Domestic Revenue Mobilization for Health

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What is DRM for Health?

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- USAID defines DRM as “the process through which countries ***raise and spend their own funds*** to provide for their people – is the long-term path to sustainable development finance. DRM not only provides governments with the ***funds needed to alleviate poverty and deliver public services***, but is also a critical step on the path ***out of aid dependence***.”

- Other donors take a broader view of DRM ***including the expenditure side*** and acknowledge the role ***efficiency and effective*** use of funds has in ***overall sustainability and self sufficiency.***

- The IMF defines PFM for health as: “The translation of government policy ***into sustainable budget and policy targets***, and implementation of the budget in a manner that ***supports service delivery*** including health (from national and sectoral planning, to program based budgeting).”

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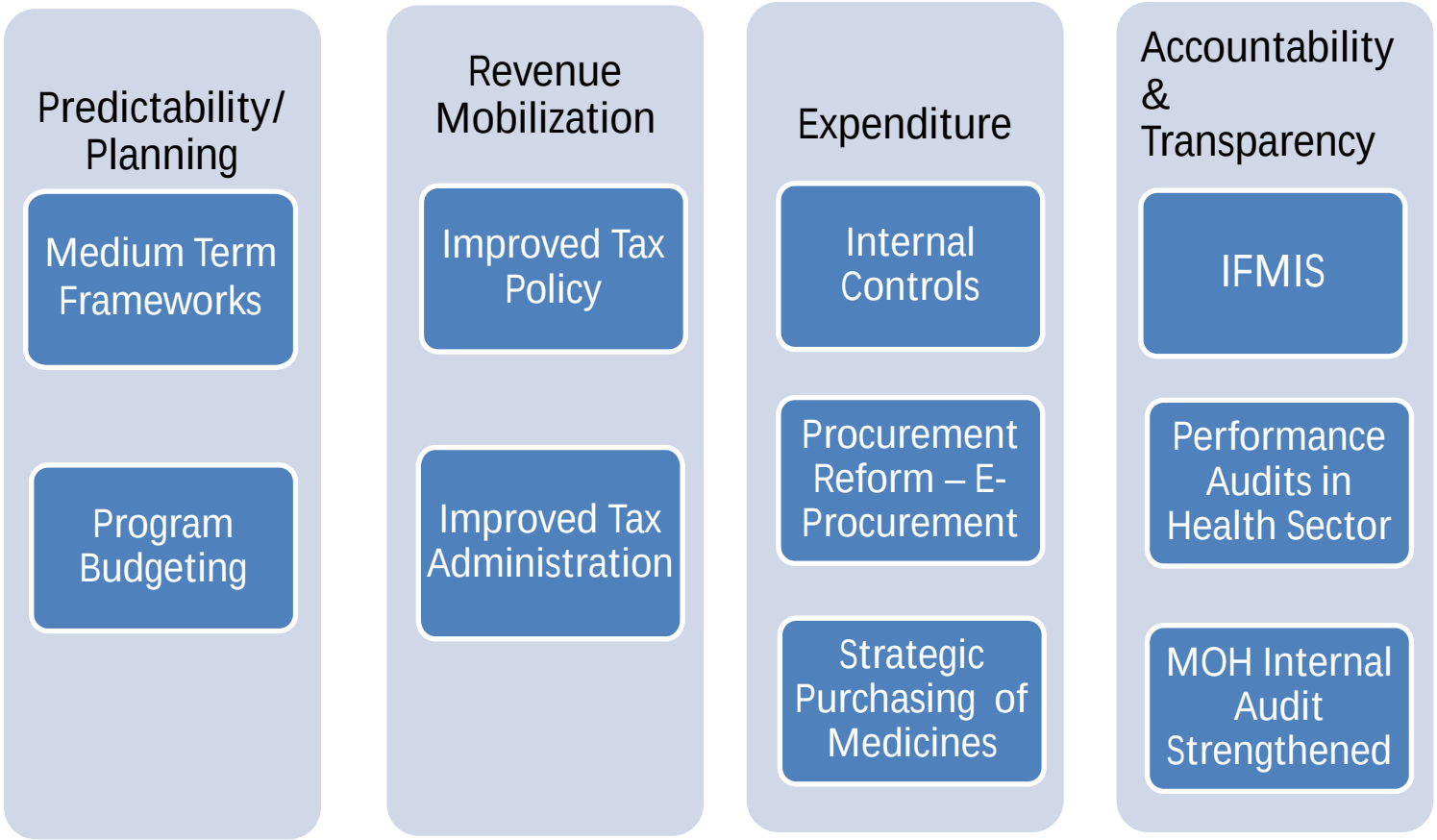
Phases and Interventions



Approaches to DRM/PFM for Health

- **Top Down:** Cabinet, finance, health, macro fiscal planning, healthcare policy development
  - Tax policy and administration
  - Medium-term planning
  - ICT consolidation – e-government roll out
- **Bottom Up:** Collection of data at the facility/patient level, fiscal decentralization program budgeting
  - Development of KPIs
  - Budget inputs
  - Advocacy for budget allocations/envelopes
- **Measuring Impact**
  - Utilization of both *qualitative* and *quantitative* indicators as evaluation criteria
  - How does it effect tangible health outcomes

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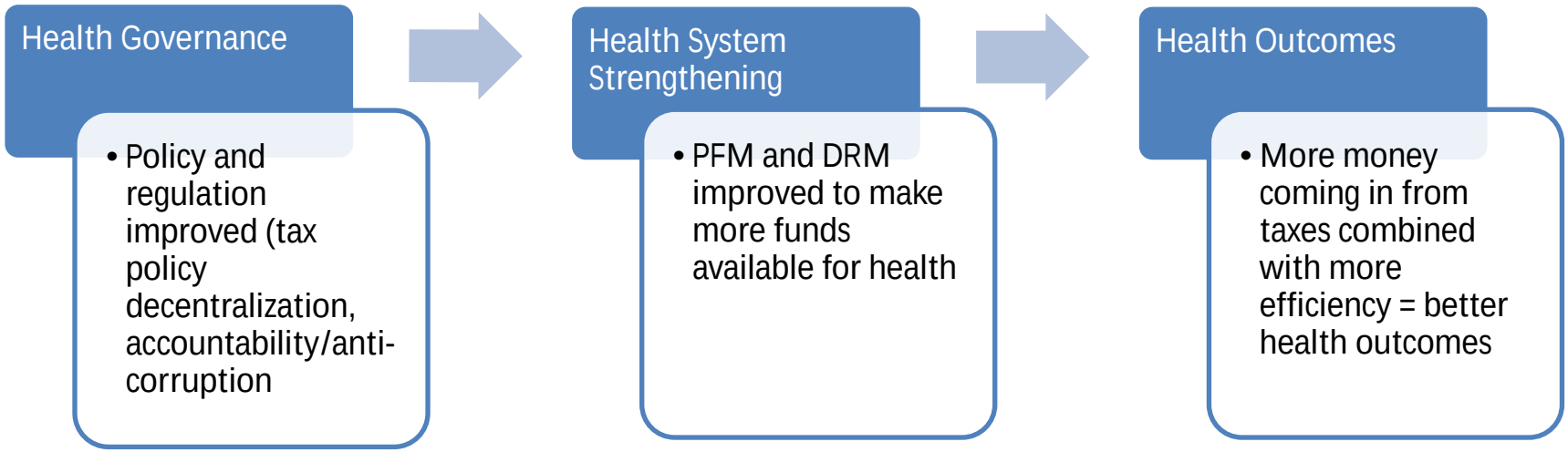
Linking DRM to Health



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Linking DRM/PFM to Health Outcomes

Current DRM Work – Evidence

§ Marshalling the evidence: Looked at all the evidence around linking interventions to health outcomes – we compiled evidence form over 40 studies

Intervention	Finding – effect on health outcomes
Earmarks for Health	Positive correlation: not favored because of decrease in flexibility
Medium-Term Expenditure Frameworks	Mixed reviews: positive correlation when certain external factors were controlled
Decentralization	Mixed/Negative: without some central guidance may undermine health outcomes
E-Procurement	Positive correlation: reduces price of drugs and health equipment
IFMIS	No studies on impact for health
Program Budgeting	Mixed results: dependent on development stage & implementation

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Current Work -- Evidence

- DAI is working under the HFG project to develop a policy paper on how to influence a disproportionate increase in health spending with increased revenues.
  - This could serve as a guide for health programs to frame their thinking around DRM interventions

Current DRM Work – Project Based

- DRM for HIV:
  - Worked with state coordination units in Nigeria to make the case for allocation to the HIV coordination body - budget planning and advocacy exercise
- DRM for epidemic preparedness and response
  - Drafted a global DRM strategy helping national coordination units think through how to approach raising government money for preparedness and response to epidemics

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Discussion Questions

- How do we begin to fill out the evidence around DRM and its effects on the health sector – how do we go about potential attribution in instances where health money is used for DRM?
- How can DRM and health programming better coordinate to achieve mutual goals?
  - This would be applicable to other sectors such as education as well.

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DRM for Health Case Study

Case Study: PFM Reforms in Indonesia's Health Sector

- The health sector in Indonesia embarked on two important PFM reforms from 2013 to 2017.
  - Implementing PBB and MTEF
  - Preparing for Universal Healthcare Coverage (Jaminan Semesta)
- The World Bank and AusAID were the main supporters of the reforms.
- A series of laws were passed in 2003 to roll out PBB and MTEF across the GOI, but very little progress was achieved until 2013.
- The transition to universal healthcare coverage will roll out over a five-year period, and it will ensure all Indonesians (237.6 million according to the 2010 Indonesian Census) are eligible for coverage by 2019.

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Challenges to Implementing *Jaminan Semesta*

- Regional comparisons between levels of health expenditures show that Indonesia's spending levels are below those of its regional neighbors with approximately 1.2 percent of GDP and only 2.5 percent of total government expenditure spent on healthcare services.
- Indonesia has approximately 70,000 doctors (50,000 physicians and 20,000 specialist), and the doctor to patient ratio should be 1:2,500. Supporting this internationally accepted ratio would mean Indonesia should have at least 90,000 doctors.
- Healthcare delivery to all Indonesians is further complicated by the fact that 64 percent of all doctors in Indonesia are concentrated in Java.

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Challenges to Implementing MTEF and PBB

- Lack of political will/power at the highest levels of government to implement important PFM reforms.
- The Ministry of Health's Renstra (5-year development plan) historically had KPI targets that were:
  - Repetitive and focused on administrative (or tick the box) outputs rather than outputs that measured the quality or quantity of health care service delivery:
  - Not SMART;
  - More concerned with inputs;
  - Not accurately costed; and
  - Not aligned with a MTEF.
- Unclear roles and responsibilities between the Ministry of Finance and Bappenas (Ministry of Planning).
- Weak quality control of MTEF (forward estimates) and KPI formulation, costing and M&E.

Why MTEF?

RESPONSE: If ministries are planning over five-years then why are they not thinking about resource needs over the medium-term?

- MTEF has become a common strategy of many governments around the world to better link resources with results.
- Lengthening the budget's timeframe from one year to three or four years often has the effect of making governments more focused on results.
- MTEF aligns planning and budgeting by ensuring that the financial commitments to achieve policy and spending priorities promote better budgeting.

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Reorienting the Budget to Make Policy More Important

Traditional Compliance Budget Approach	More Policy Relevant Budget Approach
Budgets are prepared annually with a risk of year-end rushes to spend and no allowance for future commitments.	Budgets are prepared within a MTEF with allowances for carry-over of commitments.
Budgets are prepared incrementally, typically with emphasis on the bottom-up demands of ministries.	Budgets are prepared with a strategic direction, providing a top-down counter to MDA's bottom-up demands.
Budgets are based on line items of expenditure so that control focuses on inputs rather than outputs and outcomes.	Budgets are driven by policy priorities, and programs to meet those priorities control emphasize outputs and policy outcomes.
Budget documentation and reports are for compliance purposes by institution or agency and approved costs have little emphasis on policy.	Budget documentation and reporting are not only for compliance, but for assessing efficiency and effectiveness in meeting policy objectives.

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PBB or Managing for Results

- The Indonesian Minister of Health decided that implementing PBB was important because it measures the budget and operational performance of the health sector in Indonesia.
- The four components of PBB in Indonesia include:
  1. Policy delivery linked to program costing;
  2. Accurately costing programs, sub-programs and activities;
  3. Performance measurement; and
  4. Accountability to let managers manage.

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Some Results of Implementing PBB and MTEF in the Ministry of Health

- Many administrative or bureaucratic indicator targets were converted to indicators that described the results of activities like research and development.
- The number of indicator targets for the Renstra 2014 to 2019 were reduced to 121 (from 286 for the Renstra 2010 to 2014).
- The quality of the MTEF's forward estimates improved by 87% from FY 2015 to FY 2016.
- All 121 indicator targets for the Renstra 2014 to 2019 were accurately costed.
- Reforms at the Ministry of Health served as a pilot to PBB and MTEF reforms at other ministries.

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Discussion Questions

1. What have been some of the challenges other governments have faced when trying to align planning and budgeting?
2. What are important elements to PFM systems for sustaining PBB and MTEF?

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Revenue Collection for Healthcare

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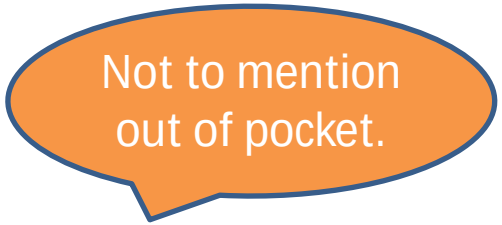
Collecting Revenue for Healthcare

How are revenues for healthcare collected?

- Dedicated source of funds for health services
  - Social contributions
  - Wage withholdings
- Use of general budgetary funds
  - Taxes for the general budget
  - Non-tax revenues (when a substantial contributor to the budget)
  - Self-assessment and voluntary compliance
  - Tax collection and enforcement
- A combination of dedicated and general budgetary funds

Two main government healthcare funding models:

1. The Beveridge Model
2. The Bismarck Model



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Unified Collection of Social Contributions Reform

Experience from:

Armenia
Bosnia-Herzegovina
Macedonia

Goal: Reduce administrative and compliance costs and increase collection of social contributions

- A reform conducted in many Central and Eastern European Countries.
- According to the Bismarck model, health, pension and unemployment insurance funds collect payroll deductions jointly from employers and employees.
- The reform focuses on the following main elements:
  1) Unifying registration for employers and employees in one place—the tax authority.
  2) Processing social contribution reporting in one place—the tax authority.
  3) Exchanging data with the social funds for provision of social benefits.
  4) Shifting collection of all three types of social insurance to the tax authority.
  5) Empowering the tax authority to use the strongest enforced collection techniques for social contributions.

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Lessons Learned from Reform

The reform was successful in many Central and Eastern European (former communist) countries with similar lessons learned:

- Employer compliance costs were reduced substantially as expected.
- Collections increased allowing lower contributions rates, as employers in the past tended to pay contributions only when employees needed benefits.
- Even with efficiency gains, the political will to reduce government staffing levels was very limited.
- Enforcement of social contribution collections continued to be weaker than it should.
- The use of enforced collections procedures were limited, even though tax authorities have the strongest enforcement tools.
- Even with improved collection of social contributions, general budgetary funds were often used to supplement healthcare spending.

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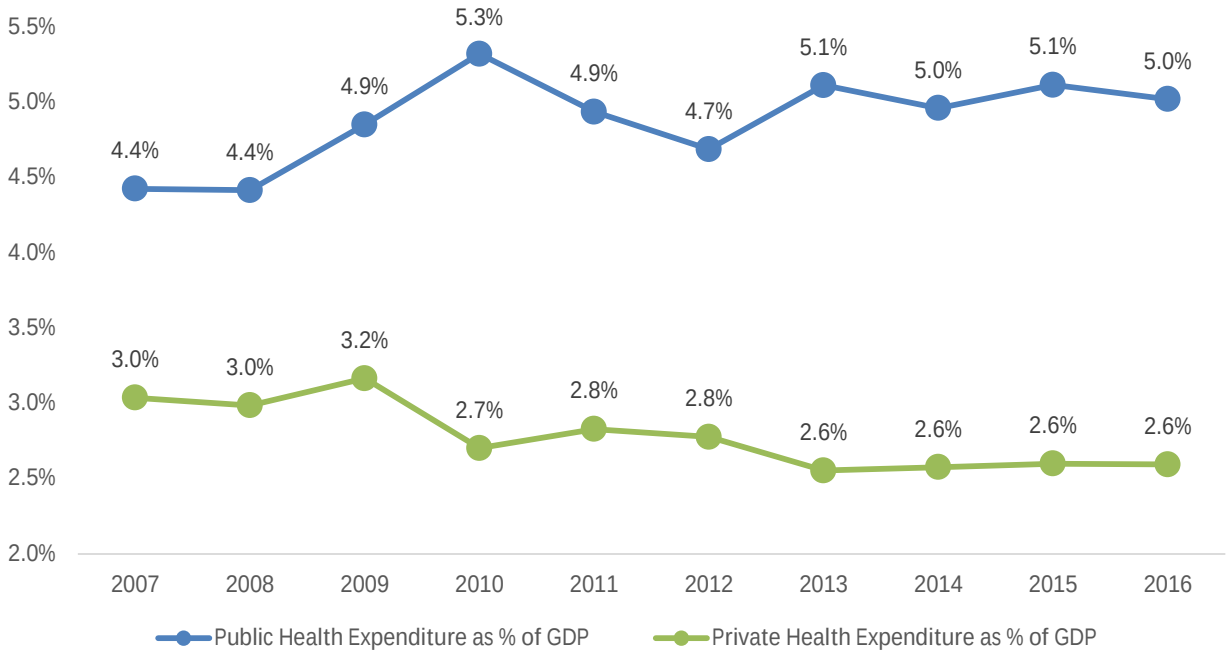
Challenges for Developing Countries

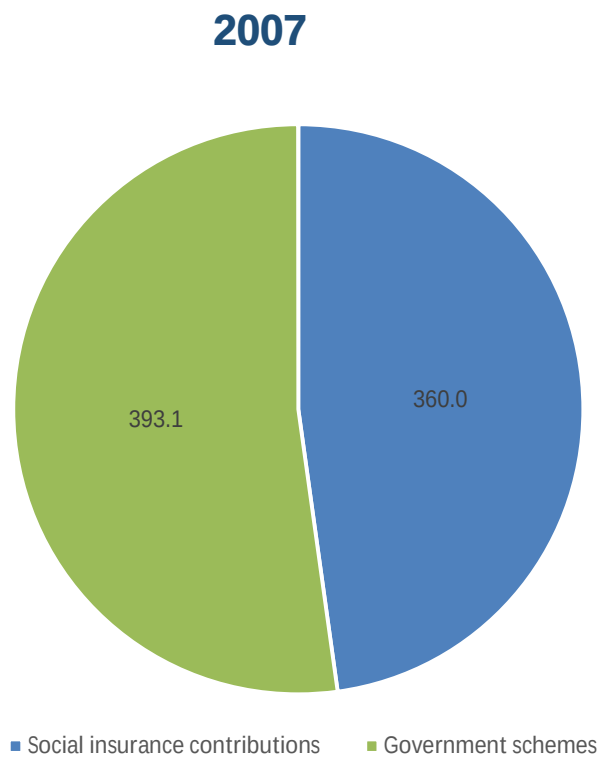
- Governments in developing countries often do not have the revenues to substantially improve healthcare.
- Epidemics and chronic diseases, such as HIV/AIDS, malaria, and tuberculosis, consume substantial health resources.
- Many of the poorest countries are dependent on donor funding to support healthcare, in particular countries hit hard by HIV/AIDS, malaria, and tuberculosis.
- Much of the population works outside of the formal economy, reducing the opportunity of collecting revenue based on employment.
- Taxes funding the general budget, in particular VAT and excise tax, tend to be regressive in nature.
- Increasing revenue collection and thus increasing spending on health has marginal impact.
- The economic impact of poor healthcare compounds the problem.

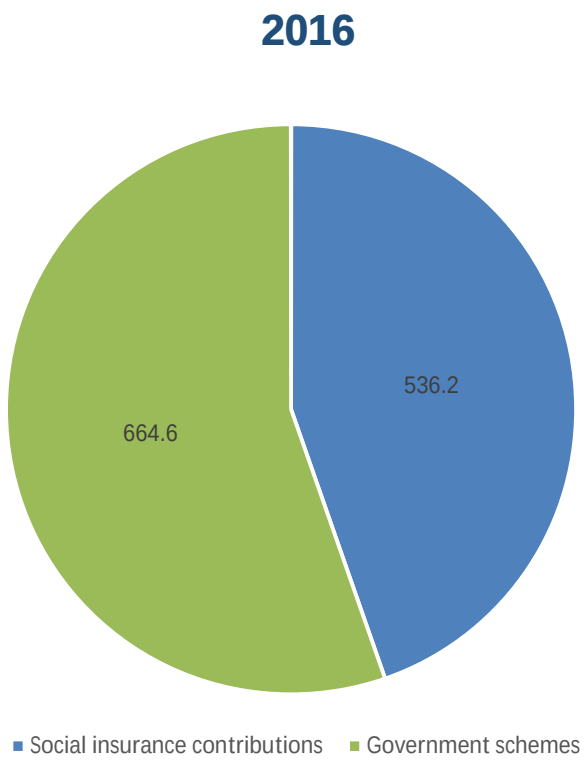
Experience in El Salvador: Public and Private Health Expenditure as % of GDP, 2007-2016



Source: Data from MINSAL and the Central Reserve Bank of El Salvador

Collection of Social Contributions vs. General Budget Expenditures





Source: Data from MINSAL

Discussion Questions

1. Should social insurance fund universal healthcare in developing countries?
2. What is needed to sustain substantial increases in healthcare spending in developing countries?