GLOBAL FINANCING FACILITY

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The role of the Investment Case in Domestic Resource Mobilization

GFF Implementation Workshop

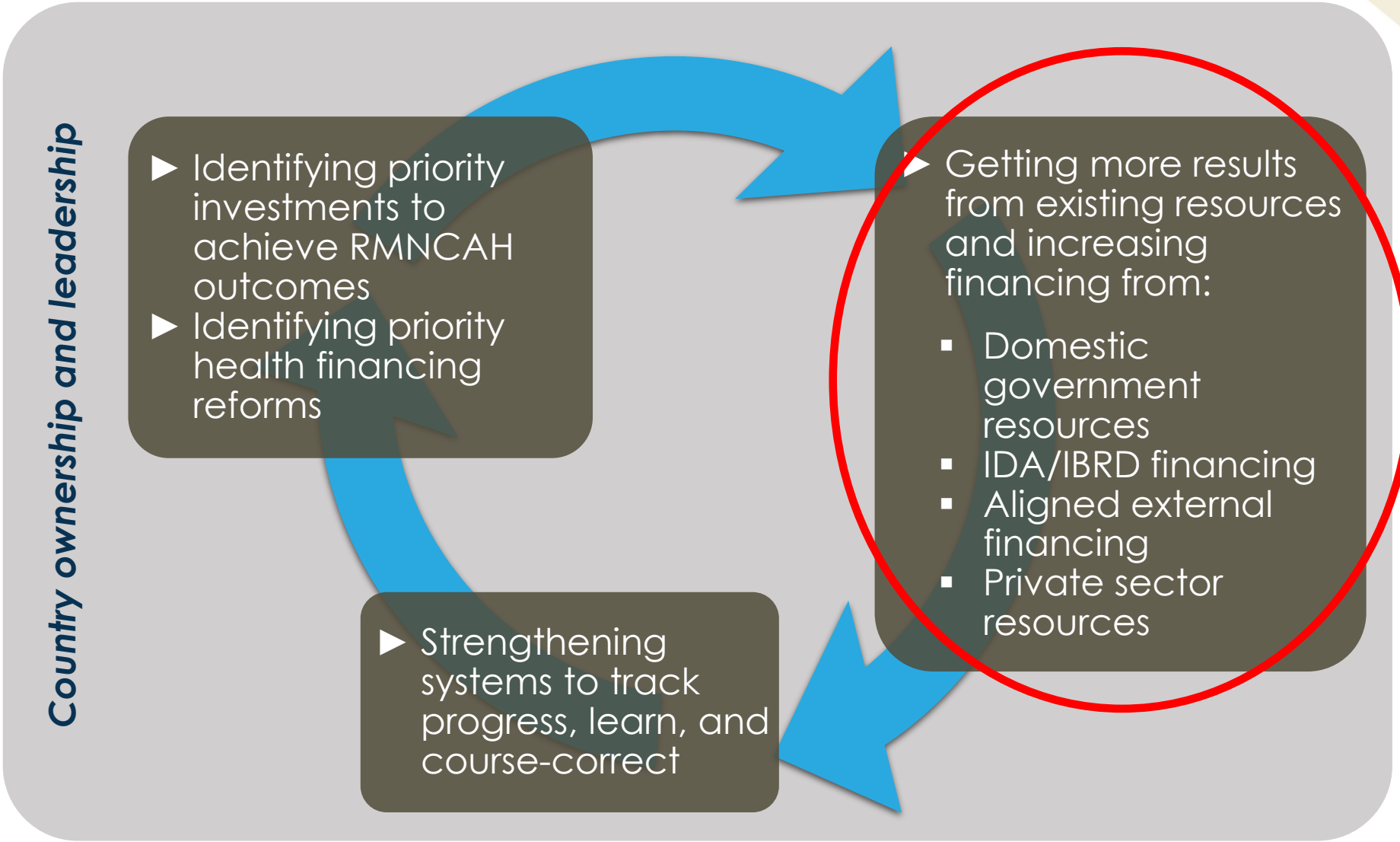
Dar es Salaam, September 2018

M.E. Bonilla-Chacin and Mark Blecher

Presentation Index

- GFF Results and Process
- Domestic Resource Mobilization (DRM) and Universal Health Coverage
- Sources of Domestic Resources for Health
- Making the Case for additional Domestic Resources for Health and the Role of the Investment Case and Role of the Investment Case in DRM for Health
- Importance of Integrating Investment Case in the Budget Process

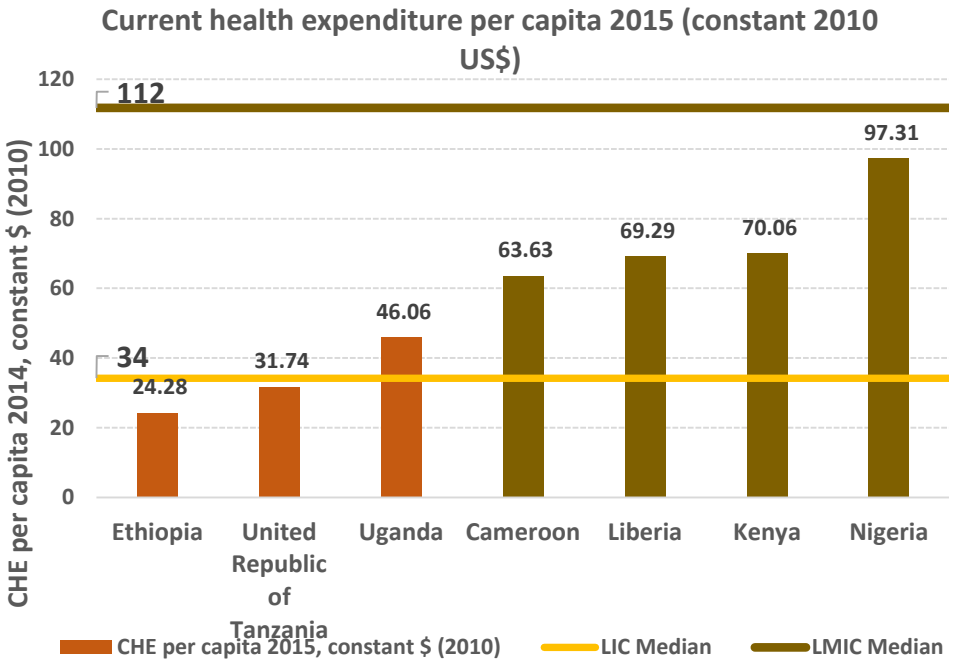
GFF supports countries to get on a trajectory to reach the SDGs and UHC through three related approaches



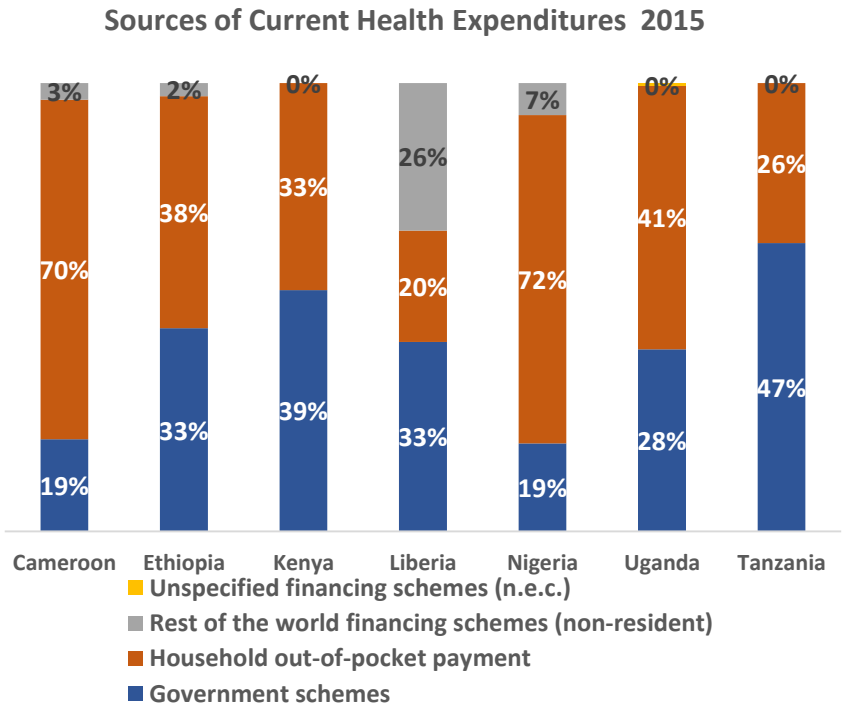
Domestic Resources for Health and Universal Health Coverage

Importance of Domestic Resource Mobilization (DRM) to achieve UHC

- Health expenditure per capita is still too low to ensure universal coverage with a core package of needed health services, including RNMCAH – N services
  - McIntryre and Meheus estimated $89 per capita needed in 2014

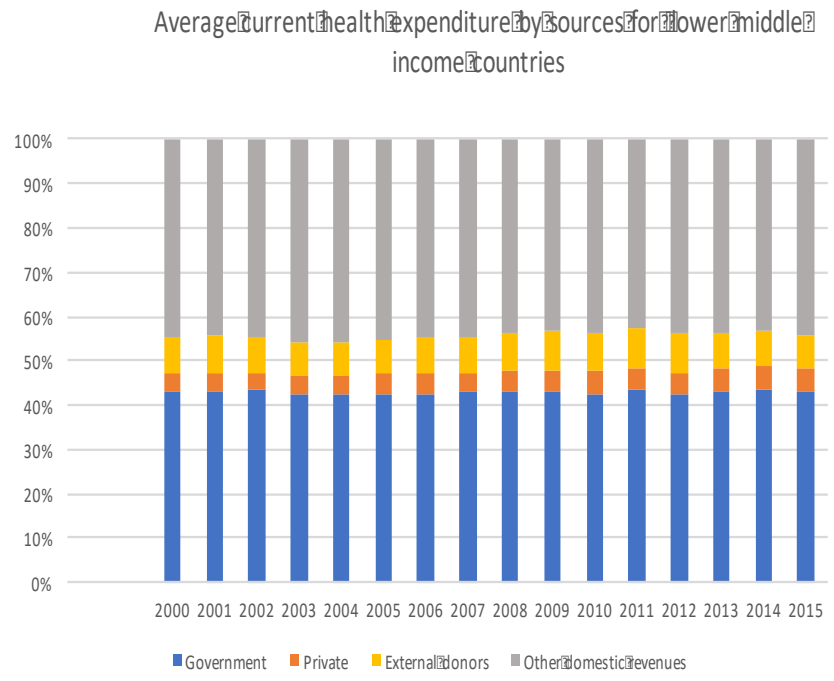


Source: WHO GHED 2015

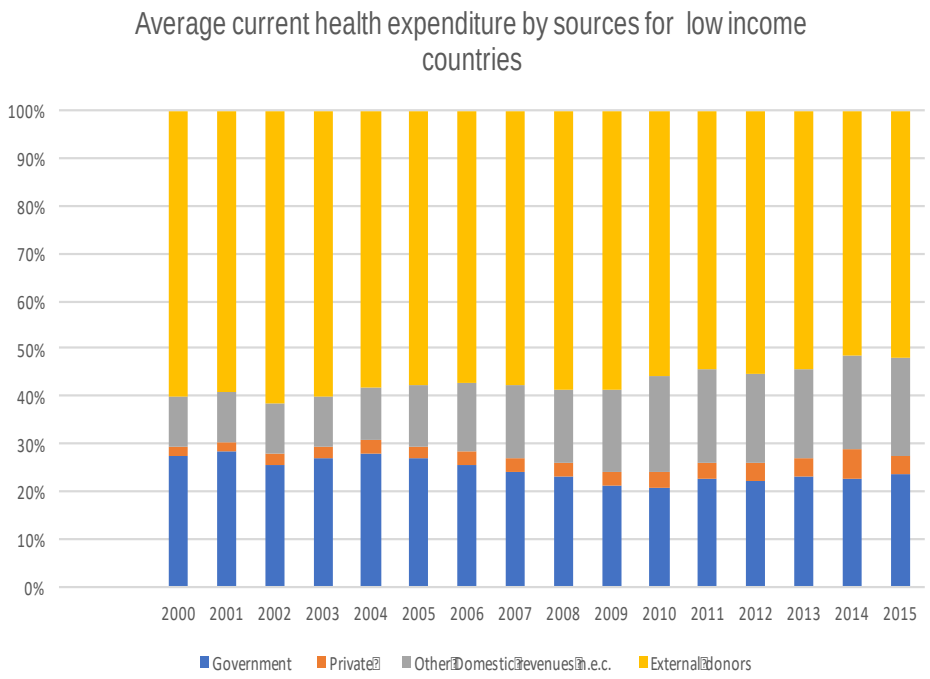


Source: : WHO GHED 2015

Most expenditure on health is domestic
DAH constitute a small part of total health expenditure overall, although it varies across countries

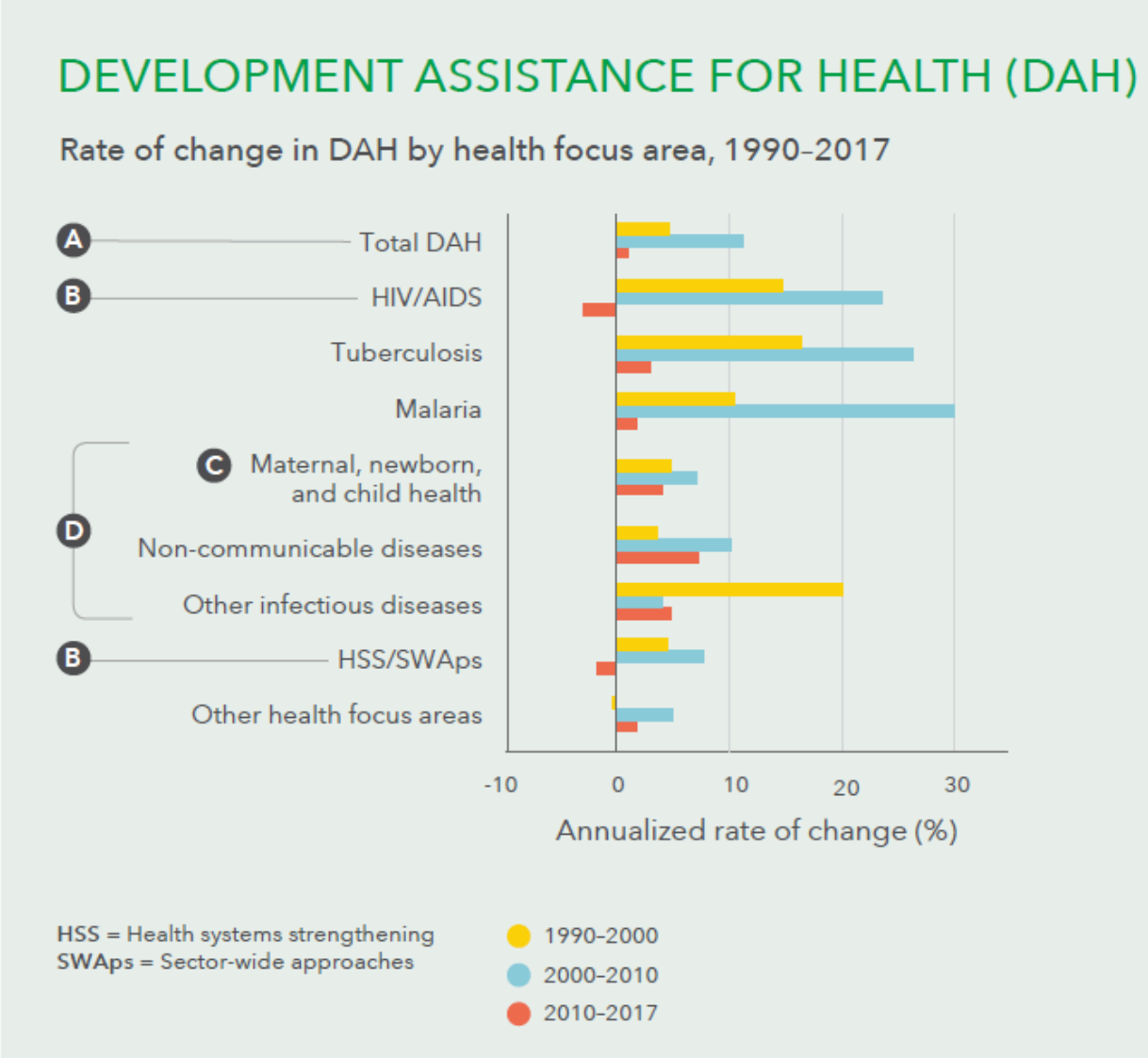


Source: WHO GHED (2017)



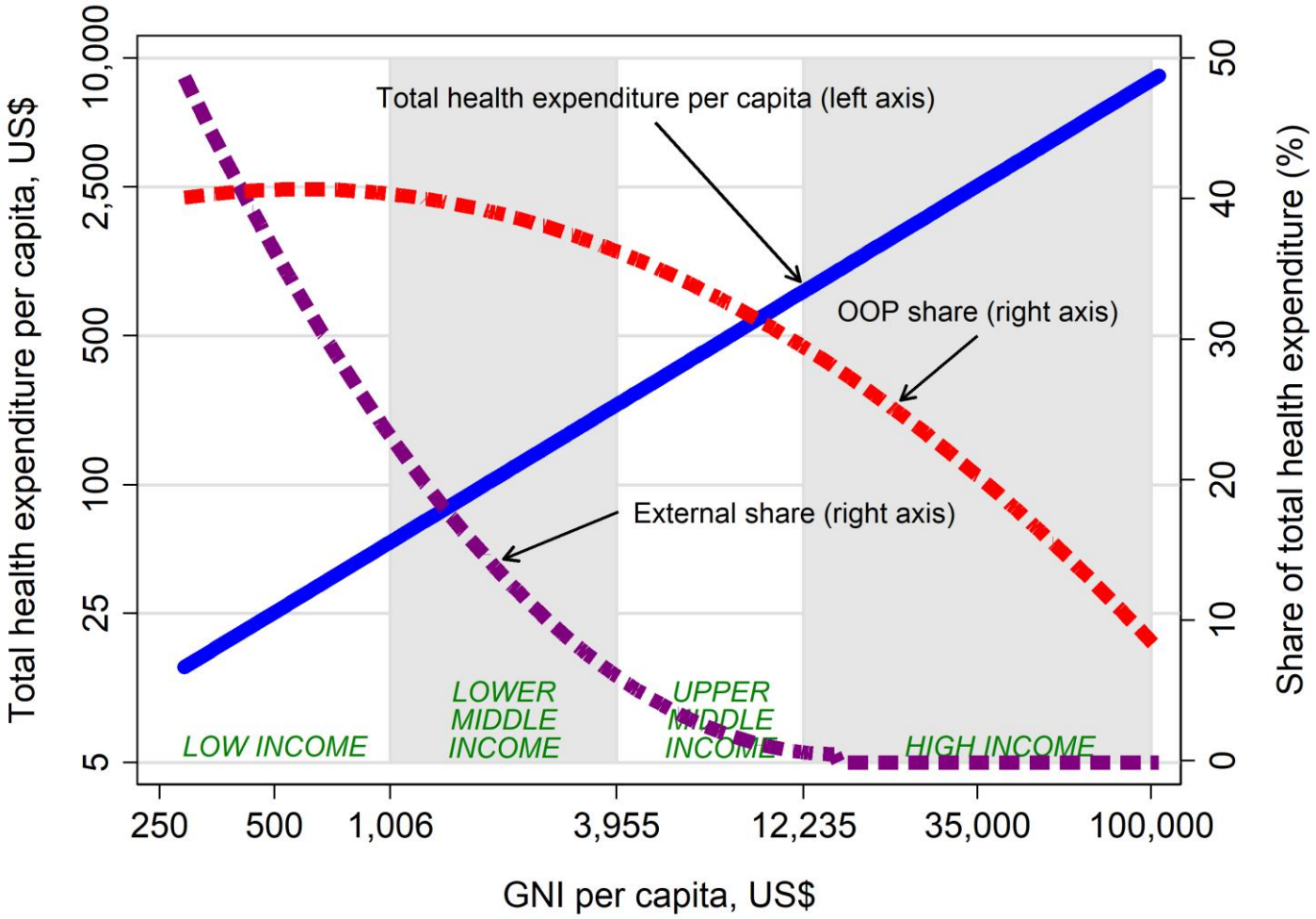
Source: WHO GHED (2017)

Development Assistance for Health is Leveling off



IHME

Health Financing Transition



Source: World Development Indicators; WHO Global Health Expenditures Database

The HFT is not only about DAH, it is also about **moving away from OOP** spending towards **domestic, prepaid/pooled** financing for health

Source: JLN / DRM collaborative

Many factors affect the health financing Transition and thus progress to UHC

Factors Outside the Health System

- Economic growth
- Government revenue effort
- Differing costs of adequate health services (e.g. higher in HIV-affected countries)
- Decline of development assistance

Factors within the Health System

- Different starting points for OOP & THE
- Inefficient use of health resources
- Overpromising benefits/Poor BP design
- System readiness for expansion
- Political will for reform

Source: JLN / DRM collaborative

Countries facing simultaneous transitions

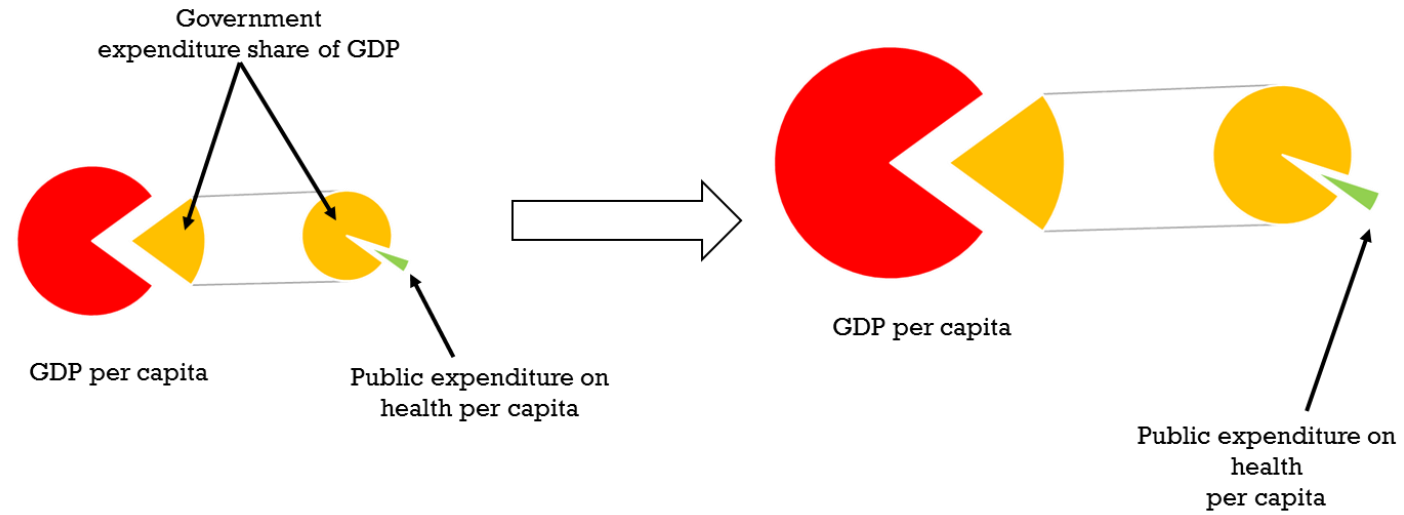
Countries Likely to Face Simultaneous Transition in the Next 5 Years

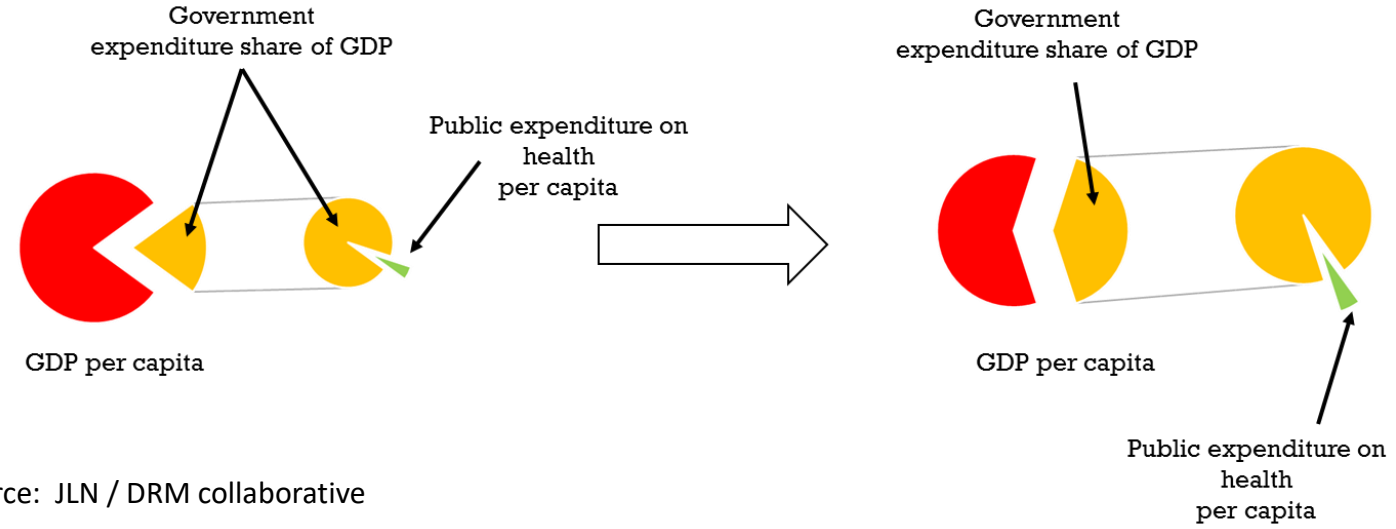
Country	Region	Gavi Transition Status (2017)	Global Fund Transition Status	IDA Transition Status	GPEI
CAMEROON	Africa	PHASE 1	ELIGIBLE	BLENDED FINANCING	PRIORITY
CONGO, REPUBLIC OF	Africa	PHASE 2	ELIGIBLE	BLENDED FINANCING	BY 2020
COTE D'IVOIRE	Africa	PHASE 1	ELIGIBLE	ELIGIBLE	BY 2020
INDONESIA	South Asia	PHASE 3	ELIGIBLE	not eligible	PRIORITY
KENYA	Africa	PHASE 1	ELIGIBLE	BLENDED FINANCING	BY 2020
NIGERIA	Africa	PHASE 2	ELIGIBLE	BLENDED FINANCING	PRIORITY

Source: Action Global Aid Advocacy Partnership


Sources of Domestic
Resources for Health

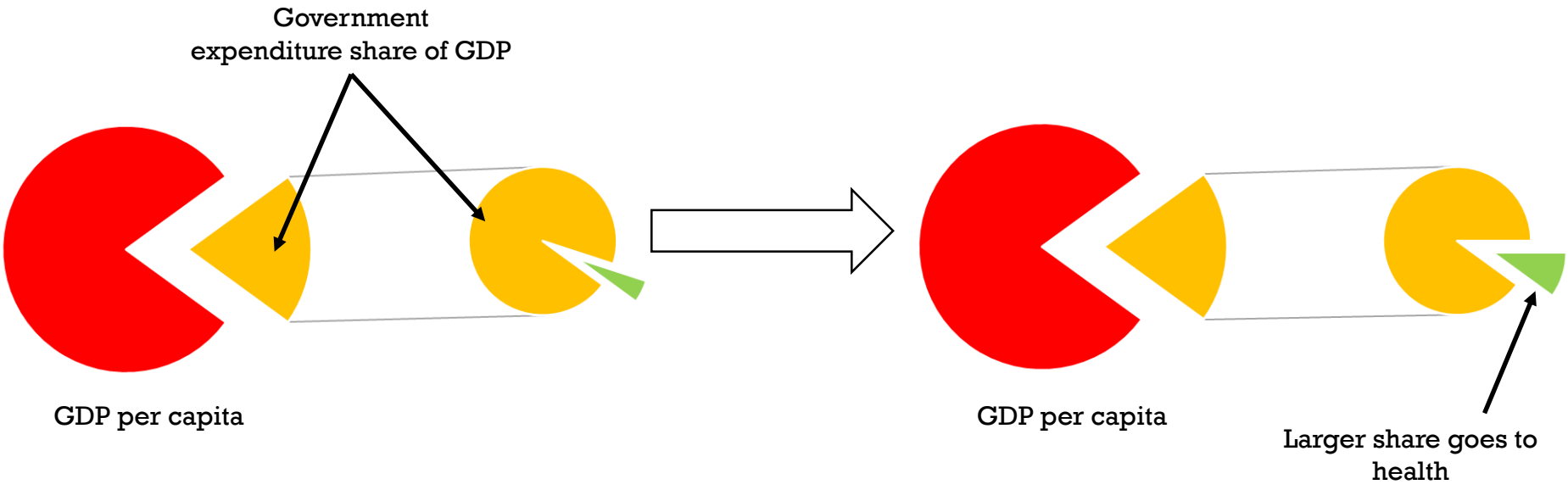
Macroeconomic Conditions: Economic Growth and Revenue Growth





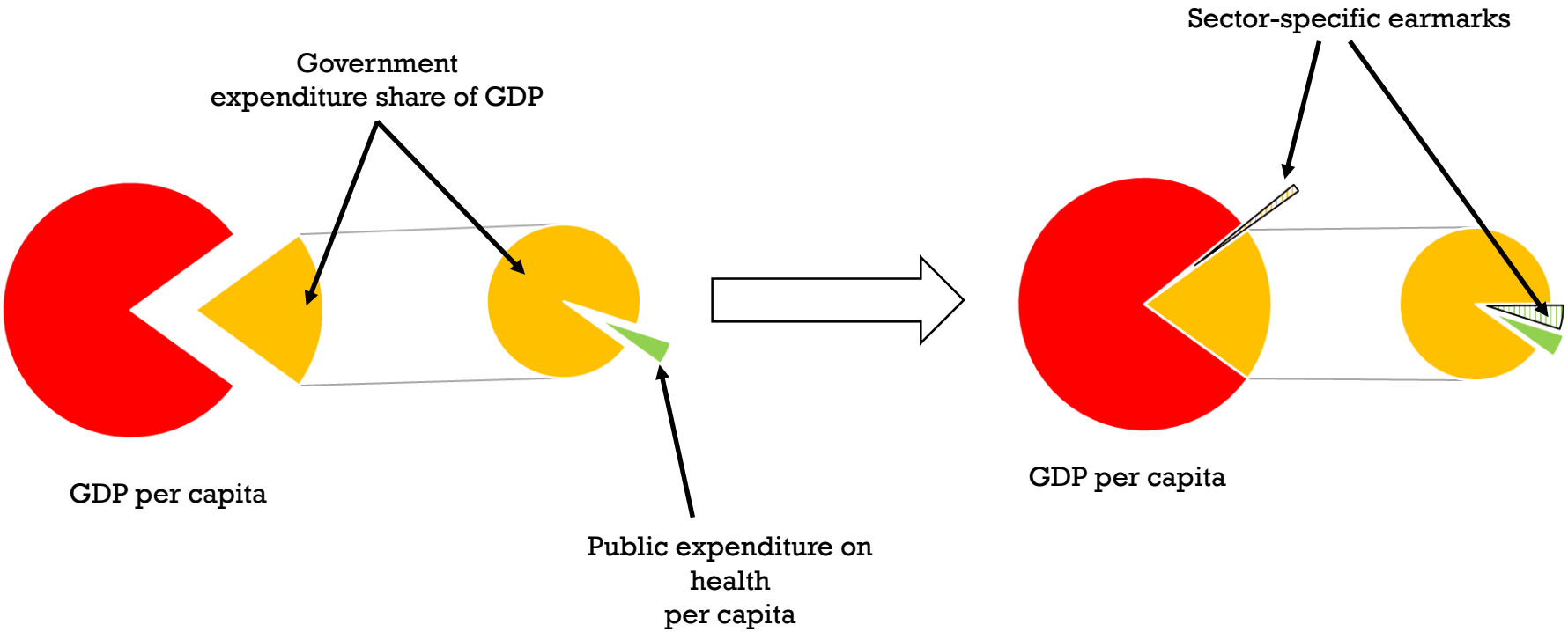
Source: JLN / DRM collaborative

Re-Prioritization: Often Key for Fiscal Space



Source: JLN / DRM collaborative

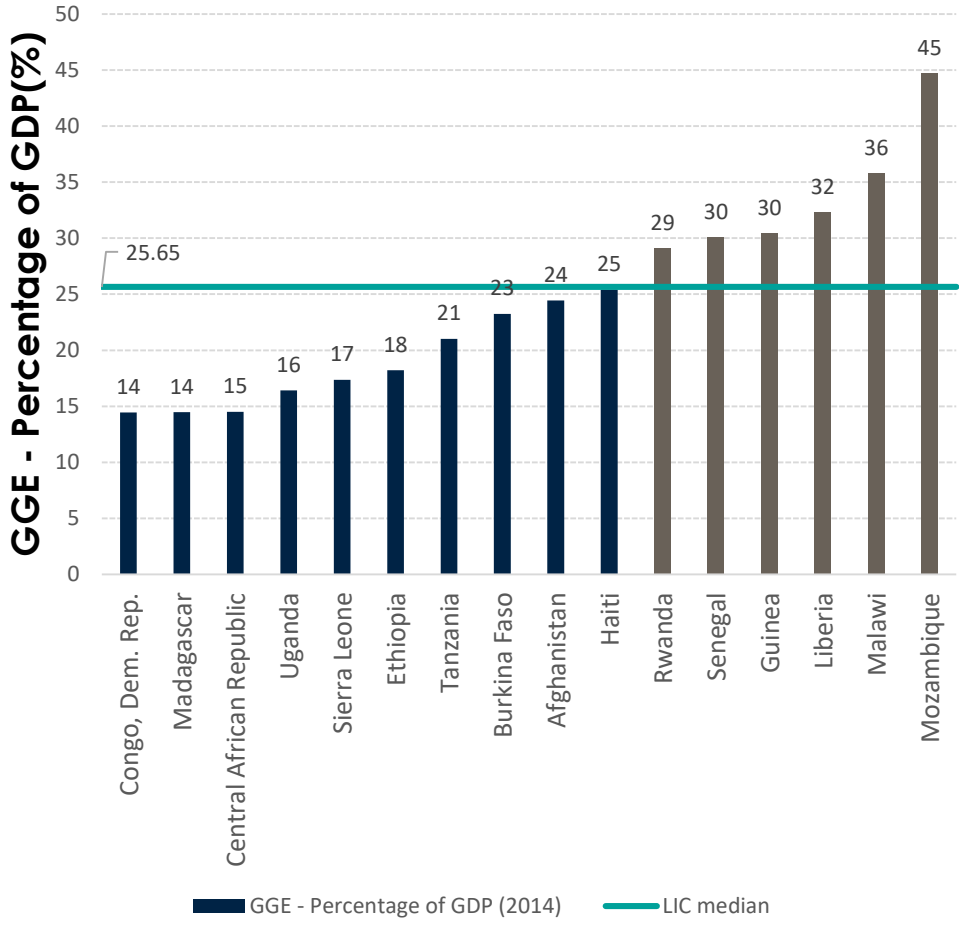
Sector-Specific Revenue Sources for Fiscal Space

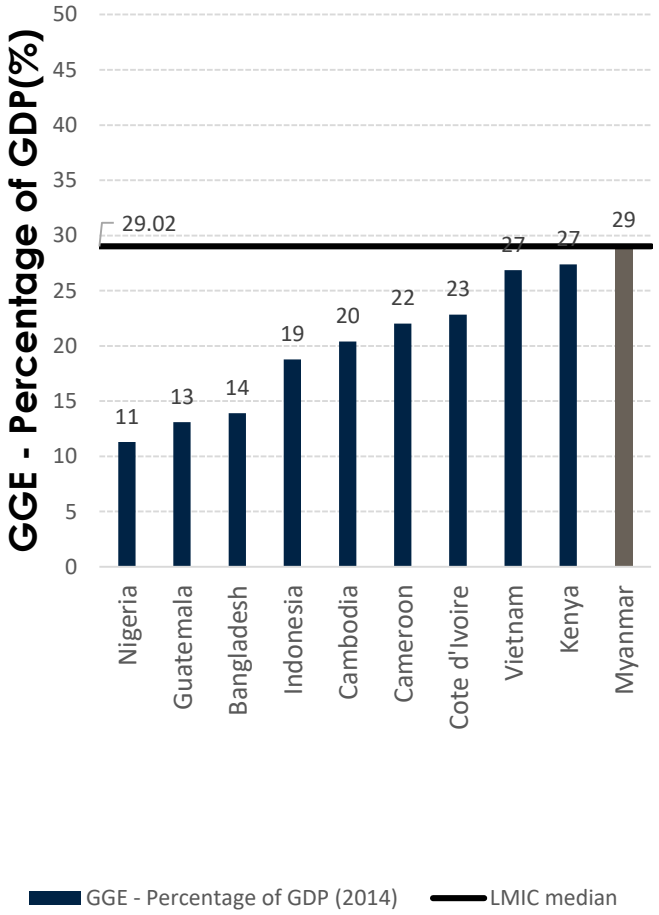


Source: JLN / DRM collaborative

Most GFF countries have the potential to raise more revenue

General Government expenditure (GGE) as a share of GDP (2014)

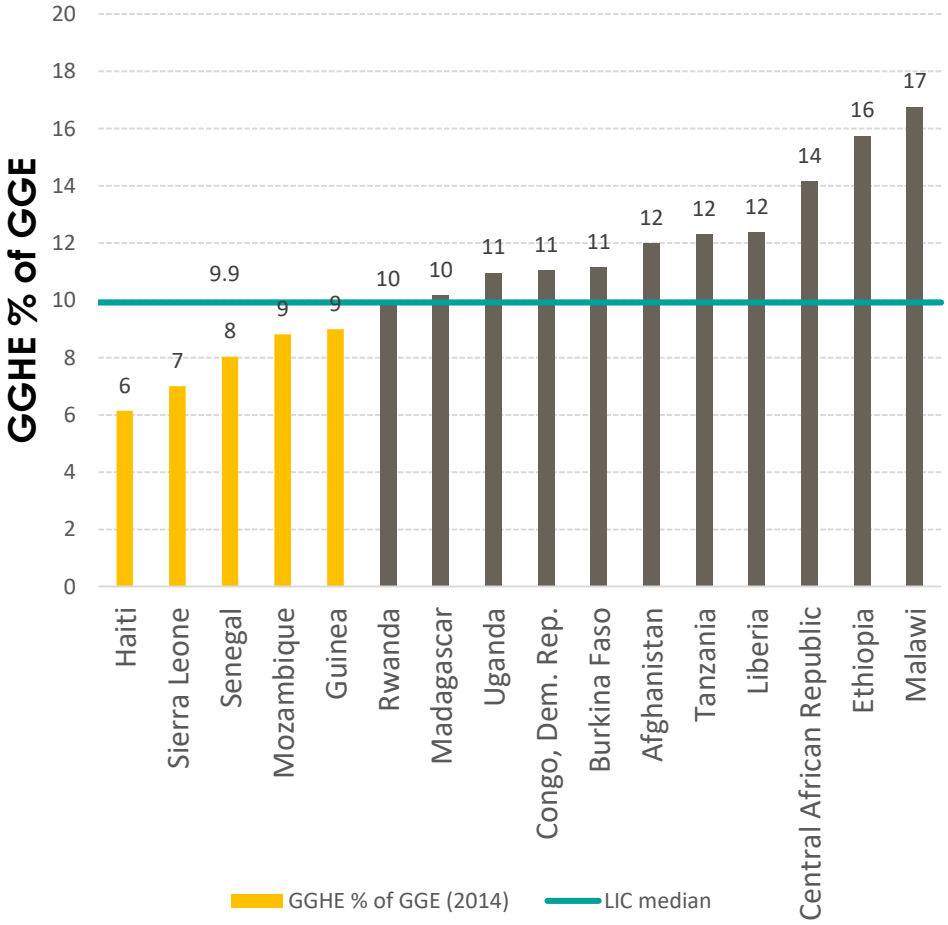


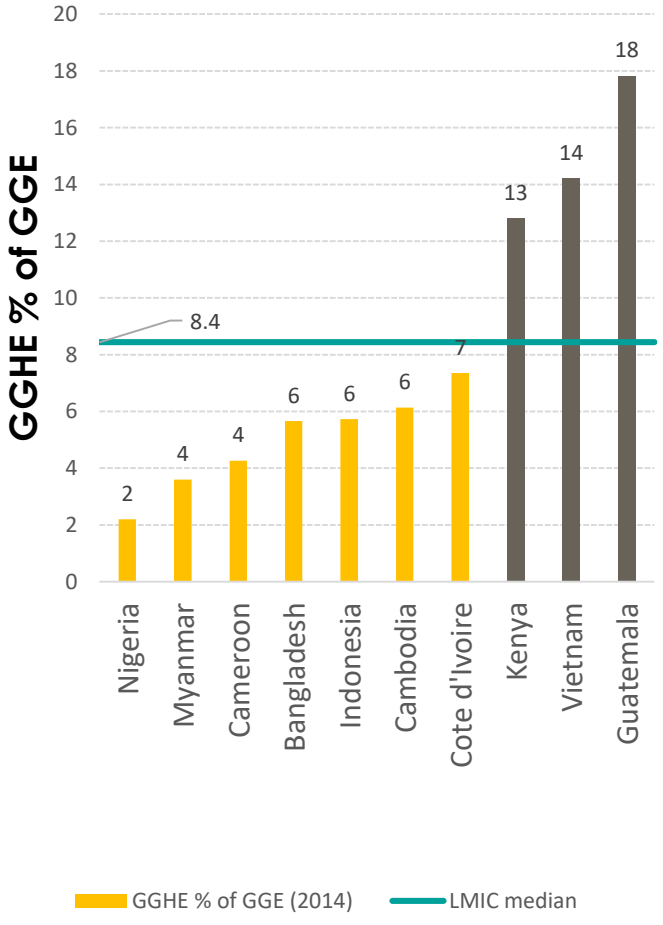


Source: GHED 2016

Several countries are below the median for prioritization of the health sector of general budget

Government Priority to health in the budget GGHE as a % GGE





Making the Case for Additional Domestic Resources for Health and the Role of the Investment Case

Ten Minute Break - Discussion

- What issues finance/treasury considers when deciding whether to increase resources for health?
- What do you think would the role of the Investment Case in budget bids?
- How should the IC be done differently to get it anchored into the budget?

Arguments / inputs to further the agenda – role of the IC

- Efficiency improvements in the use of current resources allocated to the sector
- Execution rate of budgetary funds to the sector
- Refer background strategic plans when making the case. Need for this plans to be realistic, costed, and include results to be achieved
- Improved accountability in the use of resources
- Discounting all scenarios ("due diligence") before making the case for investment in health
- Show how increases in health can have benefits on economic growth
- Demonstrate the linkage between health and the political economy

Role of the Investment Case

- National plan for improving maternal, child, and adolescent health and nutrition
- Improved efficiency in the use of resources given prioritization process and alignment of funds towards a national plan
- These are costed plans with monitoring and evaluation frameworks and with a theory of change
- On the health financing, they often includes plans to improve public financial management – improve budget execution

Role of the IC: Lessons learned from first years of GFF implementation

- Initial data suggests IC in majority of countries has not been entering domestic budget process
- Appears historically IC not serving as basis for budget bids from domestic MoH to MoF in annual budget cycle
- Most MoFs not fully aware of IC and its funding and not consulted early on
- Most ICs essentially forming basis for donor funding, albeit more coordinated donor approach.
- But if domestic government does not fund the national RMNCAH-N plan as in IC, then:
  - It is likely the country government is using a different plan for domestic funding purposes
  - There is little financial sign of support from the domestic government
  - If the domestic government really supports this as the national plan, why do they not put funds to it
  - If the IC is only a small plan for say 1% of the country health expenditure, then it will almost by definition be limited in scope and is unlikely to significantly impact domestic resource allocation
  - It is also unlikely to be sustainable
  - If a country government does not put money to a plan….does that government really support that plan as the national plan at a political level?
- Major weakness is that IC currently largely not part of the domestic funding and budgeting process and this perhaps core reason it is currently not succeeding with DRM, which is a core objective.
- Propose IC needs to be reconsidered as the national RMNCAH-N plan (with additional annexures) largely for domestic funding and implementation and for which the GFF is playing only catalytic support role

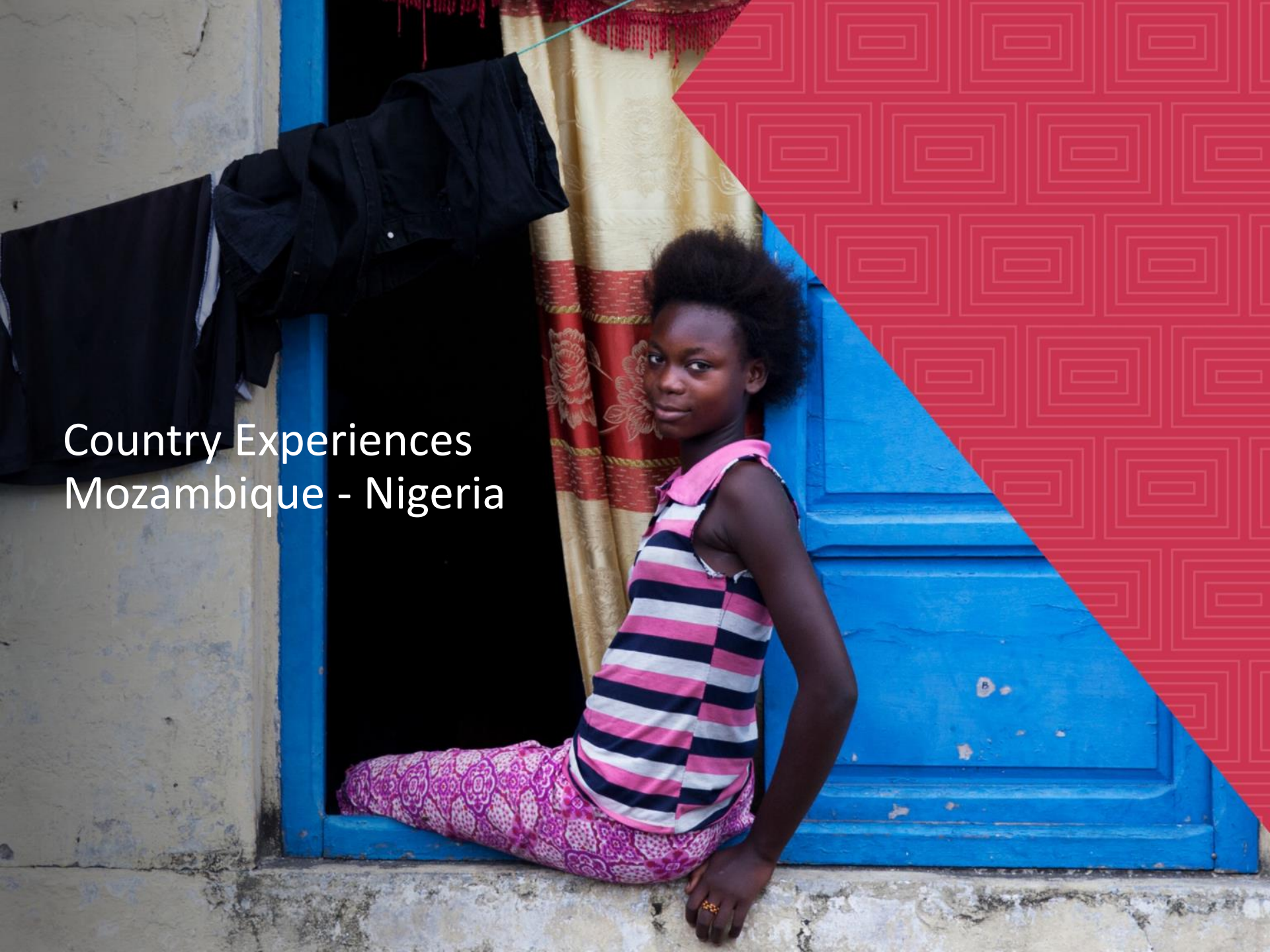
Integrating the Investment Case in the Budget Process

How will the objectives of the IC be translated into the government's budget?

How will IC implementation be tracked and monitored?

Promoting Alignment of the IC with the Budget Process

- Understand the budgeting process
  - Medium-term expenditure framework (MTEF)
  - Timeline and process for annual budgeting
  - Budget classifications system and chart of accounts (CoA)
  - Spending units and responsibilities
- Align investment case targets with the budget structure
  - Establish a baseline of current spending allocations and levels
  - Set targets on how the IC will shift expenditures
- Engage throughout the budgeting process
  - Discussions with the budgeting and finance departments
  - Promoting dialogue between the finance and health ministries



Country Experiences
Mozambique - Nigeria

DOMESTIC RESOURCE MOBILIZATION – THE NIGERIAN PERSPECTIVE

DR NNEKA ORJI
FEDERAL MINISTRY OF HEALTH, NIGERIA
GFF IMPLEMENTATION WORKSHOP, TANZANIA.
SEPT.2018

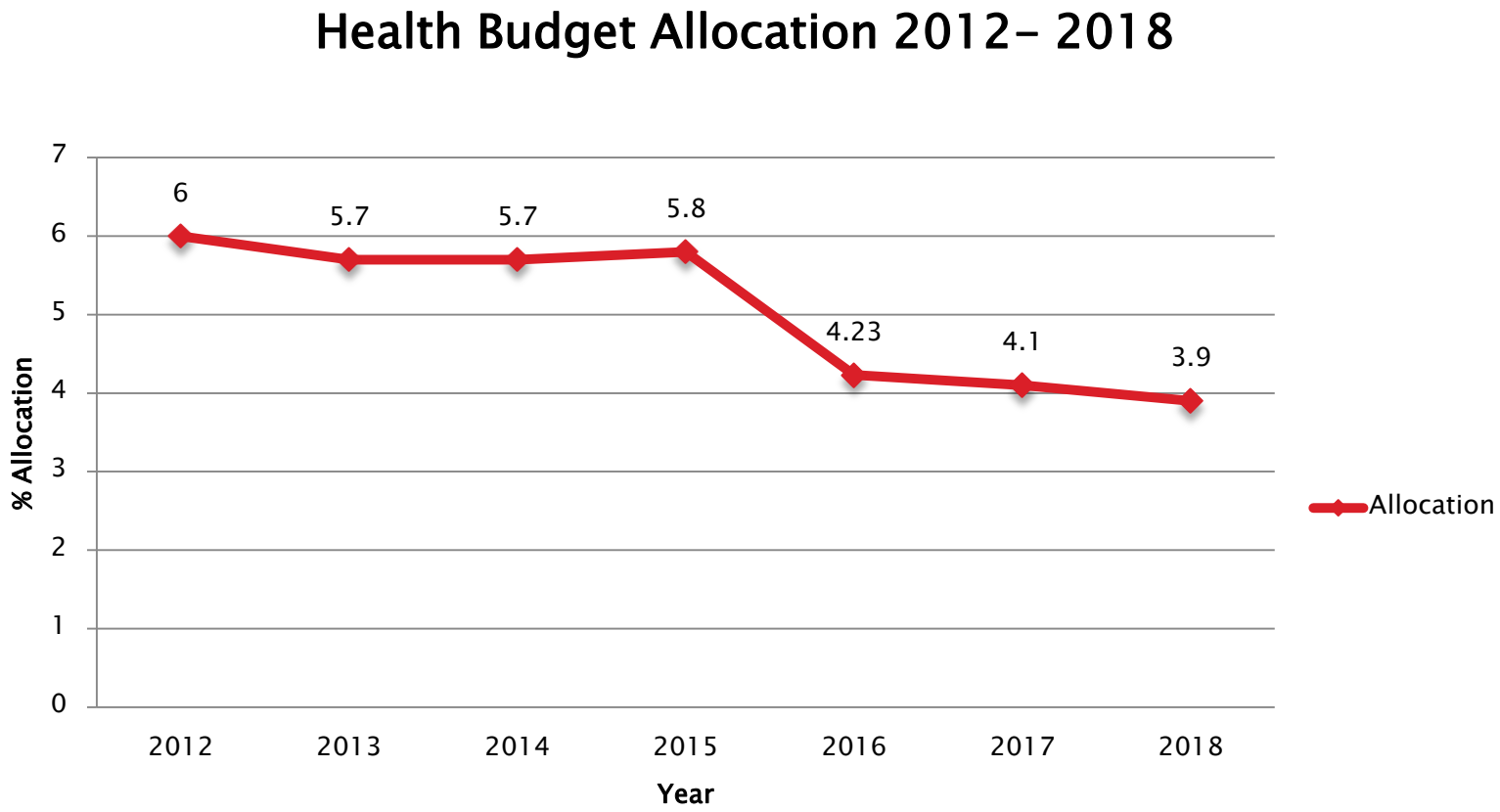
OUTLINE

- **INTRODUCTION:**
  - **BACKGROUND**
  - POOR BUDGETING
  - POOR HEALTH OUTCOMES:
- **NEED FOR A PARADIGM SHIFT:**
  - Legal and policy basis for new approach: NHAct
  - Operational and Implementation basis for new approach: NSHIP, Investment case, BHCPF, NSHDP II
- **OPPORTUNITY TO DO SOMETHING DIFFERENT:**
  - Advocacy efforts.
  - Resources for implementation from GFF
  - GFF PRESENTED AN OPPORTUNITY TO SHOWCASE WHAT WILL BE DIFFERENT:
- **KEY HIGHLIGHTS OF BHCPF IMPLMENTATION – SHOWING THE EFFCICIENCY AND ACCOUNTABILITY FEATURES OF THE BHCPF:**
  - Efficiency
  - Accountability
  - All the above led to a strong case to the parliament leading to increased resources
- **CHALLENGES AND SUMMARY:**

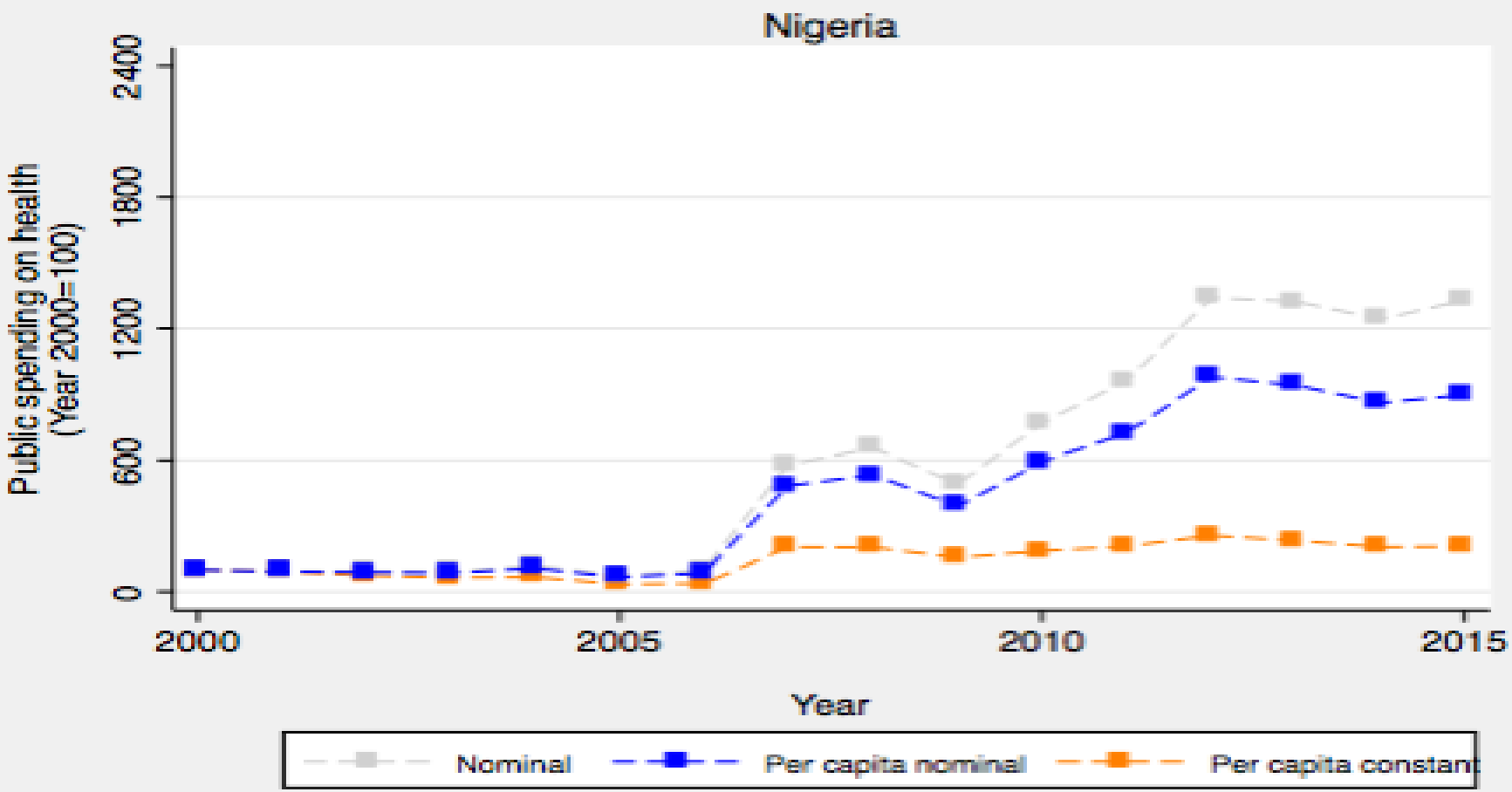
BACKGROUND

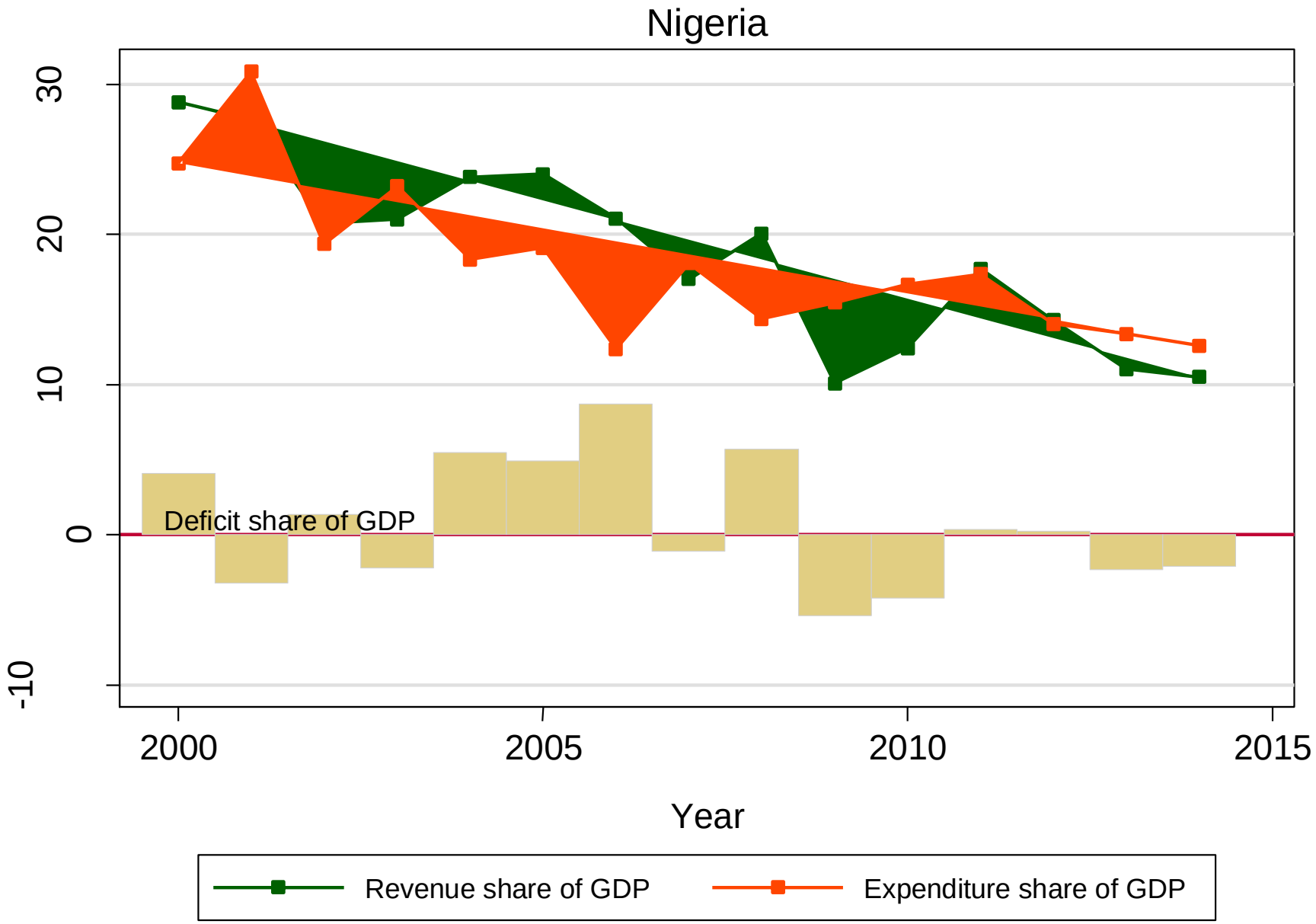
- Governance Structure
- Total Population
- GDP per capita
- HF mechanisms

INTRODUCTION

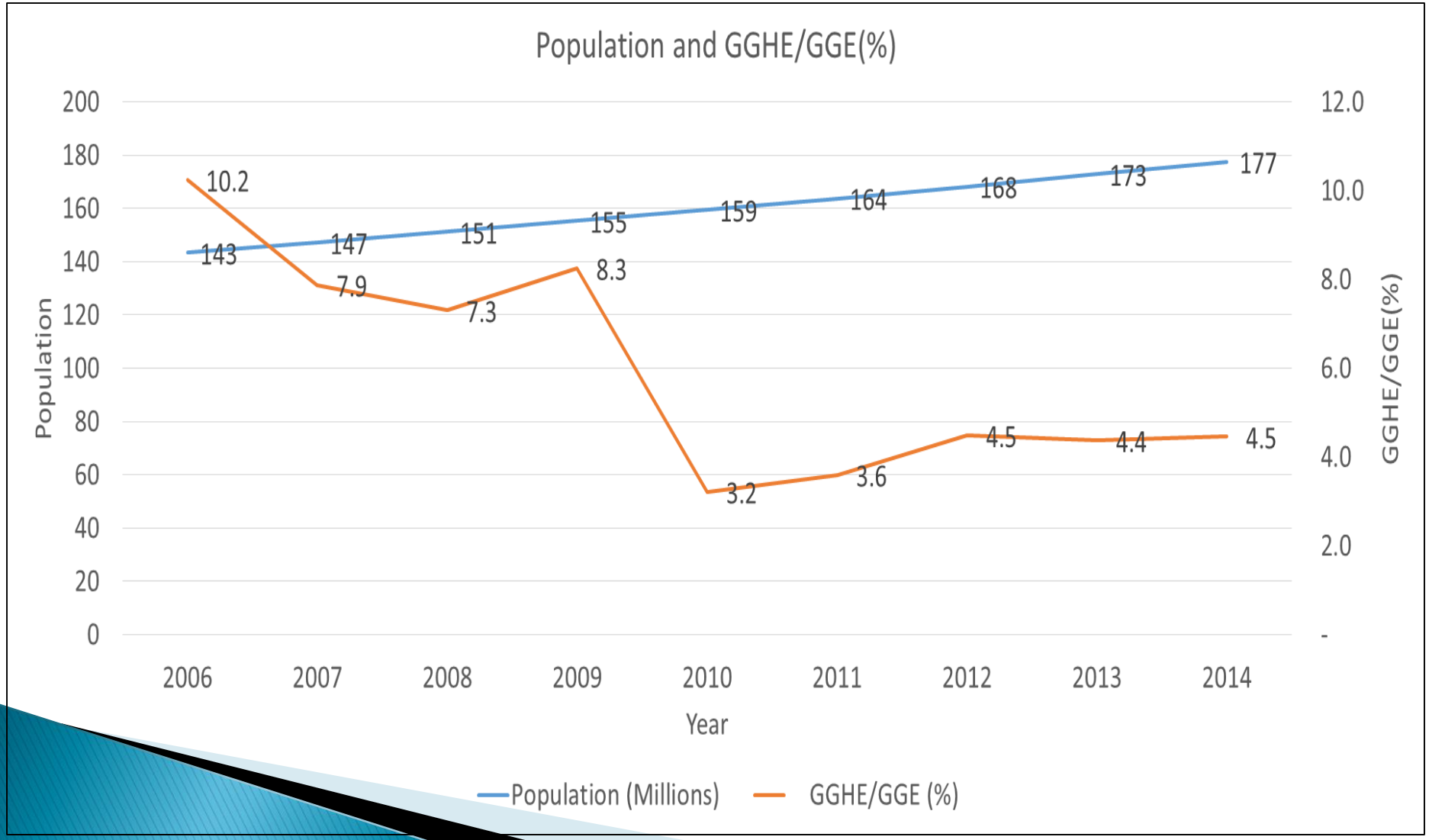


Public spending on health (in real prices) slightly increased in 2006-07, but stagnated then after.
Although there is increase in public spending nominal prices, the increase is offset by the high inflation and population growth rates.

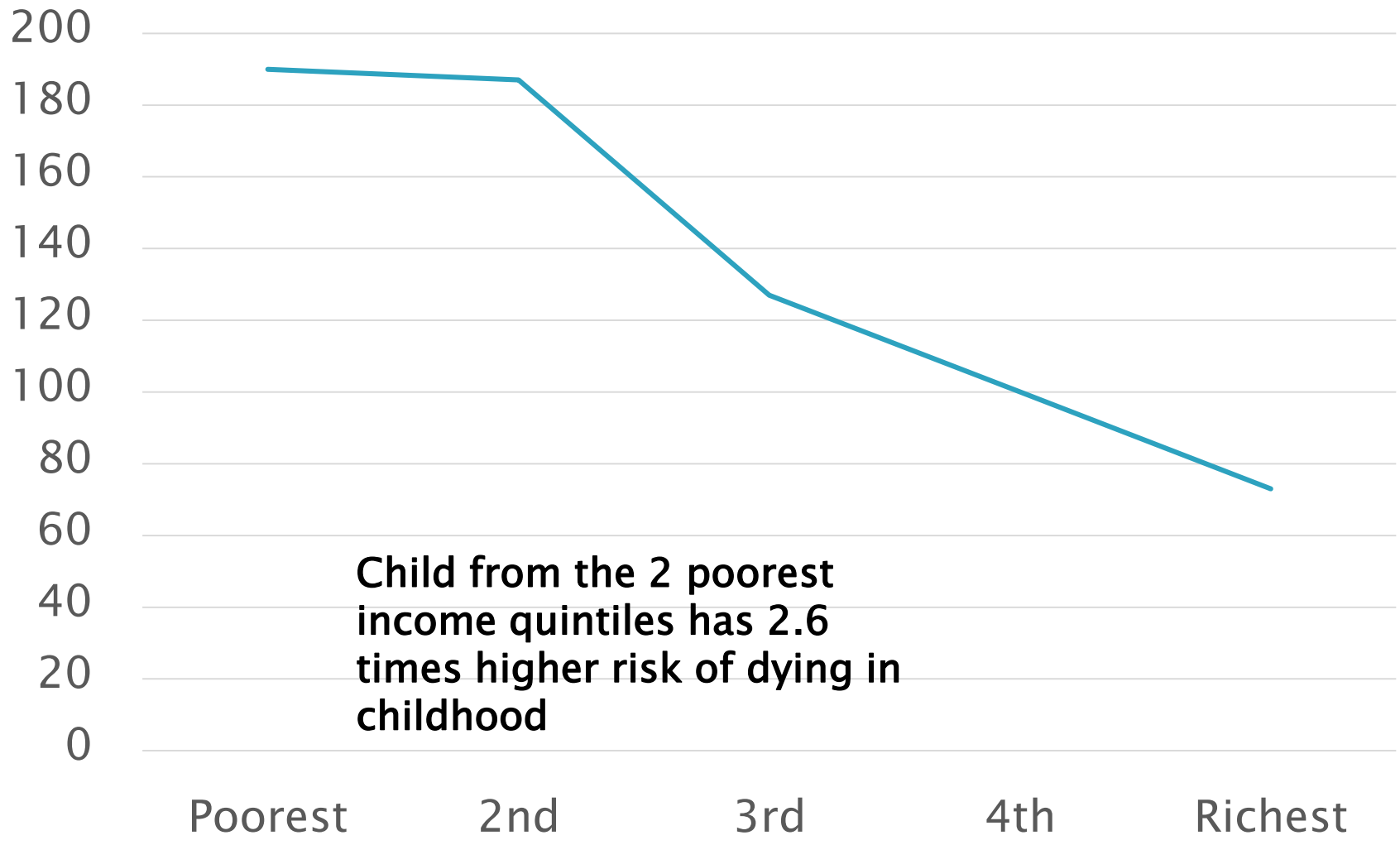



Nigeria
30
20
10
0
-10
Deficit share of GDP
2000
2005
2010
2015
Year
Revenue share of GDP
Expenditure share of GDP

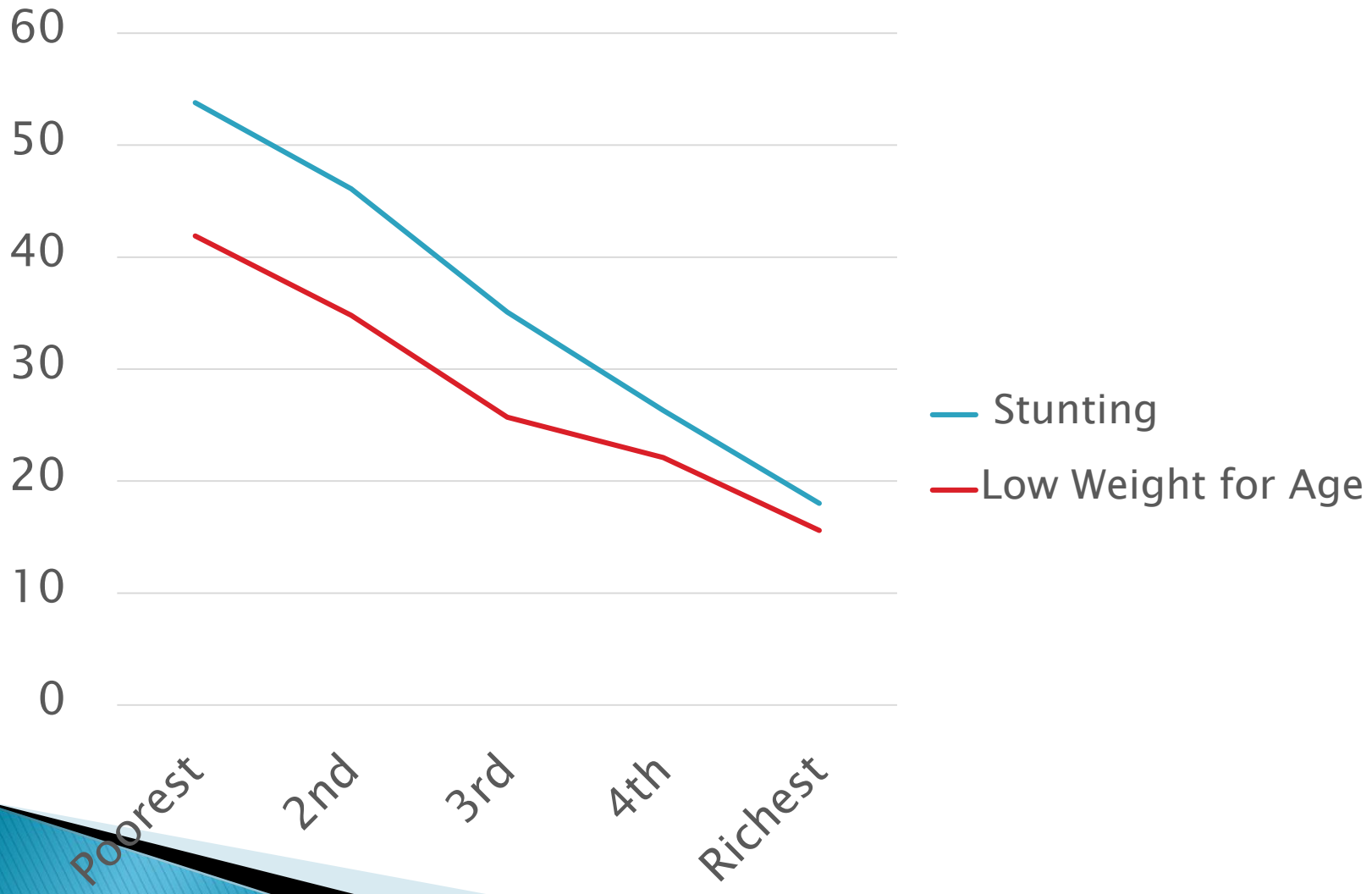
Increasing population and decreasing public expenditure on health



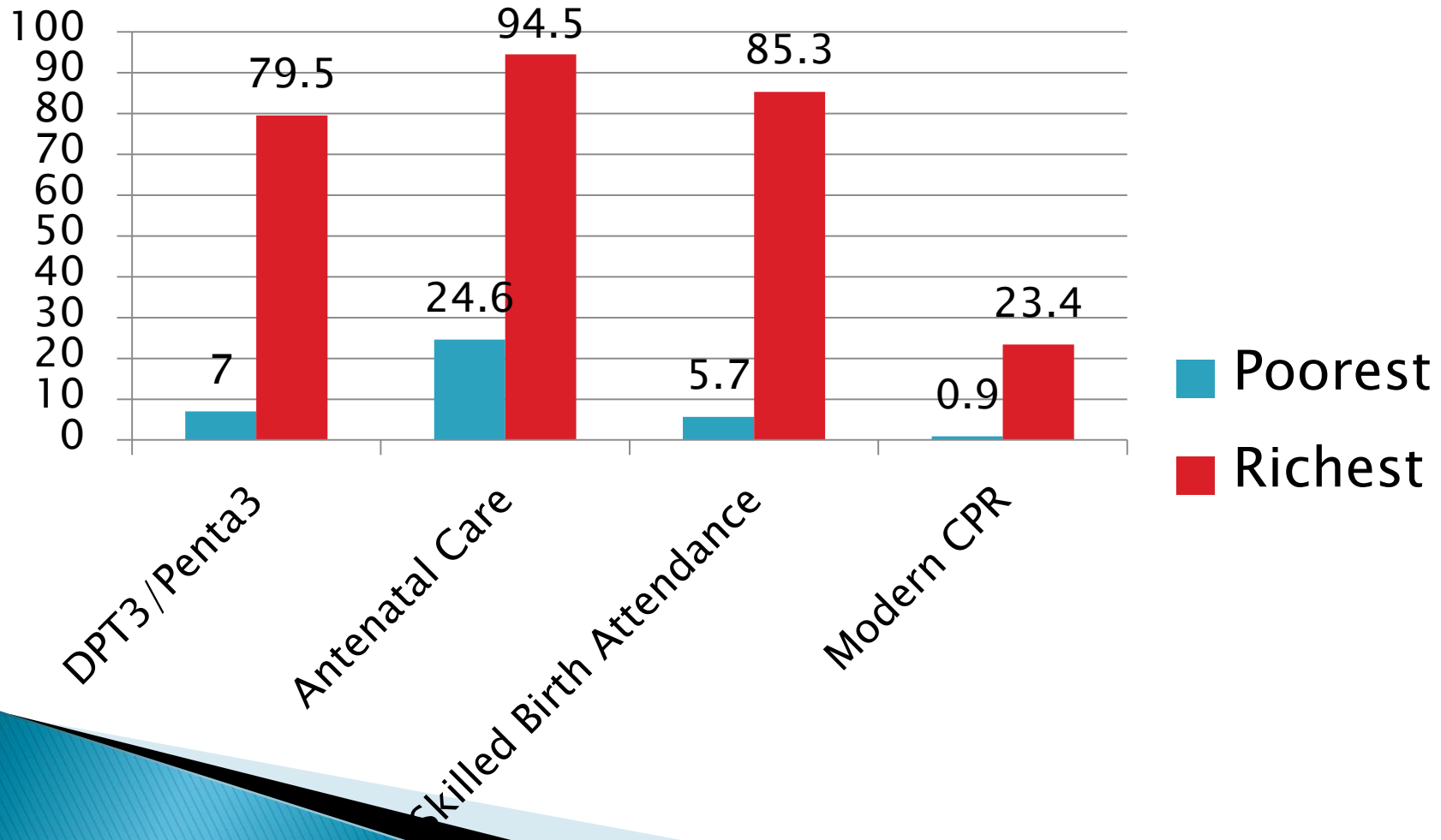
Poorest 40% of Population Accounts for 56% of all U5 Mortality



% of Children who are Malnourished by Income Quintile – 2013 NDHS



Coverage of Key Health Interventions by Income Quintile – NDHS 2013



NEED FOR A PARADIGM SHIFT – Legal basis for a new approach

- National Health Act-2014
- BHCPF as a legal instrument for additional financing for health.
- Three sources – 1% CRF, Donor contributions and from any other source.
- Three gateways for disbursement of the BHCPF
- BMPHS for all Nigerians

Operational basis for a new approach/1– Investment Case

- **The problem with Nigeria's health sector is not just inputs** and so the IC was envisioned to implement strategies that will foster dramatic, cost effective and sustainable results.

- Specifically, it will support and strengthen the commitment of GoN on improving RMNCAH+N services over the next five years and beyond.

- It lays out strategies for targeting rural population where most maternal and perinatal deaths occur

- Strategies to engender strategic purchasing to increase efficiency and build trust for more investments in health in line with the provisions of the NHAct

Operational basis for a new approach/2 – Lessons from NSHIP

- A performance based health financing intervention to improve PHC.
- Focuses MCH, System strengthening including HMIS
- Lessons learnt from DFF and the PBF showed efficiency and accountability- HF were able to use operational funds to improve on service delivery and staff were motivated to work.
- These lessons formed the operational basis for operationalizing the BHCPF using GFF funds
- These results and improvements also led to additional financing credit for expansion from the WB of about $125 million and a GFF grant of $20m

OPPORTUNITY TO DO SOMETHING DIFFERENT

- Strategic Advocacy efforts

- Results of advocacy efforts –
  - The Legislative arm constituted a legislative network for UHC and swung into action.
  - Results of Political engagement – 1% CRF in 2018 budget
  - Additional resources from GFF and other partners

  - Domestic resources to implement the BHCPF,
  - CSO groups played critical role in advocating for more resources for health

PATHWAY TO UHC:

KEY HIGHLIGHTS OF BHCPF IMPLMENTATION – SHOWING THE EFFICIENCY AND ACCOUNTABILITY FEATURES OF THE BHCP

The BHCPF establishes systems and approaches that will be very critical in accelerating UHC in Nigeria

The government will buy services from both public and private providers of services using a level playing field for all

The BHCPF establishes a system of accreditation in order to improve quality of care

It will finance a rigorous system of verification that helps to ensure value for money

Creates a robust payment systems via electronic transfer to providers and thus reducing corruption

CHALLENGES

- Federal Level
- State Level
- Diverse Stakeholders
- Sustaining the gains

SUMMARY

- Showcased how poor budgetary allocation to the health sector has resulted in poor health outcomes over the years.
- The need for a paradigm shift and how the Act provided a legal basis
- Lessons from NSHIP and NSHDP review including the development of the IC and operationalizing the BHCPF provided an operational basis for new strategies.
- Strategic advocacy provided new opportunities for DRM and GFF in Nigeria
- Efficiency and Accountability features of the BHCPF

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GFF Country Workshop,
17th - 22nd September 2018

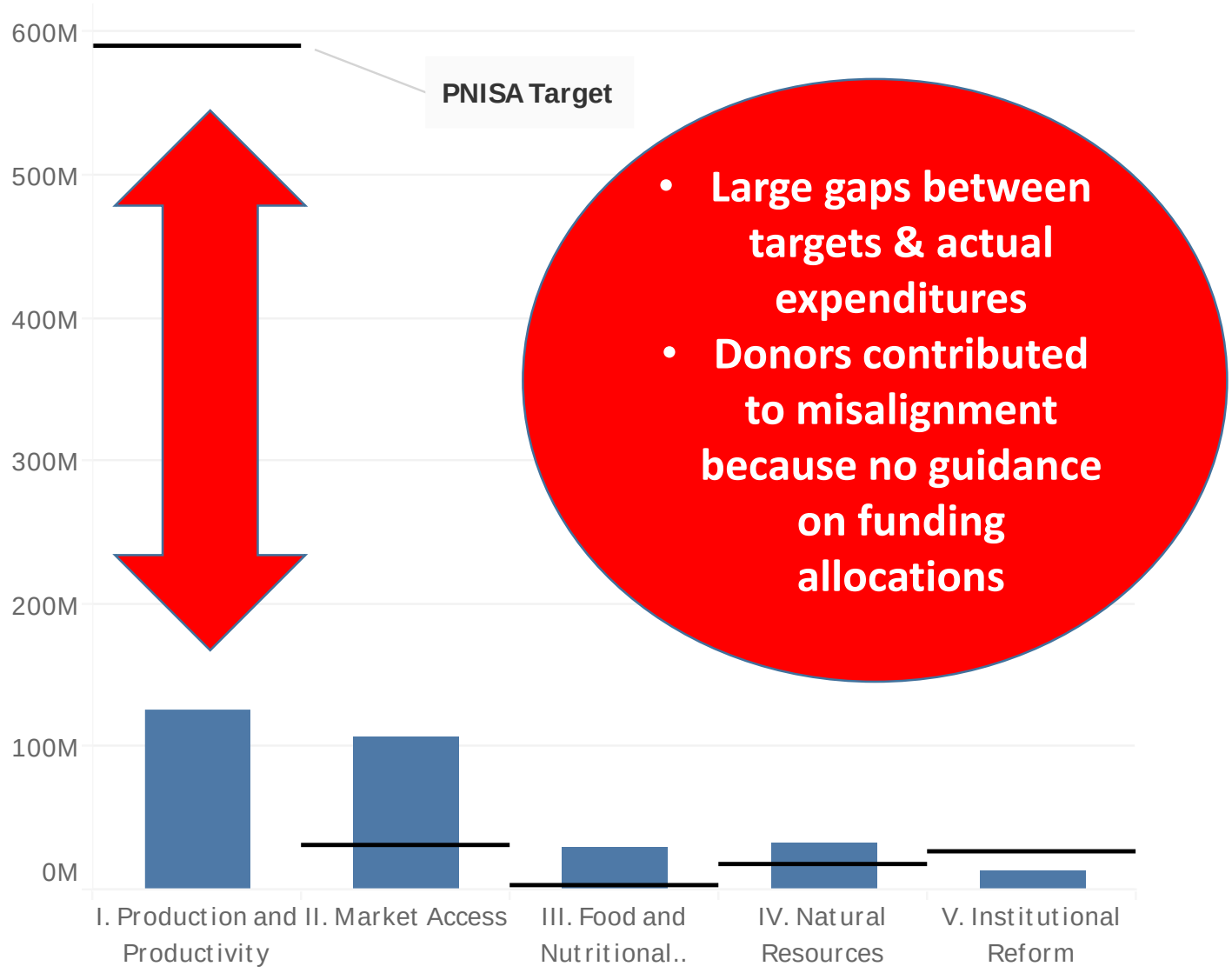
Case study Mozambique

Aligning IC priorities to the budget process

Agriculture experience showed that IC doesn't automatically translate into more money

- Mozambique developed a sector strategy and investment plan for the agriculture sector (PNISA) for 2013-2017
- PNISA used a separate program structure without linking to the budget
- Evaluation in 2016 found that expenditures were not aligned to PNISA targets

Expenditures in PNISA Components Compared to Targets in 2015



- Large gaps between targets & actual expenditures
- Donors contributed to misalignment because no guidance on funding allocations

What happens when a sector strategy is not aligned to the national budget process?

No realistic targets or prioritization:

- Without realistic targets, stakeholders do not have to prioritize spending to the priorities defined in strategy
- Institutions continue to spend as before

No monitoring or accountability:

- Tracking a sector plan that is not aligned with the government's budget is time- and labor-intensive, and may not take place regularly
- Without monitoring or reporting on progress, institutions can not make course-corrections during implementation

Reduced sector support:

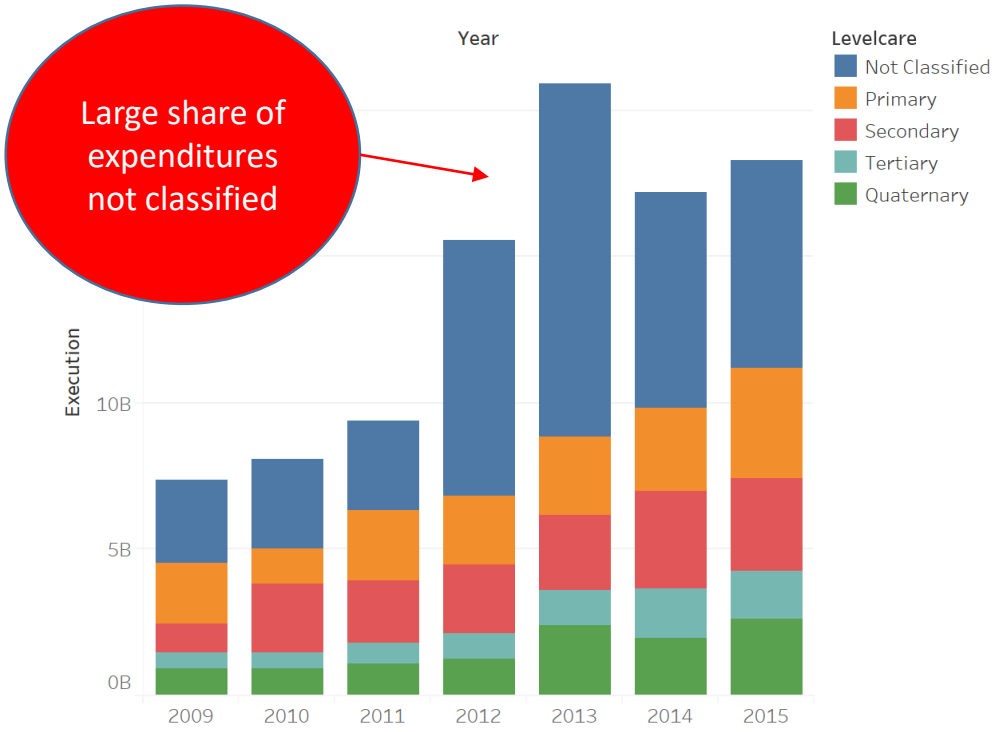
- With no accountability for increasing spending or meeting targets, many may choose to allocate resources elsewhere

►Need to develop a strategy to make sure IC priorities are aligned with the budget

First step: How are resources currently spent?

- Expenditure analysis helped understand how resources are currently spent & challenges in budget classification

HEALTH EXPENDITURES BY FACILITY LEVEL FROM 2009-2015

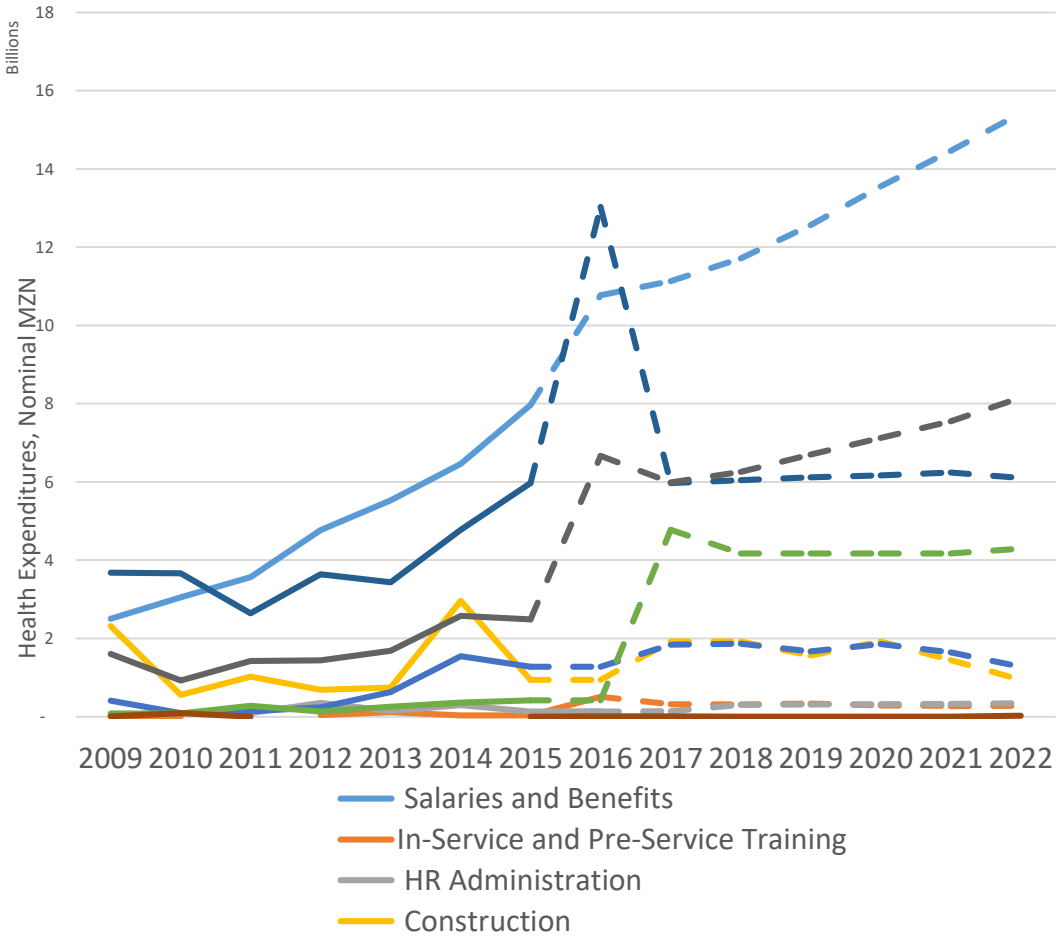


Lessons:

- Budget is structured as line-item budget with little information on programs
- Only 14% of all expenditure records use program classifiers and 85% are classified as "unknown"
- Most consistently tracked budget classifiers are administrative, economic and functional.
- 'Functional' classifiers have several limitations which makes it difficult to track if IC priorities are aligned with budget

Second step: What changes are we expecting if expenditure follows the IC priorities? (set targets)

Figure 2: Initial Estimate of current spending levels (baseline) and proposed increases (targets) to achieve IC priorities



Lessons:

- One Health tool was used for IC costing. This methodology didn't link to budget activiites, spending units and existing budget classification system
- We create initial estimate (figure 2) of baseline and target spending level but IC costing needs to be redone to aling with government budget classification system

Third step: Understanding the budget process and how to influence it

- Mapped out annual budget formulation calendar & IC engagement action plan

Months	Annual Budget Calendar	Priority Actions for Engaging with Government on IC Prioriti
Oct - Dec	--	Begin discussions with MOF and MOH on last year budget
Jan – Mar	Districts review plans and collect statistics to inform spending needs	Review previous year's data according to expected increases i investment with suggestions of changes for the upcoming yea
Feb – Apr	The medium term fiscal framework (CFMP) is elaborated – initial budget limits are communicated, and budget proposals are submitted for central government review	Begin discussions with provincial focal points about the budge and expected budget targets for each spending unit
May 31	The central government communicates the second budget limit and budget guidelines	Adjust IC targets based on CFMP projections and budget limits year
Jun – Jul	Provincial and sectoral planning meetings are held	MOH budget unit working with Provincial budget units to discu priorities in the provincial budgets
Aug	Budget proposals are submitted and consolidated for provinces, districts and sectors	Review the Global Economic and Social Plan (PES) in comparis targets and discussions with MOH budget unit before their me with MEF on total sector allocations
Sept	The PES and government budget are submitted to the Council of Ministers for approval by Sept 15th, then to Parliament for approval by Sept 30th	Review the final spending approved for the health sector in th government budget
Dec 15	Final date for the approval of the PES and government budget by Parliament	Begin discussions with MOH budget unit on allocations in the l execution module (MEX) and funds flow to local facilities

Source: Budget calendar adapted from, World Bank (2014) Mozambique Public Expenditure Review, Action plan developed in August 2017.

Forth step: Support to ensure integration of IC priorities in national budget

Work program to improve alignment between IC and national budget process:

- BASELINE ANALYSIS
  - Redo IC costing and map to associated budget lines → more reliable baseline and target
  - Train IC provincial focal points in the provincial budget process
  - Review annual budget data and report on annual progress to IC targets

- STRENGTHEN PLANNING AND BUDGET CLASSICATION SYSTEM TO ALIGN WITH IC
  - Training of local finance officers and accountants on the correct use of functional classifers (as 37% of expenditures are classified as "other") to improve tracking in the future.
  - Workshops with districts and provinces to discuss changes in expenditures to reflect IC priorities

The End..

Structure of Mozambique Budget (Classification system)

Classifier	Objectives/Description	Comments
Functional	Aggregates public spending according to government action areas related to the nature of State functions - largely in accordance with COFOG.	Detailed use of the functional classifier, especially in hospitals, however 37% of health expenditures used 'Health, Not Otherwise Classified' as their third level of functional classifier.
Administrative	Aggregates public spending for each the state institution / spending unit (UGB) responsible for budget formulation and execution.	UGBs in the health sector include the Ministry of Health (MISAU), hospitals (except for district hospitals), provincial health directorates (DPS) and district health units (SDSGCAC).
Programmatic	Tracks the government activities into programs and sub-programs in pursuit of government policy objectives and enables monitoring of results.	Only partially applied to expenditure records: for example, the first level 'Health' program classifier was only applied in 14% of all expenditure records in 2015, while 85% are classified as 'Unknown'.
Economic	Identifies the economic nature of the expenditure such as salaries, allowances, goods, services, subsidies, transfers etc.	The economic classification is reasonably elaborate and consistently tracked.
Geographic	Allows separate tracking for the central government and each of the sub-national governments at provincial and district levels.	Complements the administrative classification in terms of identifying the level of the UGB and helps defines the state accountability with each level.
Sources of Funds	Identifies the source of funding (treasury, loans, donations, own revenues). Detailed source ID identifies the specific development partner.	Can be used to track project disbursement receipts and expenditures in case of externally-financed projects.

[1] Servicos Distritais de Saúde, Género, Crianças e Acção Social, previously known as SDSMAS.

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