
How to make budgets work for health?

A practical guide to designing, managing and monitoring programme budgets in the health sector



Edited by Hélène Barroy,
Mark Blecher & Jason Lakin

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Foreword

COVID-19 has been the ultimate stress test for government budgets. In country after country, the management and allocation of public budgets has been as important to the COVID-19 response as overall levels of funding, both in terms of getting money to the frontlines in the midst of the crisis and for the longer process of recovery. Inflexible budget formulations, weaknesses in budget planning and approval processes, and a lack of performance monitoring have all constrained effective responses to the pandemic. This book on budget formulation reform is released at a time when all countries are looking to rebuild their institutions, delivery systems and spending priorities or, put more simply, to build back better. The hard lessons of COVID-19 will need to be translated into policy responses that better protect societies and promote health and economic well-being. All of these efforts require budgets that are aligned to these objectives and that enhance flexibility while maintaining clear accountability for results.

Nowhere is budget reform more critical than in relation to those functions and foundations that support health security and overall progress towards UHC. The absence of investments in common goods for health, such as comprehensive surveillance, data and information systems, regulations, and communication and information campaigns, puts all of the gains achieved in providing universal access to affordable and high-quality health services at risk. Without effective budgeting processes there is a continued risk that these investments will never lead to lasting change.

This is where the key lessons and messages that emerge from this book become so critical. The transition away from rigid, line item budgets towards output-oriented budgeting is driven by the logic that expenditures should be grouped by and aligned with policy objectives or outputs, which are defined as programmes. For example, programme budgets can create an enabling environment to achieve health security. Interventions to achieve this objective may be related to disease surveillance, information systems, immunization, antimicrobial resistance, and stockpiling of drugs and supplies. While the specific departments or agencies responsible for each of these functions and related inputs may be distinct across the health sector, they can all contribute to a common and shared performance objective. This type of coordination, performance orientation and joint accountability is one way that budgeting processes can contribute to the actions needed to achieve relevant objectives.

As shown throughout this book, the devil is always in the details when it comes to implementation. The move towards programme budgets globally is driven by strong, underlying principles to empower budget holders to adapt and coordinate efforts to meet performance objectives in a transparent and accountable way. This book provides key tools and lessons for health ministry officials to harness the potential of programme budgeting through improved design, management, and performance monitoring. However, doing so successfully requires moving beyond the pilot phase, building close working relationships between health and finance authorities, and establishing strong PFM (Public Financial Management) systems that can support effective approaches for the health sector.

Joseph Kutzin

Head of the Health Financing Team, WHO



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Abbreviations

ABF	Activity-Based Financing	MTEF	Medium-Term Expenditure Framework
AIDS	Acquired Immunodeficiency Syndrome	MTSF	Medium-Term Strategic Framework
ART	Antiretroviral Therapy	NCD	Noncommunicable disease
CHF	Community Health Fund	NDP	National Development Plan
COFOG	United Nations Classification of the Functions of Government	NGO	Nongovernmental organization
CSO	Civil Society Organization	NHIF	National Health Insurance Fund
DBM	Department of Budget and Management	OCoB	Office of the Controller of Budget
DFF	Direct Facility Financing	OECD	Organisation for Economic Co-operation and Development
DHB	District Health Board	ONDAM	Objectif National des Dépenses d'Assurance Maladie
DIPRES	Dirección de dresupuestos	PBB	Programme-Based Budgeting
DoH	Department of Health	PBS	Portfolio Budget Statements
EHIF	Estonian Health Insurance Fund	PDIA	Problem Driven Iterative Adaptation
EPI	Expanded Programme on Immunisation	PEFA	Public Expenditure and Financial Accountability
FFS	Fee-For-Service	PFM	Public Financial Management
FMIS	Financial Management Information System	PHC	Primary health care
FONASA	Fondo Nacional de Salud	QBF	Quality-Based Financing
HIV	Human Immunodeficiency Virus	RHA	Regional Health Authority
IBP	International Budget Partnership	SGBP	State Guaranteed Benefit Package
IMF	International Monetary Fund	SMART	Specific, Measurable, Appropriate, Realistic, Time-Based
LGA	Local Government Authority	STI	Sexually Transmitted Infection
LGU	Local Government Unit	TB	Tuberculosis
LHIN	Local Health Integration Networks	ToR	Terms of Reference
LMIC	Low- And Middle-Income Country	UNICEF	United Nations Children's Fund
LOLF	Loi Organique Relative aux Lois de Finances	USHCN	Under Secretariat of Health Care Networks
LOLFSS	Loi Organique Relative aux Lois de Financement de la Sécurité Sociale	USPH	Under Secretariat of Public Health
MCH	Maternal and child health	WAEMU	West African Economic and Monetary Union
MHIF	Mandatory Health Insurance Fund	WB	World Bank
		WHO	World Health Organization



Editors' note

A collaborative effort

This book is a result of a WHO programme of work on PFM and budgeting in health led by the Department of Health Systems Governance and Financing between 2017 and 2021. The work emerged from a rewarding collaboration among independent PFM experts and experts working with the OECD, the World Bank Group and the IBP, all of whom contributed extensively to the book's development. Those who contributed to the book brought with them a wide range of experience on budget reforms and health financing policies, providing a unique mix of skills to guide practitioners in their future budget reform efforts.

A practical tool

The primary purpose of the book is to provide key stakeholders with a better understanding of the design, implementation and monitoring of programme budgets in the health sector in LMICs. This book is the first comprehensive examination of budget formulation issues in the health sector and the first attempt at providing a comprehensive list of lessons and recommendations for programme budgeting in health, grounded in practical experience. As the editors, we wanted this book to address, as much as possible, the practical concerns expressed by health stakeholders when introducing reforms. Without advocating for a single approach or tool, we highlight trade-offs that may arise when making choices around the design, implementation and monitoring of programme budgets in health. At no point in the book do we recommend a one-size-fits-all solution; rather, health stakeholders are prompted to consider key technical questions and assess potential trade-offs that may need to be addressed as they introduce budget formulation reforms or refine already existing programmes in the sector.

We speak PFM to health and health to PFM

Previous experience has shown us that programme budgets in health are more successful when health stakeholders are engaged in defining and implementing budget reforms. This guide is a tool to support that engagement. While this product is primarily intended to serve the health community's learning, it may also resonate with non-health actors, for instance budgetary authorities involved in the introduction of budget reforms. While reforms have proven to be challenging for all sectors to define and implement, reforms in the health sector present some unique challenges that require a tailored approach. By highlighting these features, the book offers an opportunity to resolve some of the sector bottlenecks that occur during the reform process and provide a platform for deepening the dialogue between health and budgetary authorities.

COVID-19 as an opportunity to foster budgetary changes

The COVID-19 crisis has shown that flexible budget formulation can facilitate the emergency response. Countries with a long history of programme budgets have been able to make flexible use of existing programmatic envelopes to direct resources to priority needs for COVID-19 testing, treatment and vaccine roll-out. Despite its challenges, the crisis is an opportunity to accelerate budget formulation transformations in LMICs with a view to more effectively supporting UHC and health security. We hope the book will contribute to this effort.

Hélène Barroy, Mark Blecher and Jason Lakin



Introduction

Hélène Barroy

Budgets are political and technical tools. When used optimally, they have the potential to reflect a government's policy priorities, allow for the efficient use of public resources and ensure transparency and accountability in the use of those resources. Public budgeting is the process by which governments prepare and approve strategic allocations of public resources. From the perspective of PFM, robust public budgeting serves several important functions: it sets expenditure ceilings, promotes fiscal discipline and financial accountability, and enhances efficiency in public spending (Dorotinsky, 2004).

Budget formulation is an important part of the budgeting process. The way budgets are presented, formulated and structured has an underrated influence on actual budget implementation. If multiple budget classifications can be used to present budgets, the dominant classification selected ends up shaping budget appropriations. The choice of budget classification is therefore crucial for actual spending as it largely defines how money is received and spent by different budget holders, as well as how public money is controlled and accounted for (e.g., by consumption of inputs versus by achieved service outputs) (Barroy et al., 2018).

Because programme budgets force the allocation and appropriation of public resources by policy goals and outputs, they have been one of the most promising PFM mechanisms to help link public resources to priorities and needs for a sector. It is a major reform to foster public sector performance, tested in nearly all countries across the world. In many LMICs, budgets have long been formulated and spent by inputs, a common occurrence that often creates inflexible budget structures which are too rigid to adapt to service delivery needs. The programme-budgeting approach offers an opportunity to introduce flexibility and greater orientation toward services.

Despite the potential benefits of the reform, health sector stakeholders have often lacked a solid understanding of the approach, its key merits and its requirements for success. When reforms are introduced, there is often a desire to define a common framework across sectors. However, there is often limited guidance given to sector stakeholders on how they can engage in the reform, which means the reforms are often poorly understood, only partially implemented and not tailored to the sector's needs.

The book is designed to improve the understanding of health sector stakeholders on budget formulation reforms by clarifying key concepts, synthesizing key challenges and lessons from country experiences, and offering evidence-based recommendations for ongoing and future reforms.

In Section 1 of the Introduction, we clarify key terms related to budget formulation, classifications and structures, and describe the conceptual background in which budget formulation reforms have been introduced. Section 1 also provides an overview of the general features and attributes of successful programme budgets. Section 2 describes the book's scope, rationale, and intended audience and explains how the book was developed. It also introduces the three main sections of the book: Part A) country evidence, Part B) reform challenges and policy options, and Part C) key recommendations.



1. Theoretical foundations

1.1 Budget formulation and classifications: Key definitions

In the public finance taxonomy, **budget formulation** refers to the organization of a government budget and is based on standard **budgetary classifications**. Budgetary classification systems follow commonly defined principles of sound budget management: the principle of comprehensiveness (i.e. the budget provides a consolidated and complete view of all transactions by government entities), the principle of unity (i.e. the same system is used for all government operations), and the principle of internal consistency (i.e. recurrent and capital needs are fully consolidated in the budget).

Budgetary classifications generally include four categories used across sectors (Jacobs, Héris & Bouley, 2009). Applied to health budget provisions,¹ they consist of the following:

- **Economic:** expenditure by economic category, generally referring to inputs (e.g. compensation of personnel), presented by line item (e.g. fuel, dialysis equipment) or grouped into broader categories (e.g. goods and services, subsidies and transfers).
- **Administrative:** expenditure by administrative divisions or departments responsible for budget implementation (e.g. health ministry department, district, hospital, agency).
- **Functional:** expenditure by sector (e.g. health, education) and predefined functions within sectors as per the United Nations Classification of Functions of Government (COFOG) (e.g. outpatient services, research and development).
- **Programmatic:** expenditure grouped by policy objectives or outputs, defined as programmes (e.g. primary health care, quality of care).

Historically, countries have organized their budgets predominantly by **economic classification**, which provides a framework for controlling the use of inputs. An **input-based budget** refers to a budget that is formulated around the main inputs upon which expenditures are based, for example personnel, goods and services, or capital (Table 1). The strengths of such a system are its relative simplicity and its potential to control public spending through the detailed specification of inputs.

A **line-item budget**, a term often used in relation to an input-based budget, presents expenditure by disaggregated objects of expenditure (e.g. fuel for primary care facilities, dialysis equipment for district hospitals, utilities and office supplies). A prominent feature of a line-item budget is to specify the line-item ceiling in the budget allocation process and to ensure that budget holders do not spend in excess of their caps.² The line-item approach can stand in the way of efficient planning and management of public resources, as well as output-oriented accountability given its focus on allocations and expenditure per line item. This tends to drive decision-making around the details of the budget, leading to micromanagement by budgetary authorities of budget holders and limiting managerial discretion over resource management (Shah & Shen, 2007).

1 Health budget provisions are defined in this book as budget allocations to health ministries and to their attached agencies and bodies. Purchasing entities (e.g. national health insurance funds) that contract and purchase individual services to providers are often placed outside regular budget processes with various levels of institutional and financial autonomy. Such separate arrangements frequently have their own budgeting processes, as well as formulation and classification requirements for expenditures. However, budget transfers and other subsidies from various central ministries (generally from health ministries, treasury or social affairs authorities) or local government entities that are then directed to those purchasing entities generally continue to abide by regular public budgeting and formulation rules. They are therefore included in this book's scope.

2 While inputs refer to the content of budget lines, a line item refers more directly to the presentational characteristics of input-based budgets (i.e. disaggregated lines of inputs). However, in practice, the two terms – input and line item – are often used interchangeably.



TABLE 1.**Example of a line-item budget in health**

OBJECTS OF EXPENDITURE	
21	COMPENSATION OF EMPLOYEES
211101	Basic salary – civil service
211110	General allowance
211126	Professionals
22	USE OF GOODS AND SERVICES
221101	Foreign travel – means of travel
221102	Foreign travel – daily subsistence allowance
221103	Foreign travel – daily incidental allowance
221202	Water and sewage
221203	Telecommunications, internet, postage and couriers
221208	Internet provider services
221209	Scratch-cards
221401	Fuel and lubricants – vehicles
221402	Fuel and lubricants – generator
221501	Repair and maintenance – civil
221502	Repair and maintenance – vehicles
221601	Cleaning materials and services
221602	Stationery
221105	Drugs and medical consumables
221114	Vaccines and vaccination supplies
221116	Family planning supplies
221907	Scholarships – local
222103	Food and catering services
222109	Operational expenses
222115	Guard and security services
222106	Vehicle insurance
25	SUBSIDY
253102	National drug service
253104	Family Planning Association of Liberia
253202	Seventh-Day Adventist Cooper Hospital
253203	Eternal Love Winning Africa Hospital
253204	St. Joseph Catholic Hospital
253107	West African College of Physicians

Source: Government of Liberia (2020).



Budgets may include both **functional classifications** and economic classifications. Generally, functional classifications allow budgets to be split into consistent functions or subfunctions, meaning split according to the purpose for which the funds are used. COFOG is a tool developed by the OECD and published by the United Nations Statistical Division that classifies government expenditure by the purpose for which the funds are used. It includes 10 first-level functional groups, such as health, which are then split into up to nine second-level subgroups. For health, COFOG defines six main categories of expenditure (see Table 2).

TABLE 2.

Functional classification for health under COFOG

Health	• Medical products, appliances and equipment
	• Outpatient services
	• Hospital services
	• Public health services
	• R&D health
	• Health N.E.C.

Source: OECD (2011).

When an **administrative classification** appears in budgets, it generally provides a breakdown of expenditure by entities in charge of implementing the budget. In health, administrative classifications can include budget provisions for implementing agencies (e.g. a disease control agency), subnational levels (e.g. regional or district levels in decentralized settings) and health facilities, often autonomous hospitals that are recognized as separate spending units. Some administrative classifications may also include provisions for purchasing agencies (e.g. national health insurance funds), though these often operate under separate budgets with their own formulations, processes and execution rules, much like extrabudgetary funds (Allen & Radev, 2010).

A **budget formulation reform** is a change in the predominant budgetary classification used to formulate and appropriate budgets. Generally, it is associated with a country's shift from an economic classification to a programme classification, which groups budgetary lines according to policy goals and outputs. Budget formulation reforms are accompanied by a change in spending rules to drive more effective spending.

A **programme budget** refers to a budget that is formulated by budgetary envelopes that aggregate budget provisions into programmes that contribute to a common set of policy goals and outputs (Table 3). Budget reforms try to remedy some of the deficiencies associated with input-based budgets and shift the focus from inputs to outputs, empowering budget holders with more managerial control over programmatic envelopes tied to agreed targets. Programme budgets can boost performance and efficiency in the planning and use of public resources.

TABLE 3.

Example of a programme budget in health

Programmes
1. Administration
2. National Health Insurance
3. Communicable and Non-communicable Diseases
4. Primary Health Care
5. Hospital Systems
6. Health System Governance and Human Resources

Source: Republic of South Africa (2019).



Currently, there is a renewed interest in performance budgeting systems (Shah & Shen, 2007). In the early 2000s, multiple terms emerged to describe budget systems that strengthen performance through resource allocation and management, such as **performance-based budgeting and output-based budgeting** (Robinson, 2013, 2018; Ho, de Jong & Zhao, 2019). While these terms are often used interchangeably, there is a significant conceptual difference between programme budgets and performance-based or output-based budgets. The former refers to budgets formulated by programme, with resources often linked to a performance framework. The latter refers to budgets that use performance information to inform budget monitoring, irrespective of its formulation. In performance-based or output-based budgets, the link between performance management and the budget allocation system is not formalized. But, in fact, most performance-oriented budgets use programmes to formulate budget expenditure.³

In this book, programme budgets refer to budgets that have transitioned to a programme-based formulation to align allocations with policy priorities and provide greater spending flexibility and accountability to budget holders in health. While the term **programme** is often loosely used in many situations, in this book the term is tied closely to budgets, as a budgetary envelope that funds a defined set of policy goals and outputs.⁴

In programme budgets, programmes are generally presented alongside a narrative that explains the background and rationale for policy goals, and a **performance monitoring framework** that defines **indicators** and **targets** for predefined **outputs**.

A **programme structure** typically includes subcategories, which are the means for implementation. These subcategories are often subprogrammes or activities, which may also be called products, interventions, initiatives or projects (see Glossary p.160).

1.2 Budget formulation reforms: origins and key features

Budget formulation reforms were first introduced in the United States of America to enhance flexibility and accountability in the use of public resources. The Hoover Commission pioneered the approach in the late 1940s to enhance government efficiency after the Second World War. The Commission introduced a federal programme budget to shift the focus away from government inputs and towards its functions, activities, and key accomplishments (United States General Accounting Office, 1997).

Political scientist Allen Schick built on the theory in the 1960s, framing the transition in the United States as a radical shift in budgeting – redesigning budget categories, developing programmes and activities, and introducing output measurement (Schick, 1966). Schick (1966, p. 243) viewed this reform as a “revolutionary development in the history of government management” and a major contribution to better management of resources in government systems.

During the 1990s, with New Public Management having been introduced as a potential approach to running public service,⁵ budget formulation reforms gained currency in other high-income countries, including Australia, France, the Netherlands, New Zealand and the United Kingdom (OECD, 2007; Kraan, 2007). In these settings, reforms often included a change in budget formulation and the integration of private sector management practices, like performance monitoring, into public budgets.

Since the late 1990s, budget formulation reforms have been increasingly introduced in lower-income countries with support from international financial institutions, primarily the IMF and the World Bank Group.⁶ Over the past three decades, budget formulation has been at the forefront of PFM reforms to improve efficiency, transparency and accountability in the use of public money in LMICs. When reforms are introduced, the health sector or other social sectors are often chosen to pilot the endeavour, putting the sector at the forefront of reforms in many LMICs (Ho, de Jong & Zhao, 2019).

3 Programmes may be presented as programmes (e.g. France, Republic of Korea), outputs (e.g. New Zealand), outcomes (e.g. Australia) or requests for resources without formulated programmes (e.g. United Kingdom) (CABRI 2013, 2019).

4 Budgetary programmes are different from operational programmes. In the public finance literature, a budgetary programme is a budget line that groups, within the same budget envelope, inputs to facilitate public spending. However, a budgetary programme can be implemented by various agents and entities that report against predefined outputs. An operational programme, a term generally used to refer to disease-oriented interventions in health policy literature (e.g. HIV/AIDS programme, leprosy programme), is an operational approach that refers to the implementation of certain activities and operations, generally through a programme cycle management approach. The operational programme can be funded through various sources, including budgetary programmes, where they exist.

5 New Public Management was first introduced by academics in Australia and the United Kingdom (Hood, 1991; Hood & Jackson, 1992) to describe approaches that were developed during the 1980s to improve public service efficiency by using private sector management models.

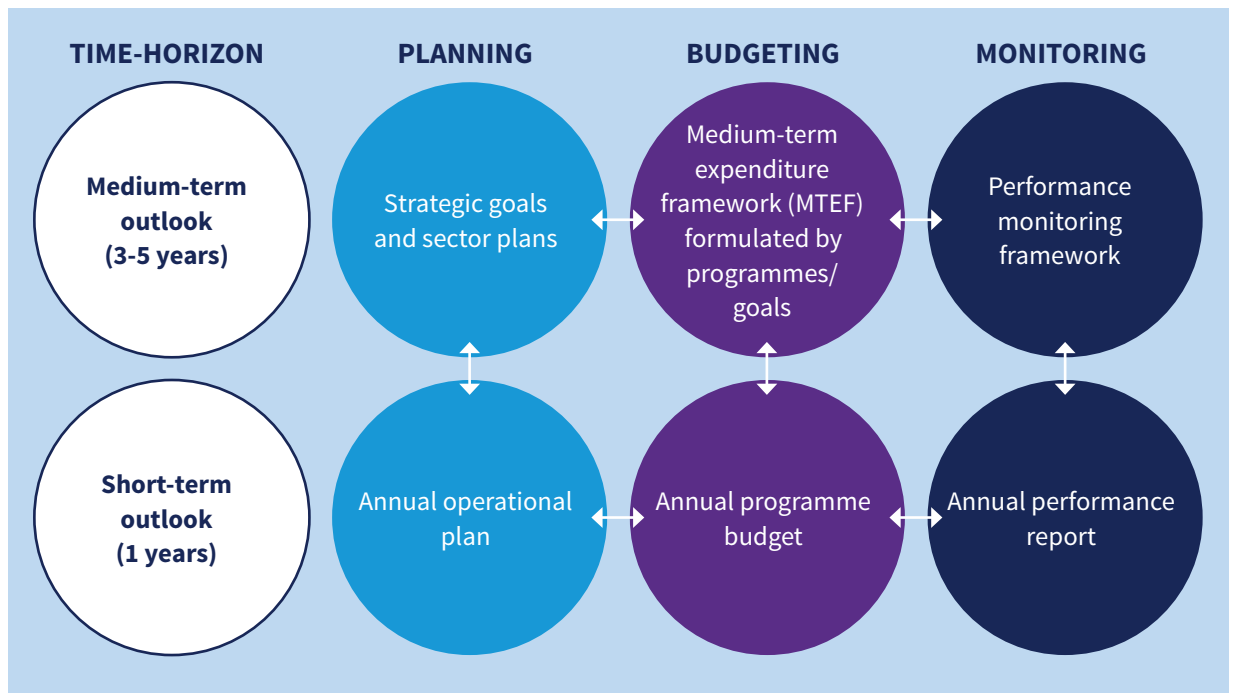
6 Budget formulation reforms were introduced as part of broader PFM reforms to enhance public sector performance and overall accountability. PFM reforms typically include a range of interventions (Allen et al., 2017), such as: introducing multi-year budget planning and expenditure frameworks; changing the overall formulation and structure of the budget; and strengthening financial information systems.



Over time, budget formulation reforms have increasingly been viewed as an effective means to address traditional spending rigidities associated with input-based budgets (Schick, 2004). Reforms have eventually been universally acknowledged as an approach that can effectively link the allocation of funds to the achievement of certain outputs, and one that can reconnect planning, budgeting and monitoring processes. Reforms were also viewed as a means to empower budget holders to manage resource envelopes and to hold them responsible for achieving results, as budget holders would be given lumpsum appropriations and have the flexibility to use the funds to achieve agreed-upon outputs (Figure. 1).

FIGURE 1.

Planning, budgeting and monitoring in programme budgets



Public sector expert Mark Robinson, one of the designers behind the model for budget formulation reforms in LMICs, has argued that successful reforms involve: i) ensuring public funds are allocated to results-based programmes; ii) radically reducing line-item controls; and iii) collecting programme performance information and using it to inform decisions throughout the budget preparation process (Robinson, 2007). These key attributes have been used as the basis for implementing reforms across sectors (Box 1) (Diamond, 2013; Ho, de Jong & Zhao, 2019; Robinson, 2007, 2018; Robinson & Last, 2009).

BOX 1.

Generic guidance for the introduction of programme budgets

When introducing programme budgets in any sector, certain programme categories can be used to group expenditures. Generally, between three and five programmes (and a maximum of eight) are selected per sector or within each ministry often including:

- **policy-based programmes**, which serve a specific policy goal (e.g. quality of care, preventative health care);
- **population- or service-based programmes**, which focus on certain segments of the population or on a set of services (e.g. primary care, secondary education, support for migrants); and
- **support or administrative programmes**, which include support the delivery of other programmes.

Ideally, programmes are structured hierarchically, with programmes divided into subcomponents which are then further divided by activities, interventions or projects. The most common programme structure consists of three layers: programmes, subprogrammes and activities (Robinson, 2007). Activities may support implementation but they do not always need legislative review and approval. When a chain of results links a programme's goals to its subcomponents, it adds to the likelihood that programme outputs will be achieved (Tat-Kei Ho, 2019).

When introducing programme budgets, robust documentation, generally submitted for legislative approval, should lay out: i) the programme's objectives and how they are linked to sectoral priorities; ii) key outputs that the programme plans to deliver; and iii) how the programme will achieve its objectives, including activities, projects, allocated resources for specific activities, and key performance indicators.

A conducive environment for budget formulation reforms requires broader technical and institutional conditions to support implementation (Shah & Shen, 2007). These conditions may include: ensuring line ministries have the motivation and technical capacity to engage in the design of programmes; making sure that all necessary legislative and regulatory changes are made to the PFM framework; eliminating resistance to relaxing input-based controls; creating managerial capacity so that management gears resources towards the achievement of outputs; and tailoring financial information systems to the reform. Experience has shown that there should also be clear lines of managerial responsibility for each programme and that programmes should be tailored to fit existing institutional arrangements to ensure their effectiveness and to improve accountability.

As more LMICs try – and sometimes fail – to transition to the new approach, the challenges to successful implementation of budget formulation reforms have become increasingly clear (Diamond, 2013). Critics of the approach, including some experts and policy-makers, have raised questions around both the complexity of reforms and the capacity needed for implementation. Several experts have stressed the need for broader changes and additional PFM reforms, beyond the budgeting process alone, for reforms to be fully operational (Allen, 2009; Andrews, 2010, 2011).

To tailor reforms to the specific needs and challenges of each country, experts have recommended careful sequencing, through a process like Problem-Driven Iterative Adaptation (PDIA) (Andrews, Pritchett & Woolcock, 2017; Allen, 2018). There is now a general understanding that basic PFM functions – such as a credible budget, a system that can support full budget execution, and a reliable reporting system – must be in place before introducing more sophisticated budget formulations, such as programme budgets.



2. Book overview

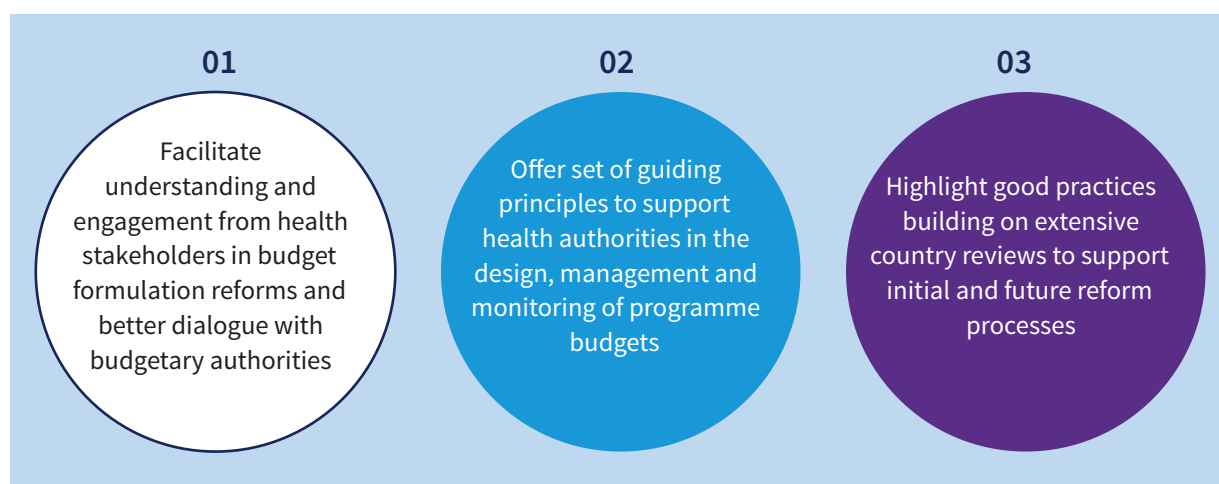
2.1 Audience and goals

Health authorities in LMICs have frequently expressed concerns around engaging in budget formulation reforms, given the disconnect between budget processes and reforms and health policies. Transformations in budget formulation often seemed abstract and unrelated to health sector priorities. On several occasions, health authorities have asked WHO and partners for sector-specific guidance to support more proactive engagement in the reform process, to inform their collaboration with budget authorities and to assist budget holders – central departments, health districts and facilities – in the design and implementation of these reforms.

This book offers practitioners in MoH planning and budgeting units a set of guiding principles and policy options to help them face key challenges related to the design and implementation of reforms, from formulating and structuring programmes to managing funding flows in collaboration with budget authorities and setting up reliable performance monitoring frameworks.

FIGURE 2.

Key objectives of the guidance book



The book may also be useful for health facility managers, providing them with a better understanding of how budget formulation can affect funding flows to frontline facilities and how it can create incentives to enhance health service delivery. Such an understanding can improve how facility managers engage in reform processes and help tailor reforms to service delivery models.

Policy-makers may also find this book of interest, especially budget and finance leaders eager to understand health-specific challenges related to budget formulation reforms. Treasuries sometimes struggle to put on a sector lens. A better understanding of these challenges may lead to improved collaboration and compatibility between the health sector and finance.

The book may also be of interest to global development partners, such as the World Bank, Gavi, the Global Fund, UNICEF, and bilateral health sector donors and foundations with an interest in using domestic PFM systems in LMICs to transition away from international aid. The book offers direction to those interested in the use of budget formulation reforms to serve priority needs in primary care, foster sustainable gains in the fight against certain diseases (e.g. HIV/AIDS, malaria, noncommunicable diseases) and/or to improve key public health functions (e.g. surveillance, diagnostics, immunization). The book details how programme budgets can help tailor budget arrangements for these long-term investments, allowing both flexibility and accountability for outputs.

2.2 Development

The book was developed in five distinct and complementary phases between 2017 and 2021, involving a range of country and topic experts working under the guidance and leadership of the WHO. (Figure 3)

FIGURE 3.

Book development process



Phase 1. Literature review and budget mapping

Work began in 2017 with a review of existing literature on budget formulation reforms. The goal was to generate a better understanding of the main features of reforms and their rationale, as well as overall issues related to their design and implementation. During this phase, budget documents from more than 100 countries were also retrieved from primary finance sources and stored in a publicly available repository.⁷ The repository was later updated to include budgets from 2018 to 2021. The documents were analyzed for structure and formulation, with a focus on the health-related parts of each budget. The review and mapping process provided a clear image of existing budget formulations in the health sector and an overview, based on 2019 budget laws, of the penetration of reforms.

Phase 2. Reform implementation assessment

Following a review of published and grey evidence on reform implementation, the WHO, IBP and OECD began an in-depth review of budget formulation reform implementation in health. The review took place between January 2018 and December 2020 and covered 14 countries across a range of income groups and regions of the world.⁸ The main goal of the country analysis was to better understand the reform process and its outputs on the ground, and to identify good practices and common challenges for the health sector. Countries selected for the in-depth review were at a relatively advanced stage of the reform process – a deliberate choice to improve the chances of generating meaningful lessons about the process and its outputs. Country studies were released as stand-alone publications (see pp. xx) and have been summarized as country briefs for this book (see Part A, Chapter A3).

7 The repository is available at <https://www.who.int/news/item/18-04-2021-updated-repository-of-health-budgets-2021>

8 The countries included in the review are: Armenia, Brazil, Burkina Faso, Chile, Gabon, Ghana, Indonesia, Kyrgyzstan, Latvia, Mexico, New Zealand, Peru, Philippines and Uganda.



Phase 3. Stakeholder consultations

Multiple global, regional and national consultations were held with a range of health and finance stakeholders to enhance the understanding of the challenges associated with introducing budget formulation reforms in health. The consultations also provided an opportunity to discuss the relevance and feasibility of possible policy actions. Meetings were held with country planning officials, budgeting officials, health planners, those involved in MoH financing and budgeting, development partners supporting budget reforms, and NGOs active in health budget advocacy and reforms. Key consultation meetings included:

- a pre-meeting workshop on budget formulation reform in health, held in Montreux, Switzerland, 30 October–2 November 2017: 3rd Meeting of the Montreux Collaborative on Fiscal Space, Public Financial Management, and Health Financing, Public financing for UHC: towards implementation (WHO, 2017);
- consultative sessions on budget formulation reforms in health, held in Nairobi, Kenya, 25–28 September 2018: Public financial management for sustainable financing for health in Africa: first regional workshop (WHO, 2018);
- an organized session, held in Accra, Ghana, 11–14 March 2019: 5th International Conference of the African Health Economics and Policy Association (WHO, 2019a);
- meeting sessions on budget formulation, held in Montreux, Switzerland, 12–14 November 2019: 4th Meeting of the Montreux Collaborative on Fiscal Space, Public Financial Management and Health Financing (WHO, 2019b); and
- budget formulation country workshops, held in Armenia (February 2018), Burkina Faso (July 2018), and Ghana (December 2019).

Phase 4. Guidance notes

The fourth phase of the work consisted of producing a series of short guidance notes on the most problematic aspects of budget formulation reforms for health which emerged during the review and consultation processes. Between 2019 and 2020, subject matter experts from the WHO, World Bank, OECD and IBP developed three guidance notes to address key aspects related to: i) the design of programme budgets; ii) implementation and management of programme budgets; and iii) performance monitoring under programme budgets, with a specific focus on health. A fourth note was commissioned to the OECD on lessons learned in high-income countries on programme budgets in health. Two complementary surveys were conducted between January and March 2020. Fifteen country case study authors and country stakeholders were surveyed about the costing of budgetary programmes and political economy considerations for the introduction of reforms in the health sector.

Phase 5. Book development

The book's editors worked together in 2020 and 2021 to compile lessons learned throughout the study process and to structure the book. Building on the guidance notes and country study findings, the book's contributors (see list of contributors, p. V) developed the core chapters of the book, meeting regularly in-person and virtually in 2019 and 2020. All of the book's country briefs were produced jointly by the editors and study authors and reviewed by WHO regional and country colleagues, as well as country authorities. A final review process was organized in October and November 2020 with a select group of external peer reviewers from international organizations and targeted country experts.



2.3 Structure

The book is split into three main parts: Part A provides an overview of country evidence; Part B offers an analysis of key challenges and policy options; Part C summarizes key recommendations for policy leaders, practitioners and development partners.

Part A. Country evidence

Part A provides an overview of reforms in countries with varying income levels and from different regions of the world. These experiences provide insight into the progress of reforms and offers practitioners the opportunity to learn more about the objectives of reforms and the diversity of approaches in the health sector.

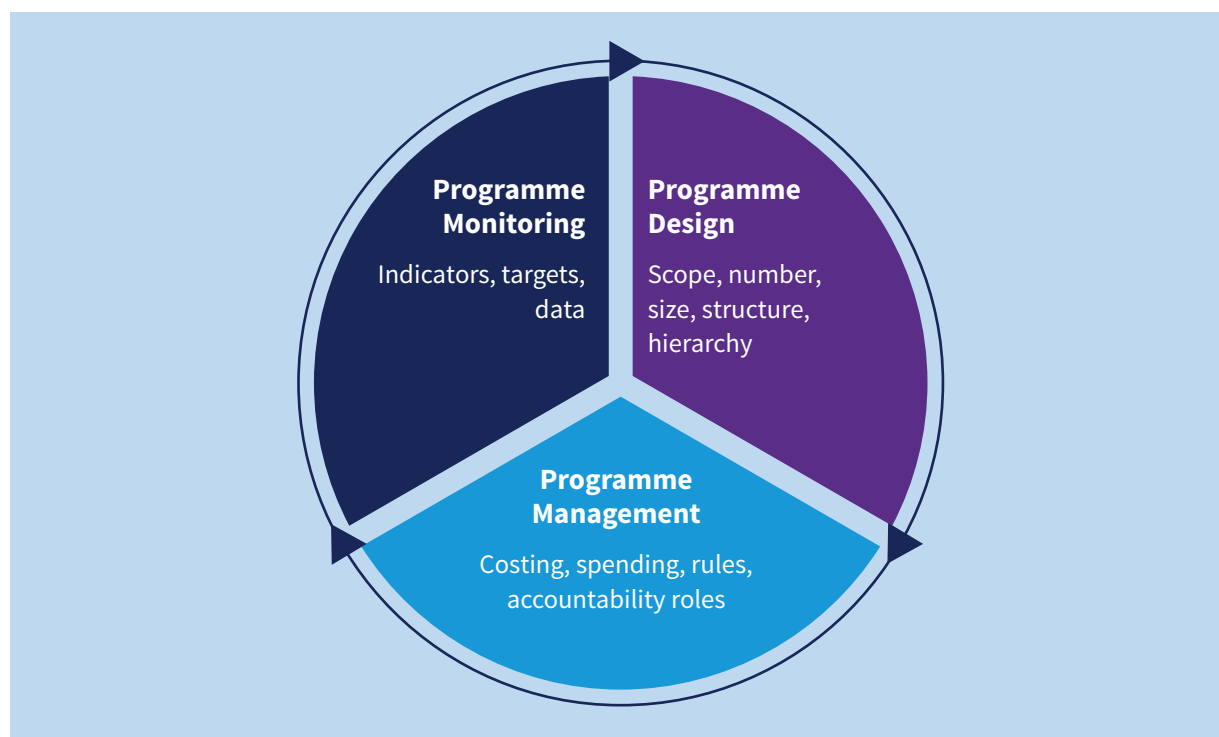
The first chapter in Part A summarizes how reforms have been implemented in OECD countries; the second chapter summarizes the implementation of reforms in LMICs; and the third chapter provides detailed information on the development of budget formulation reforms in health in 14 countries: Armenia, Brazil, Burkina Faso, Chile, Gabon, Ghana, Indonesia, Kyrgyzstan, Latvia, Mexico, New Zealand, Peru, The Philippines and Uganda. The fourth and last chapter in Part A offers practical insights from three policymakers from health and finance who were directly involved in implementing budget formulation reforms.

Part B. Challenges and policy options

Part B discusses the challenges that often arise in the health sector when introducing or refining budget formulation reforms. The challenges are grouped into three broad categories aligned with the budget cycle: programme budget design, management, and monitoring (see Figure 4). The chapters in this part of the book describe i) the challenges commonly encountered at each stage of the budget cycle and ii) offer policy options based on good practices across countries.

FIGURE 4.

Focus areas of the guidance book – a full budget cycle approach



1) Programme budget design: The health sector often faces challenges aligning programme budgets with health sector priorities. Often, programmes end up poorly formulated and poorly structured, without a clear chain of results. Programmes also often mix inputs and outputs and treat disease interventions separately. This can lead to overlap, duplication and unnecessary complexity in expenditure management at both the central and provider levels. Chapter B1 describes these questions that arise when designing health-specific programmes and offers guiding principles to address design-related challenges based on the practical experience of LMICs.

2) Programme budget management: Implementing reforms requires a change in spending practices, which has proven to be the most challenging aspect of implementation. Input-based controls often remain in place despite changes in budget formulation. When this occurs in the health sector, service providers struggle to implement a real, output-based financing system. Chapter B2 covers the key challenges of expenditure management in health following a change in budget formulation. Chapter B3 focuses on the link between budget formulation and provider payment reforms, and the degree to which these processes align and reinforce each other to drive health outputs.

3) Programme budget monitoring: When it comes to accountability, introducing budget formulation reforms is both an opportunity and a challenge. Countries often define a performance framework alongside budget formulation reforms to increase accountability towards results. A monitoring framework provides an opportunity for countries to consolidate financial and non-financial performance information, including those that span disease components. However, performance monitoring is not without its own challenges, such as determining the quality of information gathered and how that information will be used to monitor performance and make budget decisions in the future. These issues are discussed in detail in Chapter B4, which also offers practical insights to help address common concerns.

Part C. Policy recommendations

Part C offers a comprehensive set of recommendations for high-level policy leaders, reform practitioners and development partners. The recommendations can help guide stakeholders through future budget formulation reforms.

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Part A. Country evidence



1. Programme budgeting in health in OECD countries

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Introduction

OECD countries have a long-established history with programme budgets. Australia, Canada, France, New Zealand, the Netherlands, Spain and Sweden have had programme budgeting frameworks in place for many years. In Spain, a change in budget classification came through the legislature with the introduction, in 1977, of a budget act requiring line ministries to formulate the budget by programmes. Australia began a process of budget reform in 1984 to remove tight controls on the management of public finances. In 2001, France introduced a budget law, the *loi organique relative aux lois de finances* (LOLF), which included the development of the programme budget structure. The law was introduced in stages and was applied to all departments in 2006. The Netherlands used a big bang approach to quickly implement programme budgeting reforms between 2001 and 2007, focusing heavily on performance information.

Latin American countries, including Brazil, Chile and Mexico, also have a long history of programme budgeting. In Chile, reforms date back to 1993 when the national budget directorate (*Dirección de Presupuestos, DIPRES*) of the Ministry of Finance (MoF) implemented a pilot programme with performance indicators in five public institutions. By 2001, DIPRES had a results-based budgeting process in place covering almost every sector of government and all the major institutions in the public sector. Mexico introduced programmes in the 1970s. In 2008, further reforms were implemented to develop a performance budgeting system with a programme structure requiring that the budget include objectives, goals and indicators for programmes. Initial programme budgeting reforms in Brazil began as early as the 1930s and 1940s, with attempts to link public spending to specific objectives. In the 1960s, programmes began being introduced in a more systematic way, with an annual programme budget detailing the implementation of multi-year programmes (de Renzio, 2018).

In all these countries, the reform journey was not without challenges. Many of the challenges faced by OECD countries echo those faced by lower-income countries. This chapter examines OECD country experiences in programme budgeting for health and highlights the lessons learned. Section 1 looks at the key features of budgetary programmes used in the health sector in OECD countries, while Section 2 highlights key challenges associated with the implementation of programme budgets given the characteristics of health systems in various OECD countries. The chapter ends by looking at the links between programme budgets and performance monitoring.



1.1 Key features of programme budgets in health

Scope of programme budgets

In Latvia and New Zealand, programme budgeting covers most of the expenditures on health. The national health systems in these countries allocate pooled funds to health-care providers. Programme budgeting in Australia, Canada, Chile, Mexico, Norway and Spain covers some expenditures, including those for national health agencies and central ministries, and has been implemented by some or all subnational governments or social health insurance institutions. However, programme budgeting initiatives do not cover some expenditures related to service delivery.

The scope of programme budgeting reforms in the health sector in Estonia, France, Italy, the Netherlands, and Sweden is limited. The reforms only cover core expenditures within the MoH and focus instead on public policy or the monitoring, regulation and supervision of the health system. In Italy and Sweden, most expenditure is included in the budgets of subnational governments. In Estonia, France, and the Netherlands, most expenditure is covered by single or multiple health insurance funds.

Number of budgetary programmes

The number of budgetary programmes varies markedly across OECD countries. Canada, Estonia, France, and Latvia have a limited number of programmes, though these can be broken down into a range of subprogrammes. Latvia, for example, has 27 subprogrammes. Conversely, the budgets in Mexico and New Zealand contain a greater number of programmes for health.

Budgets for health vary widely in their nature and scope. Precise recommendations on the number and size of budget programmes prove a challenge. A notable change to the programme budgeting formulation in Latvia occurred in 2011 with the breakdown of one major programme into multiple subprogrammes, which were based on the type of service provided. The change bolstered the traceability and transparency of expenditures.

A budget containing many small programmes can also present challenges, by complicating the process and creating rigidities meant to be eliminated by programme budgeting. Most OECD countries have avoided this approach. Countries that have a high number of budget programmes split them among several agencies within a portfolio, as in Australia. Managers are granted the flexibility to allocate resources within their agencies.

Programme budgeting has been used in New Zealand as a tool to manage and allocate costs for most health expenditures. Vote Health is the main source of funding for the health system, covering the majority of functions such as governance, service delivery, information systems, and the health workforce; this justifies the higher number of programmes. Twenty of the programmes provide funding to 20 District Health Boards (DHBs), which are responsible for delivering health services.

OECD countries with the most experience in performance budgeting – Australia, Canada and France – have steadily reduced the number of health programmes over time. Italy, the Netherlands, New Zealand, Norway, Spain and Sweden have seen little change in the number of programmes (OECD, 2019b).

TABLE A1.1.

Overview of programme budgeting design

Country	Coverage of Programme Budgeting	Number of Programmes on Central Budgets for Health	Central Budget/s for Health Care
High – programme budgeting covers most health expenditure (including service delivery)			
Latvia	All expenditure of National Health System	13	Ministry of Health
New Zealand	All expenditure of National Health System	53	Vote Health – Ministry of Health
Medium – programme budgeting covers some health expenditure (including at subnational level, or by social security institution)			
Australia	National agencies responsible for health, and implemented by some subnational governments (SNG)	23	Health Portfolio
Canada	National agencies responsible for health, and implemented by some SNG	13	Health Portfolio
Chile	National agencies responsible for health and the National Health Fund (FONASA)	21	Under-Secretary of Public Health, the Under-Secretary of Health Care Networks, and FONASA
Mexico	MoH, and some social health insurance (SHI) expenditure (Seguro Popular and IMSS)	31	Secretary of Health
Norway	Some expenditure of National Health System	10	Ministry of Health and Care Services
Spain	MoH expenditure, and implemented by some SNG	6	Ministry of Health, Social Services and Equality – Health Expenditure Policy
Low – programme budgeting covers limited health expenditure (excluding most service delivery)			
Estonia	MoH expenditure, excludes budget of SHI	3	Ministry of Social Affairs – Health
France	MoH expenditure, excludes budget of SHI	2	Health Mission (under the supervision of the Ministry of Solidarity and Health)
Italy	MoH expenditure, excludes SNG expenditure	16	Ministry of Health
Netherlands	MoH expenditure, excludes budget of SHI	11	Ministry of Health, Welfare and Sport
Sweden	MoH expenditure, excludes SNG expenditure	6	Expenditure area – Health care, medical care and social services (Ministry of Social Affairs)

Note: This table relates to the number of health programmes at the central government level. A programme refers to the lowest level defined in the budget appropriations bill and where the authorisation of spending takes place.

Programme structure

Each country has a unique programme structure, with programmes defined, aggregated and disaggregated in a variety of ways (see Table A1.2). Most countries have designed programmes with more than one level, breaking down programmes into smaller units. Some have disaggregated using subprogrammes, actions or activities. Estonia has one of the more complex programme hierarchies, with four levels in its budget documents, including a higher level for strategic planning and two lower levels for agency management. Initial findings suggest that Estonia's programme hierarchy is clear and has provided full transparency and a strong system of accountability. In contrast, only Chile and New Zealand include one programme level.

Experiences across OECD countries suggest that disaggregating programmes can promote transparency, especially when programme objectives are broad. However, excessive detail below the programme level should be approached with caution if it leads to an excessive administrative burden on external reporting requirements. A programme hierarchy with many levels also increases expenditure monitoring requirements during budget execution. Moreover, the disaggregation of programmes is heterogeneous across countries but should be consistent within a country and across ministries.

TABLE A1.2.

Programme hierarchy structure

Australia	Outcome, programme
Canada	Programme, subprogramme
Chile	Programme
Estonia	Programme, measure, programme activity, service
France	Mission, programme, action
Italy	Mission, programme, administrative unit, action
Latvia	Programme, subprogramme
Mexico	Programme
Netherlands	Policy articles, instruments
New Zealand	Output
Norway	Programme area, programme category, chapter
Spain	Programme, activities
Sweden	Expenditure area, policy area, subpolicy areas

Types of programmes

OECD countries diverge in the mix of programmes used in their budgets for health. All analysed countries other than Norway organize their budget around health policy programmes, grouping activities with similar policy objectives together. Countries may include service-based programmes alongside policy programmes at the top level of the hierarchy, as is done in Chile, Latvia, Mexico, New Zealand and Norway. The organization of health coverage and financing arrangements in other countries has shifted most service delivery expenditures into the budgets of subnational governments or social security institutions. Some of which have moved towards a programme budget formulation.

Australia, Canada, Italy, Latvia, Mexico, the Netherlands, New Zealand, and Spain include top-level programmes that cover the administrative expenses of ministries or support a well-functioning health system. They can control input on items such as salaries and wages and avoid the burden of allocating expenditures across programmes.



Most countries have designed programmes around the existing organizational structures of the MoH and other health agencies. Programmes are allocated to a single manager or entity and avoid overlapping responsibilities (see Table A1.3).

TABLE A1.3.

Overview of top-level programme types

	Health policy	Disease-based	Service delivery			Support programmes
			Programmes for service delivery in central budget	Expenditure contained in budget of SNG	Expenditure contained in SHI	
Australia	X			X*		X
Canada	X			X*		X
Chile	X		X	X	X*	
Estonia	X				X	
France	X				X	
Italy	X			X		X
Latvia	X		X			X
Mexico	X	X	X		X*	X
Netherlands	X				X	X
New Zealand	X		X			X
Norway			X	X		
Spain	X			X*		X
Sweden	X			X		

Note: SHI – social health insurance; SNG – subnational government

* Indicates the use of programme budget by all or some subnational governments or social insurance institutions.

All countries have programmes designed to improve public health through health promotion and disease prevention. Ministries assume this role not only to improve well-being but to reduce the burden on health systems and pressure on public budgets. Often, programmes are framed to promote healthy behaviours and protect citizens from public health threats such as infectious diseases or environmental risks. Vaccination and immunization components are included as subprogrammes or activities, along with tobacco control and the promotion of cancer screening.

Ministries usually take a leadership role to ensure all citizens have access to services. Countries frequently include programmes which incorporate policies to strengthen and improve the performance of the health system. Policy objectives may include increased access to services, improved quality of services, and the sustainable financing of services. These objectives are often achieved through subprogrammes or activities, such as health technology research, payments to communities to provide services for specific population groups or strengthening primary care facilities through targeted funding or incentive mechanisms. In Canada, the health-care systems programme aims to ensure a modern and sustainable system in which Canadians have access to appropriate and effective services. This programme requires close cooperation with regional and territorial governments, which are responsible for delivering health services.

Across other OECD countries, disease-specific actions are built into programmes as subprogrammes or activities. For example, Estonia's health risks programme includes disease-specific activities such as reducing the infection rates of HIV/AIDS and TB (see Table A1.4). These activities are not specified on budget documents. Instead, they are included within the management documents of the Ministry of Social Affairs. Similarly, departmental plans in Canada contain expenditure plans for each appropriated federal department or agency and outline disease-specific programmes such as cancer control.



TABLE A1.4.**Incorporating disease-specific activities in Estonia**

Programme	Health risks	
Programme measure	Reducing health risks and empowering communities to promote health	
Activity	(1) Reducing the incidence of HIV and AIDS	(2) Reduction of TB infection
Service	(1) Ensuring availability of antiretroviral medicines for patients (2) Supporting the operation of the HIV-positive patient database (3) HIV prevention, research and impact reduction	(1) Providing anti-TB drugs, including side effects, for patients (2) TB prevention, research and impact reduction

Source: Ministry of Social Affairs, Estonia, 2018–19.

Latvia, New Zealand and Norway organize their budgets around service-based programmes at the national level. Chile and Mexico also use service-based programmes but only for selected services provided at the national level (see Table A1.5). In other countries, expenditure on core services is not included in central government budgets but in the budgets of subnational governments or social security institutions. Expenditure on services may also be integrated at the subprogramme or activity level.

In Latvia, health services are organized into either health-care provision, in which the subprogrammes follow a level of care logic, or specialized health-care provision, as discussed below. In New Zealand, most of the budget is allocated to the District Health Board programmes for the provision of health and disability services.

In Norway, the budget for the Ministry of Health and Care Services is organized around programme areas and categories. The largest programme area is for specialized health services. This includes grants to regional health authorities to finance hospitals. Primary care, social care and mental health services are predominantly financed and delivered at the municipal level. However, the municipal services programme provides central government grants for the development of municipal services and provides a secondary source of financing.

TABLE A1.5.**Examples of service-based programmes**

Country	Programme
Chile	Primary care
Latvia	Health-care provision Specialized health-care provision
Mexico	Public service provision
New Zealand	Nationally-funded services District Health Board services
Norway	Public health services Specialist services Municipal services Dental services



Ideally, programmes should group all resources required to achieve its objectives, including salaries, goods and services, subsidies and transfers, and investments (gross budgeting) (OECD, 2019b). However, finance ministries may want to maintain partial control over the choice of inputs to prevent resources from being misused. Some OECD countries that have moved towards a programme budget have maintained separate line items for certain costs to ensure that spending directly contributes to achieving programme outcomes rather than, for example, increasing wages. These line items can include large-scale investments, infrastructure maintenance, and salaries, either for all civil servants or just those in general oversight roles.

Other countries may choose to allocate costs to programmes that support the health system rather than those that provide services. This can avoid the burden of trying to meaningfully allocate costs across programmes, or of creating a mechanism to share costs. Examples of these types of services include health sector management, human resources management, and information services. The approach to allocating costs for administrative expenses or support programmes is unique to each country (see Box A1.1).

BOX A1.1.

Allocating general administrative costs and support programmes

The Netherlands divides its programmes into policy articles and non-policy articles. Spending included in non-policy articles contains expenditure that is not able to be meaningfully allocated to a specific policy article, such as spending on staff and material expenses, expenses related to international cooperation, and unforeseen expenses to account for changes in prices or wages.

In Germany, the budget contains a chapter for the federal health ministry's centralized administrative expenditure and for other agencies such as the Robert Koch Institute, which is responsible for disease control and prevention. Expenditure contained within this chapter includes personnel expenses and administrative overhead.

In Canada, the internal services programme consists of groups of related activities and resources for services in support of programmes or those that are required to meet the corporate obligations of an organization. Examples of these services include legal services, human resources management, financial services management and information technology.

Latvia's programme for sector management and policy planning aims to improve planning and coordination in the health-care system and contributes to maintaining and improving the health of the population.

In Spain, programmes under health expenditure are subdivided into those for general administration and those for public actions relating to health. Programmes under general administration include actions such as technical and legal support for the ministry, coordination of international relations, and human resources management.

1.2 Key challenges with programme budget implementation

1.2.1 Managing cross-cutting programmes

The programme budget structure across most OECD countries is aligned with health sector structures. In this context, structures refer to the organization of government agencies responsible for health or the responsibilities across levels of government. Programmes in Australia, Canada, and Latvia are allocated to a single government entity that is responsible for multiple programmes. Where an organizational unit is responsible for multiple budget programmes, units must be able to control the direction of resources between programmes. In Chile, programmes are designed around the existing organizational structure of the sector. Budgets are allocated to organizational units including the Under-Secretariat of Public Health (USPH), the Under-Secretariat of Health Care Networks (USHCN), and the National Health Fund (Fondo Nacional de Salud, FONASA). Each institution executes and monitors its own internal programmes, without the direct involvement of the MoF. Examples within the MoH include the HIV programme, the national cancer programme, and the food safety surveillance programme.

Norway and Sweden use another approach. For some programmes, several agencies under the MoH contribute to achieving a single programme objective. A programme is split into subprogrammes, each of which is responsible for a single organization. In Mexico, different administrative units may execute



budgetary programmes jointly to meet objectives and goals. Only one of those units reports on performance, for simplicity.

In Mexico, Norway, and Sweden, multiple entities are responsible for a single programme. The experience of other countries demonstrates how programmes work together across policy areas to achieve cross-cutting goals. In New Zealand, all spending initiatives must demonstrate engagement across agencies and portfolios (see Box A1.2). In Australia, budget appropriations are specified in terms of public spending outcomes, which are determined at the agency level and reflect the administrative structure. However, outcomes are also linked to other programmes, from other government entities, that contribute to their success.

BOX A1.2.

Strengthening accountability with programme budgeting: an example from New Zealand

In New Zealand, the structure of budgetary programmes follows the organizational structure. The overriding aim of the output model is to make managers accountable for results and resources, not to compare programme alternatives (Korea Institute of Public Finance, 2007). A clear and systematic reporting framework for both nationally funded and decentralized services supports the model.

The main source of funding, Vote Health, is organized into 53 appropriations. Programmes include services that receive national funding, such as national child health services, national elective services and national maternity services. Appropriations commission services from service providers, including crown entities or NGOs. Other programmes include services provided by the MoH for support, oversight, governance and development of the health and disability sector. Capital expenditures are also contained within separate programmes.

Programmes are defined in terms of their scope, which provides the legal boundaries for what appropriations can be spent on. Every financial year, entities must provide concise explanations for appropriations, including what will be achieved with the funding and how performance will be assessed. These descriptions are given to Parliament to explain how the strategy or expenditure will benefit New Zealanders.

Programme for National Child Services, New Zealand

National Child Services

Scope of appropriation

This appropriation is limited to the provision, purchase, and support of child health services.

What is intended to be achieved with this appropriation

This appropriation is intended to provide services that support the development of New Zealand children and establish a foundation for those children to live longer, healthier and more independent lives.

Source: Vote Health Estimates 2018/2019, Government of New Zealand.

Most of the appropriations are for health services provided by 20 District Health Boards. These DHBs provide and fund hospital care, most aged care, mental health care, primary health services and some public health services for geographically-defined population groups, as well as managing the pharmaceutical budget. Performance information is integrated into DHB spending programmes, first during the development of annual plans and then during year-end reporting on financial and performance outcomes. Annual plans must include an explanation of how strategic priorities will be met, as well as a report on financial performance and performance expectations.

1.2.2 Programme budgeting and social health insurance

Some social health insurance systems are funded by a health budget that is separate from central government budgeting processes and regulations. Chile, Estonia, France, and the Netherlands all have health systems characterized by single or multiple health insurance funds or companies. The experiences of France and Estonia demonstrate the differing degrees at which programme budgets are integrated in social insurance systems.



In 2001, France introduced a by-law (LOLF) in the State Budget Act to initiate performance budgeting reforms. After the law was introduced, budgets were presented according to mission, programme and action and included associated objectives and indicators. Programme managers were granted a high degree of flexibility on spending within appropriated operating expenses, with some exceptions made to maintain control over salaries. The health mission includes expenditures related to disease prevention and health protection. However, most health financing is provided by a section of the Social Security Financing Act.

In 2006, a new law (loi organique relative aux lois de financement de la sécurité sociale, LOLFSS) was introduced to promote similar transparency and accountability in the Social Security Financing Act, in line with the State Budget Act. Another initiative, the National Objective for Healthcare Spending (objectif national des dépenses d'assurance maladie, ONDAM), sets and caps health spending for the following year. The Social Security Financing Act contains several annexes comparable to those in the State Budget Act, one of which presents programmes on quality and efficiency. This annex includes performance information, including objectives and strategies for state health insurance policy.

In Estonia, the Ministry of Social Affairs has transitioned towards an activity-based budget that is presented by programme. The ministry is responsible for health protection and disease prevention and must compete for funding at the state level. Reforms have not yet been applied to the Estonian Health Insurance Fund (EHIF), which accounts for around two-thirds of total health expenditure (OECD, 2019a). The EHIF budget is not approved by Parliament but instead by a supervisory board, which consists of state representatives, an MoF representative, employers and employees.

1.2.3 Programme budgeting at the subnational level

In many OECD countries, subnational governments play a significant role in financing health systems. Like their federal counterparts, subnational governments should design, present and implement budgets that reflect policy objectives and provide flexibility in decision-making to public sector managers. These governments have started to redesign budgeting practices, including appropriations by programme and the use of performance indicators to measure programme outputs and outcomes. Subnational governments retain much autonomy. Therefore, programme budgeting practices can vary within a country. Subnational governments in Australia, Canada and Spain have adopted programme budgeting. Their programme budgets vary in the type and number of programmes, as they do with central governments.

The autonomous region of Catalonia in Spain and the provinces of Alberta and Ontario in Canada organize programmes primarily around the type of service provided. Catalonia follows a level of care logic, differentiating between primary care and specialized care, such as care provided in inpatient facilities, specialized outpatient consultations, day hospitals, emergencies and home hospitalization. In Canada, subnational governments organize their budgets around the type of service and the provider. The state of New South Wales in Australia, meanwhile, has followed the outcome framework of the central government, budgeting around high-level outcomes such as improved service in hospitals, and mentally healthy communities. (see Table A1.6).

TABLE A1.6.

Subnational programme budgets

Subnational government	Number of programmes	Programme design
Australia – New South Wales	5	Organized around outcomes, such as improved service in hospitals, mentally healthy communities, and healthy, resilient communities
Canada – Alberta	14	Organized around the type of service and support services, such as Alberta Health Services, primary care, and information technology
Canada – Ontario	10	Organized around type of service and support services, such as the Ontario Health Insurance Program, and the eHealth and Information Management Program
Spain – Catalonia	5	Organized around type of service, such as primary health care; specialized health care and public health



BOX A1.3.

Programme budgeting at the subnational level: an example from Canada

The national budget includes all expenditure related to the Health Portfolio, which is comprised of five government agencies working to improve and maintain the health of Canadians. However, health care in Canada is predominantly delivered by 13 provincial and territorial systems, through a public system called Medicare. The system accounts for around 90% of public spending on health (Canadian Institute for Health Information, 2016).

Provincial governments have autonomy over the adoption and implementation of fiscal management practices and processes, which must be in line with the principles of good governance, including transparency and integrity (Arsenault, 2011). The governments of Canada's three territories have less autonomy in public management.

Each provincial or territorial government has a health ministry or equivalent and a budget for health. The preparation, presentation and organization of budgets for health differ across provinces and territories. In Ontario, health spending for legislative approval is presented by programmes, known as votes, and subprogrammes. Two programme votes – the Local Health Integration Networks (LHIN) and Related Health Service Providers, and the Ontario Health Insurance Program – account for 80% of projected health spending. The Ontario Health Insurance Program funds coverage for more than 6,000 health-care services provided by physicians, optometrists, dental surgeons and podiatrists. The LHIN and Related Health Service Providers Program includes transfer payments from the MoH to 14 LHINs. These, in turn, are responsible for allocating funding to service providers including hospitals, long-term care homes and community service providers in their region (Financial Accountability Office of Ontario, 2018).

2018–2019 Ministry of Health and long-term care budget, Ontario

Programme name	Share of total spending (%)
LHIN and Related Health Service Providers	49
Ontario Health Insurance Program	35
Provincial Programs and Stewardship	7
Health Capital Program	3
Population and Public Health Program	2
Health Policy and Research Program	1
eHealth and Information Management Program	1
Information Systems	<1
Ministry Administration Program	<1
Health Benefit Program	<1

Note: Spending also occurs through standalone legislation and by provincial health agencies and hospitals that can raise and spend their own funds (less than 6% of total spending).

Source: 2018–19 Expenditure Estimates, Financial Accountability Office of Ontario.



1.3 Programme budgets and performance monitoring in health

Most OECD countries include additional performance indicators, beyond the defined output or outcome, to monitor the progress of budget programmes. Performance information can provide additional context for budget allocations. However, performance information should be limited to a small number of relevant indicators for each policy or programme area and should be clearly linked to government-wide strategic objectives (OECD, 2015d).

Performance indicators are either presented alongside budget documents or presented in an annex or supporting document. Supporting documents are often a parliamentary requirement. In Australia, for example, Portfolio Budget Statements (PBS) contain details of annual appropriations and include a set of outcomes, programmes and key performance indicators. Legislation requires that these statements are taken into account during the interpretation of the appropriations bill.

The volume of performance information included in budgets documents varies across OECD countries (see Table A1.7). Spain tracks more than 400 performance indicators alongside health budget programmes. By comparison, Canada, France, and the Netherlands track fewer than 50 performance indicators in their budget documents.

TABLE A1.7.

Number of performance indicators in health budgets

High (400+)	Spain
Medium (100–200)	Latvia, New Zealand
Low (50–100)	Australia, Sweden
Very low (<50)	Canada, Estonia, France, Netherlands

Note: The health budget refers to the central health budget as defined in Table A2.1.

Some OECD countries including Chile, France, Italy, Mexico, New Zealand and Norway choose to reduce the number of performance indicators included in budget documents (OECD, 2018a). Early efforts to move towards a performance-based budget in the Netherlands resulted in a high number of performance indicators being tracked. This added to the administrative burden on line ministries as budget documents contained lengthy and often irrelevant information. In 2011, reforms reduced the number of performance indicators to around 20, remaining low ever since (Kooij, 2017).

Rather than a one-size-fits-all approach, a performance monitoring framework must be robust and responsive to all different types of programmes within the budget. A smart system recognizes that the relationships between budget resources and outcomes vary considerably across different programme types, such as policy-based programmes and programmes for support or administration. A robust framework allows departments a degree of flexibility while maintaining a consistent approach (OECD, 2019b).

Most OECD countries track different types of performance indicators, with outcome indicators being the most common type recorded. These can be used to monitor the effectiveness of a programme and to understand whether it has achieved its objectives. Output indicators, by comparison, measure what has been produced. Outcomes are a broader performance measure and are generally harder to gauge since factors outside a government's intervention influence outcomes.

Countries commonly use activity indicators. In Australia, many of the performance indicators describe actions to support the programme that will be carried out during the current budget year or following one. These may include signing contracts with providers, establishing working groups, or working towards legislative changes.

Formulating the budget around programmes allows for a shift from input-based line-item methods towards output-based provider payment methods. Programme managers are given increased flexibility to allocate expenditure according to outputs or performance, rather than being restricted by controlled input lines on budgets. In Norway, budget flexibility allows resources to be allocated to providers based on performance information (see Box A1.4).



BOX A1.4.

Quality-based financing in Norway

Norway is divided into four Regional Health Authorities (RHA) which are responsible for providing care services to their regional populations and secondary care on behalf of the MoH. In the past, RHAs were funded through a mix of block grants and activity-based financing. A pay-for-performance scheme known as quality-based financing (QBF) was introduced in 2014.

QBF redistributes block grants based on the National Quality Indicator System, a set of performance indicators and quality criteria for hospitals. Indicators fall under three categories: outcome, process and patient satisfaction.

Reallocations are made based on the achievement of indicators, valuing approximately 0.5% of the total block grant budget. This arrangement serves as an incentive to increase overall quality and patient care.

Conclusion

OECD countries have a long history of programme budgeting, both government-wide and in the health sector. Their individual and common experiences underscore key health policy findings on programme structure, programme categories, and performance.

There is no ideal number of programmes in a programme structure. In the 13 countries studied, the number of programmes at the central level ranged from two to 53. Programmes are usually designed around a health system's existing organizational structure. This helps to ensure budget allocations map to the day-to-day management of governmental departments and specific health providers.

Countries choose the type of programme categories used within budgets. Most OECD countries organize budgets around broad health policy objectives. These objectives are typically for collective services such as improving overall public health and strengthening the health system. Health ministries are given the flexibility to choose the mix of inputs needed to achieve these objectives. Disease-specific programmes or programmes for specific population groups are less common and are typically organized as subprogrammes, to maximize flexibility.

Most OECD countries use performance indicators to monitor budget programmes and create links to performance. The indicators are either presented alongside budget documents or in an annex or another supporting document. The choice of indicators is specific to each country. OECD country experiences suggest that indicators should be linked to government-wide objectives, usually outlined in national health plans. This can help align and focus the programme structure and associated indicators with government priorities.



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2. Budget formulation reforms in health in LMICs

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Introduction

While the key characteristics and potential impact of budget formulation reforms on overall public spending are well understood (see Introduction), little evidence exists on budget reforms in health. Many health stakeholders, especially in LMICs, have a limited understanding of the rationale behind reforms and possible benefits and challenges for the sector. Are budget formulation reforms important for health expenditure? What do they change from a health financing and service delivery perspective? Can reforms make public funds more flexible and responsive to health needs? Is programme budgeting the only tool to provide more flexibility in health spending?

There is also limited evidence available on the progress of reforms in the health sector, despite health having been a priority sector in most LMICs for introducing reforms. What is the level of reform implementation in health? Is programme budgeting driving resource allocation for most LMICs? Are some countries more advanced than others when it comes to implementing reforms and, if so, why? What are the main technical and political bottlenecks when countries fail to transition?

To address these gaps in understanding, a comprehensive review of reform implementation in the health sector in LMICs was undertaken. The methodological approach included four main components: i) a mapping of health budget formulation for 130 LMICs (using 2017–2019 finance laws); ii) the development of a dataset compiling the characteristics of programme budgets in health for 30 LMICs;⁹ iii) in-depth assessments and consultations in 14 countries on reform implementation issues in health (January 2018–January 2021); and iv) complementary surveys related to the political economy of budget formulation reforms in health (February–March 2020).¹⁰

The first section of this chapter analyses evidence on how reforms in LMICs changed health budgeting and spending practices. Section 2 outlines the status of reform implementation in health in LMICs and analyses country experiences at each stage of the reform – when piloted, first enacted, and fully implemented – and highlights key challenges at each phase. Section 3 outlines key political economy considerations that emerged in the surveyed LMICs when introducing reforms in health.

2.1 Budget formulation reforms and health spending in LMICs

The benefits and potential impact of budget formulation reforms on health budgeting and spending have been poorly appreciated by those in the health sector in LMICs. As an MoH director of planning in one LMIC noted, potential effects of the reform are a “concept to be proven” and are often viewed as an “approach with a limited or unclear effect on health expenditure”.

The evidence gathered from LMICs for this book shows that budget formulation reforms can have a significant effect on health budgeting and spending (Figure A2.1). When reforms are introduced in countries where public spending has historically been driven by rigid input-based allocations, reforms have helped to improve the alignment of public resources with health priorities and have enhanced accountability for performance. However, there are more mixed results when it comes to flexibility; reforms do not consistently generate more flexibility in the use of public resources in health. Each of those aspects are described in more detail below.

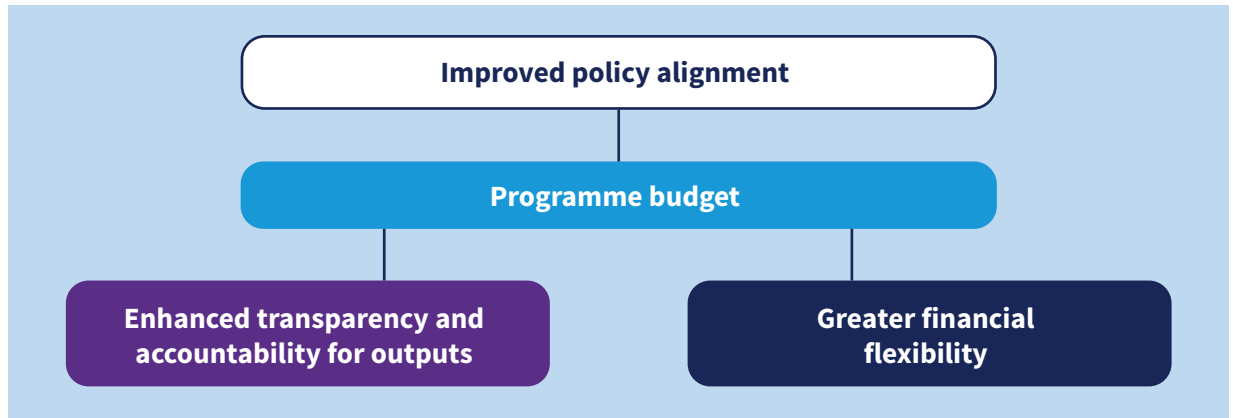
9 The dataset was published on the IBP website: <https://www.internationalbudget.org/publications/program-budgeting-health-sector-dataset/>

10 To better understand the influence of factors related to the political economy on the implementation of reforms, seven country case study authors and experts were asked a short set of questions about: i) programme budgeting supporters and opponents; ii) strategies used to overcome points of opposition; and iii) the impact of the political economy on reform implementation.



FIGURE A2.1.

Potential benefits of programme budgets for health expenditure



Better alignment of budgets with health priorities

In many LMICs, budget formulation reforms have helped to align public funds with health priorities and have created new opportunities to direct public spending from general budget revenues to priority needs, for example towards primary health care.

Historically, input-based budgets have made it challenging to steer resources towards priorities and to track achievements, especially where national health strategies have been developed without considering resource constraints or where budgets were developed with little reference to health policy objectives (Barroy et al., 2019).

When MoH planning, budgeting and financing units work together to define programmes, programme budgets become a powerful opportunity to reconnect planning and budgeting functions. Several countries working to define budgetary programmes have used it as an opportunity to align MoH budget allocations with priority health needs. In Peru, for example, the MoH was able to prioritize funds to respond to malnutrition, an emerging need in the early 2000s. In Burkina Faso, public funds were directed to the frontlines for primary care using the programme budget as a tool to channel general revenues to priority needs (see Box A2.1).

BOX A2.1.

Aligning health priorities and budget allocations through programme budgets: examples from Peru and Burkina Faso

Peru introduced programme budgeting between 2007 and 2008. The strategy used to define MoH programmes was based on a clear, logical framework built on priority health needs. The design began with the identification of a quantifiable problem, such as the number of children affected by malnutrition. Solutions were determined based on scientific evidence and were presented using a problem tree. This then led to the definition of programmes, activities (policy solutions) and outputs. The results of this effort were programmes with clearly formulated objectives in the areas of highest need, linked to the most effective interventions. The successful reduction in malnutrition in Peru has been associated with prioritized funding under the programme budget approach. (Dale et al., 2020).

Burkina Faso used the introduction of budgetary programmes to reprioritize sector policies and align budget allocations with the national health strategy. A new national strategic plan was drafted in 2011. A mapping exercise was used to explore possible links between national priorities and budget allocations. This process resulted in the definition of three budgetary programmes that became part of the programme budget, which was piloted in 2011 then formally adopted in 2017. The national health plan and budgetary programmes have mirrored and reinforced each other ever since the 2016–2017 budget. Aligning funds with the national strategy helped prioritize funds for primary health care providers to enhance access to essential health services under Programme 2 (Barroy, André & Nitiema, 2018).

In some situations, the introduction of programme budgets has also helped to address inefficiencies inherent in input-based budgets. For example, in countries formerly part of the Union of Soviet Socialist Republics, the rigid budget formulations that were common in the 1990s created perverse incentives that encouraged health service providers to overuse certain inputs for budget compliance purposes. National health budgets were derived from historical norms for infrastructure and other inputs at each facility, “creating incentives to establish and maintain a very inefficient cost structure with enormous excess capacity in the hospital sector” (Chakraborty et al., 2010, p. 273). In these countries, defining programmes based on expected outputs was a move away from historical budgeting and enhanced service delivery efficiency (Hawkins et al, 2019).

The COVID-19 crisis has demonstrated the relevance of programme budgets for aligning funds to emergency preparedness and response interventions. Countries with programme budgets were able to integrate health security provisions either as stand-alone budgetary programmes (e.g. Gabon’s health security budgetary programme, introduced in 2017) or as a subcomponent/activity of broader budgetary programmes (e.g. Armenia’s public health programme or Indonesia’s disease prevention and control programme) (see Table A2.1). By allowing budget inputs to be grouped under consolidated envelopes, programme budgets have proven to be effective at aligning budgets with system-wide functions (WHO, 2021). The flexibility embedded in the programme structure helps activate funds, which are disbursed based on needs and not pre-defined inputs.

TABLE A2.1.

Health emergency preparedness and response in programme budgets

Country	MoH budgetary programme	Subprogramme or activity
Armenia	Public healthcare services	Population’s sanitary and epidemiological safety and public health services
		National immunoprophylaxis programme
		Blood collection services
		Hygiene and anti-epidemic expert examination service



Country	MoH budgetary programme	Subprogramme or activity
Burkina Faso	Health service delivery	Crisis preparedness and management
	Support to MoH	Health information and surveillance
Gabon	Prevention and health security	Sanitation and hygiene
		Health education and awareness
Kenya	Disaster management	
	Preventive, promotive and reproductive, maternal, newborn, child, and adolescent health (RMNCAH)	Health promotion
		Environmental health
General administration, planning and support services	National quality control laboratories	
Kyrgyzstan	Public health	Measures to ensure safety standards for human health (food safety, indoor air, water, radiation levels)
		Immunization policies
		Population awareness and education on health promotion
		Measures for epidemiologic surveillance and prevention of vector-borne diseases (plague)
		Ensuring quality control of laboratory services for diagnosis of infectious diseases including HIV, brucellosis, hepatitis, syphilis
Indonesia	Pharmaceutical programme and medical device	Medicine and medical supplies
	Disease prevention and control	Prevention and control surveillance and health quarantine
		Prevention and control vector and zoonotic infectious diseases
		Prevention and control infectious diseases directly
Mexico	Epidemiological surveillance (federal programme)	
Morocco	Epidemiologic surveillance, sanitary security, prevention and disease control	
Peru	Zoonotic and vector-borne diseases	
Philippines	Public health	Public health management
		Environmental and occupational health
		National immunization
		Elimination of infectious diseases
		Prevention and control of other infectious diseases
	Epidemiology and surveillance	Epidemiology and surveillance
	Health emergency management	Health emergency preparedness and response
	Health regulatory programme	Health facilities and services regulation
	Consumer health and welfare	
	Routine quarantine services	

Source: adapted from WHO (2021).



Enhanced accountability and transparency

The shift to budgets that are linked to outputs has generally helped to make the health sector more transparent and accountable for delivering on objectives. Among health policy-makers, the introduction of programme budgets has generally increased awareness of performance and the need to monitor the achievement of outputs (Barroy, André & Nitiema, 2018; Dale et al., 2020).

The introduction of programme budgets has also helped foster conversations among health stakeholders about whether budget holders are making the right choices in the use of public money. In this way, programmes have served as “an intermediate conceptual step in the process of converting funds into higher level outputs by providing mid-level objectives that guide budget holders through the results chain” (Lakin et al., 2018).

Many LMICs have buttressed programme budget reforms with performance monitoring frameworks (Ho, de Jong & Zhao, 2019). These frameworks have often been designed to consolidate financial and non-financial performance information. Good practices show that using one tool to monitor both aspects of performance in the health sector can lead to a better understanding of how the budget directly contributes to key outputs, as has been observed in Kenya (see Table A2.2).¹¹ A clear results chain and accountability are tightly linked; as one improves over time, so does the other.

TABLE A2.2

Linking budget allocations to health outputs, an example from Kenya

	Programme name	Programme outcome	Expected outputs	Medium term performance indicators and targets
1	Curative Health Care Services	Reduced incidents of curable diseases and ill health	<ul style="list-style-type: none"> • Patients getting curative interventions • Trained health personnel • Hospitals inspected and accredited • Patients receiving specialized curative interventions 	<ul style="list-style-type: none"> • No. of patients treated • No. of eligible inpatients on ARVs • Proportion of inpatient malaria mortality • Proportion of fresh still birth No. of trained health personnel • No. of health facilities inspected and accredited
2	Preventive and Promotive Health Care Services	Reduced incidents of preventable diseases and ill health	<ul style="list-style-type: none"> • Children under 1yr immunized. • New TB cases detected and treated. • Pregnant mothers receiving LLITN's in endemic districts • Eligible pregnant women receiving preventive ARVs • Health Commodities available at the health facilities • National radioactive waste management facility 	<ul style="list-style-type: none"> • % of children under 1 yr immunized • TB detection rate and TB treatment completion rate. • % of pregnant women receiving LLITN's in endemic districts • % of eligible pregnant women receiving preventive ARVs • Drugs fill rates at primary health facilities • radioactive waste management facility in place

Source: Lakin & Magero (2015), based on Kenya MoH programme budget for FY 2013/14.

¹¹ Budget tagging is also made possible by programme budgets. Shifting from fragmented inputs to grouped activities allows certain items of interest in budgets to be identified and mapped. For instance, countries that have not included separate programmes for health security or specific diseases but instead embedded them in broader programmes can still identify and track activities that relate to those goals using programme structure information.



When responsibilities are very clearly assigned to specific budget holders or organizational units in programme budgets, accountability improves. In many LMICs, such as Gabon, Indonesia, or the Philippines, programmes have been aligned to some degree with the existing organizational structure to enhance accountability (Aboubacar et al, 2020; Lakin, 2018b; Nurman, 2018). In countries where that alignment does not exist, accountability mechanisms have been introduced to assign responsibility, either by assigning specific indicators to budget holders or by assigning specific entities to subprogrammes to enhance multi-stakeholder engagement (Lakin, 2018a; WHO, 2021).

Transparency has also been enhanced in several LMICs. One approach to enhancing transparency is to make more information publicly available, especially budget outputs that require legislative oversight. A publicly available data platform in South Africa, for instance, improved public transparency around budget outputs and the use of public funds. It also helped generate public buy-in for the budgeting approach. Providing the public with more information about how public funds are spent in the health sector and what those funds have achieved has been a key success of programme budget reforms in the country (M Blecher, 2019, pers. comm.).

In some other countries, the introduction of programme budgets has also been associated with increased participation by the public in the budget-making processes. In Kenya (Lakin & Magero, 2015) and Mexico (Rajan, 2019), shifting from input-based budgets to output-focused budgets improved public engagement in priority-setting processes, perhaps because the health sector is so intimately connected with the population's vital needs (see Box A2.2).

BOX A2.2.

Programme budgets and civil society engagement: an example from Kenya

In Kenya, the introduction of programme budgets has helped civil society organizations (CSOs) highlight challenges in budgeting that would have been overlooked in traditional line-item budgets. Using six years of recent data, IBP Kenya assessed how consistently baseline data and changes in the number of targets and indicators were presented over time and whether data collection systems were adequately tracking indicators. The survey has provided a platform to continuously monitor progress over time, highlighting variations in practices across the country and providing CSOs with information to build their own capacity and to hold officials to account. Efforts to improve reporting against programme budgets have started to have an impact. The Office of the Controller of Budget (OCoB) is now working on a reporting format that will allow it to regularly report on the targets and indicators approved with annual budget estimates. This came after a series of meetings between OCoB and its CSO partners, who had prepared a template on how to report on performance against targets. There are also ongoing improvements being made to financial management systems to include performance data and other financial information. However, programme budgets are still not widely understood among the general public, nor are their benefits as a more transparent and service-oriented approach widely recognized. That has limited public pressure on government to deepen the reforms and raises challenges of accountability for commitments made in the budget each year.

Source: unpublished notes from an interview with John Kinuthia (IBP Kenya) and Jason Lakin, editor, in 2020.

Mixed evidence on financial flexibility

Budget formulation reforms have the potential to create more flexibility in the allocation and use of resources. In principle, programme budgets allow for the flexible release of funds, generally by programme envelopes and not by line items, and provide budget holders with more freedom in the use of funds.

Compared to input-based controls, programme budgets generally reduce the volume of approvals required for budget changes and increase the amount of flexibility given to sector ministries, like the health ministry, over resources (Robinson, 2007). With programme budgets, sector ministries generally have more autonomy to define and manage their own budget, with ceilings set at the programme level and programme managers



receiving fixed lump-sum allocations. Generally, with reforms comes a major shift in virement rules – in-year reallocations are often made possible within programme envelopes (Robinson & Last, 2009).

In fact, below the appropriation level – the level in the programme hierarchy at which the legislature appropriates money in the annual budget – the degree of flexibility accorded to health ministries has differed considerably across LMICs. In some advanced countries, there is no central control over the manner in which health ministries allocate funds between subprogrammes and activities. In other countries, health ministries have some flexibility, though not full flexibility, to make changes within lower levels of the programme structure. In several countries, having controls below the programme level has hampered managerial flexibility and the ability to meet programme objectives by shifting expenditures related to subprogrammes and activities (Aboubacar et al., 2020; Barroy, André & Nitiema, 2018; Dale et al., 2020; Osei et al., 2021). Staff salaries, which generally represent more than half of all health spending, have often been excluded from programme management along with some other key inputs which greatly reduces managerial discretion for budget implementation

In many LMICs, including Burkina Faso, Gabon and Ghana, programme budget funds in the health sector continue to be authorized for disbursement to subnational levels or service providers by input or by economic classification (Aboubacar et al., 2020; Barroy, André & Nitiema, 2018; Osei et al., 2021). In a few countries, such as Kyrgyzstan, providers receive lump-sum payments for operational costs, giving them the flexibility to choose the right mix of inputs to deliver health services. Box A2.3 describes Kyrgyzstan's approach, which is more of an exception among the countries reviewed rather than the general rule.

BOX A2.3.

Programme budgets and financial flexibility for health service providers: an example from Kyrgyzstan

In the face of input-based budgetary constraints, Kyrgyzstan's on-budget purchasing agency was actively pushing for relaxing ex ante controls and allowing funds to be reallocated across providers. One way of achieving this was to introduce a single line envelope within the budget's economic classification, covering all expenditures related to the State Guaranteed Benefits Package. As a result of this action, Kyrgyzstan ended up with a hybrid budget structure, with a standard economic classification and a programmatic line encompassing almost 80% of health sector expenditures. Theoretically, this created more flexibility. However, gradually it became clear that more systemic changes were needed. The health sector became one of the strongest supporters of efforts by the Ministry of Finance (MoF) to implement a programme budget, which became part of the annual budget law in 2019. The introduction of a programme budget along with a series of complementary PFM reforms led to more flexibility in the management of funds at the provider level. In 2016, the adoption of a new law on the Budget Code integrated programme budgeting into the regular budget cycle. Starting in 2019, spending units in the health sector were required to report quarterly on programme performance indicators. Virements of +/-5% of programmatic funds are now allowed within programmes. In addition, facilities can retain any savings earned, including savings earned by optimizing staffing.

Source: Hawkins et al., 2020.

In the early stages of the COVID-19 pandemic, programme budgets, where they existed, allowed public funds to be reprogrammed for COVID-19 diagnostics, testing and treatment. Having a flexible budget formulation already in place made it possible to quickly direct resources towards emergency needs. In South Africa, for instance, where programme budgets have been in place for nearly 20 years, flexible reallocations were made possible through several budgetary programmes in health, namely the communicable and noncommunicable diseases programme, primary health care programme, and the health system governance and human resources programme. At the subnational level, provinces were also allowed to reprioritize funds within existing programme envelopes for COVID-19 expenditures. Compared to input-based budgets, programme budgets seemed to support a more agile emergency response (Barroy et al., 2020). However,



maintaining funding for other essential health services proved to be a challenge – flexibility should not derail budget holders from continuing to meet other routine and priority needs.

2.2 Status of reforms in the health sector in LMICs

As of 2019, 80% of LMICs – 107 countries out of 135 – have introduced some form of programme budgets for health expenditure. However, the extent to which reforms have been introduced is wide-ranging. Figure A2.2 shows the progress of reforms in LMICs by three distinct phases: i) pilot phase; ii) enactment phase; and iii) full implementation phase (see Annex 2 for a list of countries in each phase of the reform pg. 159).

FIGURE A2.2.

Health budget formulation reforms in LMICs by phase and income group, 2019



Note: income status is based on 2019 World Bank classifications.

Pilot phase

Out of 135 LMICs, a total of 107 countries or 80% have worked on the introduction of programme budgets for the health sector. As of 2019, 76 of those countries (17 low-income and 59 middle-income countries) or 71% are in the pilot phase. This means that most LMICs have started engaging in efforts to define budgetary programmes by grouping inputs into policy goals, but no formal change has been institutionalized in the budget law, which continues to follow standard economic classifications.¹²

In many countries, the pilot phase was launched as part of a World Bank exercise, with finance or planning authorities in the driver's seat and an initial focus on a few pilot sectors (CABRI, 2013). When the exercise took place in the health sector, MoH planning and budgeting units were generally not closely engaged in identifying or defining budgetary programmes for health. As a result, health-related programmes were often not aligned with health sector priorities and often reflected vested institutional interests (Abewe et al., 2021; Aoubacac et al., 2020).

In countries that lack the human, financial or technological capacity to fully enact reforms, the pilot phase has largely been only a bureaucratic task. While budget templates may have been developed, there have been no further efforts made to reform budget planning processes for the sector (Barroy et al., 2014, Sulemane, 2006).¹³

Other approaches to improve flexibility and accountability in spending have been tested concurrently in pilot phase countries. Several countries have aggregated detailed line items into broader budget lines, with more flexible rules for transferring funds within that line in the budget (Saxena & Yläoutinen, 2016). Generally, when 10% to 20% of funds can be reallocated within a broader line item such as goods and services, it is a positive advancement for health spending.¹⁴

Performance information has also been used to improve expenditure outputs within traditional line-item budgets. Performance-based management approaches, such as those introduced in most sub-Saharan African budgets in the early 2000s (Basheka & Tshombe, 2018), have helped to assess the impact of public spending even when money continues to flow by inputs and there is no explicit connection between the formulation of the budget and the performance framework.

Enactment phase

Out of the 107 LMICs that had introduced a programme budget by 2019, 21 countries or 20% were in the enactment phase. In these countries, the health ministry formulates budget proposals according to programmes and submits them to the executive and the legislature for approval, often with a supporting narrative that describes each programme's goals and expected outputs.¹⁵

Technical obstacles often emerge during the enactment phase as reforms are being institutionalized. This can lead to long and complex transitions to effective programme budgeting. Though some countries like the Philippines were able to formalize a programme budget within a couple years, most transitions have taken 15 to 20 years.¹⁶ Armenia, for example, started its transition to a programme budget in 2004 and ended the process in 2019 (see Figure A2.3).

12 The number of countries in the pilot phase in the health sector is higher than the number piloting general budget structure reforms (CABRI, 2013, 2019). This is because, in many countries, the health sector is the first to pilot reforms and programmes may have been designed for the health sector alone.

13 Sector evidence echoes cross-sectoral analyses highlighting the “vast bureaucratic activity with minimal or no benefits in terms of PFM objectives and public service effectiveness” that accompanied the process of defining budgetary programmes (Schiavo-Campo, 2017, p. 32), raising questions in terms of the adequacy of the approach in countries with limited capacity.

14 Reforms like these have generally been accompanied by the transfer of spending authority from the finance ministry to line ministries to provide more autonomy in the release of funds in countries where this was not previously the case, such as in francophone countries (Lienert, 2003).

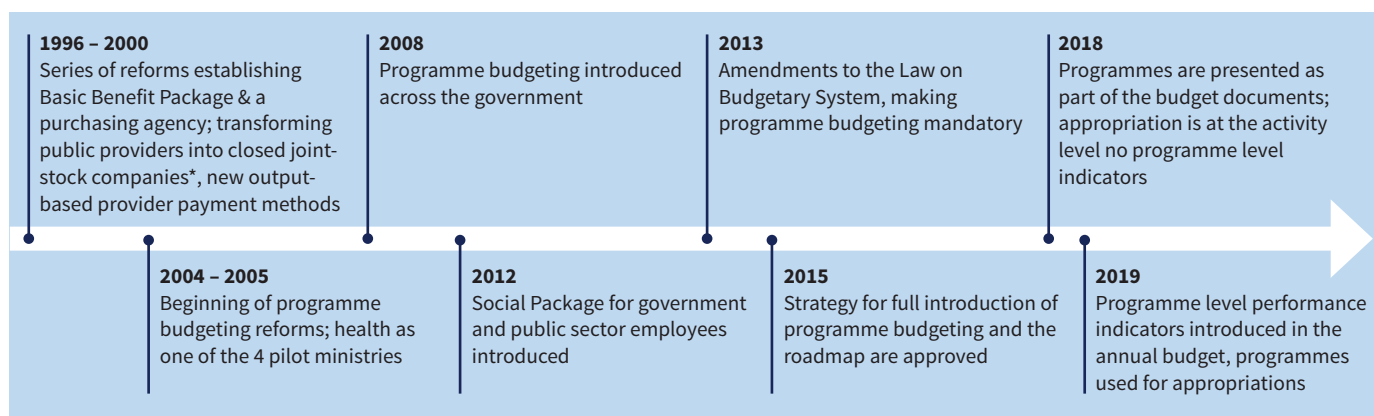
15 Generally, countries have kept pre-existing budget classifications (e.g. economic, administrative) and have added programme classification (separately or as an over-arching classification, further broken down into other types of classification).

16 When programme budget reforms are delayed or poorly implemented, the health sector sometimes tests alternative approaches. Sometimes, as a response to delayed or cumbersome implementation of the programme budget reform, alternative approaches have been tested in health to improve spending and provide more flexibility. In Kyrgyzstan, for example, the health sector introduced programme-like budget lines in the early 2000s to give service providers more flexibility in the use of resources to improve outputs and performance (see Box A1.3). In 2010, Burundi did the same, including a programme-like line in the input-based budget so the sector could allocate resources to primary care facilities based on outputs (Basenya et al., 2011).



FIGURE A2.3.

Timeline to transition to programme budgets in Armenia, 2004-2019



Source: Dale et al (2018).

One of the main PFM bottlenecks that often prevent reforms from being institutionalized has been a resistance by budget authorities to release input-based controls (Table A2.4) (CABRI, 2013, 2019). This is often a result of a lack of confidence in reporting processes and internal incentives for accountability. By not relinquishing input-based controls, existing rigidities remain even after reforms are introduced. When public funds in the health sector continue to flow by inputs even under programme budgets, it prevents funds from being reallocated across services and providers.

On the health side, part of the challenge has been a result of flaws in design, which have often led to fragmented budgets that have too many programmes, an unclear results chain, or programmes that are not connected to health priorities or that treat disease interventions separately. In some countries, programme budgets have perpetuated service delivery inefficiencies, such as allocating resources to separate entities for certain disease interventions, despite hopes that pooled envelopes and other programme budget tools would end them. Because of the way funds are channelled through the health sector, reforms can be harder to institutionalize compared to other sectors. Multiple funding streams and funding sources tied to separate allocation and spending procedures have often created additional complexities in budget reform implementation (Abewe et al., 2021; Dale et al., 2020; Osei et al., 2021).

TABLE A2.3.**General and sector-specific bottlenecks when institutionalizing reforms**

General PFM bottlenecks	Sector bottlenecks
Lack of guidance or capacity to institutionalize programmes across sectors	Limited understanding of the benefits of reforms for health spending and a low-performance mindset across the sector
Delays in the implementation of other PFM reforms, such as revising the legal framework	Competing reform streams with similar objectives, such as output-based allocation mechanisms for providers
Weaknesses in support systems, such as financial information systems or performance monitoring frameworks	Issues with funding, including: fragmented funding flows; multiple implementers and agencies; large off-budget spending; and external funding streams
Resistance to relinquishing input-based controls, leading to inconsistencies and inefficiencies in the release of funds	Health-related design issues, including poorly defined programmes and siloed interventions, such as disease interventions, that operate through separate programmes and entities
Complex reporting procedures and poor penetration of guidelines in each sector	Limited collaboration with the finance sector on the requirements for reform implementation, such as the appointment of programme managers, the relationship between programme managers and existing departments and providers, and reporting requirements

Full implementation phase

Of the LMICs that had introduced a programme budget by 2019, 10 countries, including seven upper-middle-income countries, had fully implemented a programme budget, meaning they had an annual budget that was formulated, adopted, released and monitored by programmes. In countries with full-fledged programme budgets, the medium-term expenditure framework (MTEF) is also presented according to the same programme structure. Ex ante controls that previously operated by inputs are generally released and funds are authorized or appropriated by programme envelopes. Programme managers are given the flexibility to allocate funds to different activities within given envelopes to improve the delivery of expected outputs.

Shifting to a programme budget has often required other PFM support systems to help ensure the appropriate use of funds. These could range from improving the financial management capacity of providers, to the appointment of programme or facility managers. In Mexico, it involved the introduction of a financial information system and a performance monitoring framework, aligned with the programme budget. After three decades of reform, the country now has an elaborate performance monitoring system within the programme budget. Programmes include performance indicators at each level, from activities, outputs, and intermediate goals to the final long-term goals, which are based on the national plan for the health sector. Performance is monitored on an annual basis. Checks and balances are built into the programme framework as external evaluations. These evaluations provide detailed, publicly available feedback on the quality of the programme structure, the use and measurement of indicators, and programme performance (Lakin, 2018a).

Among LMICs with fully implemented programme budgets, few have shifted completely to output-based spending due to fears about the possible misuse of resources and the overuse of certain inputs. As a result, most countries have maintained some control functions from their previous expenditure management systems, generally for staff and capital expenditure. In South Africa, all public funds are formulated, approved and monitored by programmes, but the release of funds is done both by programme envelopes and by inputs for certain budget items, like personnel salaries and capital expenditures (M Blecher, 2019, pers. comm.)



2.3 Political economy considerations when introducing reforms in the health sector in LMICs

Complex political economy dynamics often delay the implementation of reforms. Budget documents are, ultimately, political statements, reflecting policy priorities. Budget reforms are therefore also an inherently political process as budgetary programmes reflect government priorities (Jackson, 1972). Budget reforms have a direct impact on a variety of stakeholders, who may each hold a different position on the reform process. Some stakeholders may seek to advance reforms while others seek to block them; both may influence the design of the budget and the pace of implementing reforms. Reforms may be delayed, uneven or incomplete when reforms are developed by a limited set of actors, without consensus among the wider group of stakeholders, and when other political dynamics are not taken into full consideration. These dynamics may include issues related to bureaucracy, bureaucratic entities, or political jockeying between the executive and legislative branches of government or between service providers and government authorities.

In the countries reviewed in depth for this book, reforms were generally initiated by finance authorities, either international financial institutions like the IMF and the World Bank or country finance authorities such as those in the MoF. This is not unexpected, given the government-wide nature of reforms, but the approach can create a complex dynamic between the finance sector and other sectors, especially as it relates to accountability. For example, finance authorities driving the reform process may want to shift the health sector's budget and activities towards performance goals, but finance professionals within the health sector may feel they have the best understanding of sector-specific budgeting processes and what is needed to achieve results. This potential tension can be compounded if there is a lack of consultation, understanding or buy-in within the health sector. This dynamic often results in poorly designed programmes, as was the case in Gabon and Uganda (Abewe et al., 2021; Aboubacar et al., 2020). In Ghana, the dynamic between the health and finance sectors led to a misalignment in their budgeting approaches over a number of years, with the MoH using four budgetary programmes and the MoF using five (Osei et al., 2021). The fact that this disconnect could exist for so long points to the relatively superficial use of programme budgets as a tool to prioritize and allocate resources.

When there are inconsistencies in the design of a programme budget, it may indicate a lack of understanding by the MoH, a lack of capacity within the MoH, or a lack of cooperation among various stakeholders. It may also be an indication that competing priorities were at play. If all the stakeholders involved – the finance ministry, health agencies, government authorities and the public – all have different perspectives on how the budget is organized, the result is likely to be a mix of programme types that are inconsistent and overlapping, increasing fragmentation and reducing accountability.

In Burkina Faso, the health sector was selected to pilot reforms and was fully involved in the design process (see Box A2.4 and also viewpoint by Abdoulaye P. Nitiema on page 77). In Armenia, one of the challenges of implementing reforms was bureaucratic resistance, as well as a lack of understanding within the health sector about the content and purpose of reforms (Dale et al., 2018). This lack of ownership and understanding hindered progress and limited the extent to which reforms were implemented. Ultimately, full reform implementation requires health sector involvement at all levels, especially when it comes to understanding bottom-up budgeting inputs and needs. Programme budget reforms can improve performance and provide greater flexibility for health spending. However, as the reform roll-out in Ghana and Uganda has shown, these objectives cannot be achieved without shifting the behaviour of frontline personnel and improving their capacity to manage funds effectively. It is important to understand that the benefits of reforms among health sector stakeholders are not always clear, particularly when the vast majority of budgets are comprised of salaries that are not immediately impacted by the transition to programme-based budgeting.

Ministry of Health engagement in defining budget programmes: an example from Burkina Faso

In Burkina Faso, reforms were driven by the finance ministry but the health ministry still had a substantial say in how health-related budget programmes were defined. The health ministry was one of six ministries chosen to pilot programme-based budgeting. In 1998, soon after the six pilot ministries were chosen, the MoF launched a series of discussions over multiple years to define new programmes. The Department of Studies and Planning led the discussions on behalf of the MoH. Eventually, a consensus between the health and finance ministries emerged around the number of programmes and how they would be defined. These programmes were then well aligned with the strategic focus of the National Health Strategy (2011–2020).

Source: Barroy, André & Nitiema (2018).

In most LMICs, budget formulation reforms have been iterative, adjusted and refined over time. This is understandable, given the nature and complexity of reforms. In the health sector especially, the scope of programmes often must evolve to meet changing needs. However, too many changes to the size, number or scope of programmes can have a major effect on actual spending. Some countries have tried to limit the number and frequency of these adaptations. As a person involved in the reform review process from the Philippines noted,

Many of the experts surveyed as part of the reform review did not note any links between political economy dynamics and delays in implementation. This may be due in part to the fact that many countries had only recently begun the reform process. In Ghana, for example, there have been no delays but the country has yet to determine how resources will be allocated below the central line ministry, after which the budget is developed and spent. In some countries, however, the dynamics surrounding the adoption of reforms have had an effect on how programme budgets are implemented or adapted. In Armenia, factors related to the political economy led in part to a lack of performance controls and adequate performance monitoring and assessments. In Indonesia, staff rotations complicated efforts to help bureaucrats understand the budgeting approach.

International actors with their own agendas can also influence how budgetary programmes are designed and implemented. The Global Fund and Gavi have both become more engaged in budgetary mechanisms in the health sector and the dynamics around implementation. For example, Gavi has been working to ensure that line items for immunization- or vaccine-related expenditures appear in all budgets, regardless of structure (Griffiths et al., 2020). The Global Fund has been working to secure domestic resources for HIV/AIDS, TB and malaria by including them in national budgets as disease-focused programmes, particularly in countries that are transitioning away from international support. This can create fragmentation in health budget formulations and in service delivery (Abewe et al., 2021).

One question to consider is whether partially implemented reforms should be seen as a failure or as part of an ongoing, non-linear process in which reforms are adapted over time to achieve a better fit and to secure broader acceptance. Some individuals consulted as part of the reform review process argued that when reforms are initiated, even if they are not fully implemented, it can spark organizational or cultural change which may eventually create the conditions for further reform. In South Africa, for example, the introduction of programme budgets did not solve all the issues related to fragmentation in the country's health financing system, but it did generate more openness to releasing budget and performance data publicly and improved civil society and public participation in budget decisions (see Viewpoint by Mark Blecher on page 75).

“

Iteration is good on paper; its effectiveness depends on the size of the undertaking. Some policy-makers even think that iteration is an undoing or reversal of the original reform. Most of the time, a new head of a department is amenable to change, hence iteration happens only once every six years in our case.



Conclusion

Programme budgets are used to link budget allocations to results. When programmes are well-designed around health priorities, they become budgetary envelopes that can be managed more flexibly than input-based budgets. Programme budgets that are supported by a performance monitoring framework can offer LMICs the opportunity to align their budgets with sector priorities, to use resources more flexibly and to improve accountability.

Introducing programme budget reforms can be challenging. As a result, reforms in many LMICs are unfinished. In most, reforms have not moved beyond the pilot stage and budgets continue to be formulated and spent based on inputs. Few LMICs have moved to full implementation.

Technical bottlenecks often exist, preventing the benefits of reforms from being fully realized. When funding continues to be tied to inputs, either when funds are obtained or when they are spent, it creates rigidities that compromise flexibility in health spending. Most bottlenecks are linked to technical considerations, but the political economy also plays a role. This underscores the importance of a transparent and inclusive approach that considers the interests of all stakeholders.

Comprehensive stakeholder involvement across all levels is critical. In its absence, it can be harder to engage all actors towards implementation, stunting efforts to reach the full potential of reforms. Two-way dialogue between the health and finance sectors can help those in the MoF understand the unique needs of the health sector, and it can help the health sector build the capacity to implement programme budgeting.

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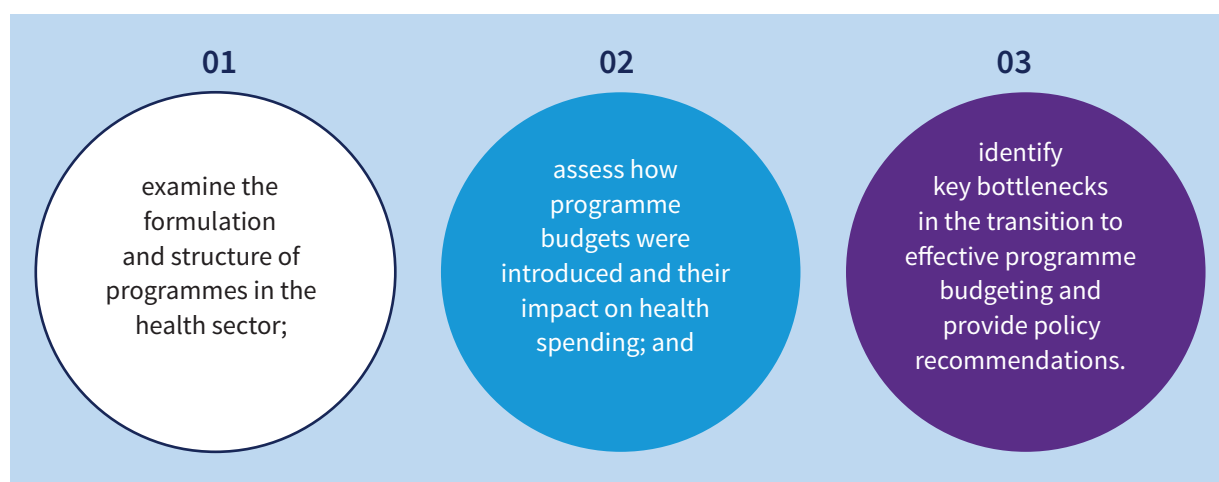
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3. Programme budgeting in health: lessons from 14 country case studies

3.1 Evidence from case studies

This chapter provides a snapshot of 14 countries at a relatively advanced stage of the reform process. The countries represent a variety of regions and income levels and reflect both insurance-based and budget-funded health systems. Viewed as a whole, these case studies demonstrate the significant benefits of programme-based budgeting reforms for health as well as challenges that may arise.

The case studies were developed using a common analytical framework (see Annex 1). The objectives of the case studies were to:



The studies were developed between 2018 and 2020 by the WHO (Armenia, Burkina Faso, Gabon, Ghana, Kyrgyzstan, Peru and Uganda), the OECD (Chile, Latvia and New Zealand) and the IBP (Brazil, Indonesia, Mexico and the Philippines), in close collaboration with country experts. The country reports are publicly available and listed below.

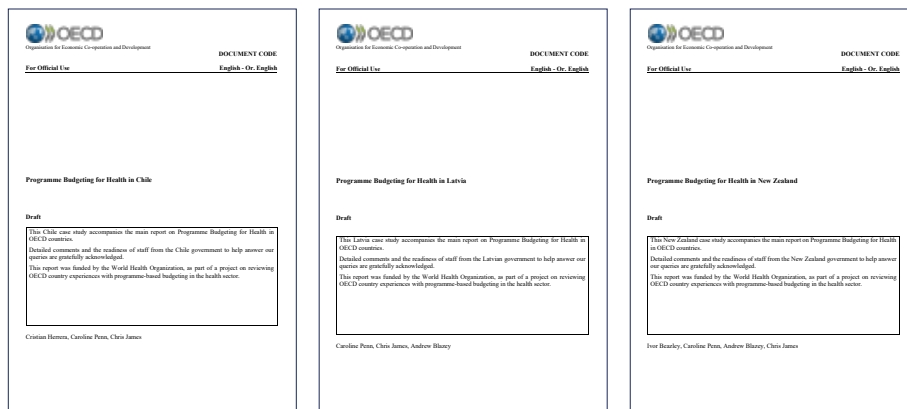
Case studies produced by the WHO



Case studies produced by the International Budget Partnership



Case studies produced by the OECD



3.2 Country briefs

Country briefs, developed to summarize key aspects of each country experience, were also developed on Armenia, Burkina Faso, Chile, Gabon, Ghana, Kyrgyzstan, Latvia, Mexico, New Zealand, Peru and Uganda. They were presented and discussed at the 4th meeting of the [Montreux Collaborative on fiscal space, public financial management and health financing in 2019](#). The briefs are organized around three main areas:

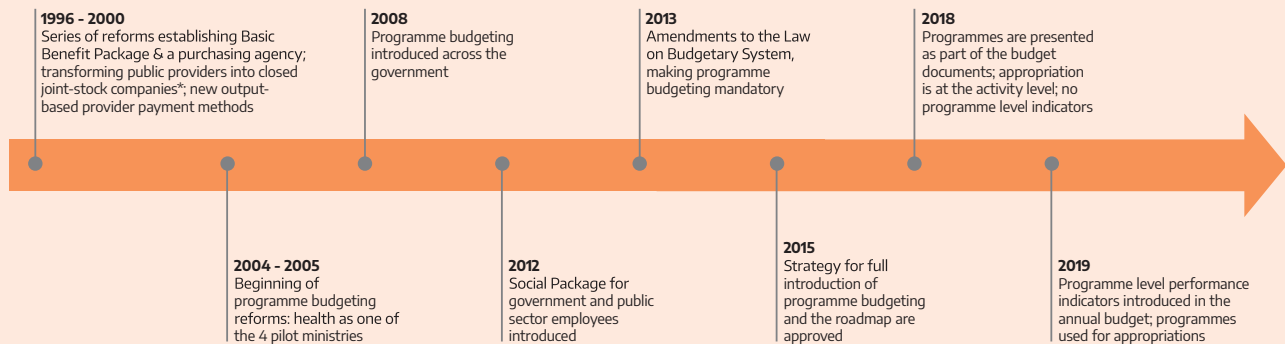




ARMENIA

PROGRAMME-BASED BUDGETING FOR HEALTH

TIMELINE OF IMPLEMENTATION OF KEY PROGRAMME BUDGETING AND HEALTH FINANCING REFORMS IN ARMENIA



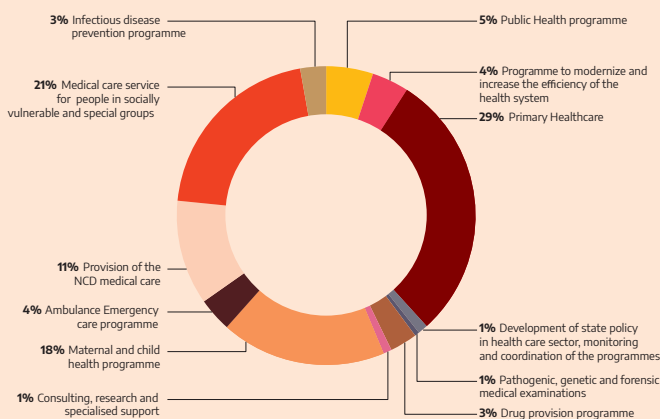
KEY OUTPUTS

- Numerous activities, which existed prior to introduction of programme budgeting, consolidated into 12 programmes with accompanying performance indicators
- Programme classification is part of the annual budget and is used for appropriations
- Programme budgeting structure allows tracking of the resources allocated for specific services, including the Basic Benefit Package (BBP)
- Performance indicators are actively used and reviewed by the Legislature, MoF and MoH
- Ministry of Health actively engaged in programme design discussions the Ministry of Finance and has been continuously working towards refinement of its programmes and activities, although it is limited to particular parts of the Ministry and specific experts

REMAINING CHALLENGES

- Programme structure, particularly the level below programmes, is of mixed quality with unnecessary fragmentation
- Programme statements, which are key in articulating the programme objective, its logic, evidence for proposed activities and performance measurement framework, are not yet developed or updated regularly
- Post appropriation controls continue at the detailed activity level, limiting flexibility in resource management and posing excessive burden on line ministries, including health
- Requests for changes in budget allocations between activity lines submitted by service providers get processed through a complex system involving multiple layers of government
- Overall context of extremely low public financing to health undermines all other efforts in health reform

BUDGET ALLOCATION BY PROGRAMME, 2019



MOVING FORWARD

- Programmes and activities within each programme should be further reviewed, many of the activities could be combined into large sub-programmes, others could benefit from more scrutiny/ breakdown
- The role of programme managers should be clarified and strengthened, including during the design of the programmes
- Programme statements should be developed and updated regularly for all programmes; they should also be made easily available to the civil society and legislators
- Method of contracting with providers should be reviewed to shift from the situation where budget ceilings are set for each detailed activity / type of service with targets set in absolute terms (e.g. number of couples who received infertility treatment) and any deviations from these requiring MoH and MoF approval
- Prioritization of health in public spending should be reassessed; this should be combined with review of spending priorities within health (e.g. activity on health insurance for government employees)

Budget structure in health and transition to programme budgeting: lessons from Armenia. Dale E, Kyurumyan A, Kharazyan S, Barroy H (WHO, 2018)

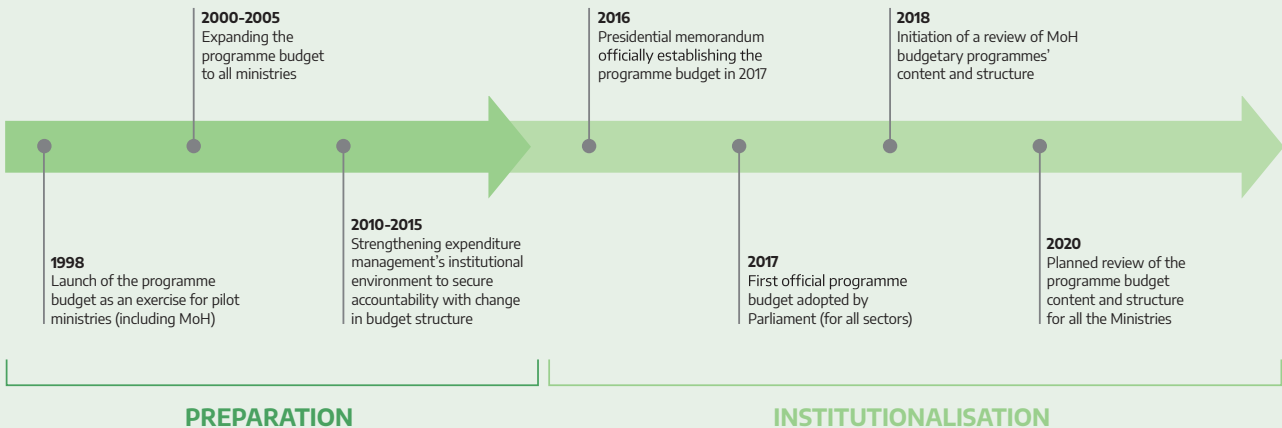




BURKINA FASO

PROGRAMME-BASED BUDGETING FOR HEALTH

HISTORY OF THE TRANSITION TO THE PROGRAMME BUDGET IN BURKINA FASO



KEY OUTPUTS

- Aligned budget formulation: alignment between the 3 budgetary programmes (access to health services, health service delivery and MoH oversight) and sector priorities, thanks to MoH Planning Unit engagement in programme design
- Clear programme structure with 3 distinct and articulated levels (programme, action, activity)
- Health system approach: disease interventions (e.g. prevention and treatment of malaria; immunization activities) integrated in broader budgetary programmes
- End of historical budgeting: year-to-year adjustments between and within MoH budgetary programmes
- Financial flexibility: budget re-allocations made possible within each budgetary programme envelope

REMAINING CHALLENGES

- Content of budgetary programmes: sub-levels (actions and activities) of mixed quality and often not consistent with programmes' outputs
- Half-way transition: programme managers don't have the expenditure authorizing power that continues to be with finance teams and administered by inputs
- Accountability system: MoH was re-organized to fit the new budget structure but delays in appointing programme managers caused issues for reporting and overall accountability
- Links with other health reforms: missing links between programme design and ongoing health financing reforms (e.g. creation of a main purchaser – RAMU – and new payment mechanisms for primary care providers)

MoH BUDGETARY PROGRAMMES AND ACTIONS (2018)

Programmes and actions
055 Access to health services
05501 Training of health personnel
05502 Constructing/rehabilitating health facilities
05503 Purchase and maintenance of sanitary equipment
05504 Improving the availability of quality health products
05505 Promoting systems to divide risks in the area of health
05507 Promoting traditional medicine and pharmacopoeia
056 Health service delivery
05601 Community participation
05602 Reducing morbidity and mortality associated with endemic/epidemic diseases
05603 Quality mother and child health services
05604 Disaster health management
05605 Health promotion
05606 Health product quality assurance
057 Oversight and support of Ministry of Health services
05701 Oversight, coordination and intersector collaboration of Ministry of Health actions
05702 Increase in health sector financing
05703 Management of financial and material resources
05704 Management of human resources
05705 Planning, monitoring and evaluation
05706 Building/rehabilitating and equipping administrative and educational infrastructure
05708 Health information
05709 Promoting health research
05710 Communication

MOVING FORWARD

- Update content of budgetary programmes, especially at activity level to improve consistency between activities and programmes' outputs
- Strengthen programmatic and financial managerial capacity of programme managers to secure good accountability in results
- Fully transfer spending authority to programme managers for better efficiency and flexibility in health spending
- Improve quality of performance monitoring framework, by making sure performance indicators do match with the expected outputs
- Tighten links between budget reform and the health financing strategy to allow contracting and performance-based payment of primary care providers.

Transition to programme budgeting in health in Burkina Faso: Status of the reform and preliminary lessons for health financing. Barroy H, André F, Nitiema A (WHO, 2018)

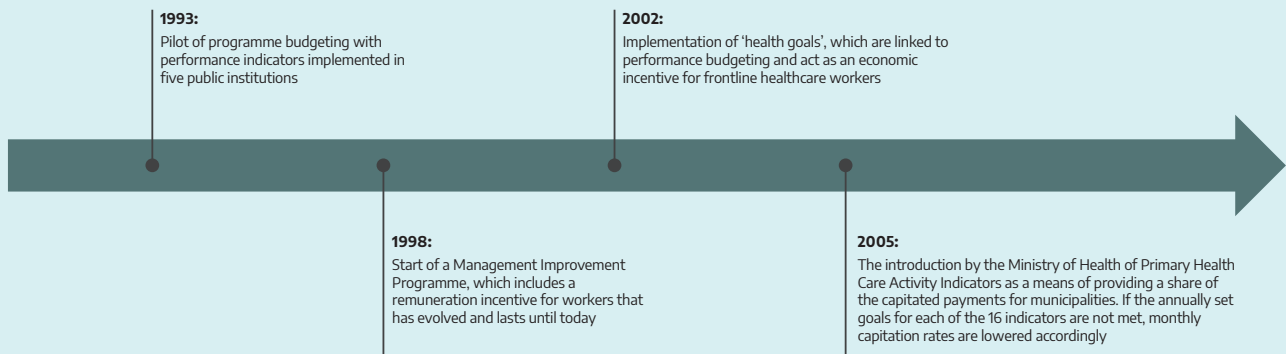




CHILE

TIMELINE FOR INTRODUCING PERFORMANCE BUDGETING

HISTORY OF THE BUDGET APPROACH IN THE HEALTH SECTOR IN CHILE



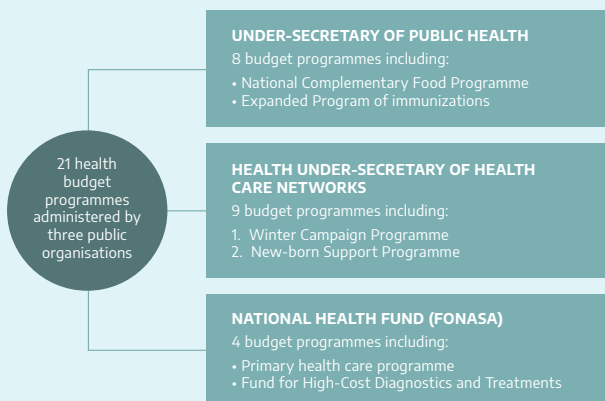
KEY OUTPUTS

- Chile has experimented over the past 25 years with implementing programme budgeting at the national level and using performance indicators to monitor the adequate use of public resources
- The performance budgeting structure in Chile has contributed to increase public transparency and accountability, both in terms of showing to the general public the objectives and activities that each public institution pursues, and to release the main results or measures of progress in relation with those aims and actions
- Various performance budgeting initiatives have enhanced the collaboration between the Ministry of Finance and the Ministry of Health, creating bridges for dialogue and project building among them

REMAINING CHALLENGES

- Budget allocations still remain strongly linked to health system organization entities, making spending less clearly linked to government priorities
- Despite the increase in transparency, there is low citizen participation in budgeting-related discussions in the health sector, including at the local levels of the health system (e.g. municipalities, hospitals)
- There has been an increase in the number of performance indicators collected for managerial and budgetary purposes, which overburdens the system and creates excessive bureaucracy
- Not many of the performance budgetary schemes that are linked to remuneration and budget allocation have been evaluated

BUDGET PROGRAMME ADMINISTRATION



MOVING FORWARD

- The performance indicators used should be reviewed for their relevance to avoid having an overly burdensome performance framework
- Formal evaluations of the performance budgeting schemes could provide relevant information to improve the system and, ultimately, enhance the value gained from public expenditure on health.

Programme Budgeting for Health in Chile. Herrera C, Penn C, James C (OECD, forthcoming)





GABON

TIMELINE FOR INTRODUCING PERFORMANCE BUDGETING

HISTORY OF THE BUDGET APPROACH IN GABON

Late 1990s:

Initiating reforms to the country's public financial management (PFM) system with the goal of making the budget more transparent, more flexible for managers, and more accountable through clearly defined outputs

2015:

Programme-base budgeting introduced with four budgetary programmes defined for the MoH budget, mirroring the institutional structure of the MoH

2007:

Initiating a fundamental reform of health financing to support the goal of universal health coverage

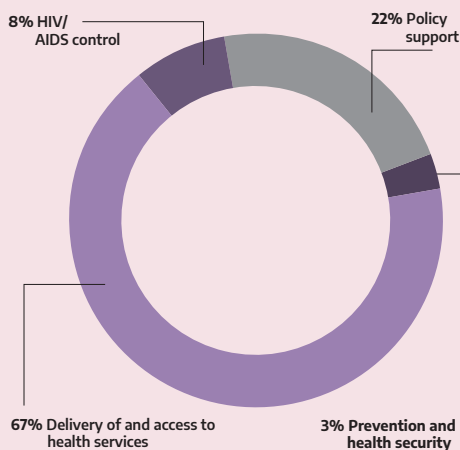
KEY OUTPUTS

- The adopted reforms (PFM and health financing) have led to major changes in health financing and public financial management frameworks
- The adoption of the new PFM framework and the shift to a programme-based budget exemplify the government's efforts to introduce greater transparency and improve performance in public spending
- The introduction of the programme budget helped the MoH identify policy goals that were then included in the budget documents
- The reform introduced a performance monitoring system with annual performance plans for the MoH presented as an annex to the finance law

REMAINING CHALLENGES

- Both the PFM and health financing reform suffer from a lack of harmonization and coordination, which has led to inconsistencies
- Both the PFM and health financing reforms also suffer from incomplete implementation, leading to financial fragmentation and escalating costs for the national purchasing agency, and to complex resource management and poor budget execution for the MoH
- Several health programme design challenges exist. Notably, the existing four programmes are not aligned with sector priorities, are too concentrated, and do not allow MoH leaders to set the right spending priorities
- Remaining input-based controls, caused by the lack of effective implementation of programme-based budgeting, hamper flexibility in managing the budget envelope
- Budget execution has dropped dramatically in recent years, mostly because of budget design flaws and complexities in spending procedures. The execution rate for MoH expenditures following the introduction of the programme budget remains below 60%.

BUDGET ALLOCATION BY PROGRAMME, 2017



MOVING FORWARD

- Working towards a single-payer arrangement could reduce administrative costs, streamline financial and data management for providers and ensure better protections for users
- To improve strategic purchasing, the national purchasing agency (CNAMGS) should explore alternative payment methods, such as capitation or diagnosis-related groups to ensure the financial sustainability of the model
- New tax policies and earmarking of revenues should be explored to ensure the continuity in public funding for the GEF scheme, which offers critical protection for the poorest Gabonese
- The content and outline of budget programmes in health should be redefining to better align with health sector priorities
- The development and use of a robust performance monitoring framework for the health sector should be a priority to enhance sector accountability
- To improve consistency and coordination in reform decision-making and implementation, a joint MoH/MoF task force could be established

Health financing and budgeting reforms in Gabon: Progress and challenges on the road to universal health coverage. Aboubacar I, Essono M, Mailfert M, Barroy H. (WHO, 2020)

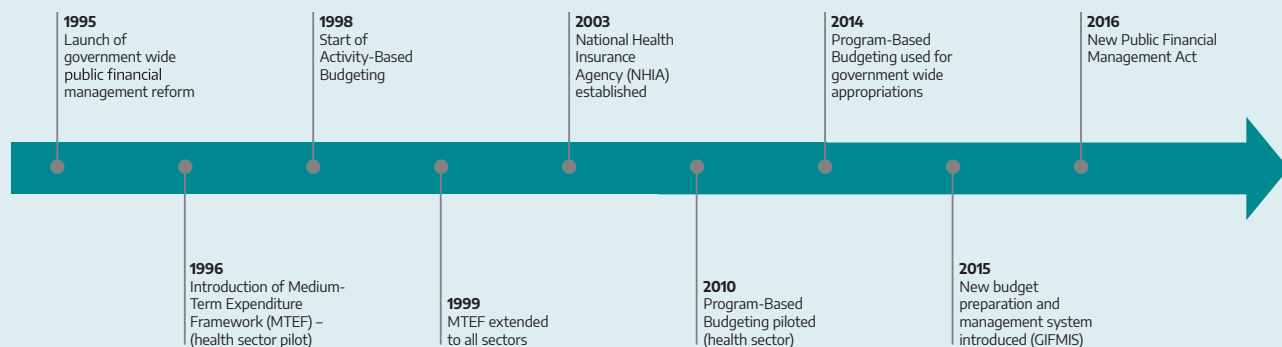




GHANA

PROGRAMME-BASED BUDGETING FOR HEALTH

HISTORY OF THE TRANSITION TO THE PROGRAMME BUDGET IN GHANA



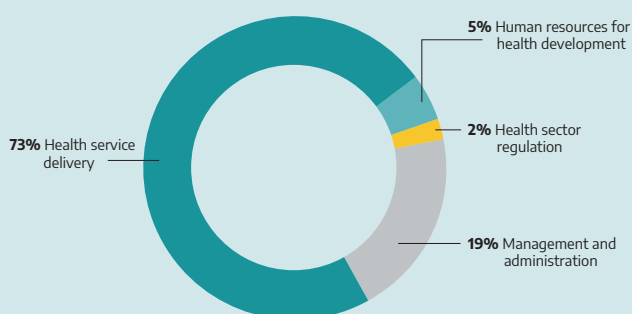
KEY OUTPUTS

- Health sector has successful introduction of medium-term expenditure framework (MTEF) to lay groundwork for programme-based budgeting (PBB)
- Health sector pilots and transitions to PBB; consolidating activities into budgetary programmes
- Introduction of performance indicators which serve to orient health sector towards outputs and outcomes
- Use of Ghana Integrated Financial Management Information System (GIFMIS) responsible for expenditure tracking
- Architecture in place to enable coordination and consolidation of budgeting lines across health sector and autonomous agencies
- Coordination of performance indicators across development plans and budgets

REMAINING CHALLENGES

- Programme-based budgeting logic has not disseminated below the central Ministry of Health
- Budgets across more than 500 budget management centres in the health sector continue to be managed by inputs with little flexibility to reallocate across lines
- Misalignment in number of budgetary programmes that are used to manage funds between Ministry of Finance and Ministry of Health
- National Health Insurance Agency (NHIA) funds are budgeted by inputs and are not released timely, which contributes to difficulties in fund management at facility-level
- Programme budgeting logic has not changed how input-based budgets for disease-based programmes are managed contributing to duplications and misalignments
- Performance monitoring has not been implemented and therefore does not drive actions within the sector
- A large share of the health sector budget is comprised of salaries and wages and therefore there is very little flexibility for reallocations

BUDGET ALLOCATION BY PROGRAMME, 2019



MOVING FORWARD

- Ghana Health Service, the service provision agency of the health sector, should adopt programme budgeting to transition towards more flexible allocation and greater coordination across disease programmes and broader service delivery units
- Performance monitoring framework should be reviewed with focus on implementation and accountability
- MoH should undertake comprehensive review of the PBB structure, incorporating budget requirements from development partners and disease programmes, and should come to formal agreement on budgetary programmes with Ministry of Finance
- PBB preparation and reporting and Holistic Assessment processes should be further integrated to strengthen performance monitoring and streamline processes and systems
- Budget Management Centres should be given flexibility to reallocate across line items, particularly internally-generated funds and NHIA revenues

Implementing programme-based budgeting in Ghana's health sector. Osei D, Sapatnekar S, Sparkes S, Addai Frimpong K (WHO, 2020)

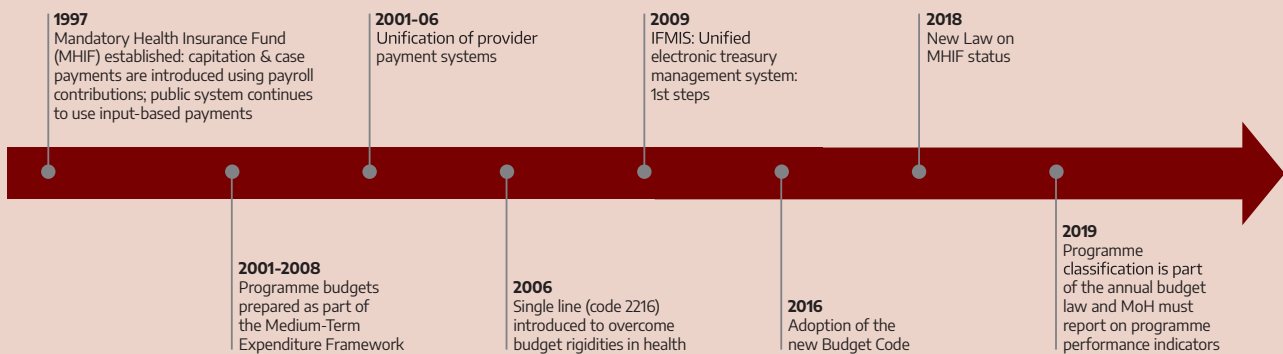




KYRGYZSTAN

PROGRAMME-BASED BUDGETING FOR HEALTH

TIMELINE OF PURCHASING AND PROGRAMME-BUDGETING REFORMS



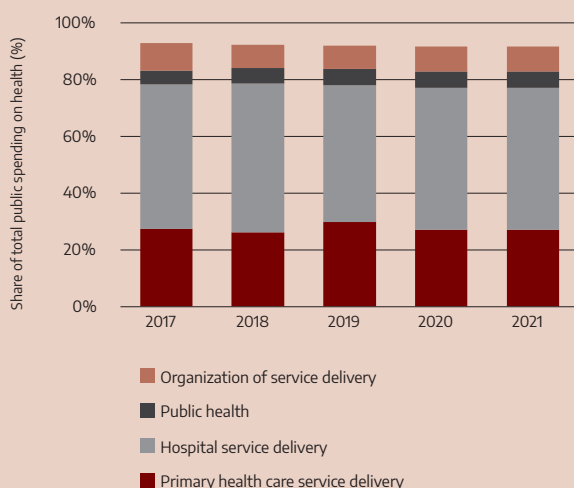
KEY OUTPUTS

- Budget transparency has improved: the legislature and the public can link budgets more closely to the purposes of spending (e.g. one can easily identify budget allocation and spending for key priorities such as outpatient drug package)
- Performance measures are part of the annual budget documents, gradually shifting the focus from input controls to accountability for results
- Savings from staff optimization to be retained at provider level, although there is residual distrust in the health sector
- Ex ante controls of resource shifts across providers have been removed with elimination of facility-level caps which were previously imposed during the post appropriation stage by the MoF, enabling the purchasing agency to shift funds across providers and line items

REMAINING CHALLENGES

- Budget is still formulated based on historic trends (previous year's budget) and does not account for the expected growth in the cost of health services, including the guaranteed benefits package
- Programme budgeting is not yet used for budget prioritization and budget allocations do not seem to reflect the stated priorities (e.g. primary health care)
- In 2019, programme classification is still used mainly for information as an alternative presentation of the budget, though the law requires it to be the main basis of appropriations
- Budgetary programmes in health are of mixed quality when it comes to programme design
- Alignment issues between MoH and MHIF programmes and performance measures

BUDGET ALLOCATION ACROSS FOUR MAIN PROGRAMMES, 2017 – 2021



MOVING FORWARD

- Prioritize detailed review of regulations and audit/inspection methods that continue to restrict changes to the input mix in MoH, MHIF and healthcare providers
- Review programme and sub-programme definitions to allow improved prioritization of spending on the basis of programmes and alignment of programmes across MoH and the MHIF
- Revise budget formulation process to ensure that programmes receive appropriate funding to deliver on the policy commitments and achieve the set targets
- Invest in complementary efforts to strengthen financial management capacity in MoH and healthcare providers
- To address the legacy of concern about punitive use of performance measurement articulate a clear policy on how performance targets and indicators will and will not be used, and communicate this clearly to budget and programme managers in line Ministries, MoF own staff, staff involved in inspecting/auditing, and legislators

Budget structure reforms and their impact on health financing system: lessons from Kyrgyzstan. **Hawkins L, Dale E, Baizakova N, Sydykova A C (WHO, 2020)**





LATVIA

TIMELINE FOR INTRODUCING PERFORMANCE BUDGETING

HISTORY OF THE BUDGET APPROACH IN THE HEALTH SECTOR IN LATVIA



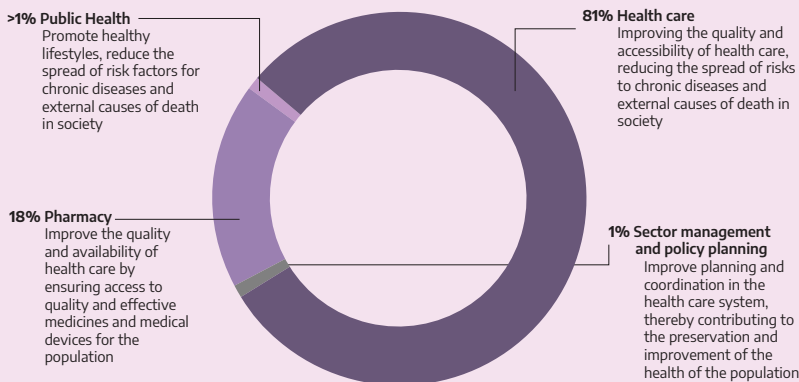
KEY OUTPUTS

- Close alignment between the programme structure and the existing organizational structure of the health system simplifies budget allocation
- Although approval is needed for budget reallocation between large economic classes, such as wages, some flexibility within budget programmes is maintained through broad economic classes
- Data from the performance monitoring system, which targets the entire programme structure, including policy targets, programmes, and subprogrammes, is central to parliamentary discussions on the health budget

REMAINING CHALLENGES

- Despite the effort to create a rounded performance indicator framework, some challenges to its use still exist
- Some indicators lack relevance to the policy objective and are only partially attributable to the actions carried by the programmes and subprogrammes.
- A repetition of policy performance indicators, such as years of potential life lost and average life expectancy of new-borns, across multiple policy targets shows an inability to effectively measure the success of each policy target
- For many of the performance indicators, the targets, which are set to define clear expectations, do not increase over the period and therefore are of little use.

ALLOCATION BY MINISTRY OF HEALTH POLICY TARGET



Programme Budgeting for Health in Latvia. Penn C, James C, Blazey A (OECD, forthcoming)

MOVING FORWARD

- Review the performance indicators to ensure they are fit for purpose and match with the expected outputs
- Ensure the focus on financial control does not impede the flexibility needed to effectively manage budget programmes in health

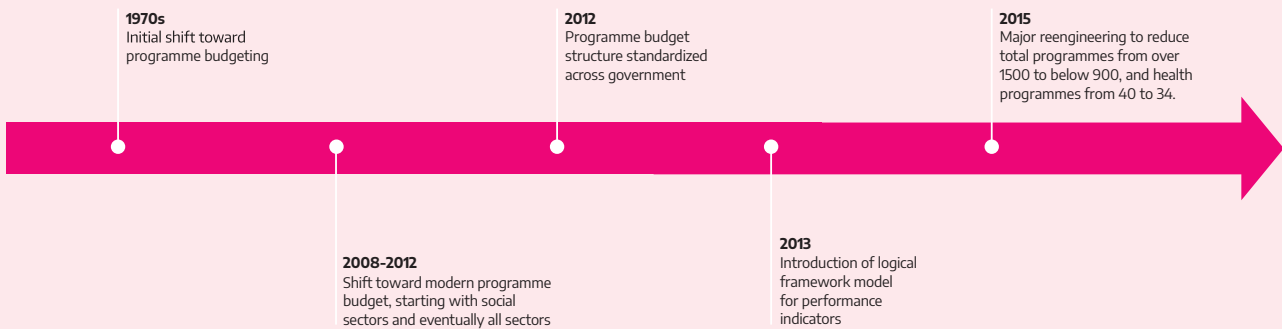




MEXICO

PROGRAMME-BASED BUDGETING FOR HEALTH

HISTORY OF THE TRANSITION TO THE PROGRAMME BUDGET IN MEXICO



KEY OUTPUTS

- Programme structure partly rationalized over time
- Elaborate hierarchical performance framework modelled on the logical framework implemented to track progress from activities to final outcomes
- Rigorous process for introducing new programmes created
- Regular evaluation of programme structure and performance indicators by third party evaluators in place
- Improved transparency of programme structure and indicator frameworks

REMAINING CHALLENGES

- Number of programmes still large by global standards rather than a programme/sub-programme hierarchy that represents the relationship between activities effectively
- Programme structure dominated by very large programmes in terms of budget, making trade-offs with smaller programs difficult and leaving large parts of the budget opaque
- Some programmes (e.g. Seguro Popular) actually finance other programmes (e.g. vaccination), meaning programme structure does not elucidate trade-offs clearly
- “Responsible units” in the indicator framework have limited authority to ensure that other units contribute to common goals
- Links between health budget programmes and the health sector plan are tenuous due to the way these were aligned, with programmes forced to adopt the plan goals as final goals in their indicator frameworks

TYPES OF BUDGET PROGRAMMEMES IN MEXICO’S HEALTH BUDGET IN 2018

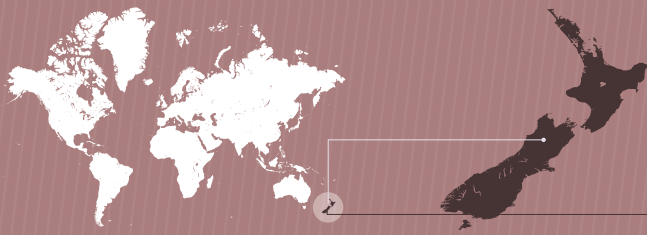
Programme Classification	Type
S	Subsidy programmes with special regulations
U	Other subsidies
E	Public Service Provision
B	Provision of Public Goods
P	Planning and Evaluation
G	Regulation and Supervision
K	Investment Projects
M	Support to the budget process and institutional efficiency
O	Support to government administration and good government

MOVING FORWARD

- Further consolidation of the programme structure and the creation of sub-programmes would make the programme budget more transparent and clarify relationships between activities
- Programmes should be organized consistently around objectives, reducing or eliminating the problem of confusing financing flows between programmes
- There may be a need to refine the concept of “responsible units” to ensure that they are able to manage other units that are meant to contribute to common performance targets

Program Budgeting in Health Within Mexico’s Results-Based Budgeting Framework. Lakin J (IBP, 2018).

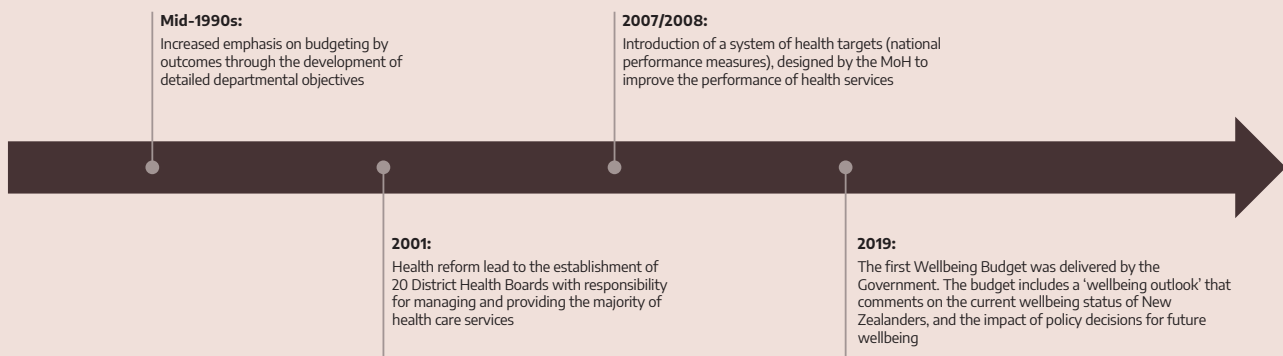




NEW ZEALAND

TIMELINE FOR INTRODUCING PERFORMANCE BUDGETING

HISTORY OF THE BUDGET APPROACH IN NEW ZEALAND



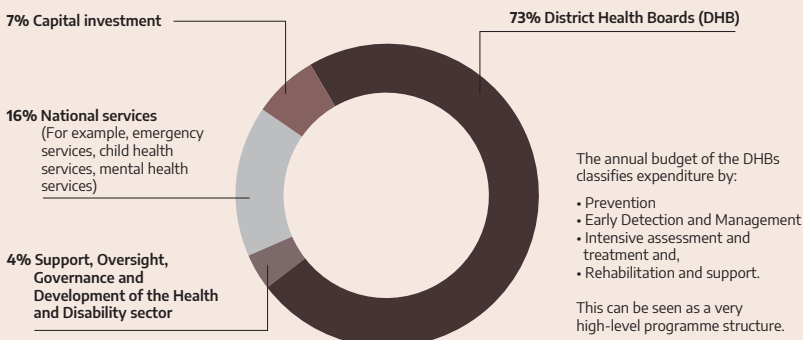
KEY OUTPUTS

- A clear programme framework is in place and District Health Boards (DHB), responsible for the majority of service provision, have flexibility on how to spend their budget within a strong accountability framework.
- Health targets are a set of national performance measures, which cascade down to the District Health Board level. Progress per DHB is reported on four times a year.
- Performance indicators have been refined and improved through dialogue between programme managers and clinicians, and are limited in number to reflect key priorities.
- New Zealand has developed a Living Standards Framework, to help understand the impact of budget initiatives on the living standards of New Zealanders.

REMAINING CHALLENGES

- The population-based funding formula used to distribute resources to the District Health Boards – despite being reviewed by the MoH every 5 years – is often criticised for bringing about financial constraints with consequent negative impact on health services and staffing.
- Some DHB that provide health services cover a very small population. Although this is intended to deliver better value local services, there exists a trade-off with the coordination and administration required to maintain them.
- Although an extensive performance framework is in place, as performance information is not directly linked to the budget process, its impact on the budget is still minimal.

NEW ZEALAND'S 53 HEALTH BUDGET PROGRAMMES DIVIDED BY TYPE OF APPROPRIATION



MOVING FORWARD

- The development of indicators and targets remains a work in progress with further work to be done, for example to integrate the high level system performance indicators into the planning and budgeting process and programme structure.

Programme Budgeting for Health in New Zealand. Beazley I, Penn C, Blazey A, James C (OECD, forthcoming)

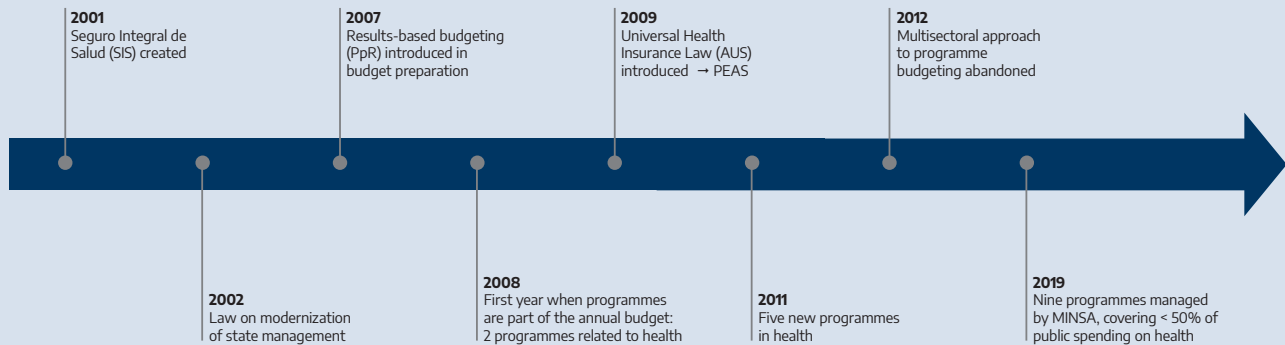




PERU

PROGRAMME-BASED BUDGETING FOR HEALTH

HISTORY OF THE BUDGET APPROACH IN PERU



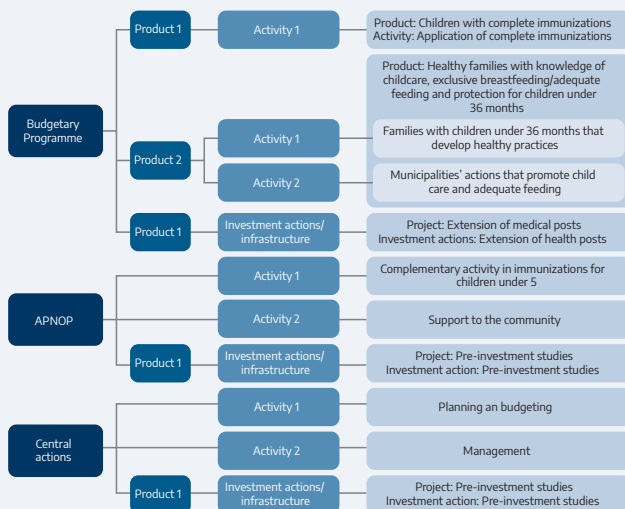
KEY OUTPUTS

- Real documented changes in health outcomes for conditions targeted by budgetary programmes, particularly malnutrition and maternal and neonatal health
- Programmes based on a process oriented towards rigorous evidence-based approach
- Robust IFMIS (SIAF) operating as one single system for all three levels of government (i.e. central, regional and local) with a special module to monitor financial and non-financial performance as part of programme budgeting

REMAINING CHALLENGES

- Programme budgeting still covers less than half of public spending on health: a large portion of spending is categorized as “Budget assignments that do not result in products” (APNOP)
- Current programme structure does not support a system-wide approach and integrated care: fragmentation in budget structure affects service provision
- Budget prioritization towards the essential package of health services (PEAS), a key step on the path to UHC in Peru, is not supported by current programme structure: ~ 40% of the services covered by PEAS are not part of the programmes
- Programme budgeting increased budget rigidities faced by service providers

BUDGET STRUCTURE



MOVING FORWARD

- Strengthen the role of MINSA as a body setting national health policy and spending priorities
- Adopt a system-wide approach to designing programmes and move away from focusing on specific population groups and health conditions and allow budget prioritization of essential package (PEAS)
- Enhance spending flexibility within programmes, shifting focus from compliance budgeting to results accountability
- Revise the budget structure to increase programme coverage and eliminate the category APNOP which will require reviewing the methodology of developing programmes in Peru
- Results or output orientation in budgeting should be translated to the way providers are paid to align incentives from top to bottom

Budgeting for results in health: key features, achievements and challenges in Peru. Dale E, Prieto L, Seinfeld J, Pescetto C, Barroy H, Cid C (WHO, 2020)

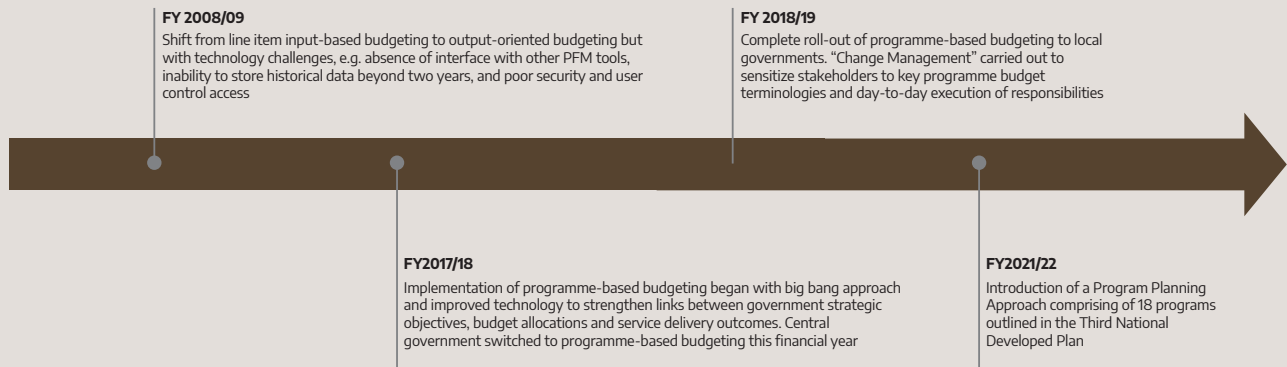




UGANDA

PROGRAMME-BASED BUDGETING FOR HEALTH

HISTORY OF THE BUDGET APPROACH IN UGANDA



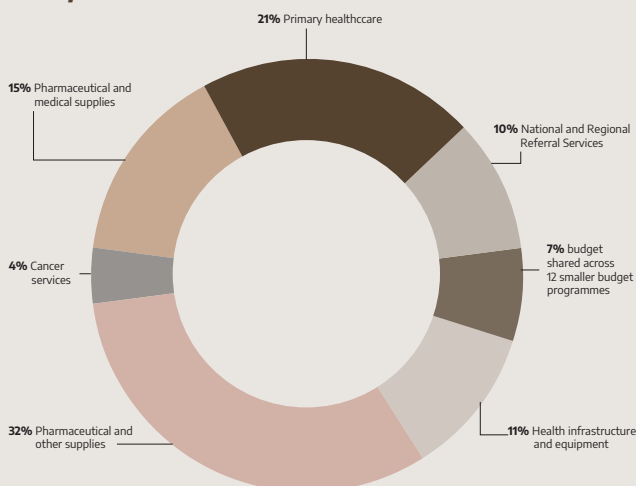
KEY OUTPUTS

- PBB sector objectives defined and clear linkages established between annual plans, health sector strategic plan and the National Development Plan
- Definition and tracking of sector performance indicators improved, allowing for sector assessment of progress towards objectives
- Technology weaknesses addressed, e.g. programme budgeting system is web based, allowing for easy use and reporting

REMAINING CHALLENGES

- Frequent changes in MTEF affects allocations towards outputs
- Stability of the programme budgeting system tool remains a challenge especially during peak periods
- Inter-connectivity of the programme budgeting system tool with other public financial management tools yet to be fully completed
- Low and inflexible resource envelope hinders the sector in autonomy and flexibility
- Programs follow administrative structures
- The definition of indicators remains problematic, as they tend to be process and output oriented.

BUDGET ALLOCATION BY PROGRAMME, 2019/20



MOVING FORWARD

- Full implementation of interfaces with other public financial management tools
- Classification of budget programmes, outcomes, indicators and targets should be reviewed to ensure proper alignment to sector objectives
- Implementation of shift from line items to programmes should be monitored
- The focus of period performance reports should move from measuring outputs to final results, i.e. programme outcomes
- Indicators and targets should be realistic with credible baselines and timelines

Case study in transitioning to programme-based budgeting in Uganda's health sector. (MoH, 2019)



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4. Introducing programme budgets in health: Insights from practitioners

In this chapter, three experts who have been directly involved in the design and implementation of budget formulation reforms in health share their insights.

Their insights provide concrete guidance on a variety of issues for practitioners implementing their own reforms: policy alignment, transparency, countrywide coherence, disease integration, balancing control and flexibility, performance monitoring, and linking accounting and budget formulation.



March Blecher

**National Treasury,
Republic of South Africa**



Abdoulaye P. Nitiema

**Former Director of Planning,
Ministry of Health, Burkina Faso**



Yuriy Dzhygyr

**Former Deputy Finance Minister,
Ukraine**



March Blecher

National Treasury,
Republic of
South Africa

What has been your involvement with budget formulation reforms and the introduction of programme budgets in health?

I have been working at the National Treasury of South Africa for almost 20 years. During my time there, I have had the opportunity to contribute to a major reform process which transformed the nation's overall budget, moving it from an input-based formulation to one based on budgetary programmes aligned with key policy priorities. In my role as chief director for health and social development at the National Treasury, I have been particularly involved in reforms for the two sectors under my supervision. In the health sector, this meant creating eight budgetary programmes at the provincial level and six at the national level. As other countries initiate similar reform processes, I am pleased to be able to share key takeaways from my experience.

What are the main benefits of a change in health budget formulation from your perspective?

In my view, adopting a programme-based budget has been vital in aligning budgets with key health services and needs. At the provincial level, 37 subprogrammes were created under eight health programmes. These subprogrammes were designed around integrated service packages linked to service platforms, including community health centres and regional hospitals. **This model helped align services with administrative responsibilities and provided a basis for clearer channels of accountability.**

In addition to improving alignment, the reform opened new spaces for public transparency. Compared to a traditional input-based approach, programme-focused budget documentation provides more information on where money is spent and what the budget aims to achieve. **As a result, programme-based budgeting has contributed to greater public debate about the budget.** In South Africa, the budget formulation reform was part of a broader set of reforms that also contributed to increased transparency. These reforms helped position South Africa as a leader on the Open Budget Index, with clear and positive results on budget transparency. In fact, South Africa has ranked among the top four highest-performing countries on budget transparency ever since the Open Budget Index was established in 2006.

The reform has also resulted in better monitoring and accountability towards results. Our quarterly and annual reporting systems have been strengthened and are now aligned with performance. At both the programme level and, in the majority of cases, at the subprogramme level, **we have found that a performance framework with clearly defined indicators for health, including targets and timelines, promotes better monitoring and accountability.**

What are the key challenges of a change in health budget formulation from your perspective?

Initially, there was no coherence between the national budget formulation and budgets at the provincial level. In many countries with a decentralized health delivery model, like South Africa, programme-based budget formulations have been set up at the subnational level. This setup makes it very difficult for the national government to understand how spending at the subnational level aligns with specific policy priorities and makes it challenging to plan coherently. In South Africa, we solved this challenge **by gradually defining and negotiating a common budget formulation for all nine provinces across the country.** Each province now uses the same template to present its budget and for benchmarking. **This countrywide coherence is one of the greatest strengths of the South African reform experience.** If each province had set up a completely separate budget formulation it would have been very difficult to assemble a comprehensive national picture of revenues and expenditure.

Another major challenge we faced was how to integrate specific disease responses into the formulation of the budget. For example, HIV/AIDS was initially a stand-alone budgetary programme, due in part to the burden of disease in the country and in part to political pressure. With money being allocated separately for HIV/AIDS, service delivery became quite fragmented. Over time, we broadened the scope of the budgetary programme and incorporated other services. The programme now includes other communicable and noncommunicable diseases



and funds flow through more integrated pathways and service platforms. I would recommend that countries endeavour to design more integrated service programmes from the very beginning of their budget design process or, at the very least, to move in this direction over time. **If it is necessary for a country to introduce a vertical programme for an urgent priority, like for a specific disease, it would be beneficial to view it as an interim effort and plan for the programme to eventually be integrated with other services over the long term.**

There were also important lessons learned in South Africa around finding the right balance between control and flexibility. This was an ongoing challenge for us throughout the reform process. We eventually found a balance that works for us, at least for now. **Money no longer flows based on inputs, instead it flows through a single stream to the provinces.** However, we still have a capping system in place for four main items at the local chapter level – personnel, goods, transfers and capital – and virements are possible among these four chapters. **Other countries may find their own way of balancing flexibility and control, and may even move further down the provider chain, giving providers greater flexibility in the use of resources within programme envelopes.** There are myriad ways to gradually release input-based controls while introducing budgetary programmes.

Upon reflection, I believe countries would do well to remember that moving to programme-based budgeting is a continuum, with many possible interim solutions to be found along the way.

Facilitated by Hélène Barroy and Linnea Mills, WHO



**Abdoulaye P.
Nitiema**

**Former Director of
Planning, Ministry of
Health, Burkina Faso**

What has been your involvement with budget formulation reforms and the introduction of programme budgets in health?

My engagement with reform efforts goes back at least a decade and is linked to my responsibilities during my 19 years with the health ministry in Burkina Faso.

The Burkinabe health sector experienced a series of budgetary reform trials between 2000 and 2009. During this time, I worked as the head of planning, monitoring and evaluation at the MoH Department for Research and Planning (2003–2005) and, subsequently, as a technical officer for the National Health Development Plan 2001–2010 (2005–2009). It was during this period that the first generation of the Poverty Reduction Frameworks and the MTEF emerged. Because of my work at the MoH, I was very involved in various budgetary reform processes, including efforts to modernize the budget system based on a 2002 decision to adopt a results-based management logic, a wider action plan to strengthen budget management (2002–2006), and a strategy to strengthen public finances (2007–2015).

In 2010, the MoH, as a pilot ministry, made the transition from an input-based budget to a programme-based budget. **An initial seven programmes were reduced to five, coupled with 24 actions which aligned with the health benchmarks stated in the National Health Development Plan 2011–2020.** Between 2017 and 2018, the MoH, along with most ministries, reduced the number of budget programmes in their sector. The MoH settled on three programmes.

What are the main benefits of a change in health budget formulation from your perspective?

The member states of the West African Economic and Monetary Union (WAEMU) have undertaken reform efforts to harmonize the framework for public finances. The reform has two fundamental objectives: i) improving the efficiency of public policy-making for the benefit of all, including all citizens, users, taxpayers and state officials, and ii) creating transparency in public management, by making budget documents more understandable for both parliamentarians and citizens.

The overhaul of the public finance framework is enshrined in Directive No. 06/2009/CM/WAEMU of the Finance Act in WAEMU, which aims to promote a multi-year strategy to improve transparency and efficiency. Aware that development requires efficiency in programming and budget execution, the Burkinabe government firmly committed to a results-based management approach through the programme budget approach, and, to this end, instituted the WAEMU directive into domestic law (organic law 073-2015/CNT, 6 November 2015).

In my opinion, the expected benefits from the change in health budget formulation are:

- **More flexibility** in how public resources are used, resulting in more widespread health benefits. This flexibility is achieved through i) the introduction of new actors with associated responsibilities, ii) the relaxation of certain ex ante controls to authorize expenditure (with authorization transferred to the health minister and then delegated to the MoH planning department, and iii) significant changes that took place in 2017 to initial programme allocations and the application of asymmetric fungibility within programmes.
- **Improved accountability** in the health sector through management and performance dialogue. **This dialogue is based on procedures, deadlines and tools, including work plans, dashboards and performance contracts.** The programme budget is accompanied by a performance monitoring framework, which links resource allocations to changes in the sector's performance.
- **Improved alignment between spending and health sector priorities** based on political and strategic benchmarks for the health sector.

What are the key challenges of a change in health budget formulation from your perspective?

Overall, the process of introducing programme-based budgeting has worked well. However, some challenges remain. **There is a need for continuous training and capacity-building among reform stakeholders, especially given how few actors are sufficiently equipped to carry out reforms and how quickly turnover takes place.** A related challenge is the adoption and use of reform-related tools, as these have not been mastered by all relevant actors in the reform process. The reform process has not always been respected and adhered to, which has resulted in delays. **Delegating authority to programme managers has not always worked effectively, nor has putting in place well-trained operational teams for budget programmes. Challenges remain to effectively integrate salaries into budget programmes.** Continuous efforts are needed to improve the programmes in order to reap the expected benefits from the reform.

Facilitated by H el ene Barroy, WHO





Yuriy Dzhygyr

**Former Deputy Finance
Minister, Ukraine**

What has been your involvement with budget formulation reforms and the introduction of programme budgets in health?

Introducing programme-based budgeting in Ukraine took 16 turbulent years. While this budgeting philosophy now has deep roots, we are still working to make it more effective.

In 2001, I was a junior economist working with a team to draft the country's Budget Code, which broadly mentioned programme-based budgeting for the first time. (Ukraine's first programme-based annual Budget Law was approved in 2002.) Introducing programme-based accounting was only a very small step in changing the line-item budgeting mentality of our post-planned system. In the following decade, most spending lacked a results-based orientation, even if budgets were formally attached to a programme.

The 2012 World Bank assessment of health system governance in the Ukraine, which I coauthored, concluded that rigid input-based spending norms made it impossible to use programme budgets in a meaningful way. Spending choices were driven by precise rules based on economic classifications, such as salary grades for doctors, controls on the numbers of personnel, bans on firing staff and wage protections. Budget totals were grouped under programmes without any underlying strategy.

As part of post-Maidan reforms, we started a full-blown attack on input-based budgeting in all sectors including health. **In 2017, our health system financing was completely rewired, removing unfunded input-based mandates and mismatched decentralization arrangements.** I was a member of a working group which designed this reform and was deputy minister of finance during the rollover to the new system at the primary care level (2018–2019). The new budget programme to capture health spending allocated by the new approach – Ukraine's first Programme of Medical Guarantees – became, I believe, one of the first truly results-oriented spending lines in Ukraine's history.

What are the main benefits of a change in health budget formulation from your perspective?

Even at the level of budget accounting, introducing a new formulation is a breakthrough. It imposes a new degree of honesty on a system which used to run based on inertia and unaffordable illusions.

During the years when Ukraine's spending units were still planning by inputs but were already reporting by programmes, the sheer act of having to formulate results and progress indicators started to change perspectives. It became possible to look at expenditure based on intent. It also became evident how some spending lacked purpose and logic.

In 2019, the MoF launched a series of spending reviews – the first of its kind in the Ukraine – looking into particularly problematic programmes in five sectors, including health. Some of these programmes were notoriously eclectic, piling together diverse activities and making it impossible to analyse their efficiency as required by law. For example, a programme on highly specialized health care provided by facilities owned by the MoH was basically a budget line to ensure uninterrupted funding of existing facilities rather than spending united through a coherent objective. It included quasi-private in vitro fertilization clinics, a redundant but lavishly-funded leprosy, and medical resorts. Ironically, it was programme-based classification which helped to collect these opaque activities under a joint heading, which called for a radical review.

What are the key challenges of a change in health budget formulation from your perspective?

The first challenge is flexibility. **Programme-based budgeting is supposed to shift focus from inputs to outputs. This requires both a clear vision of results and a readiness to relinquish an input-based structure.** In our experience, the latter takes much more time and effort. If hospitals and clinics have no choice in the composition of their teams, remuneration policies and business management models, no programme can achieve a results-based orientation at the facility level.

The second challenge is capacity. **After decades of operating in an input-based system, spending units often find it hard to budget based on expected results.** Releasing requirements on inputs shifts responsibility for choosing inputs on to the spending agent; making those choices requires both skill and guts. When Ukraine abolished a Cabinet of Ministers Resolution which used to mandate hospitals on the exact numbers of yard-keepers, vegetable-peelers and elevator attendants per one hospital bed, many facilities felt strained rather than relieved. Hospital administrations often had no capacity to decide on the optimal number of personnel and their salaries, having relied on central directives throughout their careers.

The third challenge is cross-functionality. **Programmes can cut across functions, which can create new challenges for budget accounting and stakeholder cooperation.** Ukraine's new Programme of Medical Guarantees (the country's universal guaranteed benefit package) is a single new budget programme which includes primary, specialized and emergency medical care. This new budget line needs to be reasonably and transparently broken down across relevant functional classification items, and there are no rules yet to clearly guide this process. We need to preserve the possibility of cross-functionality in programmes rather than demand that any programme should correspond to a single functional classification item as a matter of principle. But that will require new solutions and a new level of agility that we still need to master.

Facilitated by Elina Dale, formerly at the WHO Country Office in Ukraine



Part B. Reform challenges and policy options



1. Designing programme budgets in health

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Introduction

Poorly designed budgetary programmes can complicate resource management, undermine accountability, and introduce inefficiencies in public spending (Robinson, 2013). The introduction of programme budgets in health has faced challenges that are similar to those in other sectors. Most common challenges in programme budget design include the number of programmes selected, approaches to costing, and the formulation and hierarchy of programmes, sub-programmes and other subcomponents.

The country evidence also suggests that some programme design challenges have emerged specifically in the health sector. These challenges most frequently pertain to three dimensions. First, the programme structure often mixes different types of classifications serving potentially divergent goals, which can create overlaps and complexities for resource management at service provider level. Second, programmes are overly focused on diseases, which can exacerbate fragmentation in service delivery. Finally, inconsistencies in programme structure across levels of government can create additional concerns when subnational levels take on responsibility for health.

This chapter examines these issues, often from the perspective of a service provider (Section 1). It explores good practices that have emerged in LMICs to address these challenges. And it highlights the advantages and disadvantages so practitioners might make choices appropriate for their context (Section 2).

1.1 Key design issues

1.1.1 Hybrid classifications hinder alignment with health needs

Countries that transition to programme budgets often retain some aspects of the previous approach to budget formulation. Some budget provisions follow an input-based logic; others serve programme outputs. This hybrid budget formulation encumbers implementation in the health sector particularly if inputs such as health personnel, drugs, medical equipment and infrastructure are separated from the management of programmes. In Jordan, for example, serums, vaccines, and medicines are separated from primary and secondary care budget lines though they represent a major input into the delivery of these services (see Table B1.1).

Programme budgets often maintain a separate capital programme even though capital investments are often central to the objectives of other MoH programmes (e.g., infrastructure upgrades for primary health care programmes) (Lakin, 2018a). In Morocco, infrastructure and human resources are detached from service programmes, which obscures how these inputs contribute to programme goals and how related expenditures are allocated and reported within operational programmes (see Table B.1.2).

TABLE B1.1.**Jordan Ministry of Health budget formulation by programme (2019)**

Primary health care
Secondary health care
Expanding health insurance coverage
Serums, vaccines, medicines

Source: Budget of the Ministry of Health, Hashemite Kingdom of Jordan (2019)

TABLE B1.2.**Morocco Ministry of Health programmes (2019)**

Human resources and strengthening of health system capacities
Planning, programming, coordinating and supporting health system missions
Reproductive, maternal, child and youth health and population with specific needs
Epidemiologic surveillance, sanitary security, prevention, and disease control
Primary care, pre-hospital and hospital care
Health infrastructure

Source: Finance Act, Kingdom of Morocco (2019)

Another common challenge when designing programme budgets in health is the mix of programme types. For example, mixing health service-oriented with population- or policy-goal-oriented programmes may create a puzzle of funding streams and accountability structures, with each stream funding providers for potentially overlapping or conflicting purposes. In Morocco, some activities within the programme on reproductive, maternal, child and youth health overlap with those in the primary care, pre-hospital and hospital care programme, which is the main health care service delivery programme (see Table B1.2). This renders accountability difficult; resources and management for a single goal are divided across programmes.

The use of functional classifications like COFOG as the basis upon which to formulate MoH programmes (see table 1 on page 4) create another design challenge. This is common practice in Latin America, where health budgets mix inputs and output-oriented programmes (Lakin 2018a). COFOG may facilitate expenditure benchmarking across countries. However, this classification is not country-specific and does not clearly organize spending around outputs and outcomes in the health sector. COFOG categories classify health inputs such as medical products, health services including those for outpatients, and thematic areas such as research and development at the same level (OECD, 2011). This is suboptimal for shaping budgetary programmes. COFOG should not be the principal formulation used to develop MoH budgetary programmes and to appropriate expenditures unless the health categories it uses evolve to reflect current thinking about how health programmes function.

1.1.2 Disease-focused programmes create fragmentation in service delivery

The integration of disease interventions into programme budgets has been a core challenge across LMICs. Some countries have chosen to define programme budgets around a disease or a particular aspect in the fight against a disease. Often, they have done this early in the reform process, when programme budgets are first introduced or in order to secure funding for priorities such as an epidemic. The temptation is understandable and may appear efficacious. However, disease-oriented programmes are at odds with the logic of a programme budget and a system-wide approach. Defining disease- or condition-specific programmes separately from other programmes threatens to narrow budget allocations to vertical streams and can exacerbate fragmentation in service delivery. In Peru, multiple disease-oriented programmes sit within the programme budget structure and are linked to distinct goals and outputs (see Box B1.3). One provider could be assigned to several disease programmes, amplifying fragmentation in how services are funded and potentially delivered.



BOX B1.1.

Peru's Ministry of Health fragmented programme budget (2017)

Peru's programme structure does not support a system-wide approach. The fragmentation in the budget affects the ability of providers to deliver services. Providers must work within nine programmes that, together, amount to half of all health spending. Each programme has its own activities, products and expected results. Other health interventions are excluded from these programmes, which imposes an additional administrative burden on providers. The situation encourages narrow planning based on specific conditions and fragmented population groups, perpetuating fragmentation in service delivery.

	Programme and Programme Code	Target Population	Objective
1	0001: PAN (Nutrition programme)	Children under five	Decrease chronic malnutrition (stunting) in children under five
2	0002: SMN (Maternal and neonatal health)	Women of childbearing age, pregnant women and newborns	Reduce maternal-neonatal morbidity and mortality
3	0016: TB-HIV/AIDS (Tuberculosis and HIV/AIDS)	Respiratory symptoms identified, contacts of people affected by pulmonary tuberculosis, and the population in general	Reduction of the rate of incidence of sensitive and resistant TB in the community, and low morbidity and mortality due to sexually transmitted diseases, including HIV
4	0017: Zoonotic and vector-borne diseases	Population susceptible to acquire a zoonotic and vector-borne diseases, often residents of endemic areas of these diseases, as well as migrants who move to these areas. All ages and sexes are susceptible to getting sick.	Decrease in morbidity and mortality due to zoonotic and vector-borne diseases through health interventions, according to the risk scenario
5	0018: Noncommunicable Diseases (NCDs)	Populations at risk of NCDs related to eye health, oral health, chronic diseases, heavy metals	Reduction of morbidity, mortality and disability due to NCDs
6	0024: Cancer prevention and control	Entire population for promotional preventive actions, treatment and population with the disease for palliative care	Decrease cancer mortality and morbidity by improving access to oncology health services
7	0129: Prevention and handling of secondary health conditions in persons with disabilities	Poor people with permanent disability, (excludes EsSalud and private insurance beneficiaries)	Decrease secondary health conditions and the degree of disability of people with disabilities
8	0131: Control and prevention in mental health	Entire population for promotional preventive actions and screening according to age and gender, the population for diagnosis, treatment and rehabilitative care is one that presents a mental health disorder	Reduce prevalence of mental health disorders in the Peruvian population
9	0104: Reduction of mortality for emergencies and medical emergencies	All persons who report an emergency or medical emergency, whether identified by the same or by third parties	Reduce mortality due to emergencies and medical emergencies

Source: Dale et al. (2020).



A related dilemma in programme design for health is whether to create programmes by level of care. Programmes grounded in levels of care often have one programme dedicated to primary health care (PHC) or outpatient care and another dedicated to secondary care or tertiary and specialized care. This approach can help match spending with a conventional organization of care and allow budget prioritization. Budgeting separately for PHC services, as opposed to budgeting per disease, may help to protect funding for PHC, a goal shared by many country health systems (WHO & UNICEF, 2018) and create incentives for driving efficient spending and equity. However, a programme structure by level of care could become a challenge if a more integrated model is introduced to address complex health issues (WHA, 2016). Coordinated care approaches would require an aligned programme structure to financially support effective links between preventive, curative, and specialist services within a continuum of care (Jakab et al., 2018). As with COFOG, when the modality for providing services shifts (e.g., care that was provided at one level or in an inpatient setting becomes possible to provide at a lower level or in an outpatient setting), the level of care programmes can quickly become outdated and inflexible.

1.1.3 Inconsistent programme structure across administration levels is problematic for service efficiency and accountability

Countries moving towards programme budgets often experience inconsistencies in budget formulation between the national and subnational levels. Some countries may evolve towards a programme budget at the national level. The reform process slows at the subnational level, where input-based budgets may still be in use. This creates challenges when health is among the sectors being devolved. An inconsistent programme structure can create problems for resource prioritization and accountability (see Box B1.4). In Kenya, all counties have been legally required since 2013 to use programme budgets. Some have complied with the legislation. However, many county budget documents still use an input-based logic, creating misalignment and inconsistencies in how funds are disbursed.

BOX B1.2.

Devolved budget formulation: an example from Kenya

Kenya began an ambitious experiment in devolution in 2013. The country shifted responsibility for services such as health care from the central government to 47 newly created counties. The counties were given the authority to formulate and implement their own budgets, approved by local legislative bodies independent of the national government.

Different levels of government can formulate budgets independently while still following standards related to budget classification and reporting. However, in Kenya, the national treasury did not create a standard programme budget classification system for the counties. Creating the system would have required negotiation between the central and county governments, since counties have different responsibilities and may choose different goals. Consequently, the counties have presented their budgets in different ways, making it difficult to consolidate and compare national information. Some have tagged spending in accordance with the national financial management information system, even when these categories are not relevant to county expenditures. This hinders a coherent national response to specific health problems. Ideally, a uniform programme budget formulation with a limited menu of standardized options would be developed to balance both central and local needs (Lakin & Magero, 2015).

In the health sector, some counties still spend based on inputs, maintaining separate procedures for certain health inputs. As responsibility over the health sector has decentralized, spending in some areas has become more centralized. Fees are now centralized at the county level. Hospitals and other providers have had limits imposed on their ability to use funds. For them, the change in budgeting practices did not result in more flexibility in the use of local resources because the changes conflicted with other reforms that affected how county funds were allocated and used (Barasa et al., 2017).

Some countries have separate purchasers for health services. They make large budget transfers from the main budget to these entities. Programme-based formulation can facilitate this transfer by grouping inputs into a lump sum envelope. Bundling all subsidized expenditures together under one programme line – a subsidized benefit package, for example – can allow more flexibility to the purchaser. This is particularly relevant when the rest of the budget is still based on rigid line-item controls (Chakraborty et al., 2010). However, such bundling may make it more difficult to prioritize spending and to ensure accountability when such subsidies make up a significant portion of overall sector expenditures. In 2015, prior to the full implementation of the programme budget in Kyrgyzstan, transfers to the Mandatory Health Insurance Fund (MHIF) made up nearly 70% of overall public expenditures for health. Such an approach may result in a lack of accountability and transparency without strong performance measures and ex post reporting mechanisms (Hawkins et al., 2019).



1.2 Good practices in addressing key design issues

Practitioners interested in addressing those key challenges in the design of programme budgets in health can draw upon several good practices. Some LMICs have balanced the trade-offs to i) make budgetary programmes more compatible with health needs; ii) integrate disease interventions in programme formulation; and iii) consolidate a programme framework across levels and entities.

1.2.1 Making programmes compatible with health needs

Each type of programme has a different underlying logic and not all formulations are compatible with health sector priorities. Understanding how one type of programme complements another is an important step in ensuring programmes are formulated appropriately in health. Practitioners who understand the underlying logic of each type of programme may be better able to choose the right approach.

LMICs tend towards several common programmes including: i) service-oriented or level-of-care oriented; ii) policy- or population-based; or iii) administrative. They all have advantages and disadvantages (see Table B1.1) for channelling funds and incentivizing efficient service delivery. Defining the right combination is critical to ensuring alignment with sector priorities, while avoiding overlaps in funding streams and reporting activities for providers.

The use of administrative support programmes may be a temporary measure to enhance a sectoral coordination function. However, health ministries should aim to gradually incorporate personnel costs into operational programme envelopes to support more efficient health services (see Chapter B3 on implementation).

TABLE B1.3.

Advantages and disadvantages of programme types for health

Type of budgetary programmes	Definition	Examples	Advantages	Disadvantages
Service-oriented	Programmes categorized by service platform, type of service or level of care	Primary care, secondary care, district services, outpatient services	Promotes integrated service delivery; offers an opportunity to place more emphasis on primary care; aligns well with health system architecture	Programme broken down by level of care risk fragmentation and management complexities when facilities provide different types of care at the same level (e.g., a district hospital providing primary and secondary care services)
Policy-based	Cross-cutting programmes that serve an identified policy goal, the general population, or a specific group	Strengthened, quality of care, public health, health security	Supports clear orientation towards outputs	May duplicate activities embedded in service-oriented programmes
Administrative support	Programmes include general expenses for supporting MoH administrative and policy functions	Oversight and support for ministry services	Supports policy and coordination function for central level MoH	Missed opportunity for distribution of key inputs by programmes if MoH salaries are embedded under administrative support programmes



1.2.2 Integrating disease components into programme structure

The transition from external funding for disease-related interventions to domestic funding prompts LMICs to integrate disease responses into their domestic programme budgets. One approach may be to integrate disease components into broader budgetary programmes such as primary care, access to care, or public health at the subprogramme, action, or activity level. Disease responses can be integrated and positioned where budget implementation occurs. This facilitates expenditure tracking as each subprogramme typically has a defined envelope. If funds can be reallocated within the broader programme envelope, the approach can ensure flexibility as needs and costs evolve for disease interventions. This is the case in South Africa and Burkina Faso (see Box B1.5).

BOX B1.3.

Integration of disease components into broader budgetary programmes: examples from South Africa and Burkina Faso

South Africa integrated disease interventions into programme budgets gradually which led to a gradual increase in integrated service delivery. As of 2020, the MoH budget included a programme for communicable and noncommunicable diseases. The programme was initially established for HIV/AIDS alone, and then developed into a programme for HIV/AIDS, tuberculosis (TB), and maternal health before expanding to include all communicable and noncommunicable diseases. The programme develops and supports the implementation of national policies, guidelines, norms and standards and works “to achieve national targets to decrease morbidity and mortality associated with communicable and noncommunicable diseases; and to develop strategies and implement programmes that reduce maternal and child mortality”. The scope of the new programme is broad. However, it focuses on specific diseases through its subprogrammes, which include the following components:

- HIV/AIDS and sexually transmitted infections (STIs)
- Tuberculosis management
- Women’s, maternal and reproductive health
- Child, youth, and school health
- Communicable diseases
- Noncommunicable diseases
- Health promotion and nutrition (Republic of South Africa, 2018).

Burkina Faso’s budget is based on a programme-action-activity hierarchy. Immunization, for example, is embedded as an activity within larger MoH programmes for health service delivery. The access to health services programme and the health service delivery programme include immunization-related activities that are in line with delivery approaches. For example, local service providers organize outreach campaigns. Incorporating disease-specific work into broader programmes helps programme managers to better coordinate their approach compared to what is possible when programmes are formulated around specific diseases (Barroy, André & Nitiema, 2018).

Programme	Action	Activity
Access to health services	Improved availability of health products	Purchase vaccines and consumables
Health service delivery	Quality health services for mother and child health	Organize national immunization days



Another way to include disease components into programme budget logic and ensure accountability towards certain disease outputs is to include disease-specific indicators/targets in the performance monitoring frameworks of programme budgets. Many countries take this approach, regardless of whether disease-focused budgetary programmes exist (see Chapter B4). A disease target would mean that the disease must be addressed even if the intra-programme allocation can be shifted, which is one mechanism to guarantee outputs. In Philippines, disease-related targets are incorporated into the public health budgetary programme (see Box B1.6).

BOX B1.4.

Disease indicators and targets within Philippines public health programme

	Disease indicators and targets	Budgetary programme name
Philippines	<ul style="list-style-type: none"> • 95% fully immunized children • Number of malaria-free provinces • Number of filariasis-free provinces • Number of rabies-free areas • 75% of people living with HIV and eligible for antiretroviral therapy (ART) on ART • Treatment success rate for all forms of TB • Decrease in premature mortality rate attributed to noncommunicable diseases 	Public health

Source: Lakin (2018b).

Mature programme budget structure can also be used to incentivise an integrated care approach, as has been observed in higher-income contexts. Programmes or subprogrammes may directly serve integrated approaches such as family medicine or multidisciplinary practices; home-based or community care approaches, as in China, India, and Mali; or coordinated care pathways, as in Thailand (WHO, forthcoming). The formulation of budgetary programmes can be accompanied by a composite set of indicators that integrates system-level measures of population and service proxies for improved health outputs such as reductions in avoidable deaths for treatable conditions, avoidable admissions to hospitals, lengths of hospital stays, and reductions in adverse events. Brazil has experienced persistent challenges with the MoH budget formulation. Still, several activities are merged into a broader budgetary programme that supports more integrated care at the regional level (de Renzio, 2018). Some areas are better served through good performance information as opposed to having infinite levels of detail within the budgetary system.

1.2.3 Developing a consistent results chain across agencies and levels of government

Countries can align national and subnational budgets within a programme structure while respecting the differences between their functions and priorities. Developing a consolidated framework at the national level can pull together budget allocations across all levels. Gabon and Peru have taken this approach, incorporating budget allocations from national to subnational levels under each programme and assigning performance targets for each (Aboubacar et al., 2020; Dale et al., 2020). In South Africa, the national programme budget provides a framework for overall sector accountability and expenditure monitoring, and promotes harmonization across provinces (M Blecher, 2019, pers. comm). It includes a standardised programme structure for all provinces and has some linkages between programme categories at central and provincial levels (see Box B1.7). To be effective, such approaches must recognize functional differences in the roles of different levels of government in the health system.



BOX B1.5.

South Africa's central and provincial programmes for health

Central programmes	Provincial programmes
<ul style="list-style-type: none"> • Administration • Communicable and noncommunicable diseases • National health insurance • Primary health care services • Hospital systems • Health system governance and human resources 	<ul style="list-style-type: none"> • Administration • District services, with subprogrammes: district administration, clinics, community health centres, HIV/AIDS, nutrition, district hospitals • Emergency ambulances • Specialized hospitals • Nursing and ambulance colleges support • Health facility construction

Source: Republic of South Africa (2018).

Countries with programme budgets should follow programme logic when making transfers to separate purchasing agents. Expenditures should be linked to outputs or policy objectives. Some countries align the purchaser's budget formulation with the MoH's programme budget framework to ensure accountability across the sector. In Peru, the national health insurance agency, Seguro Integral de Salud, receives the subsidies and has a budget that reflects the existing programme logic (Dale et al., 2020). In Kyrgyzstan, transfers to the MHIF are broken down by programme line.

If a purchaser, MoH or any other agency or level of government is involved in spending public money for the same output, their programme and subprogramme structures and indicators for those expenditures should be harmonized. In Kyrgyzstan, the MoH and the National Health Insurance Fund are both funding PHC, maternal and child health, and haemodialysis diagnosis and treatment expenditures. The two agencies share programmes and performance measures. By providing a basis for consistent priorities and accountability, an aligned programme budget can help to mitigate fragmentation within the health financing system.

Conclusion

Well-designed programmes allow countries to reap the benefits of programme-based budgeting. The type of programmes, undue focus on specific diseases, and programme structure and hierarchy across administrative levels can all present design challenges for programme budgets in health.

Many countries have developed a hybrid programme structure. Programmes overlap and have little to distinguish them. Fixing a problematic budget formulation requires an understanding of how different types of programmes work on their own and how they complement one another.

Many LMICs struggle with fragmented programme structures that are often the result of adopting standalone disease-focused programmes or programmes that focus on specific levels of care such as primary, secondary, tertiary, or specialized care. Disease components should be integrated into broader programmes rather than adopting programmes for specific diseases. Disease interventions can be integrated at the subprogramme level and tied to specific performance indicators. Similarly, programmes that focus on an integrated care approach can where appropriate support a continuum of care.

Countries also wrestle with defining a programme structure that links programmes to results and establishes a clear results chain across the levels and entities involved in health spending. A lack of alignment between programmes across national and subnational levels of government levels or across purchasing and spending entities can lead to a lack of financial transparency and accountability. Developing a consistent programme logic that is applied across programmes, subprogrammes and performance indicators for transfers to subnational levels and separate entities can remedy this problem.

Clarifying the results chain, ensuring programmes are clear and distinct, and integrating diseases prudently requires coordination among budget stakeholders. Unless they agree on what the budget should deliver, they will face pressure to add or modify programmes in ways that undermine the coherence of



the structure. Stakeholders in the MoF, the MoH and related agencies should agree on how to ensure a reasonable degree of flexibility and accountability for the use of funds and for the delivery of national health priorities. Challenges will inevitably arise around these issues during implementation. However, they can be partly addressed when budget programmes are formulated. This initial conversation can foster a better dialogue during implementation.

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2. Managing programme budgets in health

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Introduction

Programme budget reforms potentially hold great promise in improving public sector performance by shifting the focus from inputs to measurable outputs or results. This approach allows a government to deploy resources according to priority areas and hold executing managers accountable for the delivery of targets. However, the benefits of programme budgets depend on how they are implemented.

Once a new budget formulation design has been approved, several actions are required to prepare for implementation, including; inserting new budget formulation into the financial management information system, appointing programme managers and clearly defining roles and responsibilities; defining the relationships between programme managers and institutional managers in programmes; developing formal objectives, plans and performance indicators for the programme; and planning annual budget cycle including the development of the annual programme budget, implementation, and expenditure and performance reporting and evaluation.

The chapter is structured to first outline some key challenges in programme budget management, and secondly provide a set of solutions on how these problems can be addressed, with a specific focus on health sector needs.

2.1 Key implementation issues

Programme budgeting fundamentally changes the way a budget is managed and goes beyond merely adding a layer to the budget. A programme budget is introduced into an existing budget management system and administrative structure. Implementation challenges arise if processes relating to these legacy structures are not corrected to ensure the program budget reform is comprehensive and programme budgeting requirements are met.

2.1.1 Poor costing undermines budget execution

Countries moving from input-based budgets to programme budgets can struggle to estimate the cost of budgetary programmes, depending also on how big a change the new structure is from the previous classification used. The introduction of programme objectives suggests budgets should be reorganized to allocate costs in relation to them. The process requires that existing costs be reallocated or mapped to the new formulation. For example the MoH must determine how to allocate existing costs, usually accounted for by administrative unit, to the new programmes. Some countries have tried to follow a bottom-up approach to cost programme allocation. They have estimated the costs of policy objectives. However, this has often led to unrealistic budget proposals and a combination of top-down and bottom-up budgeting is often preferable. Programme budgeting should be about revisiting the budget from the perspective of objectives and creating opportunities to stop purchasing certain inputs and shift towards others. Cost estimates are frequently based on historical allocations rather than arrived at through a costing and prioritisation exercise.

Accurate costing can be difficult. Specific expenditure items in health are particularly challenging to apportion in a programme structure. Personnel, drugs, and medical supplies tend to be significant cost factors. Many fail to incorporate staff costs in the programme budget. This substantially reduces the power and efficiency of programme managers and service providers. Ideally, programmes should include all costs required to achieve programme objectives. This entails wages and other personnel costs, which often constitute the majority of expenditures, as well as goods and services, subsidies and transfers, and investments. However, this exercise can prove challenging, depending on the way programmes have been



defined. If a spending unit maps to multiple programmes, estimating how much staff time should be mapped to a particular programme can be difficult in the absence of a time recording system. Many countries keep these costs separate or outside of the MoH programme budget, which is not recommended. This often occurs when a different government authority, such as a planning ministry, handles personnel, or when budget envelopes for expenses such as capital costs are kept separate, as they are with the development budgets in Pakistan and the United Republic of Tanzania.

Inaccurate apportioning or costing that remains unresponsive to developments such as performance and demographic changes, wage increases or costs of new treatments, will lead to inadequate budget provisions. This engenders problems in execution and undermines performance incentives and accountability for programme managers who will not get the necessary resources to reach targets (see Box B2.1).

BOX B2.1.

Kyrgyzstan: continuation of funding gaps and risk of inefficiencies due to inadequate programme costing

Adjustments to the MHIF budget for inflation are still based on input costs. Increases in wages are applied to approved numbers of staff posts. This disincentivises the health sector to rationalize excess vacant posts. Worse, the budget formulation does not use any methodology for projecting growth in the cost of the State Guaranteed Benefit Package (SGBP) to meet rising demand due to population growth and aging. Further, no strategy has been developed to close the current financing gap for the SGBP, either through patient payments or rationing of services (Hawkins et al., 2020).

2.1.2 Programme budget can create new rigidities in budget execution

Moving from input-based to programme-based budgets requires a shift from an input-based to results-based control mechanisms. If controls are carried over from the legacy system and are at an excessively detailed level, programme managers will have little flexibility in achieving results.

Overly detailed classification, usually down to the activity level, may indicate a programme structure that reflects an input focus disguised as a modern programmatic structure (Farooq and Schaefer 2017). If a bottom-up costing process from activity level is used and is the justification for budget allocation, the allocation often follows the same formulation: by programme, subprogramme, activity, and line item. Funds that are defined and controlled to this level require additional layers of control at the activity and subprogramme levels and are typically too inflexible and bureaucratic to manage effectively. A programme manager and spending unit may not be able to move money between a subprogramme, activity, or line item without getting additional approval. This can inhibit virement of resources across subprogrammes for spending units. Programme managers may have no flexibility to adjust allocations to subprogrammes as these have been predetermined. Subprogramme budgets are by activity and line item. Spending units in their executing function cannot shift spending among activities financed from various subprogrammes (see Box B2.2). Such a scenario would undermine efforts to strengthen provider autonomy and spoil the objectives of programme budgeting. This may lead to complete rigidity and warrants close attention.

BOX B2.2.

Programme budget and increased rigidity: examples from Zambia and Philippines

Zambia: The transition to programme budgeting in Zambia was inspired by a need to shift the budgetary process towards outcomes. However, the administrative structure and associated controls prevailed. Funds were released against line items, activities and subprogrammes. This has undermined the effectiveness of the reform and led to rigidities at the spending unit level. Previously, spending units were able to vire funds across line items. However, controls at the activity and subprogramme level have constrained flexibility in the use of funds. Virement was possible within a spending unit and a spending category such as goods and services. With the reforms, virement became further constrained as it could only be done within certain subprogrammes. The more subprogrammes a spending unit draws funds from the more restricted virement becomes. Furthermore, introducing the subprogramme and activity level has led to the proliferation of transactions and recorded line items.

Philippines: Up to 2018, programmes were not yet being used to appropriate or control funds. Appropriation is done at the activity level, limiting freedom for implementers to shift funding within programmes. Changes at the activity level require authorization from the Office of the President. The detailed notes in the General Appropriation Act also put extensive limits on how funds may be used at the scheme or initiative level. Programmes rather than activities will also need to be used for appropriation and control in the transition to programme budgeting.

Source: Chansa et al. (2019); Farooq & Schaeffer (2017); Lakin (2018); World Bank (2016a).

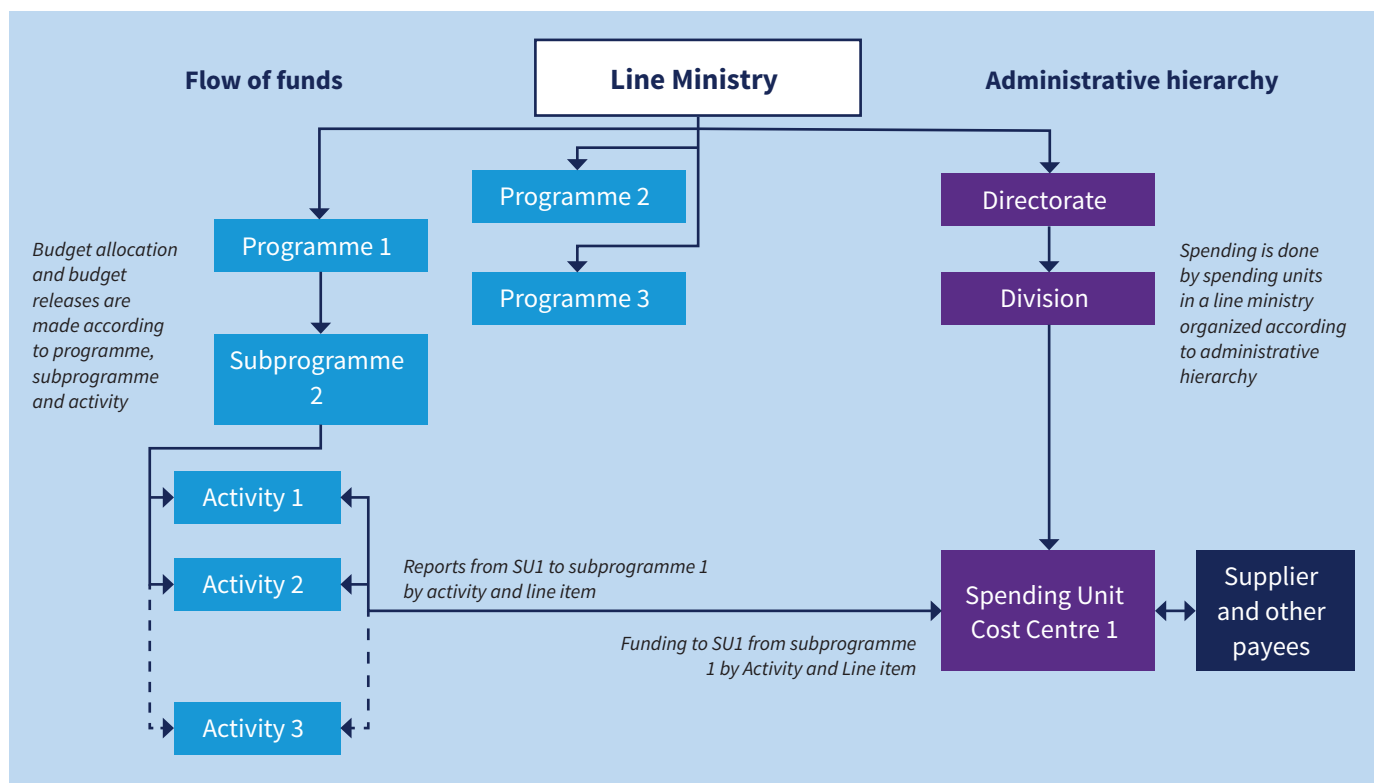
A programme budget formulation where spending units can receive funds from multiple subprogrammes, depending on purpose of activity, can fragment the purchasing arrangements for providers. They will receive funds from multiple sources or subprogrammes. This complicates effective planning and can undermine strategic purchasing reforms.

If funds are allocated and controlled at the subprogramme, activity and line-item level, the transactions associated with budget apportionment and allotment and the related expenditures will increase relative to what they would have been under an input-based formulation. This will increase the transaction workload even in an environment with a functioning FMIS. Expenditures related to the activities in a subprogramme need to be recorded and processed as separate transactions (see Figure B2.1). The workload in a paper-based system would become unmanageable (Hashim & Piatti-Fünfkirchen, 2018). The MoH budget in Zambia contains 3,000 activities and more than 15,000-line items to execute. This administrative burden reduces economies of scale and hampers efficiency (Farooq & Schaeffer, 2017).



FIGURE B2.1.

Budget programme structure that proliferates transactions



2.1.3 Programme spending is often misaligned with reporting lines

Countries often struggle to align a programme structure with the organizational structure of the MoH and its implementing agencies. Resolving this challenge is essential for both budget implementation and accountability. No single approach is replicable across countries. Countries often use the organizational structure of the MoH to formulate budgetary programmes, especially early on. Organizational units or agencies are responsible for the management of specific programmes and are accountable for associated outputs, helping to ensure managerial accountability. Gabon, Indonesia, Philippines and South Africa formulated budgetary programmes that, in some ways, mirror the organizational structure of their respective MoHs (Aboubacar et al., 2020; Lakin 2018; Nurman, 2018). However, they need to make trade-offs. The approach may limit the risk of fraud and misuse of funds; it may also reinforce existing organizational boundaries and inefficiencies and deviate from the functional approach that should be inherent in programme budgeting. Tying programme structure too closely to the MoH organizational structure limits the possibilities for structuring programmes around policy goals and the flexibility to explore new ways of delivering on priorities. Conversely, aligning administrative structures to programmes and policy objectives requires agility in adjusting to shifting priorities. The introduction of COVID-19-related programmes, for example, requires a corresponding change in the administrative structure.

To allow full oversight and to facilitate programme accountability, expenditures should be reported by programme or subprogramme, in line with the governmental administrative structure such as the ministry, department or spending unit. These steps are often neglected, which compromises accountability. In Cambodia, reporting on transactions is not captured at the level of detail necessary to keep health stakeholders accountable and enable adequate costing. When budget allocations follow programmes and subprogrammes, activities and line items and when the spending unit codes – for district hospitals, for example – are not captured in the transaction, reporting will only be possible by line item at activity, subprogramme and programme level. This is inadequate for reporting against the administrative structure. Programme-based reporting and accountability requires an understanding of the spending units that received funds, the amounts, and the uses. Failing to record the spending unit in the transaction inhibits an understanding of how much each spending unit drew from the subprogramme budget. One spending unit could draw down the majority of funds from a subprogramme and deprive others of carrying out their

programme activities. Most modern multi-axial Financial Management Information Systems (FMIS) are capable of capturing multidimensional axes of spending information.

The payroll is calculated by spending unit. Not recording the spending unit in the transaction impedes the allocation of payroll by subprogramme or programme for costing. These problems materialized in Cambodia where the shift to a programme structure led to dropping the spending unit in the chart of accounts. Providers were no longer captured in the administrative structure (Hashim & Piatti-Fünfkirchen, 2018; World Bank, 2016b).

Lacking clarity on roles and responsibilities between programmes and spending units can trigger power imbalances and inefficiencies in service delivery. Purchasing services against outputs is challenging if the contractual relationship between programmes and spending units does not reflect the separate functions. Payments that continue to be based on item-based inputs with strict controls may serve as a disincentive. The situation can inhibit the ability of facilities to rapidly amend their mix of inputs to maximize performance. In more mature models, output-based reimbursement incentivises performance, while input controls are minimized. The less power facilities have to retain revenue, have their own bank account, hold petty cash, etc., the less power they have to adapt and deliver efficiently

2.2 Good practices for better management

2.2.1 Consolidating costs within budgetary envelopes

Cost estimation, although always challenging, could be addressed by mapping existing spending units – central administration, district health office, provider – to programmes. The programme costs can then be estimated by costing the items under the corresponding units. This approach risks embedding existing organizational inefficiencies into the delivery costs of programmes. Still, several countries take this practical first step.

Allocating cost centres to each programme might help to avoid complex allocation decisions, at least initially, even where cost centres cross over programmes. Managers should as far as possible avoid complex cost splitting across different programmes, to facilitate monitoring and implementation by programme. Over time, revisiting the cost base of each programme activity would move closer to an output-oriented costing approach. Countries may consider various approaches in this transition, to limit historical budgeting (see Box B2.3).

BOX B2.3.

Updating programme costs: examples from Kyrgyzstan, Latvia and Ghana

Cost centres and spending units were mapped according to programmes during the initial stages of reform in Kyrgyzstan. Then, the costs previously associated with each provider were divided into these programmes. Incremental adjustments were made to the cost structure, including increases in input costs as wages increased (Hawkins et al., 2020).

Latvia was a middle-income country when reforms were initiated. Costs for the primary care programme are based partly on the size and demographics of the population, with adjustments based on the expected demand for services and the geographic area the programme covers. Incremental budgeting is still common and, for most programme items, baseline expenditures are still carried over. The budget is flexible enough that policy can change if programme objectives are not achieved. This includes re-estimating costs and reallocating funds. Resources, expenditures and results are linked. Accordingly, historical budgeting is no longer the dominant method used (Penn, James & Blazey, forthcoming).

Ghana adopted its approach to programme costing gradually. The method is both bottom-up and top-down. The bottom-up costing of goods and services is done by defining and costing the inputs for each activity. Top-down costing is done by earmarking funds to critical activities such as the procurement of vaccines, antiretrovirals, essential public health drugs and activities, then allocating the remaining budget by programme and subprogramme based on past allocations (Osei et al., 2021).



Managers aiming to get the full cost of a health programme need to apportion the cost of centrally managed programmes. The spending unit must be recorded in the transaction. Capturing item inputs such as personnel and medicines within the service programmes better reflects management inputs and programme costs. These are essential to managing these programmes and assessing value for money. Some countries forgo this and create complexities in understanding programme costs. The number of personnel posted to a directorate – for preventive care, for example – can be found in the payroll system and identified to associate costs. Drugs and supplies issued to that directorate from the central programme will go against the total cost of the project. Managers should be able to determine the total cost of the specific programme with reasonable accuracy. This provides a sound estimate of the total cost of health programmes, can be compared to performance indicators to assess whether the government is getting value for money and will inform subsequent budget allocation decisions.

BOX B2.4.

Approaches to allocating personnel costs

Approaches to allocating cost of personnel to programmes vary. A WHO survey identified three methods:

1. Group personnel expenditures into one administrative support programme. In Indonesia, staff receive a regular salary from a central administrative programme. They can receive additional remuneration from the programme's executing institution when they get involved in specific activities of implementing programmes. This approach is not recommended
2. Allocate personnel expenditure directly to specific programmes. Cost allocation of staff per programme can be identified readily when the programme conforms to the organizational structure, as in Ghana, Kyrgyzstan, and Mexico.
3. Split personnel expenditures across programmes. Splitting personnel cost by programmes requires estimates of time spent on programme-specific tasks. In Peru, the cost of a physician may be allocated to various programmes. The lack of a time recording system makes cost allocations imprecise (WHO, 2020). This is one of the problems of defining programmes in such a way that fragments what may be better considered as integrated services.

Some large expenditure items such as wages and salaries, bulk procurement, and capital spending are key parts of programme costing. However, if these are managed separately at central government level, which happens in some jurisdictions and is not recommended, the amount of discretionary funding controlled by the spending unit manager becomes relatively small. Therefore, executing managers in these units may not be held fully accountable for the performance of these units. Although this can be partially mitigated, it greatly weakens programme budgeting. The payroll can be centrally managed; the staffing costs can still be allocated to individual programmes. The programme manager still has the flexibility to deploy staff within the programme among spending units. Similarly, capital spending can be allocated to a particular spending unit. Spending units could requisition drugs or pharmaceutical supplies from a central medical store. The cost would be drawn from the programme budget. This allows for adequate costing for all items and adequate budget allocations.

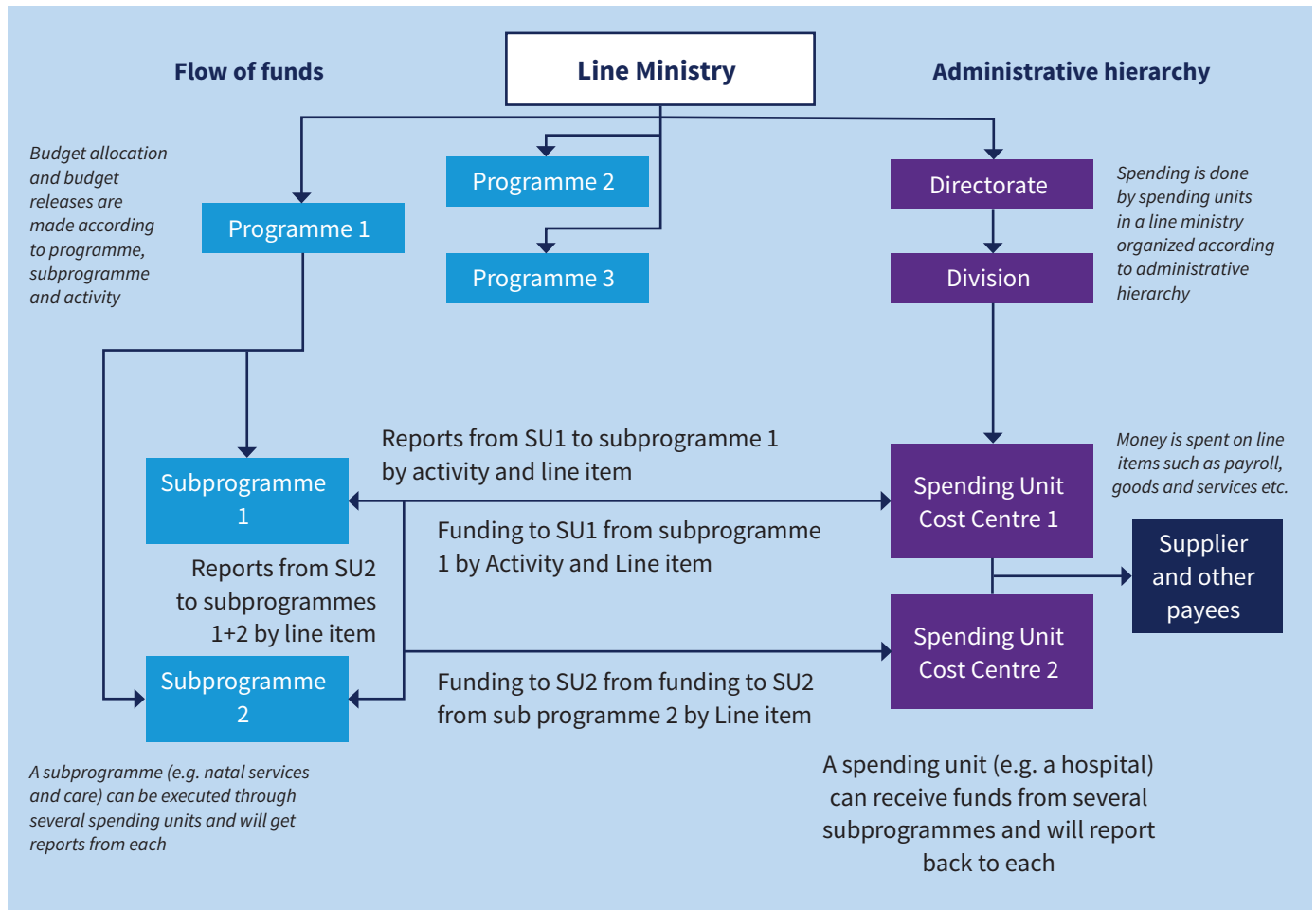
2.2.2 Releasing funds by programme to allow flexibility below programme level

Budget allocations and associated controls can be limited to the programme or subprogramme level to address the rigidity problem and allow programme managers greater flexibility in the use of funds. This is not always practiced. Still, it is an important feature in programme budgeting (Ho, de Jong & Zhao, 2019; OECD, 2019). This will adjust the flow of funds and administrative relationships (see Figure B2.2). The line ministry releases funds to programmes and subprogrammes. A bottom-up costing exercise determines the budget for each subprogramme. When possible, funds at the facility level should not be allocated on an input or line-item basis. Instead, facilities should operate on a global budget with flexibility to allocate funds across spending units and line items. Spending units execute the budgets of programmes and subprogrammes. Spending units report on the use of funds to the subprogrammes through which they receive allocations. Spending units can only vire funds within subprogrammes. Programme or subprogramme managers, in turn, report upwards on programme execution and the realization of programme goals.



FIGURE B2.2.

Relinquishing control for greater flexibility



This approach would relinquish controls at the activity level and the line-item level. Controlling budget allocations at the activity level provides no added benefit. The activity level is useful for costing but adapting it to release and control processes is counterproductive. Relinquishing the activity level control extends flexibility to programme managers and ensures greater accountability for outcomes and targets. Eliminating the activity level for allocation and control represents fewer transactions. Similarly, detailed line-item control can be relinquished and elevated to a broad line-item category such as wages and salaries, development budget, or goods and services. Line item and activity level controls are associated with the legacy input-based budget allocation system but, during reforms, need to be dismantled.

BOX B2.5.

Removing rigidities in budget execution: an example from South Africa

South Africa's electronic financial management system allows for capturing of spending according to multiple axes including budget programme, administrative responsibility, and item. National and provincial legislatures pass and publish budgets by budget programme. The Public Finance Management Act prescribes some limited rules for shifts of funds between programmes but with substantial flexibility within the programme. Each national and provincial Department of Health (DoH) reports on spending and performance in line with the published budget programme structure. This structure provides the basis for annual reports and strategic and annual departmental performance plans. A transversal committee considers any needed changes to the common budget formulation. Parliament approves the use of funds. Then, funds flow to each department in line with its approved cash flow or drawings. Each programme manager can spend up to the approved budget ceiling without needing any additional approval. Grouping similar facility types within a single subprogramme – putting all clinics within the clinic subprogramme of the District Health Services programme, for example – allows for comparisons of performance, cost and efficiency measures across service platforms of a similar type.

Most countries shifting to a different type of control under programme budgets have retained some line-item control based on a simplified classification: by grouping certain inputs into broader chapters. Governments may need to retain key controls to protect capital spending and control increases in payroll. (OECD, 2019). Wage and salary payments are statutory in nature and cannot easily be reallocated. The principle is that programme and subprogramme managers should have flexibility to shift funds around line items, particularly for routine operating costs with a high number of low-cost transactions. However, large parts of programme expenditure such as salaries or bulk procurement, including that for drugs and medical supplies, may not immediately appear to be fungible. However, given that these are the typically the largest parts of health spending seeking efficiencies in these areas is often critical to better performance.

2.2.3 Harmonizing programmes and MoH institutional organization

Implementing programme budget structures is simpler and requires less capacity when administrative or organizational structures and budget programmes are consistent. This will reduce the capacity requirements to implement budgetary programmes. Congruence can be achieved through programme alignment to existing administrative structures or the alignment of the administrative structure to programme structures. Governments should aim for alignment through shifts in organizational structure, to better meet programme objectives. The reverse signals a failure to reorganize spending around objectives as opposed to existing administrative domain. A balance should be struck between organizing the budget programme structure around ideal objectives and recognizing the need for some stable administrative structure to implement the annual MoH budget.

(i) Aligning programmes to existing administrative structures

Full alignment between programmes and the organizational structure can ensure accountability early in the reform. However, such alignment also risks replicating institutional inefficiencies and disconnecting the budget structure from the achievement of results. Countries including the Philippines have demonstrated how partial alignment can provide a middle ground where the lines of responsibility and accountability are clearly identified (see Box B2.6).

BOX B2.6.

Programme structure in the Philippines

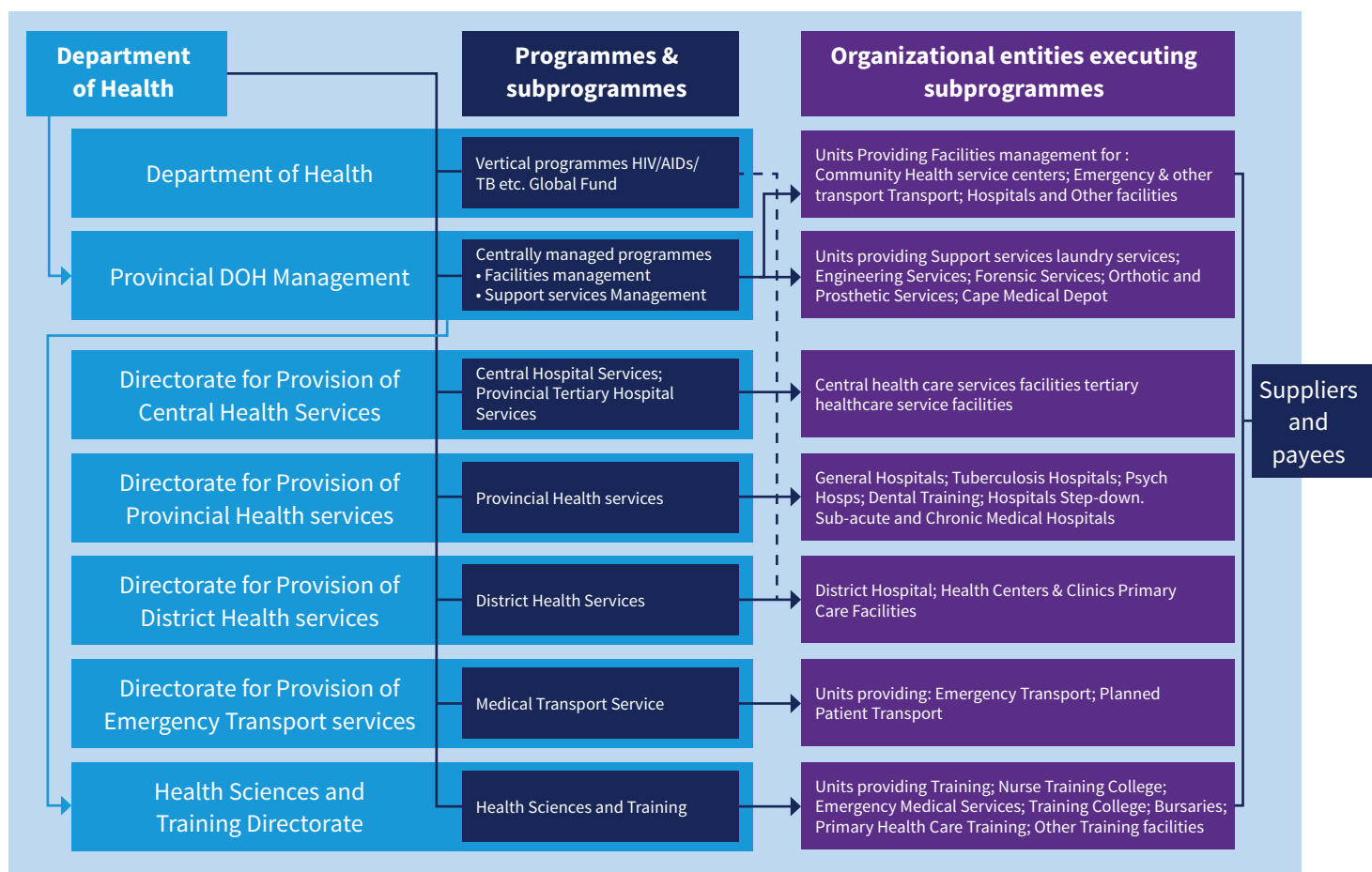
Budgetary programmes were introduced in the Philippines to address accountability issues with the previous performance system. That system only included output measures and had no clear budget allocations aligned with each output. The introduction of programmes resulted in some overlap with the structure of the DoH. For example, an epidemiology and surveillance programme was created, in part, to accommodate the DoH Epidemiology Bureau. Similarly, the health emergency and planning programmes aligned with corresponding bureaus in the DoH. An effort was made to match programmes to the organizational structure of the DoH, but was unsuccessful. The DoH has 20 departments but only 10 programmes, including two administrative support programmes. Alignment between organizational structure and programmes is only partial, as in many countries. This partial alignment creates opportunities but also carries risks with respect to accountability and the provision of desired outputs. Well-defined performance monitoring frameworks are always required to ensure programmes serve expected goals, irrespective of their institutional arrangements (Lakin, 2018).

In other contexts where programmes largely align with health system organization, as in South Africa, service platforms integrating multiple services at the delivery level (e.g. Clinics, district hospitals) are mapped to provincial programmes to correspond to budget outputs (see Figure B2.3). In this country example the District Health Services programme consists of all the primary care services in the province including district hospitals and the HIV/AIDS subprogramme. The District Hospital sub-program in-turn consists of all the district hospitals in the province. In practice, budgets are compiled through a mixture of top-down and bottom-up budgeting with facility, geographic district and programme managers working together in an iterative way to craft the budget. The relative powers of programme vs for example geographic district managers tends to vary over time and across programmes, with in some cases district managers holding considerable power across subprogrammes within the overall programme of District Health Services.



FIGURE B2.3.

Programme structure and administrative structure alignment: an example from South Africa



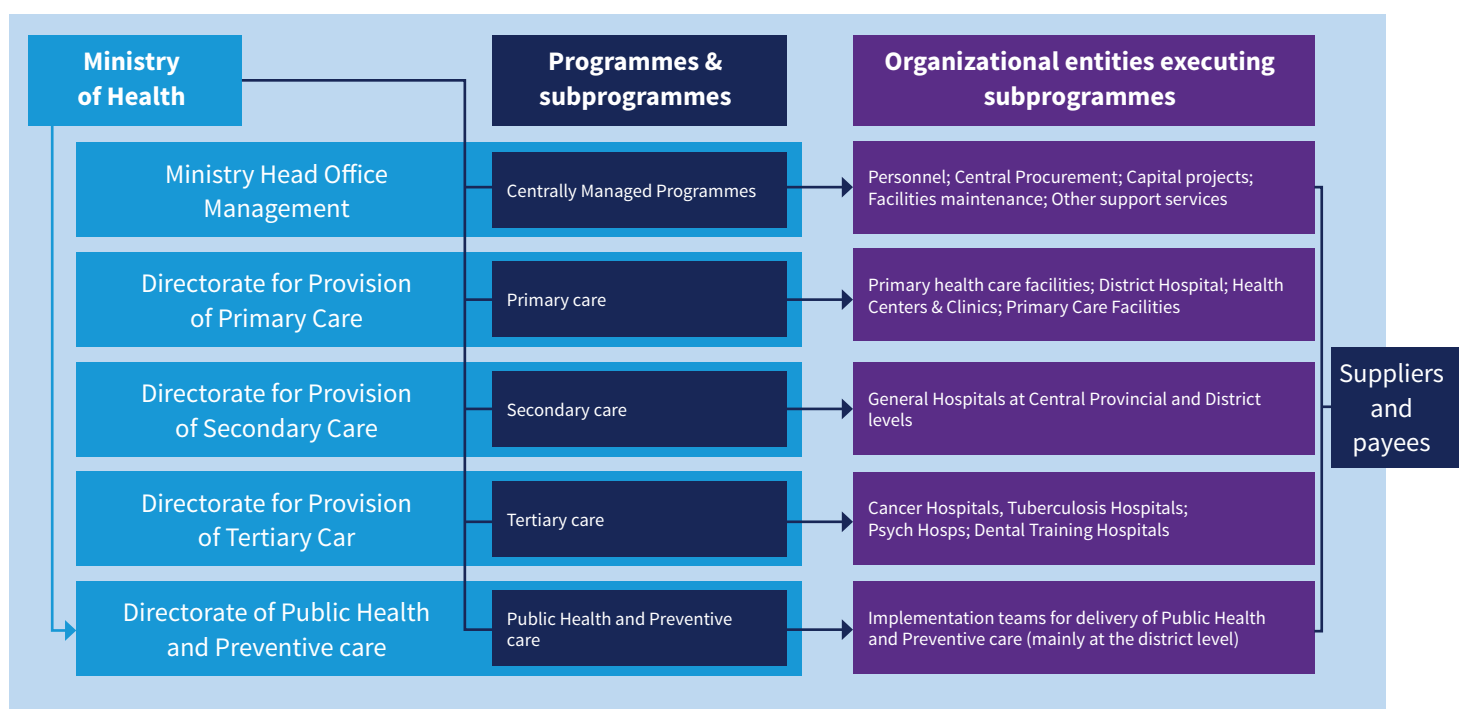
(ii) Aligning administrative structures with an output-oriented programme structure

In this scenario, a conscious effort is made to align administrative structures with the programme structure. This endeavour will require organizational and administrative reform within the MoH, which will be more difficult to achieve than aligning programmes with the prevailing administrative structure. Output-oriented health programmes could be primary, secondary, tertiary, or public health and preventive care. Budgets are allocated to these programmes. New administrative structures aligned with programme structure would carry out these programmes. Each of these directorates is responsible for executing one programme. Spending units within them, such as general hospitals or health clinics, are mapped to the respective directorate. This model requires administrative agility within the MoH as priorities and programmes change over time, to allow for a corresponding change in MoH administrative structures.

The spending units are primarily responsible for executing one subprogramme and draw funds from one subprogramme. The primary health care programme is executed through primary care facilities. Some activities related to preventive care may also be carried out at clinics, creating some overlap with the preventive care work programme. Facilities that provide both primary and higher-level care may still draw on funds from two programmes (see Figure B2.4) though different departments in such facilities may need to be recorded as separate cost centres.

FIGURE B2.4.

Administrative structure and programme structure alignment



In this format, a lot of problems are addressed. Programme managers have flexibility and clear accountability. Subprogrammes or directorates can purchase health services directly from providers or spending units. Spending units have flexibility on how to use funds. They report to programme and directorate which have become compatible. The outcome orientation allows for a budget allocation by purpose. For example, responding to COVID-19 could be prioritized and implemented or used as the basis for strategic purchasing. Such delineation of function will, however, complicate the delivery of integrated care.

BOX B2.7.

Coordinating programme and administrative structures in Indonesia

Shifting political priorities, difficulties with allocating personnel cost, and the transience of some events such as the COVID-19 pandemic can all disrupt programmes and administrative systems. Indonesia managed to overcome such challenges. A development planning document was arranged by programmes and activities during the first stage of reform. The governments used this to allocate those programmes and activities, with budgets, to government institutions. They dismissed institutions that did not fit any programme then merged and renamed institutions to fit programmes. Expenditures were allocated or distributed to institutions or programmes since most institutions handle one programme each. Consequently, the reform brought about significant administrative changes.

Source: Nurman (2018).



Programme managers need to set objectives and targets. Mature health systems have seen a transition from input-based controls and item-based payments to health facilities towards strategic purchasing arrangements with output-based global budgets. Separating functions by programmes and facilities and contracting arrangements between programmes/subprogrammes with service providers can smooth this transition. The programme structure will allow for flexibility in paying service providers according to strategic purchasing principles. Service providers receive a global budget and are granted more flexibility in their use of funds, with some limitations. This requires congruence among programme and administrative structures, to avoid fragmentation in the provider payment environment.

2.2.4 Ensuring adequate financial management and reporting

Adequate reporting on programme expenditures is necessary for accountability and performance management. FMIS facilitate spending, expenditure controls and financial reporting. An FMIS that automates transactions may be a prerequisite to implementing a programme structure as the number of transactions increase. The introduction of a programme budget structure will require amendments to the FMIS to reflect the changes, including any revised control protocols. This should be simple from a programming perspective (Hashim, Farooq & Piatti-Fünfkirchen, 2020). The FMIS should also facilitate spending at the spending unit level in remote locations. Use of innovations in fintech may help extend the reach of FMIS without extensive investments in information and communication technology (ICT) (Piatti-Fünfkirchen, Hashim & Farooq, 2019). Capturing all spending, including that at the facility level, should enable the FMIS to provide adequate expenditure reports for comparison with the broader view in the chart of accounts (see Table B2.1) and make these accessible to programme managers. The managers can triangulate this data with performance information to make evidence-based decisions.

TABLE B2.1.

Example of adequate expenditure reporting from FMIS

Programme	Subprogramme	Spending unit	Economic classification
Programme 1	Subprogramme	Spending unit 1	
		Spending unit 2	
	Subprogramme 2	Spending unit 3	
Programme 2	Subprogramme 4	Spending unit 4	
		Spending unit 5	
...	

Conclusion

Historical context matters in the successful implementation of a programme budget. Countries build upon pre-existing formulations such as input-based budgets or activity budgets. The legacy of these structures is often difficult to undo. MoFs are often reluctant to relinquish control. Therefore, input-based controls or activity level controls may get carried over into a programme budget structure. This leads to unnecessary rigidities and an unmanageable number of transactions. A partial reform, one that introduces new programme elements without undoing legacy controls, can sometimes be more detrimental than beneficial. Pursuit of such a reform should be contingent on MoF willingness to relinquish legacy controls.

Adding a programme structure in which funds follow programme objectives is often different from the prevailing administrative structure. Unless this is well managed this can become conflictual, particularly in an environment with low capacity. Funds follow programmes; other reporting lines follow the government administration. When the programme and administrative structure are inconsistent, providers may draw on funding from multiple programmes or subprogrammes. This fragments the provider payment system and undermines provider flexibility in spending. This situation complicates reporting structures and makes adequate costing a challenge. Therefore, conformity will likely require restructuring the health

sector administration towards functional structures. Such changes require significant political support and administrative agility. These issues need to be considered in designing budget programmes as some structures are much easier to implement than others. The promise of simplification and reduced capacity requirements, direct lines of reporting, adequate costing, a unified payment system, and increased spending flexibility may, however, be worth the effort. Implementing budgetary programmes without such congruence is challenging even in a high-capacity environment.

Adequate reporting on programme expenditures is necessary for accountability and performance management. FMISs that automate transactions may be necessary to implementing a programme structure as the volume of transactions increase. The FMIS should also facilitate spending at the spending unit level, even in remote locations. Fintech innovations may extend the reach of the FMIS without extensive investments in ICT. FMIS that capture all spending down to the spending unit level in expenditure reports will reflect the full picture in the chart of accounts. Programme managers should be granted access to these reports.

Implementation challenges in programme budgets often relate to a programme design that does not take into consideration the capacity to implement or the political willingness to undo controls from the legacy system. These factors should be assessed and discussed during the design process. Making progress and reaching agreement on these issues should be obligatory before proceeding.

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3. Linking budget formulation and provider payment reforms

Elina Dale, Loraine Hawkins, H  l  ne Barroy, Cheryl Cashin and Sheila O’Dougherty

Introduction

The manner in which public budgets are formed, allocated, disbursed and accounted for influences how service providers in the health sector are paid. The approach to budget formulation and management can hinder the effective implementation of output-based provider payment systems, preventing payment reform from having the desired impact on equity and efficiency (Barroy, Dale & Sparkes, 2018; Cashin et al., 2017). Traditional approaches to budget management can impede strategic purchasing, obstructing efforts to allocate resources to meet the goals for improving population health and health system performance.

First, the methodologies for determining the budgetary ceilings may penalize managers who make efficiency gains, if the budget is based on the actual number of staff, for example. These methodologies may be disconnected from the resources needed to provide services such as a guaranteed benefit package or to change the mix of services or models of service delivery to improve outcomes.

Second, input-based budgets are executed and accounted for by inputs and may be accompanied by inflexible ex ante controls on inputs. Public providers of health care are often subject to staffing norms and detailed spending guidelines governing other input categories.

Third, public sector personnel policies may not allow health care providers the flexibility to optimize staff numbers to mix and motivate performance. Finally, a central budget set at a detailed level may be too fragmented and inflexible to allow health care purchasers or subnational health sector managers to reallocate resources optimally across different providers and service programmes to respond to the needs of a population. By contrast, if rules allow budgets to be created, approved and controlled based on categories of outputs such as programmes with a common objective or services of different types, most payment method options are likely to be feasible.

Researchers have carried out little systematic investigation of these links. Many budgeting reforms have been implemented with little coordination with separate financing reforms affecting how providers are paid. In many countries, the links between the budget formulation and the allocation and disbursement of funds to providers are not understood. Terms such as line-item input-based budgets and input-based payments, for example, refer to different concepts and stages in the budget cycle. In the taxonomy of PFM, line-item input-based budgets refer to how budgets are formulated and approved. In the taxonomy of health financing, input-based payments refer to how service providers receive funds from a purchaser (Barroy, Dale & Sparkes, 2018; Mathauer et al., 2019). Still, the terms are sometimes used interchangeably. The definitions become more confusing when a country, Peru is said to have moved to output or performance-oriented budgeting while providers are still paid based on inputs with strict ex ante controls on those inputs. Providers might refer to this as an input-based or line-item budget (Cashin et al., 2015; Dale et al., 2020). This ambiguity has implications for policy reform design and interventions.

The main objective of this chapter is to clarify the terminology and to examine the links between budget formulation and provider payment (Section 1). We also investigate the extent to which and the conditions under which moving towards programme-based budgeting supports a shift towards output-oriented payment for service providers (Section 2).



3.1 Provider payment and budget formulation: key definitions and issues with misalignment

Purchasing refers to the allocation of pooled funds to public and private health care providers for the services they deliver to patients. Strategic purchasing links information to payments in a continuous search for the ways to maximize system performance, by deciding which interventions should be purchased, how, and from whom (RESYST, 2014). A strategic purchaser will allocate its budget based on a plan for achieving its goals for improving health care such as goals for improving access, equity, quality and efficiency for the population it covers. Provider payment methods, along with contracting and performance monitoring, are key instruments in purchasing for translating this strategic plan into flows of funds to providers consistent with meeting these goals and motivating providers to improve their performance in line with these goals.

3.1.1 Issues with input-based budgeting persisting alongside output-based health financing reform

Most purchasing systems are passive rather than strategic. Resource allocation is based on inputs, most commonly on historic patterns of service delivery, and is not linked to information on provider performance or population health needs. Reforming provider payment is one element of making purchasing more strategic (Mathauer et al., 2019).

Some types of output-based payment can also be inimical to efficient, equitable resource allocation. Passive fee-for-service (FFS) payment systems hamper direct health spending towards strategic goals. However, it is not the focus of this chapter to discuss in detail how to choose among different payment methods.

The provider payment method and contracting form the basis for determining how much funding to transfer from the purchaser of services to providers (Langenbrunner et al., 2009). The method is defined primarily by the unit of payment such as per bed day, per case, per lab test, or per person per year (Cashin et al., 2015). Provider payment methods can be input-, output- or outcome-oriented (Table B 3.1). Blended approaches in which two or more payment methods are used to incentivise providers have become increasingly common (Mathauer et al., 2019). References in this chapter to output-based payment denote the strategic use of a mix of payment methods, not to any one method.

In some countries, civil servants provide most of the staffing of health services. Salary payment tends to remain input-based, from the government budget to the provider. Other types of costs may be funded by output-based payments to the provider. Salaries consume a substantial portion of public spending on health (Hernandez-Peña et al., 2013). Therefore, excluding salaries from the output-based element of payment limits the effects of output-based payment reform on resource allocation and the manner in which services are provided.

TABLE B3.1.**Main provider payment methods**

Method	Description	Usual setting	
Fee for service	Activity based billing of individual services, patient visits and bed days	Predominantly used for PHC and outpatient services	Useful for strategic purchasing
Payment per case	Payment per patient admitted, classified by similar clinical condition and activities, e.g. DRGs	Predominantly for hospital inpatient care	
Capitation	Lump-sum payment per enrolled patient covering a range of services	Predominantly used for GPs	
Global budget	Lump-sum payment for services independent of actual volume of care	Payment for public hospitals in a number of countries	
Pay-for-performance	Payment for defined targets (results or outcomes) fixed in advance	Combined with any of the other methods e.g. quality bonuses	
Payment by budget line items	Fixed allocation for input costs, e.g. personnel, utilities, medicines, supplies	Used for public healthcare providers in many countries	

Source: adapted from OECD (2016).

Over the last 30 years, many LMICs have tried to improve the use of resources and service coverage by establishing a purchasing function or agency to allocate resources strategically to health care providers. These reforms typically include the introduction of new payment methods to allocate resources to providers based on population needs and outputs such as the number of patients diagnosed with different ailments and treatment needs. The expectation is that providers will be free to adjust their inputs and produce outputs that might serve a population more efficiently. Some reforms have allowed providers greater autonomy to respond to the changes in financial incentives introduced by the purchaser. In many LMICs, however, this autonomy is limited due to issues related to trust in providers, their capacity and PFM systems.

3.1.2 Mismatch between programme budgeting structures and provider payment methods

Over these three decades, many countries have tried to improve their aggregate fiscal discipline, their strategic resource allocation and their use of resources (Andrews et al., 2014). They have introduced a range of PFM reforms to achieve these objectives including modifications to public sector human resource management and payroll management; clearer rules on extra-budgetary funds; and changes in budget formulation, approval, execution and reporting. Budget formulation reforms in upper-income countries have involved a shift to classification systems based on outputs or programmes and greater delegation of financial management responsibility to line ministries and agencies, as has been the case in France, New Zealand, Sweden, and the United Kingdom of Great Britain and Northern Ireland. Programme budget reforms have similar objectives and take a similar approach to the health purchasing reforms in LMICs. One might expect these types of reforms to be consistent. In many LMICs, however, programme budgeting reforms have been partially implemented or they have been implemented in form but not in substance (Schiavo-Campo, 2009) (see Chapter A1). LMICs with lower capacity are understandably cautious about delegating greater financial management responsibility to line ministries and agencies. Some countries have seen mismatches between the programme categories and performance measures used in the budget and the output categories and performance measures used in the health purchaser's plan and for provider payment. These inconsistencies have led to constraints on strategic purchasing and conflicting signals to health care providers.



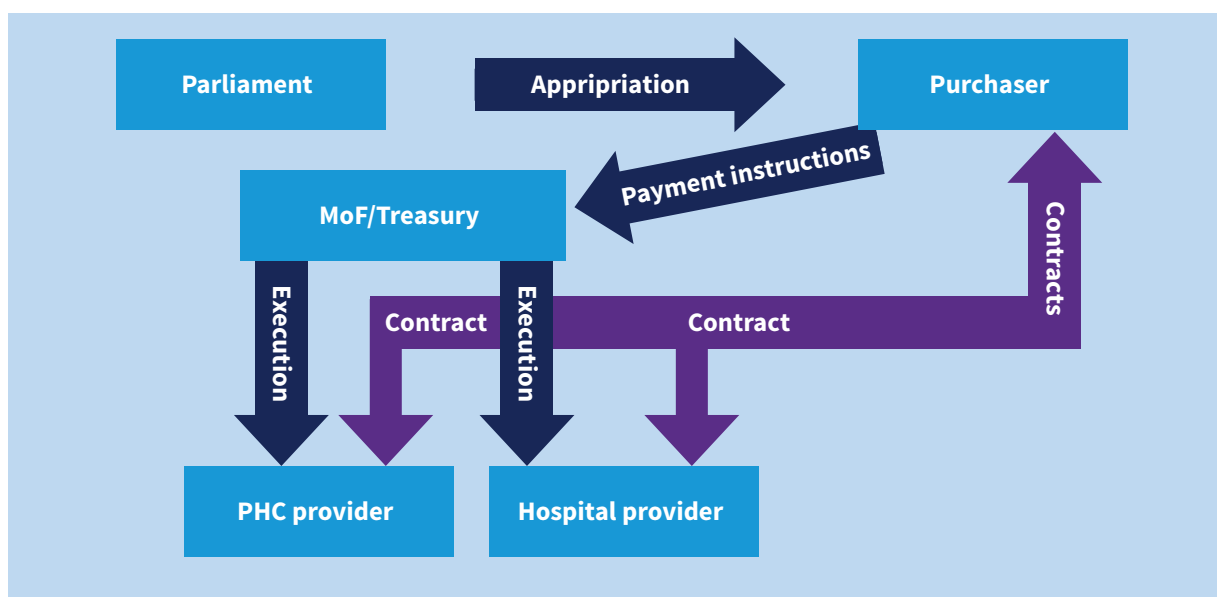
3.1.3 Issues due to inflexibility and bottlenecks in PFM of health purchasers and public health care providers

Provider payment methods are developed to motivate providers towards certain behaviour. They do not work if budget appropriation, payment instructions and execution are not aligned with payment methods. Purchasers cannot easily create incentives for efficiency based on paying providers for the number of treated cases if the budget is appropriated and disbursed to providers based on detailed inputs and administrative categories with strict controls on shifts between these lines. Such providers face contradictory incentives. In historic input-based budgeting, budget ceilings are based on factors such as the number of staff and the cost of utilities. This approach discourages providers from economizing on personnel inputs and improving energy efficiency because their efforts would result in budget reductions. At the same time, case-based payments are designed to improve efficiency by creating flexibility and incentives to optimize the mix of inputs and decrease the input costs per treated case. This situation can be avoided by using output-based logic throughout, when appropriating and executing budgets and when setting contracts and provider payment methods.

Budget management and purchasing in a health system which has a single organization purchasing services takes places through a series of steps (see Figure B3.1). If output-based categories are used in budget appropriation and in the payment methods in the purchaser's contracts with providers, these two processes are aligned. Similarly, if budget execution processes apply controls on spending by output category, budget execution is aligned with the purchaser's payment methods.

FIGURE B3.1.

The bodies and processes involved in budgeting and purchasing¹⁷



17 The purchaser in this case can be a MoH, a regional government, or a separate purchasing agency, assuming its budget is part of the main budget law and follows the same budgeting principles as other ministries and agencies. Contracts specify provider payment methods and include the total amount allocated to a given provider.

In many countries, different structures or categories are used in these processes. Provider payment methods and budget appropriation structures can be aligned or misaligned, irrespective of overall health financing arrangements, through four identifiable situations:

- Both budget appropriations and provider payment methods are based mainly on inputs although elements of output-based payments can exist at project/pilot levels, as in Sri Lanka;
- Both budget appropriations and provider payment methods are based mainly on outputs although mixed provider payment methods exist, as in Estonia;
- Budget appropriations are based on inputs but provider payment methods are based, at least partially, on output, as in the United Republic of Tanzania; and
- Budget appropriations are based on outputs while provider payment methods used by public facilities are based mainly on inputs although mixed provider payment methods exist, often due to fragmentation and not design, as in Burkina Faso.

In some countries, the relationship between provider payment methods and budget appropriation structures is even more complex and fragmented.

First, budget funds may be disbursed to providers through two or more funds flows, using different payment methods. Part of the budget might be paid through a purchasing agency using output-oriented case payment, FFS, capitation or other payments set at levels that cover part of the costs of inputs, usually non-salary operating costs. Input-based budgets of ministries that operate public facilities fund other input costs, often salaries and capital lines. Facilities in such systems often have greater autonomy over the FFS, capitation payments and co-payment revenue. Consequently, these sources can be used for any line item.

Second, facilities may receive funding for patients from two or more sources. Case payment, FFS or capitation is paid for a subset of patients insured through public or private methods at levels that cover the full cost of care. However, a line-item budget allocation to facilities is supposed to subsidize service delivery for uninsured patients. Funds for facilities are fungible. Budget funds may pay some of the costs for insured patients. Insurance payments may cross-subsidize those patients.

Case payment, FFS or capitation is paid for a subset of patients insured through public or private methods at levels that cover the full cost of care. At the same time, facilities receive a line-item budget allocation to subsidize services for uninsured patients. However, funds are fungible and public budget funds may cover some of the costs for services provided to insured patients.

These situations of fragmented funding and payment arrangements make it difficult to create incentives for efficiency using programme budgeting and output-based payment methods unless the fragmented funding streams are consolidated into a single pool of funds.



BOX B3.1.

The United Republic of Tanzania (Mainland) – misaligned incentives across funding streams to public providers generating a mix of input and output-based payments

The United Republic of Tanzania has a detailed, input-based appropriation structure with output-based provider payment methods. The budget, which is approved annually, is based on administrative and detailed economic classifications. The main provider payment method in the public system is a line-item budget. However, public providers also receive output-based payments such as fee-for-service (FFS) and capitation for insured patients through the National Health Insurance Fund (NHIF) for particular population groups and for some external development assistance.

The annual budget has the following formulation:

- vote in which each ministry has a separate voice; for example, Vote 052 is the Ministry of Health Community Development, Gender, Children and Elderly (MOHCDE) – Health;
- sub-vote in which each referral, regional hospital or department within a ministry has a separate sub-vote;
- items using detailed economic classification consisting of five digits, for example, 21113 Personnel Allowances (Non-Discretionary), 22003 Fuel, Oils, Lubricants; and
- one-line budget transfers for the NHIF which cover civil servants and their dependents under Vote 022

Source: Ministry of Finance and Planning, United Republic of Tanzania (2018).

The NHIF board examines and approves a detailed expenditure budget. The budget does not go through Parliament. Treasury releases the funds to NHIF as one line. The NHIF has more flexibility than the MOHCDE in managing its budget, including the ability to have carry-overs.

Budget financing is also fragmented by decentralized responsibility for service delivery. The United Republic of Tanzania (Mainland) is divided into 26 regions which are subdivided into district and town councils and municipalities, known collectively as Local Government Authorities (LGAs). A significant portion of health expenditure falls under regional budgets. Budgets for regional hospitals and transfers to districts, towns and municipalities for district hospitals and health centres form separate sub-votes. These transfers are divided into two line items: i) 21111 Basic salaries – Pensionable posts; and ii) 26312 Local Government – cash, which includes all other charges, except salaries. The LGA budgets itemize the transfers received under code 26312 into detailed economic classifications. Facilities have limited flexibility or incentives to efficiently reallocate the inputs financed from the budget; for example, to reduce non-medical staff costs and reallocate savings in the wage bill to inputs such as medicines and medical supplies.

Recently, capitation payments have been introduced for primary health centres and dispensaries using the Health Basket Fund; that is, on-budget external assistance. The NHIF pays FFS to accredited public or private health service providers for its civil servant members, creating strong incentives to serve this population and early stages of cost escalation. The Community Health Fund (CHF), a voluntary scheme covering informal and rural sectors, pays health providers using a combination of capitation and FFS. Facilities have flexibility in spending revenue to procure inputs. However, they must adhere to spending guidelines for different funds flows including general revenue, the NHIF, the Health Basket Fund, the CHF, result-based financing and user fees.

3.2 Good practices for aligning reforms with the provider payment system

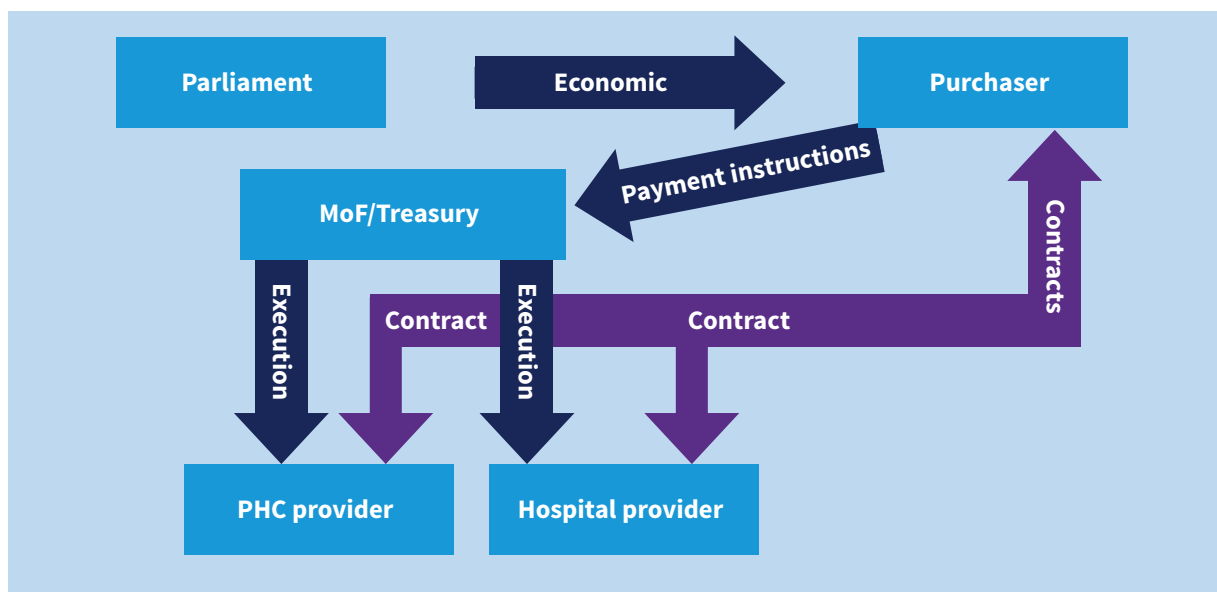
3.2.1 Implementing payment reform in countries which still use input-based approaches to allocating and disbursing the budget

Appropriations based on detailed economic and administrative classifications are problematic in the health sector. Central agencies cannot set a predetermined, fixed input mix for each patient case because of the variation in patient needs and in the optimal costs of care for services. The managers of the health care provider are better placed than the MoH or purchaser to decide appropriate inputs for a given patient and to understand and manage local variation in demand. However, MoHs and purchasers can influence and support providers with analysis, evidence and clinical guidelines. Output-based payment is intended to incentivise providers to make these decisions efficiently. Traditional budgeting approaches based on inputs provide the opposite incentives; for example, to use as many inputs as possible within the budget ceiling. Providers are faced with an unnecessary burden when they need to change their input mix in contexts where the MoF must approve even small changes to input lines during the year.

The move towards output-based payments for health services without changing budget formulation has proven difficult in many settings although temporary and creative solutions have been found, as in Burundi and Kyrgyzstan (Sibomana, Reveillon & Belgium, 2015). A shift to output-based payment methods is challenging in environments where providers remain public entities and the overall budget is formulated based on historical input-lines such as the previous year's budget with adjustments based on number of staff. Providers tend to use fewer inputs while providing the same or a higher volume of services in situations where the health sector uses output-based provider payment methods oriented towards increased efficiency. Consequently, the sector budget can suffer from budget cuts (Chakraborty et al., 2010). Kyrgyzstan introduced output-based payments in the sector while appropriation and execution were still based on administrative unit and input line items (see Figure B3.2). The sector changed provider payment methods along with other financing reforms, improved efficiency and cut the number of beds and staff. The following year, the sector received lower public funding which undermined the reform process and had a negative impact on the quality of care and motivation for those in the sector (Jakab, Akkazieva & Kutzin, 2016).

Figure B3.2.

Output-based provider payment methods in an input-based budgeting environment



Even when creative solutions are found, contradictions between the budgeting formulation and execution approaches and the provider payment methods can undermine reforms. In Kyrgyzstan, a line item for the State Guaranteed Benefit Package (SGBP) was introduced into its economic classification to overcome challenges related to input-based logic in budgeting. Output-based payment was used in the budget allocation for providers. However, budget execution included detailed ex ante line-item controls on inputs by the MoF. Providers received funds for each line item. Any shift between input lines required a long chain of approvals from the MoF and others. Shortfalls in revenues would prompt budget sequestration. Only salaries were protected. Consequently, no incentives existed to further decrease staffing levels (see Box B3.2).

BOX B3.2.

Kyrgyzstan – alignment of budget formulation and output-based payments

Kyrgyzstan found creative solutions to align output-based provider payment methods by their purchaser with an unreformed input-based budget allocation system. The example highlights the importance of PFM reforms in avoiding contradictory input-based controls in budget execution and perverse incentives that undermine efficiency and equity.

Health financing reforms introduced output-based provider payment methods between 2001 and 2006 and preceded PFM reforms by more than a decade. The purchaser, the MHIF, pools all public funding for current health expenditures on primary and secondary health care, including the wage bill. By 2006, the MHIF introduced capitation for primary health care and a case-based payment schedule for hospital inpatient care. The budget classification system was based on inputs, an economic classification. An ad hoc solution was negotiated with the MoF within the input-based budget classification to avoid conflict between output-based payment and input-based budget appropriations: a new single line budget code in the MHIF budget for payments to providers.

The MHIF used its new provider payment methods to set budget ceilings and output-based contracts for providers. These reforms, coordinated with the parallel optimization of rural health service delivery, allocated a larger, and more equitable, share of the MHIF budget to primary health care.

However, the reforms failed to create incentives for provider managers to optimize their input mix to improve efficiency. MoF methods for formulating the MHIF budget ceiling created systemic disincentives. Until recently, the MoF would cut the MHIF budget ceiling in the budget formulation process if health facility bed numbers or staff numbers had been reduced in the previous year.

Further, misalignment with PFM rules and other regulations at the budget execution stage weakened opportunities and incentives for providers to increase the efficiency of their input mix. Their budget plans had to use detailed line items and had to be prepared separately for four sources of funding for the MHIF. These plans, divided by month, were used as the basis for prior control of disbursements from the single treasury system during budget execution. Obtaining MHIF and MoF approval to vire funds between line items during the year was not guaranteed and it was slow. The virement of funds across sources of finance was not possible. These misalignments made it difficult and unattractive for providers to respond to the incentives towards efficiency inherent in output-based provider payment methods.

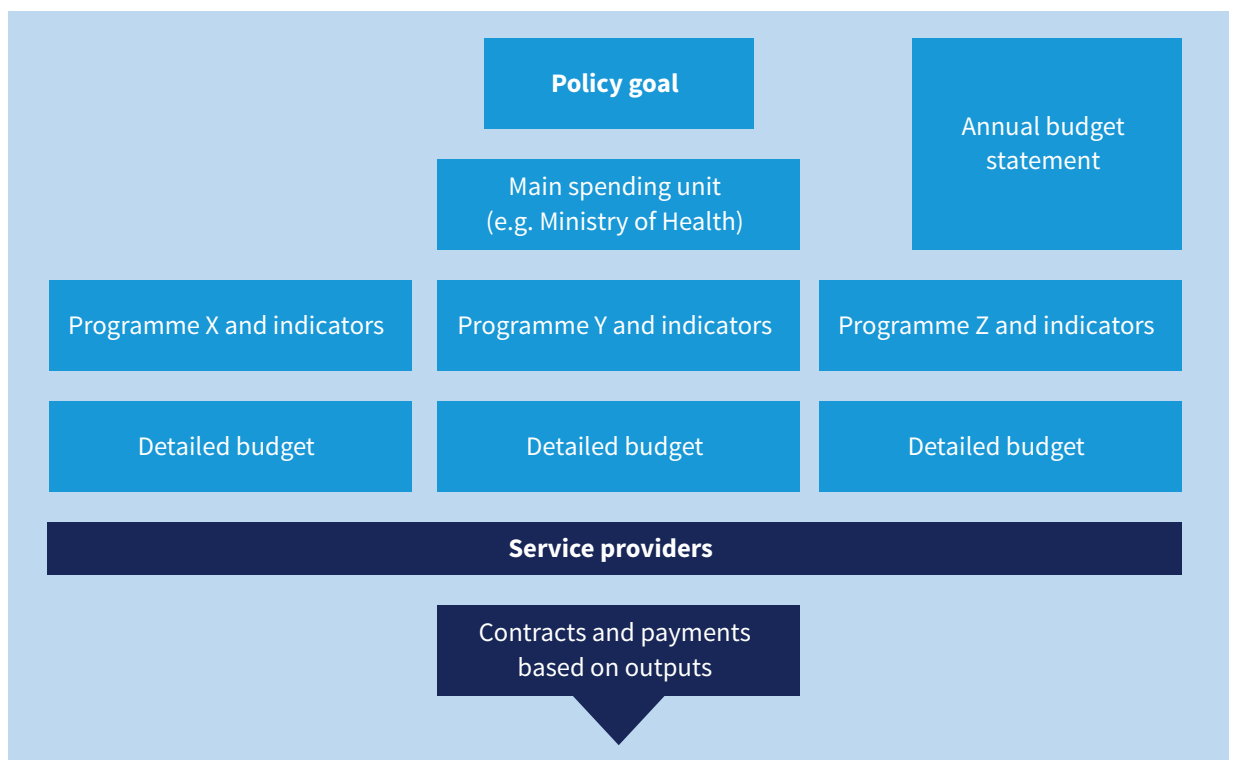
3.2.2 Implementing programme budgeting so as to align programme structures and performance measures with provider payment reform

In principle, a programme budget provides a foundation for the strategic purchasing of health services. Programme budgeting and strategic purchasing reforms share the objective of linking resource allocation to policy priorities and performance information. Detailed input-based budgets are inconsistent with output-based payments. In a system where budgeting, contracting and provider payment methods are aligned, annual budgets are approved based on programmes, to reflect health policy priorities. The managers responsible for the budget are held accountable (see Figure B3.3). If there is a separate purchaser, that agency’s managers administer the budget programme. Major components of the benefits package such as primary health care and hospital and specialist services may have separate budget programmes with their own contract specifications and payment methods. This helps to remove any conflict between programme budget formulation and provider payment method. However, budget programmes should be large enough to permit the efficient and equitable pooling of funds. Health care providers use detailed, input-based budgets for internal management. Service providers are contracted and paid based on outputs and have a large degree of operational and financial autonomy. The budgetary autonomy comes with several financial control requirements and regular steering of the providers’ financial situation. In return, agencies are expected to adhere to strict performance reporting rules (Downes, Moretti & Shaw, 2017).

Budget formulation reform and programme budgeting have clear merits. However, the design, implementation and commitment to them in many LMICs has not always promoted change in provider payments (see Chapter A1).

FIGURE B3.3.

Alignment in budgeting, contracting and provider payments



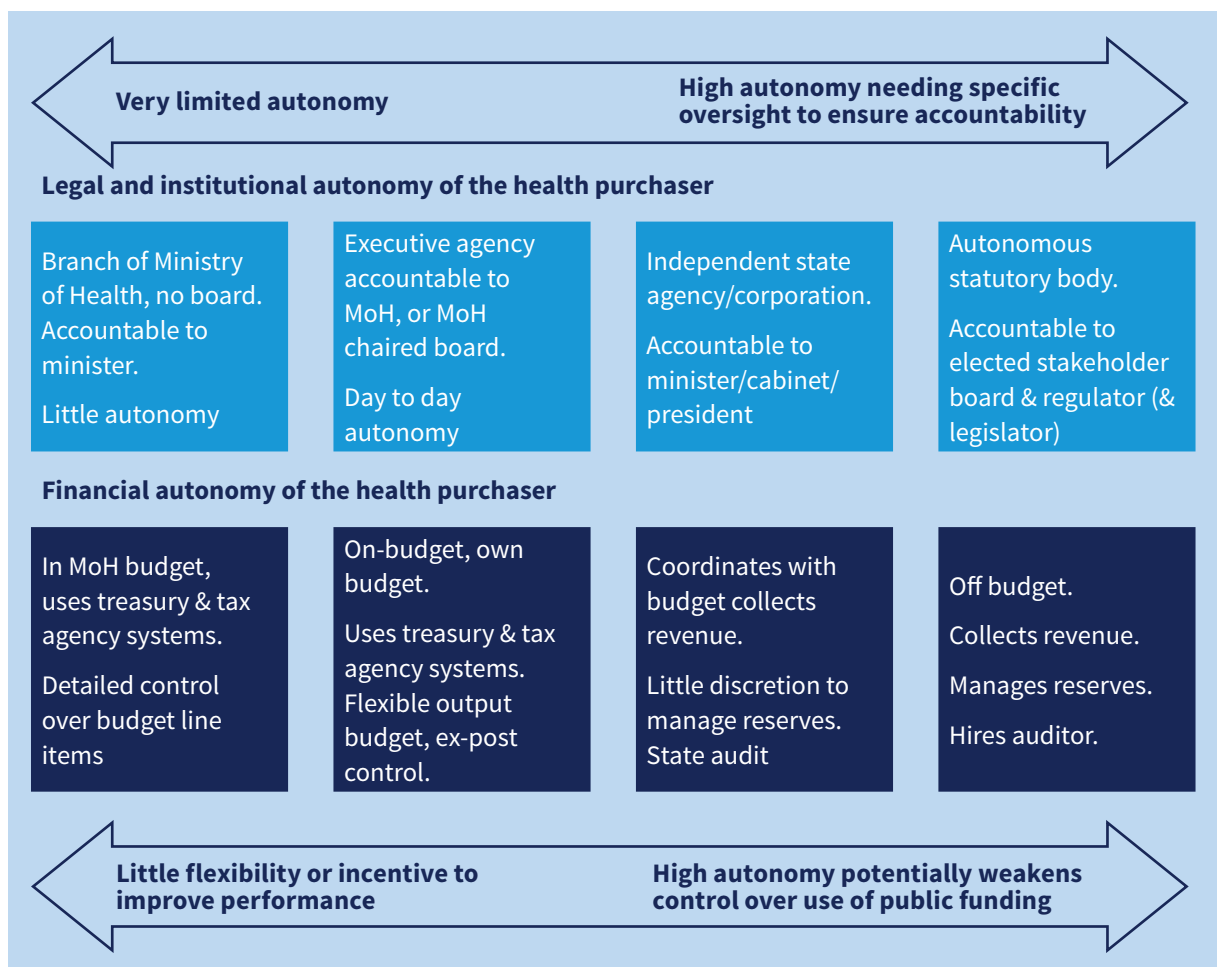
3.2.3 Institutional arrangements to align programme budgeting, PFM and provider payment

(i) Creating a health purchaser as an agency with more flexible PFM than budget agencies

Many countries establish independent statutory bodies to act as purchasers of health services. These are usually separate from the MoH and are not responsible for managing providers. Independent statutory purchasers often have a high degree of legal, institutional and financial autonomy. They have more freedom than the MoH in how they manage their funds. Their budgets are often approved separately and are subject to fewer ex ante controls from the central financing authority (Cashin et al., 2017). The purchaser can adopt a range of possible roles (see Figure B3.4). This can make it possible for the purchaser to introduce output-based budgeting and payment reforms in the health sector ahead of programme budgeting and PFM reforms across the rest of the public sector. The degree of autonomy given to the purchaser varies across countries. At one extreme, the agency can have a limited role and serve as a unit of the MoH (Model 1). At the other, the purchaser can serve as an independent state institution with a supervisory board subordinate to the government rather than the MoH (Model 4). The MHIF in Kyrgyzstan before 2009 could be categorized under Model 1. However, the fund gained more autonomy and is now closer to Model 3 (Hawkins, 2017a). In the United Republic of Tanzania, the NHIF had significant independence from the start, similar to Model 4. The fund has been able to implement FFS while the public system was based on strict input-based line-item budgeting. The extent of purchaser autonomy influences the degree to which provider payment methods will be determined by prevailing budgeting practices in the public sector. However, in many cases, the autonomy of the purchasing agency is less important in influencing the power of output-based payment than the degree to which providers are subject to PFM rules on the use of the funds.

FIGURE B3.4.

The role of a purchasing agency: a spectrum of options



Source: Hawkins (2017a).



A purchaser-provider split with persistent bottlenecks in budgeting processes for health care providers can have negative consequences. An autonomous purchaser may have little effect on providers governed by numerous other staffing norms and spending guidelines. The purchasing agency in Indonesia pays providers based on outputs, but 11 regulations govern how providers can use the funds. These are not line-item restrictions. However, the regulations are enough to dampen or nullify the incentives. Moreover, many facilities cannot deviate from the budgetary plan and have unspent capitated payments in their bank accounts (JLN & GIZ, 2017).

The introduction of an independent purchasing agency and output-based payment methods can also create negative effects and should be carefully evaluated before such reforms are implemented (Allen & Radev, 2007). In the Philippines, the costs the purchaser, PhilHealth, should cover in its prices or the inputs the DoH or local government units (LGUs) should cover from their budgets are not defined. Therefore, any increase in funding from PhilHealth can prompt the LGU to cut their own contribution rather than leading to a net increase in public spending on health (see Box B3.3). In decentralized contexts, having a clear allocation of fiscal responsibility for each level or stream of government funding is one of the golden rules of PFM.

BOX B3.3.

Philippines – programme budget in a decentralized health financing system

LGUs manage most public health facilities and fund them through their budgets from a mixture of national grants, local revenues, resources from the DoH budget (a mix of grants and in-kind resources for particular inputs or activities) and output-oriented payments from the national health insurance fund, PhilHealth. These financing sources use different provider payment methods: output-oriented for PhilHealth, budget line-item budgets for most LGUs, and DoH provision of in-kind resources or funds for specific inputs. The experience demonstrates that when multiple payment methods to a provider are not aligned and the responsibilities of national and local funders are unclear, the goals of both provider payment reform and programme budgeting become more arduous.

The responsibility of each source for various costs is not clear. PhilHealth pays capitation for public primary care, FFS for inpatient care, and has piloted case payments and bonus payments for quality. Public providers rely on varying levels of LGU and DoH budget funding to cover their costs. In most LGUs, providers are administered by the LGU and all PhilHealth reimbursements and user fee revenue go to the local treasury. Each LGU decides how much of the PhilHealth revenue to pass on to providers. Some LGUs have used their PhilHealth revenue for other local spending priorities rather than for improving health care. Such LGUs have not responded to output-oriented financial incentives. Even where LGUs pass on these revenues, most do this by adjusting the level of input-based budgets for providers. As a result, the output-based incentives for efficiency and responsiveness in PhilHealth's payment methods are not transmitted to providers. Increases in payments may lead some LGUs to reduce their own budget allocations to health care.

PhilHealth has little leverage over the overall resource allocation and financial incentives for public health care facilities without any clarification of LGU responsibilities or alignment of policy priorities and payment methods.

In 2018, Philippines introduced programme budgeting and performance indicators into budget presentations for line ministries to clarify responsibility for delivering on national strategic goals and to increase accountability. However, programme classification is not used for appropriation and control. Budget execution controls continue to be carried out at the level of activities and line items though with reasonably high-level line-item controls. The Appropriation Act places many other restrictions introduced by legislators on specific DoH initiatives, introducing further rigidity. The DoH is not free to align its methods of paying providers with PhilHealth's output-based methods, even after the introduction of these reforms. A significant portion of DoH spending on health care is capital investment through a special Health Facilities Enhancement Programme, which has its own rules. The DoH is constrained in its ability to coordinate capital investment priorities with the priorities of PhilHealth and LGUs.

The DoH faces difficulties in achieving its performance indicators without the required resources or any coordination of strategy with PhilHealth and LGUs. The department has limited ability to be accountable. LGU grants through the Ministry of Local Government, funding for the premier national public teaching hospital, and a 35-billion-peso transfer to PhilHealth to finance coverage of poorer Filipinos, are presented in other parts of the budget. PhilHealth contributions, LGU revenues

and facility revenues are outside the national budget. Therefore, total public expenditure on health is not captured in the national budget. The budget cannot serve as a platform for the alignment of health purchasing and provider payments. A greater alignment of programme structure and health performance indicators across chapters of the budget relating to health may be possible. However, programme budgeting cannot play a significant role in aligning policy and incentives for all sources of public financing for health. Instead, Philippines has adopted new legislation on universal coverage to address these problems through the greater pooling of funds and the coordination of responsibilities at the provincial level.

Source: Lakin (2018).

A separate purchaser with significant legal, institutional, and financing autonomy can allow for the introduction of output-based provider payment methods in an input-based environment. However, this approach has several disadvantages. Off-budget entities, unless they are carefully managed, come with risks (Allen, 2016). Providers are likely to face contradictory incentives and fragmented fund flows in cases where an independent purchaser manages only part of the public funds for health, as in Philippines. In other cases, as in parts of Africa, independent purchasing agencies cover only a small, and typically wealthy, segment of the population. The risk of conflict or competition with the ministry over policy and strategy can arise, as in Kyrgyzstan. The degree of autonomy of the purchasing agency is not as critical for the functioning of output-based payment methods as the degree of managerial autonomy and the capacity of service providers.

But in countries where the risks of a full purchaser-provider split are significant, a more incremental approach to reform, for example based on incremental implementation of output and performance-based elements of budget allocation for health care providers and incremental increases in PFM flexibility, is aligned with health financing goals.

(ii) Provider Autonomy to give providers more flexible PFM than budget agencies

Provider status and autonomy is an important factor in facilitating the shift to output-based payments. Managerial and operational autonomy refers to the right to make financial, personnel, service delivery and other decisions. The more areas over which providers have decision rights, the more flexibility they have in responding to incentives both beneficial and perverse. Experience with decentralized or direct facility financing (DFF) in Nigeria and in the United Republic of Tanzania are promising examples. Health facilities in Nigeria were provided with operating budgets and were allowed to set priorities and spend funds, strengthening management and local governance. Preliminary results from the experiment suggest these modifications improved the coverage and quality of maternal and child health (MCH) services (Kandpal et al., 2019).

Provider payment and budgeting reforms in Indonesia, Kyrgyzstan and Mongolia serve as examples of the power of output-based payment (JLN et al., 2015). They demonstrate that the ability of providers to overcome challenges posed by input-based budgeting systems depends on the extent to which providers are subject to PFM spending rules. However, unchecked autonomy can amplify perverse incentives within payment systems. Therefore, complementary strategic purchasing measures are needed, as has been seen in Viet Nam (London, 2013).

Programme budgets can be made more effective for health spending by addressing civil service rigidities. A significant portion of health workers in LMICs form part of a heavily regulated civil service. Salaries can consume two-thirds of public spending on health.¹⁸ Civil servants appointed in Indonesia are usually tenured for life. As in many countries, a lack of civil service reforms constrains programme budgeting (Nurman, 2018). In the health sector, the central government controls all permanent civil servants (*Pegawai Negeri Sipil*, PNS) working at the district level. The government controls the payroll, hiring, firing and the conditions of employment (Efendi & Kurniat, 2012). A more comprehensive approach was taken in Estonia, which reformed its public system as part of a political, economic and social transformation following the break-up of the Soviet Union. The result was a performance-based approach throughout the public sector (see Box B3.4).

¹⁸ According to Robinson (2013): In most countries, effective program budgeting also requires a systematic attack on expenditure rigidities: in other words, on the range of barriers to the rational reallocation of resources which are so often present in the government, such as ...unduly rigid civil service employment arrangements which may make it impossible to reduce employment and expenditure on low priority or ineffective programmes.



Estonia – alignment through parallel reform of PFM and health financing

Estonia demonstrates the benefits of aligning PFM and health financing reform together with the “autonomisation” of public health care providers. The result is a coherent approach to reforms and a health purchasing system that is performance oriented. PFM and health financing reforms took place in the early 1990s when the country was changing politically, economically and socially. Health financing and PFM reforms may appear to have been implemented in parallel. However, both sets of reforms had a common objective: shifting from input-based compliance-oriented logic to a system oriented towards performance. Autonomisation of public health care providers took place through a series of steps and was not fully implemented until 10 years later, when managerial capacity, data and purchasing capacity were better developed. This helped to minimise the risks and realize the benefits of provider autonomy.

Estonia regained independence in 1991. The organic budget law, the State Budget Act, was passed in 1993. Recommendations from the IMF and the European Union helped shape revisions to the act in 2003 and the introduction of the strategic planning procedure, including a performance budgeting system and an expenditure framework for the medium-term. The framework included extra-budgetary funds including the Estonian Health Insurance Fund (EHIF) budget in the definition of the general government budget. Performance data has been incorporated into budget documents since the early 2000s.

Changes in health financing were also implemented after the restoration of independence. The 1991 Health Insurance Act established a health insurance system with what were called regional sickness funds. Historical line-item payments for hospitals were replaced with a German-style FFS. Personnel employed by hospitals were released from the civil servant pay scales.

The EHIF Act became effective on January 1, 2001. The 17 regional sickness funds were consolidated into the EHIF as an autonomous public agency. That year, the Health Care Services Organization Act set that all public hospitals be incorporated under private law as foundations or joint-stock companies by 2003 while remaining in the ownership of national or local governments, which appoint their hospitals’ governance boards.

Private law regulates employment relations, hiring and firing between providers and health professionals. Salary levels are established through individual negotiations between employers such as hospital management boards and employees and take into account collective agreements between associations.

Reforms have enabled the EHIF to use its contracts and provider payment methods to create performance incentives. The national budget and transparent public reporting capture measures of the fund’s performance towards universal health coverage objectives.

Source: Habicht (pers.comm. 2019).

Conclusion

Programme budgeting can enable the shift to output-based provider payment methods and support the strategic purchasing of health services. But these benefits have only been achieved under certain conditions.

The two reform streams need to be aligned and coordinated, particularly in fragmented systems. The shift to output-based provider payment has to be accompanied by changes in budget formulation, appropriation and execution rules. Moreover, payment methods across government levels and schemes need to be harmonized to ensure incentives produce the intended effects.

Labour regulation for civil servants must be tackled for programme budgeting to work and for output-oriented provider payments to have the desired impact. The proportion of resources under a programme manager’s or health care provider’s control becomes minimal in contexts where most health workers are protected civil servants whose salary scale and deployment are governed centrally. This is particularly the case in LMICs where salaries can account for more than two thirds of the health budget.

Programme budgeting and output-oriented provider payment reforms must be accompanied by increased flexibility for managers to decide how best to deliver public services. In return, measures to ensure stronger accountability must be put in place.



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4. Monitoring programme budgets in health

Maarten de Jong and Linnea Mills

Introduction

When countries introduce programme budgets, they develop a performance framework to support performance monitoring. In theory, a performance framework establishes a chain of accountability for the budget and results all the way from Parliament to executive agents.

For a performance framework to contribute effectively, performance information cannot only be generated and reported. Performance needs to be assessed systematically. The results of this analysis need to be part of a performance dialogue that affects decision-making within ministries and agencies. Incorporating performance information into budgeting is a long-term endeavour that takes persistent effort and attention.

Some monitoring challenges have to be overcome to realize the potential of programme budgeting especially in LMICs. OECD countries struggle to meet expectations with their programme budgeting and performance frameworks. LMICs encounter other challenges in applying performance frameworks in the health sector. The aim of this chapter is to identify some common challenges, particularly in the health sector in LMICs, and to offer some strategies to overcome these challenges.

4.1 Key performance monitoring issues

Performance frameworks have been introduced as part of programme budgeting reforms in diverse national settings. Some common obstacles have surfaced, which are described in more detail in this section.

4.1.1 Lack of comprehensive national performance framework in health

Strategic planning and budgeting often exist in separate silos. National strategic plans are developed without reference to resource constraints. Budgets are developed with little reference to strategic policy objectives. These silos may persist even when programme budgets are introduced. Many LMICs initiate programme budget reforms but, while they await formalisation, use the programme structure with performance information as a supplement to the traditional input-based budget. The traditional budget is still legally binding. Therefore, the programmes and performance information receive little attention. The national budget may play a limited role in the fragmented funding structure in the health sector, especially when a separate insurance fund manages most of the expenditures. This structure complicates comprehensive coverage of performance frameworks (see Box B4.1). Further, some disease-specific performance frameworks have been set up without being consolidated into a coherent monitoring system under the state budget.

BOX B4.1.

Misalignment of performance frameworks in Indonesia

Strategic targets and the national priorities in Indonesia do not clearly translate into the health budget programmes. Programmes should be used to control the flow of funds during budget implementation and to ensure priorities are met. However, the MoH does not report back against programmes. Health performance and the budget remain separate silos after more than a decade of efforts to implement a programme budget. A district health office reports on finances to the Ministry of Home Affairs and, indirectly, to the MoF; it reports on performance to the MoH. A unit within the MoH usually handles a programme. The MoH reports back on budget implementation through a Performance Accountability Report and a Budget Implementation Report. Budget documents are presented to allow budget lines to be traced according to both functional and programme classification. However, the separation of reports between financial performance and programme performance makes it difficult to measure the connection between programmes and the budget. The government acknowledges the inconsistencies between the work plan and budget performance. The MoF circulates ministerial regulations on how to ensure consistency between the budget and the workplan in an effort to align the underlying laws (Nurman, 2018).

4.1.2 Unclear and methodologically flawed indicators

Performance indicators should define chains of policy results, the chain of inputs, activities, and outputs leading to goals or outcomes. These indicators ought to illuminate the degree to which a policy achieves its aims. The selection of indicators is among the most contentious debates in the development of programme budget performance frameworks. Many indicators used in health performance frameworks lack strategic relevance, have doubtful validity or are methodologically flawed.

Some performance indicators are designed without balancing bottom-up input from MoH programme managers and implementation staff and top-down input from the MoF and the MoH finance department. A bottom-up approach easily leads to confusion as outputs of one unit can be considered inputs to others. Strategic goals should always be at the starting point of a performance framework and guide the defining of subsequent goals, objectives and targets. However, a top-down approach in which the finance department or the budget office dominates and determines the selection and quantity of indicators is also problematic (see Box B4.2).

BOX B4.2.

Lack of input from health policy managers to performance framework design in Armenia

The participation of MoH policy staff and programme managers has been underemphasized in many countries that have created performance frameworks. In Armenia, the MoF and the finance division of the MoH defined health programmes. The responsible policy departments were not involved in the formulation, management or reporting of budgetary programmes. Consequently, the financial and accounting divisions of the MoH appear to be responsible for the budget. The policy departments have no clear lines of accountability. The performance indicators are mostly activity or output measures, of quantities of different types of health services. The indicators need tighter links to the objective of each programme; for example, to achieve immunization coverage targets and reduce deaths and hospital admissions for some preventable non-communicable diseases. This requires input from the MoH's policy staff managers (Dale et al., 2018).



The quality of indicators in many countries is viewed as problematic. In Gabon, Ghana, Indonesia, Kyrgyzstan, and South Africa, many of the available indicators measure internal administrative processes without a clear relation to health outputs. In Burkina Faso, many indicators do not follow a logical framework between inputs and results (Barroy, André & Nitiema, 2018). An indicator may be difficult to measure or it may be inconsistent or unclear. Indicators that are unclear make it hard to determine the extent to which a goal is attained. In other cases, an indicator may not logically or accurately measure the programme's objectives and potential impact (see Box B4.3).

BOX B4.3.

Unclear indicators in the Philippines' performance framework

The previous Philippine strategic health plan (National Objectives for Health 2011–2016) measured access to quality health facilities for the poor by the percentage of DoH-retained hospitals being upgraded, rehabilitated or constructed using a multiannual target. In this case, combining improvements to existing hospitals (upgrade and rehabilitate) with newly constructed hospitals makes the indicator unclear seeing that the total number of hospitals for which the percentage is calculated inevitably changes when new hospitals are constructed.

Strategic Objective	Indicator	Data Source	Latest Baseline	2016 Targets
Access to quality health facilities and services, especially those commonly used by the poor is improved.	% DOH retained hospitals upgraded/ rehabilitated/ constructed	DoH Report	10 (Upgraded 2010)	95
	% Provincial Hospitals upgraded/ rehabilitated/ constructed	DoH Report	25 (Upgraded 2010)	95
	% District Hospitals upgraded/ rehabilitated/ constructed	DoH Report	30 (Upgraded 2010)	95
	% RHUs upgraded/ rehabilitated/ constructed	DoH Report	30 (Upgraded 2010)	100

Source: Department of Health, Republic of the Philippines (2012).

4.1.3 Problem with inadequate data quality

Lack of valid data is one of the most common problems with operating performance frameworks, particularly in LMICs. One of the basic requirements of a programme budget performance framework is sufficient investment in the quality and timely reporting of underlying data. Many countries in the initial stage of programme budgeting reforms struggle with appropriate methods to ensure the validity, relevance, and measurability of performance goals and indicators (de Jong & Ho, 2019a). Difficulties with assessing health service delivery outputs are often of a technical nature such as the quality of data, the comparability of data, and the measurement of service outputs and service quality. This is challenging in OECD countries and even more so in LMICs where health facilities, particularly rural and primary care facilities, lack the technology and skilled staff needed for efficient, accurate and timely reporting. (OECD, 2019).

Countries with an ambitious performance planning and reporting framework face challenges in keeping pace with data availability. The lack of baseline measurements of performance indicators is a common sign of this issue (Lakin, Torbert & Hasan, 2018). The absence of this data makes it impossible to assess the level of ambition or the severity of deviation from targets and inhibits the use of performance frameworks by managers, politicians and other stakeholders (see Box B4.4).



BOX B4.4.

Missing baselines in Gabon's performance framework

Gabon's prevention and health security programme is an example of a budget programme with performance indicators that lack baselines. The forecast and target numbers make little sense without knowing the current state of achievement.

Title	Unit	2017 Achievement	2018 Forecast	2019 Target	Multiannual targets 2021
Percentage of injectable polio vaccine doses purchased	Percentage	Not available	Not available	60	100
Number of vaccinated children aged 0–11 months	Number	Not available	101 762	145 767	Not available
Number of vaccinated pregnant women	Number	Not available	61 292	77 284	Not available

Source: Gabonese Republic (2018).

4.1.4 Problem with how data is used

Governments can struggle to optimize the use of performance data. Three pitfalls deserve some consideration.

The first pitfall concerns the underutilization of performance information. The advantages of a performance framework largely depend on the degree to which the performance information generated is used in decision-making. Most countries that have introduced programme budget performance frameworks have been disappointed with the degree to which public sector managers have used performance information particularly for budgetary decisions (Moynihan, 2008; OECD, 2007; United States Government Accountability Office, 2004).

Analysis of rich countries shows capacity constraints and a lack of analytical culture in spending ministries leads to this underutilization of performance information (Moynihan & Beazley, 2016; OECD, 2018). These factors are likely to be even more pronounced in the health sector in LMICs (WHO, 2019). The neglect of performance information may be due to an excessively complex performance framework or not having the right kind of information available in the time frame and level of disaggregation needed for the budget cycle. This is a common problem in health performance frameworks that use population health outcomes such as maternal mortality rates as performance indicators. In other cases, information might be available and the capacity to use it but a lack of engagement in system-wide analysis and strategic prioritization leads to underutilization (see Box B4.5).



BOX B4.5.

Underutilization of performance information for decision-making

In Peru, performance monitoring remains a perfunctory exercise. The extent to which the information collected is used for decision-making is questionable. A lack of technical capacity and an overly complex framework inhibit the rigorous use of performance information. An overview of the budget programme on nutrition runs to 268 pages. The document analyses the literature on malnutrition and builds on national statistics to estimate its prevalence among children under five. The system is rigorous in using research evidence to link activities and outputs to final health outcomes. However, population health outcome data is not available in time for use in the annual budgeting process and is based on national-level data which have little relevance to the health spending unit (Dale et al., 2020).

In Gabon, performance plans are firmly in place and performance-related information is published annually. Still, the information is underutilized or not used at all. There is no real performance audit. The Supreme Court of Accounting publishes only a few comments in its annual reports (Aboubacar et al., 2020; Gabonese Republic & PEFA, 2017).

The second pitfall concerns information overload. A surfeit of performance indicators leads to lack of prioritization and heavy administrative burdens (see Box B4.6). The quantity of indicators surpasses the quality and usefulness of indicators. The intended users in the sector, the MoF and elsewhere do not see the performance information as relevant. Professional peers, legislators, and other stakeholders often ask ministries and agencies to create more data augmenting the number of measures and indicators and contributing to more information overload (Moynihan & Beazley, 2016; OECD, 2018; Shaw, 2016).

BOX B4.6.

Holding back on the number of indicators in Philippines

The Philippines DoH wanted to include more indicators than the Department of Budget and Management (DBM) was willing to accept. Some managers wanted to include indicators used for internal management, to enhance their department's profile and protect their department's budget from being deprioritized. The DBM advised against this and encouraged managers to maintain a larger set of internal indicators linked to a reduced set of external-facing indicators that would not overwhelm budget users. The DBM also took the view that every subprogramme should have an indicator which has resulted in budget programmes having a varied number of indicators (Lakin, 2018).

Information overload is problematic for two main reasons. First, the multiplication of indicators results in a lack of focus and has a negative effect on transparency. The technical nature of many indicators together with the length of documentation discourages this information from being widely used. Second, performance indicators require resources to monitor, verify, report, aggregate and analyse the information generated, so an overload of performance information creates an administrative burden (see Box B4.7). Countries with a longer history of programme budgeting systems have explored ways to reduce the number of goals and performance indicators in their frameworks (OECD, 2018).

The main reason for information overload may lie in an inability to select a target audience for the information from the framework. Performance information from a framework may be relevant to the president or other elected officials, the MoF, agency managers, regional units, health providers, donors, academics, citizens, and journalists. Each of these groups may find performance information useful for different purposes. Politicians may use performance indicators to claim success or assign blame. Programme managers may use them to detect and correct errors. Policy analysts may use them to improve policy design while journalists and civil society may find indicators useful to see if government lives up to its promises. In



LMICs, multiple development partners support different health programmes in the MoH. Each partner tries to incorporate their own programme indicators in the government's performance framework. A system that tries to serve all those audiences is likely to disappoint (Moynihan & Beazley, 2016).

BOX B4.7.

An abundance of indicators leads to information overload

The performance framework in Ghana contains 14 outcome indicators and 170 output indicators. These indicators are unequally divided between the four budget programmes. Programme 2 (Health Service Delivery) alone has four subprogrammes and 118 indicators.

Period 2016–2018	Number of non-financial indicators
Operations	41
Outcome indicators	14
Output indicators	170
By programme	
Management and administration	27
Health service delivery	118
Human resources for health development	8
Health sector regulation	17

Source: Osei et al. (2021).

The MoH in Armenia manages eight programmes with 43 activities measured by 139 indicators, an average of 17 indicators per programme and 3.2 indicators per activity. Having to review so many indicators to understand the performance of one programme is burdensome and not conducive to higher transparency and accountability. Moreover, these are mostly output indicators. Several health programmes contribute to outcome indicators, which reflect the overall health system goals, and none is included (Dale et al., 2018).

The final pitfall in performance data concerns how measuring and using data effect incentives in the system, especially when performance is linked to financial consequences for an individual or organization. Several countries developing health-specific budget reforms have introduced performance-oriented bonuses for MoH personnel linked to budget programme performance indicators. Direct financial incentives to personnel can tempt staff to neglect other important ministry objectives that do not offer incentives. Such incentives can also lead MoHs to negotiate low-risk performance targets. Similar behaviour can arise in LMICs with a history of punitive approaches to holding officials accountable when performance targets are missed.

Financial incentives in the form of output-based provider-payments can be powerful tools to increase the production of particular medical services where this is strategically important. Cambodia used this approach to stimulate increases in facility-based delivery as part of a strategy to reduce maternal mortality. However, output-based incentives are prone to stimulating overproduction of inappropriate services – excessive rates of caesarean sections, for example – if not used strategically.

The incentive to report success may prove stronger than the incentive to achieve it when performance information has financial repercussions for personnel. Examples can be found worldwide. They vary from the selective presentation of results to data manipulation and fraud. At the extremes, this can lead to



damaging changes in behaviour and reporting in the form of gaming (OECD, 2018). In LMICs, this kind of manipulation is more likely to go undetected and may, therefore, occur more often. Financial incentives need to be accompanied by the capacity and capability to detect and prevent this type of behaviour, such as an independent audit. The consequences, both positive and negative, of a performance framework need to be balanced with the capacity to measure and analyse performance.

4.2 Good practices and policy options to address key performance monitoring issues

4.2.1 Aligning the performance framework based on a hierarchy of interlinked goals, objectives and actions

A performance framework for budgetary programmes in health is not a collection of separate wish lists that overlap with an ambiguous connection to the budget. Instead, a clear hierarchy of goals systematically links to annual budgets and multiannual budget frameworks while reflecting national, sectoral and regional development plans. The achievement of objectives requiring inter-ministerial collaboration needs to be supported by central government coordination of activities and budgets (OECD, 2018).

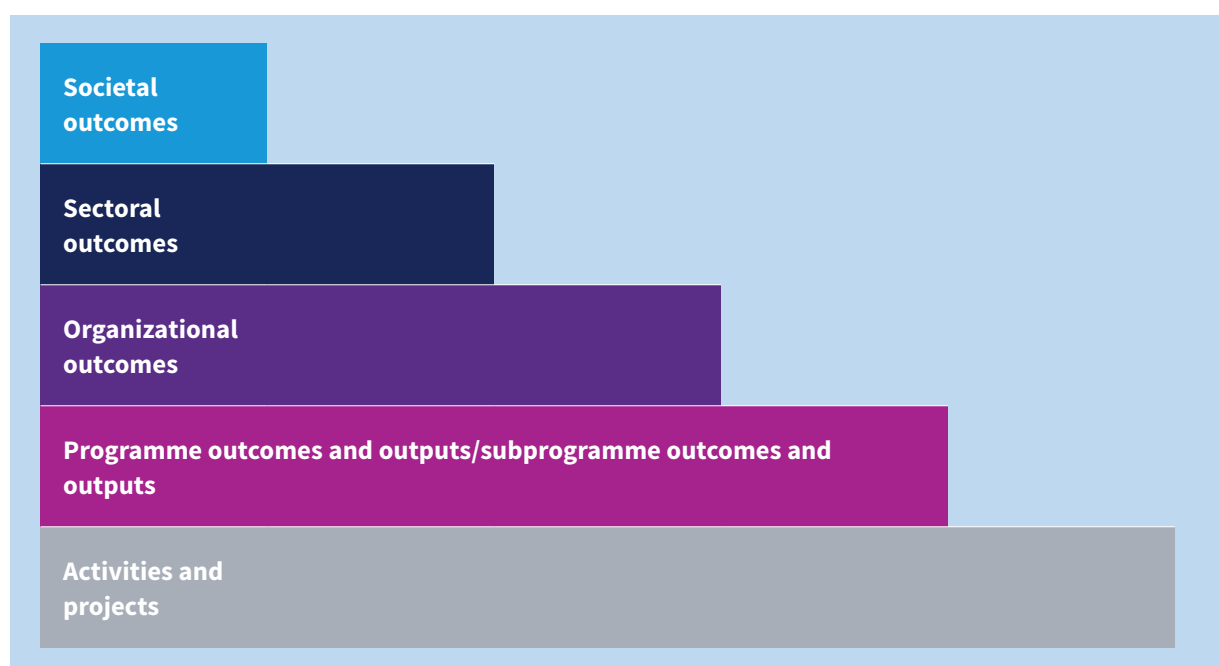
The hierarchy of goals, objectives and actions provided by a good performance framework provides information about the assumed cause and effect relationships to achieve strategic goals and realize policy priorities. This is often referred to as a logical framework or results chain and can form a link to policy and the theory of change in the health sector. Selecting and formulating objectives are among the most challenging parts of building a performance framework for a programme budget system. The most important features for outcome-oriented goal setting are:

- a problem analysis that contains baseline measurements, norms or benchmarks;
- a clear definition of the phenomenon that the policy is intended to impact; and
- clarity about the direction in which measured values should develop.

The Philippines introduced a hierarchical logical framework/results chain in its 2018 programme budget (see Figure B4.1).

FIGURE B4.1.

Logical framework used in the Philippines



Source: Republic of the Philippines (2016).

An aligned performance framework with a clear hierarchy of cascading goals and methods of funding them forms the foundation of a structured dialogue about funding and results among stakeholders. Expected programme performance can be compared with demonstrated performance and can be connected to spending levels during performance planning, execution and evaluation. Likewise, assessing the consequences of requests for extra funding or proposals for savings for performance and goal realization is more likely to get proper attention.

Misaligned plans developed separately by different stakeholders, each with their own sets of overlapping indicators, will put an unnecessary burden on staff capacity and financial resources. Different stakeholders pursuing their own goals measured by their own indicators obscures priorities. Countries can build on some encouraging examples of LMICs endeavouring to align performance frameworks to national health strategies (see Box B4.8).

BOX B4.8.

Aligning performance frameworks to national health strategies

The South African Annual Performance Plan links existing policy ambitions from the Sustainable Development Goals (SDGs), the National Development Plan, the MTEF and the MoH Strategic Goals. The plan mentions grants, public-private partnerships (PPPs) and related goals and initiatives of public entities (Republic of South Africa, 2017). By aligning health programmes this way, sector priorities will be embedded in the national framework, avoiding unfunded ambitions and limiting duplication of performance monitoring and reporting.

Sustainable Development Goal 3	National Development Plan (NDP) Goals 2030 (Chapter 10)	National Development Plan (NDP) Priorities 2030 (Chapter 10)	Medium Term Strategic Framework (MTSF) 2014–2019	National Department of Health Strategic Goals 2015–2020
Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.	Universal health coverage achieved	Financing universal health care coverage	Sub-outcome 1 Universal health coverage progressively achieved through implementation of National Health Insurance. Sub-outcome 4 Reduced health care costs	Make progress towards universal health coverage through the development of the National Health Insurance scheme and improve the readiness of health facilities for its implementation.
Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.	Posts filled with skilled, committed and competent individuals	Improve human resources in the health sector Review management positions and appointments and strengthen accountability mechanisms	Sub-outcome 5 Improved human resources for health Sub-outcome 5 Improved health management and leadership	Improve human resources for health by ensuring appropriate appointments, adequate training and accountability measures.

Source: Republic of South Africa (2017).



The performance framework used in Kyrgyzstan is well-aligned with the national key health policy document and its monitoring framework. The MoF and MoH revised health budget programmes alongside the development of the national Health Strategy 2019–2030. The current programme structure and performance measures are closely linked to the strategy, sharing many programme and subprogramme indicators (Hawkins et al., 2020).

In Burkina Faso, goals and indicators of budget programmes were aligned with the National Health Development Plan (2011–2020) and helped bring focus to priority goals. Sectoral involvement in budget reform helped in this exercise (Barroy, André & Nitiema, 2018).

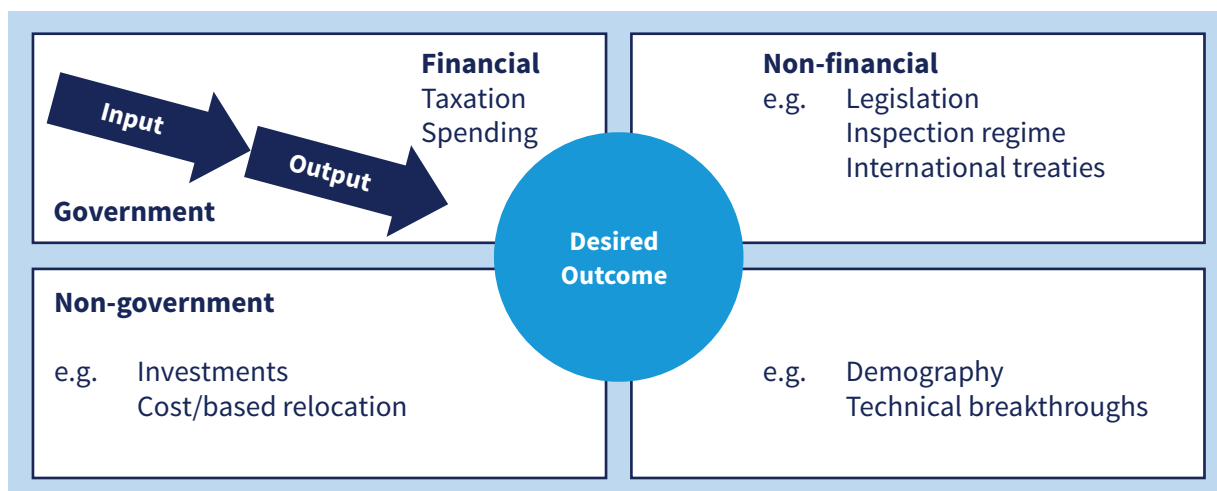
4.2.2 Developing a realistic performance framework

Objectives must be realistic and attainable. Budgetary spending on health often funds only a portion of the activities required to achieve the intended outputs and outcomes. The complex production function of public policy often obstructs a clear link between spending and outcomes. This relationship is seldom stable over time. The desired outcomes usually depend on exogenous factors only indirectly affected by government spending (Hughes, 2008). For example, requiring a local health department to report twice a year on the region’s lagging life expectancy compared to the national average in an effort to hold managers accountable may be illogical if the timeframes for changing life expectancy and its reporting are far longer. Conversely, using such figures for policy design and evaluation to determine how policy interventions and associated spending can help bring about a certain desired outcome remains a valuable exercise.

A basic analysis that takes into account all major determinants affecting a desired outcome, including those with no direct relationship to the MoH budget is useful in ensuring a realistic performance framework (see Figure B4.2). Increasing access to health facilities may depend on building new facilities and expanding existing ones but also on the available infrastructure patients can use to get there. For example, poor roads impede access to care which can impact maternal deaths at childbirth. Such lapses in infrastructure belong to a different policy area and ministry. Similarly, bringing down the death toll resulting from diarrheal diseases may require vaccinations, improvements in water and sanitation, and changes in hygiene practices in households and food businesses. Several ministries and national and local levels of government may all need to budget and implement activities to address a problem effectively. Put differently, the programme budgeting practice of determining outcomes to match spending levels is considerably less helpful than the reverse of this exercise: developing a coherent policy theory around an outcome goal and determining how government spending can best contribute (de Jong & Ho, 2019a). This way of problem-solving would also require limiting departmental silos and working towards a whole-of-government approach.

FIGURE B4.2.

Model for basic programme budgeting analysis of determinants for outcome goals



Source: de Jong & Ho (2019b).

A realistic performance framework should also factor in its alignment to the budget cycle. Introducing performance planning into the budgeting process sets expectations that performance data can match the timeframe of the budget cycle and the content of budget documents. However, expected policy outcomes often have a longer time horizon than the annual budget, so this can be a predicament (Hatry, 2008). Some flexibility and realism are required in a framework’s design to accommodate this time lag. The performance information generated by a framework are relevant beyond just during budget preparation and at year-end. In fact, time for strategic analysis will be scarce during the budget process. Multiple decision points and policy routines such as spending reviews are needed to benefit from a framework’s potential (Moynihan & Beazley, 2016).

4.2.3 Choosing indicators that are relevant and based on sound data

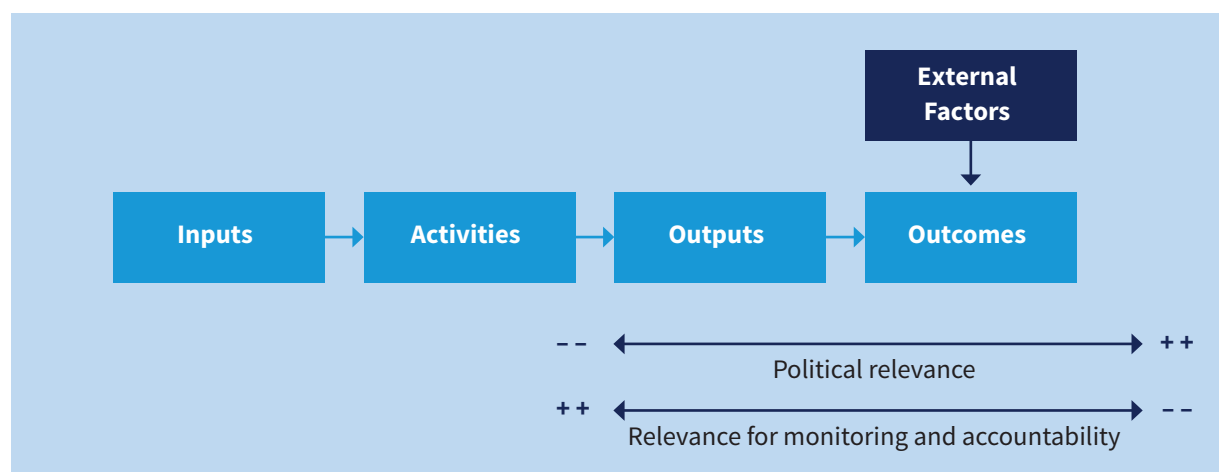
Choosing and defining outcome-driven indicators remains challenging and requires some methodological flexibility. There is no formula for choosing a good indicator. Its relevance depends on the user and the purpose of use, such as performance management, external accountability, or policy analysis. For a long time, an ideal indicator was considered one that measured an outcome in society as precisely as possible, was reported in response to a performance target or a SMART objective (Specific, Measurable, Appropriate, Realistic, and Time-based; or an alternative to this acronym) and was to be reported as part of the budget cycle.

Such indicators are likely to be the most politically appealing. However, they reflect only part of the complex and often problematic causality between funding and results. Outcome goals such as “child mortality of minus 10% in three years” are often more useful for analytical, explorative and motivational purposes than for accountability. Civil servants can look negatively upon such ambitious and precise performance targets especially when the impact of an individual’s work towards achieving targets is unclear and one fears that performance information might be used in a punitive manner (de Jong & Ho, 2019b).

Using the outcome-driven logic to develop and review performance goals and indicators requires some flexibility that includes next best solutions to this traditional programme budget ideal. Different types of indicators capture different parts of a policy intervention intended to lead to a policy impact (see Figure B4.3 and Table B4.1).

FIGURE B4.3.

Logical model of different types of indicators



Source: adapted from de Jong & Ho (2019b).



TABLE B4.1.**Indicators by stage of programme implementation**

Inputs	Inputs are the units of labour, capital, goods and services, or the costs of such units, utilized by government organizations or government-financed organizations to produce public goods and services.
Activities	Activities are actions or work performed through which inputs, such as financial or other types of resources, are mobilized to produce specific outputs; for example, the actions of ministry staff in efforts designed to meet a project's objectives, such as hiring staff, purchasing equipment, constructing facilities, or commissioning studies.
Outputs	Outputs are goods and services produced or provided by government or government-financed organizations. These measures are derived from the direct measurement of output volume. An example is immunizations provided. Outputs tend to be easier to measure than outcomes.
Outcomes	Outcomes refer to what is ultimately achieved by an activity. Outcomes reflect the intended or unintended results of government actions including policies, programmes and other activities. An example of an outcome is the change in the incidence of a disease following an immunization programme.

Source: OECD (2018).

Indicators situated more towards the input side of the spectrum can be better aligned with budgetary and organizational stovepipes of government. They convey little about the achievement of the ultimate policy objectives. They are, however, useful for monitoring policy execution throughout the year. Indicators on the outcome side of the spectrum have greater political relevance. However, many external factors and stakeholders play a role in achieving a desired impact. As a result, outcome indicators are more prone to problematic causality and accountability (de Jong & Ho, 2019b). Still, they are useful for performance evaluation and impact assessments.

What an indicator should measure depends on the formulation of the goal or objective and on the influence of the responsible unit or organization on achieving the objective. Indicators on the input side need to be connected transparently through the performance framework to outcomes and impacts (see Box B4.9).

Linking an output-based performance indicator to a policy objective

Properly conceptualized performance indicators have helped the health sector in Ghana monitor and evaluate how budget programmes and budget subprogrammes are linked to their objectives.

Policy objective	Enhance national capacity for the attainment of the health-related Millennium Development Goals (MDGs) and sustain the gains
Strategy	Intensify and sustain Expanded Programme on Immunization
Programme	Health services delivery
Subprogramme	Primary and secondary health services
Outcome	Reduction in child death due to vaccine preventable diseases
Output	Increase in the number of children vaccinated against measles
Performance Indicator for output	5,000 children vaccinated against measles
Operation	<ul style="list-style-type: none"> • Purchasing vaccines and equipment to administer vaccinations • Ad campaign and schedule for vaccinations • Assigning and mobilizing health care professionals to administer the vaccinations
Input	<ul style="list-style-type: none"> • Vaccines • Syringes and alcohol swabs • SMS Service Provider • Health care professionals to administer vaccinations

Source: Osei et al. (2021).

To prevent or reduce an overabundance of performance indicators of limited strategic value, focusing measures and indicators on the most crucial service delivery areas and strategic policy priorities is the best guarantee for achieving and maintaining a manageable and relevant performance framework (Moynihan & Beazley, 2016). Presentation should focus on a limited set of need-to-know indicators. Other nice-to-know performance-related data, which may be relevant for analytical reasons, can be disseminated through a web portal.

An indicator can be measured in different ways. A less precise measurement is acceptable as long as one can assess the achievement of the goal. Performance frameworks are often introduced as part of budget reforms. Therefore, many prefer that performance be measured in the same way as money is counted, on a ratio level. However, public sector performance is the domain of social sciences in which more measurement scales are available and may sometimes be more appropriate (de Jong & Ho, 2019b). Measurement on an interval level denotes an equal interval on a scale but no meaningful zero; for example, measuring customer satisfaction rates with a survey using a Likert scale (-, -, +/-, +, ++). An ordinal scale provides no more than a ranking order; for example, one's place in a top-five of regional peers. Finally, a nominal scale is merely a classification in which the indicator value can be a yes or a no; for example, the question of whether a hospital building is finished before the end of the year. These alternative scales may appear primitive. Still, they can be valuable in assessing whether a goal was achieved.

Using the same types of data that professionals use in their practice helps to ensure high quality performance indicators. Consulting with these professionals should engage them and lead to relevant indicators (de Jong, 2015). Health care providers already capture data for patient care and facilities management. As much of that data as possible should be drawn from those processes as LMICs develop and automate health information systems in their health facilities. Using established statistical and administrative data and international benchmarks as well as disclosing data sources can limit data availability and data reliability.



4.2.4 Putting the performance data to good use

Investing resources into the operationalization of a performance framework only makes sense if the information it produces is put to good use, internally in a ministry or agency and externally by other stakeholders. The framework needs to be embedded in internal systems that encourage or demand a performance dialogue to encourage the internal use of performance information. Performance budgeting can only thrive when it is embedded in managerial arrangements that make results paramount. Governments that do not manage for results do not budget for results, even if they install the trappings of performance budgeting (Schick, 2003). The successful implementation of performance frameworks relies on institutional and cultural change, which can take years to perfect. Creating and operating a performance framework requires more comprehensive changes than budget reform with additional arrangements beyond PFM and the budget.

Unrealistic goals, unforeseen circumstances, conflicting government policies and a flawed policy theory can all lead to underperformance. This demands a thorough analysis, especially if performance levels are used to inform budget decisions. This review may bolster arguments to cut, increase or reallocate parts of the budget. Countries with long experience in performance budgeting have retreated from attempts to directly link performance to increases or cuts in the budget. They have focused, instead, on encouraging line ministries to make more routine use of performance and budget information. Data-driven reviews in which performance data are routinely discussed for management purposes have been shown to be effective (Moynihan & Kroll, 2015; OECD, 2018). Structured performance evaluation and spending reviews are other ways of institutionalizing the use of a performance framework.

The introduction of routines for performance assessment, evaluation and performance-based learning are intended to stimulate a performance dialogue and strategic thinking. However, such routines may already exist in most public organizations. The performance framework and its routines should enrich and strengthen rather than replace the existing performance dialogue. Formalized performance information from performance frameworks can be contrasted with non-routine performance information such as ad hoc feedback that is passively received (Kroll, 2013). The flow of performance information within government agencies is seen more positively in sectors and organizations with a dominant single culture or sense of mission because they share a strong professional identity and ethos (Kaufman, 1960; Wilson, 1989). This is likely to apply for much of the health sector in most countries. The professionalism of frontline health care workers and their commitment to the quality of care is an asset, creating the possibility of a shared commitment to performance monitoring for quality improvement.

Governments and sectors should practice transparent and consistent reporting of results to encourage the external use of performance information. The sharing of performance data on government portals has allowed independent stakeholders to analyse that information, strengthening performance transparency (see Box B4.10). Accessible formats such as performance dashboards, performance portals, and citizen budgets help citizens, civil society organizations and the media monitor performance (OECD, 2018).

BOX B4.10.

Improved transparency of health sector performance in Kyrgyzstan

The introduction of programme budgeting in Kyrgyzstan has improved budget transparency. Members of the legislature and the public can more easily analyse the links between the budget and the purposes of spending by reading through the programme budget for health on the MoF website. It used to be difficult, if not impossible, to link funding to services. Programme budgeting has simplified this exercise. An informed user can find the programme budget in a matter of minutes and identify whether government allocations are supporting priorities such as the outpatient drug package or primary health care. Programme and subprogramme performance indicators need further work. However, the legislature, civil society, the public and development partners can see this information and assess how well public money is being used. Making budget execution data available by programme will improve transparency (Hawkins et al., 2020).



The reporting of performance data can be politically motivated. Ministries prefer to present data about their successes. External stakeholders such as advocacy organizations may be more interested in performance information that reveals failures. These exercises might help to identify and resolve poor performance. However, employees may be resistant to performance data that is associated with a punitive framework (Moynihan & Beazley, 2016). These dynamics can add to unclear or inconsistent reporting and obstruct transparency.

Conclusion

Some common challenges to performance monitoring have emerged in the health sector in LMICs as part of programme-based budgeting. But possible responses have also emerged to overcome these challenges.

Some countries have been unable to develop a comprehensive national performance framework. Strategic planning and budgeting exist in separate silos. It would be prudent to develop a performance framework based on a hierarchy of interlinked goals, objectives and actions. This requires investing in a rigorous analysis of the problem. This review should ensure the performance framework is aligned with priorities stated in national and sectoral plans and with the budget.

The health sectors in many countries use unclear and methodologically flawed performance indicators which impede the effective use of performance monitoring. They should develop a realistic performance monitoring framework that uses top-down and bottom-up approaches and be methodologically flexible in selecting the most useful indicators.

The lack of quality baseline and other data on service output and quality impedes the effective use of performance monitoring in health, particularly in LMICs. Choosing a set of relevant indicators based on data from well-established sources would be a sound policy response. Selecting indicators that health professionals use increases the likelihood these indicators will be relevant.

Finally, how performance data is used presents a challenge. The data must be put to good use in decision-making for performance monitoring to have a positive impact on the quality and quantity of health service provision. Caution should be taken to avoid performance data resulting in perverse incentives. This can be accomplished by establishing routines for performance assessments that focus on learning as opposed to penalising underperformance.

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Part C. Key Recommendations



1. Making programme budgets work for health

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There is no one right way to undertake budget formulation reforms in health. However, some good practices have emerged across countries. Our emphasis throughout has been on practical guidance, principles and examples that can help policymakers, practitioners and development partners to best support reform. These recommendations are directed at policy leaders, those directly involved in the design and management of budgetary programmes, and development partners. Some advice applies to more than one of these audiences. Therefore, readers may find it useful to peruse all the recommendations and then focus on those targeted to their interests.

Recommendations for policy leaders

Health ministers should consider budget formulation reforms near the top of their reform agenda. These reforms can align budgets with sector priorities, create more flexibility in public funds management, and ensure better accountability towards health outputs.

Programme budgets can be used as a domestic budgetary mechanism to drive general revenues to priority health needs.

The COVID-19 crisis has demonstrated the urgent need for flexible budget formulations and the relevance of programme budgets to an emergency response. Leaders should learn from this crisis and accelerate budget formulation reforms.

Transforming an input-based budget to a programme or output-oriented budget is a considerable undertaking, which requires a shift towards performance and outputs. Leadership must ensure dedicated resources and technical capacity development within the MoH for reform implementation.

Successful reforms require close collaboration between members of the health and finance sectors and among health sector stakeholders themselves. Policy leaders should explore the political economy of programme budget reforms, stakeholder incentives, and opportunities to overcome possible resistance.

To institutionalize reforms, regulatory frameworks and legacy practices must change. Initiating budget reforms without quickly institutionalizing them in the law will create hybrid budget systems and more bottlenecks for health spending.

Policy leaders must acknowledge the risks of poorly defined and poorly structured programme budgets which can impair health system functioning. Formulating programmes around disease interventions, for example, may protect funding for specific priorities in the short run, but it risks creating financial and service delivery fragmentation in the long run.

Budget formulation reforms that are initiated but not fully implemented can create more problems than they solve. Leaders must acknowledge that budget reformulation also requires significant modifications to spending procedures, and policy leaders should work with finance authorities to strike the right balance between flexibility and control over funds.



Health leaders should take ownership from the initial stages of reform of the greater operating discretion afforded to them to define budget holders' responsibilities and ensure they are held accountable for spending and outputs.

Those who receive funds should be empowered to manage programme envelopes flexibly within the results framework for health outputs.

Allowing for this flexibility requires changes to existing regulations and policy rules.

Health leaders should consider a unified budget formulation that applies to all regions, with appropriate links to all levels of the administration, to facilitate consistency in spending and a consolidated accountability framework for spending.

Combining budget formulation reforms with the introduction of a performance monitoring framework is essential. Performance information generated by programme budgets can be a powerful tool in monitoring performance. Health ministers should encourage the routine use of performance information in shaping programme budgets.

Recommendations for reform practitioners

Programme design

Reform practitioners should avoid programme budgets dominated by a single large programme or fragmented into too many small programmes. Large programmes make it difficult to make trade-offs as disparate activities are grouped together. An excessive number of small programmes can reduce financial flexibility especially at the provider level. Ideally, countries should identify three to eight budgetary programmes, with subprogrammes as needed.

Health practitioners involved in the design of programmes should understand that budgetary programmes work best when they include two to three clearly defined sublevels. A clear results chain should link higher levels such as programme goals to lower ones such as subprogrammes and activities.

Practitioners should define the right mix of service, population and policy-based programmes to ensure that programmes align with national priorities for the sector, avoid overlap and facilitate budget implementation. They should try to avoid duplicate activities that create inefficiencies and confuse accountability, such as having a primary care programme and maternal and child health programme in the same budget without clear boundaries between them.

Practitioners should consider programme budgets as an opportunity to integrate the delivery of services, by consolidating disease interventions into broader budgetary programme envelopes that serve cross-cutting functions in a health system.

Those involved in the design of budgetary programmes could include disease components or activities within broader budgetary programmes such as primary care and access to care or incorporate disease-related targets in performance monitoring frameworks. Both are valid and complementary approaches to ensuring funding for disease interventions is integrated into the expenditure chain and results are tracked. A good set of performance indicators for a specific disease priority area is usually preferable to fragmenting budgets within an integrated service.

Practitioners should work on defining a common programme budget formulation across provinces/regions especially in contexts where health is devolved. Aligning national and subnational budgets in the programme structure while respecting differences between their functions and priorities can provide a framework for sector accountability, promote harmonization across subnational levels and facilitate expenditure monitoring where responsibility for health is devolved.



Programme management

Reform practitioners should be aware that programme budgeting is only likely to increase flexibility and accountability if procedures provide sufficient autonomy to budget holders and if spending rules are aligned with the output-oriented logic.

Health and finance authorities should collaborate in defining budget allocations and associated controls in programme budgets and limit them to the programme and subprogramme level.

Funds at the subprogramme level should, to the extent that it is possible, not be allocated on an input or line-item basis but should operate as a global budget with flexibility to move funds across spending units or health facilities. Spending units would execute the subprogramme budget and report back to those subprogrammes on the use of funds. Where there are item controls these should only be at the highest levels.

Subprogramme managers should have the ability to flexibly allocate funds to spending units or to allow those units to engage in contracting modalities to purchase health services.

Reform practitioners should be aware that failing to incorporate staff costs in programmes substantially reduces the managerial power and efficiency of fundholders. Health authorities should work with finance authorities to ensure all costs required to achieve programme objectives are included.

Even within integrated programmes, some line-item categories such as wages or capital may be linked to other centres of power. Health, finance, and planning authorities should collaborate to ensure alignment between civil service reform and programme-based spending, personnel hiring and contracting rules in health.

Clear managerial accountability is a prerequisite if health ministries are to report on results. Full alignment between programmes and the existing MoH organizational structure may help to clarify managerial responsibility early in the reform. However, such coordination can lead to the replication of institutional inefficiencies and the disconnection of the budget formulation from the achievement of results over the long term. Refining the organizational structure of the MoH to align with the programme structure is one way to draw clear lines of accountability between the MoH and resources.

A functional and adaptable FMIS is essential to ensure that all spending needs are recorded appropriately.

Reform practitioners should understand that the way public budgets are formed, allocated, disbursed, and accounted for influences how health service providers are paid. Output-based payments are difficult to administer with an input-based budget. Programme budgets may help. However, they will not rectify the problem if services continue to be operated by inputs.



Programme monitoring

Reform practitioners must define programme reporting to fit the programme logic and to provide an adequate framework for accountability.

Health authorities should seize the introduction of a programme budget as an opportunity for the sector to consolidate financial and non-financial performance information into a single framework and to link funding and health outputs.

Health authorities should align the programme budget performance framework with national health priorities, budgetary programmes and existing monitoring systems such as disease-specific monitoring systems to avoid duplication and conflict.

Those involved in the reforms should consult with service providers when defining health indicators to engage them in the process. They should also endeavour to engage legislators, members of the public, and other stakeholders.

Reform designers should focus on output targets for monitoring rather than targets related to outcomes, such as reductions in child mortality. Many factors can weaken the link between government policies and outcomes.

Reform practitioners should be aware that high quality and timely reporting data are basic requirements of a programme budget performance framework. The absence of baseline data prevents managers, policymakers and other stakeholders from assessing the level of ambition or severity of deviation from agreed-upon targets, nullifying the framework.

Health authorities must understand that the implementation of a programme budgeting performance framework requires institutional and cultural change which can take years to perfect. Embedding the performance framework in internal systems can encourage the use of performance information and its inclusion in performance dialogues.

Practitioners should appreciate that a performance monitoring framework should be periodically revisited in the light of new data or new health policy priorities.

Monitoring is critical but excessive or overwhelming reporting requirements should be avoided. Focusing measures and indicators on the most crucial service delivery areas and strategic policy priorities is the best guarantee for achieving and maintaining a manageable and relevant performance framework.



Recommendations for development partners

Health development partners are encouraged to support the overall strengthening of domestic PFM systems and promote the use of existing budgeting and spending procedures rather than promoting parallel mechanisms that may complicate budget formulation reforms.

Health development partners should regard programme budgets as an opportunity to pool resources from domestic and external sources and to foster the unified and strategic purchasing of health services through general revenues.

Building the capacity of health ministries to implement well-defined budget reforms is crucial to ensuring they reduce hybrid budget formulations, move effectively to output-oriented spending and transition fully to programme budgets.

Health development partners involved in the fight against certain diseases should be aware that a programme budget is a tool to sustain their investment through domestic systems, by incorporating disease components into the programme system.

Development partners should promote a performance monitoring framework that includes well-defined health targets, to enable the tracking of operational and financial performance in the health sector.

Development partners should support efforts to reform COFOG, to enable more meaningful benchmarking of health budget formulations across countries.



Annexes

1. Example of terms of reference for country assessment

Terms of reference

To provide support for ongoing implementation of programme budgeting in the health sector in Ghana

Purpose of the work

WHO has been providing ongoing support to the Ghanaian Ministry of Health (Ministry of Health (MoH)) related to addressing inefficiencies and improving the sustainability of health financing. In recent years, Ghana's health sector has been faced with increasing fiscal pressures and challenges resulting from donor transition dynamics. These issues have made the efficient and effective use of available public funds essential for the health sector.

Public financial management (PFM) and budgeting reforms have been an important channel through which the health sector, as well as the government as a whole, have worked to improve the allocation and use of funds. Ghana has been gradually implementing Programme Based Budgeting (PBB) since 2010 as a way to "deliver results in a more efficient, effective and transparent manner."¹⁹ The new approach was adopted to orient the budgeting process towards performance, as well as flexibility.²⁰ Health was a pilot sector during the transition period, and as of 2014 all sector PBB budgets have been publicly available on the MOFEP website.

Within the health sector, PBB is a way to group or classify expenditure by policy objectives of outputs. Budget programmes vary across countries depending on priorities, as well as system organization. In this way, it has the potential to bring together different inputs under a single classification to allow for coordination and coherence across categories. An important finding from a recent analysis supported by WHO identified both budgeting and planning coordination across various health programmes (e.g., HIV, MNCH, EPI) within Ghana as a significant source of inefficiency. Ghana's budget programmes are not organized around these disease-specific programmes; however, budgeting and planning activities are conducted in silos with little coordination. This particular relates to discrepancies between the way the programmes within the Ghana Health Services (GHS) and the MoH relate to one another.

This study has two objectives. First, to document the transition to PBB within the Ghanaian health sector. This is of particular importance given the increasing movement of LMICs towards PBB. While many of these countries are at a relatively nascent phase of the transition process, Ghana is well-advanced in the process. Therefore, the key challenges and opportunities that Ghana has faced can provide lessons for other countries and also highlight areas in need of further attention within Ghana. Second, the analysis will serve as a basis to highlight ways Ghana is working to reduce duplicative activities or inputs across health programmes, as well as key challenges to doing so, as part of the PBB transition process. The output of this review will serve as a direct input into the ongoing discussions about PFM and health financing reform in Ghana, and will also help to structure WHO support to the Ghanaian MoH in this area.

19 Ministry of Finance and Economic Planning, Government of Ghana, 2010 budget guidelines.

20 Nicholas Adamtey, The Road to Budget Transparency in Ghana, International Budget Partnership, September 2017.



Background and context

PBB implementation in the health sector in Ghana

Ghana's health sector transition to PBB began in 2010. Budget programmes include: management and administration; health service delivery; tertiary and specialised services; HR development and management; and health sector regulation. In terms of the source of funds, in 2016 47.6% came from Government of Ghana, 38.2% from internally generated funds, and 13.2 from donors, with the remaining 1% from ABFA.²¹ However, 99.8% of all Government of Ghana funding was allocated to salaries. The majority of goods and services funding is channelled through the National Health Insurance Scheme, which has its own problems with only 71.4% of budgeted funds received in 2016.²² Challenges also exist with respect to budget execution, with a 41.4% variance between the original budget and actual expenditures for the health sector in 2015.²³

The practical implications of the PBB transition are important to understand and highlight. For example, the issue of unified accounting systems between the various agencies (up to 22) across the MoH. How these systems aggregate across activity lines and speak to each other remains a question. For example, it is not entirely clear how the GHS systems are aligned and coordinated both across embedded health programmes, as well as with MoH systems more broadly. Additional, anecdotal information has highlighted limitations with respect to the functionality and implementation of the PBB within the GHS operations, which

WHO's programme of work on budgeting in the health sector and addressing cross-programmatic inefficiencies

Public funds are essential for making progress towards UHC. Hence, the way public budgets are formulated, allocated and used for health is at the core of the UHC agenda. Among the key issues that influence the allocation and utilization of public resources is the way budget is structured. Budget structure, i.e. the way allocations are formulated and articulated in budget documentation, and the underlying rules for disbursements, has a direct impact on the performance of public funds and the attainment of sector results, as it affects the sector's ability to match the flow of public resources according to sector priorities.

Many countries have tested, or are in the process of testing, different types of budget structures to strengthen alignment between allocations and priorities, execution, and ultimately efficiency in public spending. Health has been a pilot sector in several LMICs for the introduction of programme-or performance-based budgeting. However, there is limited evidence on the actual effectiveness and effects of this transition on public spending on health. Despite the theoretical benefits of programme/performance-based budgeting from a health sector/health financing perspective, emerging evidence seems to indicate that countries are facing/have faced design and implementation challenges to make the transition effective and policy relevant. There is a need to take stock and generate lessons from countries that have reformed their health budget structure as part of their broader PFM agenda, and to identify key enabling factors that seem necessary for countries to consider when/if they embark on similar reform process.

Ghana provides an ideal context to understand the dynamics of this transition process. This analysis is particularly timely as efforts are made to improve the efficient and effective use of available resources, with a long-term objective of ensuring sustained improvements in the health of the Ghanaian people. The interface between health programmes and programme budgeting is critical to understand both to reduce inefficiencies in Ghana, but also to serve as an example for other countries wrestling with similar issues.

Given the current situation there are concerns about the sustainability of currently donor-financed interventions related to transition processes in terms of sustainability of coverage. Many of these financial flows and related services have been kept separate, which has implications both for efficiency as well as how domestic resources can ensure coverage. Overlaying on this entire system is the current fiscal stress that the health system and general economy are facing in Ghana. These pressures cannot be taken in isolation from programmatic financing, and rather the issues need to be tackled in a coordinated way as currently there are interrelated distortions in terms of supply chain, service delivery, and general incentives within the system.

21 Tim Cammack, Fiduciary Risk Assessment of the Ghana Health Sector, HEART DFID, April 2017.

22 Ibid.

23 Ibid.



Work to be performed

The contractor's duties will include undertaking a comprehensive analysis of the transition to programme budgeting in the health sector in Ghana. It will provide specific recommendations with respect to how to address duplications across budget categories and line items in the various health programmes.

The contractor's deliverables will be a written, analytical report, along with follow-up policy dialog and support. The annex to the TOR includes an illustrative outline that can help guide the written report, but it is expected that the consultant will adjust and change the outline based on the Ghana circumstance.

The assignment will rely on a thorough review of all key documents, including the main budget laws for 2018 and other relevant years, programme "passports", budget execution reports. These will be complemented by existing analytic reports such as Public Expenditure and Financial Accountability assessments, public expenditure reviews etc. Given the focus of the study, key informant interviews made need to take place to complement the desk review data collection and analysis.

The contractor will work in close collaboration with WHO Ghana Country Office, under the supervision of the WHO Representative, along with the WHO AFRO Regional Office and WHO Headquarters.

Proposed outline of report

An indicative outline is presented below. This is meant to serve as a baseline for development of the Ghana specific outline, which may be quite different based on the specific experience.

I. Context of transition to PBB in the health sector in Ghana

II. Structure and content of budgetary programmes

- a. Analyse the health budget regulatory framework
- b. Analyse the treatment of immunization (and related inputs) in health budget structure, and disease-specific activities/programmes, including a focus on how immunization-related activities were transferred in the budget during the transition to programme-budgeting, if any;
- c. Identify key bottlenecks associated with the current health budget structure in terms of capacity to allocate and spend effectively and efficiently on sector priorities, and possible misalignment between budget structure and expenditure management/reporting rules;

III. Process of transition and implementation

- a. Retrospectively document and assess the reforms introducing PBB in health: (a) expected goals, (b) role of key stakeholders, (c) process and output of programme definition in health, (d) effectiveness and relevance of the reform process from a sector perspective, (e) expected implications for expenditure management/reporting;
- b. Evolution of programme definitions and performance indicators over the years and motivation for these changes;
- c. Implementation process – what changed? How did it change? Dynamics between agencies?

IV. Analyse the treatment of immunization (and related inputs), as well as HIV, TB and malaria, in health budget structure, and disease-specific activities/programmes, including a focus on how immunization-related activities were transferred in the budget during the transition to programme-budgeting, if any;

V. Key bottlenecks and challenges in the transition process

VI. Focus on addressing duplications and overlaps of activities as part PBB transition process – opportunities and constraints

VII. Expenditure and performance monitoring framework

- a. Assess the effects of programme-budgeting on (a) alignment with sector priorities, (b) allocations to the health sector and individual programmes, (c) level of execution, (d) expenditure management/flexibility, (e) strategic purchasing.

VIII. Recommendations and next steps



2. Country mapping of budget formulation reform phases in health (LMICs)

Phase 1: Pilot	Afghanistan, Albania, Angola, Argentina, Azerbaijan, Bangladesh, Bolivia (Plurinational State of), Bosnia and Herzegovina, Botswana, Bulgaria, Burundi, Cameroon, Comoros, Costa Rica, Côte d'Ivoire, Cuba, Congo (the), Djibouti, Dominica, Dominican Republic, Ecuador, Egypt, Equatorial Guinea, Eswatini, Ethiopia, Fiji, Gambia, Guinea, Guyana, India, Jamaica, Kiribati, Lao People's Democratic Republic (the), Lebanon, Lesotho, Liberia, Libya, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Montenegro, Mozambique, Myanmar, Namibia, Nepal, Niger, Nigeria, Papua New Guinea, Paraguay, Russia, São Tomé and Príncipe, Tonga, Turkey, Republic of the Congo, Senegal, Sierra Leone, Solomon Islands, Sri Lanka, Sudan, Tajikistan, The United Republic of Tanzania, Timor-Leste, Togo, Turkmenistan, Tuvalu, Uganda, Uzbekistan, Vanuatu, Venezuela, Viet Nam, Zambia
Phase 2: Enactment	Armenia, Benin, Burkina Faso, Cambodia, Colombia, El Salvador, Gabon, Georgia, Ghana, Guatemala, Honduras, Jordan, Kenya, Moldova, Mongolia, Morocco, Nicaragua, Pakistan, Rwanda, Serbia, Tunisia
Phase 3: Full Implementation	Brazil, China, Indonesia, Kyrgyzstan, Mauritius, Mexico, Peru, Philippines, South Africa, Thailand, Ukraine

3. Glossary

Term	Definition
Public financial management (PFM)	PFM refers to the set of laws, rules, systems and processes used by sovereign nations and subnational governments to mobilise revenue, allocate public funds, undertake public spending, account for funds and audit results.
Budget cycle	The budget cycle refers to the life of a budget and encompasses the following four phases:
1. Budget formulation	The government formulates the draft budget. This phase comprises: i) the modelling of the economy based on the macroeconomic forecast and estimation of revenue; ii) decisions on sector expenditure ceilings; iii) the formulation and negotiation of sector expenditure budgets; iv) the release of the pre-budget statement with budgetary priorities and policies; and v) cabinet approval of the proposed budget.
2. Budget approval	The legislature reviews and amends the budget and enacts it into law. The Minister of Finance tables the budget and revenue proposals. The responsible legislative committee reviews the proposal then reports to the legislature. The legislature may propose amendments to the proposed budget. Then the legislature votes the budget into law.
3. Budget execution	The government collects revenue and spends money in line with the enacted budget law. The funds are transferred to spending agencies such as the MoH, which deliver services according to the budget. These agencies produce in-year and year-end reports on their spending of the allocated funds.
4. Budget oversight	The Supreme Audit Institution audits the budget accounts of the spending agencies. The legislature reviews the findings. The legislative Public Accounts Committee makes recommendations about the audit findings. The legislature can demand the government take action to correct any issues or irregularities.
Input-based budgeting	Input-based budgets present expenditures by objects (inputs/resources) and detailed lines, which are typically based on economic or administrative classification. This budgeting format offers hierarchical controls with little managerial discretion and limited ability to make reallocation between lines.
Line items	Line items are discrete items of expenditure such as fuel for primary care facilities or dialysis equipment for district hospitals.
Output-based budgeting	Output-based budgeting refers to a number of different budgeting practices including performance-based budgeting and programme-based budgeting which are governed by a value chain in which inputs are translated into outputs, outcomes and impact. Output-based budgeting shifts the emphasis away from strict control over line-item budgets towards programme budgets, with high levels of discretionary spending power for budget holders.
Performance-based budgeting	Performance-based budgeting links funding to the intended results by making systematic use of performance information. Performance-based budgets range from “presentational”, where performance information is merely presented in the budget or other documents, to “performance-informed”, which takes into account performance results in the budget expenditure formulation, to full performance budgeting, which aims at allocating resources based on results to be achieved.
Programme-based budgeting	Programme-based budgeting follows a budget classification by programme whereby expenditure is classified by policy objectives or outputs and the centres of responsibilities to implement them (e.g., maternal health, primary health care, quality of care), regardless of their economic nature. Programmes reflect policy objectives and are meant to be country-specific.



Other budget classifications	
<ul style="list-style-type: none"> • Economic classification 	Economic classification is categorization of expenditure by economic category (e.g., compensation of personnel, goods and services, subsidies and transfers, and consumption of capital).
<ul style="list-style-type: none"> • Administrative classification 	Administrative classification is categorization by administrative divisions responsible for budget management (e.g., MoH, hospital X, agency Y).
<ul style="list-style-type: none"> • Functional classification 	Functional classification is categorization of expenditures by sector (e.g., health, education).
Strategic purchasing	Strategic, or active, purchasing involves linking the transfer of funds to providers, at least in part, to information on aspects of their performance or the health needs of the population. The objectives are to enhance equity in the distribution of resources, increase efficiency, manage expenditure growth and promote quality in health service delivery, and enhance transparency and accountability of providers and purchasers to the population.



