TRACKING FINANCING FOR RMNCAH, UHC AND HEALTH: DEFINING INDICATORS FOR SMART, SCALED AND SUSTAINABLE FINANCING

OVERVIEW

This document presents a set of indicators on smart, scaled and sustainable financing for monitoring the impact of the GFF on key results for reproductive, maternal, newborn, child, and adolescent health (RMNCAH), universal health coverage (UHC), and health. This document is an input into a broader discussion on health financing at the Investors Group meeting, which will look at financing flows for RMNCAH and on work related to health financing strategies. In light of the detailed and technical nature of this component of the session, it is being circulated in advance of the Investors Group meeting.

ACTION REQUESTED

This document is intended to provide background information for the discussions of the Investors Group and is not for decision or approval. Members of the Investors Group are invited to submit technical comments on the document.

RECOMMENDATION

Given the centrality of smart, scaled, and sustainable financing to the overall success of the GFF, the Secretariat is requested to work closely with countries in implementing the measurement of these indicators, once finalized, and to update the Investors Group annually on progress in financing for RMNCAH, UHC, and health.

BACKGROUND

The Global Financing Facility has been established to provide smart, scaled, and sustainable financing to achieve reproductive, maternal, newborn, child, and adolescent health (RMNCAH) results at country level. Measuring the collective efforts at improving smart, scaled, and sustainable financing is an essential part of the work of the GFF, but one that is currently hampered by the insufficient availability and inadequate quality of data about financing for RMCNAH, as discussed at the first meeting of the GFF Investors Group in September 2015.

The GFF presents an important opportunity to improve country and global monitoring of smart, scaled, and sustainable financing, and this paper describes one key element of this process: it contains a draft set of indicators to track progress on smart, scaled and sustainable financing that can be used to monitor the impact of health financing activities supported by the GFF on key results for RMNCAH, universal health coverage (UHC), and health. It has been produced as a follow-up to an initial discussion at the first Investors Group meeting, and it builds on previous work on results monitoring included in Annex 10 of the GFF Business Plan[1].

Figure 1 below shows the theory of change for the GFF. Domain 1 refers to direct financing of results at country level. The GFF mobilizes complementary financing for results from a range of sources, including domestic financing (from both public and private sectors), the GFF Trust Fund, IDA/IBRD resources, the financing of Gavi and the Global Fund, bilateral donors. The results of this direct financing are tracked through a set of programmatic indicators. Initial work was done on defining these for the GFF (also included in Annex 10 of the GFF Business Plan), but at the time those indicators were prepared, the need to ensure close links with the indicators being developed for the Sustainable Development Goals and for the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) was highlighted. The World Health Organization is leading a process to define indicators for the Global Strategy, which should also serve as core indicators for the GFF. Consultations are underway with WHO about operationalizing this, and further developments will be shared with the Investors Group as soon as possible. Therefore this document does not describe indicators for the last two columns of Figure 1 (labeled outcomes and impacts), although it is important to recognize that these are the ultimate metrics of progress on RMNCAH, as the point of smart, scaled, and sustainable financing is to reduce morbidity and mortality and improve the health and quality of life of women, adolescents, and children.

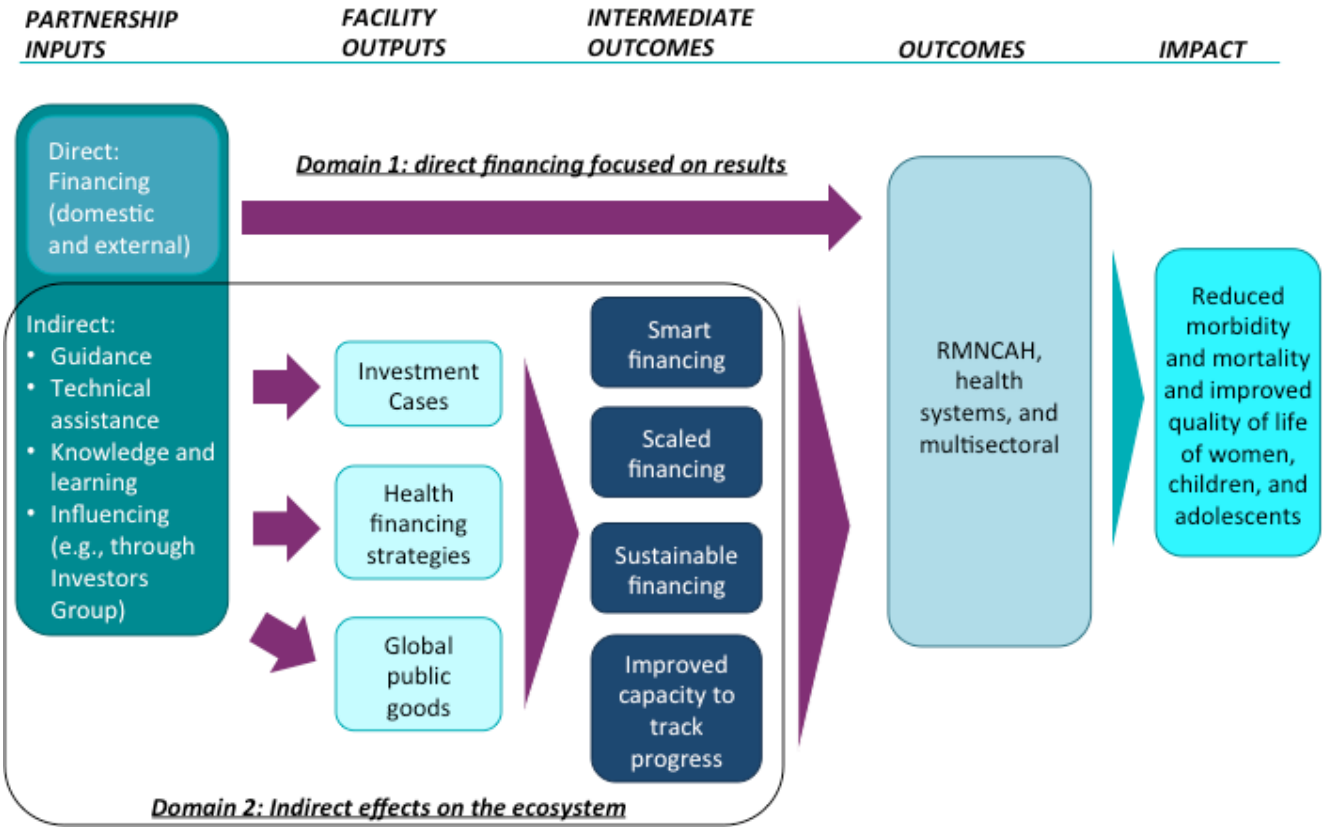
Domain 2 shows indirect actions that reflect the GFF's efforts to shift an entire ecosystem. These actions are related to the development and implementation of Investment Cases for RMNCAH (IC), the elaboration of long-term health financing strategies (HFS), and the generation of global public goods (GPG) such as innovation or knowledge and learning. These three outputs contribute to the intermediate outcomes that are summarized under the headings of smart, scaled and sustainable financing (the terms are outlined in the GFF Business Plan) and improved capacity to track progress.

Although the results chain shows these outputs combining with the direct financing domain to improve the health of women, children and adolescents (an impact), this document focuses only on the four intermediate outcomes related to smart, scaled, and sustainable financing as well as the quality of outputs

[1] Business Plan: Global Financing Facility in Support of Every Woman Every Child, May 2015

of the GFF as a facility, as described in Figure 1.[2] Because the focus is on financing for RMNCAH, UHC, and health, the discussion of GPGs is also limited to those associated with health financing and improved capacity to track progress.[3]

Figure 1: Proposed theory of change for direct and indirect financing domains



OBJECTIVE

The purpose of this document is to propose indicators on smart, scaled and sustainable financing that countries can use to monitor the impact of health financing activities supported by the GFF on key results for RMNCAH, UHC and health. It is proposed that the results frameworks of Investment Cases and the Health Financing Strategies would draw on these indicators once finalized.

CONTENT

There are a number of ways to assess the desirable characteristics of indicators. Table 1 includes indicators: 1) that clearly measure the underlying quantity of interest (listed in the first column as "intermediate outcome" or "output"; 2) can be replicated by different people, and across countries and time periods (barring measurement error); 3) where a move in one direction of the indicator clearly

[2] It is also recognized that Investment Cases, health financing strategies and the generation of GPGs will also improve people's capacity to use health services, and their health and financial wellbeing – aspects that are important to the overall results framework for the GFF but which are beyond the scope of this document.

[3] Although not shown in Figure 1, Domain 1 will also inevitably impact on the smart, scale and sustainable financing outcomes.

denotes improvement or deterioration; and 4) where measurement of this indicators would not place a too great a burden on the country in terms of administration and cost.

As much as possible, the proposed indicators draw on other internationally agreed indicators – for the SDGs, the interagency 100 Core Health Indicators, the joint World Bank/WHO framework for measuring progress to UHC, and the indicators agreed through the IHP+ process.

The columns labeled "lead" and "lag" in Table 1 are used to reflect how quickly the indicator is likely to change as a result of GFF related activities. Lead indicators are expected to change quickly (within 12 months), while lag indicators would be expected to change at a slower pace (3-5 years). In cases in which "lag" indicators can be measured annually, this is noted, even if they will change more slowly than the "lead" indicators. At the same time, although lead indicators might change relatively rapidly, for some of them it would not be possible to measure them immediately because of delays in data availability.

Indicators can be defined to fit two uses. The first is for countries to establish a baseline and then monitor their own progress and use these data continuously to improve performance. The second is to measure overall impact of the GFF activities across countries to assess global progress. The present document focuses on the indicators that countries could use themselves, although since global monitoring would need to capture progress across all country reports, this document provides a clear sense of the indicators that will be used for global tracking and reporting.

CONCLUSION AND NEXT STEPS

As noted in Table 1, many of the indicators can already be captured from ongoing activities at the country level to track progress on health expenditures. However, the systems are not currently in place to capture data for all of the proposed indicators. The implication of this is that to deliver in this area, resources will need to be invested in improved data collection and capacity building at the country and global levels.

Next steps include:

- Consult with partners on the draft indicators, particularly members of the Investors Group. A particular area of follow-up will be with WHO to build on preliminary conversations about the linkages between this work and the work on indicators for the Global Strategy.
- Validate the proposed indicators by collecting data in the 12 countries being financed by the GFF Trust Fund. Baseline data will be presented during the next Investors Group meeting.
- Estimate the likely costs associated with gathering these data, to inform subsequent discussions with the Investors Group and with countries receiving financing from the GFF Trust Fund.

RECOMMENDATION

The GFF Secretariat is requested to follow up on these next steps and report on progress during the next Investors Group meeting.

TABLE 1: Smart, Sustainable and Scaled Indicators

1.1 Smart financing

As defined in the GFF Business Plan smart financing focuses on improving allocative efficiency, technical efficiency and administrative efficiency. Improved equity is also classified under "smart".

		Lead indicator (1 year)	Lag indicator (3-5 years)	Source of data
Intermediate outcome:	**Intermediate outcome indicators:**			
Financing that is more focused on evidence-based, high-impact interventions are prioritized and delivered in an efficient and equitable manner	**Efficiency: allocative, technical, administrative** 1. **Allocative efficiency:** If the IC aims to increase the share of expenditure on prevention/promotion: % of government recurrent RMNCAH expenditure spent on prevention.[4] 2. If the HFS aims to increase expenditures on prevention/promotion: % of government recurrent health expenditure spent on prevention.		X X	1. National health accounts (NHA) distributive accounts.[5] 2. National health accounts (NHA) distributive accounts.

[4] The preferred allocative efficiency indicator would be "the proportion of government recurrent expenditure on RMNCAH spent on an agreed package of interventions as defined in the IC." This would be compared to a nationally defined yardstick of desirability specified in the results-framework of the IC. There would be a second version as well for the share of all government health spending spent on an agreed package as specified in national policies. However, it is not possible to measure this currently; doing so would require full national health accounts (NHA) distributive accounts by type of intervention. Current distributive accounts do not allow this, but the data could be obtained if GFF financed this, so the cost implications are being explored. Ideally, this would be complemented by an indicator of the allocative efficiency of external fund: "% of external funding for a. health and b. RMNCAH that finances an agreed cost-effective package of interventions as defined in national policies (health) or in the Investment Case (RMNCAH) (two separate indicators)." Measuring this would require additional breakdowns to those currently available through NHA or other donor tracking systems.

[5] All 12 GFF trust funded countries have done, or are starting, NHAs with distributive accounts and they are, hopefully, being continued annually. These distributive accounts can produce expenditure on reproductive health (including women's health linked to pregnancy and delivery), and child health. The sum is used as an estimate of RMNCAH spending. To produce more detailed accounts taking, for example, HIV prevention among adolescents would require more detailed analysis of the type that the HIV community does intermittently. It uses the distributive accounts to get the details of expenditure on HIV/AIDS, but intermittently does additional work with countries to obtain a more detailed breakdown of expenditures consistent with SHA2011.

		3. If the country has defined an essential package of health services: All key services identified in the IC for RMNCAH are included **4. Technical efficiency**. Government purchase price of a selected basket of essential RMNCAH medicines compared to the international reference price (after adjusting for freight costs) [6] **5. Administrative efficiency**: government budget execution rate for health and for RMNCAH (two separate indicators), judged against a nationally appropriate target.[7] (Where countries revise the budget during the financial year, use the revised budget.)	X	X	**3.** Comparison of the essential package with the IC **4.** Government records and reports. **5.** Government audit or public expenditure tracking survey (PETS) where available
		Equity: **6.** Incidence of catastrophic health expenditures among all key vulnerable groups (e.g. the 2 lowest income quintiles, women and people living in rural areas).		X	**6.** Routine household expenditure surveys or modules
Alignment and development assistance practices		**7.** % of external funding that is on budget for: a. health; b. RMNCAH (2 indicators)		X	**7.** Routine NHA
	Outputs	**Output indicators**			
	ICs identify priorities in a manner consistent with the GFF principles	The IC: ▪ Defines a set of results, including which aspects of the RMNCAH continuum and/or the health system that the country wishes to focus on ▪ Contains RMNCAH intervention and health systems strengthening priorities that have been costed and that can be implemented with the envelope of resources available over the timeline of the Investment Case	X for all		Qualitative review of ICs

[6] Possible additional options that are relatively easily obtainable are: a. the share of expenditures for RMNCAH and health on inpatient vs outpatient and day care; b. share of government recurrent expenditure on salaries; c. the share of recurrent expenditures to capital expenditures.

[7] Baseline to be decided when we explore various country implementation rates.

		▪ Demonstrates that issues of equity, efficiency, multisectoral determinants of RMNCAH outcomes, and upcoming structural shifts have been considered in the definition of results and priorities ▪ Describes how the desired results will be monitored and evaluated (Note: Each bullet is a separate indicator)			
	HFS address key underlying causes of inefficiency and inequality in financing	The HFS identifies and includes strategies for addressing key inefficiencies in the health system. (Note: Inefficiencies will differ by country but often involve the choice of interventions (indicator 1 & 2 above), sources of technical efficiency (3 above) and administrative efficiency (4). They might also include inefficiency associated with purchasing and payment mechanisms.)	X		Qualitative review of HFS
		The HFS identifies sources of inequity in financial protection and develops policies to reduce them	X		Qualitative review of HFS
		The HFS has been formally endorsed by an appropriate authority – parliament, president's office, ministry of finance etc. – where that is required for implementation		X	Qualitative review of HFS

1.2 Scaled financing

In the GFF Business Plan scaled is described in terms of raising additional resources as the country grows, ensuring OOPs declines in importance as this happens, and harnessing private sector.

		Lead indicator (1 year)	Lag indicator (3-5 years)	Source of data
Intermediate outcome:	**Intermediate outcome indicators:**			
Scaled financing from domestic and external sources, public and private while reducing reliance on OOPs	1. Total health expenditure per capita for a. health, and b. RMNCAH (2 separate indicators).		X (data avail annually for all)	1. Routine NHA for a. Part b requires NHA with distributional matrix

		2. Pooled expenditure per capita (government plus compulsory and voluntary health insurance) on: a. health and b. RMNCAH (2 separate indicators). 3. The ratio of general government health expenditure (GGHE) as a share of total general government expenditure (GGE) (GGHE:GGE). 4. The ratio of OOPs/total recurrent health expenditure. 5. The incidence of financial catastrophe and impoverishment linked to OOPs. 6. % of the projected costs of the Investment Case for which finance is available (from inception to the date of evaluation).	X	X X X X	2. NHA 3. NHA 4. NHA 5. Intermittent HH expenditure surveys/modules 6. Government audit, donor reports
	Outputs	**Output indicators**			
	Increased domestic resource mobilization for health and for RMNCAH from public sources	The HFS assesses the availability of domestic resources for health and key subcomponents of it, including RMNCAH, and where they are considered too low, set targets for raising more.	X		Qualitative review of HFS
	Reduced reliance on OOPs	The IC considers levels and the nature of OOPs for RMNCAH services and recommends approaches to reduce them. The HFS considers the level of OOPs overall. Where considered too high, it develops approaches to reduce them.	X X		Qualitative review of HFS and IC
	Harnessing the private sector	The IC **and** HFS identify keys ways in which the private sector can contribute in financing or improving: ▪ Coverage and quality of services (RMNCAH for the IC and health for the HFS) delivery ▪ Supply chains for key commodities ▪ Access to capital for private providers ▪ Innovation	X		Qualitative review of HFS and IC

		Note: Two indicators, one for IC one for HFS. The IC develops a process for engaging with the private sector on financing RMNCAH.	X		
	IC leads to agreement on complementary financing that reduces overlaps and gaps, and improves efficiency	% of the donors that are funding RMNCAH interventions that finance only the priorities identified in the Investment Case.	X		Qualitative review of IC and agreements between World Bank and key financiers

1.3 Sustainable financing

In the Business Plan the components described are increasing fiscal space and allocations to health; diversification of domestic sources of financing; reduced reliance on external assistance; adequate size of risk pools to assure financial protection; and technical efficiency. As described above, technical and administrative efficiency indicators are included in 1.1 (smart).

		Lead indicator (1 year)	Lag indicator (3-5 years)	Source of data
Intermediate outcome: Increased capturing of economic growth to secure universal coverage with essential services for women, adolescents, and children	**Intermediate outcome indicators:** 1. Growth rate in: a. government expenditure; b. government health expenditure, and c. recurrent government RMNCAH expenditure, compared to the GDP growth rate (Note: use a 3 year moving average. These are 3 separate indicators).		X	1. Routine National Accounts and NHA for a. and b. Part c. requires NHA with distributional matrices
Reduced reliance on grants and external assistance	2. Growth rate in domestic expenditure on a. health, and b. RMNCAH, compared to the growth rate in external sources of finance. (Use a three year moving average. 2 separate indicators).		X	2. Routine NHA for a. Part b. requires NHA with distributional matrices
	3. The share of pooled expenditure in total private expenditure. 4. Where fragmentation of financial risk pools is identified as a problem in the HFS: a policy to reduce fragmentation or a form of "virtual" risk adjustment across pools is being implemented.		X X	3. Routine NHA 4. Administrative records

	Outputs	Output indicators			
	Improved long-term planning for domestic resource mobilization, risk pooling, and purchasing through the use of health financing strategies	▪ Where appropriate based on local context, the HFS includes an explicit strategy for transitioning from financing from Gavi and/or the Global Fund to Fight AIDS, Tuberculosis and Malaria to domestic financing. ▪ The health financing strategy contains an implementation plan.	X X		Qualitative review of HFS
	Increased capacity for financial protection	▪ The HFS considers fragmentation in risk pooling and whether it is a problem for equity or efficiency, and if so, develop strategies to address this.	X		Qualitative review of HFS

1.4 Improved ability to track progress and learning

		Lead indicator (1 year)	Lag indicator (3-5 years)	Source of data
Intermediate outcome:	**Intermediate outcome indicators:**			
Improved capacity to track availability and use of funds including for RMNCAH	1. A timely audited report of government expenditures (including on-budget funding from external partners) including on RMNCAH is available for the most recent financial year. 2. A set of national health accounts (NHAs) with distributive matrices has been produced in the last 3 years. 3. A more detailed distributive account for RMNCAH has been done for baseline, and one is planned after 5 years (or less), at least for government expenditures.[8] 4. A household expenditure survey/module including health expenditures has been undertaken in the last three years.	X X		1. Country audit reports 2. NHA database

[8] Information that is available from the full distributive accounts of NHA typically provide expenditures on reproductive health (including women's health) and child health. Additional work would need to be added to these processes to include expenditure on adolescent health as defined for RMNCAH.

				X X	**3.** Country assessment **4.** Country assessment
	Outputs	**Output indicators**			
	Improvements in tracking financing flows for universal health coverage and RMNCAH	▪ The IC includes metrics on resource flows for RMNCAH. ▪ The HFS reviews the capacity to track expenditures including for RMNCAH, and defines strategies to produce more timely or more information where necessary. ▪ A strong audit system for government, donor and NGO health expenditures including on RMNCAH exists.	X X X		Qualitative review of IC Qualitative review of HFS Country/partner assessments
	Country learning and contribution to the development of global public goods that address knowledge gaps	▪ Number of learning exchanges and performance benchmarking events on health financing and/or investment cases in which the country has participated. ▪ Existence of an annual review of progress and lessons learned in implementing HFS and/or IC for RMNCAH (separately or as part of a broader process like a review of the national health plan/strategy).	X X		Country/partner assessments