**FORWARD-LOOKING ANALYSIS OF FUNDING AND STRUCTURAL OPTIONS FOR THE HEALTH SECTOR GOING FORWARD, AND HOW THEY COULD BE OPERATIONALISED**

For: Delegation of the European Union to South Sudan, and the Ministry of Health – Government of the Republic of South Sudan

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**FINAL REPORT ANNEX D: MOH Policies and FY2017/18 Budget**

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## Health budget low as % of government budget by international standards, dramatically reduced in effective value; overall funding of the sector reached a post-Independence low in 2016-17

- The health budget is far below the Abuja Declaration, which recommends 15% of government budget, and international comparators. In FY16-17, health reached a low of 1.66% of GRSS budget; security and rule of law sectors took the lion's share.
- There has been a dramatic shift in the balance of financial resources for the health sector, between government and partners:
  - in 2014-15, MoH, budgeting to spend $123m pa, was the single biggest funder of the health sector, budgeting to provide c.60% of estimated sector budgeted funding of >$200m (including HPF, RRHP, ISDP, ICCM, DELIVER)
  - In 2016-17, MoH budget was worth just <$8m, and made up ?10% of total sector funding; HPF was the principal funder of the sector, with DFID recording £33m
- Utilisation of health sector resources/sector VfM is reduced by relatively high operational overheads and duplication of services.
- There is not clear alignment of partners for a unified approach to health sector interventions
- There is a weak drug supply and storage chain, with medical supplies often expiring before they are used.
- Limited human resources for health in skilled cadres
- Need for affordable and equitable access to health services in the Counties, Payams and Bomas

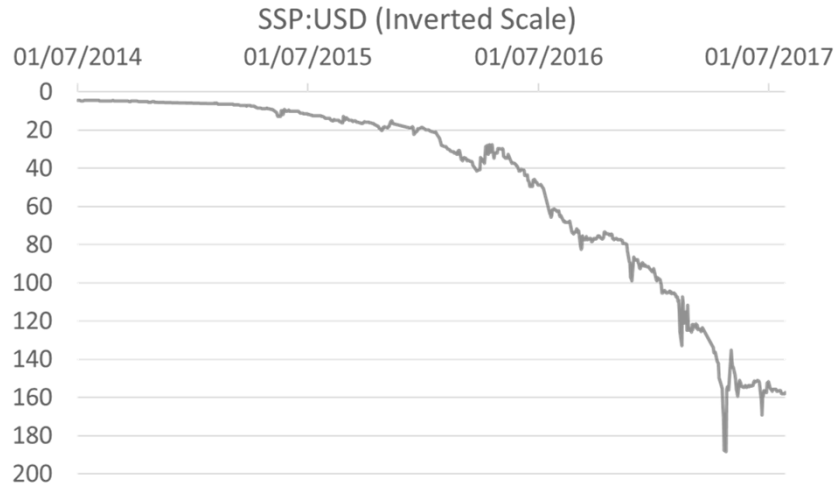
## The MOH has seen the value of its budget fall drastically in real terms over the past three years

- As the world oil price fell from the end of 2014, GRSS oil revenues declined sharply creating a significant 'gap' between income and expenditure. This gap was partly filled through an expansion of the money supply ('printing money') in the form of a series of loans from the Bank of South Sudan to the Ministry of Finance and Economic Planning
- Such 'monetary financing' may have been unavoidable to prevent a collapse of government services, but it helped fuel inflation which by mid 2016 was running at over 600%
- The Ministry of Labour and Public Service decreed an increase in civil service salaries in 2016, MOFEP subsequently increased the allocations to spending agencies but insufficiently to cover their increased salary bills. This squeezed other areas of funding and increased the share of the budget going to security and rule of law – these are the largest payrolls.
- Budget execution rates vary significantly between sectors. The MOH budget is chronically under-executed, the national budget as a whole has tended to be over-executed. This implies lower allocations to health than the budget implies, and is the process by which greater resources reach the security sector



## Since 2014 South Sudan has experienced very high price inflation…

## … and the $ value of the SSP has fallen drastically






## LSS Proposal for FY 2017/18 Budget Across Social Sectors

1) Partly restore the value of **social sectors' operating transfers to subnational administrations**
2) Partly restore the value of **transfers and grants made to service delivery units (SDUs) at subnational and national level**
3) Partly restore the **value of block transfers to subnational administrations**
4) Invest in **targeted retention measures for key service delivery staff**.
5) Ensure **funding for national agencies' oversight function**.

## Rationale for 2017/18 LSS Budget Proposals: steps to restore function of and access to front line services

- Proposals 1), 2) and 3) above are a response to the drastic decline in real value of these transfers
- This has led to a) a sharp reduction in operational capacity of SDUs and of state and county administrations
- Compensating practices that undermine the policy objectives of the transfers have become increasingly common – with evidence of schools and health facilities resuming levying high fees or charges, State and County administrations levying funding from SDUs, and State central agencies diverting sector conditional transfers from their intended purposes to finance the state government core functions.



## Total transfers per capita (in USD value) are almost tenfold smaller than in 2012/13

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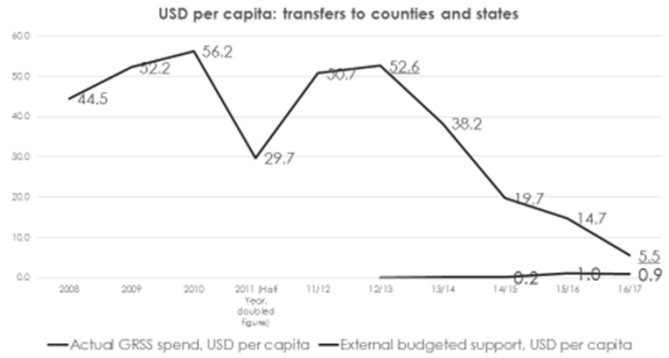
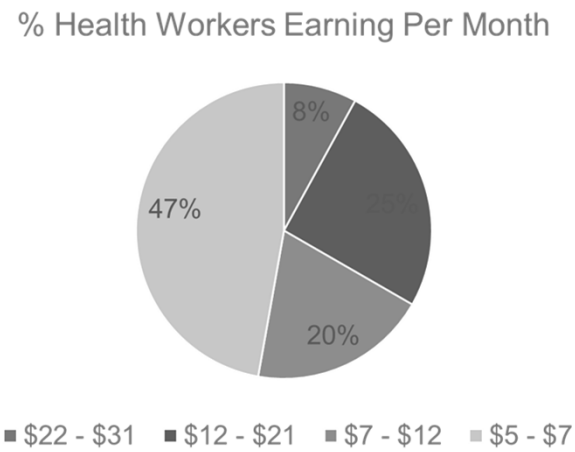


## Despite 2016 uprating, value of GRSS health workers' salaries is low



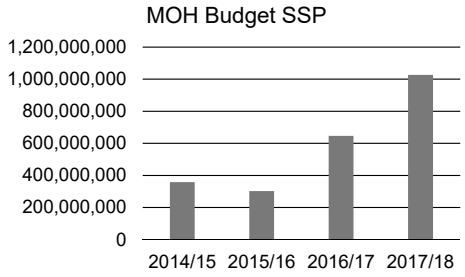

67% of government health workers earn less than $12 a month, a hospital director earns around $27 per month, a qualified nurse or midwife $18. The international global poverty line is $1.90 per day, or $57 per month.



## MOH Priorities and Budget Proposal

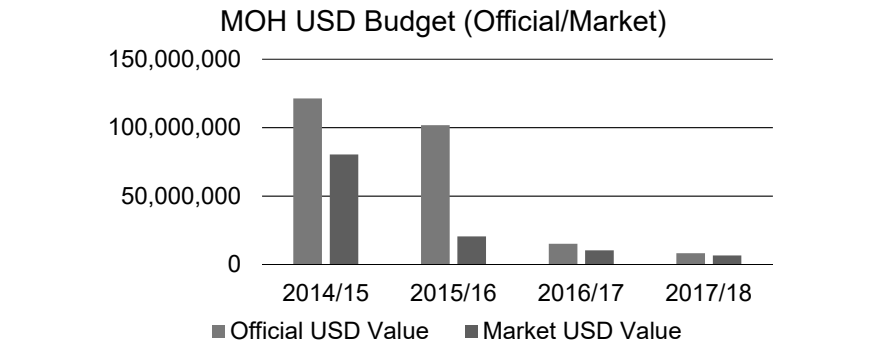
## The MOH budget has almost doubled in nominal terms, but this has not been enough to counteract price inflation, implying a fall in the budget in real terms

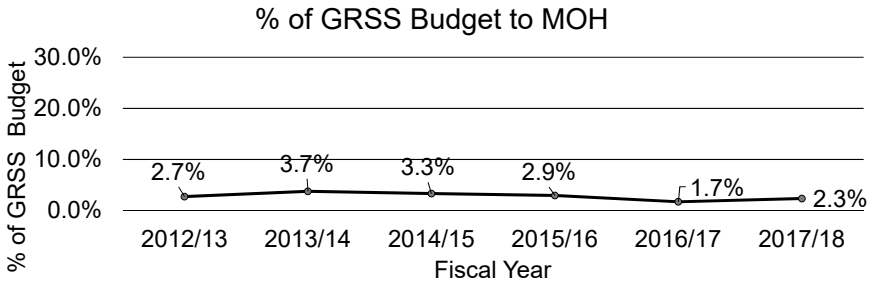
| Year | Nominal Budget | Official USD Value | Market USD Value | % RSS Budget |
|---|---|---|---|---|
| **2014/15** | 357,863,924 | 121,309,805 | 80,418,859 | 3.3% |
| **2015/16** | 301,280,278 | 101,783,878 | 20,550,472 | 2.9% |
| **2016/17** | 646,525,084 | 15,141,103 | 10,323,754 | 1.7% |
| **2017/18** | 1,026,382,281 | 8,211,058 | 6,595,228 | 2.3% |




- Although the value of the MOH budget fell again for FY2017/18, the overall GRSS budget fell more as the Government seeks to reign in inflation. This implied an increasing percentage of public expenditure for health
- Though a relative improvement on the previous year, 2.3% is still very low by international standards





## Transfers Remain a Priority for the MOH

| Year | Transfer - SSP | Transfers - $ | Transfers % |
|---|---|---|---|
| 2014/15 | 151,003,341 | 51,187,573 | 42.2% |
| 2015/16 | 252,045,868 | 85,439,277 | 83.7% |
| 2016/17 | 383,366,561 | 8,978,140 | 59.3% |
| 2017/18 | 779,006,525 | 6,232,052 | 75.9% |

In the context of rapid inflation and a falling real terms allocation, the MOH has sought to try and restore some of the lost value of transfers in the FY 2017/18 Budget and their share of spending.

It had originally sought to triple the value of transfers, in the event the budget allocation was not sufficient for this. Transfers to fund primary healthcare delivery received the biggest increases, whilst those for tertiary services were frozen

The MOFEP struggled to honour the FY 2016/17 budget, even salaries and transfers which have historically had high execution rates fell several months into arrears. This compounds the problem of their reduced value- and value further eroded during delays due to continuing high inflation



## Budgeting for different Health Care Levels: priority to primary and preventive/community care (Boma Health Initiative)

- From 2015/16 to 2016/17 **the budget priority given to basic health care in previous budgets 2011- was partly undone**
- Within this trend **primary health care** (County & PHCC transfers) has been **most affected** (share falling from 33% to 21% of MoH budget).

MoH wants to **redress these trends for 2017/18**, by giving **priority** to

- More resources for PHCCs & State/County hospitals
- Properly resourcing the Boma Health Initiative

| Transfer shares in total MoH budget | 15/16 | 16/17 | 17/18 |
|---|---|---|---|
| Primary health care - county level | 33% | 21% | 48% |
| Secondary/tertiary health care - state level | 19% | 21% | 23% |
| Human Resource Devt | 2% | 1% | 4% |
| National/teaching hospitals | 24% | 17% | 1% |

# MoH 2017/18 Budget Priorities (1)

- **Increasing operating transfers to State and County Administrations**
- **Increasing transfers/grants made to** primary health care centres (PHCCs), State and County hospitals, and Health Science Training Institutes (HSIs).
- **Increasing state and county block transfers** would:
  - Help states to align staff compensation levels with those of the national government

    (agreed as a priority by the Council of Ministers)
  - Better provide for state/local governments' core functions, thereby reducing the temptation for state/county central agencies of diverting other transfers from their intended purposes.



# MoH 2017/18 Budget Priorities (2)

- **Investment in targeted retention measures for key service delivery staff** aims to begin to address this – giving priority to frontline staff working in the SDUs.
- Complement ongoing/planned DP-financed retention schemes (eg IMPACT in education) and seek to ensure fair treatment of key staff categories not included in these schemes.
- Particular priority for MoH is supporting 'volunteer' health workers under the Boma Health Initiative

## Transfers

- **Straight through to service delivery units (SDUs)**
  - Health Science Institutes (HSI) – National SDUs
  - State and County Hospitals – SDUs under State Ministry of Health
- **Increased emphasis on PHCCs**, including role of **overseeing and guiding PHCUs and the Boma Health initiative teams**.
- PHCCs that meet access conditions will receive and manage **three types of transfers** for the following purposes:
  - **PHCC grant for operating expenses** of the PHCC and the PHCUs under it
  - Transfers for **PHCC and PHCU staff retention incentives**
  - **BHI team incentive transfers**



# Boma Health Initiative (BHI)

- BHI teams are considered as a new SDU, focusing on preventative health
- The BHI team incentives could then be budgeted under the **same directorate (Community and Public Health) as for the PHCC grant, but under the 'preventive health' activity** to distinguish these transfers from the grants to PHCCs that are budgeted under 'primary health'.
- The estimates above assume that MoH would pay an incentive of 1,000 SSP/month, equivalent to Gr17 monthly salary (Feb 2016 pay scale), to the 3 members of the BHI team in 2,500 bomas, for 12 months.
- In the 2016/17 budget MoH had implicitly budgeted for 300 SSP/month for each BHI team member. This was included in the CHD operating transfers, though these were reduced from their 2015/16 as PHCC budgets were moved up to State level

## Retention of Health Staff

**Key issues**

- Very low, late GRSS salaries ➔ health workforce leave profession, or go to work for NGOs
- Poor employment practices at state/county level ➔ no space in GRSS for existing qualified health workers
- **NGOs' pay scale massively out of reach** of GRSS (e.g. qualified non-SS nurse at 2,000$/month)

**MoH's priority** = Return to **GRSS/NGO pay scale alignment**

- Mobilise DP support for strategy of retention of qualified SS health staff,
- E.g. instead of hiring non-SS nurse at 2,000$, hire four or five SS nurses at 400-500$, either on 'NGO payroll' or on GRSS payroll with GRSS salary & top-up by DPs



# Strengthening health service delivery at local level: longer-term considerations

# Health Service Delivery at Local Level (1)

Today, **States and Counties** are **much smaller** entities (from 10/79 to 32+1/?250)

- Recent fieldwork:
  - Weak capacity even at state level, with notably, new States' structures not yet established, or working from former State's HQ as 'hub'
  - Disconnect between States and Counties; Counties left to themselves
- MoH view that **service delivery systems must be adapted** to new configuration, in coordination with other LSS agencies, incl.:
  - **Roles & responsibilities of States & Counties** to be revised – in line with population-based health service coverage policy
  - Need for simpler, more robust systems adapted to much lower infrastructure and HR sub-national capacity levels



# Health Service Delivery at Local Level (2)

- MoH view that the current **single treasury account principle** applied at all government levels **works against the delivery of local services**
  - System prone to political interference as all resources are concentrated in one place
- MoH suggested that this should be reconsidered at senior level as a matter of urgency
- More broadly, the **constitutional review** process should carefully consider issues of **accountability for basic service delivery**
  - With consideration of the respective roles of and relationships between national line ministries and sub-national political authorities
  - Drawing on lessons learned so far.

# Notes on 3rd Health Summit, March 2017



# 3rd Health Summit Position Papers [1/2]

8 position papers were presented:

- National Health Policy 2016-2026,
- Boma Health Initiative,
- Service Delivery,
- Human Resources for Health,
- Medicines and Health Supplies,
- Health Financing,
- Health Management Information System,
- Leadership and Governance.

- The Position paper on policy provides the overarching direction for improving service delivery, better management for health resources and strengthening partnerships for health service delivery.
- The rest of the position papers are subsidiary and provided details on the specific Building Blocks of the health system.

# 3rd Health Summit Position Papers [2/2]

- The Position papers are a summary of highlights of the National Health Policy 2016 – 2026 which was discussed with a wide range of the key stakeholders at national and sub-national levels including health partners over the years 2014 – 2016.
- It outlines **what** needs to be done, but the **how** will be addressed while developing the Health Sector Strategic Plan which will be guided by the principles in the position papers, the emerging issues from the Health Summit and a series of consultative processes over the coming three months.
- The Roadmap to finalise and cost the Health Sector Strategic Plan (HSSP) 2017 – 2021 and strengthen the overarching coordination framework for health partners, will describe the key outputs of the consultative processes to come.



# 3rd Health Summit Key Resolutions

- The 3rd National Health Summit of South Sudan under the theme, "Harnessing strong partnerships for a resilient health system towards attainment of Universal Health Coverage" Identified 14 thematic areas.
- The thematic areas are key to build a resilient health system to deliver comprehensive health services to all citizens guided by the National Health Policy (2016-2026) and underpinned by ongoing, forthcoming and emerging policies, strategies, guidelines and other efforts.
- These thematic areas recurred throughout the discussions at the Summit. These emerging issues formed the *Key Resolutions* of Health Summit, found as essential pillars to ensure a robust health system ready to serve the people of the Republic of South Sudan.

**Key Resolutions**

- Re-activation of the Health Sector Working Group
- Finalization of the National Health Sector Strategic Plan (NHSSP)
- Roll-out of the Boma Health Initiative (BHI)

# 3rd Health Summit: Resolution on Health Financing

- MoH budget in 2016/17, of 645.5 million SSP, represented <2% of the total GRSS budget.
- 3rd National Health Summit expressed concerns about the extent to which GRSS can claim to 'own' its own health sector: e.g. for several years Government did not budget for pharmaceuticals...
- ....donors' funding will largely dependent on Government's commitment to increase the health budget..
- ...targeted a return, in FY17-18, to health's previous budget share of 4%.



# An initial analysis of logical priorities to complement GRSS funds

- GRSS funds of far less value than they were, fiat redivisions have weakened systems – but would still be prohibitively expensive to replace all services currently provided by govt.
- Emphasis on basic and community-based health care – capacity constraints at national and state-level for oversight and management, at county and community/facility level for planning, budgeting, managing and accounting for funds
- Training of skilled health workers – salaries are far too low for retention of skilled personnel at any level of health system

- How to build on the current model of service delivery, but with a much stronger focus on local capacity development particularly at the level of CHDs, with continued **partnership** with NGOs in service delivery (different from NGO service delivery)
- How to make the referrals chain work and the associated **infrastructure (priority, but beyond GRSS Budget at present)** required
- Capacity development focused on mid-level cadres; strengthening of the HTIs.
- Pharmaceutical chain management.
- Funding arrangements building on HPF and WB but looking to move beyond the 8+2 (former states) into one national set-up/ sector-wide framework. Action plan for this, starting with a proper SWOT analysis of the sector.