21 STRENGTHEN NATIONAL FINANCING

KNOWLEDGE SUMMARY: WOMEN'S & CHILDREN'S HEALTH

National financing for health refers to funds from public or private sources within a country that are committed to the health sector. Compared with funds provided by external donors, national financing represents an increasing proportion of total health expenditures in low- and middle-income countries (LMICs). Average total health expenditures in low-income countries are estimated at approximately $25 per capita. Of this, assistance from external donors represents just $6.[1]

External assistance will continue to be required in many low-income countries but paying for reproductive, maternal, newborn and child health (RMNCH) interventions can also be facilitated by increasing the value for money of existing resources, mobilizing more funds from public and private sources within LMICs, and improving accountability for these resources.

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What do we know?

Improving health outcomes for mothers, newborns, and children requires sufficient funding to implement proven interventions that span the continuum of care from pre-pregnancy to delivery, the postnatal period, and childhood. The global economic crisis has led to a slowdown in the growth of international development assistance for health,[2] and prompted increased focus on value for money of existing resources ("more health for the money"),[3] raising additional public and private resources within LMICs ("more money for health"), and accountability for resources and results.[4]

What works?[5]

Mechanisms for "More Health for the Money"

Improving RMNCH outcomes from the resources available can be achieved by making service delivery more effective, efficient, and equitable.

Effectiveness: Ensuring the effectiveness of investments requires priority-setting so that funds are allocated to those interventions and services that have the most impact. The LiST tool, the OneHealth tool, and other evidence-based methods can help facilitate priority-setting but will only lead to changes in RMNCH policy and outcomes with commitment from governments and partners to utilize findings in funding allocation decisions.

Efficiency: Poor donor coordination and poor alignment with national priorities can hamper efficiency of health sector funding. Harmonizing mechanisms such as sector-wide approaches, the Health Systems Funding Platform, and country compacts under the International Health Partnership (IHP+) may address these inefficiencies.

Performance-based financing (PBF) is a supply-side results-based financing mechanism by which health facilities and/or health workers are rewarded according to measurable improvements in quantity and/or quality of their output. The objective of PBF is to incentivize the facility or provider to increase efficiency, improve quality of care, and/or improve equity through expanded service provision, as shown in Rwanda (see Box 1). Studies of the impact of PBF programs have shown improvement in some (but not all) RMNCH indicators. In many contexts, it has been difficult to attribute gains achieved to PBF since the mechanism has usually been implemented alongside other health reforms. A recent systematic review concluded that more robust and comprehensive studies are required.[6]

Decentralization, a process of devolving responsibilities of the health system to local levels of government, can be a more efficient way of producing health outcomes because programs can be designed by local actors who are accountable to locally elected officials and have knowledge of the local context. Studies of the impact of decentralization reforms have however shown mixed results.

Box 1 – Paying for performance in Rwanda

Rwanda's performance-based financing (PBF) program links rewards to clearly defined output (services delivered) and quality indicators related to a basic package of health center services, determined in part by business plans developed by the facilities. Rewards are monthly bonus payments to top up provider salaries and provide support for health center administration and training. Most indicators are RMNCH-related, with an emphasis on increased antenatal visits, institutional deliveries, vaccinations, growth monitoring, and family planning.[7]

Rwanda saw marked improvement in some, but not all, RMNCH indicators after adopting PBF including institutional deliveries, preventive care visits for children, and growth monitoring.[8] In one study, institutional deliveries increased in project intervention districts by 23%, preventive care visits for children under 23 months increased by 56%, and preventive visits for children aged 24 to 59 months increased by 132%.[9] PBF added value to health systems by reforming human resources management structures as well as improving processes of decentralization by empowering health centers to make decisions relevant to their own needs and that of the communities they serve. PBF was also used as a mechanism for inter-sectoral cooperation by scaling up performance-related contracting to non-health ministries and district councils.[10]

Equity: Prepayment schemes such as national or social health insurance (SHI) have the objective of sharing healthcare costs equitably across a population group (such as formal sector workers) or the entire population in order to improve access to health services and reduce poverty from catastrophic health expenditures. Prepayment schemes exist in many high-income countries, but also LMICs as varied as Brazil, Chile, Ghana, Rwanda and Thailand. They have proven

superior to direct out-of-pocket payments for health services: a recent review found that SHI improves service utilization and reduces out-of-pocket expenditures.[11]

Demand-side financing refers to mechanisms—conditional cash transfers (CCTs) and vouchers—that have two main objectives: (i) to reduce poverty and improve equity by transferring cash, indirect reimbursement, or in-kind rewards to poor patients; and (ii) to encourage uptake of specific health services by making the cash transfers conditional upon use of such services. CCTs, widely implemented in Latin America, have shown measurable results for RMNCH. For example, the Oportunidades program in Mexico has resulted in improved indicators relating to both growth and anemia in children between the ages of 12 to 36 months from poorer households, and has led to a 22% decrease in the probability in children under three being ill in the preceding month.[12] But these programs have also encountered challenges such as government difficulties in sustaining payouts and the inability of many of the poorest of the poor to meet the conditions attached to the cash transfers. An example of a voucher program is India's Chiranjeevi Yojana maternal health voucher scheme in Gujarat state (see Box 2). Equity gains may also be realized through subsidies for RMNCH-related medicines or commodities that reduce the consumer price of these commodities for more equitable access.

Some terms explained

National financing: Funds raised from public or private sources within LMICs for a particular sector or sub-sector (such as health or RMNCH), as opposed to funds coming from external donors

Effectiveness – or "doing the right things" – refers to the extent to which policies and programs leads to measurable improvements in health

Efficiency – or "doing things right" – refers to using resources so that the production of health services and outcomes is maximized while minimizing costs

Equity is the fair distribution of health amongst individuals or groups

Mechanisms for "More Money for Health"

Additional funds for RMNCH can come from both public and private sources within LMICs, using pre-payment mechanisms such as taxes and levies, social health insurance, and investment funds. Out-of-pocket payments are another way to raise funds, but have been shown to be less equitable and efficient than prepayment mechanisms in financing the health system.

Taxes and levies: One method to raise and sustain resources for health includes improving efficiency of tax collection. Indonesia reformed its tax system and administration in 2001, leading to a tax yield rise which raised government revenue; health spending increased faster than for other sectors.[16] Another method is to earmark Value Added Tax (VAT) or sales tax. For example, Ghana utilizes a National Health Insurance Levy to finance 70% of its National Health Insurance Scheme. Earmarking corporate taxes has also been used, as in Gabon where the government since 2008 has implemented a 10% tax on mobile phone companies' profit to cover those not able to contribute to National Health Insurance.[17] In the Lao PDR, electricity sales from a hydropower project go to social and environmental projects, including a public health program to improve services for women and children.[18] Other taxes that have been utilized by countries to raise revenue are excise-taxes on products that pose risks to health (such as tobacco and alcohol) and financial transactions-related tax, tourism tax, and luxury tax.

Social health insurance and investment funds: Social health insurance (SHI)—where workers and employers pay contributions to cover a package of services for workers and their dependents—is an important mechanism to raise national funds for health. SHI has been expanded in many

Box 2 – Vouchers in India's Gujarat state to encourage uptake of services

India's Chiranjeevi Yojana maternal health voucher scheme in Gujarat state focuses on improved institutional deliveries and access to emergency obstetric care by the poor. Eligible private providers are selected by Block Health Officers after meeting basic infrastructure and staffing requirements. Service utilization is encouraged by the provision of transport costs and loss of wage support for accompanying family members. Block Health Officers monitor quality and make payments to providers, who receive reimbursement per package of 100 deliveries at the average cost of US $46/delivery.[13] Further support is provided by supply-side incentives to midwives for following up with enrolled women. Accountability mechanisms include the requirement of multiple approvals before issuing reimbursement to providers. The scheme has provided financial protection for clients who saved around US $82 for delivery compared to those that did not benefit from the scheme.[14] It has also led to an increase in institutional delivery rates from 27% to 53%.[15]

countries to the informal sector and to the poor through government revenue and also through external donor support. Investment funds can be an additional source of national financing.[19] Examples are diaspora bonds (utilized by India, Israel, Lebanon, and Sri Lanka) and impact investments (private financing directed to projects or industries in LMICs that generate social benefits along with financial returns).

Mechanisms for Ensuring Accountability for Results and Resources

Accountability for financial resources and health outcomes is a critical part of strengthening national financing for RMNCH and involves three interconnected processes of monitor, review, and action.

Mechanisms include resource-tracking tools that assess whether resources are being used as intended and Ministry of Health-led annual health sector reviews that examine progress of implementing national health plans. Annual reviews can be supported by mechanisms such as the IHP+ country compacts and country Countdown to 2015 events. Parliaments and courts are also important entities for ensuring government accountability. In the Ugandan parliament, for example, the women's caucus spurred legislation to protect women during and after pregnancy through provisions in the national Employment Act and Labour Act, clear budget lines for RMNCH were established, and the budget was held up until the RMNCH allocation was increased.[20]

Civil society can play an important role in holding government to account for the use of RMNCH resources and results. A social accountability approach using village health report cards and public hearings has been used in India's National Rural Health Mission. Social accountability tools are more effective in settings when they are used with incentives for service providers to change behavior in response to citizen views, and when they are embedded in programs and systematically implemented.

Conclusion

Ensuring sufficient funding for the proven interventions that span the continuum of care requires the strengthening of national financing for RMNCH through mechanisms that give more value for money, raise funds for RMNCH, and ensure accountability for resources and results. Each of the mechanisms in this paper has been applied in diverse ways and circumstances; many of them are implemented as part of a package of health reforms. These financing mechanisms must be carefully coordinated and integrated to promote universal coverage and avoid fragmentation of health systems.[21]

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