HEART
HEALTH & EDUCATION ADVICE & RESOURCE TEAM

Helpdesk Report: National- and district-level funding in the health sector

Date: 21 April 2014

Query: Is there any research that compares district level donor funding to national level? Is there any documentation on the costs and benefits of district level funding and also district compared to national.

Content

1. Overview

Contact with health financing experts and a rapid literature search found no research that compares district level and national level donor funding. The literature suggests that effectiveness of funding at the national-level is likely to depend on how well central funds are disbursed and on the capacity of local services receiving the funds.

Frumence at al. (2014) note that, in Tanzania, funds from the central government are not disbursed on a timely basis. Research showed the late disbursement interrupted implementation of health activities in the district health system. The council health management team in Kongwa has adopted three main strategies to cope with delays in financial disbursements. A similar situation was found in Ghana (Asante et al., 2006).

The Independent Commission for Aid Impact (2012) finds evidence that funds transferred from the national budget down through sub-national government to local service delivery units (e.g. schools and health centres) often suffer substantial losses, due to excessive layers of bureaucracy.

Pearson (2010) finds that decentralised financial resources for health services can better reflect local priorities in Malawi. Associated benefits include: easing of the crisis in essential drug supply, and increased availability of maternal health services (as a result of decentralisation and the Sector Wide Approach).

An OECD policy brief (2011) advocates for the use of public financial management systems to help strengthen national capacity and performance. The argument is mainly for national-level funding as opposed to project-level funding but a similar argument could apply against funding directly to the district level. It may seem more efficient to fund directly to district services but in the long-term it would be better to strengthen central administration to disburse the funds effectively themselves.

2. Useful resources

The dependency on central government funding of decentralised health systems: experiences of the challenges and coping strategies in the Kongwa District, Tanzania
Frumence, G. et al. 2014. BMC Health Services Research, 14 (39).
http://www.biomedcentral.com/1472-6963/14/39

Background
Decentralised health systems in Tanzania depend largely on funding from the central government to run health services. Experience has shown that central funding in a decentralised system is not an appropriate approach to ensure the effective and efficient performance of local authorities due to several limitations. One of the limitations is that funds from the central government are not disbursed on a timely basis, which in turn, leads to the serious problem of shortage of financial resources for Council Health Management Teams (CHMT). This paper examines how dependency on central government funding in Tanzania affects health activities in Kongwa district council and the strategies used by the CHMT cope with the situation.

Methods
The study adopted a qualitative approach and data were collected using semi-structured interviews and focus group discussions. One district in the central region of Tanzania was strategically selected. Ten key informants involved in the management of health service delivery at the district level were interviewed and one focus group discussion was held, which consisted of members of the council health management team. The data generated were analysed for themes and patterns.

Results
The results showed that late disbursement of funds interrupts the implementation of health activities in the district health system. This situation delays the implementation of some activities, while a few activities may not be implemented at all. However, based on their prior knowledge of the anticipated delays in financial disbursements, the council health management team has adopted three main strategies to cope with this situation. These include obtaining supplies and other services on credit, borrowing money from other projects in the council, and using money generated from cost sharing.

Conclusion
Local government authorities face delays in the disbursement of funds from the central government. This has necessitated introduction of informal coping strategies to deal with the situation. National-level policy and decision makers should minimise the bureaucracy involved in allocating funds to the district health systems to reduce delays.

Getting by on credit: how district health managers in Ghana cope with the untimely release of funds
Asante, A.D., Zwi, A.B. & Ho, M.T. 2006. BMC Health Services Research, 6 (105).
http://www.biomedcentral.com/1472-6963/6/105

Background
District health systems in Africa depend largely on public funding. In many countries, not only are these funds insufficient, but they are also released in an untimely fashion, thereby creating serious cash flow problems for district health managers. This paper examines how the untimely release of public sector health funds in Ghana affects district health activities and the way district managers cope with the situation.

Methods
A qualitative approach using semi-structured interviews was adopted. Two regions (Northern and Ashanti) covering the northern and southern sectors of Ghana were strategically selected. Sixteen managers (eight directors of health services and eight district health accountants) were interviewed between 2003/2004. Data generated were analysed for themes and patterns.

Results
The results showed that untimely release of funds disrupts the implementation of health activities and demoralises district health staff. However, based on their prior knowledge of when funds are likely to be released, district health managers adopt a range of informal mechanisms to cope with the situation. These include obtaining supplies on credit, borrowing cash internally, pre-purchasing materials, and conserving part of the fourth quarter donor-pooled funds for the first quarter of the next year. While these informal mechanisms have kept the district health system in Ghana running in the face of persistent delays in funding, some of them are open to abuse and could be a potential source of corruption in the health system.

Conclusion
Official recognition of some of these informal managerial strategies will contribute to eliminating potential risks of corruption in the Ghanaian health system and also serve as an acknowledgement of the efforts being made by local managers to keep the district health system functioning in the face of budgetary constraints and funding delays. It may boost the confidence of the managers and even enhance service delivery.

Impact Evaluation of the Sector Wide Approach (SWAp), Malawi
Pearson, M. 2010. HDRC (Now HEART).
http://www.heart-resources.org/wp-content/uploads/2012/02/Impact-Evaluation-of-the-SWAp-Malawi.pdf

The Government of Malawi (GOM), in collaboration with the Development Partners (DPs), finalised a six-year Programme of Work (PoW) for the Health Sector in 2004, which has been implemented at the national and district level.

The Ministry of Health (MoH) has taken significant steps to decentralise the delivery of the Programme of Work and the Essential Health Package (EHP) to strengthened District Health Management Teams and has developed zonal offices to support the decentralisation process. Decentralisation of health service management has enabled financial resources to flow directly to districts, where services are delivered, giving greater control over how these resources are used to district health managers. In particular, operational health budgets have already been devolved to District Assemblies with the District Commissioner as the Controlling Officer for those funds. District Health Officers are, increasingly, empowered to develop and implement District Implementation Plans to ensure these reflect local priorities in the context of delivering the EHP to all Malawians.

Decentralisation of health service management has allowed financial resources to flow directly to districts, where services are delivered; giving greater control over how these resources are used to district health managers. Some of the crisis in essential drug supply has been eased by districts having their own budgets from which they can purchase drugs privately that are not available through the public system.

The availability of maternal health services has increased significantly as a result of the SWAp and the decentralisation process; more emergency obstetric care facilities are available and they are better resourced. The Emergency Human Resource Programme has enabled more staff to be trained, recruited and retained, so providing better clinical cover in

the facilities. The key benefits that District Health Officers note concerning the SWAp are the improvements made to infrastructure, and their own ability to use funding for supplies and maintenance to improve the quality of their services, particularly in terms of infection prevention and innovation to address local constraints

The National AIDS Commission (NAC) has established a district resource allocation formula which uses proxy indicators of need and is applied effectively. However, the approach places little emphasis on cost-effectiveness, and the Mid-Term Review suggested that "there is scope for further improving the disbursement of HIV and AIDS funding through the NAC to better align resource allocation with need".

As part of a second phase of Banja La Mtsogolo-support the aim was to improve efficiency and cost-effectiveness by 30%. A study of district and rural hospitals found significant levels of inefficiency and estimated that it would be possible to increase outputs by around 40% without increasing the current level of inputs. It found major underutilisation of capacity in mission facilities suggesting that performance-based contracts might be a cost-effective way of increasing access. The NHA also shows that the MoH continues to provide free care for services that fall outside the EHP e.g. the substantial cost of overseas referrals.

What are the benefits of using country systems? Policy Brief 3: Sector audiences.
Task Force on Public Financial Management. 2011. OECD.
http://www.oecd.org/dac/effectiveness/48780926.pdf

Aid that uses country systems can provide incentives and momentum to strengthen their capacity and performance, enhance domestic accountability mechanisms, and contribute to better Public Financial Management (PFM) practices. It thereby helps to improve the effectiveness of all public expenditure, not just that financed by aid.

The use of recipient country PFM systems involves specific issues at sector-level, in terms of risk assessment, choice of aid modalities, and the necessary coordination with national-level dialogue and policies. Different issues stand out in different sectors: international drug procurement may be an issue in the health sector, as well as the challenge of reconciling vertical programmes with country systems.

Aid that uses recipient country systems can provide incentives and momentum to strengthen national capacity and performance. It can shift both donors' and recipient governments' focus towards strengthening the recipient country's own systems as opposed to developing parallel ones. This is expected to reduce the transaction costs involved in managing aid for partner countries, and to lead to more sustainable improvements in the long term.

The use of recipient country PFM systems can also contribute to establishing widely accepted good PFM practices in recipient countries, in particular comprehensiveness and transparency. It can also contribute to more efficient allocation of domestic resources. This is expected to make recipient countries' public financial management more efficient as a whole, including both domestic and external resources.

The use by donors of each specific component of PFM systems carries specific expected benefits, as well as risks and transaction costs. For example, ensuring aid is adequately reflected on plan, on budget or on reports carries minimal risks but may bring about significant benefits in terms of transparency, allocative efficiency, ownership and accountability. In deciding upon the use of recipient country PFM systems, donors should carry out a balanced analysis of risks and benefits involved, considering both national and sector-specific issues.

The Management of UK Budget Support Operations
Independent Commission for Aid Impact. 2012.
http://www.oecd.org/derec/50359937.pdf

The value for money of budget support is determined by the overall efficiency of public spending on poverty reduction. Many factors can influence this, from the quality of budget processes to the accuracy of national statistics. The quality of national procurement systems is an important factor. There is evidence from case study countries that funds transferred from the national budget down through sub-national government to local service delivery units (e.g. schools and health centres) often suffer substantial losses, due to excessive layers of bureaucracy. This can significantly undermine the value of national development expenditure and therefore of aid funds provided via the national budget.

CTL-for-Health/FTT-with-Health: Resource-Needs Estimates and an Assessment of Funding Modalities
Baker BK, Action for Global Health and International Civil Society Support, 2010
http://ec.europa.eu/health/eu_world/docs/ev_20101013_rd05_en.pdf

This document proposes a funding model for health. It then discusses how to distribute funds raised.

The pros and cons of budget support:
Questions about the intermediate "destination" of funding must be addressed. Proponents of sector budget support, general budget support, and other pooled financing mechanisms at the country level argue that such pooled funding increases government ownership and control, aligns with government budget cycles, and eases public finance management. With pooling, the government knows its total resource envelope and can plan and spend accordingly. If existing government capacity to handle pooled funding is less than desirable, then proponents argue that governments should receive technical assistance to build durable public sector management capacity. Proponents argue further that the alleged incapacity of governments to manage pooled funding must be weighed against its less-than-perfect alternative: the inefficient, convoluted, duplicative, and uncoordinated mechanisms of finance administration orchestrated by donors.

Critics of pooled financing directly to governments admit these potential benefits, but focus as well on historical analysis of some governments' poor planning, inefficiency, corruption, and incapacity to even spend as planned or to monitor and account for the actual flow of resources. Critics worry that most governments neglect important health needs and/or vulnerable populations and that some governments persistently refuse to grant resources to NGO/CBO/FBO organisations for community level health-related activities. A related concern about pooled funding mechanisms from a civil society perspective is that of governance – civil society feels that government-controlled pooled financing modalities have often been planned and implemented without the participation and oversight of civil society. In sum, critics fear that donor funds get put inside a black box and then disappear both in terms of tracking and performance outcomes. They have evidence that government-controlled resources do not reach the local level (as little as 20%), where health programming is most needed, and thus that direct funding to CBOs might have a larger payment.

Financing and Decentralisation Reforms in Zambia: Is there evidence that district autonomy makes a difference to health outcomes or outputs?
Chitah, M.B. 2012. Harvard School of Public Health
http://www.hsph.harvard.edu/takemi/files/2012/10/RP180.pdf

For developing countries, such as Zambia, health reforms have not been associated with an appropriately designed framework for evaluation of health sector performance. A lack of systematic theoretical and evidence-based methodologies to resolve emerging constraints in the health systems has existed. Zambia's decentralisation has been embedded in the macro – organisation framework that tried to address financing and principal agent behaviour through performance-based accountability for determining health status. Outputs in the health system such as immunisation have not shown corresponding response to the objectives of improving equity and accessibility. Financing deficits between demand as defined through the formulation of a costed basic health care package and supply through inputs correspondingly required to address demand on the basis of health needs clearly emerged. This examines the relationship between demand, a function of immunisation coverage and supply as defined by human resource and expenditures. Correlation and regression results show some level of relationship between resources in terms of staff and the lack of improvement in immunisation coverage. This cannot be attributable to decentralisation per se as other issues pertaining to the poor economy and the associated decline in resource allocation to district heath services.

3. Further resources

Pakistan: Punjab Devolved Social Services Program
ADB. 2012. Evaluation Report. Asian Development Bank (ADB).
http://www.adb.org/sites/default/files/PPER-PUNJAB-DSSP.pdf

The Asian Development Bank (ADB) approved a loan in 2004 to strengthen devolved social services for a more equitable, efficient, effective, and sustainable delivery of social services in line with the Punjab Local Government Ordinance (PLGO) of 2001. ADB provided a loan and UK DFID co-financed USD30 million as budget support and USD20 million as a technical assistance grant. The funds were allocated as follows: 65% in health, 17% in education, and 18% in water supply and sanitation. The programme is rated as less than successful. While the design and technical content of the programme were largely sound, the programme itself was not attuned to the political and institutional dynamics surrounding the federally driven devolution agenda. Following the 2008 national elections, the new national and provincial governments withdrew their commitment to devolution. The programme, as complex and ambitious as it was, lacked elements or emphasis that international experience has shown to be necessary to successfully devolve.

Performance-based financing and changing the district health system: experience from Rwanda
Soeters, R., Habineza, C. & Peerenboom, P.B. 2006. Bulletin of the World Health Organization, 84 (11),
http://www.scielosp.org/scielo.php?pid=S0042-96862006001100013&script=sci_arttext

Evidence from low-income Asian countries shows that performance-based financing (as a specific form of contracting) can improve health service delivery more successfully than traditional input financing mechanisms. The authors report a field experience from Rwanda demonstrating that performance-based financing is a feasible strategy in sub-Saharan Africa too. Performance-based financing requires at least one new actor, an independent well equipped fundholder organisation in the district health system separating the purchasing and service delivery, as well as regulatory roles of local health authorities from the technical role of contract negotiation and fund disbursement. In Rwanda, local community groups, through patient surveys, verified the performance of health facilities and monitored consumer

satisfaction. A precondition for the success of performance-based financing is that authorities must respect the autonomous management of health facilities competing for public subsidies. These changes are an opportunity to redistribute roles within the health district in a more transparent and efficient fashion.

Costs and revenue of health care in a rural Zimbabwean district
Plaetse, V.B. 2005. Health Policy and Planning, 20(4): 243-251
http://heapol.oxfordjournals.org/content/20/4/243.full

The District Health Executive of Tsholotsho district in south-west Zimbabwe conducted a health care cost study for financial year 1997–98. The study's main purpose was to generate data on the cost of health care of a relatively high standard, in a context of decentralization of health services and increasing importance of local cost-recovery arrangements. The methodology was based on a combination of step-down cost accounting and detailed observation of resource use at the point of service. The study is original in that it presents cost data for almost all of the health care services provided at district level. The total annualised cost of the district public health services in Tsholotsho amounted to US$10 per capita, which is similar to the World Bank's *Better Health in Africa* study (1994) but higher than in comparable studies in other countries of the region. This can be explained by the higher standards of care and of living in Zimbabwe at the time of the study.

About 60% of the costs were for the district hospital, while the different first-line health care facilities (health centres and rural hospitals together) absorbed 40%. Some 54% of total costs for the district were for salaries, 20% for drugs, 11% for equipment and buildings (including depreciation) and 15% for other costs. The study also looked into the revenue available at district level: the main source of revenue (85%) was from the Ministry of Health. The potential for cost recovery was hardly exploited and revenue from user fees was negligible.

The results of the study further question the efficiency and relevance of maintaining rural hospitals at the current level of capacity, confirm the soundness of a two-tiered district health system based on a rational referral system, and make a clear case for the management of the different elements of the budget at the decentralised district level.

The study shows that it is possible to deliver district health care of a reasonable quality at a cost that is by no means exorbitant, albeit unfortunately not yet within reach of many sub-Saharan African countries today.

Decentralization and Human Resources: Implications and Impact
Kolehmainen-Aitken, R.-L., 1997, WHO
http://www.who.int/hrh/en/HRDJ_2_1_01.pdf

In the Philippines, decentralisation threatened both the benefits that health workers were entitled to under a centrally set labour agreement (the Magna Carta) and the salary increases that were mandated under a national Salary Standardization Law. The financial base for devolved functions was inadequate, because the variable cost of devolved functions was not congruent with the fixed formula that was used to allocate national revenue among the Local Government Units (LGUs). The poorer LGUs were simply unable to fund the payment of Magna Carta benefits and salary increases. The LGU executives in the poorer LGUs were probably also not very motivated to push for extra funding from their own resources, since the financial compensation of devolved health workers in these LGUs was higher than that of the local mayor.

Decentralisation of health care and its impact on health outcomes
Jiménez, D. & Smith, P.C. 2005. University of York
http://www.york.ac.uk/media/economics/documents/discussionpapers/2005/0510a.pdf

This paper explores the impact of health care decentralisation on a characteristic of human development: the overall level of a population's health. While much of the literature on decentralisation in health care has stressed the advantages of sub-national provision of health services, in the absence of a quantitative measure of the magnitude of the effect of decentralisation, there is little that can be said in terms of its benefits and costs for the health sector. The purpose of this study is therefore to contribute to the limited empirical literature on this issue by investigating the hypothesis that shifts towards more decentralisation would be accompanied by improvements in population health. The analysis draws on a theoretical model of local government's public finance applied to health. The study uses the ten provinces of Canada as a case study. Apart from being one of the most decentralised countries in the world, Canadian data required to estimate the model was found to be one of the best. The results of the empirical analysis suggest that decentralisation in Canada has had a positive and substantial influence on the effectiveness of public policy in improving population's health.

5. Additional information

Author
This query response was prepared by **Laura Bolton l.bolton@ids.ac.uk**

Contributors
Sumedh Rao, GSDRC
Kathy Attawell, Independent Researcher
Diane McIntyre, University of Cape Town
Rebecca Wolfe, LSHTM
Emilie Combaz, GSDRC
Doris Kirigia, KEMRI-Wellcome Trust
Ayako Honda, University of Cape Town

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