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The Fiscal Calendar Of Universal Health Coverage:

A Budget Impact Analysis Of Implementing Somalia's Essential Package, 2026–2030

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Abstract

Background. Costings state what a health package requires; budget impact analysis (BIA) states what adopting it does to each year's budget, against the financing actually in prospect. For Somalia's Essential Package of Health Services (EPHS), the question has become acute: the package's requirement rises along its planned coverage trajectory precisely as external financing — 99% of institutional health financing — contracts.

Methods. Following budget-impact good practice adapted to a sector-level programme, we take the payer (health sector) perspective over a five-year horizon (2026–2030), in undiscounted nominal US dollars. The requirement path is the national EPHS costing (Scenario 1, existing facilities: US$251.8 million rising to US$501.0 million; Scenario 3, facility expansion: US$295.4 to US$655.2 million). The financing baseline is 2026 committed resources — US$126.0 million external plus US$9.3 million federal allocation. Three financing scenarios are analysed: F1, financing frozen at the 2026 level; F2, external financing recovering to its 2025 level (US$320 million) by 2028 with the federal allocation growing 20% annually; F3, scenario F2 plus health-tax revenues of US$43.5 million annually from 2027, per the national health-tax framework.

Results. The five-year requirement is US$1,818.4 million (Scenario 1) to US$2,266.1 million (Scenario 3), with the annual increment rising from +US$44.7 million (2027) to +US$82.9 million (2030) even without facility expansion. Under F1, the cumulative gap is US$1,141.9 million — 63% of the requirement unfunded — with annual gaps widening from US$116.5 million to US$365.7 million. Under F2, the cumulative gap falls to US$440.1 million (24%): the gap nearly closes in 2028 (US$17.6 million) but re-opens to US$82.0 million in 2029 and US$161.7 million in 2030 as the coverage trajectory outruns even fully recovered financing. Under F3, the cumulative gap is US$266.1 million (15%), with 2028 in surplus (US$25.9 million) — yet gaps of US$38.5 million and US$118.2 million re-emerge in 2029–2030. Across all scenarios the binding year is 2029: the point at which the trajectory's steepening increments exceed any financing path assembled from recovery and currently proposed domestic instruments.

Conclusions. Somalia's EPHS is financeable through 2028 under plausible recovery plus the proposed health taxes, and unfinanceable from 2029 without either new resources or explicit re-phasing of the coverage trajectory. That is the decision the budget impact analysis surfaces: not whether to prioritise, but when the re-phasing choice arrives — and it arrives in the 2029 budget, which is prepared in 2028. The fiscal calendar, not the costing total, is what negotiation and planning need.

1. Background

The costing of Somalia's Essential Package of Health Services answers the question what does universal coverage cost: US$251.8–295.4 million in 2026, rising to US$501.0–655.2 million at the 80% coverage endline in 2030 [1, 2]. It does not answer the question a ministry of finance, a health sector coordination committee or an external financier actually decides on: what does adopting this trajectory do to each year's budget, given the financing realistically in prospect? That is the province of budget impact analysis — a standard instrument for new technologies and programmes [3] that is rarely applied at the level where fragile-state financing decisions are made: the whole essential package.

The application is urgent in Somalia because the two sides of the ledger are moving in opposite directions. The requirement rises every year by design, as intervention coverage scales toward 80%. The financing base has contracted abruptly: committed external resources for 2026 stand at US$126 million against US$320 million in 2025, leaving the year's requirement roughly half financed [4, 5]. Whether the trajectory is financeable at all — and if so, until when, and with which instruments — has not been formally analysed. This paper analyses it.

2. Methods

Framework. We follow budget-impact good practice [3] adapted to a sector programme: payer (health sector) perspective; five-year horizon (2026–2030); undiscounted, nominal US dollars, consistent with budget planning convention; requirement and financing paths specified explicitly; results as annual and cumulative gaps.

Requirement path. The national EPHS costing [2]: Scenario 1 (delivery through existing facilities) — US$251.8, 296.5, 351.0, 418.1 and 501.0 million for 2026–2030; Scenario 3 (facility expansion to population norms) — US$295.4, 355.4, 431.3, 528.8 and 655.2 million. Annual increments under Scenario 1 rise from +US$44.7 million (2027) to +US$82.9 million (2030); under Scenario 3, from +US$60.0 to +US$126.4 million.

Financing baseline and scenarios. The 2026 baseline is US$135.3 million: US$126.0 million in committed external financing per the Ministry's resource mapping [4] plus the US$9.3 million federal health allocation [5]. Three scenarios:

- **F1 — frozen:** total financing constant at US$135.3 million.
- **F2 — recovery:** external financing recovers linearly to its 2025 level (US$126 → 223 → 320 million by 2028, then constant), reflecting re-engagement and late commitments; the federal allocation grows 20% annually (US$9.3 → 19.3 million by 2030), continuing its demonstrated upward trajectory.
- **F3 — recovery plus health taxes:** F2 plus US$43.5 million annually from 2027, the estimated yield of the national health-tax framework (khat, tobacco and sugar-sweetened beverage excises) at its central scenario [6].

Scenario 1 is the primary requirement path (the feasibility floor); Scenario 3 results are reported as the expansion case. Sensitivity to the recovery speed and tax yield is discussed qualitatively; the workbook accompanying the series permits re-running all paths.

Ethics. Analysis of government costing and financing data; no human participants; ethics review not required.

3. Results

3.1 The requirement path: rising increments, not a rising line

The five-year requirement totals US$1,818.4 million under Scenario 1 and US$2,266.1 million under Scenario 3 (Table 1). The politically relevant feature is not the total but the *increments*: each year of the trajectory demands more additional money than the year before — +US$44.7 million in 2027 steepening to +US$82.9 million in 2030 without facility expansion, and to +US$126.4 million with it. A financing strategy adequate for the trajectory's early years is therefore not evidence of adequacy for its later ones.

Table 1. EPHS financing requirement and annual increments (US$ millions).

Year	Scenario 1	Increment	Scenario 3	Increment
2026	251.8	—	295.4	—
2027	296.5	+44.7	355.4	+60.0
2028	351.0	+54.5	431.3	+75.9
2029	418.1	+67.1	528.8	+97.5
2030	501.0	+82.9	655.2	+126.4
2026–2030	**1,818.4**		**2,266.1**	

3.2 Scenario results: the gap under three financing paths

Figure 1

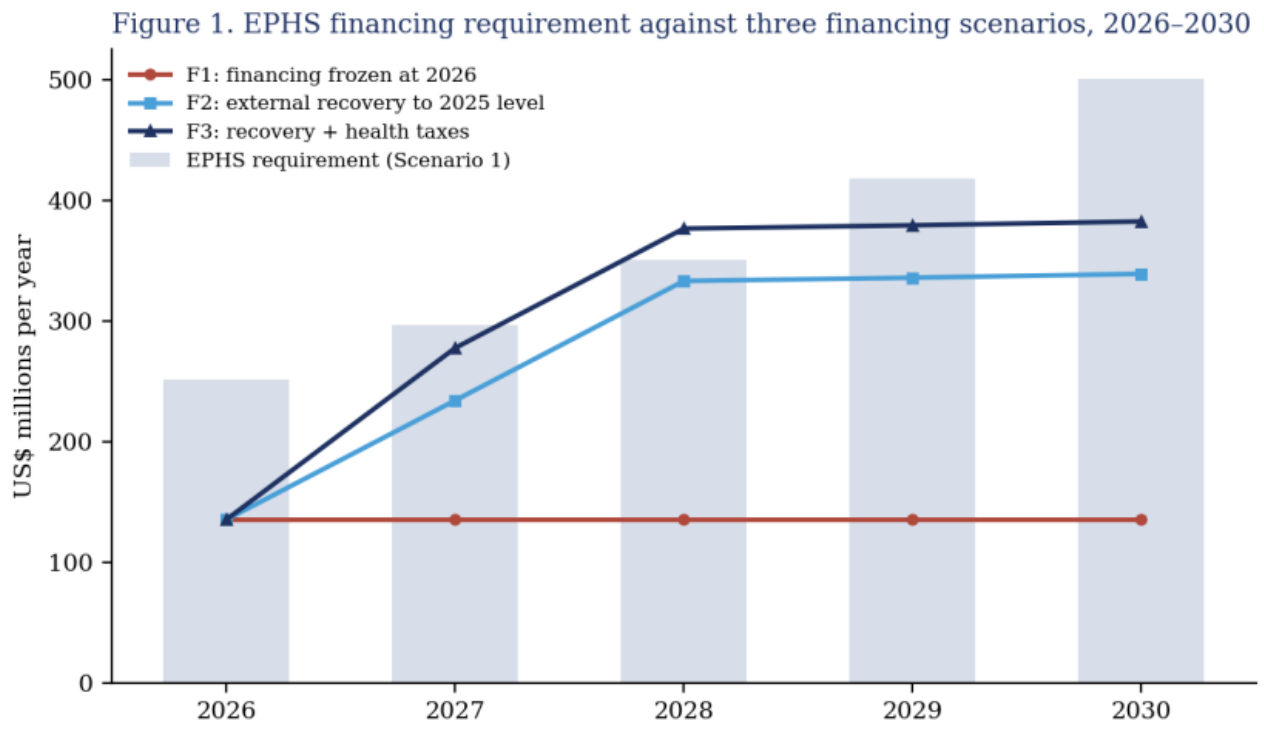

Figure 1. EPHS financing requirement against three financing scenarios, 2026–2030.

Table 2. Annual and cumulative financing gaps, Scenario 1 requirement (US$ millions).

Year	Requirement	F1: frozen	Gap	F2: re-covery	Gap	F3: re-covery + taxes	Gap
2026	251.8	135.3	116.5	135.3	116.5	135.3	116.5
2027	296.5	135.3	161.2	234.2	62.3	277.7	18.8
2028	351.0	135.3	215.7	333.4	17.6	376.9	−25.9
2029	418.1	135.3	282.8	336.1	82.0	379.6	38.5
2030	501.0	135.3	365.7	339.3	161.7	382.8	118.2
Cumulative gap			**1,141.9 (62.8%)**		**440.1 (24.2%)**		**266.1 (14.6%)**

Negative gap denotes surplus. F2: external financing recovers to US$320m by 2028; federal allocation grows 20%/year. F3: F2 plus US$43.5m/year health-tax revenue from 2027.

Under **F1 (frozen financing)**, the trajectory is not remotely financeable: 63% of the five-year requirement is unfunded, with the annual gap nearly tripling to US$365.7 million by 2030. Frozen financing is not a steady state; it is a widening annulment of the coverage plan.

Under **F2 (full external recovery plus sustained federal growth)**, the picture transforms — and then deteriorates. The 2027 gap narrows to US$62.3 million and the 2028 gap to US$17.6 million: near-closure. But from 2029 the requirement's steepening increments outrun a financing path that has, by construction, already given everything recovery can give: the gap re-opens to US$82.0 million in 2029 and US$161.7 million in 2030. Full recovery to the sector's best-ever financing level funds the plan for exactly two more years.

Under **F3 (recovery plus health taxes)**, 2028 moves into modest surplus (US$25.9 million) and the cumulative gap falls to 15%. Yet the same structural result recurs: gaps of US$38.5 million (2029) and US$118.2 million (2030) re-emerge. The proposed domestic instruments, at their estimated yield, buy roughly one additional financed year.

Under the Scenario 3 requirement, all gaps widen by US$43.6–154.2 million per year and no financing path examined closes any year from 2027 onward: facility expansion is, on present prospects, unfinanceable alongside full coverage scale-up, sharpening the access-versus-coverage choice analysed elsewhere in this series [7].

3.3 The binding year

Across every financing path, the analysis converges on a single structural fact: **2029 is the wall.** Through 2028, plausible recovery plus the proposed health taxes can finance the Scenario 1 trajectory nearly in full. From 2029, the increments (+US$67.1 million, then +US$82.9 million) exceed what any examined combination of recovery and currently proposed domestic instruments supplies. The choice at that point is arithmetic, not rhetorical: new resources of roughly US$40–160 million per year (insurance contributions, expanded taxes, new external compacts), or explicit re-phasing of the coverage trajectory — a slower path to 80%, or a prioritised sub-package at full coverage. And because the 2029 budget is prepared during 2028, the decision date is not 2029; it is next year.

4. Discussion

Three implications follow. First, **the debate is mis-specified as "affordable or not."** The trajectory is affordable through 2028 under achievable conditions and unaffordable thereafter under all examined ones; the useful output is the calendar, not a verdict. Framing sector negotiations around the 2029 decision point — with the pooled financing mechanism, the health-tax legislation and any new external compacts sequenced to land before it — converts a chronic financing anxiety into a datable planning problem [6, 8].

Second, **recovery is necessary and insufficient.** The strongest available external scenario — full restoration of the 2025 envelope — finances two years. This reframes the resource-mobilisation agenda: domestic instruments and new compact models are not supplements to recovery but the only route past 2028, and their legislative and institutional lead times are exactly as long as the calendar allows.

Third, **re-phasing should be planned, not suffered.** If the 2029 gap is not pre-financed, the trajectory will be re-phased implicitly — by stockouts, hiring freezes and pro-rata scale-downs, the costliest form of prioritisation [7]. An explicit, cost-effectiveness-informed re-phasing option, prepared in advance as a contingent plan, is the difference between choosing the sector's path and having it chosen by cash flow.

Limitations. Five apply. The requirement path is the national costing's — normative, at fixed prices; realised costs will differ. The financing scenarios are constructed paths, not forecasts: F2's recovery speed and F3's tax yield are the central estimates of their source documents, and slower recovery or lower yield moves the wall earlier, never later. Nominal, undiscounted treatment follows budget convention but ignores inflation's effect on real coverage. The federal-growth assumption extrapolates one exceptional budget year. And the analysis is sector-level: it does not allocate gaps across programmes, which is the province of the allocative analysis elsewhere in this series [7].

5. Conclusions

Implementing Somalia's essential package requires US$1.82 billion over 2026–2030 through existing facilities and US$2.27 billion with facility expansion, with annual increments that steepen every year. Frozen financing leaves 63% of the requirement unfunded; full external recovery closes the gap only through 2028; adding the proposed health taxes buys 2028 in surplus and little more. Every path converges on 2029 as the year the coverage trajectory outruns the financing frontier — and on 2028 as the year the decision must be made. The budget impact analysis thus delivers what the costing alone cannot: not a price, but a deadline.

Declarations

Contributors. KMM conceived and designed the study, conducted the analysis, and wrote and revised the manuscript. KMM is the guarantor.

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Competing interests. The author serves as Health Financing Specialist at the Ministry of Health and Human Services, Federal Government of Somalia, leading the Health Economics and Financing Office, and is Chief Executive Officer of the Institute of Public Finance, Somalia.

Ethics approval. Not required: analysis of government costing and financing data; no human participants.

Data availability. All requirement and financing paths are stated in full in the tables; the series workbook permits re-running the scenarios under alternative assumptions.

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