

## **PRS(P) implementation: A health sector perspective**

Discussed below are key issues that have emerged from preparing and implementing PRS(P)s in the health sector. These have been organised around five sub-headings that corresponds directly to the thematic areas of the WB/IMF Review:

1. *Strengthening the medium-term orientation of the PRS.*
2. *Enhancing linkages between the PRS, the MTEF, and budgets,*
3. *Broadening and deepening meaningful participation.*
4. *Utilizing the PRS as a mutual accountability framework between countries and donors,*
5. *Tailoring the PRS approach to conflict-affected and fragile states.*

### **1. Strengthening the medium-term orientation of the PRS**

Health planning in most countries can take various forms -- a long term 'vision', usually spanning 20+ years, lays out desirable health status outcomes; more medium term strategies are often an aggregation of various categorical programmes; the PRS(P) has introduced a three-five year cycle as part of a broader poverty reduction approach; and, finally there is annual budget-driven planning which, in fact, tends to dominate health planning. PRS(P)s could provided the anchor for medium/long term planning that effectively weaves all other processes together.

The **MDGs** provide an opportunity for **priority-based, results oriented** planning with a **medium term perspective**. However, integration of MDGs into the health component of PRS(P)s is still incomplete. Child and maternal MDGs have been most successfully linked to national goals, with downwards/upwards revisions where targets are too high/low in the country context.

Disease specific goals and targets are less incorporated into the health component of PRS(P)s. Also, a lack of appropriate and adequate information makes adherence in planning, implementation and monitoring difficult. Further, the MDGs exclude some health issues that are important in specific countries and

countries are weary of the global attention on MDGs dictating national planning and skewing activities away from other priorities diseases, particularly the in-flow of international funding for related activities (as with HIV and AIDS).

There are two aspects that health-related MDGs ignore and which are also not adequately reflected in the health component of PRS(P)s. First, the health-MDGs refer to population targets rather than call for focus on particular disadvantaged groups. This makes it possible to be 'on-track' for the MDGs on *average* with such national statistic hiding little changes in outcomes for the poor. The health component of PRS(P)s need to set sub-targets to secure '**disaggregate**' **progress**, especially for poor. Second, the health-MDGs make no reference to urgently needed improvements the underlying institutional and systems bottlenecks to better health status. This omission of **health systems** issues, while emphasizing causes of morbidity and mortality, risks continued fragmented and programmatic health planning. The health component of PRS(P)s needs to particularly address the cross-cutting health systems issues that limit equitable scaling-up of categorical approaches in a comprehensive and consistent health plan.

#### ***Adjusting MDGs targets in Health-PRS(P)s***

- **Ethiopia** has revised down MMR targets in line with the base-line and country capacity.
- **Uganda** has made substantial progress towards the HIV and AIDS MDG target and has revised these to be more challenging.

#### ***Keeping the focusing on country specific disease priorities in health-PRS(P)s***

- **Yemen** has identified TB has a disease priority while a preventive strategy is already in place to stem (the currently low) spread of HIV and AIDS. The global focus on the latter needs to be adjusted to country requirements both in terms of steps already taken as well as efforts needed to combat other diseases.
- **Vietnam** places urgent and substantial importance on addressing the use of tobacco, an area overlooked in the MDG framework.

**Key omissions in health-MDGs that need to be addressed in Health-PRS(P)s**

- Progress towards MDGs needs to be disaggregated by population groups, especially the poor, to ensure equity in achievements.
- Health systems issues need to be emphasized and focused on in planning as cross-cutting bottlenecks to equitable scaling up of priority interventions.

**2. Enhancing linkages between the PRS, the MTEF, and budgets**

Budget sanctions from Ministry of Finance, Planning and Development (MoFPD) can be binding on health planning and implementation. In the extreme, cash budgets or budgets 'revised' by MoFPD to 'fit' allocations make plan/strategy sequencing leading up to a vision effectively redundant. In addition to the **overall resource constraint and unpredictable levels of financing**, MoH itself does not have the technical capacity to formulate and 'sell' health as being central to development and development financing. Identifying priorities and setting targets is the first step.

Then, accurate **budgeting** for priorities needs detailed **costing** of expenditures necessary to achieve those targets. This allows adjustment in planning once budget allocations are actually made, without compromising on key priorities. Also, using costed interventions to create output/outcome scenarios using alternative availability of resources has been useful in illustrating what could realistically be achieved -- it clearly brings out the gap between health needs, 'visions' and agreed targets on the one hand and actual and projected resources on the other. Some countries have used these to successful bid for increases in budgetary allocations to health. To do this effectively, cost estimates need to be prepared in a form that may be clearly linked to budgets, including cost implications of addressing systems/ institutional constraints, so that strategies include explicit analysis of the relationship between costs-outputs-outcomes. Broad-based efforts at costing have been made around MDG-based PRS(P)s to cost interventions required to achieve the goals. Information and technical requirements can be difficult to meet in most developing countries and it is

important for donors to ensure that developing this tool does not prove to be a additional burden on countries without clear links to existing processes, including costing information and methods already being used.

<b><i>Using costing to reconcile 'needs based' and 'resource constrained' strategies and bid for resources</i></b>
<ul style="list-style-type: none"> <li>○ <b>Rwanda, Senegal and Niger</b> have used multiple scenarios in their H-PRS(P) exercise to illustrate a 'high' scenario to bid for higher funding for potentially better outcomes and a 'low' case with prioritized expenditures to achieve best possible outcomes with more limited resources.</li> </ul>
<ul style="list-style-type: none"> <li>○ Detailed costing in support of rapid progress in reducing child and maternal mortality for <b>Mauritania</b> reported resulted in a 40 per cent increase in budgetary allocation to health.</li> </ul>
<ul style="list-style-type: none"> <li>○ In spite of a limited information base, <b>Yemen</b> has made substantial progress towards costing for health priorities, starting from MDGs and going on to include the broader National Health Plan (H-PRSP). For better use of this tool, alignment with existing methodologies and techniques needs to be better integrated into overall costing exercises to avoid duplication and inconsistencies (specifically, between existing GAVI costing and more a recent MP exercise for the same interventions. There was similar tension in costing exercises in <b>Ethiopia</b>, this time between the World Bank Marginal Budgeting for Bottlenecks and the MP costing approach).</li> </ul>

Linking budgets to **MTEF** in health needs to be anchored in agreed sectoral and national priorities. This is key as the MTEF 'approved' is essentially the annual budget for the base year and therefore must secure consistency between annual budgets, medium term expenditures and planning i.e. there needs to be clear mapping between sectoral and national budgets, MTEF and PRS(P) based on agreed priorities. This requires close collaboration between MoFPD and line ministries -- ideally, PRS(P) should identify spending priorities in consultation with MoH and based on the health component of the PRS(P)s and the MTEF/budgets shift resources towards these, both at national level as well as sectoral level. Country experience indicates problems with this coordination of sectoral and national budgets-MTEF-PRS(P) s and some cases are illustrated

below. In addition, minimum levels of public expenditure management are needed to ensure coordination of these three process at and between sectoral and national levels, including monitoring and evaluation and resource tracking. These are further discussed below.

<b><i>Coordinating budgets, MTEF and PRS(P)s based on priorities</i></b>
<ul style="list-style-type: none"> <li>○ Budgetary identification of priority expenditure programmes is often at the aggregate level, though in <b>Uganda</b> this is effectively supported by alignment with national goals, performance based reviews and transparency in processes.</li> </ul>
<ul style="list-style-type: none"> <li>○ Budgetary decentralisation as in <b>Ethiopia</b> makes a central MTEF focused on national priorities difficult to implement. One solution is addressing priorities through resources for national programmes anchored at provincial level as with the poverty health funds in <b>Vietnam</b>.</li> </ul>
<ul style="list-style-type: none"> <li>○ In <b>Ghana</b> bottom-up detailed costing has made it difficult to link these activities to budgetary shifts towards priorities in the MTEF.</li> </ul>

***Macro-economic frameworks*** are perceived as being too restrictive by MoH. One of the main issues here has been 'imposition' of expenditure ceilings argued on the basis of a lack of sectoral 'productive' absorptive capacity and consequent upsetting of macro-fundamentals -- exchange rate and inflation in particular -- should spending not be checked. However, evidence suggests that the binding constraint is, in fact, a lack of finance rather than a lack of capacity. Further, even these may be overcome relatively easily if the kinds of management problems highlighted through this document are tackled effectively, especially financial management. What is necessary then is open debate on the assumptions and rationale underlying macro frameworks and their practical implications for sectors. These then need be integrated into the PRS(P) processes so that both planning and budgeting can take be adjusted to address the implications.

<b><i>Identifying the source of limited sectoral absorptive capacity</i></b>
<ul style="list-style-type: none"> <li>○ Large disease specific programmes, specifically HIV and AIDS, associated with substantial in flows of funding ( as much as half the existing health budget in <b>Tanzania</b> for example) without requisite health systems scaling up do put absorptive capacity into question.</li> </ul>
<ul style="list-style-type: none"> <li>○ Centralised and complicated bureaucratic procedures in <b>Benin</b> and <b>Burkina Faso</b> have limited the use of available funds and require reform to overcome the absorptive capacity issue.</li> </ul>
<ul style="list-style-type: none"> <li>○ In <b>Uganda</b>, implementation rates have fallen off due to recruitment constraints linked to restrictions on public spending in a overall macro-agenda, creating issues of absorptive capacity. Public-private partnerships (with faith-based organisations) are being explored to overcome the problem.</li> </ul>
<b><i>Balancing the macro agenda and health priorities: lessons from the education sector</i></b>
<p><b>Tanzania</b> demonstrates that policy concerns can become important elements in parliamentary committee work -- there has been successful expansion of basic primary education in which MP's played a significant role by making education a priority and by mobilising efforts in their constituencies. In <b>Uganda</b> too similar political commitment to universal primary education has resulted a a relaxing of expenditure ceilings for the sector.</p> <p><i>MoH needs to be equipped with the same capacity for political lobbying.</i></p>

### **3. Broadening and deepening meaningful participation.**

One of the factors limiting MoH capacity to strongly lead and profile the health agenda has been the inability to cement **partnerships** with main actors. The key line ministry that impacts the functioning of MoH most critically is the **MoFPD** (sometimes two ministries -- finance and planning and development -- but very closely integrated). The PRSP process has increased awareness of health as a dimension of development but this has not been translated into health being profiled in the macro agenda and development efforts which continue to be strongly focused on tradition areas of economic growth. This is reflected in the strong dominance of MoFPD in its relationship with MoH. Beyond the lack of leverage in sector financing already discussed, the PRS(P) could provided MoH

with a platform to participate in development planning. However, the health component of the PRS(P) has often been written by MoFPD staff with little consultation with MoH or reference to any background health document prepared. As underlined above, MoH capacity for comprehensive planning is limited, however, the opportunity to strengthen this by enforcing a truly participatory PRS(P) process at the level of central governments has not been exploited.

Further, MoH have also not always been able to draw on support from **inter-sectoral partnerships** with sectors that directly impact health and their associated line ministries -- the health component of the PRS(P) remains largely a health *sector* document. Importantly, in a climate of constrained resources, there are efficiency gains to be made through joint activities in overlapping areas e.g. staff training and monitoring and evaluation.

**The private sector** provides a substantial share of health care in PRS(P) countries -- both the private-for-profit and private-not-for-profit sector (the entire range of NGOs, CBO and CSOs). Importantly, they are often the only providers in poor and remote areas underserved by publicly provided care. In spite of this, they have traditionally been left out of MoH planning for health, including crucial areas like accreditation and regulation of private sector activities. The PRS(P) process has begun to involve the more visible of these in some countries, usually faith-based organizations and international charities/NGOs in health planning. What is urgently needed in all countries is to successfully focus the private sector on stated health priorities with accountability -- they could make a potentially large contribution to progress towards the MDGs.

There is a lot of activity at **donor** level around the PRS(P)s, much of it around coordination and harmonization to improve aid effectiveness. These are discussed below as well. In terms of forging partnerships, there is a lack of clarity in, and over-burden of, donor approaches/processes that persist in three areas:

first, policy messages and approaches can differ substantially between donors requiring careful reconciliation and a phasing in of changes accepted based on country capacity; second, while there is considerable consensus at the global level to align donor activities at country level, this has yet to be fully operationalised in countries -- appropriate mechanisms as well as adequate capacity to implement agreements at donor country offices is still lacking; and third, increased donor activities almost always imply additional processes for MoH and, without full alignment, has meant a plethora of different contents, timelines and tools, not all which improve and consolidate partnerships.

<b><i>Strengthening MoH capacity to lead partners</i></b>
<ul style="list-style-type: none"> <li>○ In <b>Yemen</b> multi-sectoral technical committees for planning, implementation and monitoring and evaluation for PRS(P)s have been set up. These are useful platforms for strengthening inter-sectoral ties. However, the 'weight' of these committees depends critical on the interest on the interest taken in them by MoF.</li> </ul>
<ul style="list-style-type: none"> <li>○ The health SWAp has been difficult to implement. With low MoH capacity to integrate and lead this from within, agreement between partners on a mechanism to operationalise SWAps has been challenging in Yemen.</li> </ul>
<ul style="list-style-type: none"> <li>○ In <b>Uganda</b> an increase in public sector salaries for health staff caused an in-flow of workers from private, faith-based service providers. In recognition of the critical gap that these providers fill in health services (50 per cent), especially in poor, remote areas, the government has entered a partnership whereby it subsidizes the salaries of these organization, effectively drawing in private providers into public priorities.</li> </ul>
<ul style="list-style-type: none"> <li>○ This public-private partnership has also been effective in dealing with the freeze on public sector recruitment and resultant shortage of health staff. However, there still is lack of clarity regarding IMF 'recommended' restrains on expansion of the public sector and cases, like health, where this critically impacts key sectoral inputs.</li> </ul>

## 5. Utilizing the PRS as a mutual accountability framework between countries and donors

This is examine from the perceptive of MoH capacity and donor actions that could strengthen this capacity (in additional to points already raised in the previous sections).

Other than weaknesses in MoH capacity for overall planning and budgeting/expenditure planning, there are two other specific areas that need further attention in MoH for effective linkage between PRS, MTEF and budgets -- **financial management** and decentralization. Low and unpredictable budgetary allocations to health are exacerbated by inefficiencies in management of available resources. Most countries still have very centralized financial structures and cumbersome flow-of-funds mechanisms that result in inefficiencies in the distribution of resources to sub-national levels as well as difficulties in resource tracking and accountability. Also, allocations across items of expenditure need to be monitored, especially to balance monetary incentives for retention of staff with operational expenditures that impact quality.

<b><i>Strengthening financial management</i></b>
<ul style="list-style-type: none"> <li>○ <b>Ethiopia</b> has perhaps the lowest health expenditure per capita in the world, falling well short of set targets. Also, regional subsidies are not managed optimally -- forecasted to be 'flat', they provide little incentive for efforts to increase expenditures at sub-national level.</li> </ul>
<ul style="list-style-type: none"> <li>○ Actual disbursements have been low in <b>Benin</b> -- about 2/3 of the two percent GDP commitment to health expenditure (which in turn was about 90 per cent envisaged by the health-PRS(P) -- resulting in a reduction in the budget share in line with 'absorptive capacity'.</li> </ul>
<ul style="list-style-type: none"> <li>○ In <b>Burkina Faso</b> the MTEF indicated an increase in the health share of the budget based on availability of HIIPC resources but allocations to health actual fell in real terms due to low HIIPC spending.</li> </ul>
<ul style="list-style-type: none"> <li>○ Health spending has increased beyond targets in <b>Ghana</b> but this has been largely on salaries with expenditure items key for improvements in productivity have fallen off.</li> </ul>

The health component of the PRS(P) has not always been accompanied by an in-depth and comprehensive administrative review to ensure that the necessary underlying structure exists for implementation, especially key changes in doing business that it attempts to advance -- **decentralization** to promote ownership, transparency and accountability. In the health sector this a particular challenge as two difficult aspects need attention simultaneously -- implementation is dominated by fragmented categorical programmes which need to be fitted into a comprehensive whole based on common health systems constraints on scaling up and, at the same time, sub-national health systems need to be strengthened. Countries perceive pressure for 'full' decentralization - including fiscal decentralization - and have proceeded with legislation before the prerequisite structure (particular financial structure) has been established and capacity built for these substantial changes in administration.

<b><i>Problems in effective decentralisation</i></b>
<ul style="list-style-type: none"> <li>○ A policy of decentralisation (including public-private partnerships and performance-based contracts) in <b>Benin</b> has been limited in implementation by difficulties posed by over-centralised budget management. This is now being addressed with PRSC support.</li> </ul>
<ul style="list-style-type: none"> <li>○ In <b>Burkina-Faso</b> decentralisation has been slow in implementation due to complex and multi-level planning and procedures as well as low budget execution and late release of funds (due to constraints on HIIPC funds). Again, phasing in of decentralisation is now being supported through the PRSC process.</li> </ul>
<ul style="list-style-type: none"> <li>○ Division of roles and responsibilities in <b>Ghana</b> need more effective definition. MoH has a performance contract with General Health Services (GHS) but retains procurement, staffing and training responsibilities. Further, accessing MoH funds by districts is weighed down with multiple steps and procedures.</li> </ul>

PRS(P)s provide an opportunity for **donor harmonization** for strengthening MoH capacity which is yet to be fully utilized. There is the attempt at comprehensive planning for poverty reduction lead by the MoFPD. There is also area lead-- as by national commission of HIV and AIDS supported by GFATM -- that tries to bring all stakeholder under '3 ones'. What results is a reinforcement

of a fragmented approach that underplays overall health issues and dissipates the health effort, especially with respect to the overarching need to strengthen health systems that is a necessary prerequisite to all scaling-up strategies, including for HIV and AIDS.

Predictability of external financing is a key underlying determinant of **aid effectiveness** and a key prerequisite for creating the fiscal space necessary for scaling up health services. Financial commitments from donors need to be timed to inform the budget and equally important they must then be disbursed on according to schedule as well. A number of countries have experienced GFATM delays in matching disbursements to commitments causing critical disruptions in implementation, not just in HIV and AIDS programmes but, being very significant proportions of health expenditures, for overall implementation. This is particularly relevant if countries are to be 'fast-tracked' towards the MDGs.

***Other areas for reviewing donor assistance to strengthen the health component of the PRS(P)***

- The PRSC and SWAp (and general budget support) have been appropriate vehicles for addressing issues that are crosscutting for MoH and MoFPD. In Uganda this coordination is now strong enough for the PRSC to draw on sector reviews for health assessments.
- Joint reviews of sector performance need to be coordinated with the MTEF and national budget process and feed in to a national PRS (P) review processes. This has been effectively achieved in Uganda and Tanzania, where external partners work closely with Government and where the sector dialogue is coordinated around the annual budget cycle. Also, where emphasized by countries, this can also support the shift towards budget support as the main aid modality.

**5. Tailoring the PRS approach to conflict-affected and fragile states.**

***Experience from Sudan***

**Background**

The PRSP process was initiated in the North with the understanding that this would be part of a single PRSP document for the whole country once a peace agreement was reached and a corresponding document prepared for the South.

Progress has been slow -- and effectively stalled for the past two years -- but there are important lessons to be learnt here about *additional and specific* problems of developing and implementing PRS(P)s in conflict situation, notably in relation to governance and financing.

### **Additional and specific issues in conflict areas**

Clearly ***governance*** is a key problem and in conflict areas there two particular issues that stretch MoH capacity still further. First, consensus building is much more difficult, making agreements on health priorities harder to reach.

Underlying this is the magnitude and nature of the multi-dimensional problems that accompany conflicts. This makes it all the more difficult to identify health priorities specifically as well as their solutions without confronting the larger problems of the conflict itself. Second, peace agreements between conflicting domestic parties often have implications for the structure of government -- in Sudan, the South is to have a different administrative structure to the North. This in turn will impact both planning and implementation of health priorities in a single PRS(P) -- there would need to be, effectively, two management strategies.

Unpredictably in ***financing*** is more acute in conflict situations. In addition to the problems discussed above, MoH in Sudan receives a cash budget. And, due to the complete break down of health information systems-- such that did exist -- makes it difficult for MoH to respond to MoFPD requests to justify increases in allocations to health (the Finance Minister was in fact supportive of increases to health but needed evidence to argue MoH's case). In areas where external resources are available, the administrative shortcomings noted above have resulted in non-disbursement. Specifically, two rounds of GFATM grants have been delayed because of a lack of agreement on an administrating (international) agency in (perceived) absence of government capacity to handle funds.