Sector Budget Support in Practice (SBSiP) Seminar

Zambia Health Sector Case Study

Ann Bartholomew, Mokoro Ltd

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Outline

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- Service delivery and sector outcomes
- SBS in the health sector (EC and DFID)
- SBS in practice – design, sector planning, service delivery
- Effectiveness of SBS in health
- Conclusions
- Good practice lessons
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Health Sector Context

- Health reform process began in 1991
- A Swap was established 1994
- Basket funds supported the Swap (district, hospital and expanded basket)
- ODA has increased from 11% of health sector budget in 1995 to 41% 2006
- Importance of basket has decreased as rise in vertical funds, move to SBS and donors have left the sector (2000 63%, 2005 39%). In 2009 only Sida, USAID, Netherlands, Cida and UNFPA remained.
- Vertical funds have led to a decline in on-budget funding (2000 84% ODA was on-budget, in 2004 only 59%)
- GRZ health budget was 3% GDP in 2008 and 11.2 % of discretionary expenditure

Service Delivery and Sector Outcomes

- Despite high health expenditure per capita there have been some improvements in health service delivery, but these are not always translated into better sector outcomes

- On target to meet MDG 6 on HIV/AIDS, potential to achieve MDG 4 & 6 on child and maternal mortality

- Major constraints faced by the health sector are:
  - a high disease burden exacerbated by HIV/AIDs and malaria
  - shortage of essential workers
  - inadequate infrastructure, especially in rural areas
  - shortage of drugs and medical supplies

SBS in the health sector in Zambia

- EC and DFID moved away from basket funding & began SBS in 2006
- EC pilot SBS 2006-2008 (euro 10 million for human resource plan to support human resource retention). SBS program broadened 2009-2013
- DFID earmarking of $5 million GBS funds to health to eliminate user-fees (2006-2010)
- No additionality requirements from either donor
- Notional earmarking by both donors
- EC conditionality/disbursement requirements linked to fixed and variable tranches
- DFID conditionality/disbursement linked to budget support process

SBS in practice…….design

Design Issues

- Predictability – year to year predictability was an issue for EC SBS, as was within year predictability for DFID SBS
- Earmarking – although this was notional it was taken literally by the MoH
- Additionality – MoH expected SBS funds to be additional, but MoFNP sometimes transferred SBS funds separately, other times they used normal cash management procedures
- Conditionality – caused problems due to design of SBS in both cases

SBS in practice…..sector planning etc

Sector Policy, Planning, Budgeting and M & E issues

- SWAp process is separate from funding channels used by donors
- SBS is aligned with sector policy, planning and budgeting mechanisms
- Monitoring and reporting processes are aligned with the SWAp for DFID, but not for the EC

Partnership and ownership

- SBS is perceived by MoH as contributing to the fragmentation of basket funding which is seen to have worked well
- Unpredictability has undermined MoH confidence in SBS
- EC tranche system seen as unnecessary burdensome
- Communication between MoH and MoFNP did not improve

SBS in practice……service delivery

Service delivery and institutional capacity

- DFID funding to user-fee elimination delayed in year 1 and 2 which may have impacted negatively
- Elimination of user-fees has increased attendance at health facilities
- Delays in EC funding to HR retention resulted in delayed implementation
- EC funds more flexible than other ODA as able to be used to pay wages
- Currently mixed picture, but potential to have greater impact on service delivery and institutional capacity

Effectiveness of SBS in health

Little contribution to sector policy processes, institutions and delivery systems as they are well established and SBS has been very limited in scale. Despite this a small contribution from SBS can be seen in three areas:

i) Focus through notional earmarking on key areas and bottlenecks that need to be addressed
ii) Increased funds on-budget
iii) Highlighting of constraints in PFM systems

It is too soon to measure any impact on sector outcomes

Conclusions

- SBS has had limited impact to date and problems related to design, delays in disbursement and cash management have led to frustration within the MoH, which have prevented other donors moving to SBS and has resulted in DFID giving up earmarking funds to health

Good practice lessons

- Use of existing mechanisms for sector planning, dialogue and reporting which reinforced the SWAp
- Notional earmarking of funds to priority areas that are under-funded
- Use of GRZ PFM systems has increased accountability and funds on-budget
- Pilot SBS to test design, systems and identify bottlenecks
- Use of government systems to fund service delivery without additional derogations
- Allowing funds to be used in flexible ways

Practices with negative effects

- Additional reporting and assessment procedures by EC
- DFID requirement of traceability of funds
- Opaque and unpredictable budget system
- Lack of clarity on how SBS would operate (additionality and earmarking)
- MoFNP not following normal cash management procedures
- Lack of accountability and effective communication between the MoH and MoFNP
- Transition to SBS was not jointly managed by the MoH, MoFNP and donors