR, Gavi, GF TB, HIV, Malaria	IDA, Gavi	IDA, GPEI, Gavi	GPEI, Gavi, GF TB, HIV and Malaria
IDA Disbursements to Health Sector in 2016, US\$ Millions	21	69	-	12	-	27	3	-
Estimated Volume of Concessional Finance Lost in Next 10 Years (Excluding IDA), US\$ Millions	28	90	10	30	82	69	334	109
Government Health Expenditure in 2016, US\$ Millions	841	882	450	791	11,557	1,222	2,078	1,954
Projected Government Health Expenditure in 2022, US\$ Millions	1,127	1,792	706	995	19,682	1,734	3,295	5,637
Concessional Finance Lost as a Share of 2016 Health Expenditure	3.3%	10.2%	2.3%	3.8%	0.7%	5.7%	16.1%	5.6%
Concessional Finance Lost as a Share of Projected 2022 Health Expenditure	2.5%	5.0%	1.5%	3.0%	0.4%	4.0%	10.1%	1.9%

HEATMAP KEY

	Already Graduated
	Projected to graduate by 2020
	Projected to graduate by 2025
	Projected to graduate by 2030
	Projected to graduate by 2035
	Not projected to graduate before 2040
	Not Applicable/Does not recieve support

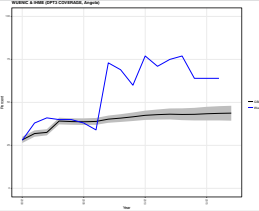
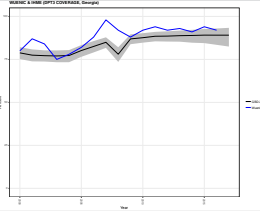
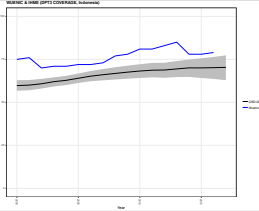
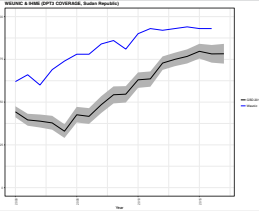
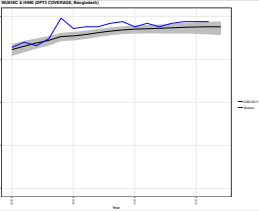
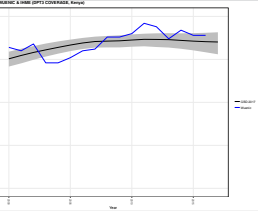
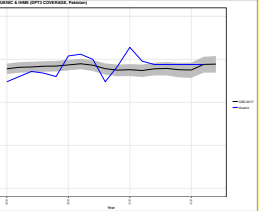
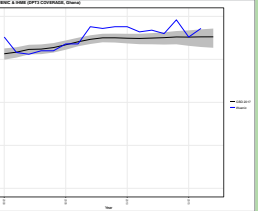
NOTES ON DATA:

Projected graduation dates and timelines are rough estimates only based on projected GNI per capita growth. IDA and GFATM take into account other factors (such as creditworthiness, epidemiological factors, and country-specific economic conditions) that cannot be estimated with a high degree of accuracy.

Estimated volume of concessional finance lost are estimates using funding levels for each program in 2015. Gavi estimates include both vaccine support and HSS support.

Health expenditure projections are calculated using IMF GDP and government expenditure projections and assume that health's share of government's expenditure stays constant at 2015 levels

ANNEX 2: CHARACTERISTICS OF SELECT GAVI TRANSITIONING COUNTRIES

	ANGOLA	GEORGIA	INDONESIA	SUDAN	BANGLADESH	KENYA	PAKISTAN	GHANA
Transition Date (January)	2018	2018	2018	2024	2027	2027	2027	2028
Entering accelerated phase				2019	2022	2022	2022	2023
Gross National Income (GNI) per capita, Atlas method (2018)	\$3,450	\$3,830	\$3,400	\$2,140	\$1,330	\$1,380	\$1,500	\$1,380
Comparison of WHO-UNICEF (WUENIC) and IHME Coverage Estimates (2017)								
	WUENIC = 64%	WUENIC = 92%	WUENIC = 79%	WUENIC = 93%	WUENIC = 94%	WUENIC = 89%	WUENIC = 72%	WUENIC = 93%
Number of New Vaccines Introduced with Gavi	3	3	3	4	5	4	4	6
Pentavalent								
Pneumococcal (PCV)								
Rotavirus								
Human Papilloma Virus (HPV)								
Measles/Rubella								
Meningitis A	N/A	N/A	N/A		N/A		N/A	
Yellow Fever		N/A	N/A		N/A		N/A	
Japanese Encephalitis	N/A	N/A		N/A		N/A		N/A
Typhoid								
Deaths Averted with Current Gavi Vaccines (through 2030)	153,000	100	259,000	192,000	144,000	130,000	515,000	311,000
Deaths Averted From Additional Vaccines (through 2030)	61,000	1,000	214,000	46,000	182,000	93,000	135,000	46,000
Annual Cost of Additional Vaccines (\$m)	18.4	0.74	160	27	78	32	104	16
Estimated Annual Delivery Costs for Additional Vaccines (\$m)	7	0.32	65	15	44	19	64	7
Total Estimated Annual Additional Costs (\$m)	25	1.06	225	42	122	51	168	23
Average Cost/Death Averted	\$3,620	\$8,880	\$8,972	\$7,043	\$5,143	\$4,129	\$9,244	\$4,174
Vaccines as % Government Expenditures (2018)	0.05%	0.03%	0.01%	0.02%	0.01%	0.01%	0.04%	0.04%
Vaccines as % of Government Health Expenditures (2018)	0.10%	0.50%	0.10%	0.20%	0.20%	<0.1%	0.90%	0.60%
Global Polio Eradication Initiative Funding (2017,m)	\$7.16	N/A	\$0.907	\$7.96	N/A	N/A	\$218.82	N/A
Expected GPEI Funding Change (2017-2019)	-37%	N/A	-3%	-71%	N/A	N/A	-55%	N/A
Current GEPI Staffing (WHO/UNICEF)	77	N/A	7	38	N/A	N/A	19,395	N/A
Participates in the Vaccine Independence Initiative				2016, 2017		2016		
World Bank loan for Gavi co-financing					Yes			
Received a Gavi default letter; came out of default	2011-2015						2012-2015	2013, 2014, 2016
Current member of Gavi Learning Network for Countries in Transition	Yes	Yes	Yes	Yes	Not yet	Not yet	Not yet	Yes

NOTES: Data on deaths averted are estimates of routine immunization impacts (2018-2030) from the Vaccine Impact Modelling Consortium (VIMC). These also include impacts from HepB birth dose. | Cost of additional vaccines based on weighted average prices, target population, dosage and 100% coverage. Operational costs estimated at \$2 per dose for HPV and \$1 per dose for all other vaccines. | Bangladesh also introduced measles second dose through Gavi for 5 introductions. | Source of expenditure data: Gavi Secretariat | Source of GPEI data: GPEI. | Georgia introduced the hexavalent vaccine on its own.