DAY 3 Q&A				
DIRECT FACILITY FINANCING				
#	**Question**	**Asker Name**	**Answer(s)**	
1	"Wednesday is a difficult day"?? as "April is the cruelest month":))…. Not to worry, Joe, so far: amazing line up and great and engaging interactions, so we will survice Wednesday:))	Godelieve Van Heteren	Welcome back Godelieve! So nice to have you back for this session	
2	Joe - at risk of introducing further metaphors - we often refer to the 'plumbing' of financial systems (rather than engineering)!	Tom Hart	I am hoping it's not a conceptual difference :). Am fine with "plumbing". I've gone with "engineering" in part because of trying to distinguish "architecture" from "engineering". Many reforms (of health financing, of public bureaucracies) are focused on the "architecture" (structure) but not many really address the underlying processes by which those structures work (which yes, could be usefully seen as the "pipes"), which I've chosen to call "engineering". But either is fine - maybe this needs some work or dialog to get to consensus on the best framing.	
3	Wonderful topic! What of the challenge of rearrange the packages offered at primary care (rural care) to be attractve(this including a more capacitated workforce). As moslty rural health/primary health in LMIC have small unttractive packages and manned by low level skilled workforce.	Abdul Njai	A focus of direct facility financing is generally supporting a shift to PHC and specifically better functioning of remote rural PHC facilities to deliver services to poor/underserved populations, increase access, equity, efficiency, etc. Meeting the principles of facility autonomy and better facility management are possible in remote rural PHC facilities. The output-based payment principle is particularly important as defining the output (or service or package) to purchase as bundled PHC services incentivizes more comprehensive and seamless PHC services on the front-lines.	
4	A different context example is Ukraine. I believe they have DFF without necessarily labeling it this way because funds from the purchaser are transferred directly to provider bank accounts. Loraine can clarify/ correct. It would be good to look at these other contexts.	Elina Dale	live answered	I agree, Elina. Differences are often around the labels, more than the actuality. Look forward to hearing more about other contexts and experiences --- It is more about decision rights. Like who gets to order drugs. Stockouts is a major problem in NHS systems using Central Medical Stores model. Drug a availability is mission critical for the success of phc --- I agree. We have documented similar issues around limited facility autonomy in Philippines and Indonesia with PhilHealth and BPJS-K payments going to LGUs/districts instead of the PHC facility in the public sector
5	Very relevant topic!! however, We should bear in mind that primary health facilities often don't have the someone with the right skills (Accounting or financial management background) to manage funds which in turn affect the trust to directly transfer funds to them.	Joshua Elaigwu	live answered	I think this is the "chicken and the egg" point Sheila and Sophie were making.... --- In small facilities, it is relatively simple accounting and management. PHC facilities can be compared to small businesses where owners are responsible for both product/service and management/finances. But it is a good point in longer-term preparation for health facility management.
6	As usual: great presentation by Sophie. Thanks. Question: the idea of 'moving cash/money to the frontlines' (which is what DFF rests on) is shared by a lot of implementers of systems strengthening. There has been considerable discussion along the same lines in the wider PBF community of implementers and in large programs, such as NSHIP in Nigeria, some first attempts have been made to compare DFF sec and PBF (which could be seen as a kind of DFF with extra performance ingredients built in to address some of the issues of governance at local level also brought up in Sophie's presentation. Nigeria's experience has made clear that the PBF extra efforts helps adding quality life years. So a rising number of studies of PBF and DFF efforts are emerging. Would this be the time to start to join these various efforts to get to what 'ground work' is really required locally?	Godelieve Van Heteren	live answered	Good question, Godelieve, let's come back to this in the discussion - very relevant. A commentary is coming out shortly which tries to highlight what is shared between PBF and DFF and where the difference lie. It also highlights the common prerequisites, which are many.
7	Thanks so much Sophie. Is there not a risk of devising yet another system which may lead to the further fragmentation of allocation and payment systems?	nouria brikci	Hi Nouria I am not sure this is a new system, it is potentially just a (?better) way of channelling resources which are already meant to be filtering down the system. Or do you have a different experience?	
8	Thanks Sophie. Do you see DFF as having some of the benefits of PBF (ie greater autonomy of facilities to decide on priorities)without the complex and costly verification systems as well as concerns about by-passing gov't systems	Sarah Fox	Yes, I think they share many features but there are also differences (particularly for verification, DFF is simpler and more integrated)	
9	In short: the PFM, DFF, PBF conversations should start to join firmly (as in practice they actually already start to do).	Godelieve Van Heteren	Absolutely. They share many concerns and approaches	It's likely that these conversations will open the door to more technical discussions on choice and methodology of provider payment systems (e.g. fee-for service vs. formula-based, level of bundling and purchaser vs. provider risk, etc.)
10	In addition, experience in implementing financial management intervention in Nigeria by building the capacity of the health worker hasn't been successful because this workers are often burden with provision of healthcare services.	Joshua Elaigwu	Wole will provide some further insights on Nigeria.	
11	Question for Sophie: At the country level, how do countries decide to go into DFF in the context of parallel private sector delivery systems? DFF is a substantial investment.. how do countries decide? urban versus rural? lack of private sector?	Sarbani Chakraborty	DFF tends to focus more on the public financing, Sarbani, and should focus on the levels which are delivering the essential service package to the population (which are often underfunded)	Through output-based payment principle, DFF has the same purchasing options as health financing/purchasing in general. Meaning ownership doesn't have to matter, contracting with private providers is possible, etc.

12	In DFF, who would be the facility "managers"? Are we expecting health workers to allocate time to management (which they may not currently be doing)?	Lorena Prieto	Thanks so much for your question, Lorena. This resource on Direct facility financing principles may help you answer your insightful question: https://b7ef309d-372b-4222-850b-df85c90598f2.filesusr.com/ugd/18961e_1e2504a1902848f2a2a8d9486750a880.pdf	
13	Thanks for the presentation. Could you explain how is the participation of the population in the management of services? what role do they have?	Vilma Aurora Montanez Ginocchio	I think they are often represented on health facility management committees, to overview budgets, activities etc	Yes, in general, the population should participate more in facility governance than facility management. Specifically, being members of health facility governing committees or participating in facility citizen engagement including public planning and budgeting meetings (which might be more active meetings if the facility has funds to plan and budget).
14	I don't see DFF as another system but rather an opportuntity to improve how funding reaches the providers. This could be used to get government budget funding to primary healthcare providers as opposed to being "stuck" at the district level which is what happened in Kenya because they were not considered accounting units and therefore could not receive funds directly from Treasury for O&M costs.	Agnes Munyua	Totally agree, Agnes	Totally agree. It shouldn't be another system or program or scheme
15	I think in many of the RBF/PBF experiments the DFF element was the magic ingredient, the thing that made it work. If I remember correctly the study by Friedman et al showed it for Zambia. Would be interesting to hear from Sophie and others on this and hence, one can have other payment methods like capitation, FFS etc with DFF (hence disentangle DFF from PBF, which it gets entangled with sometimes).	Elina Dale	I think there is lots of debate about magic ingredients! But flexible resources, autonomy to use them, and discussion in results/problem solving with supervisors commonly come out as top. So these matter whatever the label. I agree that the basis for paying can vary, Elina	Zambia started with Swedish style decentralization but also quasi autonomous county boards outside MOH where they were paid more. This is a getting to Denmark issue. If the countries were like Denmark they wouldn't need development assistance
16	and suspect DFF lends to increasing transparency of facility level funds?	Masuma Mamdani	It should do, I agree - and good to put systems in place to support that, e.g. through committees that include the community	Yes, should increase transparency of facility level funds in a number of ways including output-based payment where the amount the facility should receive is clear and transparent, role of facility governing committees in separation of functions, and facility accounting and reporting systems.
17	Sheila O´Dougherty, interesting. What are the funds control mechanisms? How do you avoid corruption problems?	Vilma Aurora Montanez Ginocchio	live answered. A number of ways to increase transparency and reduce corruption: 1) better facility financial management (mgmt) through planning, budgeting, procurement, internal controls, accounting, financial reporting, internal and external audit (better public financial mgmt similar to private financial mgmt); 2) better separation of functions at facility level with facility governing committees having roles in approving plans and budgets, authorizing procurements, signing for goods delivery, etc.; 3) better separation of functions across the system with the facility and higher level governments both having roles in authorization and payment making it more transparent; 4) publicizing payment rates so everyone knows how much funding facility should receive.	
18	As you are aware, Afghanistan health services financing moved back to emergency and humanitarian approaches. As before the NGOs are awarded short term contracts for managing number of health facilities in a province. Despite claimed performance based financing, the health facility staff never received incentives to improve performance. With that I wanted to ask whether it is time to recommend DFF for Afghanistan? And what are some of the precondition that should be satisfied?	Farhad Farewar	Interesting to think about how far the preconditions are met in crisis settings, Farhad. DFF does rely on systems having basic functionality (transfers, accounting etc). Are those in place in Afghanistan at the moment?	This resource on Direct facility financing principles may help you answer your insightful question: https://b7ef309d-372b-4222-850b-df85c90598f2.filesusr.com/ugd/18961e_1e2504a1902848f2a2a8d9486750a880.pdf ¨ --- The short answer is yes in the sense that DFF is intended to establish basic principles while leaving space for country flexibility. Facility autonomy and management would seem to be requirements in fragile countries without strong governments. There is an important provider payment aspect in that output-based payment should pay average cost across a group of providers. If short-term contracts pay a different rate to facilities providing the same services to populations with largely the same characteristics, it'll be very hard to shift to national or strategic purchasing later (facilities addicted to their own rates)
19	No experience with this no Sophie, I was trying to understand how it would fit with payment mechanisms. I understand it may be better way of allocating resources, but there seems to be output based indicators associated with the disbursement itself, hence my question on how fits with other payment mechanisms. I will read up some more and try to get my head around this!	nouria brikci	In the literature I reviewed, the budget were set prospectively, so not linked to outputs, but it is clear that it varies across contexts	It could "fit" with payment mechanisms through the type of provider payment system used: either flat fee or formula-based where policy objectives or "indicators" may be built into payment adjustors (relative payment weights) and provide incentives.
20	Sheila's sheets show very clearly what the required 'ground work' for DFF consist of (systemically). To those who complained about the 'administrative burden' of PBF/RBF programs in the recent past: they were composed exactly of the same 'ground work' costs. So shifting things to PBF/DFF will NOT do away with that type of investment needed (in local governance, accountability etc.)	Godelieve Van Heteren	I agree. DFF is not simple. The investment in systems is needed whether for RBF or DFF	No doubt investment is needed in any type of system strengthening or management improvement. However, valid almost philosophical questions do arise related to respect, trust, and whether health facility capacity needs to be built or unleashed. Small public health facilities can be compared to small owner-operated private businesses, to start, the management does not have to be that complex. And the "groundwork" to build a sustainable basic management platform is not the same "groundwork" as 100% vertification or auditing of transactions with its high administrative costs.
21	Agree with the views expressed before that DFF is not a new financing method but rather a general principle about getting cash to front line facilities. RBF schemes, purchasers also deliver funds to front line facilities directly. So need to bring all together under common umbrella and discuss what is needed to make it work, including PFM requireoments, autonomy. Whether funds are provided linked to some outputs or without, in the direct facility financing context are nuances that come with their own up- and downsides.	"Toomas Palu	I agree. We try to make this point in a commentary that should come out shortly -I will share it, hope you find it meets your point	

22	How is the verification system organized in the DFF? By whom is it carried out? Does this verification also involve the community? What are the institutional arrangements involved? Do you have an estimate of how long it'll take to pay the health facilities with this approach?	SERGE MAYAKA MA-NITU	Standard facility reports and audits, Serge, at least in my understanding	Basic business financial management (public or private) does not tend to include "verification" as it's more associated with auditing. The focus is on accounting and financial reporting. Roles include facility management, facility governing committee (including citizen representation), and local, regional and national government oversight. Step-by-step, facilities are being included in internal and external auditing in Tanzania. All aspects of direct facility financing in Tanzania were introduced in the space of about 1 year although continuous improvement will go on for years to come.
23	Corruption is with this scheme avoidable or controllable?	Sabine Schmitt	Corruption is not completely avoidable but is controllable using: 1) more transparent output-based payment rates; 2) better facility management including procurement internal controls, accounting and financial reporting; 3) better separation of functions between facility management and governing committee including citizen participation; 4) better separation of functions and transparency between national or local governments and facilities; and 5) beginning to incorporate facilities into country internal and external audit functions.	
24	So, basically, DFF is how it works in a single-payor systems, right? If agree, would you say having such a system is the best environment for DFF? Or that it is a precondition?	Saro Tsaturyan	Thanks so much for your question Saro. General principles on DFF principles can be accessed through this resource: https://b7ef309d-372b-4222-850b-df85c90598f2.filesusr.com/ugd/18961e_1e2504a1902848f2a2a8d9486750a880.pdf Additionally, you may want to look into this review of country level experiences on facility level financing which may give you a broader overview of ral world experiences: https://b7ef309d-372b-4222-850b-df85c90598f2.filesusr.com/ugd/18961e_c8d59b32460042bfb8b9ae77462dfe29.pdf I hope you'll find them useful!	Where single-payer does exist, DFF can increase facility autonomy and improve facility financial management/accountability which is likely to enable more strategic purchasing and provider response to financial incentives. Where single-payer does not exist, DFF can help move towards either a single payer or less funds flow fragmentation in two ways: 1) improve facility autonomy and financial management /accountability; and 2) unify payment across fragmented funds flows to harmonize financial incentives at the facility level
25	Question: est ce que le GFF utilise l'approche Financement basé sur les Performances (FBP) pour payer les prestations des services et soins de santé offèrent par les Formations sanitaires aux populations qui les fréquentent? Aussi, les structures de santé ne peuvent elles pas avoir l'appui de GFF et prester les services de santé? Prof ELOKO	Prof ELOKO EYA MATANGELO Gérard	Non, ce n'est pas la meme approche, mais il y a des ressemblances entre les deux, et ils peuvent etre utilises en meme temps	
26	and in continuation to Serge's comment, would this DFF system not suffer from the same limitations that PBFs suffer from in relation to management burden, or verification costs for example? Not familiar enough with DFF so thanks for enlightenment!	nouria brikci	The reporting on DFF should be part of the integrated reporting system, not additional. Same for verification. (In theory.) So poses a bit more by way of risk, but also potentially simpler and more integrated system	
27	Not to open a can of worms: but 'Drugs supply is complicated' is the understatement of the year. We all know it is a business model for some. How to move on this aspect (which takes up quite a bit of money, centrally/decentrally)	Godelieve Van Heteren	Prime vendor model or adding competition/accountability is mission critical to success.	
28	Thanks!	Lorena Prieto		
29	How does vertical financing - direct to the districts or possibly to the facilities fit into the DFF model? pooled or remains a separate fund for purposes of reporting?	Masuma Mamdani	In TZ vertical programmes are still operating separately. However, there are some projects that are starting to align to DFF modality and use country PFM systems (PlanRep and FFARS).	
30	Excellent and nuanced presentation, Sheila! Muchas gracias!	Godelieve Van Heteren		
31	Great presentation, Sheila! I appreciated the links between DFF and other elements of the health system. Great to "see" you!	Lisa Fleisher		
32	fabulous presentation, thanks Sheila. Are interoperable information systems a prerequisite for successful DFF?	Matthew Boxshall	While interoperability is not a minimum requirement for DFF implementation, having it helps to simplify management at service delivery level. In Tanzania, Planning, budgeting and financial management system a interoperable hence plans and budgets are automatically exported to the FFARS (facility level financial management system for execution). Interoperability also help to simplify national level consolidation of accounts hence building more trust with the ministry of finance. And interoperability of PFM and health information systems brings together health and finance data and reduces fragmentation.	
33	Michael, you are funny as usual :) This is my quote of the day: If the countries were like Denmark they wouldn't need development assistance.	Elina Dale		
34	Evidence seems limited but what about evidence on DFF and impact on equity, has there been analysis of this e.g. benefit incidence analysis? Some (not strong) evidence on user fees, but what about the impact of greater community involvement in DFF and making a stronger link between resource allocation decisions and what the public wants – does this lead to greater access for all/most marginalised?	Iain Jones	Equity is inherent in DFF in at least 3 ways: 1) financiing front-line PHC facilities serving poor/underserved directly; 2) building in an equity payment adjustor (relative payment weight) in formula-based provider payment system (paying remote facilities in underserved areas more); and 3) reducing fragmentation and increasing efficiency to extend coverage.	
35	Could you post the link to the meeting resources (that Helene posted a few times yesterday) in the chat? The background documentation for this meeting is really useful. Thanks!	Kara Hanson	Hi Kara, you can access the resources here: https://www.pfm4health.net/projects-2-3	
36	Nirmala, thank you. You made a very interesting point. Public financial accounting helps to better manage and control resources, but I believe that it is taking a position that goes beyond its role. Financial management in health oriented to the search for results goes further and that is perhaps the mistake, trying to get the first solution to solve both	Vilma Aurora Montanez Ginocchio	thanks, i agree. sequencing is always critical...	
37	Do I understand right that 3rd world countries will receive money from the IMF or Worldbank to build hospitals and health institutions? Will those hospitals receive then more credit for running the hospital and will it thus be under control of an installed international system? Is the respective country free to decide which company will build the hospital? Will the hospital have contracts with international pharmaindustry? Can the respective country terminate the contract with the financing bank, with the control systems, with the pharmacompanies?	Sabine Schmitt	From the example I gave, the World Bank has moved away from infranstructure support to service delivery and health financing reforms to help government to be more efficient in the use of funds and to address equity - make government services pro poor	

38	Thanks all, great presentations. Sheila, you mentioned that there was political will for DFF for schools, and this was what made it politically possible to introduce it for helath facilities too. Could you say a bit more about that?	Julia Watson	Answered live. DFF first in schools was interpreted as high level political support to improve front-line public service delivery so extended to health. The perception was that heatlh benefited from school DFF as there are more schools with more predictable use, better management and greater (happier....) citizen involvement.	
39	'@Elina DFF ('cash to the frontline) definitely helps. But so do some of the operations around it (unified systems as Sheila sketched), accountability mechanisms set up, data culture being more structured. So it is a mix. PBF for me is like DFF and all the systemic groundwork sketched by Sheila and Sophie. That's why the PFM/PBF and DFF people should start to work even more together than they already do)	Godelieve Van Heteren	I agree, and I think that these conversations at Montreux are helping to advance that process. Many of these 'labels' are converging, which is great	
40	I agree with Wole on the multiple approval being a challenge. That is also compounded by the fact that the funds after reaching the facilities can only be utilized by the managers only after their workplan are approved, which shows the lack of trust and autonomy.	Joshua Elaigwu	Interesting point. i wonder if integrating facilities fully into PFM processes might also feed into this, with facilities now needing approval for budget changes.	We'll see....but to date in Tanzania, in facility financial management (not clear yet on purchasing side), integration into PFM systems is bringing more trust and flexiblity including the right to do mid-year plan revision and to carry over funds to next year.
41	I do agree that efficient PFM and DFF should be in place to ensure on-time fund transfers to health facilities and the sufficiency of their financing. However, implementing the PFM and DFF highly requires practical and efficient manuals for PFM and DFF. Thus, would you mind sharing such manuals?	Soulaxay Bounthideth	Thanks for your question, Soulaxay. A prelimary document which conceptualises DFF can be accessed here: https://b7ef309d-372b-4222-850b-df85c90598f2.filesusr.com/ugd/18961e_1e2504a1902848f2a2a8d9486750a880.pdf A more comprehensive manual is currently under development	
42	Question to Michael: Of course we would love to hear more about how TGF relates to the DFF/PBF debates	Godelieve Van Heteren	We don't really have a position but in countries were we were supporting PBF, which is few, this is the direction of travel for all partners. But it is not just a bank account, it is basic accounting, management etc which is beyond scope of GF and we would do in partnership most likely with WB or other multilaterals	
43	The Foundation has supported DFF-related investments in Northern Nigeria and elsewhere and many of points raised in the excellent presentations resonate. Goals were to increase PHC/immunization financing through DFF, including: strengthening financial management and management overall; close connection to the community and validation of services provided; clear accountabilities for results- linking to repeated engagement with local governors; organization and flow of data, etc. Challenge is opening bank accounts where there are no physical banks-- but banking can be virtual. Lots of experiences to share at a future meeting.	Logan Brenzel	Thanks. In all cases in my experience all health facilities have bank accounts on the projects I referred to and for the BHCPF. You can have your bank in LGA HQ if it is not locally available in the town or village	
44	I like FLF used in the report for the Global Fund (facility level financing) ;-)	Bruno Meessen	Yes, both are FLF, with different conditionalities and verification arrangements	
45	Nice summary from Sophie on common elements: Autonomy, direct transfer of funds, importance of information systems, and a definition of performance (although how it is defined differs in PBF and DFF).	Elina Dale	She missed clinical strength in hand professionalization of phc as a speciality and CME for doctors, nurses	
46	Are facilities operating under DFF public or they can be private as well?	Farhad Farewar	Also private as long as they are authorised to deliver services to patients and communities. More can be found here: https://b7ef309d-372b-4222-850b-df85c90598f2.filesusr.com/ugd/18961e_1e2504a1902848f2a2a8d9486750a880.pdf	
47	The picture shows Nirmala and not Sophie	Sabine Schmitt		
48	I agree with where this conversation is going. I think it's more helpful to think of DFF not as a model but as a way of carrying out a function	Cheryl Cashin	Indeed, we agree	
49	What evidence do we have on cost (and cost-effectiveness) of PBF vs DFF? From recollection in Nigeria, PBF cost about twice as much as DFF (because half of the funds in PBF were used for staff bonuses). This will be a crucial issue for many resource-constrained countries, especially with the post-covid fiscal challenges we heard about yesterday.	Tom Hart	The short answer is: not enough evidence! The few studies to date have found lower costs for the 'dff-like' approach or arm, compared with PBF. With similar outcomes. But we need more depth and better methods for analysing this	Tanzania has evidence on reduced cost from efficiency gains and lower administrative costs related to reducing fragmentation and duplication in health systems, PFM systems, and across public sector systems.
50	Sophie's list of comparing DFF/PBF is good and yes: there is tremendous convergence in practice: (i) autonomy = both; (ia) output based = both (ii) cash to the frontline = both (iii) accountability requirement = both; (iv) separation of functions = bit more in PBF but also needed in DFF; (v) performance definition = more prominent in PBF; (vi) indicators of performance and verification = bit stronger in PBF (but most likely also needed in groundwork of DFF); (vii) systemic integration = in both. (viii) link to decentralization processes = in both. In short: in practice, a lot of convergence is happening which is GREAT, for now we can all get serious about realistic output based financing.	Godelieve Van Heteren	I agree, though depends a bit how you use output-based payment; DFF often uses prospective payments, but gets away from rigid input-based budgeting	
51	Can I ask a very stupid question? Joe, Sarbani, if we have a system where providers are in CoA and the budget is approved at facility level (like we had at some point in KGZ when a purchasing agency could not shift funds between providers without going to MOF), is it a DFF? I mean the budget is approved for each facility and one can trace budget execution to the facility level. But Sheila kind of answered it now: DFF has to be accompanied by the output-based payment. Is this right?	Elina Dale	Sheila is using output-based payment in a broad way, to include capitation etc (I think - Sheila will correct me if I am wrong)	Kyrgyzstan finances facilities directly as it has facility autonomy (bank accounts or Treasury sub-accounts), output-based payment (yes, PHC per capita and case-based hospital/DRGs are output-based), and facility financial management systems. A big difference between Kyrgyzstan and Tanzania is single-payer/less funds flow fragmentation in Kyrgyzstan. In Tanzania, DFF is a good first step to move towards more pooing in national health insurance. Have personally always believed it's harder to compare PFM rigidities in Kyrgyzstan to other countries as labor costs (and their major regulatory issues) were incorporated into output-based payment.
52	My question is for Odutolu. Can he go back to the lessons learned from the DFF in relation to PBF in relation to the experiences he has followed? What's the added value of the DFF in relation to the PBF/RBF and how to achieve a good articulation or complementarity in the institutional set-up or design between these approaches?	SERGE MAYAKA MA-NITU	◦DFF and PBF are on the same spectrums and PBF is just one end of that spectrum - provider autonomy, financial management capacity, and output orientation. Sheila put it very well - DFF is like the base of a pyramid - make fund available for operations and you can build on that - with PBF or other output based approaches or demand side intervention	

53	'@Sheila - a bit of a follow-up from Nouria earlier on fragmentation. DFF is more integrated than PBF, but is still not 'fully integrated'- is it? What was the reason in Tanzania for keeping the Basket Fund DFF grants separate from the government local grant for operational costs (Other Charges)? Is there going to be scope for further integrating these in future?	Sierd Hadley (ODI)	Good question. Two reasons for less than optimal integration or retention of greater than optimal funds flow fragmentation: 1) in an underfunded system, receipt of revenue wins out over reducing fragmentation; 2) it was explicitly viewed as a step-by-step process with the assumption that both domestic general revenue and envisioned national health insurance revenue would be incorporated.	
54	DFF is meant to get the optimal value of domestic budget allocated to public health facilities. Is there any attempt to use that "output-based approach" to ensure good service provision from private health service providers? In Tanzania, there are other instruments to contract out private facilities (or at least there were) and give them a public mandate (service agreement), but how do all these reforms "align" to ensure that the overall service provision meets its objective, in terms of outputs, but also in terms of input mix, whcih implies	"Fahdi Dkhimi (Q&A support	I hope others on the panel will answer, but ccertainly I can imagine DFF being used for the PNFP sector in many settings.	Absolutely. Output-based payment and its associated delegation of rights to facilities (autonomy and financial management/ accountability) can enable contracting with both public and private facilities. However, there are difficult issues including how to handle labor and capital costs, and tax status and policy.
55	Excellent presentations and discussions. Not a question, but i feel we need to move away from being able to track every source of funding separately at the facility (and possibily even loal govt) level, and monitor the total and composition of that income, while focussing on the outputs, and broad categories of expenditure. Zambia had that right from 1993 when the decentralisation and the health basket were first employed, and is something which Tz has been unable (as far as i'm aware) to let go of .	Sally Lake	There has been movement on this front in Tanzania through the use of one accounting and financial reporting system (FFARS) for all revenue sources/funds flows and their expenditures. The transformation is not yet complete as facilities still track....but by adding revenue accounts and their expenditures in one system rather than using multiple systems. Step-by-step.....	
56	In other countries, like DR Congo or Niger, we have instances where there are no banks and need to find alternatives.	Logan Brenzel	This is a clear challenge to both models, I agree, Logan. What alternatives has anyone come up with?	
57	ALso, to move toward strengthening the supervisory level (eg council/regional etc to focus on the monitoring, supervision and verification functions	Sally Lake	agreed. this is a very important role for the local govt.	Yes, shift from operational management to a combination of support and oversight.
58	Will all these great questions be available to view after the event? I can't keep up with them all now but would love to be able to go back to them.	Julia Watson	The questions and answers will be posted on the Resource Portal for this session, as well as others.	
59	Many thanks Federica for your sharing.	Soulaxay Bounthideth		
60	Thanks @Gemini Mtei for very rightfully pointing out that with any shift of money from A to B comes a shift in roles, accountability, governance. That is all part of the 'groundwork' of transition, and that is where the concerted efforts should be, whether in PBF/PFM at decentral level, or DFF. So a lot of shared work ahead.	Godelieve Van Heteren	Agreed	
61	For Michael and Nirmala, in Indo, one ST solution is that over 50% have voted with their feet and moved to private PHC providers. For the public PHC, the sadder issue is the poor often have no choice, but forced into the public Puskesmas by the local governments.	Jack Langenbrunner		
62	Sophie you mentioned a review of literature previously done: woudl you be able to share link to it?	nouria brikci	We did a report for the Global Fund - it should be on the participant portal for you to access. If not, let me know and I can share directly	You can access it here: https://b7ef309d-372b-4222-850b-df85c90598f2.filesusr.com/ugd/18961e_c8d59b32460042bfb8b9ae77462dfe29.pdf
63	Priority is the wellbeing of all human beings, and not money, greed, power, etc.	Sabine Schmitt		
64	excellent session thanks	victoria bertolino		
65	Mike of the IT support: you have a great BBC style radio voice (if ever you consider a career shift):))	Godelieve Van Heteren	Thank you! :)	
BUDGET EXECUTION				
66	Great slide, Mauritz. I wonder if poor execution is related to (relatively) large share of supplies (goods and services) in health budget?	Kara Hanson	live answered	Thanks so much Kara - yes very good point. In countries with a larger wage bill, the health budget is better executed. Also means that the smaller the goods and services budget, the less likely under-execution will happen. Hence, only looking at the execution rate can be misleading.
67	Really nice, Moritz, would add that P Berman and associates did State by State in India a few years back, and found a similar (sad) correlation of poorer states with higher levels of unspent funds.	Jack Langenbrunner		
68	Does the data points out deprioritization of health for any particular buildings blocks of health systems in budget of LMICs? And would data be different for federation vs confederation vs unitary system countries?	Dr Muhammad Fahim	The data unfortunately doesn't always allow for clear differentiation of building blocks. Wage payments tend to be executed in full. In a federal context, the credibility of fiscal transfers to states becomes very important. This can be an additional layer of uncertainty compared to a unitary system.	
69	Thanks Moritz. These are fascinating slides! Anyone aware of similar analyses applied to aid actors involved in UHC? ;-)	Bruno Meessen	Hi Bruno, from Sierd below in case not seen: @Bruno - there are some studies of the gap between commitment and disbursments by donors. A bit old now, but here's one that looks sector by sector: https://www.sciencedirect.com/science/article/pii/S1879933713000249	
70	Very interestin. In terms of efficiency, colleagues by the IDB once noted that an efficiency review would be taken by MoFs to first press MoH on improving its budget execution, rather than address underlying causes of inefficiencies in health.	Odd N Hanssen		
71	En RDC, le Budget de l'Etat alloué à la Santé n'est pas exécuté à 100% la moyenne des exécutions est au tour de 67 % (CNS 2020 RDC) Prof ELOKO	Prof ELOKO EYA MATANGELO Gérard	Bien noté.	
72	Data is very useful and would be great to have published by the Bank / IMF / etc. One question related to Kara's - did you look at different sectoral execution rates for non-wage recurrent spending specifically (rather than overall spending)? Does it tell the same story of relatively poor execution?	Sierd Hadley (ODI)	Thanks Sierd. Yes, aboslutely. Would be great to systematically collect and publish this data. PEFA annex data are available, but could become more accessible. On wage/non wage spending, wage spending tends to be implemented in full while non-wage recurrent is often crowded out. In cases where the wage budget is over-executed (e.g. unplanned wage increase) this has repercussions on implementing the non wage budget.	
73	It is a great start for me to have a better understanding of budget execution. As I understand, budget execution generally refers to circumstances where the approved budget is not spent all (below 85% as under execution). In the case of some LDCs, the budget ceiling (plan) is revised one or two times before approval. The revision usually brings the budget ceiling lower as a budget constraint, which is often not enough for health financing to ensure UHC. In this case, is it still referred to low budget execution?	Soulaxay Bounthideth	Budget execution rates (even if implemented in full) can mask problems in the detail. E.g. there can be overexecution of some items, and underexecution of others. I am not aware of an explicit threshold. PEFA classifies 'D' if over/under execution of 15 percent.	

74	'@Bruno - there are some studies of the gap between commitment and disbursments by donors. A bit old now, but here's one that looks sector by sector: https://www.sciencedirect.com/science/article/pii/S1879933713000249	Sierd Hadley (ODI)		
75	The health sector is organizationally more compex that other sectiors, e.g., eductiuon, with multiople playewrs. Poor budget execxution may therefre arise because of thuis comoplexity and the assoicated fragmentation, as well as lack of coordination.To what extent is poor budget execution in health a result of a very weak center, i.e., the finance or budget department in the Ministry of Health. If the center were strengthened and took reposniligy among other things for montoriing budget execution would this not health enormously.	Richard Allen	live answered	
76	Is there observed differences between Beveridge/Semashko (integrated) vs Bismarcian (purchaser) systems in absorbing funds?	"Toomas Palu	live answered	Thansk so much @Toomas. YEes, very important question. We don't have systematic data on this, but found that countries that subsidize a central purchasing agency implement the subsidy more reliably than if they deal with multiple providers directly. The multiple providers have less bargaining power and political weight than the central purchaser
77	Can you please share the link to the recordings again? Thanks	Saba Waseem	Hi Saba the recordings will be available on the event page after the meeting : https://www.who.int/news-room/events/detail/2021/11/15/default-calendar/5th-meeting-of-the-montreux-collaborative	
78	In my opinion, one of the reasons for the under execution of health budget or deprioritization of health, in practice, is that the share of health is not reasonably determined in compare to other sectors such as education. Iran is a clear example. The health share of GGE in 2018 is about 23 percent of the government's public budget; In contrast, the 8% share of education or other sectors such as employment is a larger and significant share.	Tayebeh Moradi	The de-prioritization of health in mid-year budgets is another aspect we see in the data analysis. Health is systematically de-prioritized in comparison to other sectors in LMICS, between 2008-2018.	
79	Excellent presentation by Dr Helene Barroy, very clear and concise. I would like to know whether the assessment framework for health budget includes a recent Health Systems for Health Security framework by WHO. And with limited data input from LMICs would the framework be adaptable for executing a good health budget.	Dr Muhammad Fahim	Not to my knowledge	
80	Apologies bu I sent my question to early. Here it is again.The health sector is organizationally more complex that other sectors, e.g., eduction, with multiple players. Poor budget execution may arise because of this complexity and the assoicated fragmentation, as well as lack of coordination across the sector.To what extent is poor budget execution in health therefore a result of a very weak center, i.e., the finance department in the Ministry of Health? If the center were strengthened and took reponsibility among other things for montoring budget execution would this not help enormously?	Richard Allen	live answered	
81	Question to Helene, I have not see provider payment as a possible cause for low budget execution. If I am correct, Niger was among Moritz' countries with low budget execution. Yet, there is a selective free health care policy with substantial arrears to be paid to health facilities. So it would be quite 'easy' to execute the budget at the end of the year. But maybe the payment of the detailed bills sent by facilities requires a lot of paper review at higher level... Maybe a lumpsum payment to compensate the free health care would do better (although I also saw Burkina in Moritz' list). I have not see Burundi in the list. It would be another comparison point. Any thought on that?	Bruno Meessen	Absolutely. The way money is allocated and "paid" to providers matters a lot, ie by inputs, through a lumpsum, global budget, etc, for the quality of budget execution in health.	
82	can't hear Loraine.	Elina Dale		
83	Also on the de/prioritization of health compared to education: Health is highly individualised whereas education can generally be provided in a more 'uniform' manner. Also the concept of "universal" in education sector refers to a min. level of schooling but in health, universal health coverage is much more challenging for countries to determine what public money should cover...	Justine Hsu	Agreed.	
84	The observation that cash rationing leads to a reversion to input-based disbursements is really interesting. Would be interesting to find out if this is the case in other countries (I would assume it might be) and to what effect.	Danielle Serebro	It does happen in Ukraine too when there is cash rationing. This is one of the reasons health sector fought hard to put providers outside the Treasury account system	
85	I think the last slide on Ukraine is very valuable. It shows also that just giving autonomy is not going to solve the problem of budget execution. Lack of accountability framework and under-resourced audit of health provider invoices to NHSU are very important. Excellent demonstration of the utility of the analytical framework.	Elina Dale		
86	Shall we be able to access the recorded sessions?	Boniface Mbuthia	Yes, they will be posted on the event page.	
87	Question to Loraine on whether UKR experience is very unique or if there are other settings where this was the case. Also, what is the role of the purchaser in addressing these challenges?	Elina Dale	live answered	
88	Félicitations à Helène Borroy pour sa présentation très claire et précise	Prof ELOKO EYA MATANGELO Gérard		
89	Question to Moritz/Helene - are you doing some qualitative country case studies (positive and negative deviants)?	Bruno Meessen	Yes, case studies are ongoing by WB and WHO. We can present the results of this work in the next conference.	
90	Also just in case people are interested - the UK faces similar issues with capital budget execution relative to plan and politics plays a big role. https://ifs.org.uk/publications/13155	Sierd Hadley (ODI)		
91	very good points from Helene!	Elina Dale		
92	Bonjour tout le monde	Hassan SEMLALI	Bonjour Hassan	
93	Thank you so much for the insist, which helps me to research more on that.	Soulaxay Bounthideth		
94	I live in a country there are conflicts due to military coup. The formal health systems is at a state of near collapse. Is there any specific way or model for fragile and conflict-affected countries for PFM/health financing?	Sai Htet Aung	Yes, you can look at NGO contracting and how contract management is conducted. This would be paprt of the execution system. Somalia for example offers interesting insight on this. MOH does the contract management and MOF does the payment to NGOs.	
95	How much of the reforms and work is legislative and largely outside of the health sector, working with different sets of stakeholders? How do Ministries approach these types of reforms?	Logan Brenzel		

96	The rules, the procedures that are separated from them and the administrative systems that support them help to make the execution of health budgets transparent. However, we focus so much on how much information we can collect and report that we forget that the problems of low execution are that these systems have become endocentric and do not support improving management and decision-making. For example, purchasing procedures are increasingly sophisticated in terms of procedures, but they fail more and more in opportunity and do not prevent corruption in purchasing. Another example: administrative systems obtain detailed information on the inputs used by health services but do not allow knowing how much they can achieve with that, the goals are not really linked and it is loosely deduced that they are met because they consume a certain amount of inputs. Perhaps in the budget execution we are asking ourselves the questions of what we have? But not what is expected to have? sorry my comment is too long	Vilma Aurora Montanez Ginocchio	Thanks so much for this excellent comment. Fully agree that addressing all these issues and an emphasis on curbing corruption is warranted to address efficiency. Use of financial management information systems can be valuable to track execution and ensure transparency in the process.	
97	A mon avis les insuffisances dans l'execussion budgétaire relèvent essentiellement du volet investissement dans le budget, ceci est dû essentiellement à la gouvernance dans l'exécussion de ce budget qui est généralement confié à des responsables qui n'ont aucune expérience dans le domaine, notamment pour les grands projets de construction. Si le problème ne se pose pas pour le volet fonctionnement du budget, je crois que le budget d'investissement doit être confié à des responsbles métiers qui auront les compétences requises pour l'exécussion, le suivi et l'évaluation de cette exécussion.	Hassan SEMLALI	Oui, en effet, les données montrent que le budget "investissement" (dépenses en capital) est souvent sous-exécuté. Comme vous le soulignez, le problème vient souvent de l'inexpérience des acteurs du secteur dans les projets de construction de vaste ampleur.	
98	It's interesting that purchasing agency subsidies are seen as politically motivating to improve credibility/reliability, but centralised procurement of drugs is a common area where budget credibility is poor (at least in my experience).	Sierd Hadley (ODI)	Yes, absolutely agree.	
99	Hear hear to the utility of the tool!	Godelieve Van Heteren		
100	Perhaps asked elsewhere/already, has there been some initial impression from the tool of differences between devolved/decentralized contexts vs centralized ones, and if the former is a particular driver of low budget execution, due to different causes?	Odd N Hanssen	Excellent question. This has not been disaggregated to that level. However, having fiscal decentralization in place adds fiscal transfers to regions/states. The credibility of these will then determine how well the states can execute the budget for health. So this can add complexity and risks implementation challenges. On the other hand, centralized systems can still purchase directly from providers, making it in principle easier to execute the budget. Great idea to provide extra granularity.	
101	Congratulations, Moritz!	Lisa Fleisher		
102	Thank you!	Rainy		
103	Felicitations	Prof ELOKO EYA MATANGELO Gérard		