



Integration of Financing, Governance, Operations, and Capacity Building for Strengthening Health Systems

While there is growing recognition that effective governance, financing, operations, and institutional and individual capacity building are needed to strengthen health systems and achieve health results, there is little description of how these essential elements of any health system link and inter-relate. Health Systems 20/20 (HS 20/20) seeks to employ these elements together in project activities where an integrated approach promises greater benefits than does focus on a single element alone. Increased use of PHN (population, health and nutrition) priority services can often be maximized if these elements are integrated.

This conceptual framework builds on current and past work in financing, governance, operations, and capacity building by HS 20/20 and others. *Financing* includes the mobilization, allocation, and pooling of resources and working with the effects of incentives on the behavior of actors (e.g., consumers, providers, insurers) in how they use health resources. *Governance* is the distribution of roles and responsibilities and the interactions among citizens, political and government decision makers, and service providers and the factors that govern those relationships such as accountability, checks and balances, and responsiveness to health needs and consumer preferences. *Operations*

covers the systems, procedures, and processes required to implement health system functions such as financial management, human resources, and planning. Collectively these elements serve as the underpinnings of the health system. *Capacity building* is the development of regional- and country-level capacity to support health systems strengthening. Capacity-building efforts are aimed both at strengthening the capacity of government agencies in health systems and developing capacity of local consulting firms, nongovernmental organizations, universities, and research institutions to provide technical assistance and training on health systems issues and topics.

The conceptual framework is intended to accomplish four inter-related objectives:

- Contribute to an increased understanding among health sector actors of how integration can improve the performance of health systems strengthening initiatives
- Articulate the specific linkages between the four components
- Stimulate U.S. Agency for International Development missions and country stakeholders to have a multidimensional view of activities and therefore increase demand for an integrated approach
- Provide a benchmark for HS 20/20 and other projects to use in planning and implementing activities

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The conceptual framework has two parts:

- A matrix that shows the expected results and illustrative linkages between the four components. This matrix shows a sample, but not all of the linkages between the components.
- Three briefs that illustrate how a typical health systems strengthening intervention could be

enhanced by using an integrated approach. Each brief demonstrates how an intervention that might commonly be classified as financing, operations, or governance could achieve more by being carried out using an integrated approach. The three interventions are National Health Accounts, anticorruption, and the management and disbursement of Ministry of Health financial resources.

Illustrative Linkages between Financing, Operations, Governance, and Capacity Building

Increased access to and utilization of priority health services

Expected results:

- Effective planning, financial, and human resources management systems to operationalize health policies and programs
- Improved financial access to priority health services, increased resource mobilization, and greater efficiency
- Provision of priority services through transparent policy and resource allocation processes, consultation with elected officials and communities, and systems that minimize corruption and increase accountability

Finance x Operations	Governance x Operations	Finance x Governance
<ul style="list-style-type: none"> ● Planning and financial management systems for health insurance initiatives, including community-based health insurance (CBHF) ● Ministry of Health (MOH) capacity to implement a medium-term expenditure framework and link to National Health Accounts ● Payment systems – operational mechanisms for payers and providers ● Decentralization – budgeting, spending, and accounting for health funds ● Contracting systems – e.g., setting up a contract management unit and systems 	<ul style="list-style-type: none"> ● Transparency and accountability in budgeting, spending, and procurement ● Civil society access to information from operational systems for accountability and advocacy ● Websites that post health systems information routinely ● Systems that ensure the responsiveness of providers to clients ● Capacity of civil society organizations (CSOs), media, and opinion leaders to interpret and use operational data for oversight of system performance 	<ul style="list-style-type: none"> ● Capacity of CSOs, media, and opinion leaders for informed participation in debates on health financing topics ● Public hearings about MOH's and other decentralized units' resource allocation ● Anticorruption efforts to improve efficiency ● Capacity of elected officials to identify and respond to health systems issues ● Accountability and participation mechanisms for CBHF, social security insurance/social health insurance, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), and the GAVI Alliance ● Capacity to develop home-grown reforms of health financing
Capacity		
<ul style="list-style-type: none"> ● Capacity of MOH and other government agencies to exercise stewardship, foster participation, and use health financing and operational systems ● Capacity of local and regional institutions (consulting firms, nongovernmental organizations, universities) to support health financing, governance, and operations activities ● Effective country coordination mechanisms such as national HIV/AIDS commissions and those for the GF 		

Taking an Integrated Approach to Tackling Corruption in the Health Sector

Introduction

"Everything is bribes." This quote from an informant in a service user survey in a developing country succinctly encapsulates citizens' views of their experience with public sector service delivery in too many countries. Particularly in poor countries, corruption is often systemic and pervasive. Petty corruption at the lower levels of the public service is the most widespread form of corruption, although large-scale corruption is also a problem.

Public sector corruption undermines government legitimacy by subverting the rule of law, diminishing transparency, reducing credibility, increasing cynicism, and limiting accountability. It negatively affects economic development by increasing the costs of doing business, diverting investment to nonproductive uses, distorting competition, and siphoning budget resources away from their assigned purposes. In the services sectors, corruption limits the availability, quality, and distribution of vital public services.

In a wide range of countries, and not just poor ones, the health sector is plagued by corruption. The effects are not simply squandered resources and

Defining Corruption

Corruption is a broad term, subsuming a wide variety of illegal, illicit, dishonest, irregular, and/or unprincipled activities and behaviors. Most definitions share an emphasis on the exploitation of public position, resources, and power for private gain.

reduced services; they can be life-threatening. Both the poor family that cannot afford to pay a bribe to obtain needed care, and the wealthy one that

unknowingly purchases poor-quality or counterfeit pharmaceuticals, are at risk of serious consequences.

This brief explains how corruption in the health sector can be tackled effectively using an approach that integrates governance, finance, operations, and capacity building.

The problem of corruption in the health sector

The level of corruption in a country's health sector is reflective of the extent of corrupt practices more broadly. In countries where public officials fail to address citizens' needs, lack accountability, and operate with

impunity, and institutional checks and balances are weak or nonexistent, such practices affect all service sectors. Yet, several features of the health sector make it particularly fertile ground for corruption.¹ The first feature is uncertainty; people do not know if and when they might fall ill, they are unlikely to be able to engage in "comparison shopping" for services, and they may not know if the treatments they seek are the right ones. The second is information asymmetries; service users, providers, and policymakers do not all have equal access to information about availability, quality, cost, efficiency, effectiveness, or distribution. Those with less information and less ability to interpret it accurately are at a disadvantage relative to those who are better informed and more technically skilled. For example, central oversight bodies can experience difficulties in monitoring provider performance, because providers often control the necessary information.² The third feature is the large number of actors in the health system, for example, government regulators, policymakers, legislators, enforcement agencies, insurers, payers, providers, suppliers, and service users and the multiple and complex connections among them. Each of these linkages creates the possibility for avoiding or bending the rules for private gain. The combined effect of these three features is to create numerous opportunities for abuse, pose barriers to detection and correction, and make it difficult to pinpoint accountability and/or to distinguish inefficiency from malfeasance.

An integrated approach to fighting corruption

The example in the box on the next page embodies some of the challenges in addressing corruption at the local facilities level: insufficient salaries and weak performance systems, staff non-attendance, informal payments for services, costs of exercising oversight, lack of knowledge of patient rights, social relationships with elites, etc. What can be done, recognizing that an ongoing dilemma in fighting corruption is how to address systemic issues with limited, pinpoint interventions? Emerging evidence suggests that interventions, even if limited, will have a higher degree of success if they integrate financing, governance, operations, and capacity

¹ Savedoff, W.D. and K. Hussmann. 2006. "Why are health systems prone to corruption?" In *Transparency International (ed.). Global Corruption Report 2006: Corruption and Health*. London and Ann Arbor, MI: Pluto Press, 4-14.

² Brinkerhoff, D.W. 2004. "Accountability and health systems: Toward conceptual clarity and policy relevance." *Health Policy and Planning* 19(6): 371-379.

A Facilities-level Example

In Country X,^{*} doctors, nurses, and pharmacists in public facilities routinely solicit payment for health care services and medicines – nominally available free of charge. Public-sector salaries are low, and many staff hold second jobs or in rural areas engage in agriculture. Doctors set up private practices, and steer their patients who come to the public facilities to the private practices. During office hours at the public facilities, staff are frequently absent. No effective controls exist to track pharmaceuticals and medical supplies procurement and distribution.

Performance oversight and staff monitoring are haphazard, and remote rural facilities rarely receive any supervisory visits. Because standards and criteria are vague, visits, when they do take place, are largely ineffective. A sample of staff views included the following responses:

I do not know if there is a performance evaluation, who does it, or what the criteria are. I know there is a file on me somewhere but I think it is secret and I think it must be someone in the Ministry who has it. I do not know who evaluates me.

I know one time we did a good job because the medical inspector came here and all of our program signs (leprosy, family planning, etc.) were displayed and we had a neat fence around the health center. I think the doctor was given some sort of an informal bonus. We also have to have good relations with the mayor, who we have been told is our local supervisor.

The Ministry of Health has launched a new accountability program that includes citizen participation in monitoring health facilities. However, observers confirm that the culture of non-confrontation in Country X, the respect for authority, particularly for medical personnel, not to mention fear of retribution (e.g., treatment denied) and low literacy rates, all decrease the likelihood that the program will have much impact on reducing corrupt practices or improving performance.

^{*} This example, and the quotes in this brief, are from a real country case.

building. For the Country X example, if the U.S. Agency for International Development Mission is targeting the local facilities level, then a selection of some subset of the problems enumerated above would need to be done. Starting steps would include:

- Ensure that the choice of what to work on is country-driven, since anticorruption (like many development initiatives) does not go far without domestic champions and political will. Identify who in the Ministry of Health (MOH), and/or elsewhere, is serious about reform and has sufficient latitude and commitment to pursue an intervention.
- Consider which label for intervention is likely to be effective in building support and gaining access. Corruption is a "loaded" term, and it may be that discussing the issue in terms of management efficiency, good governance, systems strengthening, or

accountability improvement may provide a better opening for change than anticorruption.

Assuming that these starting steps identify actors in the MOH and in civil society who are interested in change, a dual-focus intervention could be developed. One focus would be on the MOH and the local facilities; the other would be on one or more civil society groups. Since Country X's MOH already has an accountability initiative, this becomes a logical connection for providing outside support. On the civil society side, community associations and/or church groups are potential partners that could be supported to address issues of access to health services and corruption. These groups could be allied with a local chapter of Transparency International.

With the government, the following activities could be pursued:

- Assist the MOH in improving management systems. This could include:
 - Planning for regular supervisory visits to facilities and coordination with local government officials in oversight (operations, governance)
 - Development of guidelines for staff performance reviews (operations)
 - Controls and monitoring for pharmaceutical and medical supplies procurement and distribution (operations, finance).
- Develop an information transparency program to publicize the health services to which citizens have a right, which services are free and which may be subject to user fees, and what procedures and rules facilities are supposed to follow (governance, operations). This could include posting a statement of patient rights and responsibilities, and a list of service fees along with exemption/fee waiver rules; and disseminating information about budget allocations for health at the local level (finance). Include translating materials into local languages and broadcasting spot announcements on the radio.
- Help the MOH to design and pilot-test a facility-level pay-for-performance program where performance measures involve community members in assessing performance (finance, governance, operations).
- Establish a working group in the MOH to engage with the finance ministry and the civil service commission on public sector salaries (finance, governance, operations). Explore options such as incentive schemes for postings to rural facilities, performance-based promotion standards, and public service awards programs.

- With selected local facilities, pilot-test the new management systems, publicize the new procedures and systems, and feed the lessons into revisions and refinements (finance, operations, governance). Establish a review committee made up of facilities staff and community members.

With civil society, possible activities could include:

- Provide support to selected groups to develop a public education campaign on citizens' rights to health care, the roles and responsibilities of service providers, and corruption issues (governance).
- Help one or more civil society organizations (CSOs) to develop knowledge about health and health services/budgets so as to become intermediaries and advocates for citizens with local facilities and the MOH (governance, operations, finance).
- Assist selected CSOs to work as partners with the MOH and pilot facilities to test and adapt the new management systems and to report to their constituents on results (governance, operations). For example, involve CSOs in identifying disadvantaged groups eligible for service fee exemptions and waivers.
- Identify interested members of parliament, the national ombudsman, lawyers, and journalists, and facilitate interaction among them and the selected CSOs (governance).
- Support a network of CSOs to build a citizen coalition for service delivery improvement, good governance, and anticorruption, building on the sources of capacity and commitment that are present in Country X (governance).

For each of these activities, clearly, capacity building is an integral component. The management systems improvements are aimed at improving capacity of the MOH and local facilities. For anticorruption and accountability, targeting various actors' capacity to exercise oversight and to provide feedback to service providers is critical. For example, MOH policymakers need the capacity to detect and sanction malfeasance and corruption, procurement fraud, falsified staffing levels, and so on. For local facilities, managers who lack the capacity to identify who works there, where they are at a given time, and what they are doing cannot take the first steps toward holding staff accountable for performance or tackling corruption. Citizens and CSOs need skills in aggregating, and advocating for, their interests, as well as capacities to overcome the power imbalances between medical elites and ordinary people. Many of the changes required are long term and will not take place quickly.

In addition, enforcement capacity is key to taking steps to address performance gaps and corruption, from broad legal and regulatory frameworks to internal facility monitoring systems. The best regulatory frameworks and enforcement mechanisms will remain ineffective if there is not sufficient capacity among health sector institutions and in other public sector agencies.

Expected results

The menu of actions proposed in this brief, through integrating financing, governance, and operations, can lead to health system reforms that will make inroads against corruption and lead to better delivery and greater use of priority services. Non-integrated efforts may address some aspects of the corruption problem, but particularly when corrupt practices are embedded in the health system, integrated approaches stand a greater chance of making sustained progress against corruption. Expected results from the facilities-level anticorruption measures laid out in the above example include:

- **Improved quality of care.** Incentives for facilities staff to provide services and medicines according to MOH procedures and regulations are strengthened due to improved management and supervisory systems.
- **Greater use of services.** Informal payments for services and medicines are reduced due to better supervision, more effective control and oversight, increased information transparency, and better awareness among service users of their rights and of fees.
- **Lower costs.** Absenteeism, moonlighting, and theft decrease at local facilities as a result of new management and performance systems and of citizen monitoring and advocacy for health services.
- **Accountability.** Selected CSOs gain increased knowledge of health service delivery issues and apply that knowledge to help "demystify" the issues for stakeholders, and to partner with the MOH in providing facilities-level oversight and performance monitoring.
- **Participation.** A coalition of CSOs, media, and legislators emerges that supports good governance, anticorruption, and improved service delivery and becomes a source of advocacy and pressure for reforms in the health sector and beyond.

Taking an Integrated Approach to National Health Accounts

Introduction

Last year, a representative of the civil society organization Melcolians for Better Health confronted Melcolia's Minister of Health at a town hall meeting, saying, *"In the campaign, your government pledged to reduce out-of-pocket health expenditure, increase public expenditure for primary care, and reduce the imbalances in financial allocations for health care among our different provinces. Please tell us specifically how much household health expenditures have been reduced in the past two years. Has the recent reform reduced the gap of per capita health expenditure between the eastern and western provinces? Have your new policies increased resources for primary care?"* The Minister was sure that her policies had met the campaign pledges but could not back this up with numbers, in particular, on out-of-pocket spending and expenditures on the various functions of the health system. She equivocated, mumbling something about having increased overall Ministry spending by 15 percent and bringing up the new African Development Bank loan of \$17 million. Afterwards, she chided her advisor on financing: *"I really need a better grasp of the numbers – to answer these citizen groups, but also so that I know what is happening and can shape the system to the President's Vision for a New Melcolia."*

Financial resources are an essential input in the production of health care. As countries work to improve their citizens' health, information on health sector financing is needed to appropriately allocate resources, identify inequities in the health system, analyze provider efficiency, and improve accountability on the use of resources. National Health Accounts (NHA) is an internationally recognized framework for measuring health expenditure – public, private, and donor – and the flow of funds through a country's health system.¹

An integrated approach to conducting NHA produces financial information that is linked to other health-related information. It also requires NHA to be a country-led effort, putting ownership of the process within the government and therefore making it a part of government planning and budget cycles. Furthermore, it builds capacity at the local level by asking that level to first collect data and later to transform the resultant

information into knowledge for action. Finally, an integrated approach makes information public so that it can be discussed among and used by different stakeholder groups.

The problem

Although NHA information now is widely available and used in developing countries, its full potential is not always recognized and relatively few countries have fully institutionalized the methodology.

For more than a decade, donor partners have provided technical assistance for conducting NHA in countries throughout the world. In some places, assistance has been extensive, with partners helping countries to conduct surveys of households, providers, and donors; elsewhere, the NHA undertaking has been more limited, with assistance provided only for the analysis of available information. In countries that have done several "rounds" of NHA estimates, the value of the information is more appreciated and policymakers have used results in different ways. However, in many countries, NHA has been conducted as a stand-alone exercise of the Ministry of Health (MOH), with emphasis on collecting data and producing NHA tables, and results providing only a snapshot of health system financing. More closely linking NHA to other routine financial data collection and planning and budgeting processes could make NHA easier and less costly to prepare and result in deeper institutionalization. Further, making NHA findings accessible to a wide audience in both the public and private sectors would give it a greater constituency and enhance the ability of actors outside the MOH (for example, civil society organizations, local legislators, or regional authorities) to participate in policy debates armed with quantitative data and able to hold decision makers accountable for system performance.

An example of an integrated approach to NHA

The experience of NHA in Mexico demonstrates the benefits of an integrated approach to conducting NHA. Institutionalization of a System for Health Accounts (SICUENTAS)² has been successful largely

¹ World Health Organization, World Bank, and U.S. Agency for International Development. 2003. *Guide to producing National Health Accounts with special applications for low-income and middle-income countries*. Geneva: WHO.

² Merino Juarez, M.F., and R. Lozano Ascencio. 2004. *Uso de la información de Cuentas Nacionales de Salud en la formulación de políticas de salud en México*. Presented at EUROLAC Forum, Recife, Brasil, April 2004.

because of the establishment of a legal framework that supports the process of conducting NHA and using results to measure accountability and health system performance (see Box 1). Furthermore, the National Health Program of 2001-2006 established the adoption of such a methodology as a strategy to meet the challenges of the Mexican health system – level of health status, quality of services provided, and fairness of financial contributions. The development of SICUENTAS implied work on technical and political dimensions at the same time. An institutional home for NHA was established within the General Directorate of Health Information. Finally, resources – financial and human – were allocated to conduct this activity.

Box 1. Legal Framework to Support NHA in Mexico

Article 104 of the Mexican General Health Law states the following:

The Ministry of Health and the governments of the states, in agreement with the National Health Statistics Law and the general criteria established by the Ministry of Finance, will collect, produce, and process the necessary information needed for planning, budgeting and control of the National Health System.

The information refers primarily to the following aspects:

- I. Statistics on birth, mortality, morbidity and disability;
- II. Demographic, socioeconomic, social and environmental factors associated with health;
- III. Infrastructure, human and *financial resources*

The regulatory framework for the Ministry of Health establishes that tracking the financial resources spent in the health sector is the responsibility of the General Directorate of Health Information.

The starting point for organizing the work consisted in the technical task of identifying the financial imbalances of the health sector – evidence that would in turn be used in the political process to negotiate with Congress a reform in the way the health system is financed and the establishment of the System of Social Protection in Health.

Intensive technical work was also conducted, initially in four states and their social security institutions, to translate the line-item budget categories to the International Classification of Health Accounts used by NHA. The categories were changed in negotiations between the Ministries of Health and Finance. The information produced by the NHA methodology is being used politically to monitor reform, and it is leading to an increase in public expenditure for health. Additionally, the information is publicly available – electronically and in print, on a yearly basis. The data sets

for producing the NHA tables are considered a public good. Finally, the annual assessment of health system performance, which the MOH disseminates to the public, employs NHA indicators.

Taking an integrated approach to conducting NHA

Conducting NHA while placing emphasis on its integration with governance, operations, finance, and capacity-building efforts

contributes to the strengthening of health systems. This integrated production of NHA in any country has to happen in two dimensions – technical and political. The starting steps to

ensure an integrated approach to the development of NHA include the following:

- Establishing an institutional home for NHA is essential (see Box 2). A starting point for this discussion often is determining which unit is responsible at the country level for producing such information. In many countries, the central statistics office is the entity responsible for national accounting. In other places, the office of budgeting within the MOH is responsible for reporting expenditures. The chosen institutional arrangement will largely depend on the way each country organizes its health information system. Regardless, having an institutional home, with legal or regulatory support for the production of NHA, is a crucial step that contributes to the institutionalization of NHA.
- Establishing rules, norms, principles, and decision-making procedures that bring order and structure to the cooperation needed to conduct NHA contributes to the stewardship function of the government and to the continuous production of financial information used in planning and budget formulation processes such as the medium-term expenditure framework. Included in these norms is the establishment of a legal framework within the context of health information regulation that provides NHA with the necessary support for its successful completion.

Box 2. Institutional Homes for NHA

Different countries house NHA in different entities. In Canada, NHA is housed in the Canadian Institute of Health Information, an independent body in charge of producing NHA. In Colombia, NHA is produced by the MOH unit in charge of the health sector reform. In Georgia, NHA is conducted by a nongovernmental foundation in close coordination with the MOH. In Ethiopia, the MOH Planning and Programming Department is in charge of NHA.

Box 3. Linking Cooperation among Institutions and with Civil Society

To promote coordination among the different stakeholder institutions that must contribute to the implementation of NHA, it is important to have an NHA Steering Committee. The Steering Committee guides the NHA in a way that gives it a true sense of purpose and usefulness for decision making.

All stakeholder institutions should have a representative – preferably from top management – on the Steering Committee. It also is important to represent users of the information, for example, the MOH policy unit, the budgeting office, and state or regional representatives. Finally, civil society should be represented, to promote a sense of accountability. After all, NHA is a public good.

- Allocating a budget and the necessary human resources is essential. Additionally, making the production of NHA part of the National Health Plan ensures continuous support from the providers of information. In Ukraine, for example, it is necessary to have a cabinet decree in order to conduct NHA.
- Identifying and training a team to conduct NHA must be done within the context of existing institutions. The team should include members who are capable of analyzing the NHA data in the context of the health system, ideally integrating the analysis of NHA data with other routine information sources, such as management, service use, and surveillance data. It is then that information becomes knowledge that can be shared among the different users, including civil society.
- Linking production of NHA to locally relevant policy issues builds a constituency of stakeholders,

enhancing the institutionalization and sustainability of NHA. (see Box 3) The results can be tailored to different users of information. Policy briefs can be produced for health care policymakers, along with executive summaries for Cabinet and Congress, and media reports for the press. The data sets should also be available to the general population.

Expected results

The strengthening of the health information system in a country contributes to the strengthening of its entire health system. Working towards an integrated approach of conducting NHA contributes to the process of having a sound and integrated health information system. This strengthening of the health information system can translate into increased public expenditure for health, improved allocation of resources, and better accountability.

Having conducted NHA and studied the results, the Melcolian Minister of Health reported during this morning’s press conference: *“I am pleased to announce that public expenditure on health represents 56 percent of total health expenditure, an increase of 5 percent over the past three years. Furthermore, the new Health Law establishes a Fund for Primary Care that will ensure the continuous strengthening of the health activities at this level, focusing mainly on reaching the poorest communities.”* However, the representative of the Citizen’s Coalition for Better Health still had questions. *“Yes, I too have read the latest NHA report. But we still need to address the issue of inequities in the per capita expenditure among regions. Could you please comment on how you expect to achieve this?”*

Expected Results of Targeted and Integrated Approaches to Conducting NHA

Targeted Approach	Integrated Approach
Data are produced, but not optimally transformed into knowledge.	An increased use of evidence for decision making is translated into an improved allocation of resources.
The data produced have limited dissemination and therefore are used by only a few stakeholders.	The “culture of information” is promoted.
The technical capacity to conduct the NHA methodology is limited to a few personnel in one MOH unit, separate from other information systems. Therefore, the regular and sustained production of NHA depends on the involvement of the few trained personnel.	The processes of gathering, sharing, analyzing, and using NHA data for decision making is integrated into the procedures for gathering, compiling, and analyzing all health-related data.
The data produced inform the reform process but with a limited scope.	An improved system that engages civil society in monitoring the implementation of health reforms is in place.

Taking an Integrated Approach to Health Care Operations: Managing a Health Sector's Finances

Introduction

Ted Mayinga is a senior clinical officer in Chikwawa District, situated in densely populated southern Malawi. Since 2005, he has served as the acting district health officer for an area with a population of 500,000. The Chikwawa District Hospital has 300 beds and serves as a referral hospital for one 50-bed rural hospital and 20 health centers. Due to lack of better-trained staff, the centers are often staffed by health assistants with only 10 weeks of medical training. Monthly supervisory visits by skilled medical/administrative staff, crucial for monitoring the centers' performance and assisting in providing critical medical services, have been severely reduced due to staff shortages and delays in receiving travel funds. Non-emergency surgery at the district hospital was suspended due to lack of equipment and even basic supplies.

While Dr. Mayinga is skilled in all branches of medicine, he has never received financial management or management/supervisory training. Yet he is responsible for managing the district's service delivery system as well as the budgetary resources to finance the services. He has a only low-level clerk to assist him in handling district health monies.¹

By 2005, Malawi had received \$88 million from the Global Fund to Fight AIDS, Tuberculosis and Malaria, out of a total \$227 million approved over a five-year period to fund HIV/AIDS and malaria initiatives. Yet the underlying health system to support fighting these diseases remains fragile and constrained by lack of capacity to absorb the resources and a sufficient number of well-trained staff to properly manage the injection of new monies.

Operational problems in managing a health system

As the Malawi scenario above suggests, ensuring funding for health service delivery can be a key management challenge. Lack of funds at the local level could be the result of poor planning and budgeting, convoluted procedures for transferring funds to health facilities and then using them properly, and/or Ministry of Health cuts in funding for supervision and outreach

due to changing priorities or other health reform demands.

Poor management of available health system funding often is a greater constraint on service delivery than is the lack of funds, especially in this era of unprecedented large grants from global health initiatives and multilateral and bilateral assistance. Budget processes may be too bureaucratic and complex at both the national and subnational levels and offer few if any incentives to promote cost-effective practices. The national government and subnational units often lack the authority and financial management tools to spend money wisely. Well-trained and experienced financial management staff are located in national ministries or regional/provincial directorates and not at the district/subdistrict or facilities levels, where such expertise is also needed. Establishing good financial management systems and processes for planning and budgeting, disbursing and spending funds, and monitoring and reporting on finances, combined with mechanisms for strengthening overall management/leadership, can help address the challenges of managing health sector finances.

An integrated approach to improving financial management

A targeted approach to managing health sector finances could focus on developing or modifying existing systems and processes for financial management (budgeting, budget execution and financial controls, procurement), human resources management, and planning (program implementation, performance monitoring) in a way that facilitates timely, efficient, and accountable use of inputs for quality priority health service delivery. The approach would identify operational bottlenecks and prescribe systems and processes to address the problems; recruit, deploy, train, and supervise staff to implement the systems and processes; and develop a monitoring system to determine effectiveness for accountability purposes. Box 1 lists specific steps of a targeted approach.

While the targeted approach is useful, integrating it with complementary governance, financing, and capacity-building initiatives can achieve greater results, as seen below. Box 2, on India's NRHM Initiative, describes an example of an integrated approach.

¹ Adapted from D.M. Sanders, C. Todd and M. Chopra. "Confronting Africa's health crisis: more of the same will not be enough." *British Medical Journal*, Volume 331, October 1, 2005.

Box 1. Targeted Approach to Improved Financial Systems and Processes

- Developing financial and accounting guidelines and manuals that are periodically updated with changes in procedures to guide health officials and staff in good financial management practices
- Simplifying complex procedures for approval and release of funds
- Setting up a computerized accounting program that networks the central ministry of health and its subnational units to allow for timely reporting of financial transactions and effective monitoring of funds utilization
- Allowing health workers in remote areas to manage funds via bank accounts, where banking facilities are available, with guidelines on how to spend the funds. This will provide a source of cash to address local needs in a timely manner. E-banking solutions for transferring funds from the central ministry of health to subnational units will expedite the process.
- Improving financial systems for planning and budgeting through innovative approaches such as Program-Performance Budgeting (PPB). PPB allocates all available financial resources by program, and performance indicators measure the results of actual spending. A PPB approach would be implemented as part of broader budget reforms across all sectors in coordination with finance and planning ministries, and could be combined with the medium-term expenditure framework approach to planning and budgeting.

Governance. Governance initiatives in the health sector promote non-state actor involvement in (1) strategic decision making and (2) holding decision makers accountable, and (3) making decision makers better “stewards” of health sector finances by strengthening and establishing their roles and responsibilities.

The integration of governance with financial management can involve entities such as civil society organizations’ and media’s collaboration with health authorities on interpretation of financial information produced by the systems described above. These non-state participants will be able to use the financial information to formulate and advocate for improved health services as well as hold health authorities accountable, ensuring that those controlling resources use them effectively.

Additionally, ministries of health could be required to meet government right-to-information requirements by publishing financial information on their websites, reporting on results through the media, and holding periodic community roundtables to openly discuss the health sector’s financial status.

Finally, when a country decides to implement a broad national decentralization strategy or even gradually increase the role of subnational health units in health service management, guidelines, case studies, and models on the appropriate roles and responsibilities for each level of government in health sector financial management would make for more effective execution of the decentralization process.

Financing. Financing initiatives seek to (1) mobilize more resources for health; (2) use existing resources more efficiently; and (3) improve allocation of resources. An important complement to changes brought about by financing initiatives is improved financial management systems that allow managers operating in the new financing environment to make more efficient resource allocation decisions and respond to incentives, such as those in performance-based systems, that financing initiatives often put in place. Funds made available by new financing initiatives would be better absorbed and used in a timely manner if complemented by improved financial management, which, in turn, would provide support for advocating for additional resources.

Box 2. India’s NRHM Initiative

To address an array of problems with its public health system, including very low funds utilization and weak management/supervision of health services, the Government of India developed a health policy framework as part of its the National Rural Health Mission (NRHM) initiative. The NRHM initiative (2005-2012) is being implemented countrywide, with special focus on low-resource, weakly managed states, to increase access to priority services for the poor.

The NRHM financial management component takes an integrated approach to strengthen overall health system management/leadership, financial and program management at all levels of government, and acute shortages in qualified health workers, and ensure that infrastructure is available at the subnational level to support national programs such as the Reproductive and Child Health program. More specifically, the financial management component of NRHM’s objectives aims to:

- Improve management performance, establish local government ownership of health programs, and strengthen health institutions at the national and local levels for timely and coordinated utilization of health resources;
- Integrate vertical national programs with other health determinants like sanitation and hygiene, nutrition, and safe drinking water for optimal utilization of public funds and infrastructure and to strengthen primary health care delivery at the district level through a district planning process;
- Provide financial management systems and processes and qualified staff to strengthen health institutions to enable them to better manage the flow and utilization of funds and to have better records of expenditures tied to results.

Capacity building. Capacity-building initiatives strengthen the ability of individuals and institutions to better manage financial resources and to carry out activities on a sustainable basis. The training of individual personnel in new or modified financial management systems and management/leadership does not ensure the sustainability of improvements. Frequent personnel transfers and turnover can quickly erode a newly built skills base. Needed instead is a sustainable institutional base for financial management in ministries, decentralized units, and facilities. This can involve establishment and/or organizational development of units responsible for financial management with processes and procedures to maintain and increase the skills base even as individuals rotate positions or leave health institutions.

Expected results

The following table compares the results of using a targeted operational approach with the broader

outcomes expected from an approach integrating governance, financing, and capacity building with operations initiatives to improve financial systems.

The use of an integrated approach in Malawi would result in the development of systems and procedures that would enable funds to flow in a timely manner to the district health offices. Staff would be trained to use the system and the district health office would have an institutional home for managing its finances with the right number of staff and with clearly defined roles and responsibilities. Local civil society would be able to look at expenditure data and advocate for additional resources.

In Chikwawa District, Dr. Mayinga would then have the management systems, requisite skills, and available funds for drugs, supplies, and staff to properly run the Chikwawa District Hospital, the rural hospital, and the health centers – and thus provide the health services needed by the Chikwawa District population.

Expected Results of Targeted and Integrated Approaches to Health Sector Financial Management

Targeted Operational Approach	Integrated Approach
Government develops and implements systems and processes to produce information on the health sector's financial status.	Government builds on improved financial systems to work with civil society organizations and the media to develop ways to inform the public of the health sector's financial situation. Civil society uses the information to advocate for improved health service delivery.
Appropriate staff are recruited, trained, deployed and supervised to implement the systems and processes for improved financial management.	Staff are not only recruited, trained, or deployed to implement the financial management processes and systems but units are established and/or strengthened to ensure sustainability.
Systems and processes are developed and/or modified to improve financial management for the health sector.	Health managers use the systems and processes to mobilize more resources for health, use resources more efficiently, and improve allocation of resources.

Health Systems 20/20

Health Systems 20/20 (HS 20/20), a five-year (2006-2011) cooperative agreement funded by the U.S. Agency for International Development (USAID), offers USAID-supported countries help in solving problems in health governance, finance, operations, and capacity building. By working on these dimensions of strengthening health systems, the project will help people in developing countries gain access to and use priority population, health, and nutrition (PHN) services. HS 20/20 integrates health financing with governance and operations initiatives. This integrated approach focuses on building capacity for long-term sustainability of system strengthening efforts. The project acts through global leadership, technical assistance, brokering and grant making, research, professional networking, and information dissemination.

Why Health Systems?

The delivery of all health services, including the priority PHN services, depends on the underlying health system. To combat malaria, TB, HIV, and maternal and child health problems, the health system needs adequate and appropriately allocated financing, inclusive decision making and accountability, and financial and human resource management systems that deliver inputs where and when needed. A smoothly functioning health system maximizes the delivery of effective and life-saving technical interventions.

How to Access Health Systems 20/20

USAID missions and bureaus can access HS 20/20 by obligating funds to cooperative agreement No. GHS-A-00-06-00010-00. The project can accept all types of USAID funding, including PEPFAR, POP, CS, EFS, as well as funds through EGAT and D&G. As a Leader with Associate mechanism, missions and bureaus can also negotiate and manage separate Associate Awards for which they will designate a CTO.

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