Collaborative on Domestic Resource Mobilization
Under JLN's Revisiting Health Financing Technical Initiative
Third In-Person Meeting
New Delhi, India, February 27-28, 2019

Meeting Synthesis

Attendees

Members of the JLN Steering Group: Mr. Alok Saxena (India).

Members of the Domestic Resource Mobilization Collaborative[1]*:* Ayesha Afroz Chowdhury (Bangladesh), Subrata Paul (Bangladesh), Ankuong Fang III Lucie Claire Stephanie (Cameroon-GFF), Victor Ndiforchu (Cameroon-GFF), Konan Kouassi Clovis (Côte D'Ivoire-GFF), Abdoulaye Bakayoko (Côte D'Ivoire-GFF), Tseganeh Amsalu (Ethiopia), Kwakye Kontor (Ghana), Daniel Adin Darko (Ghana), Alok Saxena (India), Kavita Singh (India), Wahyu Nugraheni (Indonesia), Nasruddin Djoko Surjono (Indonesia), Agnes Nakato Jumba (Kenya), Munkhtsetseg Byambaa (Mongolia), Nneka Orji (Nigeria), Youssoupha Ndiaye (Senegal-GFF), Amar Hassan Omer Abdelrahman (Sudan), Hisham Abdelatif Abdalla Khalifa (Sudan), Richard Kabagambe (Uganda-GFF), William Ndoleriire (Uganda-GFF).

Members of the Leveraging Resources for Efficiency Collaborative: Kwabena Boakye Boateng (Ghana), Titus Sorey (Ghana), Ahmad Ansyori (Indonesia), Eka Yoshida (Indonesia), Nor Izzah Binti HJ Ahmad Shauki (Malaysia), Lee Kun Yun (Malaysia), Arturo Alcantara (Philippines), Muna Ismail Mohamed Elhassan Mohamed Nur (Sudan), Haider Mohammed Hashim Mohammed (Sudan).

Special Invitees, Observers, Guest Speakers, and World Bank Country Team Representatives: Indu Bhushan (Government of India), Preeti Sudan (Government of India), Chirag Sidana (Government of India), Som Chandara (Cambodia), You Pisey (Cambodia), Windu Kusumo (Indonesia), Navy Mulou (Papua New Guinea), Daw Aye Aye Sein (Myanmar), Honey Win (Myanmar), Laddavanh Sengdara (Lao PDR), Phuotthasoune Vongsavath (Lao PDR), Alexo Esperato (The Bill and Melinda Gates Foundation), Stephan Nachuk (The Bill and Melinda Gates Foundation), Y-Ling Chi (Imperial College London), Sara Wilhelmsen (Management Sciences for Health), Jorge Coarasa (The World Bank), Reem Hafez (The World Bank Indonesia Country Health Team), Pandu Harimurti (The World Bank Indonesia Country Health Team), Sheena Chhabra (The World Bank – India Country Health Team), and Owen Smith (The World Bank – India Country Health Team).

DRM Collaborative Organizing Team and Technical Facilitators: Danielle Bloom (The World Bank), Maria Eugenia Bonilla-Chacin (The World Bank), Emiko Masaki (The World Bank), Sithie Naz

[1] GFF refers to the Global Financing Facility for Women, Children and Adolescents.

Mowlana (The World Bank), Somil Nagpal (The World Bank), Lydia Ndebele (The World Bank), Aditi Nigam (The World Bank), Ajay Tandon(The World Bank), and Val Ulep (The World Bank).

Meeting Overview

The JLN Collaborative on Domestic Resource Mobilization is the second Collaborative and thematic area- after the Leveraging Resources for Efficiency Collaborative - to be launched under the JLN Revisiting Health Financing Technical Initiative. The DRM Collaborative is a community of practitioners who share knowledge and provide peer support to improve the domestic mobilization of resources for health care.

Following it's earlier convening through two in-person and three virtual meetings, the DRM Collaborative reconvened for its third in-person meeting from February 27-28, 2019 to discuss progress and next steps for the Collaborative's five deliverables. The meeting was co-located in New Delhi in advance of the March 1-2, 2019 fourth in-person meeting of the Leveraging Resources for Efficiency Collaborative, also known as the Efficiency Collaborative; members of both these co-located collaboratives were invited to participate in both meetings.

The meeting was attended by a total of 59 participants from 19 countries, including four countries who joined as observers from the East Asia and Pacific region – Cambodia, Lao PDR, Myanmar, and Papua New Guinea. Of the 19 attending countries, 4 countries – Cameroon, Côte d'Ivoire, Senegal, and Uganda - joined through the Global Financing Facility Partnership and 5 additional countries attended on behalf of the Efficiency Collaborative. Since partnering with the Global Financing Facility and to accommodate observer country interest, the DRM Collaborative has grown to include 14 countries, from its initial 9. A list of participants and their contact details is attached to this synthesis.

Participants engaged in focused discussions and group exercises on the application of key concepts, principles, and arguments for the domestic mobilization of resources for health, including through the systematic reprioritization of country budgets, an enhanced understanding of the interlinkages between efficiency and DRM (also known as DRUM- Domestic Resource Use and Mobilization), and discussed progress as well as next steps for deliverables. The DRM Collaborative aims to complete the following deliverables by September 2019, which will be launched at the global network-wide meeting of the JLN in December 2019.

Deliverable	Date for completion
#1: 'Learning Laboratory Pilots' or Policy Dialogue Workshops– country-led meetings with various Ministry of Health, Ministry of Finance, and other key stakeholders within the country, to discuss common communication challenges and share mutual targets for making the case for investment in health. Policy Dialogue Toolkit to be developed including meeting templates, TOR, simulations etc.	Pilot completed September 2018 in Sudan; Toolkit by September 2019
#2: Online Inventory of DRM Efforts. A collection of existing DRM inventories and use cases. Will also include an add-on analysis to the earmarking database and broader DRM efforts.	September 2019
#3: Messaging Guide that includes a compilation of messages used in making the case for investment in health using applied macroeconomic concepts, data, indicators, and country experience,	September 2019

as well as practitioner-led tips on communicating effectively across health and finance sectors.	
#4: A 1-2 page narrative summary of country budgetary data for countries that have submitted their budgetary data: Bangladesh, Cambodia, Ethiopia, Indonesia, Lao PDR, Malaysia, Nigeria, Vietnam. This output demonstrates how countries can summarize and analyze their historical budgetary data for informed country dialogue.	September 2019
#5: Case studies of countries that have systematically used reprioritization as a way to increase or maintain the level of health expenditure despite changes in economic growth. This work will now be undertaken jointly with IMF in the next phase of the DRM collaborative.	To be confirmed in consultation with IMF

Summary of Discussions

Below is a summary of discussions at the meeting. The English and French agendas for the meeting as well as all presentations can be accessed on the JLN DRM Collaborative Member Portal.

1. **Soft Launch and Opening Remarks by Mr. Alox Saxena,** Joint Secretary, National AIDS Control Organization, Ministry of Health & Family Welfare and **Mr. Jorge Coarasa,** Acting Country Director, the World Bank.

   Mr. Alok Saxena, who also serves as the JLN Country Core Group Chair for India and is a member of the JLN Steering Group, shared the dais with Mr. Jorge Coarasa of the World Bank India office to welcome participants to the meeting and provide opening remarks on India's health system and participation in the JLN. Mr. Saxena spoke of how the learnings from India's participation in the JLN and its subnational Forum Series which is closely linked to the JLN - in which members of India's 29 states and 7 union territories discussed their health sector challenges and their efforts to move towards UHC - helped contribute to the rapid design of the Pradhan Mantri Jan Arogya Yojana (PM-JAY), a flagship scheme sponsored by the central Government of India that provides cashless secondary and tertiary care treatment through empaneled public and private hospitals to the poorest 40% population (approximately 500 million people). Many countries have similar schemes and are at various stages of providing health insurance to their populations yet the responsibility of the policymakers is not only to mobilize and manage the required resources for these schemes, but also to ensure that the funds are utilized efficiently and that the commitment toward universal health coverage continues.

   Mr. Coarasa introduced participants to a recent partnership between the Government of India and the World Bank – 'Lighthouse India', which will continue for the next 4 to 5 years and is influenced by the JLN in that it extends the peer to peer learning modality beyond the health sector to all sectors of development. Under this joint partnership, Lighthouse India will systematically share India's experiences in development, practical knowledge and domain expertise with the rest of the world.

2. **Introduction, meeting overview and review of DRM concepts**

The JLN team presented an overview of the JLN, the DRM Collaborative, the joint learning approach, and acquainted participants with the agenda for the two-day meeting. The English and French versions of the presentations can be accessed online in the JLN member portal.

Dr. Ajay Tandon reviewed key concepts and principles of domestic resource mobilization with participants. During the presentation, Dr. Tandon discussed some levers for how UHC can be achieved, including by reducing out-of-pocket spending for health, increasing fiscal capacity, moving towards more public financing of the health budget, and through an increase in population coverage. By situating public financing within the broader macroeconomic context of the country, policymakers gain understanding of the fiscal implications of public financing for health, which can be used to create informed strategies and policies. Participants considered lessons learned from various cases of reprioritization of country health budget's, including the case of Venezuela, where health outcomes are influenced by how public expenditure per capita is allocated. In the last three years, Venezuela has seen a contraction in its GDP leading to an economic and humanitarian crisis. To address this fiscal crisis, Venezuela has deprioritized its health budget.

The discussion also considered the landscape of taxes implemented by countries. Launched in October 2018, India's Pradhan Mantri Jan Arogya Yojana (PMJAY) reforms provide health protection coverage to poor and vulnerable families for secondary and tertiary care through a 1% soft earmark (in India, this is referred to as a "cess") that is paid on top of the income tax.

The discussion also touched on external financing for health. The challenge for many countries that are in the process of graduating or transitioning from external financing is finding additional domestically public resources that can replace external financing while also maintaining the positive outcomes that external financing helps countries achieve on their path to UHC. In some cases, external financing may be heavily focused on a select few health programs – In Indonesia, the share of external financing for health is approximately one percent of total financing, but this is concentrated in a few programs and so the share of this overall modest share is much bigger for programs like TB and HIV.

Efficiency can be a source of fiscal space that allows countries to realize additional resources. Domestic Resource (DR) Use (U) and Mobilization (M), also known as DRUM, was explored later in the agenda as a sub-component of fiscal space, looking at the interlinkages between domestic resource mobilization, utilization, and efficiency.

For some countries, an increase in GDP per capita contributes to an increase in the amount of real public financing for health. India was able to capitalize its health spending during the 2004 to 2014 period of economic growth by providing central government infused spending to its states and union territories for a national health scheme that was predominantly funded by the central government.. The success of the reform was affected by the capacity of the states to absorb the funds, as well as their ownership and buy-in of the national health scheme.

Macroeconomic trends and their links to public financing for health were also discussed. On average, as countries become richer, the size of the government grows and a higher share of the budget can be spent on health; however, in some countries, defense and education

maintain a larger share of the government budget. Costa Rica does not have a military by constitution. With no defense expenditure, Costa Rica can allocate more money to health. In Indonesia, approximately five percent of the budget is spent on health while 20 to 25% is spent on education. Additionally, countries that are paying their government debt and incurring a deficit in their interest payments, may have constrained fiscal space for health.

3. **Inaugural Session with Ms. Preeti Sudan,** Secretary Ministry of Health & Family Welfare, Government of India, **and Dr. Indu Bhushan,** CEO, National Health Authority, Pradhan Mantri Jan Arogya Yojana. This session was moderated by Sheena Chhabra, JLN Focal Point, World Bank India Country Office and featured Dr. Ajay Tandon and Dr. Maria Eugenia Bonilla-Chacin of the World Bank as panelists for the session.

   The session discussed that India's health system experiences issues of equity, efficiency, affordability, and accessibility. Out-of-pocket payments for health are inequitable and inefficient and can impoverish households, subject them to a cycle of debt, and/or make it difficult to pull themselves out of poverty. Most people pay for out-of-pocket health expenditures on a need basis; OOP payments are unpredictable in that they are used to address unforeseen problems. Their involuntary nature and the inability to prepare for them can place a large financial burden on poor households, who already have a limited ability to pay and will borrow heavily, deter treatment, and/or experience chronic morbidity before death.

   Health financing in India has various sources, including cross-subsidization. Cross-subsidization of income tax revenues on the richer formal sector are used to finance social sector schemes for the poor or non-contributing informal sector. In addition to the central government levied income tax, the formal sector also pays a three percent cess (additional tax) that is earmarked for the education sector and a one percent cess for health. Pension and provident funds see contributions from both government employees and unorganized sector employees. India's strong federal democracy allows states to manage their own health systems, which contributes to varying social and health indicators by state. State health financing is sourced through states' tax revenues, states' share of central taxes, as well as additional modalities such as state bonds, the Chief Minister's relief fund (emergency assistance release fund for calamities, natural disasters, chronic diseases, etc.), IFA (infrastructure financing), the health cess (allocated from central to state budgets), sin taxes, co-payments, and external financing. India relies very little on external funding and utilizes its partnerships with donor and UN agencies for technical assistance.

   Ms. Preeti Sudan gave a broad overview of India's health financing landscape and strategies, examples of how India is engaging in Public Private Partnerships (PPP) through performance linked payments, and presented an overview of the Ayushman Bharat program launched in 2018– the national health protection scheme that consists of two components: 1) the creation of 150,000 health and wellness centers for strengthening promotive, preventive, and primary care, and 2) the PM-JAY. Ayushman Bharat is an insurance (financial coverage for unforeseen circumstances around an event, implemented through the mediation if insurance companies) and assurance scheme (implemented without using insurance companies as intermediaries) in which benefits are explicit and based on enrolment. Ayushman Bharat gives states the flexibility to provide benefits on an insurance or assurance basis; however, a strong health structure is needed for the latter. The PM-JAY program is a demand side financing scheme

that provides money for the use of services by the bottom 40% population in India, engages the private sector for quality assurance, and consolidates providers and users of services on a robust IT platform. The database provides the Ministry of Health & Family Welfare with an understanding of its users, the treatment that users are seeking, and helps the Ministry improve its policies and target its services. Since the PM-JAY empanels private providers through a PPP model, the Government of India hopes that their additional financing of INR 10,000 crore (USD $1.4 billion) will make financing more equitable, reduce OOP expenditures, and increase efficiency as well as absorptive capacity of additional money in the public and private sectors.

Dr. Indu Bhushan contextualized India's health financing and health expenditures globally. While India has seen robust growth in the last decade ranging from 6-8% annual growth in GDP and is phasing out of external assistance for health, a very high share of its financing for health is through out-of-pocket (OOP) expenditures. Globally, countries tend to pay more for the health sector as they grow. However, despite India's 6-8% growth in the last decade, government expenditure has not increased at the same pace or more than this proportion. India has the lowest expenditure on health (1.2% of GDP is spent on health) when compared to its G-20 peers. India plans to increase their spending on health as a percentage of GDP to 2.5% by 2025 and focus on improving spending so that it is efficient and equitable (i.e. ensuring that access to services does not vary by rural/urban settings, gender, or socio-economic status).

Health financing, with the patient as the focus, ensures strong health systems; however, increasing the health budget isn't effective if States do not have the capacity to absorb the funds they are given. Investment in the health system helps states increase their absorptive capacity and can be encouraged through performance incentives, a motivated health workforce, and by making people aware of health programs.

India's National Health Mission has various programs to provide performance incentives to different levels of the health workforce. Under the 'Transformation of Aspirational Districts' program, states are given an additional 10-20% of their annual entitlement if their low performing districts, also known as 'aspirational districts', increase their overall key performance indicators. The budget for this program comes from a separate account, managed and earmarked by MOH, in which MOH can reallocate funds from low performing states to high performing states. Money is released to states in installments and depending on usage, thereby maintaining a continuous balance of funds in the account.

Since 2005 India has maintained a motivated rural health workforce, known as Accredited Social Health Activists (ASHA), who engage within their community by providing maternal and child services (prenatal checkups, immunizations, etc.) and nutrition support. The 1 million ASHA field workers are encouraged to make additional visits to patients within their communities through additional service-based remuneration and in this process, are able to cultivate long term relationships with the community, help improve community health outcomes, and instill public trust in the health system.

4. Beating the 'DRUM': Domestic Resource (DR) Use (U) & Mobilization (M)

Dr. Maria Eugenia Bonilla-Chacin presented the Domestic Resource Use and Mobilization (DRUM) framework, which considers the efficient and equitable use of mandatory, pre-paid and pooled resources. With 12 years left to realize the 2030 Sustainable Development Goals (SDGs), the DRUM framework focuses on learning from the past to inform ongoing and future policy processes. Participants were asked to consider which health financing problems have the greatest potential for change, which innovations are the most promising, how can innovations be adapted and tested, and how can successful pilots be taken to scale.

Various studies have estimated the spending levels necessary for low and low-middle income countries to achieve the 2030 SDGs and have found that low and low-middle income countries are significantly underspending on health. Development assistance for health has plateaued and is not expected to increase much in the next few years. Other common challenges faced by low and low-middle income countries include misalignment between government and donor priorities, which can result in the duplication of efforts and high transaction costs.

Through the DRUM framework, it is possible to recognize commonalities among solutions – a) improved accountability such as through sharing more information with the public helps strengthen social and political demands for health services/programs, b) efficiency gains can be capitalized by building capacity and having strong financial institutions as well as by effectively using innovations and public-private partnerships, and c) health partnerships can be transformed through joint leadership efforts between Ministries of Health and Ministries of Finance and between governments, donors, and partners.

At the end of the session, participants engaged in a question and answer discussion. Nigeria shared their experience in aligning donor priorities through the implementation of the basic health care provision fund, which is financed using domestic and foreign resources. To prevent the misalignment of government and donor priorities and the duplication of efforts, donors are brought together in joint meetings with the government. They are encouraged to pool their funds into the basic health care provision fund and depending on their priorities, the Government of Nigeria exercises flexibility in expanding the basic benefit package to accommodate donor interests. To avoid misalignment at the sub-national levels, donors who seek to implement their finances at the sub-national level sign a partnership compact with the Government of Nigeria detailing their sub-national level implementation plans and operations.

5. Recap and Status of DRM Collaborative Deliverables

Dr. Somil Nagpal quickly reviewed and reacquainted participants with the five deliverables determined by the DRM Collaborative in past meetings and outlined the meeting goal to discuss planned work for each deliverable and receive participant feedback on the progress of deliverables.

6. An Inventory of Information on DRM Efforts and an Overview of the WHO-R4D Global Database of Earmarking for Health

Following a presentation by Dr. Ajay Tandon, Ms. Danielle Bloom, and Ms. Aditi Nigam on existing inventories of DRM efforts (e.g. the USAID DRM and Collecting Taxes Database, the USAID Health Finance and Governance Project, the WHO Tobacco Tax Simulation Model, the WHO Global Tobacco Reports, and the WHO-R4D Earmarking for Health Database),

participants discussed the utility and application of existing inventories in their efforts to mobilize domestic resources and considered additional complementary or knowledge gaps that can assist them in making arguments to their ministries of finance for additional resources.

7. Learning Laboratory Pilots (LLP)

Ms. Aditi Nigam presented on the LLP deliverable and elaborated on the key factors for successful implementation in Sudan in September 2018. The LLP, also known as the Policy Dialogue Workshop (PDW), was undertaken in accordance with the core values of the Joint Learning Network – it was country led, country-owned, and demonstrated shared commitment toward Universal Health Coverage. The Sudan Policy Dialogue Workshop discussed DRM options for Sudan and followed the same meeting structure as past DRM Collaborative meetings, with a policy simulation, groupwork, and MOF-MOH senior policymaker panels that discussed common communication challenges. The Sudan PDW was conceptualized and planned to be held in advance of the annual November budget planning process, benefited from sustained political will through persistent efforts by the Public Health Institute (PHI) to bring stakeholders together, and had a focused message and concept that provided an opportunity for active collaboration between three ministries – the Ministry of Finance, the Ministry of Health, and the National Health Insurance Fund – at the state and federal level.

Dr. Amar Abdelrahman (Public Health Institute, Sudan Ministry of Health) presented on Sudan's experience in the implementation of the PDW and provided the political, operational, and policy background that allowed for its successful implementation. Sudan aligned its national health policy with the SDGs and endorsed a 2017-2030 new national health policy. The new national health policy adopts a family health approach at the primary health care level, endorses a cross-sector approach in governance known as 'health in all policies', and introduces the reform of Sudan's health financing system through a transformation shift from out-of-pocket payments to a prepaid health system that protects marginalized and vulnerable populations. The Policy Dialogue Workshop followed the implementation and adaptation of a JLN UHC- Primary Health Care Toolkit in six states and required significant effort to bring all stakeholders together in a decentralized context. PHI capitalized on various opportunities to introduce and bring together participants from the state and federal level – for example, one bus was used to transport the various ministry officials from one state together so that they could begin interacting in advance of the meeting. In the final groupwork session of the meeting, states were asked to develop action plans on DRM for health. PHI plans to follow-up with states on their progress in implementing their action plans in 2019 and offered to publish state agreed action plans on the PHI website.

Although the success of the PDW also depends on sustaining momentum from the meeting, Sudan has experienced political instability since holding the meeting, which has led to a high turnover rate in the public staff at the leadership level, and the Ministry of Health has merged with the Ministry of Welfare and Social Development. Yet, since the workshop, the Ministry of Health created a national plan with one budget costed for the federal, state, and local level, and the MOF has changed the budget allocation for health from a fixed annual amount to project based financing with key performance and impact indicators.

Dr. Hisham Abdelatif (Sudan National Health Insurance Fund) provided participants with an overview of the progress in benefit package design and costing. The new health financing policy requires many health sector reforms including a purchaser-provider split and a costing of the benefit package. Under the new national health financing policy, the National Health Insurance Fund, which was previously the provider and purchaser of health services in Sudan will become the single provider of health services in Sudan. A costing of the benefit package is underway and will be completed at the end of 2019.

Following the presentations, Dr. Nagpal led participants in a discussion on the country demand for organizing similar in-country discussions such as this Policy Dialogue Workshop on DRM for health in their countries, the feasibility of bringing relevant stakeholders together, additional resources that would assist implementation in other country contexts, and sought suggestions on how to improve the Policy Dialogue Workshop model.

During the session, the following countries expressed an interest in holding Policy Dialogue Workshops (in alphabetical order): Bangladesh, Cambodia, Cameroon, Côte D'Ivoire, Ethiopia, Indonesia, Kenya, Mongolia, Myanmar, Nigeria, and Sudan (for a second follow-on Policy Dialogue Workshop).

8. What Works & What Doesn't: MythBusters Quiz

Through a short participatory and interactive session, Dr. Val Ulep and Ms. Aditi Nigam discussed common health financing myths while considering country examples and health financing concepts. In a fun and engaging modality, this helped reinforce some of the core concepts in DRM.

9. Documenting our knowledge on reprioritization

Dr. Ajay Tandon defined reprioritization for health, provided country examples to contextualize macroeconomic situations that provided opportunities for reprioritization for health, and presented data and ongoing analysis that will be used to complete the DRM Collaborative's deliverable on 'case studies of countries that have reprioritized for health'. The case studies deliverable will consider countries that have systematically reprioritized for health and where this may have led to improved health outcomes. Dr. Maria Eugenia Bonilla-Chacin and Dr. Owen Smith joined Dr. Tandon to clarify economic principles and key determinants of reprioritization. The Technical Facilitation Team sought participant feedback on the progress on analysis and requested suggestions of other countries that have reprioritized for health and which are of interest for focus in the DRM Collaborative case studies deliverable.

Reprioritization is a mechanism to mobilize resources for health and refers to increasing the health's share of total government expenditure at the expense of other 'less meritorious' or unproductive expenditures (i.e. realignment of expenditure program); however, reprioritization does not always result in higher public financing for health. Countries that have systematically reprioritized for health in the last 10-15 years were identified through an analysis of 151 countries within the World Health Organization (WHO) Global Health Expenditure Database (GHED). Through a landscaping exercise, Dr. Tandon, Dr. Maria Eugenia Bonilla-Chacin, Dr. Val Ulep, and other World Bank colleagues estimated country spending on

health as a share of the government budget. Participants were acquainted with an understanding of how to read data and analytics and given more information on the caveats to the analysis – *e.g. the dataset does not allow for the disaggregation of Donor Assistance for Health (DAH) from total government budget expenditure but does allow DAH to be disaggregated from the health budget*. Participants were cautioned against comparing across countries as health's share of government budget can be affected by the size of the country's government and other factors not apparent from the trend data; it is easier to compare across time for the same country. While Cuba's share of government spending on health is higher than Iran, the size of Iran's government is bigger.

Initial data analysis for the period from 2000 to 2016 showed that the highest annual growth in health's share of government spending among low income countries was in Myanmar followed by Guinea, Equatorial Guinea, Iran, and Sierra Leone; among high income countries, the highest annual growth in health's share of government spending was in Ireland, Singapore, Qatar, Saudi Arabia and Sweden. Conversely, the lowest annual growth in health's share of government spending among low income countries was in Venezuela followed by Iraq, Gambia, Djibouti, and Uganda; among high income countries, the lowest annual growth in health's share of government spending was in Greece, United Arab Emirates, Italy, Bahrain and Portugal. Dr. Tandon discussed potential reasons for the highest and lowest spending on health in each of these countries and provided evidence to demonstrate how a high increase in health's share of government spending can be attributed to an initial starting point of a low base of spending. Myanmar's health share of government spending was 1.6 percent in 2010 and grew to 5.0 percent in 2016 with an annual growth rate of 19.2 percent. Venezuela has seen a political, economic, and social crisis in the last ten years while Uganda may be experiencing a decline in the annual growth of health's share of the government spending due to a decline in external financing. Other low-income countries – Guinea, Equatorial Guinea, and Sierra Leone – are classified by the World Bank as Fragile, Conflict, and Violent situations. Fragility, conflict, and violence (FCV) is a critical development challenge that threatens efforts to end extreme poverty, and which affect both low- and middle-income countries. High income countries such as Bahrain, Greece, the United Arab Emirates, and Italy have a high health's share of government spending so their annual growth in health's share may be small.

At the end of the presentation, Mr. Tandon presented participants with a list of the top 30 countries (or top quintile of countries), based on an analysis of the GHED database, that had the highest reprioritization for health between 2010 to 2016. In a small exercise, tables of participants were assigned a country from this list and provided with a graphics table of indicators on reprioritization and public financing for health prior to a group discussion.

10. **Special Lunch Session on PM-JAY with Mr. Alox Saxena,** Joint Secretary, National AIDS Control Organization, Ministry of Health & Family Welfare, **and Ms. Kavita Singh**, Director – Finance, National Health Mission, Ministry of Health & Family Welfare, **with Ms. Sheena Chhabra and Dr. Owen Smith** of the World Bank India Country Health Team. **Moderated by Dr. Ajay Tandon** of the World Bank.

As an addendum to the inaugural session, the special lunch session provided an opportunity for participants to ask additional questions on the 2018 launched PM-JAY scheme.

Mr. Saxena and Ms. Singh explained that the National Rural Health Mission (now known as the National Health Mission or NHM) was conceptualized and launched in 2004/2005 with an initial emphasis on reproductive, child (immunizations, etc.), and maternal health. India has a robust private delivery system so the establishment of the NHM was intended to bolster public primary care delivery. In the 15 years prior to the launch of the Ayushman Bharat and the PM-JAY scheme, The Ministry of Health & Family Welfare (MoHFW) gradually designed and built institutional absorptive capacity, and also looked at learnings from past schemes such as Rashtriya Swasthya Bima Yojana (RSBY), which provided significantly narrower benefits compared to those now provided by PM-JAY and focused on a smaller target group for secondary care. The gradual launch and learnings from past schemes allowed Government of India to roll-out the PM-JAY in three months.

Ayushman Bharat's 150,000 health and wellness centers will create a continuum of care between primary and secondary/tertiary care for communicable (CD) and non-communicable disease (NCD) – prior to Ayushman Bharat, a continuum of care between primary and secondary/tertiary care only existed for reproductive, maternal, adolescent, and child health. With the newly introduced screening for cardiovascular diseases, diabetes, and cancer, the National Health Mission can exert greater control over their budget since spending can also be shared at the primary care level instead of being managed at only the secondary and tertiary levels. Early detection of NCDs and CDs through the provision of screening services at the primary care level is also expected to decrease catastrophic expenditures.

Participants were interested in claims management within the PM-JAY and how the scheme is prepared for collusion and fraud. Dr. Owen Smith explained how fraud is studied in three parts: prevention, detection, and deterrence. Mr. Saxena explained that fraud in PM-JAY focuses on prevention (through the smart design of the health scheme) since deterrence, such as through penalties, suspension, or disqualification will limit and disincentivize the number of providers within the scheme.

To decrease collusion in claims management, the Ministry of Health and Family Welfare established a dedicated fraud and claims management team. The scheme is implemented at the state level and each Indian state has its own state health agency. It was important to build state capacity for claims management with a robust IT system that allowed for online claims submissions and automatic claims payments through e-banking channels. If the claims management team detects patterns that could allude to collusion, the government can ring-fence services such as by reserving secondary treatment packages only for use in public health facilities. Although India does not have an anti-fraud law, it does have adequate design safeguards and field investigation teams at the state and district level.

Health service packages were designed for public and empaneled private hospitals, which apply to the scheme after learning of the associated cost of each package. The services can be executed in one of two ways – 1) through health insurance companies that apply through a tendering process and are provided with the health profile of each state prior to bidding or 2) through states, which float their own trusts using their own seed capital. Mr. Saxena stressed the importance of settling claims promptly as any delay burdens the insurance companies and can result in interest rate increases, which will allow for inefficiencies.

To prevent fraud at the point of the beneficiary – i.e. impersonation of beneficiaries or to prevent the use of services under a false identity – the scheme has pre-identified the entitled beneficiaries and uses the Aadhaar card scheme, a unique biometric mandatory identification scheme for the Indian population that is used for availing government services. In addition to the use of the Aadhaar, beneficiaries can create and establish a 'gold record' when they access the hospital at any visit, which establishes the identity of the beneficiary family and its individuals.

Participants requested more information on the referral process within the Indian health system and the challenges faced by the regulator. It was clarified that since the PM-JAY scheme is still in its implementation phase, a regulator has not been assigned. Referrals are not mandatory and entitled individuals with a specific need can walk in and avail hospitalization for secondary and tertiary care. PM-JAY's health and wellness centers will allow entitled beneficiaries who are unsure of the care they need to obtain referrals for inpatient secondary or tertiary care from public hospitals or private empaneled hospitals.

11. Discussion on determinants of reprioritization and eliciting reprioritization triggers (through a discussion of a draft questionnaire for informing case studies on what factors contributed to reprioritization)

Dr. Maria Eugenia Bonilla-Chacin and Dr. Val Ulep presented a summary of the literature on the determinants of reprioritization.

Most empirical studies on reprioritization focus on public expenditures on health as a share of GDP rather than as a share of government expenditure and will focus on cross-country differences in the share of public expenditure on health instead of the marginal change over time. Studies also noted that democratization, female political participation and income had a positive association (or higher health's share of government expenditure) with reprioritization while ethnolinguistic differences, and corruption had a negative association (lower health's share of government expenditure). External financing for health had both a positive and negative association and its impact on the share of health in the budget was unclear.

Major health reforms are characterized as sustained and deliberate and often accompany and/or trigger reprioritization of health in a country's budget. Before 2014, Indonesia had several health insurance schemes that covered different parts of the population. With the 2014 launch of Indonesia's UHC scheme - the Jaminan Kesehatan Nasional (JKN) - all of these schemes were unified and health's priority in the budget increased.

Reprioritization can also be triggered by economic, health, and political crises. Due to the Ebola health crisis, public spending on health as a share of government expenditures increased in Sierra Leone, Liberia, and Guinea; however, the increase was driven primarily by external sources.

Following a presentation on the 2017 OECD Survey on Budgeting Practices for Health, participants filled out and provided their feedback on a reprioritization questionnaire created by the Technical Team and based on the 2017 OECD Survey on Budgeting Practices for Health. The questionnaire was intended to gauge participant's knowledge of their country's health financing landscape and economy and their knowledge of reprioritization triggers within their country, while also providing the technical team with improvements to question phrasing. The technical team will use the feedback to refine the questionnaire and to determine

countries for focus in the 'case studies of countries that have reprioritized for health' deliverable of the DRM Collaborative.

12. Update on the Messaging Guide

Ms. Danielle Bloom presented the progress of the messaging guide and gathered participant feedback and country examples for the messaging guide content. Participants were encouraged to co-author, review chapters, and/or provide their country's experiences for the various chapters of the messaging guide, and several collaborative participants signed up for these enhanced roles to co-produce the messaging guide.

13. Health Financing & DRM: Exercise on Narrative Summaries

Dr. Emiko Masaki and Dr. Val Ulep led participants in a group exercise to familiarize them with the narrative summaries deliverable. Participants were assigned to tables according to their country. Country teams who had already provided their countries' past budgetary health data were provided with graphical analyses of their country data and asked to interpret the visualizations by completing a set of question prompts in a PowerPoint deck. Countries that had not provided their historical 10-15-year budgetary data were requested to interpret the graphical visualization of their peers and submit answers in a PowerPoint deck. The exercise demonstrated how participants can interpret their country's historical data for use in evidence-based arguments between Ministries of Health and Ministries of Finance and showed participants how they can co-author the narrative summary deliverable.

14. A Chat with Dr. Nasruddin Djoko Surjono, Deputy Director for Customs and Excise Policy, Ministry of Finance, Indonesia. **Moderated by Dr. Ajay Tandon** of the World Bank.

Dr. Surjono provided participants with a Ministry of Finance perspective on how to improve Ministry of Finance and Ministry of Health dialogue and engaged participants in a discussion on earmarking for health.

Indonesia has one of the world's highest smoking rates – which are rising- and with approximately 700 tobacco industries. Revenues from tobacco taxation comprise roughly 10 percent of Indonesia's total tax revenue. Ten percent of excise tariffs are local tax of which 15 percent of local tax is earmarked for the health sector. In addition to revenue earmarks for health, Indonesia's expenditure earmarks for health is a 5 percent minimum while 20 percent is for education.

Dr. Surjono explained that instead of giving health a bigger share of the government budget, the Government of Indonesia chooses to earmark recognizing that revenue earmarks and expenditure earmarks have different impacts. The legal framework and existing laws also influence earmarks. When the MOF discusses revenue earmarks for health such as taxes on sugar-sweetened beverages, the discussion involves the Ministry of Industry in addition to the Ministry of Health, which can also pose a challenging discussion for the Ministry of Finance. Any increases in tax revenues necessitates a calculation of the impact on economic growth, industry, and health. A short term and long term policy is considered and

investment in health is considered a long term policy with problems for industry in the short term.

In his moderating comments, Dr. Tandon noted that while Dr. Surjono conveyed the impacts of tax on economic growth, another consideration for a Ministry of Finance can include the impact of poor health outcomes or high out of pocket spending on economic growth. Health outcomes have also been shown to change very quickly and in contrast to the misconception that investing in health gives results only in the very long term. An investment in health is an immediate investment with immediate results. Investments in education can take 20 years to realize. Poor health is a form of distortion within the economy as people with poor health are unable to work.

Dr. Surjono also spoke of the national health insurance financing at the central and states level. The Ministry of Finance covers the premiums for approximately 92 million people through the central government and sees a very high utilization rate of hospitals under the JKN scheme.

Participants engaged Dr. Surjono in a discussion on cost control mechanisms for the regulation of health care providers and the allocation of external resources for health in humanitarian situations/natural disasters. Participants discussed the example of higher reimbursement rates for c-sections than normal deliveries in some countries, which can incentivize providers to claim reimbursement for unnecessary care. Dr. Tandon mentioned that some countries have imposed volume controls on the number of c-sections– once a certain number of c-sections are made by providers, the reimbursement rate for additional c-sections begins to decline in order to disincentivize providers. This helps protect the national health insurance system from an open ended payment system. Dr. Djoko noted that Indonesia did attempt to put a global budget on insurance reimbursements but that this has not been implemented. Indonesia is prone to tsunami's and earthquakes and has allocated a sovereign fund for disaster risk management. Sovereign funds collect resources that are raised from extractive industries such as oil and gas but are not used within a fiscal year. Indonesia also accumulates foreign exchange reserves for use in crisis situations.

Participants also discussed the elasticity of tobacco excise policy, or how responsive revenue is to an increase in prices or taxes. Dr. Djoko noted that in the last five years, the Indonesia Ministry of Finance has considered the elasticity of tobacco excise taxes in order to determine how much to increase the tobacco excise tax. In the last five years, the MOF has increased the tobacco excise tax approximately 10 percent every year. The Laffer Curve, which considers the relationship between revenue, tax rate, and economy is also considered in the determination of the tobacco excise tax rate. The Laffer Curve illustrates how the same revenue can be obtained at two different tax rates. The higher tax rate can stifle productivity while the lower tax rate can stimulate economies.

15. Summary, Next Steps and Wrap-Up

Dr. Somil Nagpal summarized the key outcomes from the meeting and provided an overview of next steps for the DRM Collaborative. The Collaborative agreed to meet for a virtual meeting in May-June 2019 and an in-person meeting in September 2019 to discuss progress

on deliverables, to contribute to any missing pieces, to consider the applications of the products in their country's context, and to determine any remaining next steps for the DRM Collaborative. Dr. Nagpal provided a quick overview of the upcoming and co-located fourth in-person meeting of the DRM Collaborative, which will provide participants with a better understanding of the linkages between efficiency and health while also familiarizing them on the progress of deliverables under the Efficiency Collaborative.

The technical team will follow up with the participant co-authors of the messaging guide and narrative summaries.

Nigeria and Senegal volunteered to host the fourth in-person meeting of the DRM Collaborative in September 2019, with co-location alongside the JLN global meetings also being an option.

Ms. Aditi Nigam thanked participants, donors, the technical team, the meeting support and AV/logistics staff, and closed the meeting.

16. Evaluation Feedback and Closing Remarks

Participants provided feedback on the third in-person meeting through a short open discussion and filled out evaluation forms. Overall, participants conveyed very positive feedback on the meeting and commended the friendliness and thoroughness of the World Bank technical team in presenting material in English and French and in engaging with participants. In their written responses, participants indicated an intent to share their learnings and materials from the meeting with their colleagues/supervisors through email and formal presentations and also expressed an appreciation for the sessions on DRUM, reprioritization, and the narrative summaries. The technical team notes that the sessions on the messaging guide and inventory of information on DRM efforts did not receive much participant feedback and will consider this in the planning of future engagements specifically on these deliverables. Participants requested clearer and larger handouts of graphical analysis used during the meeting and in the group exercises.

Next Steps

1. Meeting participants interested in co-authoring, reviewing, or providing more information on their country for case study components within the messaging guide are encouraged to kindly contact Ms. Aditi Nigam (anigam@worldbank.org) for more information.

2. Participants who would like to submit, analyze, or write narrative summaries for their countries based on their country's past 10-15 year budgetary data on health are kindly requested to contact Dr. Val Ulep (vulep@worldbank.org) for more information.

3. A virtual meeting to take stock on the development of products will be organized about two months before the fourth in-person meeting, which is planned for September 2019.

4. **Internal Communication** –
   a. **WhatsApp Group**: Collaborative participants are encouraged to send Ms. Aditi Nigam (anigam@worldbank.org) an email requesting to add them to the DRM WhatsApp group.

Please include your WhatsApp registered phone number and associated country code within the email.

b. **Online JLN Member Portal for the DRM Collaborative**: All DRM Collaborative members have access to the *DRM Collaborative's Member Portal Page* to engage in discussions and access shared materials including all presentations from this meeting. Please visit http://www.jointlearningnetwork.org/login to Login and/or Create an Account. Please contact Ms. Aditi Nigam (anigam@worldbank.org) or any member of the facilitation team with any questions related to the Member Portal.

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