World Health Organization

5th Meeting of the Montreux Collaborative

Fiscal space, public financial management and health financing in a time of COVID-19

Welcome to the 5th Montreux Collaborative meeting!

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IT information and support

Welcome to the 5th Meeting of the Montreux Collaborative

Learning Technologies Group will be providing IT support during the meeting

Please contact us at matt.matheson@leolearning.com if you have any IT related questions

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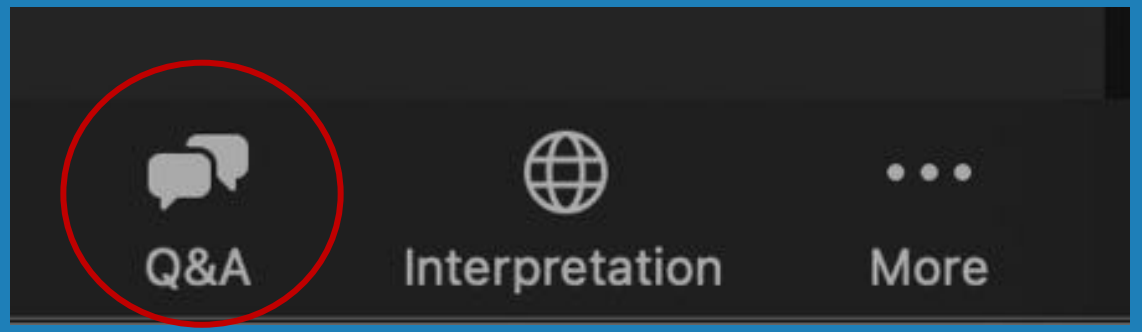
Q&A – how to ask your question

Use the Q&A function to ask questions throughout the session

These will be responded to as text responses and some questions will be posed to our panelists.

Click ‘Q&A’ to ask your question.



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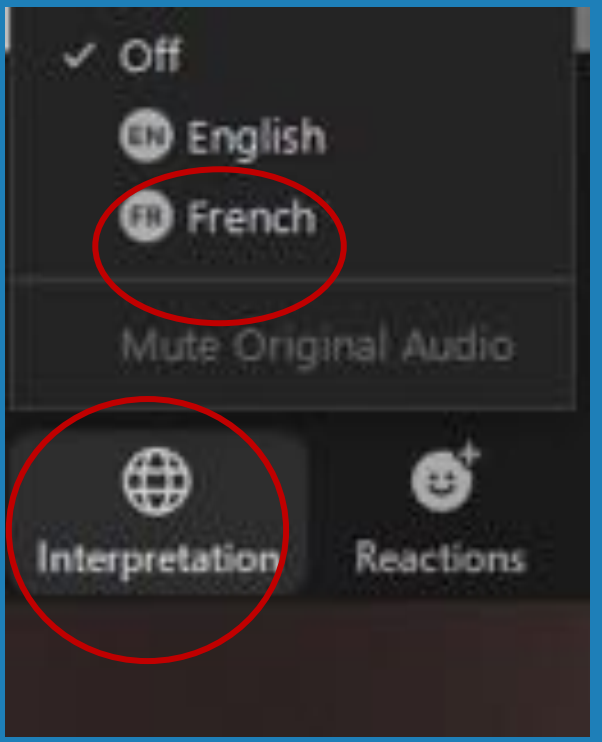

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All sessions are recorded

We are recording all sessions in English and your attendance is consent to be recorded. Only speakers will be visible in the recording.

These will be available to review on the WHO site below after the event has concluded.

https://www.who.int/news-room/events/detail/2021/11/15/default-calendar/5th-meeting-of-the-montreux-collaborative

Day 3 - Wednesday 17 November

5th Meeting of the Montreux Collaborative

13:00 – 14:30 CET : **Direct facility financing: what are the opportunities and challenges of PFM systems?**

Chair and moderator	Joe Kutzin (WHO)
Concepts and rationale of direct facility financing	Sophie Witter (Queen Margaret University Edinburgh, UK)
Tanzania: key lessons from aligning direct facility financing and the PFM system	Sheila O'Dougherty and Gemini Mtei (Public sector systems strengthening project, Abt Associates/USAID, Tanzania)
Discussion: Opportunities and constraints for scaling-up reforms	Nirmala Ravishankar (ThinkWell), Ayodeji Oluwole Odutolu (Global Financing Facility), Michael Borowitz (The Global Fund)
Questions and answers	With support from Federica Margini (UNICEF)

Direct facility financing: rationale, concepts & evidence

Professor Sophie Witter

Queen Margaret University Edinburgh & Rebuild for Resilience

17 November 2021, Montreux meeting

Section 1

BACKGROUND, RATIONALE & CORE CONCEPTS

Background and problem statement

1. funds are not getting to frontline providers, especially in primary care

2. this pushes costs onto users

3. primary care is underfunded, seen as poor quality, bypassed by users

Driven largely by:

- resource shortages
- political economy (favouring higher level facilities)
- system failures (weak PFM, capacity gaps)
- low levels of trust in managers

Funding source	% of total		
	Budget	User fees	Other
4 regional hospitals	62	37	1
6 district health centres	57	42	1
9 health posts	5	95	0

Source: my PhD fieldwork in Senegal, 2005

So why DFF?

DFF not only approach to these challenges but tries to address some of these root causes. Works on the principle that:

1. Funds should be concentrated where they are needed most – i.e. health facility levels
2. District and provincial level involvement in fund administration creates unnecessary transaction costs and payment delays, compromising the abilities of facilities to effectively and efficiently deliver quality health care
3. Needs to be complemented by addressing systemic challenges (ensuring facilities have flexibility and autonomy and skills to manage etc.)
4. Trust will be built by addressing iteratively addressing blockages and demonstrating results; at present no accountability can be enforced as resources are not made available; DFF also usually accompanied by attempts to decrease formal and informal user fees

Core concept

Direct facility financing (DFF) = direct provision of funds to health facilities to enable facilities to meet operational requirements

Basis for payments can vary but commonly prospective (e.g. capitation or budgets-based)

The main differentiating feature is that funds are directly channelled from national levels to health facilities, and that facilities are given managerial autonomy their use.

- Once districts have approved budgets, funds are transferred from national purchasers directly into facility accounts and facilities can proceed to use funds as agreed, without need for further approvals
- Auditing of transaction and expenditure records, as well as usual monitoring and supervision of health facility activity, are the main verification mechanisms

Pre-requisites

DFF requires health facilities to set up independent bank accounts, as well as to have the autonomy (and capacity) to manage the funds

- So willingness to decentralise must be present to some degree

Introduction may be accompanied by:

- additional support for budgeting, auditing and accounting, both at district and facility levels (tools + training + supervision)
- specific guidelines and rules for how/when funds obtained via DFF may be spent (e.g. in some countries purchase of medicines and supplies is excluded to ensure cost-savings and quality control via pooled procurement mechanisms)
- capacity building on community engagement to provide oversight on budgets and fund use

Section 2

EVIDENCE ON DFF IMPLEMENTATION AND EFFECTS

Implementation issues

Growing interest but still limited published literature

Studies in Papua New Guinea, Kenya, Tanzania

Kenya: overall spending across the program was high with only few isolated occasions of mismanagement (e.g. facility fake receipts, in charge absconding with funds)

However, some areas of challenge:

- Delays in disbursement

  e.g. in Kenya, districts only sent off budgets for approval to national levels once all facilities had submitted budgets and all funding agreements had to be signed off in Nairobi prior to funds being made available
- Some districts not willing to allow facilities to set budgets
- Additional accountancy training needed

Impacts

Studies ongoing in Tanzania – see next presentation - but preliminary evidence (from Kenya and PNG) suggests:

1. Increased utilisation (though may be due to increased funding)
2. User fees – no strong evidence of reduction

In Kenya, also:

1. Improvements in clinic working environment at facilities (including equipment and consumables)
2. Increases in staff attendance and outreach services provided
3. Patient-reported improvements in facility cleanliness, waiting times and treatment quality, including staff courtesy

Section 3

FINAL REFLECTIONS

Supportive components

DFF sometimes portrayed as simple but **requires considerable groundwork** in terms of:

- design and implementation of system strengthening components (such as reinforcing management skills at facility level, access to banking, improved supervision and health information systems);
- a broader supportive environment and adequate funding;
- programme design and implementation components, such as:
  - estimating funding amounts which are required at facility level;
  - determining reporting, verification and performance review approaches;
  - agreeing, monitoring and enforcing policies on charges to users;
  - determining and enforcing any rules on staff benefits from the funds, and on how funds can be used more generally.

Many of these require changes outside health sector, e.g. by MoF

DFF can be system strengthening

DFF should be seen as a **health system strengthening intervention** (not just health financing intervention), as it impacts on all system areas and should in principle be coherent with arrangements in them

- e.g. health worker remuneration, drug supply systems, governance, public financial management (PFM) systems, health information systems, service packages, infrastructure quality and distribution, and measures to address community access barriers

DFF **mechanisms of change are also more complex** than the label implies: the label focuses on finance, and resources are indeed important to effects observed. However, there are many other components which are important

- including feedback on effort, signaling of priorities, support for planning, more focus on data and results and greater autonomy for facility managers, among others

Conclusion

- It is **not a new approach** – similar features to approaches used previously (e.g. for reimbursing lost fees in fee exemption policies) and in other sectors (e.g. capitated payments to schools in Uganda)
- As a **system strengthening intervention**, DFF has promise if designed with good fit to the context and its blockages.
  - It can provide the small but essential flexible resources which are needed at facility level to support integrated care packages
  - It can contribute to strengthening the system through encouraging focus on long-term operational constraints at facility level (skill gaps, rigidities etc.)
- It requires **complementary interventions at community level** given that it focuses on facility-based services

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Thank you

Professor Sophie Witter

Queen Margaret University Edinburgh & Rebuild for Resilience

17 November 2021, Montreux meeting

Key lessons from aligning direct facility financing and the PFM system in Tanzania

5th Meeting of the Montreux Collaborative
November 17, 2021
Sheila O'Dougherty and Gemini Mtei

Outline of presentation

- Background
- Direct facility financing (DFF) principles and Tanzania implementation
- Results and Lessons Learned
- Conclusion

- Note: refer to Montreux disseminated information: Direct Facility Financing Policy Brief_2021, and DHFF Implementation Experience in TZ_2020 Gemini Mtei

Background on Tanzania DFF implementation

- All district public health facilities (5,500+) and schools (25,000+ total)
  - Direct health facility financing added to pre-existing direct school financing
  - Facilities: hospitals, health centers, dispensaries (front-line PHC), and broader facility affiliations including community health workers
- All facility level funds finance facilities directly…..but key aspect is inclusion of some general revenue (equity, cross-subsidization, UHC)
  - Budget support/health basket fund (HBF) using country PFM systems
- Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC), Ministry of Finance and Planning (MOFP), President's Office Regional and Local Government (PORALG), Local Government Authorities (LGAs), health facilities including governing committees
- Sequencing: nationwide implementation (2017-2018) followed by PORALG and DP mentoring and Help Desk user support to LGAs and facilities (2018 to present date)

Facility autonomy principle

- Ensures health facility has status to receive, manage and account for funds from any legal source or funds flow
- One end of spectrum: facility bank accounts and right to procure inputs
  - Other end of spectrum: private providers
- Country chart of accounts identifies entities that can receive and expend funds
- Realign roles and relationships across all government levels
- Tanzania meets principle (condition): all health facilities required to have a bank account and they have a code in the country chart of accounts

Output-based payment principle

- "Buy the right thing" and better match payment to prioritized services
- Provider payment systems vary by many factors:
  - Definition of service outputs including level of service bundling
  - Use of flat fees or formula-based systems
- Challenges that DFF can help mitigate are funds flow fragmentation and PFM barriers or rigidities:
  - Use of unified provider payment system across funds flows
  - Input-based budget formation, line-item restrictions on budgeting or payment, individual facility level rather than program level expenditure caps, etc.

Output-based payment principle (2)

- Tanzania meets principle using PHC per capita payment system
  - Payment formula of base rate per health facility with simple payment adjustors for catchment population (need), distance from local government center (equity), and utilization (performance)
- Mixed model: input-based payment for salaries, core output-based PHC per capita, and results-based financing (fee-for-service) on top leveraging all funds
- Working to unify payment system across funds flows to reduce fragmentation and conflicting incentives
- Focus on recurrent non-labor operating costs (low-cost, high-volume transactions)

Facility financial management principle

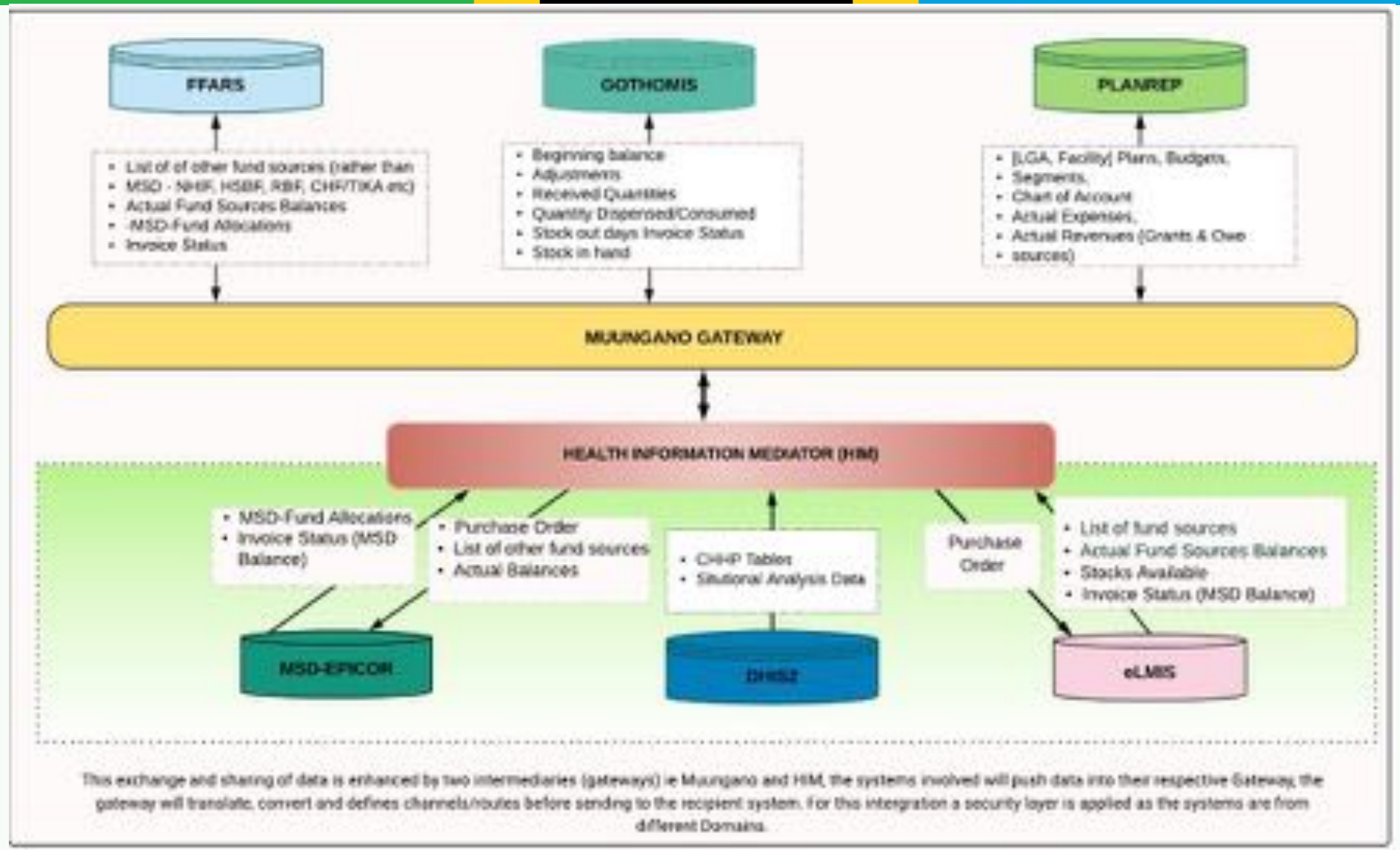
- Perform basic functions: plan, budget, procure, internal controls, account, report, use of data, audit trail
- Standard accounting system for all revenue sources or funds flows
  - Reduce fragmentation and inefficiency in management of country and DP funds
- Build finance authority confidence
- Tanzania meets principle through two cross-sectoral interoperable PFM systems extended to facility level
  - Redesigned PlanRep system for planning and budgeting
  - New Facility Financial Management and Reporting System (FFARS)
    - Web-based, mobile app, and paper versions for use in all facilities

Key links between principles: example of procurement

- If pay for outputs, by definition, delegate right to procure best mix of inputs to facility
  - Output-based payment: health purchaser determines benefit or service to purchase and its allowable costs (recurrent non-labor, labor, capital)
  - Facility autonomy: provider determines best mix of inputs and procures them to produce output
  - Facility financial management: facility is accountable to follow country procurement rules and practice good financial management
- Extending old input-based budget provider payment system to facility level does not meet DFF principles
  - Consumers purchase cars or phones
  - Context and culture around the world….

DFF Implementation Systems and Processes

Systems Interoperability



DFF Implementation Success

USAID Public Sector Systems Strengthening (PS3) project operational research to understand effect of DFF on facility management and governance

- Introduction of DFF has improved:
  - Predictability of funds flows to facility level
  - Facility level planning, budgeting, accounting and reporting
    - Demonstrated use of FFARS by 99+% of all health facilities and schools to account and report expenditures
  - Expenditure and procurement at facility level
  - HR motivation and management at facility level
  - Governance at facility level
  - Alignment of roles and relationships
- Users appreciate decreased stock-outs and improved quality of services
- Government conducting ongoing analysis of extensive FFARS database

Relationship between health financing and PFM in Tanzania implementation

- Two-pronged approach: recognition that health purchasing and facility management are related but different tasks
  - Often facility management is implicit in strategic purchasing, in Tanzania it is more explicit and differentiated
- Separate interventions (two prongs) help shine light on health financing and PFM intersection
  - Health financing lead PFM in health purchasing?
  - PFM lead health financing in facility financial management?
- Which comes first, chicken or egg?
  - Output-based payment and facility PFM systems together
- It is basic foundation not scheme, project, tool, menu, or label
- Focus on reducing fragmentation (funds flows, systems, processes)

Role of Management

- Management entity
  - Finance requires an entity to perform basic management functions
  - Build health (or education) services on sustainable platform
- Is management of service delivery undervalued? A difference between public and private sectors?
  - Let facility managers manage….both capacity and confidence
  - PHC providers are capable of managing their funds
- Management and governance are not the same thing
- Missing a discipline?
  - Public health, clinician, health economist, public finance, governance
  - Need management to produce a product or deliver a service (assemble inputs into outputs and deliver)

Relationship DFF and other health system functions

- Human Resources
  - PFM often separates labor cost (civil service) and other recurrent operating costs creating fragmentation or conflicting incentives
    - Maintain input-based payment for labor (mixed model) or include labor in output-based payment?
  - DFF can create space for facility HR management improvements
    - Planning and budgeting to integrate labor and operating costs, staff distribution, motivation and performance review
- Drug supply management
  - Tanzania mixed model of facilities financed directly (procure directly or prime vendor) and central procurement
  - Facilities can order and interoperable systems increase transparency

Cross-sectoral ramifications and impact

- The same interoperable PFM systems in health facilities and schools
  - Efficiency: Tanzania and USAID study showed 50% reduction in administrative cost of planning and budgeting
  - Local government does not have to operate different country or donor systems across sectors
- Transformation in cross-sectoral or multi-sectoral planning:
  - Planning and budgeting by service outputs….took off after extensive discussion on what are each sector's outputs
  - Budget scrutinization led to substantial improvements in transparency and content of key cross-sectoral programs: nutrition, social welfare, gender-based violence

DFF unleashes and ignites facility management to transform service delivery in 24,000+ health facilities and schools in Tanzania

Thank you

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Panel discussion

Nirmala Ravishankar
ThinkWell

Ayodeji Oluwole Odutolu
Global Financing Facility

Michael Borowitz
The Global Fund

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Break

5th Meeting of the Montreux Collaborative

14:45 – 16:00 CET : **Health budget execution performance: how to get on the same page?**

Chair and moderator	Cheryl Cashin (Results for Development)
Assessing health budget execution performance: a country-level framework	Hélène Barroy (WHO), Moritz Piatti (World Bank)
Putting the framework into practice: evidence from Kyrgyzstan and Ukraine	Loraine Hawkins (health finance consultant)
Acting together: country and global reflections	Sabeen Afzal (Ministry of National Health Service, Regulation and Coordination, Pakistan), Fazeer Rahim (IMF), and Sally Torbert (IBP)
Questions and answers	With support from Amna Silim (WHO consultant)

Health budget execution: How to get on the same page?

Hélène Barroy (WHO)
Moritz Piatti-Fünfkirchen (World Bank)

Why working on health budget execution?

- Overemphasis on revenue issues
- Significant loss of budgetary space in the health sector due to poor budget execution
- Lack of systematic understanding and assessment of the problem
- Policy status quo

Inter-agency initiative on health budget execution

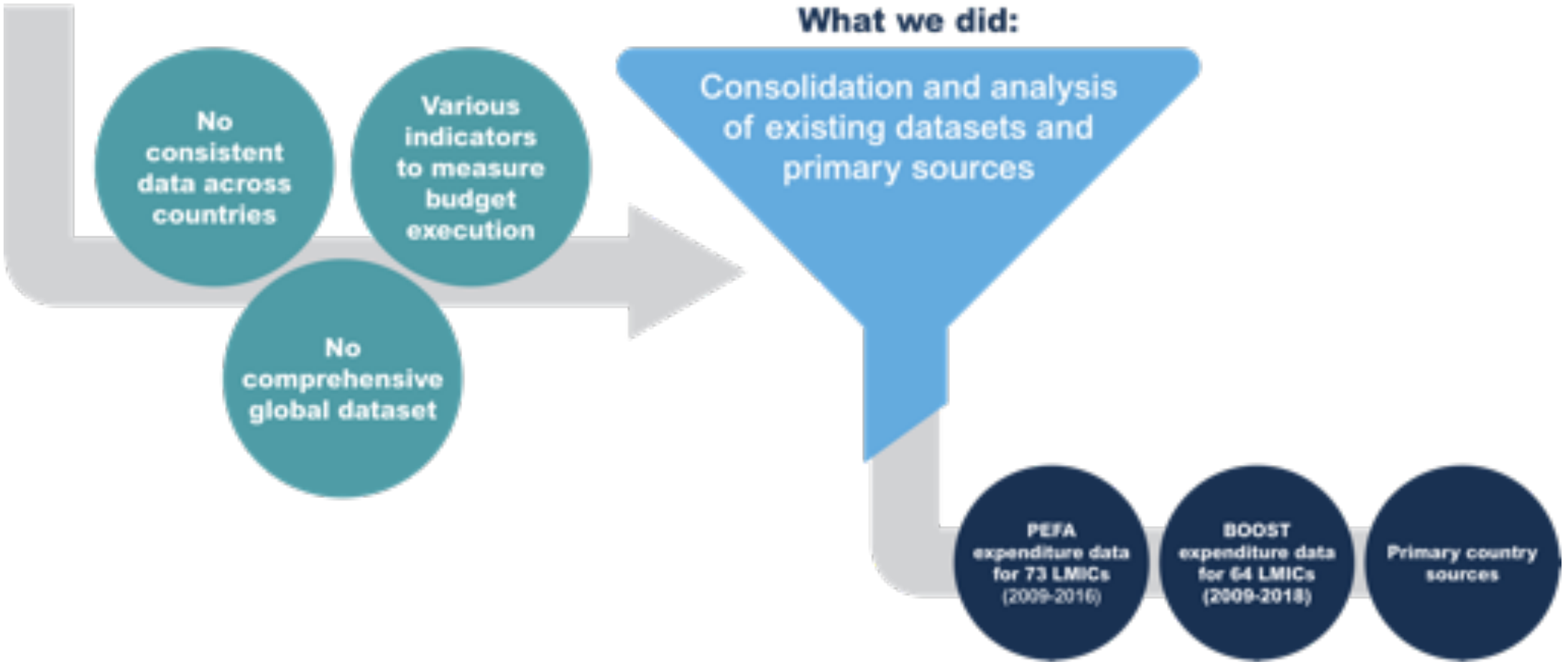
Concept and data

What is budget execution?

Definition and key steps

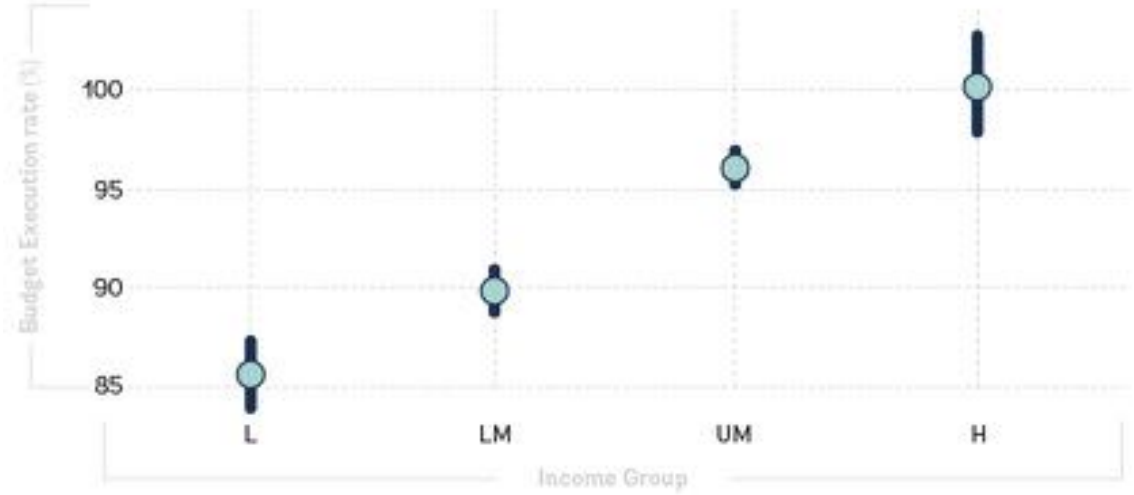
- How funds are actually spent
- Even a carefully crafted budget will be meaningless if not well executed
- Includes multiples steps: from authorization to payment
- Understanding each step is essential to determine the role health and finance play in spending

First global analysis on health budget execution

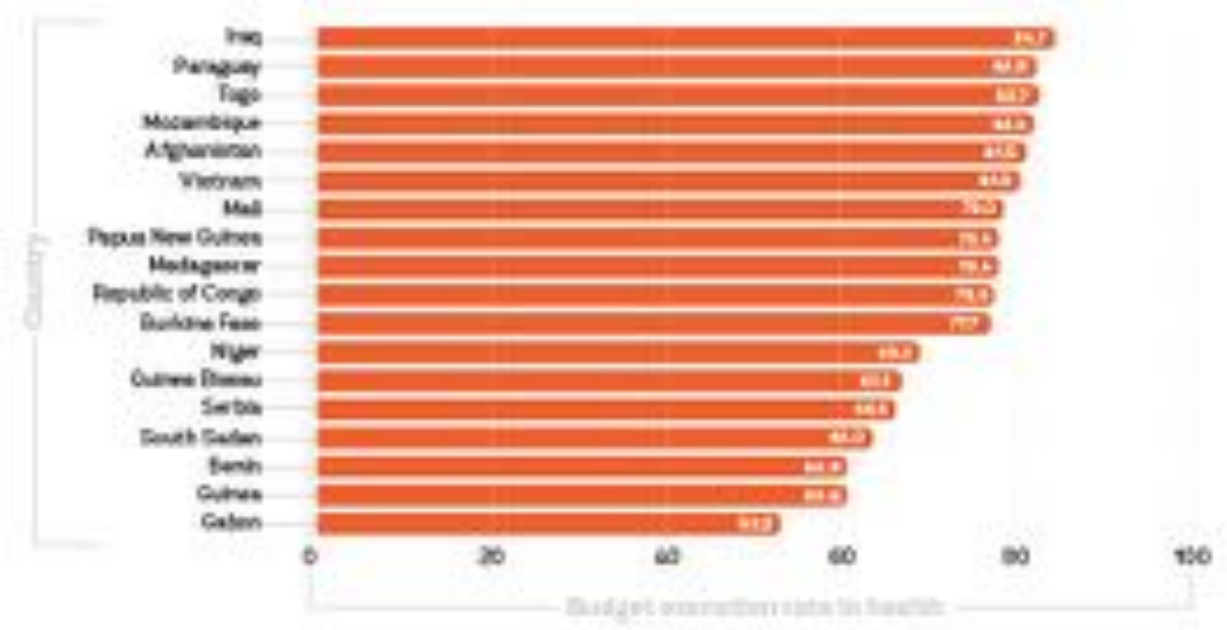


Key results

Under execution of the health budget is particularly prevalent in low income countries

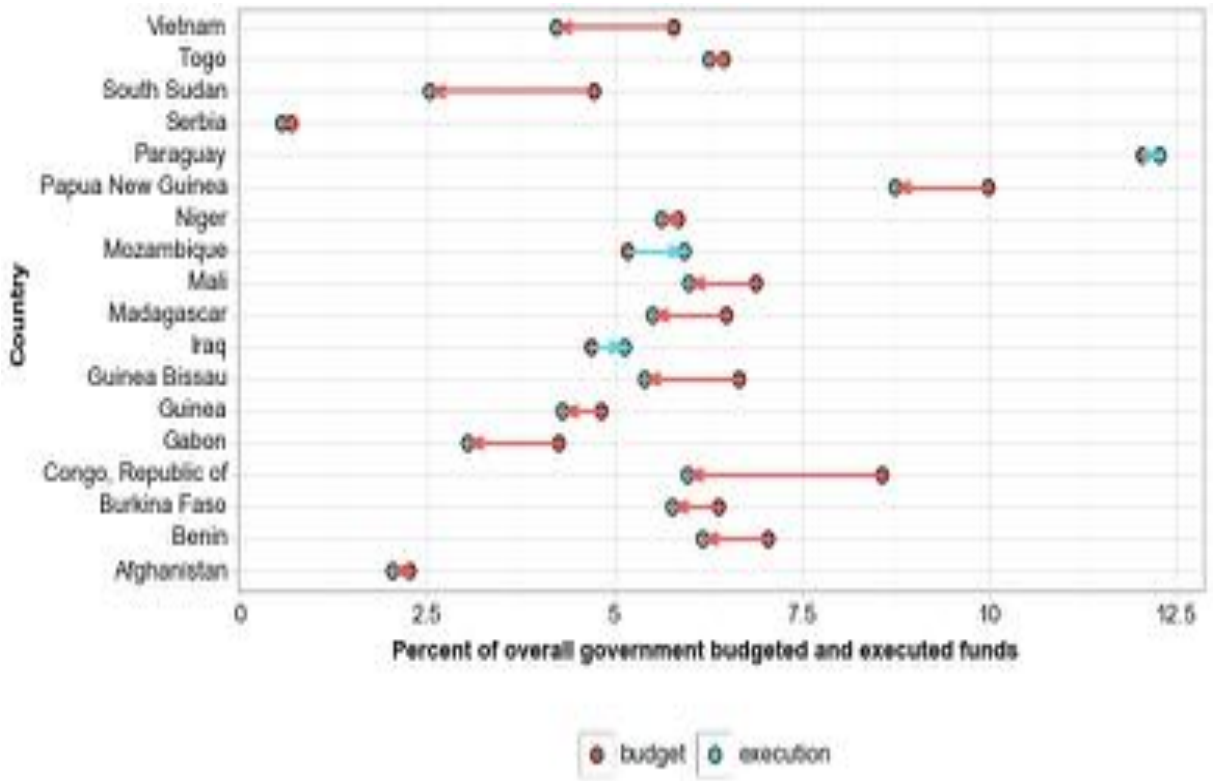


There are many countries with chronic under-execution of the budget in health

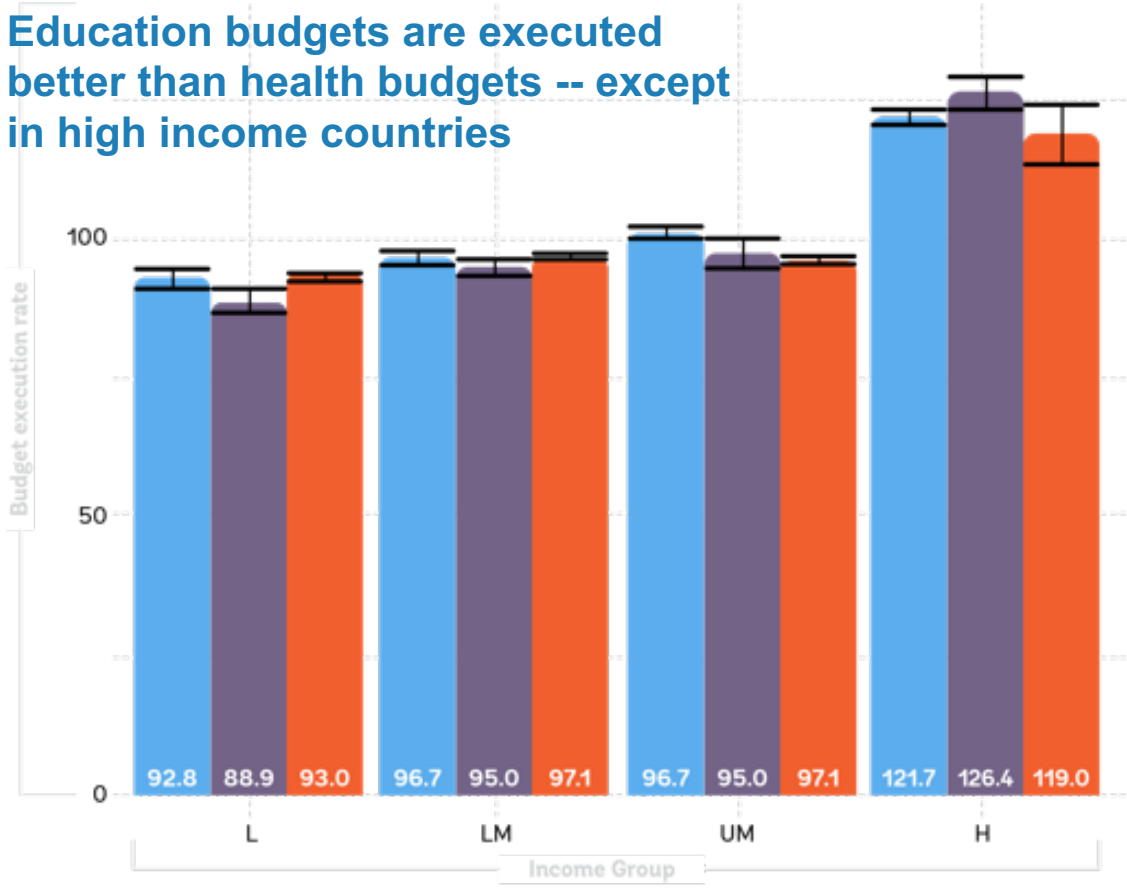


Key results

There is deprioritization of health during implementation



Education budgets are executed better than health budgets -- except in high income countries



Legend: Education Health Other

Source: PEFA annex data; authors' calculations

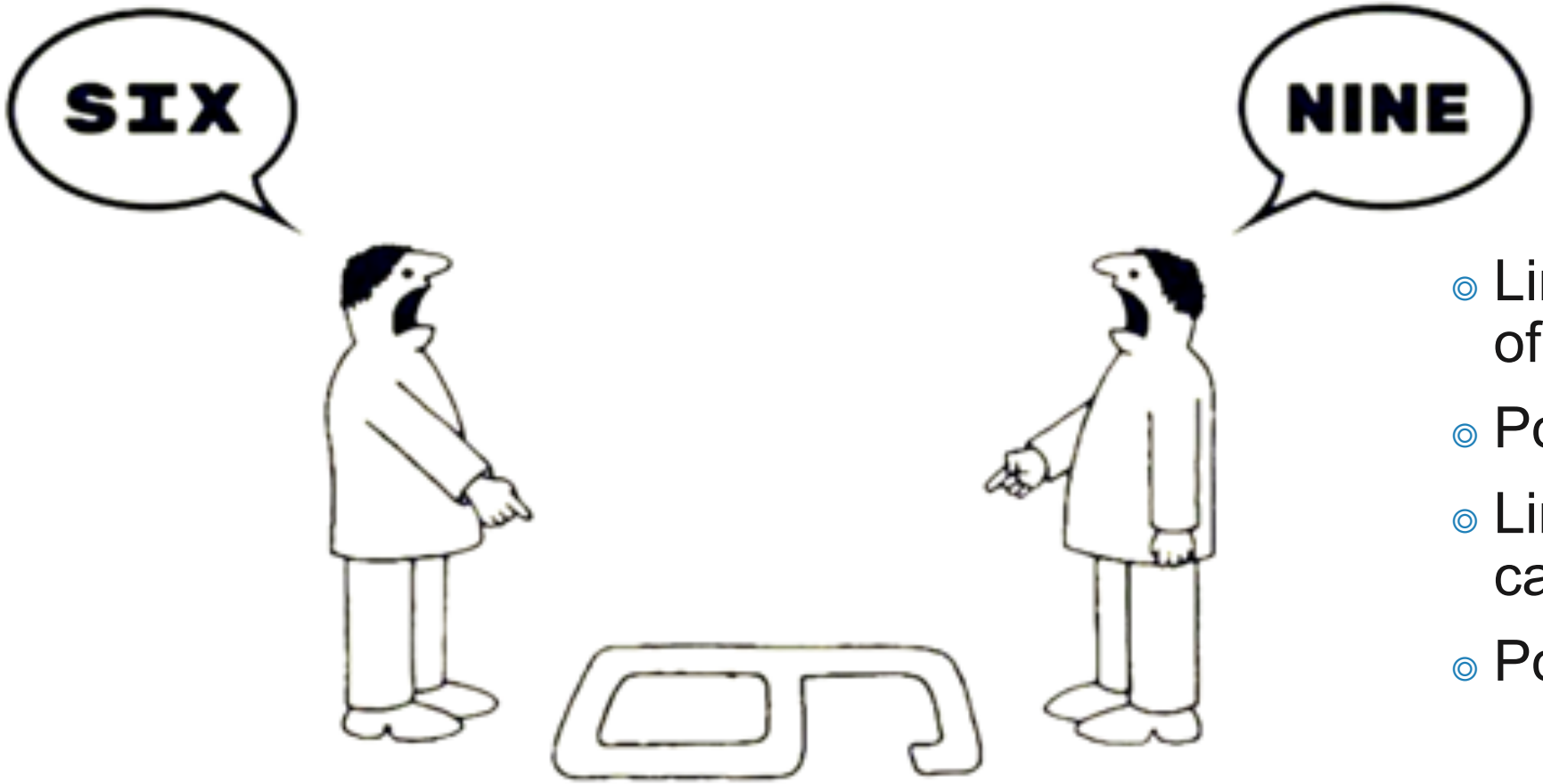
Note: Bars represent group means, brackets represent standard errors of the mean

Budget execution matters for UHC

UHC goal	How budget execution issues affect the UHC goal
Efficiency	Lacking budget credibility
	Delay in fund release
	Operational budget cuts
	Arrears
	Rigidity in spending rules
	Fragmentation in budget execution protocols
Equity	Equity considerations in budget distorted
	Increase in user fees to compensate for funding shortfalls
Quality	Poor budget credibility compromise quality
	Slow and irregular cash releases compromise service quality
Accountability	Overspending without appropriations
	Lacking accountability undermines autonomy
	Excessive financial management requirements

Country-level framework

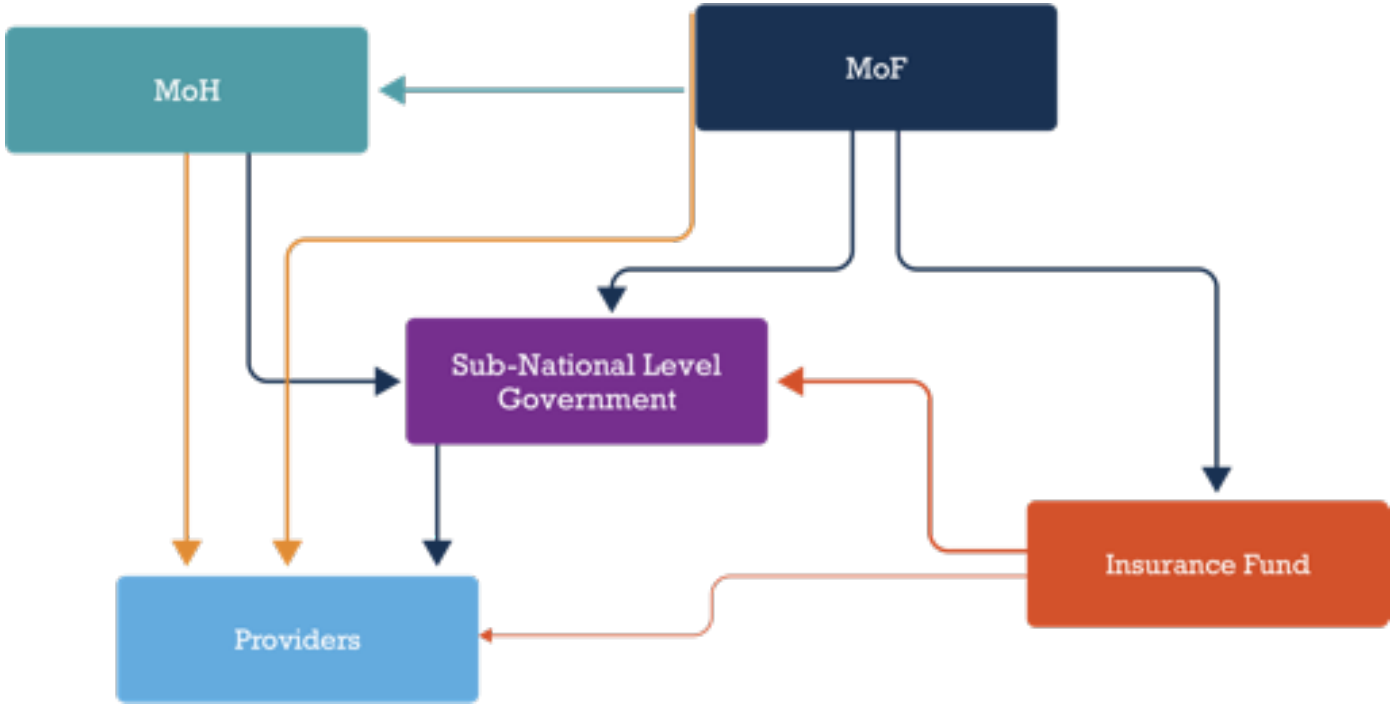
Rationale for a country-level analytical framework on health budget execution



- Limited understanding of health specificities
- Poor measurement
- Limited unpacking of root causes
- Policy status quo.

1— Defining a health budget execution system

Health budget execution system depends on sector's financing arrangements and associated allocation and spending rules.

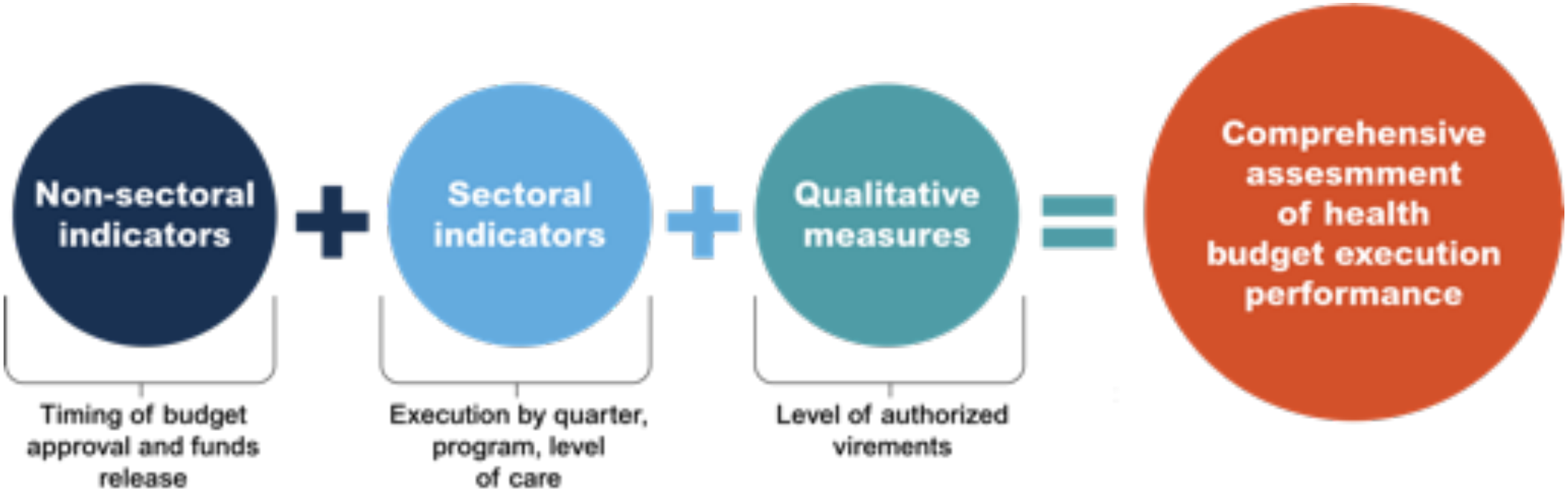


What makes health unique?

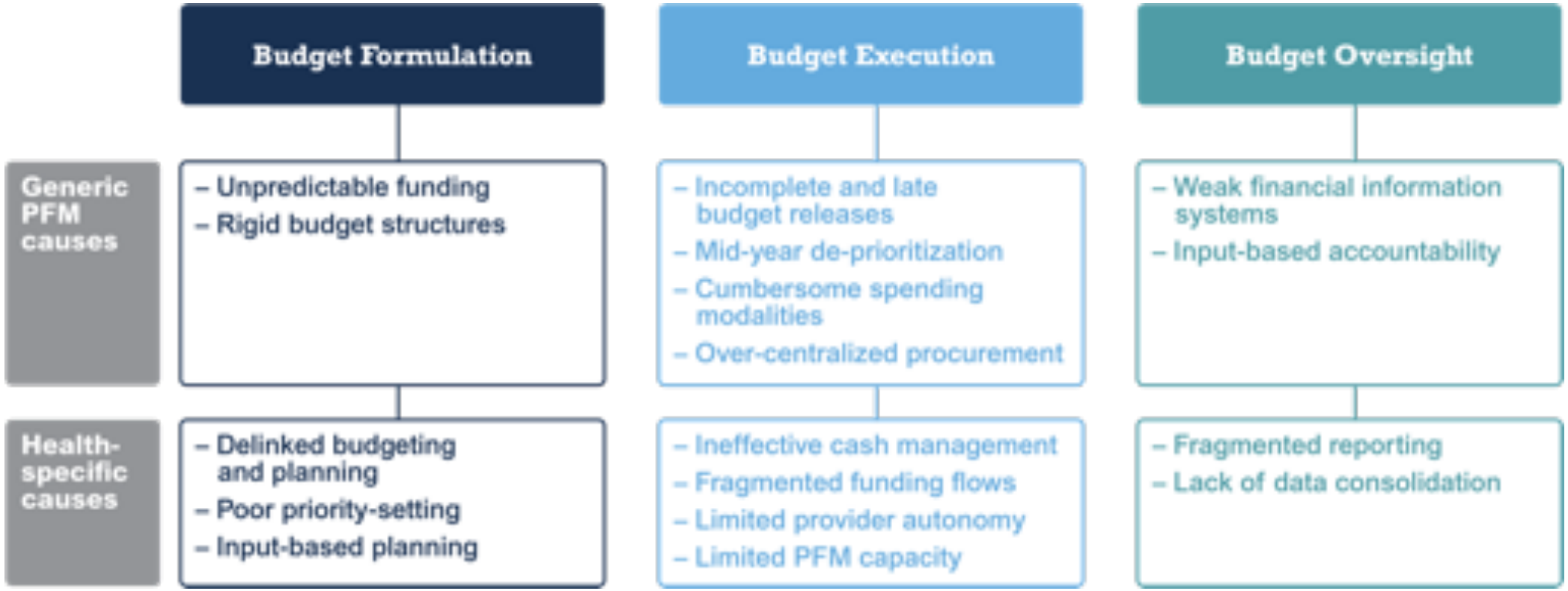
- Modalities of fiscal decentralization for health and **inter-governmental transfers**
- Existence and autonomy of a **purchasing agent**
- Contracting arrangements and **financial autonomy of service providers**.

2 — Measuring health budget execution performance

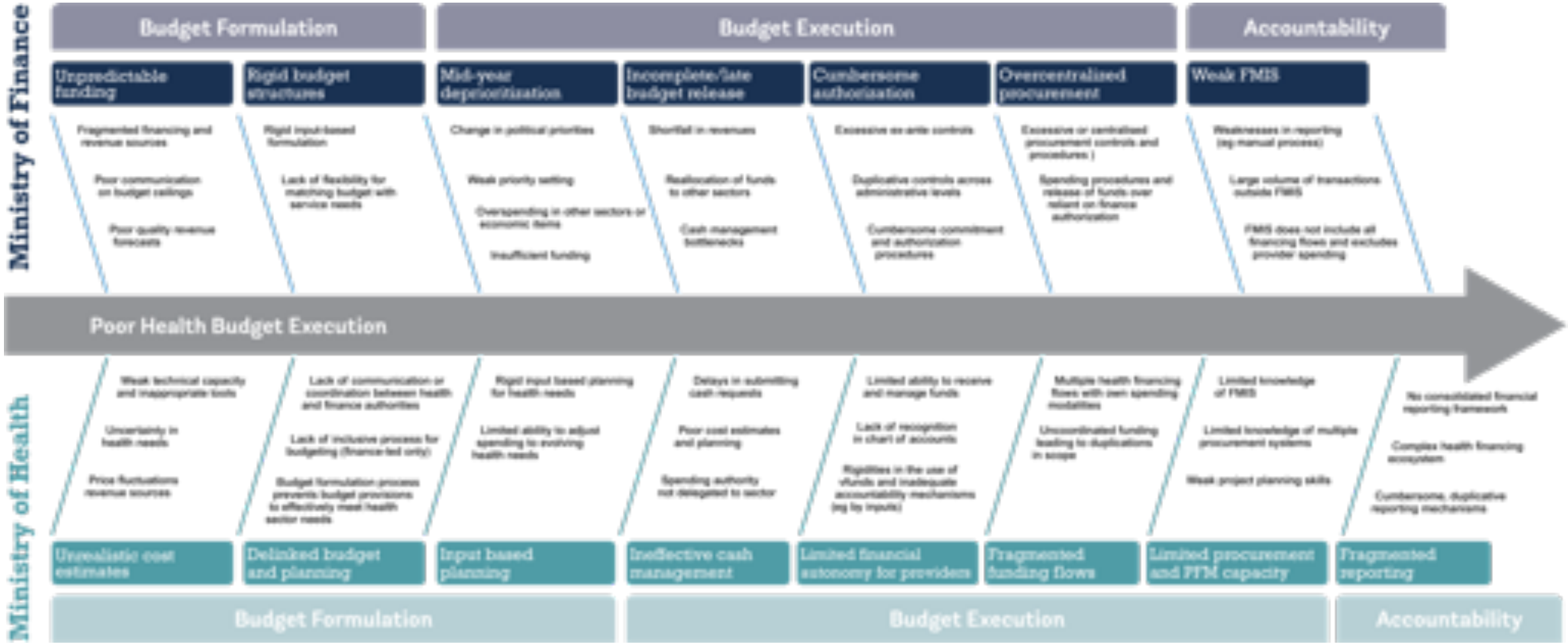
Moving from budget execution rate alone to a **comprehensive assessment based on quantitative and qualitative measures.**



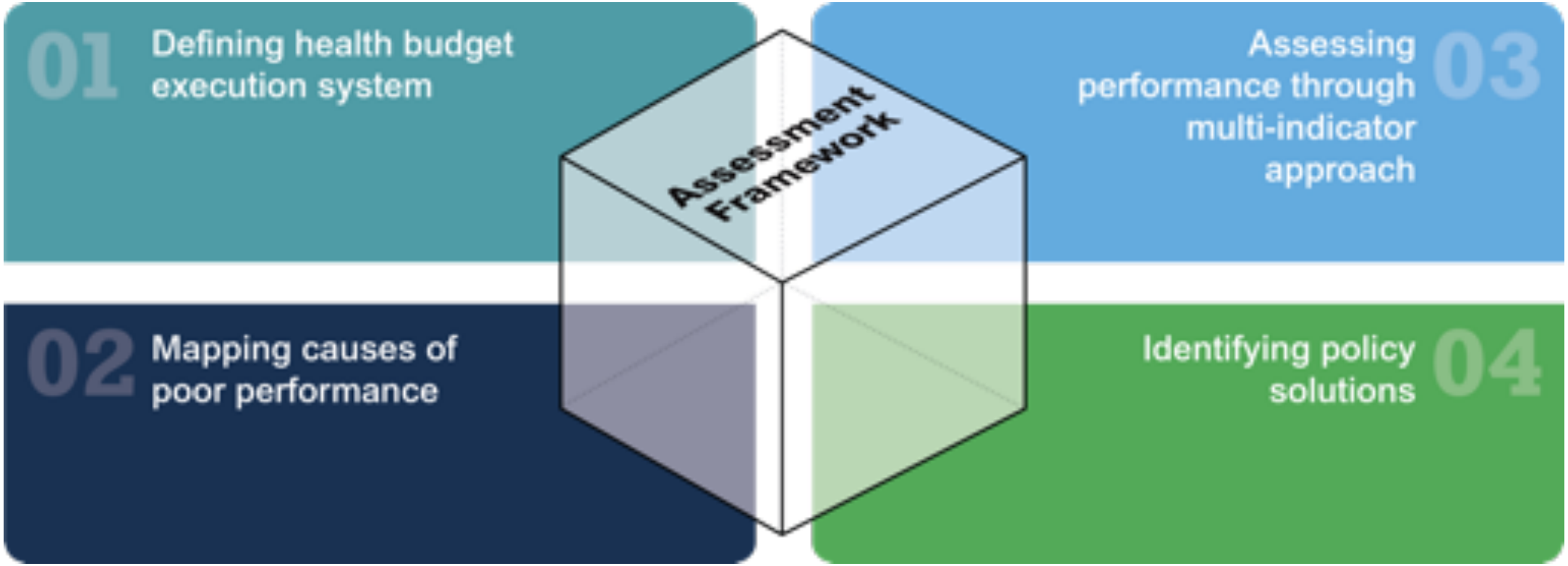
3 — Mapping drivers of poor health budget execution



4 — Identifying sub-causes — entry points for policy actions



Putting things together a step-by-step approach



Thank you!

We look forward to your insights

World Health Organization

Health budget execution: Marrying PFM & Health Finance Reform in Kyrgyz Republic & Ukraine

Loraine Hawkins (Health Financing & Governance Expert for WHO)

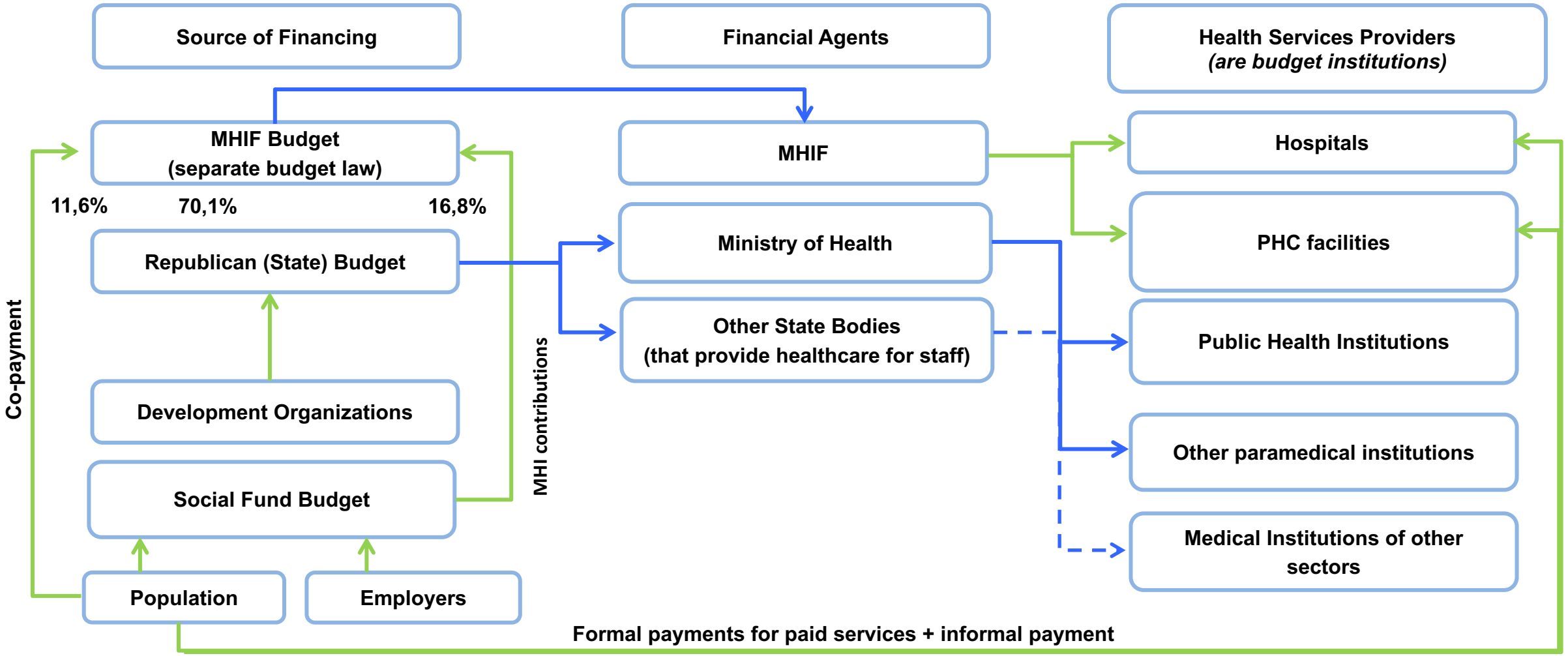
Key Country Characteristics

Characteristic	Kyrgyz Republic	Ukraine
• Pop.	• 6.3 M (2020)	• 44.2 M (2020)
• GDP/capita	• US$1312 (2018)	• US$2957 (2018)
• GGE/GDP	• 33% (2018)	• 42% (2018)
• GGHED/GGE	• 8.4% (2018)	• 8.9% (2018) rising
• OOP/CHE	• 52.4% (2018)	• 49.35% (2018)

Historic budget execution issues affecting UHC in KR

UHC goal	Budget execution issue	Present in KR?
Efficiency	Budget not credible	YES
	Delay in fund release	YES
	Operational budget cuts	YES
	Arrears to suppliers	YES
	Rigidity in spending rules undermines incentives for efficiency	YES
	Fragmented execution rules	YES
Equity	Equity in budget allocation distorted	YES
	OOP compensates for funding shortfalls	YES
Quality	Non-credible budget (capex, drugs, supplies) compromises quality	YES
	Slow & irregular cash releases compromise service quality	YES
Accountability	Overspending without appropriations	NO
	Lack of accountability undermines autonomy reforms	YES
	Excessive FM requirements, adding little value	YES

Kyrgyz Health Financing System – flow of funds



Main causes of poor health budget execution in KR 2006-2016

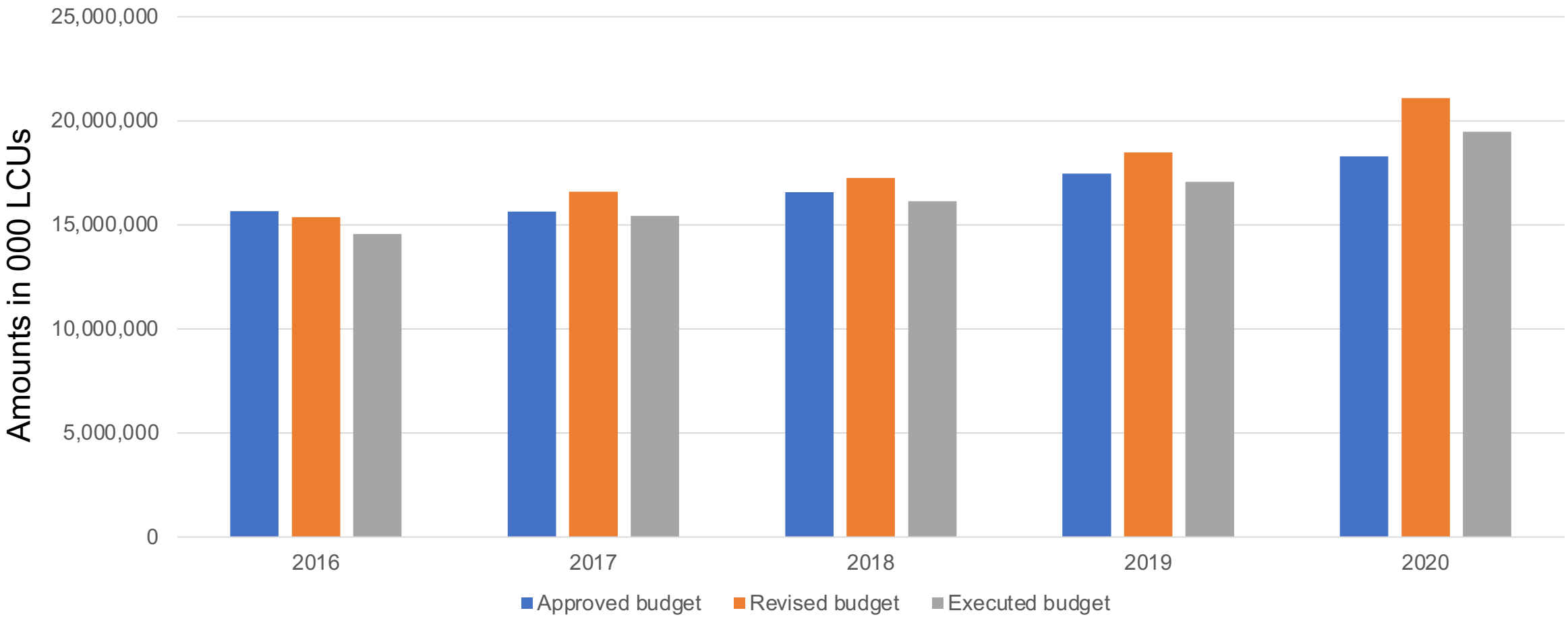
	Budget formulation	Budget execution	Budget oversight
Generic PFM causes	Chronic underfunding of policy commitments Unpredictability and poor forecasting of revenue & expenditure Rigid budget formulation based on historic spend by detailed inputs	Incomplete and late budget & Social Fund releases Mid-year budget revision Cumbersome prior Treasury & MHIF approval for all virement and all payments	Cash-based financial information systems Systemic lack of accurate personnel data Input-based accountability from Treasury and State Audit
Health-specific causes	Unrealistic, poorly costed plans & policies Strategy & benefits package not prioritised Delinked budgeting and planning Input-based norms ultimately guide staff & budget allocation	Separate procedures & accounting for 4 sources of funds Limited provider autonomy due to low PFM capacity & rent-fseeking from central controls	Fragmented reporting by 4 sources No publication of annual accounts and reports Ineffective MHIF Supervisory Body

Budget execution interventions that helped 2016-20

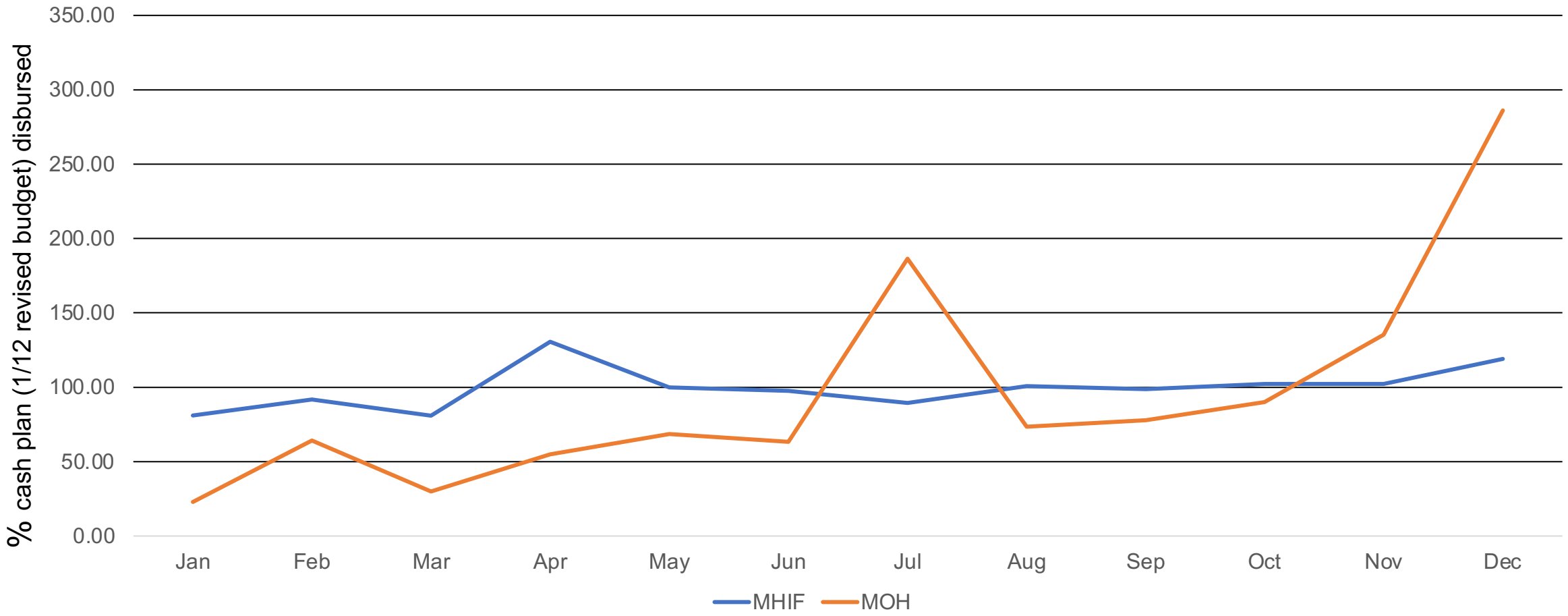
Budget formulation	Budget execution	Budget oversight
• Single line budget for MHIF • Separate MHIF budget law combining 3 sources • MOF commitment to allow efficiency gains to be retained under program budget pilots	• Reduced line items for provider budgets • Removal of prior Treasury controls on MHIF payments • Single accounts and procedures for all sources of funds • Providers retain year-end balances	• Programme budget indicators for performance against combined expenditure • Single accounting/ reporting for all sources • Support for MHIF Supervisory Body training & standard reporting

But have not solved: low budget credibility, late & incomplete budget releases, limited public reporting & input/compliance based audit

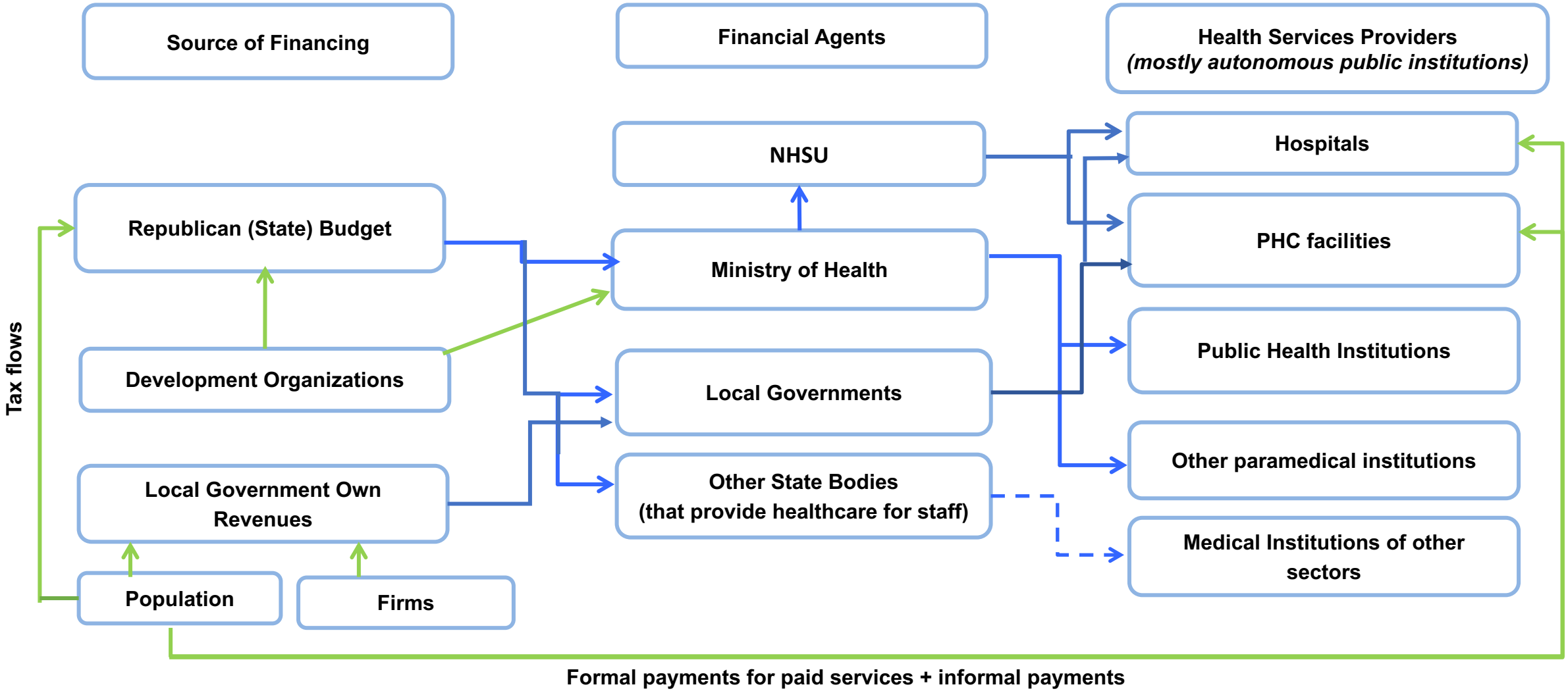
Budget execution rates in KR 2016-2020



Delayed disbursement of KR budgets – MoH & MHIF 2020



Ukraine Health Financing System – flow of funds



Ukraine has avoided most of KR's budget execution problems

Kyrgyzstan

- Late, slow PFM reform
- Disengaged, low capacity PFM institutions
- Input-based controls entrenched by rent-seeking

Ukraine

- PFM reform before (late) health finance reform
- Engaged, high capacity MOF
- Learnt from KYR case
  - Tax-financed national purchaser
  - Radical step to output-based budgets & payment to providers
  - Very rapid autonomisation of local healthcare providers
  - Early commitment to publish accounts, reports online

Budget execution challenges remaining in Ukraine

Budget formulation	Budget execution	Budget oversight
• Low budget credibility – underfunded policy promises/weak prioritisation • Fragmented budgeting by purchaser and local authorities • Late confirmation of provider contract/ budget allocation undermines planning	• Poor cash management/excess cash balances in autonomous healthcare provider accounts	• Loss of timely, consolidated accounting by autonomous public providers • Lack of accountability framework for providers covering all revenues & expenditures • Under-resourced audit of healthcare provider invoices to NHSU – increased fraud risk

Panel discussion

Sabeen Afzal
Ministry of National Health Service, Regulation and Coordination, Pakistan

Fazeer Rahim
IMF

Sally Torbert
IBP

Day 4 - Thursday 18 November

5th Meeting of the Montreux Collaborative

13:00 – 14:00 CET: **Donor funding: how to facilitate alignment with domestic PFM systems?**

Chair and moderator	Magnus Lindelow (World Bank)
Alignment of donor and domestic PFM systems: rethinking opportunities and bottlenecks	Moritz Piatti (World Bank)
Insight from country practices	Zachee Iyakaremye (Ministry of Health Rwanda)
Reflections from partners	Amir Aman Hagos (Chair of working group on donor alignment, GFF), Eric Boa (The Global Fund), Agnès Soucat (AFD)
Questions and answers	With support from Sarah Alkenbrack (World Bank)

5th Meeting of the Montreux Collaborative

14:15 – 15:15 CET: **Digital technologies: what are the opportunities and risks for better PFM in health?**

Chair and moderator	Sanjeev Gupta (CGD)
How digitalization can improve PFM operations and service delivery	Manal Fouad (IMF)
Country perspectives with a focus on PFM practices in health	Anupam Raj (Ministry of Finance India), Erick Kitali (President's Office - Regional Administration and Local Government, Tanzania)
Global reflections	Neil Cole (CABRI), Inke Mathauer (WHO)
Questions and answers	With support from Fahdi Dkhimi (WHO)

Thank you!

We look forward to your insights

World Health Organization