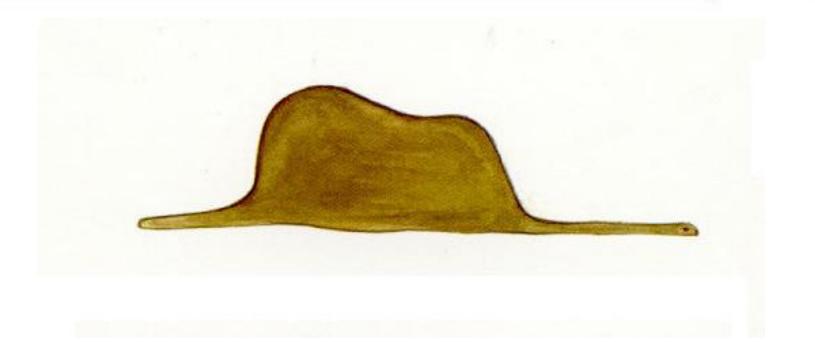




Monitoring the Health Financing agenda





Aims of this session

- 1. (re)Introduce GFF HF results indicators
- 2. What are (your) health financing reforms and how do they relate to the IC?
- 3. How to develop a Theory of Change for impact on HF indicators?
- 4. How to develop a results framework for Health Financing reforms?

- Health expenditure per capita financed from sources
- Ratio of government health expenditure to expenditures
- Percent of current health expenditures on health care
- Incidence of financial catastrophe due to

- Health expenditure per capita financed from domestic sources
- Ratio of government health expenditure to expenditures
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- Health expenditure per capita financed from domestic sources
- Ratio of government health expenditure to total government expenditures
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- Health expenditure per capita financed from domestic sources
- Ratio of government health expenditure to total government expenditures
- Percent of current health expenditures on primary health care
- Incidence of financial catastrophe due to

- Health expenditure per capita financed from domestic sources
- Ratio of government health expenditure to total government expenditures
- Percent of current health expenditures on primary health care
- Incidence of financial catastrophe due to out of pocket payments

2. HF reforms and relation to IC

Example of HF reform relevant to their country and explain relationship to IC results?

3. The need for a Theory of Change for HF reforms

- HF reforms challenging to implement
- Core impact indicators only available with long delay

Let's take 3 HF reforms that impact RMNCAH-N outcomes

1. DRM

- Increase share of the budget going to health
- 2. Efficiency
 - `right sizing' the health sector to improve quality
- 3. Financial protection
 - Reduce OOPs on medicines and drugs

Imagine.....

Indicators:

- Lower-middle income country, expected high growth (transition)
- Poor health outcomes given GDP/cap: MMR of 645, IMR of 60
- Health expenditures/cap: 80 USD, of which 13 by government, 10 by donors, 57 by OOPs
- Government spending on health has been stable at 5% of total spending (among lowest in SSA)
- 23% of government spending goes to primary care

Context:

- Country wants to launch UHC through a Social Health Insurance.
 Purchasing agency already established
- PBF (WB and GFATM) in 1/4th of the districts. Results have been promising

Goal: Increase the share of the budget going to health

Impact indicator:

- Increase share of the government budget spent on health from
 5 to 10% in the next 5 years
- Double the share going to primary health care (to 40%)
- With the ultimate aim of reducing maternal mortality by half

How?

Scale up of the PBF, integrate into government budget and combine with targeted user-fee exemption for the poor

Activity: Implement eLMIS for medicines

Activity: Refurbish 100 facilities

Activity: undertake MoH recruitment drive

Activity: roll out basic EMOC training

Activity: Improve road services, build bridges

Output: Facilities have necessary drugs and equipment

Output: facilities have trained staff

Improved access to health centers Outcome: increase in skilled attendance at delivery

Impact: reduced maternal mortality

Outcome: more women with 4+ ANC visits

Outcome: improved contraceptive prevalence rate

ToC for increasing share of budget spent on health

Activity: data collection on hh income

Activity: develop method for identification

Activity: fiscal space analysis

Activity: support policy dialogue

Activity: capacity building at central and district level

Activity: PFM analysis

Output: Poor hhs given insurance cards

Output: MoBudget approves ->allocate additional resources to the purchaser

Output: integrate PBF into purchasing function of insurer

Output: all health centers have bank accounts

Outcome: Effective Health insurance coverage of 30% (poorest) hhs

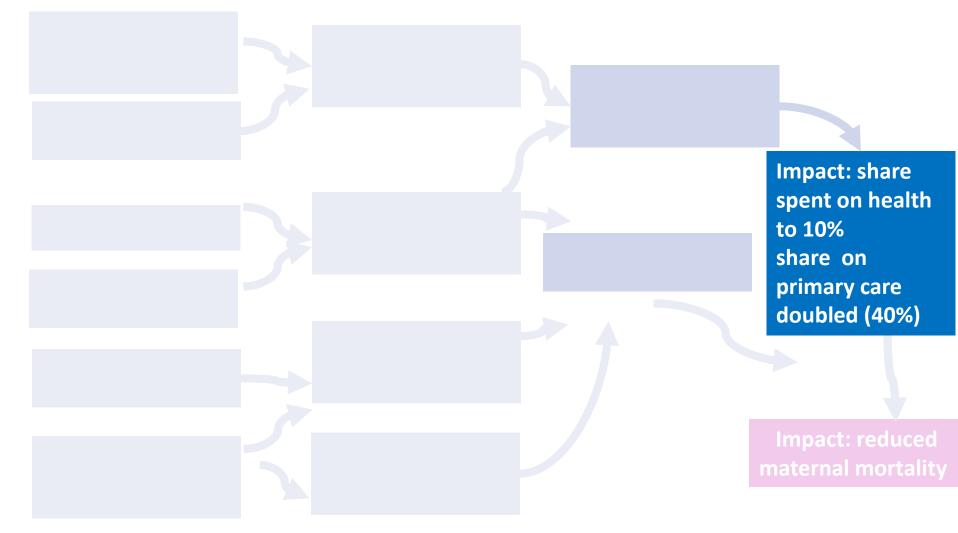
Outcome: Nationwide scale-up of PBF (all districts) Impact: share spent on health to 10% share on primary care doubled (40%)

Impact: reduced maternal mortality

ToC for increasing share of budget spent on health

Activity: data collection on hh income Activity: develop method for identification	5	Output: Poor hhs given insurance cards		Outcome: Effective Health insurance coverage of 30% (poorest) hhs	Impact:	share
Activity: fiscal space analysis Activity: support policy dialogue		Output: MoBudget approves ->allocate additional resources to the purchaser	so	utcome: Nationwide cale-up of PBF (all stricts)	spent on to 10% share of primary doubled	health n care
Activity: capacity building at central and district level Activity: PFM analysis		Output: integrate PBF into purchasing function of insurer Output: all health centers have bank accounts			Impact: maternal	

Results framework for increasing share of budget spent on health





Imagine.....

Indicators:

- Low income country, low growth (little DRM potential)
- Very poor health outcomes (MMR 1440, IMR 96) but ...
- ... High service coverage (79% of ANC4)
- Health expenditures/cap: 96 USD, of which 12 by government, 24 by donors, 60 by OOPs
- Government spending on health is 12% of total budget

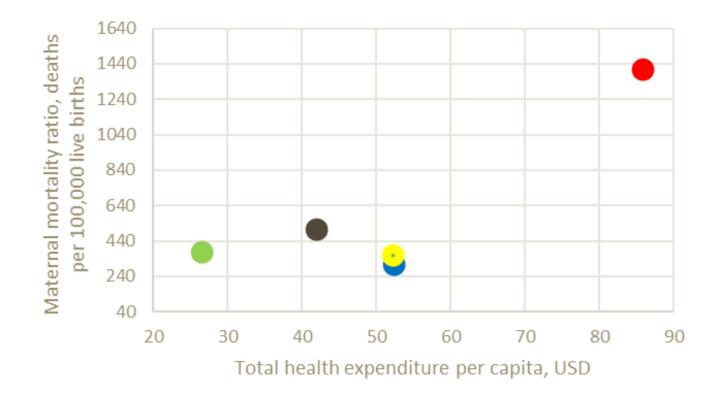
Context:

- Too many facilities in total (given the resources) and not spread equitably
- Nationwide PBF, but effectiveness limited (partly because of too many facilities to verify -> payments too little too late)

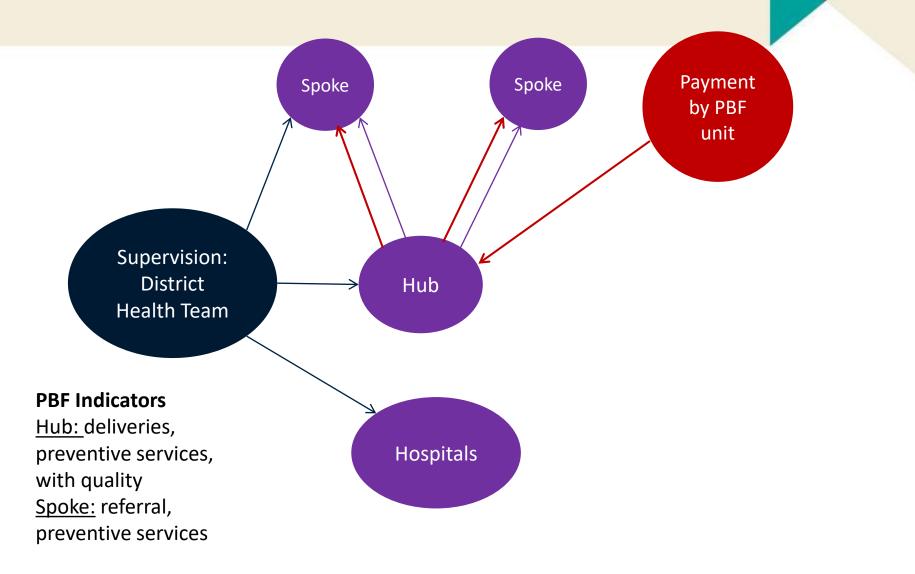
Goal: Right-size the health sector

Impact indicator:

lower maternal deaths/spending (1440 deaths/96 capita) 15->7.5



Hub and Spoke model



Activity: Implement eLMIS for medicines

Activity: Refurbish 100 facilities

Activity: undertake MoH recruitment drive

Activity: roll out basic EMOC training

Activity: Improve road services, build bridges

Output: Facilities have necessary drugs and equipment

Output: facilities have trained staff

Improved access to health centers Outcome: increase in skilled attendance at delivery

Impact: reduced maternal mortality

Outcome: more women with 4+ ANC visits

Outcome: improved contraceptive prevalence rate

ToC for right-sizing the health sector through strategic contracting

Activity: data collection (surveys, DIHS2)

Activity: mapping of facilities

Activity: pilot in two districts

Activity: implementation research on a pilot of the hub and spoke model

Activity: capacity building at district level to manage funds

Activity: sensitization at central level to create buy-in for differentiated funding Output: map of strategic facilities (hubs and spokes)

Output: hub/spoke indicator integrated added to DIHS2

> Output: implementation manual for scale up

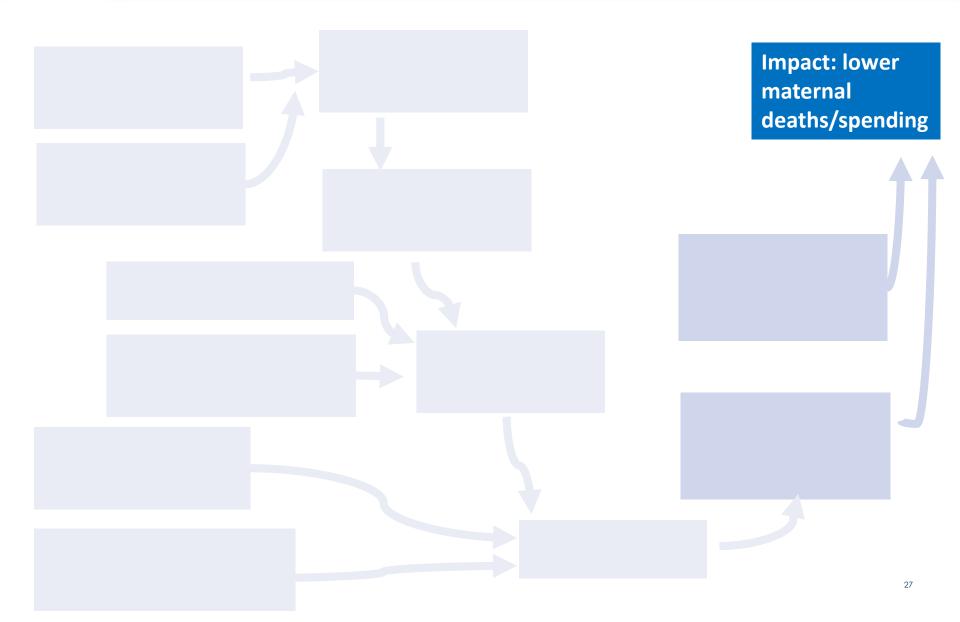
Impact: lower maternal deaths/spending

Outcome: % of births in hub facilities, number of referrals from the spokes

Outcome: % of hubs receiving PBF resources

Output: contracting model taken to scale

RF for right-sizing the health sector through strategic contracting





Results framework for increasing share of budget spent on health

Activity: survey completed, data analyzed

Activity: identification method developed

Activity: fiscal space analysis completed, disseminated

Activity: HF national workshop with MoH and MoF

Activity: workshops, trainings, study tours, in house training

Activity: PFM analysis completed, disseminated, guidelines developed Output: number of cards distributed

Output: Agreement, and disbursement

Output: integrate PBF into purchasing function of insurer

Output: *legal changes approved, a*ll health centers have bank accounts Outcome: % of poor hh receiving free care when they need it

Outcome: % of HC receiving PBF funds

Impact: share spent on health to 10% share on primary care doubled (40%)

Impact: reduced maternal mortality