





HEALTH FINANCING CASE STUDY No 15  
BUDGETING IN HEALTH

# **HEALTH FINANCING AND BUDGETING REFORMS IN GABON:**

## **PROGRESS AND CHALLENGES ON THE ROAD TO UNIVERSAL HEALTH COVERAGE**

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**World Health  
Organization**

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## ABBREVIATIONS, ACRONYMS, AND INITIALISMS

CEMAC	Central African Economic and Monetary Community
CHR	<i>Centre hospitalier régional</i> – regional hospital
CHU	<i>Centre hospitalier universitaire</i> – university hospital
CNAMGS	<i>Caisse Nationale d'Assurance Maladie et de Garantie Sociale</i> – National Health Insurance Programme
CNSS	<i>Caisse Nationale de Sécurité Sociale</i> – National Social Security Fund
CSS	<i>Contribution Spéciale de Solidarité</i> – National Solidarity Sales Tax
GDP	Gross domestic product
GEF	<i>Gabonais Économiquement Faibles</i> – Economically Weak Gabonese
MoF	Ministry of Finance
MoH	Ministry of Health
PB	Programme budget
PFM	Public financial management
ROAM	<i>Redevance Obligatoire à l'Assurance Maladie</i> – mandatory health insurance tax
UHC	Universal health coverage
WHO	World Health Organization

# SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

Despite significant efforts, health financing reforms in Gabon have not been fully implemented. Public funding as a share of total health expenditure increased from 40% in 2001 to 65% in 2016, resulting in a major reduction in out-of-pocket spending, which currently accounts for 24% of total health expenditure. While this represents significant progress, the funding model for health is fragile. Macroeconomic difficulties since the mid-2010s have led to drastic reductions in budget allocations for the Ministry of Health (MoH) (3% of the overall budget in 2016). In 2017, the government terminated one of its earmarked taxes, further endangering the sustainability of the public funding model. The mobile phone tax had existed for a decade and its termination weakened financing for the social health insurance program for the poor (*Gabonais Économiquement Faibles*, GEF), the Gabon Indigents Scheme. The Special Solidarity Contribution (*Contribution Spéciale de Solidarité*, CSS), created in 2017–2018, may not cover the gap. Ensuring continuity in support for the GEF should be a priority to guarantee the reform's protections for low income Gabonese. On the expenditure side, in the absence of a strategic purchasing policy and the predominant use of fee-for-service payments, the escalating costs at purchaser level is a primary concern. The structure of the national purchasing agency (*Caisse Nationale d'Assurance Maladie et de Garantie Sociale*, CNAMGS) is split into three separate funds for different population groups. That contributes to financial fragmentation and complex funding flows for health service providers. Workers from the informal private

sector remain uncovered. Stakeholders need to review purchasing and pooling arrangements if Gabon is to expand and sustain health coverage. They should explore alternative payment methods for CNAMGS to ensure financial sustainability. They should monitor the effects on the equity and quality of care and consider practical modalities for single-payer arrangements.

Public financial management (PFM) reforms that began in the late 1990s have not yielded all the expected results, especially in terms of health sector spending. Significant progress has been made in strengthening budgeting and spending practices. However, in recent years, there have been challenges in implementing overall PFM measures, leading to significant disruptions in the PFM system. The adoption of programme budgets for all sectors marked a significant shift. Still, several design and implementation issues have hampered results. Budgetary programmes in health are not aligned with sector priorities, are too concentrated, and do not allow MoH leaders to set the right spending priorities. Budget execution has dropped dramatically in recent years, mostly because of budget design flaws and complexities in spending procedures. The execution rate for MoH expenditures following the introduction of the programme budget remains below 60%. If the programme-based approach is maintained, MoH programmes should be redefined to better reflect priorities and align with the MoH mandate on policy development and guidance. Managerial reorganization may be needed to ensure a more efficient management of programme



resources. Consolidating the performance monitoring framework of the sector is also needed to ensure better accountability in the use of public resources, at all levels. Given the benefits of programme budgets in streamlining and consolidating operational and financial accountability, sectoral leaders in Gabon have an opportunity to prioritize and improve the monitoring of health outputs. Finally, better coordination between

health financing and PFM reform measures would ensure they better align and reinforce one another for stronger efficiency and accountability towards UHC. A joint task force with the Ministry of Finance (MoF) could be established to improve coordination and consistency in reform decisions and implementation when they impact health spending.



# INTRODUCTION

**Gabon initiated a fundamental reform of health financing in 2007 to support the goal of universal health coverage (UHC).** Country leaders expanded health coverage to the poorest segments of the population, mobilized additional public funds through earmarked taxes, and created a national purchasing agency, the *Caisse Nationale d'Assurance Maladie et de Garantie Sociale* (CNAMGS). Researchers studied the reforms in the years after they were introduced (Musango & Inoua, 2010; Saleh, Barroy & Couttolenc, 2014). Years later, Gabon is still cited as an example to leaders of other countries in the region eager to reform their own health financing systems. However, in recent years, researchers have not re-examined the process and outputs of the reform.

**In the late 1990s, Gabon, like many other countries in the region, initiated reforms to its public financial management (PFM) system.** All sectoral ministries, including health, took part. Managers introduced budgetary programmes to better align policy priorities with the budget, and to improve accountability towards results. In 2017, the International Monetary Fund (IMF) led a Public Expenditure and Financial Accountability (PEFA) analysis of the reforms. However, no one has analysed the effects on health sector spending or studied how the PFM reforms relate to the new health financing system, which relies heavily on public funds.

**This paper addresses these two research gaps. The study aims to review the two**

**reform streams, both of which affect how the sector is funded and how resources flow towards purchasing health services.** The research was mostly conducted in 2018–2019. The review is based on quantitative data obtained from Gabon's finance laws, MoH and MoF expenditure reports, National Health Accounts, the Supreme Court of Accounting (*Cour des comptes*) reports, the WHO Global Health Expenditure Database, the PEFA analysis, and analyses from WHO and the World Bank. The authors obtained updated information for 2020 for some components. For others, the financial data is only available after two years (e.g. National Health Accounts). The authors accessed complementary sources of qualitative information on the implementation of several reform measures (e.g. development and implementation of budgetary programmes in MoH), which were fundamental in informing the review. In addition, the MoH General Directorate for Planning, Infrastructure and Equipment supervised a mini survey to gather insights into the implementation of the PFM reform within the health sector and interviewed about 20 officers working in MoH and CNAMGS.

The first section of the report assesses the main outputs of health financing reforms. The second section reviews the main contributions and challenges of PFM reform on health sector spending, with a focus on the programme budget. The conclusion suggests possible courses of action.

# 1. HEALTH FINANCING REFORM: FEATURES AND CHALLENGES OF THE PUBLIC FUNDING MODEL

## 1.1. SUBSTANTIAL, ALBEIT VOLATILE, PUBLIC FUNDS FOR HEALTH

Over the last decade, Gabon has significantly increased its public investment in health. Public funding (or compulsory schemes) as a share of total health expenditure rose from 40% in 2001 to 65% in 2016 (see Fig.1). In 2016, the average for other countries in the Central African Economic and Monetary Community (CEMAC) was 30% (WHO, 2019). That year, Gabon invested more per capita into domestic public spending on health, US\$ 142, than other member countries; the CEMAC average was US\$ 43. Gabon's total health expenditure per capita, US\$ 220, was the second highest after Equatorial Guinea, where the figure was US\$281. The current health expenditure as a share of GDP in Gabon is below the regional average. Still, the country is well-placed in terms of domestic public financing for health (see Table 1).

**Increases in public funding have led to significant decreases in out-of-pocket payments.** The shift towards greater public funding for health has driven down direct household payments. When Gabon launched health financing reforms in 2007, out-of-pocket payments amounted to 50% of total health expenditures. By 2016, the country had the lowest percentage among CEMAC member nations, at 23%. In 2017, the rate

was 24%. Gabon has put compulsory funds at the core of its funding model (see Fig. 1). International evidence suggests such an environment provides better financial protection for the population (Kutzin 2013).

**Public funds have become more unpredictable since the mid-2010s despite the progress made towards improving financial protection.** The macroeconomic situation has exerted downward pressure. The collapse of oil prices, a deficit in non-oil-related revenue collections, and a slowdown in GDP growth led to budgetary adjustments in 2014 and 2015. The government's relative contribution to health financing has increased as a percentage of GDP. However, its net contribution in absolute terms declined dramatically in 2015 and again in 2016. Resources from the general budget allocated to the MoH also fluctuated significantly in percentage terms from 2014 to 2016 (see Table 2). The MoH allocation as a percentage of the state budget fell from nearly 6% in 2014 to less than 3% in 2016.

## 1.2. AN EVOLVING POLICY ON EARMARKED TAXES

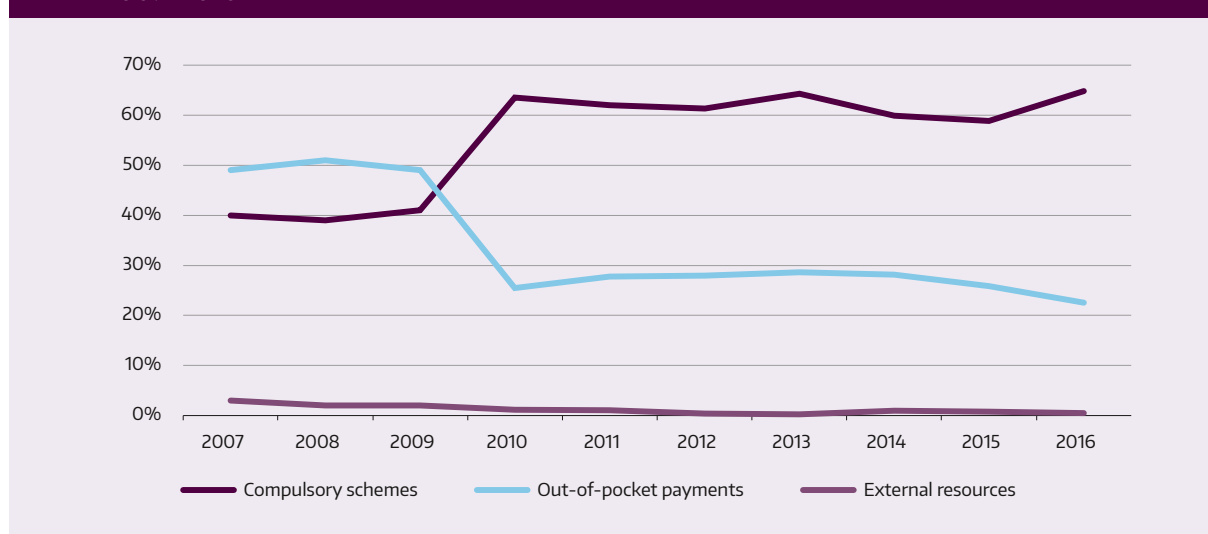
**Contributions in the form of payroll taxes have financed the civil servants fund and the fund for formal private sector employees since 2007.** CNAMGS has

**Table 1.** Health spending in CEMAC countries, 2016

	Current health expenditure per capita (US\$)	Current health expenditure per capita as % of GDP	Domestic public health expenditure per capita (US\$)	Domestic public health expenditure as % of total public expenditure	Domestic public health expenditure as % of GDP	Domestic public health expenditure as % of current health expenditure	Out-of-pocket payments as % of current health expenditure
Chad	32	5	6	6	0.9	19	61
Cameroon	64	5	9	3	0.6	13	70
<b>Gabon</b>	<b>220</b>	<b>3</b>	<b>142</b>	<b>9</b>	<b>2</b>	<b>65</b>	<b>23</b>
Central African Republic	16	4	2	5	0.6	15	43
Equatorial Guinea	281	3	66	3	0.8	24	73
Republic of the Congo	70	5	30	4	2	42	50
Average for low-income countries	24	4.5	4	5.5	0.8	17	52
Average for middle-income countries	159	4	62	5	1.4	36	54
CEMAC average	114	4	43	5	1.2	30	53

Source: Global Health Expenditure Database (WHO, 2017)

NB: To ensure comparability between countries, the values for Gabon were taken from the WHO Global Health Expenditure Database. The values may differ from those used in the analysis below, which are from National Health Accounts data.

**Fig. 1.** Composition of health expenditure as a percentage of total health expenditure in Gabon, 2007–2016

Source: National Health Accounts data

**Table 2. MoH budget 2014–2016**

	MoH budget (billions of CFAF)	State budget (billions of CFAF)	MoH allocation as % State budget
<b>2014</b>	116	1,995	5.8%
<b>2015</b>	98.9	2,068	4.8%
<b>2016</b>	56.9	2,152	2.6%

Source: General Directorate of the Budget and Public Finances – Finance law

managed both funds. The civil servants fund, Fund 1, is financed through a combination of contributions. State employers contributed 5%, employees of the civil service contributed 2.5%, and those on a civil service pension contributed 1%. In 2014, these contributions amounted to CFAF 19 billion. The private sector employees fund, Fund 2, is financed through employee and employer contributions. These contributions represented more than CFAF 26 billion in 2014 and more than 34 billion in 2015.<sup>1</sup> These contribution rates were lowered in 2017 to 4.1% for employers, 2% for employees, and 1% for retirees.

**Other earmarked taxes were introduced to finance coverage for the poorest segments of the population and were considered a major innovation within the health financing system.** In 2007, Gabon created Fund 3, a fully subsidised fund for low-income groups called the Gabon Indigents Scheme (*Gabonais Économiquement Faibles*, GEF). Between 2007 and 2017, this fund was financed primarily through a mandatory health insurance levy, the *Redevance Obligatoire à l'Assurance Maladie* (ROAM). ROAM consisted of a 10% tax on the annual turnover of mobile telephone companies, and a financial transaction tax of 1.5% on

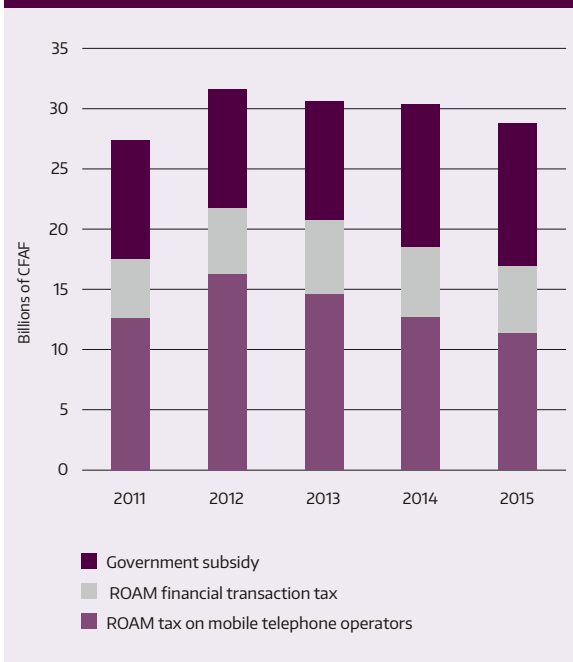
individual international money transfers outside of CEMAC (Musango & Inoua 2010; Mibindzou et al 2018). The funds were collected by the MoF then transferred to CNAMGS.

**In recent years, revenue from ROAM has not covered the increasing costs associated with the GEF.** When earmarked taxes were introduced in 2007, the goal was to have them cover 90% of GEF costs. In the following years, funding remained constant or decreased (see Fig. 2). By 2015, the tax on mobile telephone operators made up 40% of GEF revenues. The financial transaction tax made up 19%. Together, ROAM revenue covered only 60% of GEF-related costs, far from the anticipated 90%. Over the same period, the budget transferred from general revenue to the scheme remained constant, putting GEF at financial risk.

**As a result of pressure from mobile telephone operators and the growing need for additional funds, the government decided in 2017 to abolish the mobile telephone tax and explore other options to help finance GEF.** The levy was dismantled a decade after it had been introduced. The tax on individual transfers was maintained. However, the largest tax – in terms of contributions – was removed. The same year, the government introduced the Special Solidarity Contribution (*Contribution Spéciale*

<sup>1</sup> This increase corresponds to an expansion in the number of employees covered by Fund 2, due to the integration of self-employed workers in 2014.

**Fig. 2. Sources of GEF funding, 2011–2015**

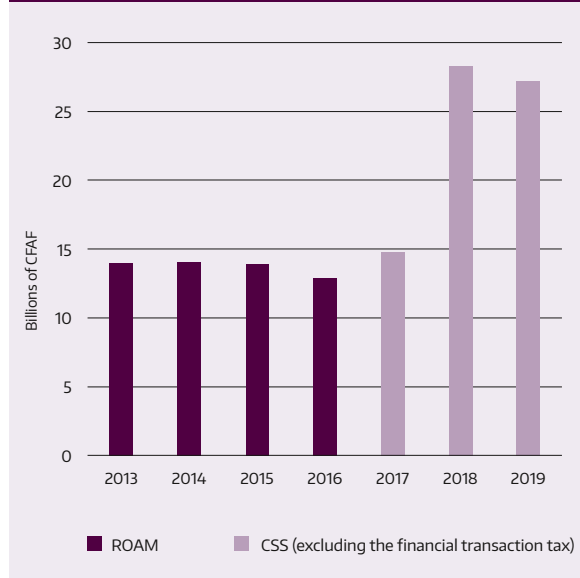


Source: National Health Accounts

*de Solidarité*, CSS), a 1% tax on the purchase of goods and services released for consumption on national territory. The CSS is collected at each stage of the production and sale of goods or services, from the manufacturer, importer, wholesaler, or retailer. It is collected separately from the value-added tax (VAT). Revenues are expected to be earmarked for health.

**The CSS should boost revenue significantly, but the modalities of its transfer to CNAMGS are unclear.** Forecasted revenue from ROAM came to CFAF 12–14 billion between 2010 and 2016. In 2018–2019, the CSS is expected to bring in nearly double that amount, approximately CFAF 28 billion (see Fig. 3). However, questions remain about the practicalities of the transfers and whether all collected revenues will be submitted to CNAMGS. Some individuals interviewed as

**Fig. 3. Predicted revenue from taxes earmarked for CNAMGS, 2013–2019**



Sources: Preliminary and amended finance laws, Ministry of the Budget and Public Accounts

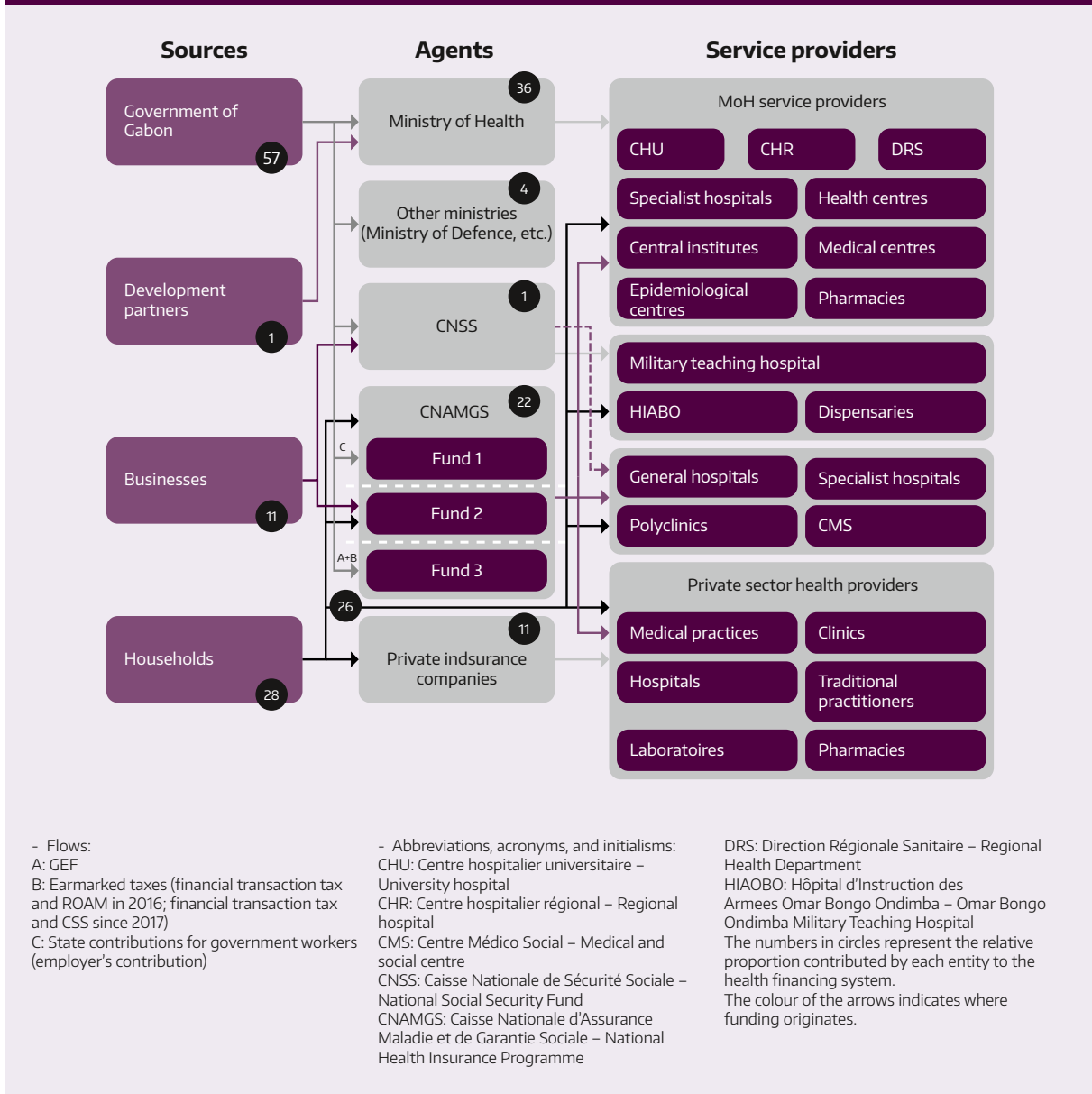
NB: ROAM data are not available for 2011 and 2012. Further, the significant increase in the CSS between tax years 2017 and 2018 is due principally to the application of the import tax in the calculation of the total.

part of the research for this report underlined the lack of transparency regarding the transfer of revenues and questioned whether some revenues may have already been allocated to other purposes.

### 1.3. SUSTAINED FRAGMENTATION IN THE HEALTH FINANCING ARRANGEMENTS

**Despite efforts to consolidate, the health financing system is still too compartmentalized, with multiple funds under one umbrella, each with its own complex financial flows.** The government contributes 57% of all health expenditures.

**Fig. 4. Financial flows in the Gabonese health sector, 2016**



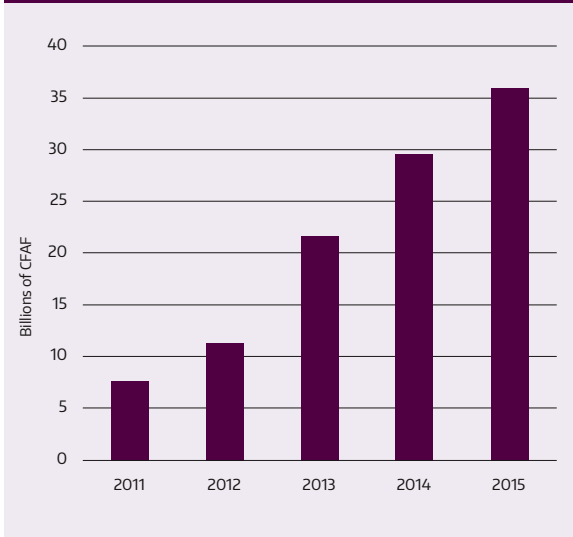
Source: Adapted from Saleh, Barroy, Couttolenc (2014) and based on data from the National Health Accounts 201

The funding is allocated to the Ministry of Defence, which finances the military teaching hospital; the National Social Security Fund (*Caisse Nationale de Sécurité Sociale*, CNSS), which finances sociomedical centres; and the MoH. The funding represents 36% of total health financing and delivers subsidies to

providers to foster the availability and quality of care. The state also supports CNAMGS as an employer through contributions to the civil servants fund (C), subsidies to GEF (A), and earmarked taxes (B) (see Fig. 4). This funding is then used to pay for health services through CNAMGS.



**Fig. 5. CNAMGS health expenditure (excluding social safety nets and GEF welfare benefits), 2011–2015**



Source: Supreme Court of Accounting, 2016

**Fig. 6. CNAMGS health expenditure (health services and medical evacuations) per beneficiary, 2011–2015**



Source: Supreme Court of Accounting, 2016

**Flows are fragmented for CNAMGS and do not allow for cross-subsidisation.** The three CNAMGS funds come from different sources: the MoF, the Ministry of Social Affairs, and private employers and employees. The funds pay for services for their respective beneficiaries separately. The idea of creating a common pool of resources to draw upon was not considered in the early stages of the reform (Saleh, Barroy, Couttolenc, 2014)<sup>II</sup>. As a result, there are now limited opportunities for cross-subsidisation between the well-funded scheme for more privileged Gabonese – public and private sector employees – and that covering the poorest segments of the population. The fragmentation in funding resources has led to complexities in resource management at provider level where patient

<sup>II</sup> This is primarily because CNAMGS was taking over the CNSS schemes for government workers and workers in the formal private sector, which already existed prior to 2007.

data management and financial reporting is not consolidated.

#### **1.4. LACK OF STRATEGIC PURCHASING POLICY LEADING TO ESCALATING EXPENDITURE**

**CNAMGS expenditures for health services have experienced an exponential increase.** Between 2011 and 2015, the total expenditure on health services by CNAMGS, excluding social safety nets and GEF welfare benefits, increased from CFAF 7.7 billion to CFAF 36 billion (see Fig. 5).

This exponential growth is linked to a growing demand for health services, an expansion in the number of people covered, and inefficient purchasing of services. Per

capita expenditures on health increased from CFAF 14.32 in 2011 to CFAF 34.54 in 2015 (see Fig. 6).

**The fee-for-service payment method is one of the main drivers of the uncontrolled increase in expenditures.** This method is the only one used in health facilities. Its application has generally proven to contribute to an excessive use of medical procedures so as to generate a funding surplus for health facilities (Langenbrunner, Cashin, O'Dougherty, 2009). Gabon's Supreme Court of Accounting has reported on weaknesses in CNAMGS's oversight process. The purchasing agency does not have enough inspectors to cover all health facilities. And irregular quality controls are not connected to payment for services<sup>III</sup>.

**CNAMGS should play a more active role in purchasing health services.** The agency should explore new payment mechanisms as a replacement for its fee-for-service model. These may include capitation payments, global budgets, or a payment system based on diagnosis-related groups (DRG). A DRG-based pilot is underway. An analysis will help to identify the consequences of such a system on the cost and quality of care. In 2017, the MoH launched discussions on the possible

adoption of a performance-based payment mechanism for other facilities. CNAMGS would oversee this alternative, possibly with a separate funding stream with international support (Mibindzou et al 2018).

**The benefit package policy may also be reconsidered.** The existing package is comprehensive for all population groups, and includes provisions for medical evacuations abroad. The copay for beneficiaries generally amounts to 20% of the cost of services. The copay drops to 10% of the cost of services for chronic diseases. The scheme covers the full cost of services for maternal health, dialysis and cancer treatments. GEF beneficiaries are exempted from copayments. Trade-offs in terms between cost reductions and equity will need to be considered if the benefit package policy is to be modified.

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III The Supreme Court of Accounting reports CNAMGS provides limited oversight of its payment system. At times, CNAMGS will perform medical checks in health facilities and validate invoices before payment. Survey respondents suggest many failures in the system.

- There are not enough inspectors in the Department of Medical Oversight and Fraud Control to cover all health facilities.
- Despite the deployment of inspectors at some health facilities, on-site controls are largely insufficient.
- The responsibilities of inspecting physicians and contracted physicians are unclear. The same is true of responsibilities covering both medical oversight and payment for services.
- The CNAMGS welfare unit only conducts sporadic community surveys.
- There are no routine quality reviews.

## 2. PFM AND BUDGETING REFORM: DESIGN AND IMPLEMENTATION OF KEY MEASURES IN HEALTH

### 2.1. STRENGTHENING THE OVERALL PFM SYSTEM: MIXED RESULTS

In the late 1990s, the PFM reform goal was to make the budget more transparent, more flexible for managers, and more accountable through clearly defined outputs. The reform included a number of key features:

- Moving from input-based budgets to output-oriented budgets;
- Decentralizing budget management centres and creating new roles within ministries, including programme managers and operational unit managers;
- Introducing a multi-year expenditure framework; and
- Developing a new financial information system.

As a result of the PFM reform, the budget is now formulated by programmes and missions, and new spending roles have been assigned to sector ministries. There are 32 missions, which are equivalent to ministries (e.g. MoH has one mission). The government must now report on the use of budgets by output for each mission. Responsibility for managing funds lies with the minister of each sector, who is essentially the chief authorizing officer for expenditures (this is called *déconcentration de la dépense*, the deconcentration of expenses). Therefore, professionals within the ministries have taken on responsibility for effective spending and reporting of predefined outputs

and are no longer simply appropriation managers reporting to the budget minister. New management rules have been introduced that give programme managers greater flexibility. They are now given a programme envelope (i.e. aggregation) and the ability to transfer budget provisions from one category to another within the same programme (i.e. fungibility)<sup>IV</sup>.

**The reform introduced a performance monitoring system across sector allocations.** Annual performance plans are established for each ministerial mission and are presented as annexes to the finance law. They include a strategic analysis of the mission and its objectives and the proposed allocation of budget provisions by programme and operational unit. In addition, budget authorizing officers and delegated personnel are now required to evaluate the objectives by producing an annual performance report to accompany the finance law the following year (Y+1). The performance-based approach extends to state-controlled entities, called operators. The state requires operators to sign an annual performance objective contract with their respective ministries, in an effort to track funds. The contract stipulates the commitments that need to be met based on the subsidies allocated to the operator during a given budget period.

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IV Asymmetric fungibility, *fongibilité asymétrique*, the practice of transferring or reducing capital expenditures towards personnel costs, is not allowed in the new system.

### Box 1. Key weaknesses in Gabon's PFM system post-reform

There is a recurrent lack of credibility in the budget documents<sup>v</sup>. Also, annual performance plans and the strategic plans included in budget documents are poorly aligned with expenditure estimates. There are significant discrepancies between annual budgets and medium-term expenditure estimates. There are also significant gaps in expenditure forecast by each mission in their annual performance plans and initial budget envelope, published in June, and the finance law, which is enacted in October of each fiscal year.

While performance-related information is more detailed after the PFM reform and programme classifications are now used in all budget documents, access to and use of this information is limited. Deadlines for publishing financial documents are seldom met and information on annual transfers to subnational administrative units is not published before the start of their financial year. The allocation criteria for transfers to these subnational entities are also unclear. Performance plans are firmly in place and performance-related information is published annually, but the information is underutilized or not used at all. Similarly, there is no real performance audit (the Supreme Court of Accounting only publishes a few comments in its annual reports) and transactions, such as those for expenditure or dividends collected by the state from public institutions and enterprises, are often not recorded.

Numerous budget adjustments made throughout the fiscal year make it challenging to predict the final budget. In 2015, these changes accounted for 57% of all authorizations granted under the amended finance law. Special waivers from general public accounting regulations are used widely, accounting for 30% of total payments in 2016. A simplified process called encumbrance/liquidation is also used for operating costs, whereby the encumbrance monitored by the budget controller is separate from oversight of the availability of budget provisions, which is the authorizing officer's prerogative.

Source: PEFA, 2017

**Despite significant progress and investment in a new institutional architecture to implement the PFM reform, many weaknesses in the PFM system remain. The**

most recent Public Expenditure and Financial Accountability analysis (PEFA, 2017) found most aspects of the PFM system, from budget development to budget execution and monitoring, to have profound deficiencies. Some aspects may have even exacerbated existing bottlenecks (see Box 1).

**More broadly, the introduction of the programme-based budget has been challenging enough that it may lead to a potential withdrawal of the reform.** MoF reports suggest the definition of programmes has been a cumbersome exercise, especially in the absence of clear guidance. The Supreme

<sup>v</sup> In 2014 and 2015, total actual expenditure accounted for just 67% of the expenditure approved at the start of the year. In 2015, the composition of expenditure, categorized by administration or by mission/programme, diverged from the initial budget by more than 15%. The level of implementation of actual revenue was well below initial forecasts. Though there has been progress on economic forecasting, more needs to be done to take full account of all provisions of the finance law. The requirement that an economic, social and financial report be annexed to finance bills has helped improve economic forecasting. However, current forecasting tools are out of date and should be updated.

Court of Accounting noted shortcomings in the design of programmes in terms of scope, content, boundaries and alignment with government priorities. The court also recognized that administrative managers were either not delegating budgetary responsibilities to programme managers or were delegating responsibility with vague criteria (Supreme Court of Accounting, 2018). The early round of negative assessments led the Council of Ministers to push for the withdrawal of the reform in 2018.<sup>VI</sup>

## 2.2. MOH PROGRAMME BUDGET: ISSUES WITH DESIGN AND STRUCTURE

The introduction of the programme budget helped the MoH identify policy goals that were then included in the budget documents. However, the defined objectives do not fully align with sector needs or delineate a policy mandate for MoH in relation to the purchaser. The defined objectives are the following:

1. to build health infrastructure;
2. to reduce maternal and infant mortality; and
3. to boost awareness and screening activities with a view to reducing behaviours and practices associated with the risk of sexual transmission.

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VI In 2018, in the absence of convincing results, President Bongo announced his intention to revisit the reform. At the end of that year, the Council of Ministers terminated the programme budget objectives. But the 2019 Finance Act still follows the provisions of the 2014 Budget Act. To the extent that the reforms meet CEMAC's requirements, it is not certain that the return to the input-based budget will be made effective.

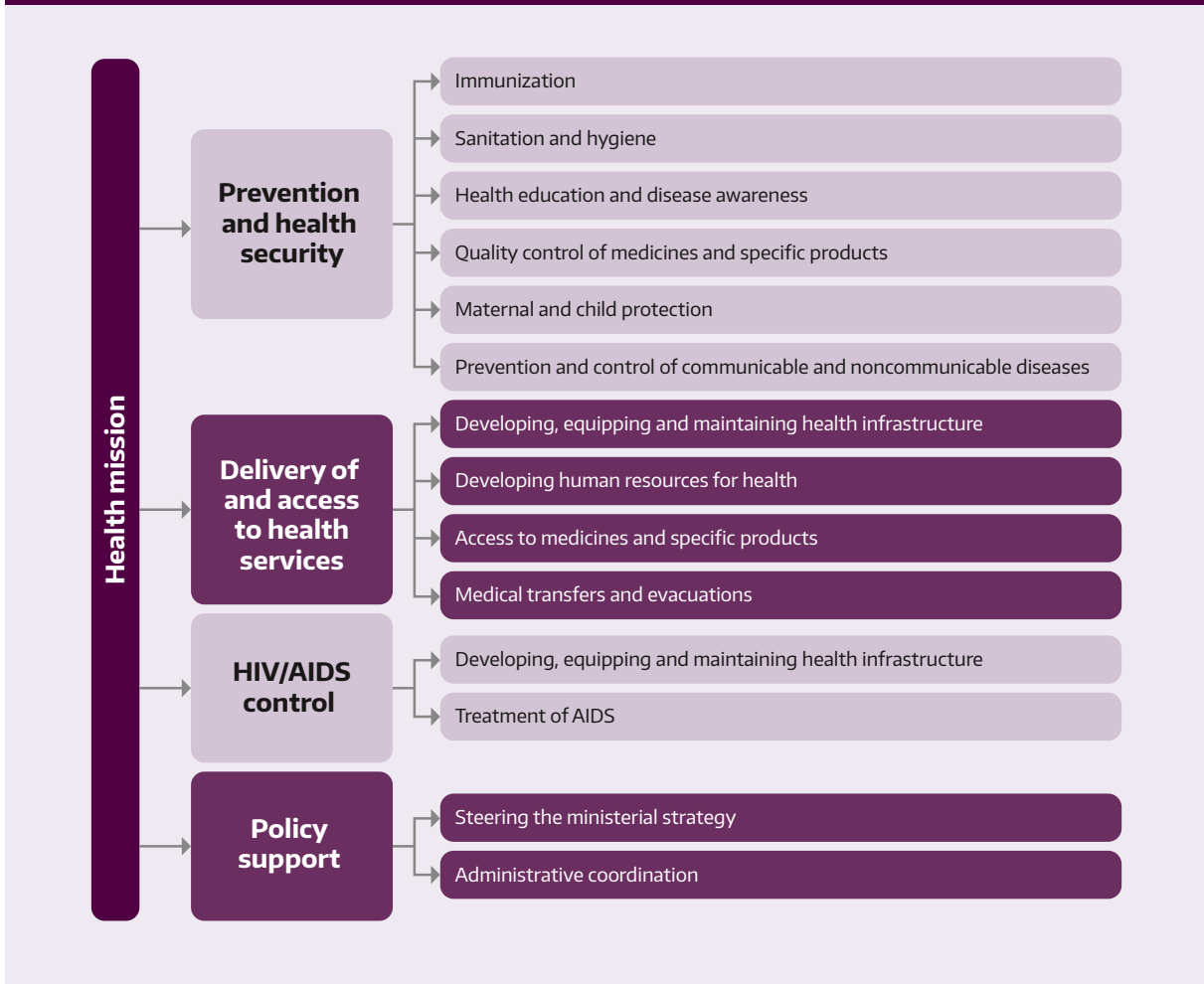
The three objectives vary widely in terms of focus. The first objective focuses on concrete actions (i.e. building facilities). The second focuses on the outcome level (i.e. reduction of maternal mortality). The third objective is focused on specific interventions (i.e. screening) that could actually serve the second objective of reducing maternal and infant mortality. The first objective seems aligned with the need to upgrade the availability and quality of facilities, especially in rural areas (Saleh, Barroy & Couttolenc, 2014). The second objective, as broadly formulated, does not support the definition of a clear mandate for the MoH. The third objective is focused and directly connected to the delivery of care, thereby overlapping with the role of CNAMGS.

**Four budgetary programmes were defined for the MoH budget in 2015. Their scope and boundaries exposed a disconnect between the budgetary programmes and the policy objectives.** The MoH health mission has four major budgetary programmes that are each divided into actions:

1. prevention and health security;
2. delivery of and access to health care services;
3. HIV/AIDS control; and
4. policy support.

The programme related to prevention and health security includes six actions. The programme on delivery and access to care includes four actions. The last two programmes, concerning HIV/AIDS and policy support, each include two actions. While some actions included in programme 2 serve the first objective of building health infrastructure, programmes 1 and 3 have limited connection to the other objectives (see Fig. 7).

**Fig. 7.** Distribution of programmes and actions within the health mission

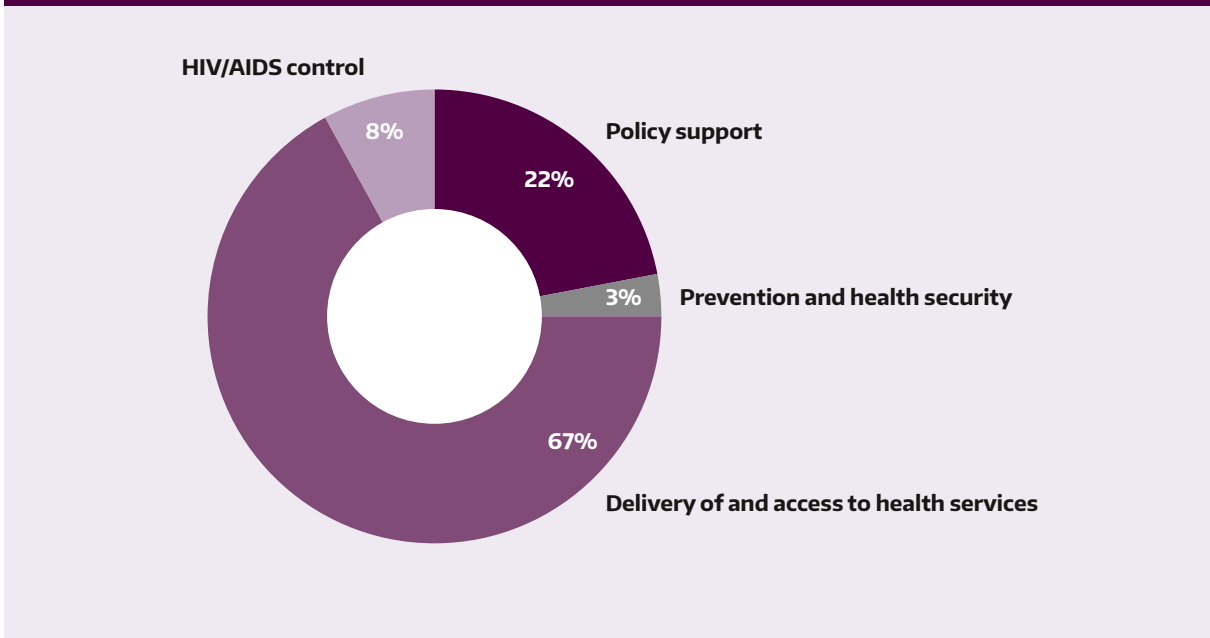


Source: Annual performance plan 2019, Ministerial Health Mission

The budget breaks down heavily in favour of the programme on delivery and access to services, which challenges the programme-based approach. In 2017, programme 2 on delivery and access to care accounted for 67% of all budget provisions under the health mission. The size of this allocation monopolizes the mission's budget and makes other programmes seem marginal. The presence of inordinate programmes limits the ability to use them as a unit for spending prioritization and may compromise accountability (see Fig. 8).

The scope of the budgetary programmes follows the institutional structure of the MoH, which has advantages and disadvantages. The four budgetary programmes were based primarily on MoH administrative logic and mirror the four main MoH directorates (see Table 3). This approach can improve accountability. However, it reinforced pre-existing administrative realities rather than newly-identified sector priorities. Instead of integrating HIV/AIDS interventions into the programme on delivery and access to services, the government

**Fig. 8.** Breakdown of the 2017 health mission budget (% of budget provisions allocated to the mission)



Source: Finance Law 2017

**Table 3.** Breakdown of budgetary programmes and oversight by the MoH

Programmes	Oversight
Health security and prevention	General Health Directorate
Delivery of and access to health services	General Directorate for Planning, Infrastructure and Equipment
AIDS control	General Directorate for AIDS Prevention
Steering and supporting health policy	General Secretariat

Source: Ministry of Health

decided to create a specific AIDS-related programme because there was already a General Directorate for AIDS Prevention. The choice to follow the institutional structure of the MoH may have represented a missed opportunity to use the programme budget as a tool for priority setting.

### 2.3. CHALLENGES IN MOH BUDGET EXECUTION

**Despite changes in budget formulation, input-based ex ante controls that remain in the expenditure process have been problematic.** Whereas the reform was



theoretically supposed to offer greater flexibility in managing the budget envelope, its poor implementation has hampered the achievement of this objective. For each disbursement, administrative managers continue to require an input-based justification to release funds. The expenditure chain is fragmented. The incomplete integration of the accounting and budgetary systems makes it difficult to reconcile the different operations, making it harder for oversight bodies to monitor ministries' payment arrears and actual budget implementation. This creates a mismatch between the formulation of appropriations specified in the finance law and expenditures.

**Design flaws, complexities in spending procedures, and a reduction in revenues have prevented the MoH from executing its budget effectively since the introduction of the programme-based budget in 2015.**

Execution is close to 60%. When personnel expenditures and expenditures from external sources are removed, the rate for 2016 drops to 28%. Complex spending procedures have been reported to exacerbate poor budget execution. Officials from MoH who were interviewed report a number of failings:

- operational units are unfamiliar with overall budget envelopes;

- budget centres are not sufficiently familiar with new budget management rules;
- there are challenges in releasing appropriations on a timely manner;
- there is instability and shortcomings with the financial information management system; and
- budget controllers are not connected to an online network and cannot report expenditures appropriately.

**All programmes except the HIV/AIDS control programme display low execution.**

The implementation rate in 2017 ranged from 2% for the policy support programme to 37% for the delivery of and access to health services programme. The higher rate for the HIV/AIDS control programme is due in part to the availability of external resources, which were executed separately (see Table 5).

**Poor budget implementation for the delivery of and access to health services programme has created significant funding challenges for health facilities.**

Insufficient funding has created financial problems for many facilities that use public subsidies to maintain and upgrade the availability and quality of care. An analysis of the 10 major operators receiving subsidies from the programme revealed considerable

Year	Adopted budget (billions of CFAF)	MoH budget implementation rate	MoH budget implementation rate, excluding external funding and personnel expenditure
2012	123.6	71%	62%
2013	146	69%	41%
2014	125.2	61%	30%
2015	98.9	61%	39%
2016	56.9	60%	28%

Source: Central Financial Affairs Directorate, Ministry of Health



financial difficulties. University hospitals have satisfactory implementation rates. However, regional hospitals in more remote areas; particularly those at Port-Gentil, Franceville and Oyem; received less than 40% of their

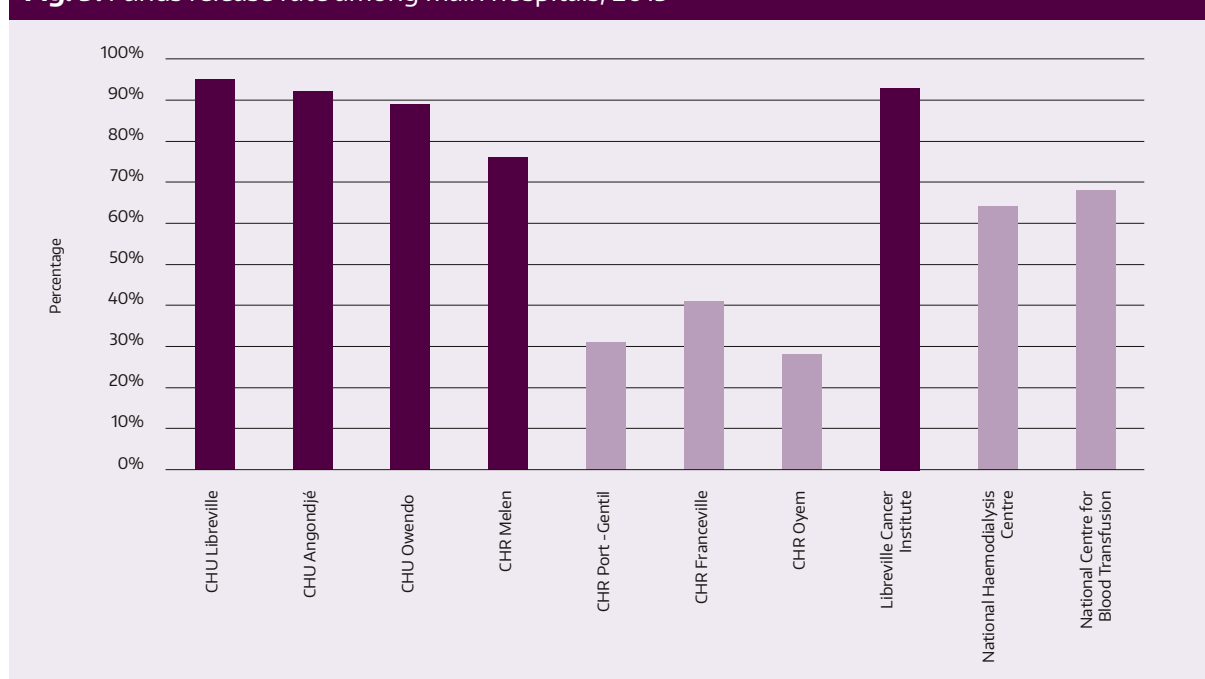
respective budget transfers in 2015 (see Fig. 9). A substantial discrepancy exists between the budgets adopted and the funds disbursed for these facilities. The situation has hampered the delivery of services.

**Table 5.** Budget implementation by MoH programme in 2017

Programme/Title	Allocated under amended finance law 2017 (billions of CFAF)	Implemented under amended finance law 2017 (billions of CFAF)	Difference	Implementation rate
Prevention and health security	18.09	1.97	16.27	11%
Delivery of and access to health services	73.88	27.15	46.73	37%
HIV/AIDS control	2.06	1.83	0.23	89%
Policy support	10.15	0.18	9.97	2%

Source: Ministry of the Budget and Public Accounts

**Fig. 9.** Funds release rate among main hospitals, 2015



Source: Ministry of Health, 2015

# CONCLUSION

The reforms adopted by Gabon over ten years have led to major changes in health financing and public financial management frameworks. The country has demonstrated its commitment to UHC by mobilizing new resources and prioritizing coverage expansion to the poorest segments of the population. Furthermore, the adoption of the new PFM framework and the shift to a programme-based budget exemplify the government's efforts to introduce greater transparency and improve performance in public spending.

In practice, both reforms suffered from incomplete implementation, leading to financial fragmentation and escalating costs for CNAMGS, and to complex resource management and poor budget execution for MoH. Finally, both the PFM and health financing reforms suffer from a lack of harmonization and coordination which has led to inconsistencies. More coherence and transparency across the entire chain of public expenditure for health is essential if the country is to maintain and increase its gains towards UHC.

Going forward, a set of coordinated reforms should be implemented to sustain gains towards UHC and improve consistency and effectiveness:

1. **Pooling arrangements:** CNAMGS is split into several funds that cover specific population groups, with no cross-subsidisation. The purchaser receives funds from various sources and redistributes them to providers in a fragmented manner. As Gabon tries to expand coverage for the informal private sector workers, a review of existing pooling arrangements is needed to explore opportunities for further consolidation. Working towards a single-payer arrangement could reduce administrative costs, streamline financial and data management for providers and ensure better protections for users.
2. **Strategic purchasing:** the predominant use of fee-for-service payments puts the funding model at risk. The escalating costs of the purchaser are heavily linked to the lack of an effective strategic purchasing policy. CNAMGS should reconsider its approach to purchasing health services by exploring alternative payment methods such as capitation or diagnosis-related groups to ensure the financial sustainability of the model.
3. **GEF funding:** ensuring the continuity in public funding for GEF should be a priority. The scheme offers critical protection for the poorest Gabonese. The mobile phone tax had been a main source of funding since 2007. Its termination in 2017 put the scheme at risk. New tax policies should be explored, and revenues collected through CSS should be earmarked as much as possible to avoid compromising these assets.
4. **MoH budgeting:** while the programme budget was introduced to provide more flexibility in resource management, flaws in design and implementation of MoH budgetary programmes have hampered results and reduced budget execution. Redefining the content and outline of programmes to better align with health sector priorities is essential to ensuring better outputs.

5. **Sector accountability:** recent reforms have not improved accountability in the absence of a consolidated framework for monitoring results that would encompass MoH, other ministries and CNAMGS funding for health service providers. Given the benefits of programme budgets in streamlining and consolidating operational and financial accountability, there is a real opportunity to prioritize the development and use of a robust performance monitoring framework for the sector.
6. **Better reform consistency and coordination:** health financing and PFM reform measures both impact health spending in various ways. In the past, these measures have not been coordinated and harmonized. A joint MoH/MoF task force could be established to ensure better coordination and consistency in reform decision-making and implementation when they impact health spending.

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