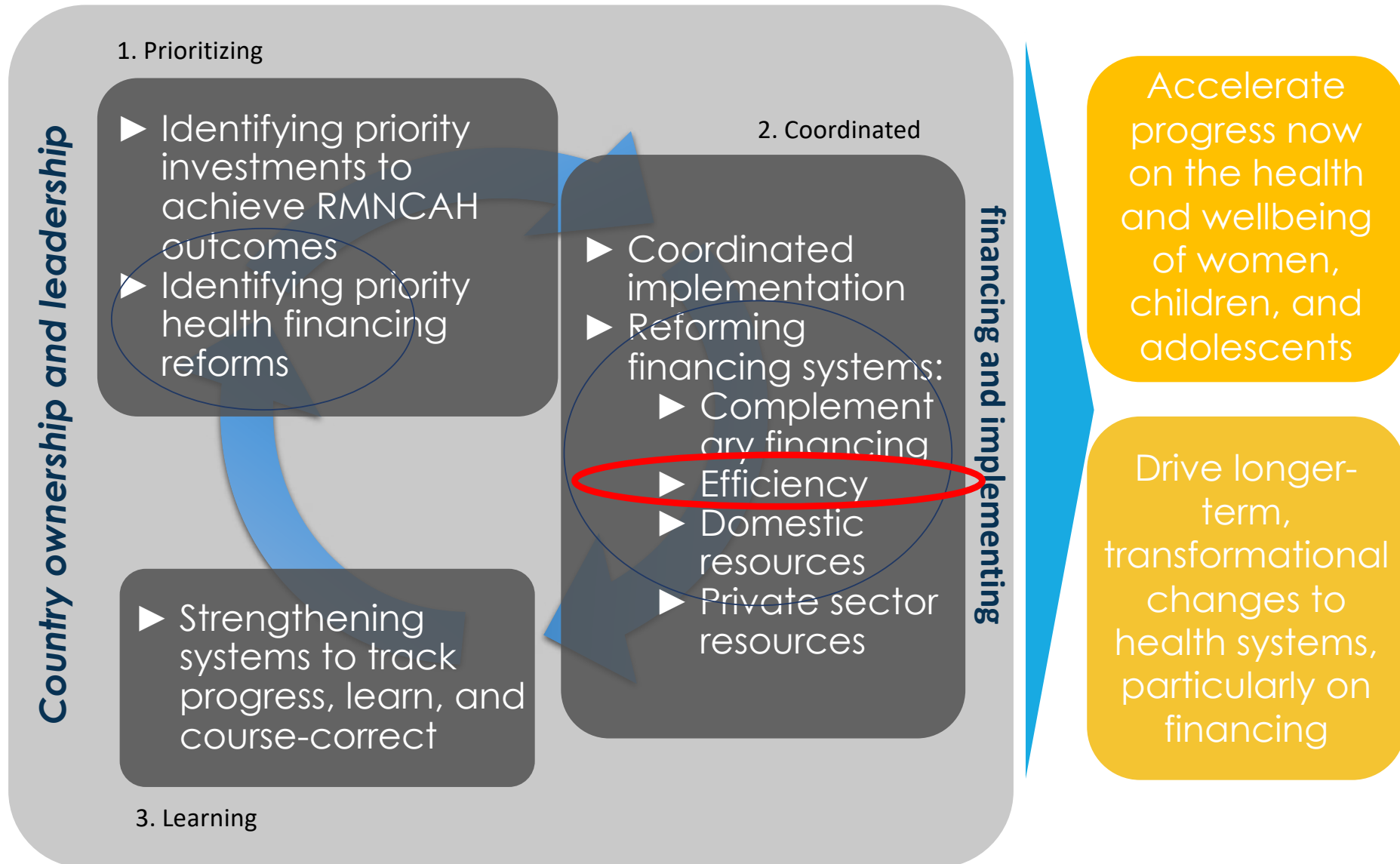


GFF Country Workshop,
January 28 – February 1, 2018

Health Financing: Achieving More with Available Resources



How the GFF drives results



- ▶ Better sustainable RMNCAH-N outcomes
 - Strengthening systems to sustain RMNCAH-N outcomes
- ▶ **Increased value-for-money** and total volume of financing from:
 - Domestic resources
 - Financing from IDA and IBRD
 - External Financing
 - Private sector resources
- ▶ Impoverishment prevented in case of illness

Doing too much of something expensive

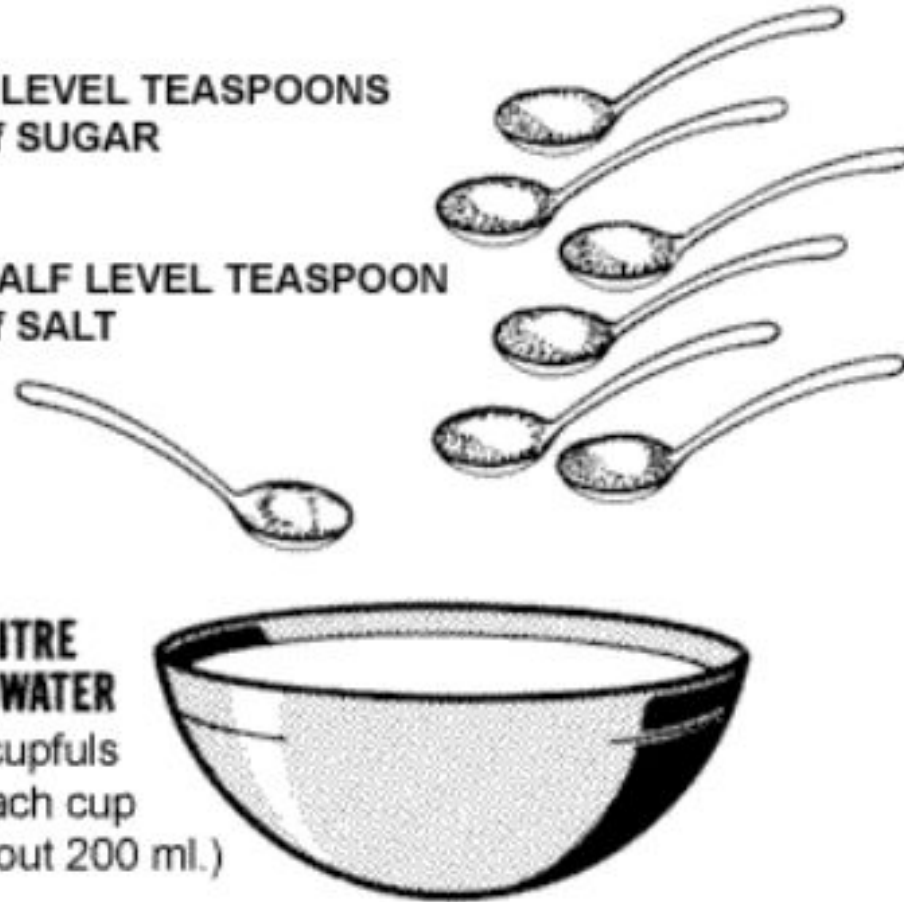


Doing too little of something cheap

**6 LEVEL TEASPOONS
of SUGAR**

**HALF LEVEL TEASPOON
of SALT**

**1 LITRE
OF WATER**
5 cupfuls
(each cup
about 200 ml.)



- ▶ Part 1 : Why is efficiency important to the GFF?
- ▶ Part 2: What is efficiency and main sources of inefficiency?
- ▶ Part 3: Measuring efficiency
- ▶ Part 4: GFF's approach to supporting countries to measure and improve efficiency
 - How to prioritize reforms/key areas?
 - How to implement?
 - How to monitor?



Part 1: Why is efficiency important to the GFF?

Large resources can be freed up for RMNCAH

- ▶ WHO estimates that 20-40% of health resources are wasted due to inefficiency
 - Eliminating inefficiencies in GFF countries would free up US\$12-24.1 billion or US\$13.5- US\$27 per capita yearly
 - These resources could be reinvested in RMNCAH-N
- ▶ To show that resources are well spent and benefit mostly disadvantaged groups are powerful arguments in budget negotiations with the MOF
 - Improving efficiency is critical for domestic resources mobilization (“scaled” financing).



Part 2: What is efficiency and main sources of inefficiency?

- ▶ Efficiency is about maximizing outcomes relative to inputs i.e. achieving more with available resources
- ▶ Efficiency analysis commonly aims to answer two questions:
 - Allocative efficiency – “doing the right thing”
 - Are resources allocated to provide an optimal mix of goods and services that maximizes benefits to society?
 - Technical efficiency – “doing things the right way”
 - Are the least amount of resources used to produce a given mix of goods and services and do they produce the maximum possible?
 - Are interventions delivered “in the right place”? (for e.g. primary, community, secondary or tertiary care; geographical distribution; inpatient/ambulatory; social/health sector)

Main sources of inefficiency

Doing the wrong things

- ▶ Low impact health services versus low cost high-impact services
- ▶ Imbalance between preventative and curative services

Doing things in the wrong place

- ▶ Provision of services at higher level (e.g. tertiary) institutions instead of lower-levels of care (e.g. community, primary level)
- ▶ Lack of mechanism to ensure continuity of care

Doing things badly

Inputs

- ▶ *Medicines*: under-utilization of generics or paying too much for any specific medicine
- ▶ *Infrastructure and equipment*: under or over-capacity in health facilities
- ▶ *Personnel*: Inappropriate mix between different cadres
- ▶ *Inappropriate mix of inputs*: health workers but no medicines

Outputs and outcomes

- ▶ unnecessary tests, procedures, visits
- ▶ Inappropriate length of stay
- ▶ Medical errors and low quality of care

Health Financing and Health System Organization

- ▶ Waste, corruption, fraud
- ▶ Fragmentation
- ▶ Administrative inefficiency

Which inefficiency is this?







Currie et al (2014) study:

4 “fake” patients sent to physician in hospital:

- | | |
|--|--------|
| A. does not ask for drugs, physician assumes drugs bought in hospital | A: 55% |
| B. directly asks for antibiotics, physician assumes drugs bought in hospital | B: 85% |
| C. asks for antibiotics but indicates will buy in another pharmacy (family) | C: 14% |



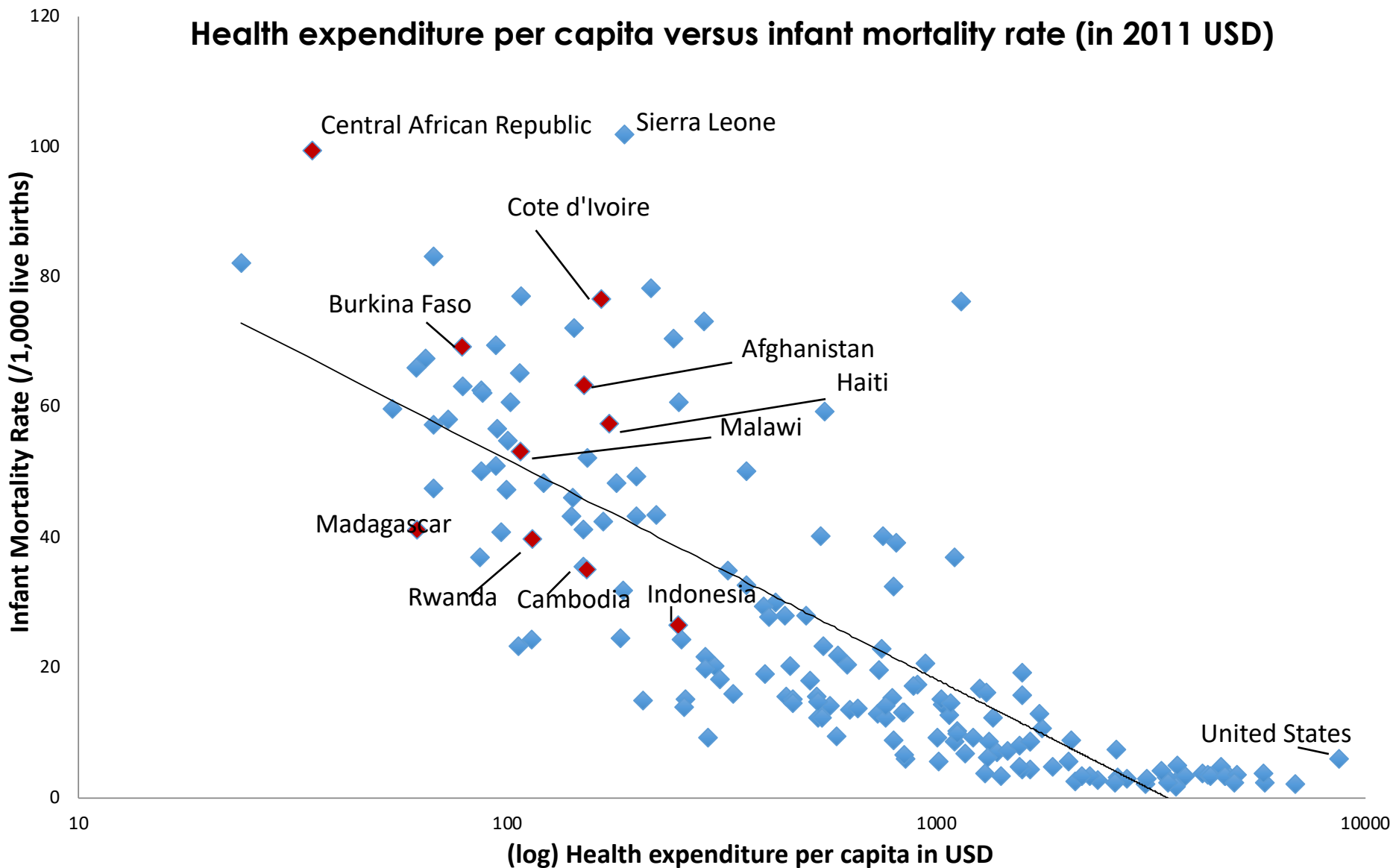
Part 3: Measuring efficiency

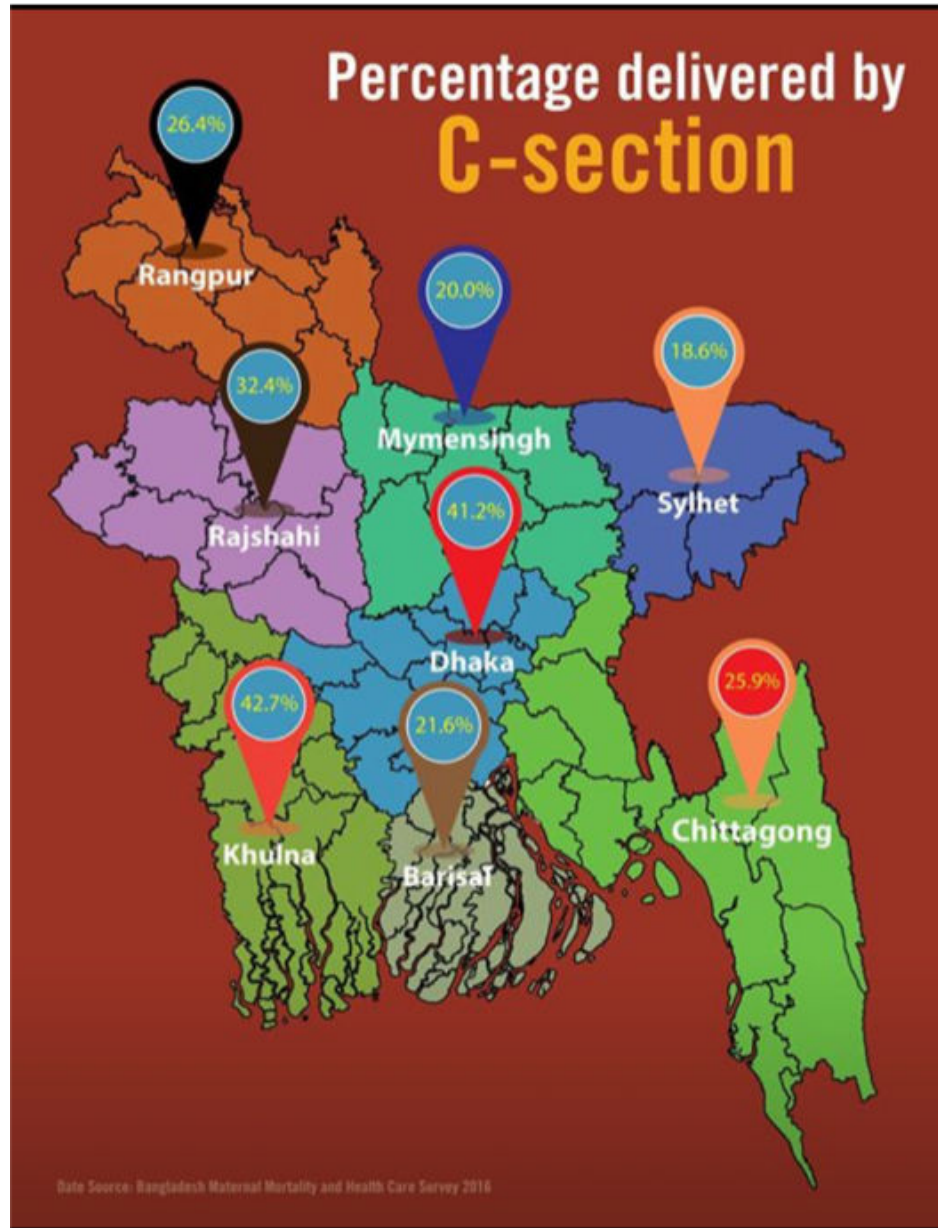
MACRO-EFFICIENCY

- Efficiency of a health system as a whole
- Comparing inputs with outcomes

MICRO-EFFICIENCY

- Each indicator captures an aspect of efficiency



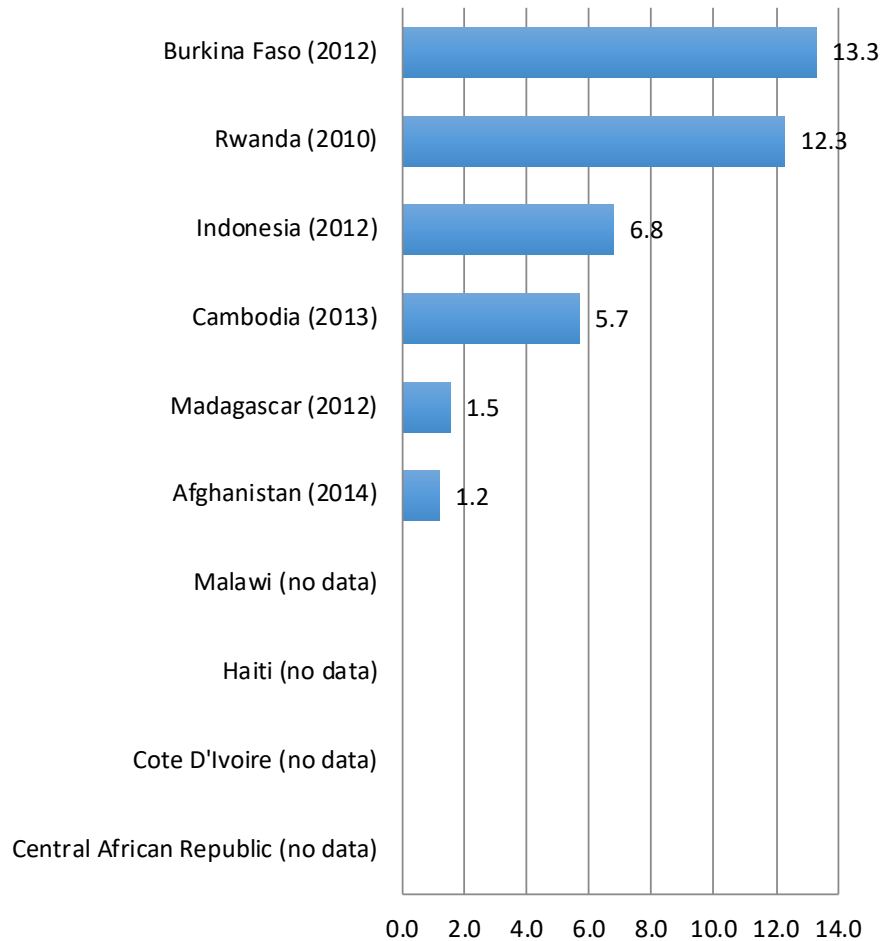


Caesarean section rate per 100 live births should be somewhere between 10% and 15% on medical grounds.

1. Systems for routine data collection do not always capture indicators that help identify key causes of inefficiency
2. Yardsticks are not always clearly defined:
 - Challenging to determine what is efficient (e.g. % of health expenditure that should be allocated to primary health care)
3. Countries do not necessarily perform relatively well or relatively badly on all indicators
 - After having identified key bottlenecks to improving outcomes, need to define country specific efficiency indicators for inclusion in Investment Cases and Health Financing Strategies

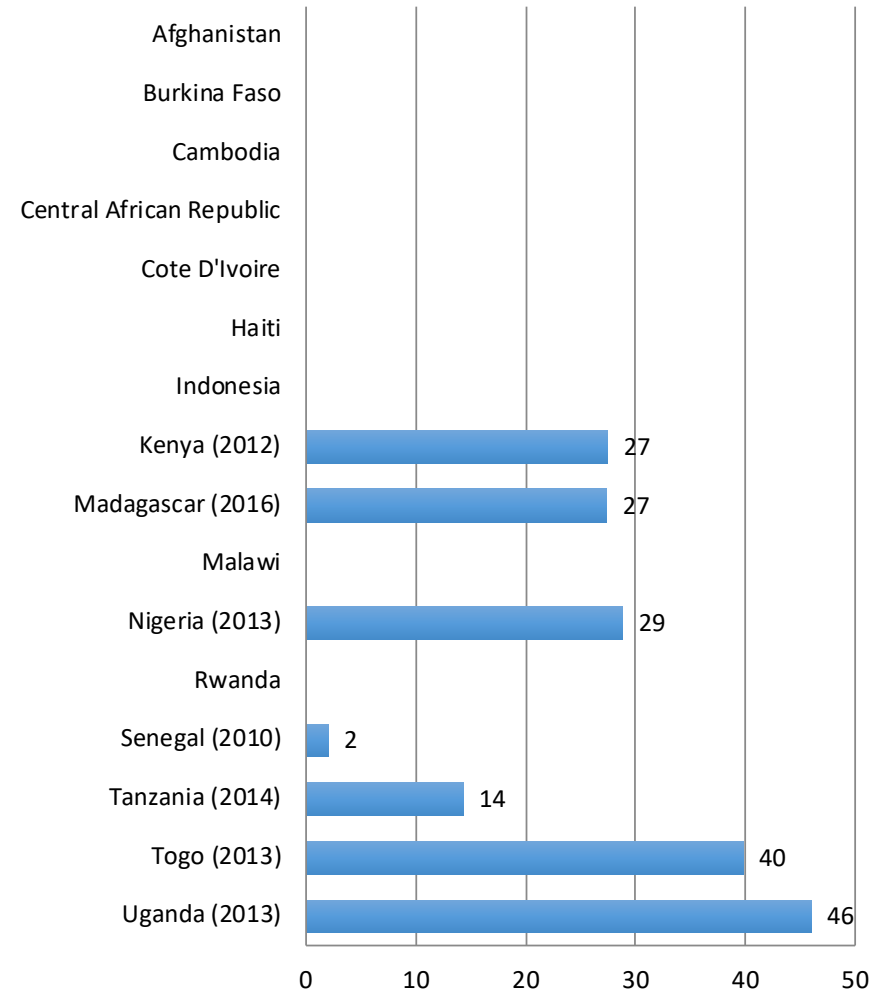
1. Routinely reported data are sparse and scattered

Ratio of Nursing and Midwifery Personnel to Physicians



Source: Global Health Observatory

Absenteeism Rate (%)



Source: World Bank SDI

- ▶ Most (GFF) countries do not **systematically review** the efficiency of their health systems and how it changes over time
- ▶ Quality of care is often key driver for inefficiency, but measurement is challenging
- ▶ There is a need to **strengthen data** on efficiency
- ▶ To do this (GFF) countries need to invest in systems for routine data collection
- ▶ Partners can provide valuable financial and technical support for these systems

- ▶ Gov. has set up a National Commission on Quality of Care (in relation to IC process)
- ▶ Senegal is rich on survey data (DHS, yearly Service Provision Assessment Data) -> used to develop regional scorecards -> help prioritize for IC
- ▶ Few countries have this frequent survey data
- ▶ Routine HMIS (DIHS2) can also include quality of care:
 - Treatment success rate for new cases of pulmonary tuberculosis bacteriologically confirmed
 - Treatment success rate of multi-resistant TB patients
 - Children <1 year completely vaccinated
 - C-section rate
 - Coverage rate of adequate ANC



Part 4: GFF's approach to supporting countries to measure and improve efficiency

“Happy families are all alike; every unhappy family is unhappy in its own way.” – Leo Tolstoy

Causes of inefficiency:

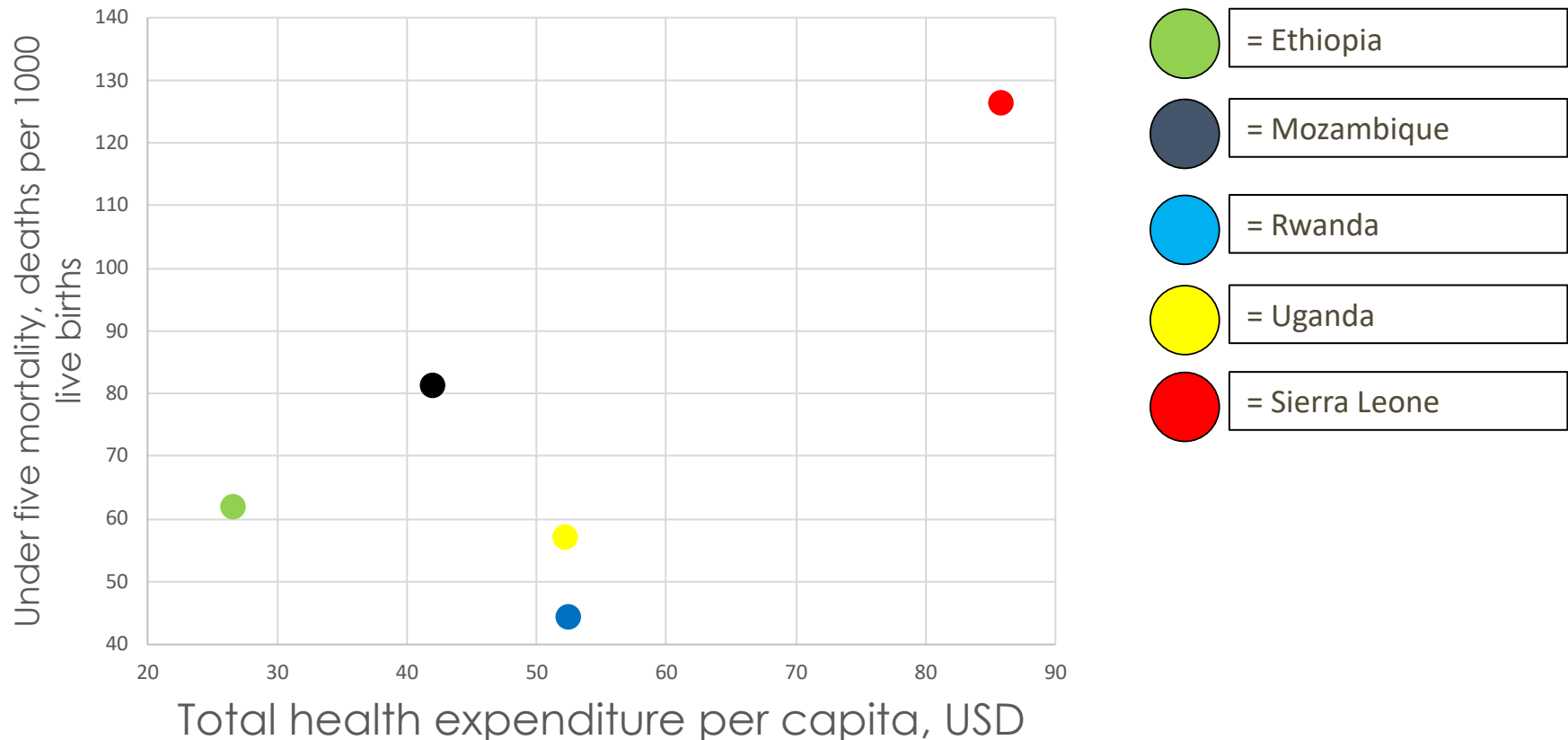
- Doing the wrong things
- Doing things in the wrong places
- Spending badly

Systematically addressing inefficiency:

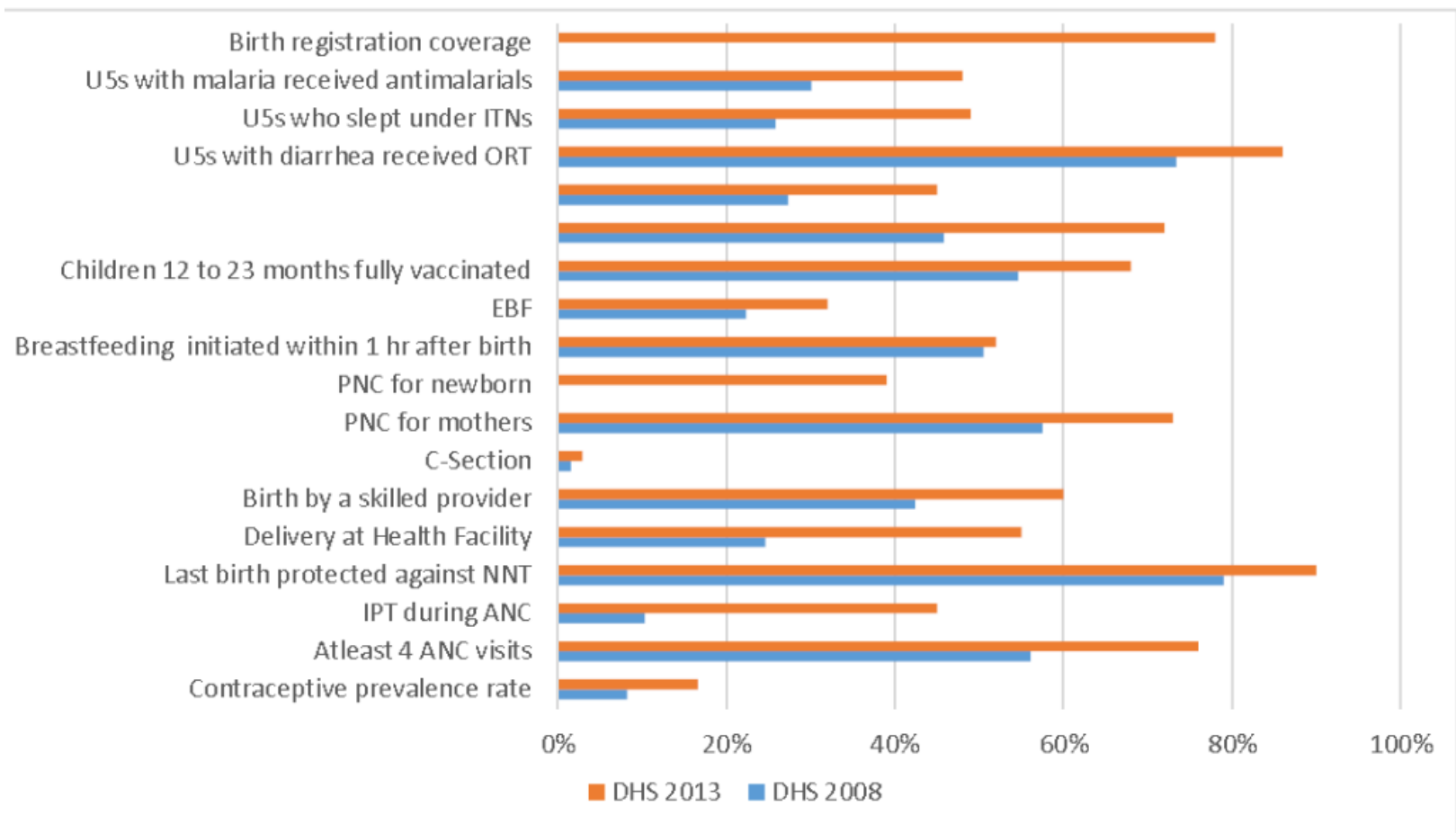
1. Identify key root causes of inefficiency through structured discussions with stakeholders
2. Examine available data on efficiency
3. Agree on national priorities for IC (considering political ownership, feasibility, etc.)
4. Develop country-tailored IC and targets for reducing inefficiency
5. Implement IC
6. Continually monitor progress and modify IC as necessary

Back to Sierra Leone - very low value for money

Under-five mortality rate versus Total health expenditure per capita (GHED, WDI 2014)

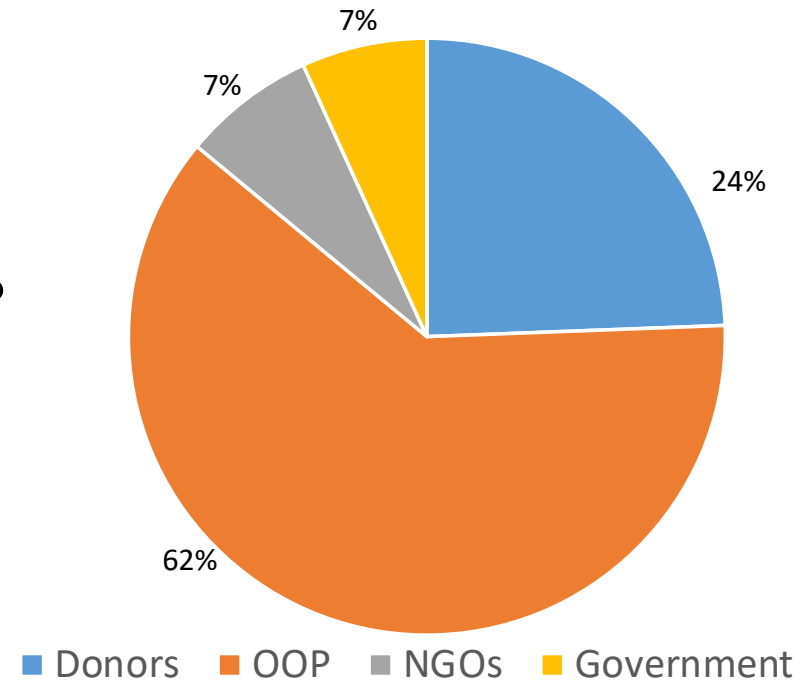


Despite impressive gains in service coverage



- ▶ Country lost large proportion of skilled health workforce during war
- ▶ Very large proportion of deliveries are now performed by staff who is only trained to supervise (community nurses, maternal health aids)
- ▶ Low retention of HR in rural areas, high absenteeism
- ▶ Very high average number of primary health facilities (20/100.000 pop) compared to other countries → resources spread thinly
- ▶ Stock outs of drugs and supplies → large OOP for medicines procured from private sector

- ▶ Very high reliance on OOP (2013 data)
- ▶ Inequitable allocation: in Freetown 20 to 30 percent population capture 70 to 80% of health resources.
- ▶ Implementation of the Free Health Care Initiative was facilitated by the nationwide RBF but current lack of funding to continue
- ▶ Plans for Sierra Leone Social Health Insurance (SLeSHI)



- ▶ Revise and pilot the RBF
 - “Right size” the health system through a hubs and spokes model
 - Incentivize quality
 - Integrate Community Health Workers into formal system
 - Using it as a stepping stone for purchasing in SLeSHI
- ▶ Supply chain
- ▶ Allow facilities to procure drugs from approved (private) source in case of stock outs

Allocative efficiency is a problem in many countries

- ▶ Large share of health budget going to secondary/tertiary care in urban areas
- ▶ Why is it so difficult to increase resources going to the frontlines?
 - HR
 - Infrastructure
 - Operational costs
 - Supply chains

How to shift more resources to the frontlines?

- ▶ Ethiopia: rollout of the CBHI (which through its fee-for-service mechanism channels resources to health centers)
- ▶ Vietnam: performance incentives to increase contact rates at the community health centers and reduce those at hospitals (especially for NCDs)
- ▶ Nigeria: Basic Health Care Provision Fund pilot to show how the fund flow to primary care can be effective in increasing coverage of essential services
- ▶ Liberia: retention of HR in rural areas through investing in Community Health Approach
- ▶ Mozambique: financial incentives to move health spending to underserved provinces and districts and to shift HRH to primary care
- ▶ Kenya: Financial incentives to ensure counties allocate enough to health and spend it efficiently

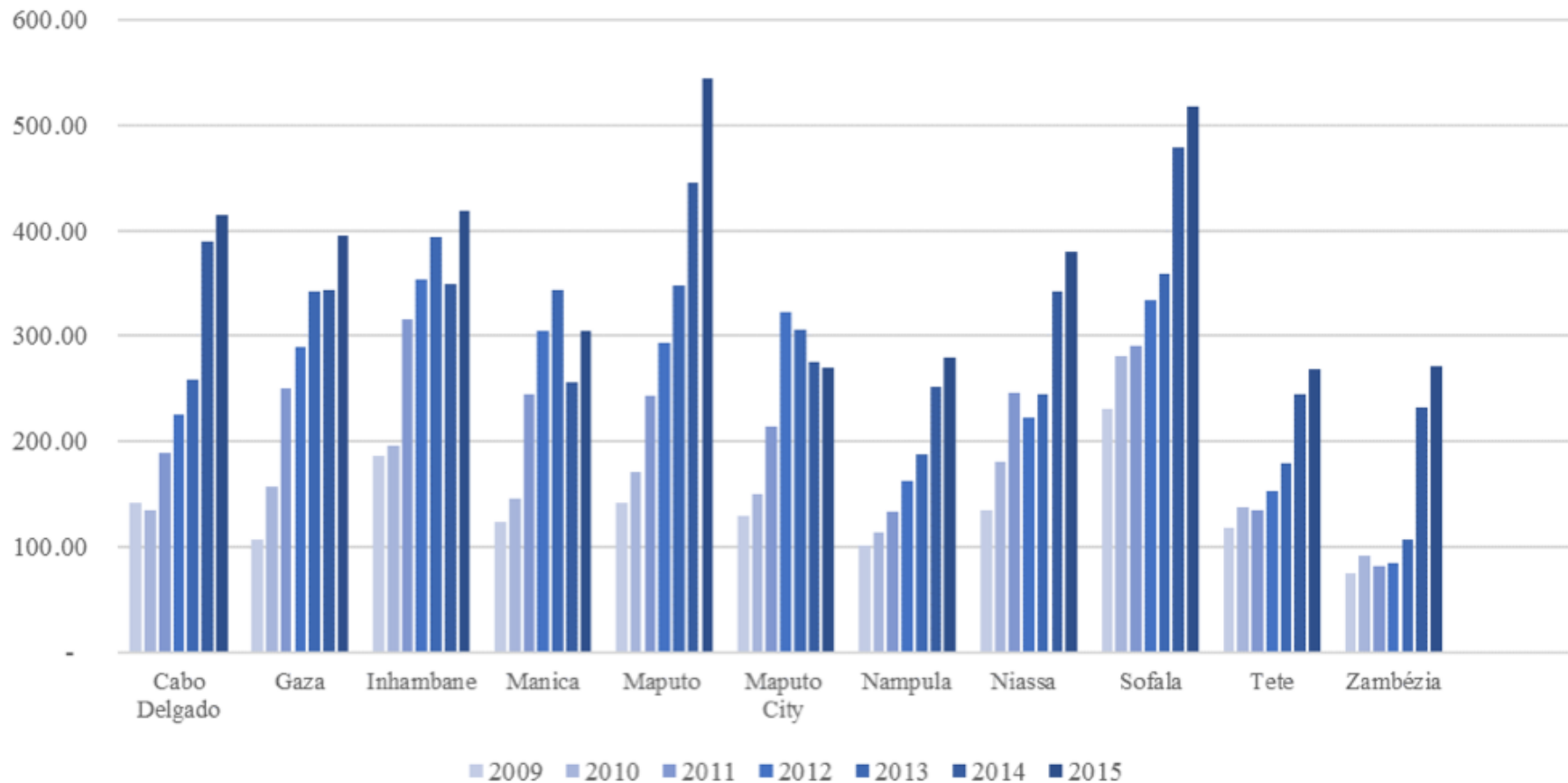


How to build incentives for implementing efficiency reforms in the IC?

- ▶ Devolved health care system
- ▶ Challenge to ensure counties allocate sufficient budget to health
- ▶ RMNCAH Investment framework comprises of county level annual plans
- ▶ External partners align their TA around these plans
- ▶ Government uses financial incentives to ensure counties spend at least 20% of their budget on health
- ▶ GFF/WB operation uses financial incentives to improve the efficiency and equity of the spending

- ▶ Limited room for DRM
 - Limited potential for increasing fiscal space in the short-run
 - Heavy donor dependence (45% of THE), mostly off budget
- ▶ Efficiency is key
 - Improved PFM – budgeting, planning and execution
 - Addressing shortage and maldistribution of HR and improving readiness of facilities to deliver
 - Improve regional inequities
 - Shift resources to primary care
 - Improve coordination of external resources

Per capita (domestic and external) resources



Expenditures vs “Need”

Province	2015 Per Capita Expenditures	Maternal Mortality Rate	Chronic Infant Malnutrition
Tete	269	272	48%
Maputo Province	269	331	28%
Zambézia	271	519	56%
Nampula	279	570	51%
Manica	304	389	48%
Niassa	380	383	45%
Gaza	395	388	34%
Cabo Delgado	415	822	56%
Inhambane	418	568	35%
Sofala	518	656	41%
Maputo City	545	364	25%

- ▶ Government development IC with focus on:
 - HRH: increasing CHWs and HWs in primary care
 - HF: increase budget share to health over 5 years and shift resources to priority districts
- ▶ All DPs aligned to IC priorities
- ▶ Pooled funding through Single and Multi donor trust fund (incl. WB, GFF, Netherlands, USAID (TBC), Canada (TBC))

- ▶ Disbursement Linked Indicators – targets that need to be met to release tranches of funds (RBF)
- ▶ Improve allocative efficiency
 - DLI 6: Health expenditures made in historically underserved areas (3 provinces and 28 districts identified)
 - DLI 7: Number of technical health personnel (Regime Especial) assigned to the primary health care network
 - DLI 10: Number of community health workers (APEs) that are trained and active

IC process
key driver
of
efficiency

- **Prioritization** process shifts focus to geographical areas most in need and high impact interventions
- **Multisectoral response** can be more cost-effective
- Scan of **private sector** initiatives provides opportunity for more strategic engagement
- **Duplication and transactions costs** of external financing decrease

Critical to
work with
MOF

- Reducing inefficiency is highly political; key to be pragmatic and work with “reformers”
- Efficiency reforms key for raising public financing for health
- Ministries of Finance can be great allies in advancing efficiency reforms

- ▶ Improving efficiency is a critical to GFF's agenda
 - Free up more resources
 - Better advocate for more resources for the health sector
- ▶ Country specific approach
- ▶ You can only improve what you can measure!
- ▶ Instruments to actually move the agenda
 - Financial incentives (RBF, DLIs)
 - Pilot effects
 - Technical Assistance



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