BUILDING STRONG PUBLIC FINANCIAL MANAGEMENT SYSTEMS TOWARDS UNIVERSAL HEALTH COVERAGE:
KEY BOTTLENECKS AND LESSONS LEARNT FROM COUNTRY REFORMS IN AFRICA
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EXECUTIVE SUMMARY

1. Weaknesses in public financial management (PFM) systems have long been regarded as impeding good governance, accountability and efficiency in government actions in Africa. In the health sector, such weaknesses have a specific resonance because they are life-threatening. A poorly-designed budget, with limited execution and a truncated ability to use funds in a flexible manner may prevent health facilities from treating patients promptly and effectively. In Africa, the PFM challenge is more acute than in other regions of the world, with bottlenecks affecting all steps of the budget cycle – from preparation to execution, reporting and auditing – putting health and progress towards universal health coverage (UHC) at risk.

2. African countries have been working on a long-term PFM reform agenda since the late 1990s, supported by many international and regional partners. In several countries, the reform package – dominated by the introduction of complex interventions, such as multi-year financing/expenditure plans, programme-based budgets or integrated financial information management systems – has in general advanced overall levels of PFM systems. However, reform implementation has been slow and has often been hindered by limited financial management capacity and other institutional factors, especially at subnational levels. Many countries in the region present a challenge of PFM interventions that are partially implemented at basic or more advanced levels, leading to apparent contradictions of complex procedures being introduced even when basic aspects of budget preparation, approval or timely execution are not fully in place. Often, lack of coordination between PFM and other reforms (e.g. decentralization) have also led to inconsistencies.

3. The health financing reforms towards UHC, as initiated in many African countries since the mid-2000s, have revitalized interest in PFM reforms. By putting public funds at the core of the health financing response, the movement towards UHC has transformed PFM into a central issue to be addressed in support of UHC-oriented policies. PFM is no longer perceived as a finance duty only; sector stakeholders are increasingly recognizing the importance of sector engagement in the PFM reform agenda when countries want to make PFM and health financing reforms more consistent and responsive to each other.

4. Health has been in the vanguard of PFM reform efforts in several countries of the region, and the health sector has the opportunity to capitalize on its advances. Several policy interventions have been introduced with success but have not been systematically followed through. For instance, the health sector has often been a lead sector for piloting programme budgets, sectoral multi-year expenditure frameworks or performance-based monitoring frameworks in the region, but the transition is incomplete and has not always translated into changes in key areas for health financing.. Results-based financing, as an approach to finance and pay service providers – mostly for primary care – has also paved the way to more performance orientation in expenditure but has often not been fully institutionalized in most targeted countries.

5. This report takes stock of PFM progress and challenges in the health sector across countries of the African Region and proposes a framework for health ministries' engagement in the PFM reform agenda, focusing on the expenditure side of public finances. While general PFM reforms have been led by finance authorities over the past two decades with generally limited involvement of health sector stakeholders, health has a significant role to play in making sure that PFM reforms are effective for responding to sector needs.
There are three distinct – non-exclusive – areas of future engagement for health stakeholders in PFM proposed here, namely: 1) strengthened interest in and monitoring of generic PFM reforms to improve predictability and stability in the financing of health; 2) active implementation of PFM reforms that directly affect the health sector (e.g. definition of relevant budgetary programmes for health, procurement rules, accounting); and 3) design and implementation of health-specific PFM interventions, including with/for subnational levels of government (e.g. contracting and payment arrangements for facilities, financial management and autonomy of frontline providers).

6. Building on country experiences and lessons learned, it is becoming increasingly clear that the health sector can “leapfrog” to accelerate implementation of PFM reform in the region. Priority interventions could consist of: moving towards budgetary programmes that pool public resources according to key sector priority goals; increasing the spending flexibility of the sector’s fund managers; developing a framework to provide financial autonomy to frontline providers; strengthening performance monitoring frameworks for sector accountability; and using performance information to support future budget decisions for the sector. Giving priority together with improved financial management systems to these reforms in health will also be likely to help reduce PFM distortions and the development of parallel systems as development partners push to limit fiduciary risks for their investments.

7. Local-level obstacles to PFM reform must also be urgently addressed to ensure that public resources are delivered promptly to the health facilities that will use them and also better match payment to priority services with appropriate financial incentives. This means developing an equitable and easy-to-understand formula for allocating resources, devising a system of financial transfers that supports poorer areas and priority needs, and ensuring that grants are always paid on time and in full. Health facilities in turn will need improved capacity for financial management, while the ministries of health, finance and local counterparts must share data and guidance in order to facilitate monitoring of expenditure. In many places the health sector uses mobile communications and digital technology to support health services. The report encourages countries to explore ways to use these platforms to speed up financial transfers, reporting and accountability.

8. Engaging more effectively in implementation of PFM reform requires an institutional and cultural shift in health ministries. These transitions are more significant than a series of mechanical shifts. PFM change is about people and behaviours. While most PFM reforms have been dominated by the introduction of new procedures, tools and frameworks, more attention needs to be put on people’s skills, responsibilities, accountabilities, motivation and rewards. Transition from traditional planning by inputs to programming and being accountable for health outputs as well as responsible for basic financial management requires long-term upgrading of health ministry’s staff, in which governments, as well as development partners, should invest more.

9. The report urges a “renewed contract” between health and finance to make sure that the ministries have a better understanding both of each other and of reform needs. The report offers common ground for dialogue and for defining a roadmap for collaboration. Building on a “problem-driven approach” to health budgeting and spending reforms is expected to be more effective and to win sustained political support.

10. WHO works side by side with countries of the African Region to ensure that health ministries are equipped to accelerate the implementation of PFM reforms in order to support UHC.
ACKNOWLEDGMENTS

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A government’s budget is among the clearest signals of a country’s high-level priorities. As such, it is much more than a simple accounting tool. Rather, it can be seen as a policy roadmap. Public budgets set out a government’s intentions for raising and using public resources to achieve national policy priorities. The budget process defines the allocation of resources, generally with an explicit aim to optimize effectiveness and efficiency in spending [1]. A sector budget declares a nation’s commitment to implementing its stated policies.

In health, public finance matters more than in any other sector. Public funds are essential to ensure protection against financial hardship that may result from use of health services [2][3]. No country has made significant progress towards universal health coverage (UHC) without relying on a dominant share of public funds for financing health. Public financial management (PFM) – the set of rules that govern allocation, use and reporting of public funds – is increasingly being recognized as a central pillar for health and universal health coverage [4]–[6]. PFM systems provide the sector with a domestic, integrated platform for managing public resources and ensuring that health spending is handled effectively and transparently. If resources are not appropriately targeted and disbursed in a timely manner, PFM may be “health-disruptive”, posing fundamental challenges for the delivery of health services and for the overall response to health needs.

In 2012, the African Ministers of Finance and Health endorsed the Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector [7], which recognizes that wider and more equitable coverage of health services can be achieved through a more effective and efficient use of both existing and additional public resources for health. A key component of ensuring more effective and efficient use of public resources for the health sector is a country’s PFM system. Among the key recommendations of the Tunis Declaration of specific relevance to PFM systems are the following:

1. Intensify dialogue and collaboration between our respective ministries and with technical and financial partners.
2. Take concrete measures in our respective countries in order to enhance value for money, sustainability and accountability in the health sector for reaching the objective of universal health coverage.
3. Solidify sustainable health financing systems that build on and coordinate the diversity of sources of finance including institutional health financing and better coordination and predictability of external resources to ensure that all have access to good quality essential health services;
4. Strengthen accountability mechanisms that align all relevant partners, build on the growing citizens’ voice and ensure the highest possible level of results for the money spent;
5. Increase domestic resources for health through enhanced revenue collection and allocation, re-prioritization where relevant and innovative financing, giving priority to immunizations, non-communicable
diseases, AIDS, Tuberculosis and malaria, as well as reproductive, maternal and child health in national budgets.

The quality of PFM systems in health is one of the necessary enabling factors for health financing reform implementation. It can help the implementation of health financing reforms in many ways [8]. PFM rules and practices affect health financing in the level and allocation of public funding (budget development), the effectiveness of spending (budget execution) and the flexibility with which public funds can be used (subnational spending and payment arrangements), as well as in the accountability and transparency of spending (accounting and reporting) [4], [5]. For all these reasons, effective implementation of health financing reforms will largely depend on strengthening and tailoring the PFM reforms in the health sector from budget planning, to execution and reporting.

In Africa, empirical evidence suggests that there are bottlenecks at all stages of the budget cycle that affect health sector spending. Health budgeting is often perceived as disconnected from the planning and costing processes, resulting in misaligned budget allocations. Weaknesses in budget-making in health are often related to an unpredictable and unstable level of resources, inappropriate costs estimates, disconnected budget formulation, and fragmentation in funding sources and budgeting processes. Weaknesses in budgeting, combined with delays and leakages in expenditure management, often translate into misspending and/or underspending [9]. While reporting and auditing systems are often in place, they rarely serve accountability for performance.

The continent has embarked on a broad PFM reform agenda since the late 1990s, led by finance authorities but often with limited coordination with sector reforms. In many countries, the package of reforms included standard provisions, with limited connection with country needs and specific PFM-related problems. Specifically, inconsistencies and lack of coordination between the PFM and health financing reform agendas may have sometimes created obstacles to more efficient spending in health [4]. Similarly, reforms are often conceived and implemented from the top level, while in most African settings it is the local levels – whether deconcentrated or devolved to various degrees – that have significant mandate over health spending.

The evidence for what has been designed and effectively implemented in the region and what has worked in health is scarce. Available evidence is related to generic PFM reform implementation [11], [12]. In health, while there has been recent advancement in positioning PFM at the core of the UHC agenda by demonstrating its importance for advancing reforms in the sector [13]–[15], there is barely any evidence as to what works and how to implement the needed PFM reforms.

In the absence of easily accessible and consolidated knowledge for sectoral PFM reform in the region, the aim of this report is to consolidate and distil evidence on key PFM bottlenecks that affect the health sector and to seek a mutual understanding from health and finance authorities on possible policy responses to enable countries to accelerate implementation of PFM reform. In addition to scarce existing literature, the report builds on several country reviews and policy dialogue and technical support activities initiated by WHO in relation to sectoral PFM reforms in the region in
2015-2018. The report also benefits from the ongoing work of several other partners that are engaged in country-level work to better understand “PFM tensions” in the context of health operations or programmes (namely UNAIDS, the Global Fund, USAID, R4D).

This draft has been produced to serve as a basis for discussion at the forthcoming Regional Workshop on Public Financial Management for Sustainable Financing for Health in Africa, organized in Nairobi, Kenya, on 25-28 September 2018. Feedback received at the conference will be incorporated into a later version of the report. In the first section, the report takes stock of core PFM weaknesses in the budgeting, execution and reporting phases of the budget cycle for the health sector. The second section analyses some of the core lessons learned from country reforms to address PFM bottlenecks in the health sector and provides guidance for future engagement between health and finance authorities.
SECTION I. PFM CHALLENGES IN THE HEALTH SECTOR IN AFRICA: WHERE POOR BUDGETING AND EXPENDITURE MANAGEMENT LEAD TO POOR HEALTH RESULTS
Challenges to PFM occur across the budget cycle in Africa – from budget definition and formulation, to budget negotiation and approval, budget execution, and budget accounting, reporting, auditing and evaluation. The sections that follow highlight bottlenecks associated with each stage of the budget cycle in African countries, emphasizing weaknesses in the health sector’s public expenditure.
Budget formulation is the backbone of well-defined and efficient spending; each step of the budget cycle relies on the success of this step. Poorly formulated budgets create a vicious cycle, undermining downstream efforts. Consequently, challenges that arise during budget negotiation, execution and auditing are often linked to those that arise in the earliest stages of budget preparation. Low-quality budget proposals in health often result from poor or inappropriate costing, inappropriate structure and poor targeting on priority needs [5].

Failure to translate health-sector priorities into aligned budget allocations significantly undermines efforts to achieve sector goals. Because planning and budgeting are often delinked processes in countries, allocations are often unconnected with priorities both in their level of funding and in their scope or focus. While the level of funding matters for results, the strategic allocation and how the money flows to the health system [4], [16] even more crucial for achieving results. While Annual Operations Plans (AOPs) have been introduced in several African countries to create a more explicit linkage between the planning and budgeting processes for the health sector, the reform has not always brought full benefits for better health budget planning [17], [18] (Box 1).

One cause of poor budget credibility in health is unrealistic revenue projections. Credible budgets occur when linkages are maintained across the budget cycle, with each component of the cycle aligned with the next. For instance, when resources that are indicated in the budget fail to materialize, progress towards health-sector goals are severely undermined since facilities may have to interrupt services while they wait for public funds to finance drug supplies. This has life-threatening consequences and can also affect the confidence that stakeholders have in the overall health system. In the Democratic Republic of the Congo, revenue forecasts have consistently been raised under political pressure, leading to finance laws that are unrealistic. Between 2011 and 2015, the realized budget rate of revenues was 63%, with a downward year-to-year trend [19], directly affecting the health budget materialization.
In several African countries, mid-term expenditure frameworks (MTEFs), which were introduced to control fiscal sustainability and improve resource predictability, have not always lived up to their promise for health. The usefulness of an MTEF is the extent to which it is used as a guide for preparing future annual budgets, providing a realistic indication of future revenues and how revenues will be allocated.
to the sector in, usually, the coming 23 years [20]. Recognized failures include poor quality revenue forecasts, widespread incrementalism within the MTEF (and a corresponding lack of strategic reprioritization), limited political enforcement (i.e. failure to use the Year 2 figures from the previous year’s MTEF as a basis for the following year’s budget), and limited engagement of sectors, including health, in integrating sector plans. In Cameroon, for example, the MTEF was not sufficiently considered during budget negotiations; the variance between the amount projected in the MTEF and the eventual budget allocation moved from 2.7% positive in 2010 to 34.9% negative in 2013 [21],[22],[23].

Instability in the priority given to health affects the quality of budgeting in the sector. While health is undoubtedly a priority sector in most African countries, this is not consistently reflected in annual budgets. The share of health varies significantly from year to year in African countries and, as a result, affects the predictability and stability in the resource envelope for the sector (Figure 2).

**Poor budget credibility is also the result of poor costing.** Health ministries often face challenges in estimating sectoral needs and costs. Underestimates or overestimates relate to poor information quality and/or inappropriate costing techniques. A frequent disconnect between what is costed (i.e. the national health plan) and what is needed for budgeting purposes lead to inconsistencies and frequent misunderstandings between the finance and health authorities. While estimates can be improved by using reliable data and improved costing [4], health sectors are typically characterized by a number of features that pose persistent challenges

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**Figure 2: Variation in budget prioritization towards health in African countries between 2000 and 2014, % of overall budget**

- [Source: Global Health Expenditure Database, WHO (pre-2017 update).]
to PFM (Box 2). Thus, even high-quality estimates may fail to predict actual needs. In Cameroon, for instance, the absence of credible and up-to-date information on the state of needs and targets generates a number of approximations in the preparation of the health budget [21].

Government budgets are typically planned and allocated according to institutional boundaries (e.g. ministries, departments, agencies) and often involve weak coordination and information-sharing between institutions. To be effective, a strategic health response involves multiple stakeholders in order to ensure that needs – from access to water, sanitation and hygiene, to quality curative and preventive services, as well as social protection interventions – are effectively addressed. Even within the health sector itself, the complexity and variety of actors in many countries in the region create challenges for ministries of health in developing realistic sector plans and budgets. For instance, in Ghana, while the Ministry of Health leads health sector policy, it has a number of subordinate agencies with varying degrees of autonomy doing planning and financial management. These include the Ghana Health Service (GHS) which is the main delivery body for health services, and the National Health Insurance Authority (NHIA) which manages the insurance scheme that finances, through payment of claims, most the non-staff running costs of health facilities. The health sector is also supported by the Christian Health Association of Ghana (CHAG) which runs more than 150 health facilities in concert with Ministry of Health. In addition to operational decentralization of services through GHS and CHAG, the governance systems of the health sector are also decentralized through 10 regional health directorates. A deepening of this decentralization is planned with further responsibilities being devolved to the district level, and it is expected that District Assemblies will be responsible for construction, equipment and maintenance of primary health care facilities.

These technical challenges are exacerbated when there is limited communication between the Ministry of Finance and the Ministry of Health. The processes for developing the top-down spending ceilings and the bottom-up budget needed to implement health sector plans often happen in parallel, with the central budget authorities focused on ensuring fund availability and the line ministries focused on policy needs. For example, in Mozambique, the General State Budget is developed at the same time as the national Economic and Social Plan, which establishes the national workplan for the year [24]. Budget timetables, which seek to align these parallel workplans, are often prone to slippage [25]. In Senegal, delays in providing indicative and final budget envelopes to the Ministry of Health have disrupted internal budget decisions and undermine internal arbitration on the use of resources. This has been cited as a leading cause of inconsistencies in allocation decisions [26]. With little coordination and communication between the workplan and the budget, it is difficult to link the priority programme areas or activities to expenditure commitments [4], [27]. Such fragmentation weakens ownership of the budget process among the line ministries and often leads to budgets that are formed via a process of incremental adjustments to prior annual budgets [4].

Budget misalignments are frequently attributed to a weak budget structure. Health budgets have traditionally been organized as input-based line-item budgets
A number of factors distinguish the health sector from other spending ministries, namely: asymmetry of information between providers and patients; uncertainty around diagnosis and treatment success; potentially unlimited demand; the combination of skilled professionals, medical equipment and technology, pharmaceuticals and changing procedures; the potential impact on livelihoods; and the unpredictable and sometimes epidemic nature of disease. All these elements are intrinsic to the health sector but are rarely found elsewhere.

While each national health system is unique, these characteristics increase the complexity of planning and budgeting in the health sector relative to other spending ministries, and contribute to some of the typical features of health systems in African countries that pose challenges for financial management:

**The way the health sector is funded** is typically marked by complex funding flows and reporting arrangements that make it difficult to obtain a complete view of sector resources (public and non-public) to inform priority-setting and budgeting. For instance:
- **Domestic financing** can come from a variety of sources and channels, such as direct funding from the central and/or local government; some form of pooled arrangements such as insurance schemes (compulsory or voluntary, with or without subsidies); or individual out-of-pocket expenditures. Each type of funding arrangement requires different PFM approaches.
- **External financing** may be significant – perhaps creating the misleading impression at finance ministries that the health sector is well funded – and may have segregated PFM arrangements. In addition to traditional multisectoral donors such as bilateral aid agencies, the major funds supporting the health sector vertical programmes, while bringing substantial benefits, may pose significant challenges to integrated financial planning and management (e.g. the Global Fund, Gavi and the US government’s PMI and PEPFAR programmes). In addition, large private foundations such as the Bill & Melinda Gates Foundation and the Clinton Health Access Initiative provide focused support to the health sector in Africa.
- **Donated goods and assets** are common in the health sector in Africa, particularly with regard to pharmaceuticals, commodities and medical equipment. The acquisition of these goods and assets largely or bypass the mainstream PFM systems, creating complications for planning, recording, monitoring and management of such items.

**The ways in which health services are structured and managed** may vary significantly between countries, and will have a significant impact on PFM requirements and arrangements. For instance:
- **The system of government** in a country is likely to influence the role of the health ministry and the arrangements for delivery of publicly-funded health services. In a decentralized setting, local and central government bodies have separate responsibilities for the various elements of health services and may have different PFM arrangements.
- **Mixture of providers of health services**, normally in a combination of public, private and not-for-profit organizations, makes it difficult to build an overall picture of resources and public-sector priorities. As a result of information asymmetry, providers may make decisions in their own financial interest and drive up costs (the “agency problem”). PFM systems need to provide protection from this risk.
- **The three main levels of care** – primary, secondary and tertiary – each require very different levels of resources and management and, particularly at the higher end, require specialist PFM staff and support.
- **Management of dispersed and remote facilities** in countries with dispersed rural populations raises specific challenges for the delivery, management and oversight of resources, as in the education sector.

**The nature of health-sector inputs and outputs** create some special challenges for PFM. For instance:
- **Human resources** are the dominant input for the health sector, and a government’s payroll arrangements are a critical PFM system for the sector. Staff often work in remote facilities with difficulty in accessing funds and training. Additionally, there are challenges not only in ensuring that staff are at work and are providing quality services but also with managing and recording the transfer of staff and their costs between facilities.
- **Medicines and medical equipment** are a unique feature of the health sector and pose PFM-related challenges in areas such as assessment of requirements, procurement, distribution, inventory management and equipment maintenance. Also, medicines may be provided to facilities in kind rather than as cash budgets.
- **Building construction and maintenance**, with procurement and oversight of construction at remote facilities, create challenges with regard to the technical requirements of some elements of health facility building and the need for open public access, often 24 hours a day.
- **Outputs and outcomes** in health are more complex to measure than in most other sectors, making the introduction of effective programme-based budgeting more complex to achieve successfully – and highly dependent on Health Management Information Systems (HMIS) and other health data systems.
in the region – i.e. they have been based on the inputs needed to deliver health services at facilities, such as human resources or pharmaceuticals [28]. For example, in Chad and Liberia, the budget is formulated using a sole economic classification; and under each chapter, detailed inputs such as fuel for ambulances or stationery for facilities serve for appropriations and spending [29]. Inflexible input-based budgets have major recognized limitations in general and for the health sector in particular. While such budgeting approaches may help to ensure a basic level of control and may prevent misappropriation of funds where there is weak financial accountability, it is generally accepted that budgets that are formulated, appropriated and controlled by inputs alone create rigidities and constrain effective matching of budget to sector priorities, in turn leading to waste of resources [8]. Poor budget structure may also mask inequitable distribution of resources if there is no visibility of allocations to districts or facilities. While presented by inputs, the Ministry of Health budget in the Democratic Republic of the Congo, for example, actually masks a biased distribution of public resources towards hospitals (87% of discretionary expenditure) and urban areas (per capita 546 LCU in the lowest province, compared to per capita 2431 LCU in the capital city province in 2013) [30].

Criticism of input-based budgets stems from both a failure to link inputs to specific health outputs and a lack of flexibility. While input-based line-item budgets are relatively simple to develop, cost and monitor, their use in the region is focused on top-down micro-management of resources rather than on achieving value for money and obtaining health sector results. Input-based budgets make it difficult – particularly in the health sector – to ensure that key activities are properly funded to accomplish stated objectives and are flexible and responsive enough to changing health needs. Input-based budgets often perpetuate historical allocations and are associated with rules that provide little flexibility to move resources between expenditure categories once budgets are approved – thus undermining operational accountability for the efficient management of resources [31].

Issues can also arise between levels when central and peripheral governments employ different budget structures for health. This is particularly the case where performance budgeting has been introduced for central government but the capacity is not yet in place for this approach at the local level. This is the case in Kenya, where performance budgeting has been adopted at the central level but input-based budgeting is still the norm in the counties. This challenge can be difficult to overcome, as is illustrated by the experience of South Africa. While South Africa is widely considered a case of effective implementation of programme budgeting [32], provincial governments continue to largely rely on input-based budgeting nearly 20 years after the central government first introduced programme budgets [33], thus posing challenges for budget planning, as well as for consolidation of financial information and overall accountability for the sector.

The final stage of budget preparation – the negotiation phase – is an inherently political process that is often not mastered by health authorities in the region [34], [35]. While health is often recognized as a top priority by governments, health ministries often struggle to make the case and to translate commitments into voted allocations. This probably reflects a number of factors, including poor preparation, as was
# Figure 3: Example of an input-based budget, Namibia: FY 17-18

## Vote 13 Health and Social Services

### Vote Past and Planned Expenditures by Major Category

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<td>331,490,000</td>
<td>364,092,000</td>
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<td>55,174,000</td>
<td>88,814,000</td>
<td>5,949,000</td>
<td>30,252,000</td>
<td>31,159,000</td>
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<td>026 Property Rental and Related Charges</td>
<td>14,541,000</td>
<td>19,606,000</td>
<td>25,347,000</td>
<td>26,108,000</td>
<td>26,891,000</td>
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<td>027 Training Courses, Symposiums and Workshops</td>
<td>64,773,000</td>
<td>35,000,000</td>
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<td>028 Printing and Advertisements</td>
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<td>25,849,000</td>
<td>14,439,000</td>
<td>14,872,000</td>
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<td>029 Security Contracts</td>
<td>43,321,000</td>
<td>56,144,000</td>
<td>54,581,000</td>
<td>56,218,000</td>
<td>57,905,000</td>
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<tr>
<td>029-3 Entertainment- Politicians</td>
<td>44,000</td>
<td>41,000</td>
<td>41,000</td>
<td>43,000</td>
<td>45,000</td>
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<tr>
<td>029-5 Office Refreshment</td>
<td>7,093,000</td>
<td>13,750,000</td>
<td>2,120,000</td>
<td>2,184,000</td>
<td>2,249,000</td>
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<tr>
<td>029-6 Office Entertainment/Corporate Gifts</td>
<td>40,000</td>
<td>340,000</td>
<td>10,000</td>
<td>10,000</td>
<td>10,000</td>
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<tr>
<td>029-7 Others</td>
<td>587,641,000</td>
<td>700,060,000</td>
<td>706,376,000</td>
<td>727,362,000</td>
<td>749,392,000</td>
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<td>030 Goods and Services Total</td>
<td>2,571,764,000</td>
<td>3,025,695,000</td>
<td>2,549,391,000</td>
<td>2,576,257,000</td>
<td>2,590,234,000</td>
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<td>040 Subsidies and other current transfers Total</td>
<td>4,070,000</td>
<td>5,093,000</td>
<td>3,044,000</td>
<td>3,135,000</td>
<td>3,229,000</td>
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<tr>
<td>041 Membership Fees And Subscriptions: International</td>
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<td>14,000</td>
<td>14,000</td>
<td>14,000</td>
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<td>042 Membership Fees And Subscriptions: Domestic</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>043 Other Extra Budgetary Bodies</td>
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<td>0</td>
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<td>044-1 Social Grant</td>
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<td>262,887,000</td>
<td>270,774,000</td>
<td>278,897,000</td>
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<td>044-2 Support to N.P.O</td>
<td>394,583,000</td>
<td>233,196,000</td>
<td>3,065,000</td>
<td>2,127,000</td>
<td>2,191,000</td>
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<td>080 Subsidies and other current transfers Total</td>
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<td>272,648,000</td>
<td>269,510,000</td>
<td>277,595,000</td>
<td>285,922,000</td>
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<tr>
<td>110 Acquisition of capital assets Total</td>
<td>70,648,000</td>
<td>208,991,000</td>
<td>85,773,000</td>
<td>88,346,000</td>
<td>90,996,000</td>
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<tr>
<td>120 Operational Budget Total</td>
<td>6,070,139,000</td>
<td>6,596,979,000</td>
<td>6,194,982,000</td>
<td>6,331,272,000</td>
<td>6,457,697,000</td>
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<tr>
<td>200 Development</td>
<td>48,771,000</td>
<td>50,000,000</td>
<td>52,000,000</td>
<td>54,000,000</td>
<td>56,000,000</td>
</tr>
<tr>
<td>210 Acquisition of capital assets Total</td>
<td>48,771,000</td>
<td>50,000,000</td>
<td>52,000,000</td>
<td>54,000,000</td>
<td>56,000,000</td>
</tr>
<tr>
<td>Source: Ministry of finance, Namibia</td>
<td></td>
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</tr>
</tbody>
</table>
found in Kenya for instance [36], but it also results from limited skills for negotiation, such as were identified in Malawi [34]. The perceived high level of donor funding may weaken the position of health ministries to lobby effectively for more domestic resources [37], [38]. Although budgeting is often presented as a purely technical exercise, some elements of the budget cycle – particularly the budget negotiation and approval processes – are deeply political in nature [39], [40], [41]. While budgeting relies on the relatively technocratic exercises required to prepare budget proposals, the final allocation of resources reflects internal power structures and political incentives [32]. This leads to a gap between how the budget process works in theory, including the roles and responsibilities of formal actors and the systems and structures in place to manage informal influence, and how the budget is developed and approved in practice. Power relations, informal behaviours, failure to follow rules, and influence by other actors all have an impact on eventual budget decisions [34], [42], [43].

Even when centralized, the budget negotiation process has been observed to be loose in many settings, with poor implementation of budgeting rules and calendar. In Malawi, for instance, the Budget & Finance Committee and the National Assembly are supposed to review and discuss budget proposals in detail and consult with civil society and other actors, but in practice the Ministry of Finance does not allow them sufficient time to do so. Without time to prepare for a substantive debate about the content of the budget, they are essentially obliged to give approval without sufficient review [34], [41], [44]. The recent formalization of budget conferences in several countries has certainly been a step towards a more systematic dialogue around budget preparation, securing more consistent involvement of health stakeholders [45]. Their implementation varies across African countries, however, with persistent by-passing of health or social sectors and a range of informal practices that typically continue to govern allocation decisions.
While globally more than 50% of total health expenditure is financed by government resources, in Africa the picture is more fragmented. In the African region, public and out-of-pocket are equal, respectively at 34 and 35% of current health expenditure (CHE), while external sources represent a quarter of CHE (Figure 4).

The multiple sources of funds, schemes and funding flows in health pose specific challenges for budgeting [46]. Several assessments have underlined the fragmentation in funding flows as a core feature of health financing in the region, posing challenges to appropriate budgeting. In one study of 12 francophone African countries, researchers identified an average of 23 discrete and generally uncoordinated financing streams per country [47]. Different rules often apply to the separate elements of funding, including inflexibilities through restrictions on the use of specific funding sources (e.g. earmarked funds for certain purposes or commodities); such funding is often reported differently and accounted for in different systems [48]. Where different components of “programmes” are financed from different sources it becomes complicated to ensure that all elements are adequately

**Figure 4: Sources of health expenditure in the African Region and globally, 2015**

Source: Global Health Expenditure Database, WHO, 2017  
Ext-che: health expenditure from external sources % current health expenditure  
OOP-che: out-of-pocket expenditure % current health expenditure  
Dgghe-che: general government expenditure on health from domestic sources % current health expenditure.
resourced or that the revenue streams do in fact materialize as expected (Figure 5).

Even on-budget funds may flow through a number of distinct channels and may be subject to different allocation rules. Most countries in sub-Saharan Africa rely heavily on transfers from the national budget to fund public services directly [49]. From a budgeting perspective, this is the simplest case, as most funds are on budget and can be easily tracked. However, capital expenditure is typically separated from recurrent expenditures and is often managed by a separate ministry (such as the Ministry of Planning), with limited coordination with operational priorities [27]. Salaries for civil servants – who make up the bulk of the health workforce in many African countries – are protected in a separate funding pool and paid according to civil service rules and pay scales which are determined outside of the Ministry of Health. In countries such as Senegal, health facilities have neither the information nor the power to influence staff regulation and spending [26]. Medicines may also be procured and managed centrally, and may be provided in kind to health facilities rather than being purchased from budget transfers or the facility’s own revenues – potentially giving less visibility, tracking ability and flexibility in the allocation of resources.

Another element of complexity is related to the breadth of expenditure in health managed off-budget or by entities outside the Ministry of Health, making it difficult to form a comprehensive view
of the health sector budget. In several African countries, disease programmes are managed by ministries other than health, on the assumption that management close to high-level leadership will secure good use of resources. For instance, in Burkina Faso, the HIV/AIDS programme is managed by the President’s office [50]. Similarly, the health system strengthening programme of the Democratic Republic of the Congo, funded from domestic resources, is attached to the office of the Head of State. The latter has rarely been fully reflected in official budget laws [30]. In several other African countries, some health revenue streams may be off-budget, with others being on-budget, but not on-Treasury, posing challenges to full reconciliation of budget information.

Funding arrangements in decentralized contexts are often a source of budget fragmentation. Subnational authorities may receive income from multiple sources, including “block grants” which they are free to allocate; conditional grants that are ring-fenced (e.g. for health or education); other forms of intergovernmental fiscal transfers (IGFTs), such as equalization grants; project funding or goods in kind from off-budget sources such as NGOs, local businesses or external donors; and also “own source” revenues which they are authorized to collect locally (e.g. property taxes, market stall fees, licence fees). Separate reporting arrangements and incompatible computer systems between different levels of government make it difficult to obtain a comprehensive picture of health sector resources, undermining the drive for equity. The experience also shows that in some cases, such as Ghana, there are transfers from the National Health Insurance Scheme to the Ministry of Health to cover public health programmes, such as immunization campaigns, that are under the purview of the Ministry of Health. The efficient utilization of these funds is critical for the effective implementation of programmes, and for the sustainability and credibility of the National Health Insurance. In the absence of good financial management systems, these transfers can be subject to inadequate transparency and accountability for value for money [51].

As a result of unfinished transition towards decentralization, the division of responsibility between central and subnational authorities for health budget development and decisions is often unclear in most African countries. In a fully devolved system, subnational authorities are free to allocate resources between sectors on the basis of local decisions, and have full control over development of the health budget, while complying with central guidelines and policies on quality and standards of services. Alternatively, in deconcentrated1 settings, central decision-making dominates. In practice, evidence from a study including 18 African countries shows that, even when local governments are effectively assigned the responsibility to deliver health services on paper, in most countries they have little or no control over local health resources [52]. This lack of local government discretion is particularly true for the management of human resources and associated wage expenditures: it remains the norm for central authorities, from Burkina Faso to the Democratic Republic of the Congo and the United Republic of Tanzania, to determine the number and composition of local sectoral staff positions, to determine the wage rates and allowances paid to local staff, and to control local hiring, firing and promotion.

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1 Units administratively part of central government but operating at the local level.
Arrangements for allocating central government funds to the local level vary widely across the region, posing additional challenges to programme resources that are appropriately in the sector. The region includes a variety of situations. For instance: a government’s health budget may be fully under the health ministry and flow through that ministry (e.g. Chad, Malawi); or it may be mainly under the health ministry but with some funds flowing directly from the finance ministry to subnational governments or health facilities (e.g. Gabon, Zambia); or the health budget may be divided between the health ministry and subnational governments, with the subnational share ring-fenced for health (e.g. Democratic Republic of the Congo, United Republic of Tanzania); or it may be split between the health ministry and subnational governments, but at the subnational level it is merged with other sector funding as block grants and is not earmarked for health (e.g. Kenya). Some components of the health budget may be determined separately (e.g. staff budgets may be negotiated primarily between the finance ministry and a central department for civil servants and other government workers). Each type of arrangement presents different challenges to finance ministries and the health sector in securing value for money, and to ministries of health in ensuring the integrated planning and budgeting of health resources. Where some of the health budget is allocated directly to the subnational levels of government, those budgets may be negotiated between the Ministry of Finance and the subnational levels of government without necessarily involving the Ministry of Health. It is probably impractical for all sector ministries to be included in such negotiations, making it essential that the Ministry of Health develops an alternative approach with the Ministry of Finance to ensure that the health sector’s needs are taken into account.

Where subnational governments are free to allocate core resources between sectors there are risks of de-prioritization of the sector. Evidence shows that prioritization for health at subnational level can be lower than at central level. In the Democratic Republic of the Congo, for instance [30], provincial budgets allocated an average of only 4% of all resources to the health sector in 2010-2014. In Kenya by contrast there does not appear to have been a significant drop in the share of health sector funding as a result of the devolution – even though, following the 2010 Constitution, health facility running costs are funded out of multisectoral “block grants” allocated by the counties. The allocation to health from two levels of government was 7.8% of government spending before devolution and 7.7% in 2015-2016 [53].

While some countries of the region are moving to large purchasing agencies, they are not exempt from budgeting issues. While national health insurance schemes are less common in Africa than elsewhere in the world, Algeria, Gabon, Ghana, Kenya, Rwanda and the United Republic of Tanzania have mandatory insurance schemes at various stages of implementation [49]. Gabon’s Caisse Nationale d’Assurance Maladie et de Garantie Sociale (CNAMGS) is one example of an umbrella fund, with separate funds for different population groups. In both Gabon and Ghana, purchasing entities have been funded by a combination of earmarked funds, directly managed by finance and general revenues (budget transfers from health and other ministries). Despite the steps taken towards integration, the revenues have not been pooled under Gabon’s CNAMGS, posing challenges in terms of sustainability for the low-income, non-contributory scheme. While separate arrangements offer some flexibility in resource use [54], they may pose
challenges for predictability in revenues and for the management of existing funds in the sector [55], [56]. In some cases, purchasing entities may also have an adverse impact on transparency in the budgeting process and may undermine accountability structures [36], as demonstrated by Kenya’s experience with fraud in the NHIF [57].

In addition to the centralized sources of funding indicated above, many African countries authorize hospitals and lower-level health facilities to charge patients directly under varying regulations on fee collection and utilization. These fees comprise a separate funding channel – though in general marginal [58] in terms of sectoral funding – with its own rules and implications for public financial management. The arrangements for budgeting and reporting user fee revenues are often weaker than for other sources of funding, and user fees are often poorly managed, off-budget and underreported. Countries have differing rules concerning retention of user fees (e.g. whether funds must be transferred to the Treasury) and use (e.g. whether funds can be used to purchase medicines or incentivize staff). In Kenya, following devolution, regional hospitals initially had to deposit all revenues and user fees with county treasuries and were not receiving the funds back on a timely basis.

In francophone African countries, the legacy from the Bamako Initiative has meant that user fees have formed a significant part of discretionary budget for primary health care facilities that has not always been fully and promptly compensated with public funds after their removal [59]. Beyond weaknesses in financial management noted in most settings, user fees have also had significant – though generally unquantified – impacts on equity, access to health care and financial protection [60] for non-exempted populations [61], [62].

Fragmented budgets sometimes result from a high dependency on off-budget external aid. The relatively heavy dependence of the health sector on external income means that the sector suffers more greatly from fragmentation than other sectors as the result of off-budget arrangements. Between 2000 and 2014, external aid increased from 13% to 24% of total health expenditure in Africa [9]. For example, in Zambia, for the four years to 2009, off-budget funding accounted for an average of 32% of official development assistance (ODA) to the health sector; for the four years to 2014, following a major fraud in 2009, the average was 80% [63]. Another analysis in Uganda found more than 75% of donor funds were spent on HIV/AIDS, malaria and tuberculosis while the government’s priority package of basic health services and supporting systems remained underfunded [4], [64]. In the case of Kenya, external donors fund 35% of health care in the country, and 60% of that funding is off-budget and targeted at specific interventions [65]. Major vertical programmes may give the impression that the health sector is well financed but such programmes generally require their funds to be kept separately; they require separate budgeting and planning processes, making it more difficult to develop integrated plans to improve the full range of basic health services.

As a result of the rigidities which come from earmarking of donor funds, health has been considered a distorting sector from a PFM perspective in several African countries. The health sector is known to have generated the development of parallel PFM systems in many African countries in order to secure investments and limit fiduciary risks for development partners. Earmarked allocations and parallel budgeting cycles, pooling procurement, reporting arrangements
and the use of fiscal agents have become a strong attribute of the sector, as the donor community has become increasingly cautious about budget support—partly due to continuing PFM weaknesses [66], [67]. While several countries, such as Senegal and Sierra Leone, are working with development partners to integrate the financial management activities of health donor programmes into the routine systems, full integration has been slow in all countries. While Sierra Leone’s separate project administrative units continue to manage donor funds, Senegal’s Department of Administration and Equipment (DAGE) manages funds using each donor’s funding flow arrangements [66].

**External funding provided as goods in kind or donated assets create specific challenges to the budgeting and management of health resources.** Medicines may be provided in kind by the large externally-funded vertical programmes. Not only are medicines provided in this way more difficult to factor into comprehensive health sector budgets, but there may be associated costs that are not budgeted. For instance, in the United Republic of Tanzania, service charges due to the Medical Stores Department for the costs of clearance, storage and distribution of medicines provided free of charge by vertical programmes were neither budgeted nor paid by the government, leading to a substantial debt that at one stage threatened the financial viability of the department [68]. In addition to goods in kind, many health facilities in Africa rely heavily on donated medical equipment which typically comes with significant installation, operating and maintenance costs that may not be adequately covered by the donor. Donated assets may include buildings as well as medical equipment (e.g. in the Mongu district of Zambia a maternity wing at Mabumbu Community Rural Clinic was financed and constructed in 2016 by Dalbit Petroleum, a local employer). Poor reporting of the existence and condition of donated assets can result in inadequate budget provision for maintenance, or inequitable allocation of capital funds.

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2. Through the Integrated Health Project Administration Unit (IHPAU) in Sierra Leone’s Ministry of Health and Sanitation, and through the Department of Administration and Equipment (DAGE) in Senegal’s Ministry of Health [66]

3. WHO estimates that the purchase costs of medical equipment only represent about 20% of the total costs incurred during the life of the equipment. [69]
Budget execution is often the weakest component of the budget cycle. A review of PFM assessments in 31 African countries finds that Public Expenditure and Financial Accountability (PEFA) scores are higher upstream in the budget cycle (i.e. budget formulation) than they are downstream in the cycle (i.e. budget execution and reporting) [12]. Budget execution refers to the release and use of funds and generally includes a series of steps, including the commitment of funds, verification of activities, authorization of payments and the actual payment. Budget execution requires the participation of multiple ministries and agencies and, in large and decentralized systems typical of many health sectors, requires significant coordination. Weak cash planning and management results in chronic underspending, the common reliance on extra-budgetary procedures, public procurement problems and weaknesses in strategic purchasing.

Underspending in health is a recurring theme in budget assessments across all areas of Africa. Data from sub-Saharan African countries indicate that 10-30% of budgets allocated for health go unspent [70]. Table 1 shows the budget implementation rate for health and for the overall budget for the Democratic Republic of the Congo for the years 2011-2015. While the low overall

<table>
<thead>
<tr>
<th>Year</th>
<th>Total budget</th>
<th>Health budget</th>
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<tbody>
<tr>
<td>2011</td>
<td>71.7%</td>
<td>73.0%</td>
</tr>
<tr>
<td>2012</td>
<td>72.3%</td>
<td>27.5%</td>
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<tr>
<td>2013</td>
<td>69.2%</td>
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<tr>
<td>2014</td>
<td>62.9%</td>
<td>40.4%</td>
</tr>
<tr>
<td>2015</td>
<td>70.2%</td>
<td>62.0%</td>
</tr>
</tbody>
</table>

Source: Ministry of the Budget, Democratic Republic of the Congo.
implementation rate suggests a need for substantial strengthening, in all but two years the overall absorption of the health budget was significantly lower than that of the overall budget.

While many countries seek to prioritize and protect the social and health sectors when funds are in short supply, nondiscretionary spending that is fixed by law has the first claim on available funding [27]. In practice, nondiscretionary spending, which generally includes government salaries, often comprises a large proportion of overall spending, particularly in countries that rely heavily on a large workforce of civil servants to deliver care. Shortfalls can have a disproportionate impact on non-salary recurrent spending and components of capital projects that can be delayed. For instance, in a health budget where 70% of recurrent funding is for salaries and 30% is allocated to goods and services, a cut of 10% in the overall recurrent budget will effectively reduce goods and services spending by one-third. Health may sometimes be deprioritized in mid-year revisions. In the Democratic Republic of the Congo, for example, budget lines for the President, the Prime Minister and the two houses of Parliament typically have significantly higher implementation rates than do other budget lines. For the years 2013-2015, the implementation rates for the Prime Minister’s budget were 244% (2013), 207% (2014) and 177% (2015), compared to 72%, 40% and 62% for the Ministry of Health [19]. In recent years, Senegal has also seen significant mid-year reallocation in accordance with the Finance Amendment Act. Changes resulting from the Act are generally not made in consultation with the departments concerned, thus undermining the implementation of annual workplans [26].

The use of exceptional procedures has become frequent for sector expenditure in several countries. In the Democratic Republic of the Congo in 2015, less than 25% of non-staff expenditures were spent through the normal channels. While the budget procedure manual allows for emergency expenditures – an exceptional procedure intended to allow exceptional spending that would follow an unpredictable expense such as a natural disaster – the procedure is frequently called upon for general expenditure; emergency expenditures accounted for 77% of non-staff expenditure in 2015, and is one of the country’s commonest sources of budget overrun [19].

Weaknesses in the cash management systems are ubiquitous. Common challenges observed in budget execution in the region are liquidity problems and late, inconsistent or insufficient disbursements of funds [4], [43], [71], [72]. In Kenya, for example, only 67% of allocations reached the district level because of liquidity problems [73]. This is often a result of cash budgeting practices in which the total amount of releases is matched to the revenues raised in the previous month and therefore can result in unexpected shortfalls in line ministry funding. Cash constraints at central government level result in the use of cash budgeting techniques which make the receipt of resources for service delivery less reliable [74]. Cash budgeting typically distorts the prioritization of different components of the health sector budget and leads to unpredictable, irregular and reduced flow of funds, sometimes together with a surge of funding towards the end of the financial year. Cash budgeting – especially where not operated transparently – may also provide opportunities for increased corruption as, for instance, irregular receipts provide greater opportunities to divert funds (Box 3). In
In African countries, funds are often released late or in insufficient amounts, posing serious challenges to the management and delivery of health services. The reliability of budget releases may vary by source of funds.

**Direct government grants:** Cash budgeting practices in many African countries are a major contributor to unpredictable and insufficient government funding for health. Cash budgeting is where the total amount of releases is matched to the actual revenues raised in the previous month. Use of the practice is typically a sign of weak forecasting, with shortfalls results from ambitious allocations supported by unrealistic revenue budgets. A review of 27 Public Expenditure Tracking Surveys (PETS) [74] found that certain widespread PFM dysfunctions – particularly the ineffectiveness of resource flows between levels of government – resulted from cash budgeting and cash-rationing practices operating upstream in the budget cycle.

**Health insurance systems:** Similar concerns exist where funds are routed through health insurance schemes. Where such schemes include government funding as part of their revenue in addition to contributions from members, the government funding can also be either late or incomplete. In addition to delays in the flow of funds from the Ministry of Finance to the scheme, even if from an earmarked source of revenue such as in Ghana or Gabon [56], [76]–[78], there are often further delays in the funds reaching the facilities. This is in part because of the bureaucratic process of submitting, reviewing and approving large numbers of claims from multiple facilities, but delays may be exacerbated by fraudulent or erroneous claims which require careful review.

**User fees:** While user fee budgeting arrangements are often weak, where user fees exist they may be the most reliable and consistent source of funds for operating costs at local health facilities. Policy changes to eliminate user fees must be accompanied by realistic measures to ensure alternative sources of stable cash flow to local health facilities.

**Donor funding:** Donor funding may appear to be more certain than government funding in the short to medium term. However, even routine grant requirements may cause delays in release of funds. For instance, the Global Fund found in a review of 27 grants across 24 countries in its global portfolio that submission of its standard routine reports – Progress Updates – took an average of 129 days compared with the expected 75 days [79]. Weak PFM typically disrupts the flow of donor funds not only because of delays in preparing financial reports and audits and protracted feedback from donors but also because of other weaknesses in grant implementation, or more stringent grant conditions and monitoring.

Ghana, where the NHIS’s claim payments pay for over 80% of health facilities’ operational expenses, underfunding of the NHIS budget leads to lengthy delays in receipt of funds by facilities – in 2016 payments to facilities had delays of 8-10 months [75].

**Other challenges result from issues upstream in the budget rules and structure.** Over-budgeting is a common practice in several countries. It is a practice used to accommodate the demands as of many stakeholders, including sector development partners, as possible. In addition, technical challenges arise in many African contexts,
when budget formulation and associated rules for spending prevent reallocation between budget lines and constrain execution. Input-based line-item budgets, in particular, are often relatively rigid and are based on historical allocations. Budget rules preclude the shifting of expenditures to respond to service needs over the course of the year [4]. In the Democratic Republic of the Congo, for example, budget lines are binding and made without consultation with the sectoral ministries.

**Underspending against health budgets is a common problem in many African countries.** The available data indicate that the proportion of unspent health budget ranges from 10% to 30% of authorized allocations in African countries, with some outliers (such as the Democratic Republic of the Congo) coming close to 60% unspent [9]. These underspends may be caused in part by the upstream problems noted earlier – including unpredictable allocations, mismatch between policy and budget allocations and inappropriate budget structures. Underspends may also be caused by underperforming budget execution systems, partly relating to the nature of the sector. Figure 6 highlights some of the causes of underspending against budgets; those particularly relevant to health sector are highlighted in dark blue.

**Complex delivery chains for funds may also impede budget execution.** The more complex the delivery chain for funds is – i.e. the more intermediaries and steps involved – the greater the risk of delayed receipt of funds due to additional administrative processes is. More intermediaries also create more opportunities for funds capture or facilitation fees. Introduction of direct payments by ministries of finance to districts or facilities remove intermediary steps, although they

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**Figure 6: Underspending in health: a multifaceted problem**

- Over-estimate of revenues
- Full disconnect between planning and budgeting
- Lack of formalization of budget preparation process
- Rigid structure of budget
- Delays in operationalizing PFM reforms, in particular transfer of spending responsibility to MoH
- Unrealistic plans with poor data
- Late and misaligned disbursements from treasury
- Mid-year re-allocations across sectors
- Limited capacity of MoH to plan and anticipate spending needs
- Health-related procurement issues, delays
- Extra-budgetary procedures
- Lack of PFM capacity and tools at local level
need to be accompanied by other financial management and reporting reforms, including capacity-building. In Zambia, government funds for the provinces and districts used to be channelled through the Ministry of Health and were recorded as “imprest” (advances), with detailed expenditure being recorded when the retirement reports were received. Since 2015, funds have been sent directly by the Ministry of Finance to provinces and districts. In Uganda, the operational funds for health facilities were channelled through the local government which used to cause delays. Since the financial year 2014-2015, the Ministry of Finance has been implementing “straight through processing” – a measure that sends funds directly to health facilities, thereby making funds available in a timely manner. However, challenges arose in delays or lack of reporting on the accountability for funds received by the Chief Accounting Officer (CAO) for the district. This was often compounded by the fact that information about the release of the funds reached the CAOs late. In the United Republic of Tanzania, operating costs for facilities are channelled through councils, which have contributed to delays in receipt of funds by facilities; since 2017 the government has been piloting direct facility transfers from the health basket fund.

Other challenges with the delivery chains pertain to multiple accounts that are used by the government ministries, departments and agencies (MDAs) and local governments (LGs) to manage public funds. In Uganda, for instance, before the recent PFM reforms, the MDAs and LGs had multiple bank accounts each serving a different purpose. These accounts facilitated misappropriation and underutilization of public funds because of the lack of effective oversight. In addition, health facilities experienced delays in accessing funds for more than seven working days due to poor management of funds [80]. Similar findings are reported in Nigeria [81].

Execution differs by nature of expense, with capital expenditure being more fragile to low implementation. In Senegal, the average execution rate for investment grants for 2012-2015 is 99%, while the rate for the more administratively complex capital expenditures is just 64% [26]. Similar differences are seen in the execution of the United Republic of Tanzania’s development and recurrent budgets for health; in Tanzania, delays in disbursements to regional units are blamed on a failure to produce timely reports that are required for the release of development funds [82]. In the Democratic Republic of the Congo during 2011-2015, the execution rate for staff costs was 94%, while the execution rate for non-staff expenditures was just 32%. In some systems such as Nigeria, subnational politicians may use their discretionary powers to spend on issues that are not identified as priorities at the central level but that are important to local constituents to whom they are accountable [35]. This latter point creates the potential for fraudulent or corrupt use of these discretionary powers, which carries significant implications for budget performance.

What matters from a sector perspective is not only the level of execution and whether each specific input line has been fully spent but to what extent the expenditure was spent to respond to needs and reached frontline services. In certain situations, limited execution of certain lines is not – or should not be – necessarily associated with poor sector performance. It might instead signal the actual shift of resources towards unplanned or emerging priority needs. In addition, in an input-budget setting, the need to plan and authorize spending by detailed inputs may create an artefact that does not
Reflect how money is actually utilized at lower levels of government (e.g. district, facility, implementing agency).

**Practices for purchasing health services are typically not strategic in the health sector in African countries.** Strategic purchasing is an approach that transfers funds to providers (health facilities) based, at least in part, on information about providers’ performance or the health needs of the population they serve [83]. Such an approach requires specific institutional structures and PFM modalities. In the absence of separate purchasing entities in many African countries, the practice – and even sometimes the concept – of “strategic purchasing” is often unfamiliar. Passive mechanisms are often in use in Africa (i.e. providers receive funds by traditional budget transfers without consideration of performance). The core components of a strategic purchasing function are generally

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**Box 4: Root causes of underspending in Cameroon and the Democratic Republic of the Congo**

Underspending is a major issue in several countries. The example of the Democratic Republic of the Congo and Cameroon are helpful for understanding the multiple factors prevailing for under-execution. Analysis of the budget cycle links under-execution to weaknesses at both the ministries in charge of health and the ministries in charge of finance that have impacts at several stages of the budget cycle.

During budget preparation in the Democratic Republic of the Congo, sector workplan and budget documents have been delivered late and are of variable quality. In particular, health authorities have systematically overestimated allocations from external resources. In 2013, for instance, the Ministry of Public Health’s forecasted budget needs for equipment, services and other discretionary expenditure came to 59% of the funds ultimately requested from the Treasury [5]. This is linked to delays in issuing quarterly Budget Commitment Plans by the central budget office. Other concerns, including errors in the preparation and delays in receiving the Minister of Public Health’s approval of the sector plans, point to capacity and organizational problems within the Ministry of Public Health as well as the lack of a formalized budget preparation process and structure [30].

Budget execution is further hampered by the structure of the financial management system. Validation of expenditures remains a highly manual process managed by the Ministry of Budget. Long delays in validation have resulted in expenditures being charged to the next quarter and a loss of quarterly transfer for the Ministry of Public Health. Once validated, the Ministry of Finance processes a purchase order through a similarly manual process, which can take 2–3 months, again resulting in the loss of quarterly transfers for the Ministry of Public Health. Payment is also frequently delayed further by errors in the authorization of payments and bank transfers [30].

In Cameroon, challenges of health budget execution are also numerous and interlinked. Major causes include: widespread ignorance of the rule of budget development; a commitment to traditional management practices; excessive concentration of funds in central services with limited involvement of peripheral levels; weak monitoring and management control mechanisms for expenses; and a continuing preference for infrastructure expenditure to the detriment of those supporting the continuity of health services [21].
not in place. While many African countries have established norms for packages of services to be provided at each level of the health system, there has been less progress in developing these into “benefit packages” that may be purchased by a strategic purchaser such as a local government or a health insurance fund, and limited thinking on how to pay providers for the delivery of these services [84]–[86].

**Fragmented budget systems introduce challenges for strategic purchasing of health services.** A particular challenge arises when salary payments are under the authority of one ministry or are subject to strict civil service laws, while a separate purchasing agency – such as the Ministry of Health or a national health insurer – attempts to introduce payment reforms [83]. Salaries are a large portion of health budgets and are a critical component of an individual health worker’s overall incentive structure. Thus, omitting salaries from payment reforms can greatly diminish their effectiveness. PFM rules can also undermine the incentive structure that strategic purchasing seeks to create. For example, rules that require that any savings must be returned to the central budget, particularly if the savings cannot be reallocated within the year by operational units to other budget lines, eliminate one incentive to provide more effective and efficient care [4].

**Multiple provider payment systems further complicate the situation by limiting the ability to pool resources and, frequently, by instituting a number of conflicting incentives** [83]. Fragmented purchasing

<table>
<thead>
<tr>
<th>Table 2: Multiple provider payment arrangements</th>
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</thead>
<tbody>
<tr>
<td><strong>Overall budget allocation</strong></td>
</tr>
<tr>
<td>Ministry of Health – DAF</td>
</tr>
<tr>
<td>Ministry of Health – Health development programme</td>
</tr>
<tr>
<td>Ministry of the Economy, Finance and Development/Ministry of Territorial Administration and Decentralization/Ministry of Health</td>
</tr>
<tr>
<td>Generic medicines purchasing agency</td>
</tr>
<tr>
<td>National council for the fight against HIV/AIDS and sexually-transmitted infections</td>
</tr>
<tr>
<td>NGO</td>
</tr>
<tr>
<td>Community-health insurance</td>
</tr>
<tr>
<td>Private insurance</td>
</tr>
<tr>
<td>Universal health insurance scheme</td>
</tr>
</tbody>
</table>

*Source: [87]*
Box 5: Burkina Faso: multiple payment arrangements and the passive purchasing of health services

Burkina Faso’s health financing system is characterized by a high level of fragmentation. A 2014 study identified no fewer than 23 separate health financing schemes [47]. This is largely attributed to the large number of free and subsidized policies in place. Subsidies are funded by a variety of sources, including the state budget, international partners, NGOs, private and community insurance funds, and households [87]. The result is a highly fragmented pooling of resources that hinders financial risk-sharing and highlights the complexity of health sector purchasing in Burkina Faso. The state is the main purchaser of health care in the country, channelling just over half (53%) of health expenditures. Funds flow largely via line-item payments based on historical spending, although the government’s ongoing budget reform efforts are expected to result in changes to the purchasing and procurement system. Personnel costs, which cover civil servants’ salaries, are governed by the 2015 Act No. 081-2015/CNT on the General Statute of the State Civil Service. Salaries levels are, therefore, largely determined outside of the Ministry of Health. However, there is scope to incorporate performance top-ups to civil service salaries. Grants and transfers may be delivered as global budgets, while vertical programmes such as the state-subsidized maternal and child health programme are paid via case-based payments. The nascent social health insurer is experimenting with a combination of capitation and case-mix payments in three districts. Community-based health insurance, private insurers and patients rely heavily on fee-for-service, with the organized insurers generally having some controls on overall spending. A review of expenditure flows finds that approximately two thirds of payments to the sector are line-item payments, and one third are case-based payments with results.

While the multiplicity of payment and procurement mechanisms illustrates a trend to experimentation and learning-by-doing that is required for any major reform, care should be taken to prioritize a system that will harmonize and coordinate the multiple different streams. The current purchasing system shows an overall lack of coherence and homogeneity that increases administrative costs while undermining the efficiency goals of the case-mix and performance payments [87].

systems make it difficult to implement a unified set of payment rules, and so may increase the overall administrative burden, particularly on facilities. In Burkina Faso, for instance, multiple provider payment mechanisms are in place, with inconsistent incentives to the delivery of services at different levels of the health system (Box 5).

PFM rules and structures also have an impact on procurement of goods such as essential medicines or other health commodities. Procurement is often managed by a centralized authority, generally the Ministry of Health or a department of a medical store. While centralized procurement systems can leverage greater purchasing power to negotiate multi-year purchasing agreements, they often fail to live up to their potential and can lead to a focus on high-cost tertiary-level medicines at the expense of resources for basic medicines for primary health care. The logistics systems underpinning procurement are often outdated and struggle to obtain and deliver the right quantity, at the right time, to the right place to meet health-service needs.
[88]. In Senegal, for instance, the procurement unit of the Ministry of Health is a two-person team that is responsible for more than 400 contracts [26]. In addition, procurement rules may be outdated or cumbersome, central administrators may lack the skills required to negotiate attractive contracts, and there may be corrupt diversion of funds [89]. Budgeting arrangements may also vary, with some countries providing cash budgets to facilities to procure medicines (typically from a central agency), and others maintaining the budgets centrally and distributing medicines to facilities as goods in kind. Francophone countries in the region that have implemented the Bamako Initiative have long relied on user fees to secure funding for medicines at primary health care level, with limited inputs from public funds until fees were removed for a core part of services and compensated by public transfers (which are sporadic and with delays in most cases) [90], [91].

Transfers of funds to health facilities – getting funds “the last mile” to remote rural facilities – is a common difficulty in the region. Several studies in African countries have found that facilities often receive a very tiny portion of the total health budget (in general less than 10%) [92] and, for several PFM-related issues (e.g. delays in disbursement, blockage at district level) do not even effectively receive or utilize public transfers supposedly intended for them. Facility health workers also often have to make journeys to district capitals to collect salaries and facility funds, or to report expenditure, resulting in absence from the facility and incurrence of costs. The lack of bank accounts – because of weak bank systems or lack of legal authorization) – poses a common challenge in remote areas in several countries [93]. In some countries funds are managed directly by district administrations – as in Zambia, where facility funds are managed by district health offices with only a very small proportion of each facility’s budget being given to it as a cash advance. While this avoids the payment challenge, it is not in line with the principle of empowering frontline staff. In Ghana an “e-zwich” debit card system has been introduced for civil servants' salaries, but there have been challenges due to an insufficiently dense network of service points [94].
Budget reporting is now routine across Africa, but accountability for results remains limited. While budget documents may analyse resources across multiple dimensions, expenditure reporting is generally more limited – typically by line items. Other concerns include the fragmentation of reporting and financial information systems, and the limited reporting of performance information alongside expenditure data. Multiple funding flows cause complex and overlapping reporting relationships and management systems, while weaknesses in the underlying information system for financial management make it very difficult to monitor the use of funds. South Africa offers a case in point. Prior to 2012, the country relied on a number of different information systems, including different financial management systems. The accounting system was cash-based, and payroll and logistics information was kept in standalone systems, none of which could be integrated for data analysis and reporting [4]. This is also a challenge in decentralized settings, with subnational governments frequently not reporting sectoral financial information. For example, in the United Republic of Tanzania, the district health budgets and fiscal transfers are reported under each of the country’s 31 regions as a single figure comingled with other sectors. Underlying district health expenditure is separately recorded for each of the 184 districts but there is no published reporting of sectoral budgets and expenditure by district.

The complexity of the health sector poses challenges for accurate reporting. The health sector is sometimes perceived to have a lack of measurable, immediate results, and this may lead to the feeling that it is ineffective and inefficient [2]. Numerous and fragmented funding sources, each with their own reporting requirements, often introduce duplicate or conflicting requirements. For instance, in South Africa in recent years at least six financial systems were being used simultaneously [95]. In Sierra Leone, the fragmentation and proliferation of financial management rules, manuals, tracking systems and bank accounts has been noted as limiting both transparency and accountability as well as contributing to inefficiencies in the health sector [96]. In Burundi, there are up to 26 parallel entities (including donors and
NGOs) working in the sector with a weak aid/donor coordination mechanism at the Ministry of Health to provide the necessary alignment and accountability [96]. The challenge of maintaining accurate and timely data weakens efforts to ensure accountability.

The expanded use of an Integrated Financial Management System (IFMS) in African countries represents a prominent effort to facilitate programme-based flexible reporting. The IFMS categorizes data according to a number of potentially relevant fields which might, for example, include funding source, programme (or subprogramme), cost centre, activity, item (or sub-item). The example shown in Table 3 was developed in 2005 in the United Republic of Tanzania and is currently being updated. The extensive coding allows reports to be generated on any of the fields. Thus, the development of budgets by administrative unit, input code or programme is no longer an issue of “either/or”. Multiple permutations are now possible and users can extract reports based on one or more of the fields indicated.

While the IFMS improves central government accounting, the complexity of such systems presents challenges, particularly at district and facility levels. Such systems may sometimes be too inflexible in the way they have been implemented to fully meet the needs of central Ministries of Health, and significant financial management activities may take place using Excel spreadsheets which are prone to error and loss. In some countries, such as Ghana and Mozambique, the ministries of health have procured their own accounting systems. At the local level, a large IFMS at central government is not normally suitable for the capacity and accounting requirements of health facilities, and sometimes also not for districts. In Uganda, challenges at the local level following the roll-out of IFMS at district level included network failure, instability of the system (especially at peak times) and poor Internet connectivity which affected implementation and monitoring of activities [80]. In Zambia, health facility budgets are managed directly by district health offices (deconcentrated units of the Ministry of Health), with only very small cash advances being given to facilities for their direct use. The district health offices are not on the government’s central accounting system, and there are no immediate plans to connect them with that system – a step that would require significant resources both for installation and also in terms of ongoing capacity to operate and maintain the system. In view of the need for basic accounting tools to manage funds and to provide assurance to external donors, many of the district health offices are installing an alternative, less complex accounting system with financial support from donors. In the United Republic of Tanzania, where direct facility payments are being piloted, a web-based cash book system

<table>
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<tr>
<th>Table 3: Example of an IFMS coding in Tanzania</th>
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<tbody>
<tr>
<td>Segment 1</td>
</tr>
<tr>
<td>Vote</td>
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<td>XX</td>
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Source: adapted from IFMS, Ministry of Finance, Tanzania
is being developed for facility accounting and reporting.

Unless consolidated around a performance framework for both operational and financial information, health sector financial reports are typically produced in silos, separated from the performance and activity data in systems such as HMIS, and from human resources and medicine stock control systems. Different professional cadres (e.g. health data specialists, human resources officers, pharmacists, economists and accountants) often work in isolation from each other, producing separate and potentially misaligned data and reports. One positive consequence of using provider payment models is to sharpen the focus on operational health data, stimulate improvements in health information systems and bring together financial and non-financial data. In Burundi the government is taking the opportunity of performance-based financing (PBF) to upgrade the health data system, increasing granularity, transparency and versatility.

In many African countries, weaknesses in the internal and external auditing systems further undermine accountability. Auditing systems are designed to supplement routine data by supplying critical information, ensuring the accuracy and completeness of the system of controls. However, health sector internal audit units are frequently underfunded and under-skilled and, in many countries, carry out “pre-audit” of payments which not only consume limited resources but also risk compromising independence. In the United Republic of Tanzania, for instance, the poor performance of the internal audit unit of the Ministry of Health and Social Welfare was blamed for non-release of allocated funds, threatening the functioning and the financial management system of the ministry [97]. Reflecting the fragmented institutional and budget structures of many health sectors, multiple audit reports are produced, making it difficult to identify key weaknesses, monitor follow-up of recommendations across the sector, and design and prioritize reforms. Meanwhile, official external audit reports are frequently produced two or three years after the events to which they relate. Their findings become less helpful with the passage of time and result in poor follow-up of recommendations. Where the structure of financial oversight is weakened in this way, sector goals are again threatened.

While most external audits focus on compliance with procedures and controls, sector performance audits provide a valuable resource if followed through. For example, the National Audit Office in the United Republic of Tanzania conducted a primary health care performance audit [98] to review whether health centres are managed efficiently and whether their performance is appropriately considered when allocating resources. The audit identified key issues and weaknesses and made a series of constructive recommendations but follow-up was poor – perhaps partly because of the difficulty of the Ministry of Health in directing improvements in efficiency in district health services.

Both IFMS and auditing systems have aimed to increase financial transparency but sector accountability remains limited. Budget and expenditure reviews are typically included as background documents to annual health sector reviews. However, expenditure information is often weak and unreliable because, for instance, of the complexity of mapping the sector budget structure to the institutional and budget structures of government, and the delays in providing expenditure data. Health sector public
expenditure reviews contribute to sector accountability but it appears that they are becoming less common. The publication of citizens’ budgets and posting of finance and other resource information (e.g. medicines, staff) on noticeboards at facilities provide more direct forms of accountability to citizens. Sector performance frameworks may help to boost accountability but are typically both high-level and yet complex; they are also complicated by the multiplicity of different performance frameworks used by
donor-funded programmes, such as vertical programmes. Greater transparency may increase public trust in government [6] but transparency may not result in accountability. Recent efforts to introduce performance frameworks in the health sector offer promise to boost accountability for performance [99], irrespective of the structure of the existing budget.
SECTION II. LESSONS FROM AFRICAN COUNTRY POLICY RESPONSES:
LARGE POTENTIAL FOR ACCELERATING PFM REFORM IN THE HEALTH SECTOR
This section of the report builds on observed practices from both finance and health ministries in responding to PFM challenges in the health sector. It clarifies the scope of intervention for health ministries, highlights areas where PFM reform can be further accelerated and institutionalized, and gives guidance on how to revitalize a trust-based contract between health and finance in the context of accelerated and tailored sectoral PFM reforms.
Budget reform is frequently considered to be the exclusive domain of budgeting and planning authorities, but reforms are rarely effective without the active participation of the spending units. PFM reform affects the most fundamental activities of government institutions, from how they define priorities to how they control the budget. The budgeting cycle affects all public activities; no public institution – from the central ministry to a health post on the periphery – is fully shielded from efforts to reform the cycle. The role of the health sector will depend, in large part, on the nature of PFM reform (Table 4).

The Ministry of Health can be classified as an “interested observer” in a number of broad PFM reforms that aim to stabilize and better predict the macro-fiscal environment. While the health sector is not the central focus of general PFM reforms, it can benefit, for instance, from the increased predictability of the resource envelope that stems from improvements to the quality of annual budget projections and the introduction of an MTEF. Health authorities should monitor the advancement of these reforms more carefully. Ministries of health, like other spending ministries, benefit most when they complement these growing strengths by ensuring the quality of the costing and utilization data when developing sectoral budget proposals.

The Ministry of Health should proactively participate in the design of PFM reform that directly affects the health sector. Even if it does not directly manage all of the public resources for the health sector, the Ministry of Health has an overarching responsibility for public health, the delivery of effective health services and the efficient use of health sector resources. The Ministry of Health has a direct role in strengthening and implementing PFM components for the health sector, such as the development of realistic and reliable proposals for the annual health sector budget. With the introduction of budget reform and the transition to programme budgets, the Ministry of Health should play an important role in defining budgetary programmes. In the most effective reform cases, Ministry of Health officers have taken the lead in aligning the programmes’ content with sector priorities and plans. In Burkina Faso,
the Ministry of Health actively mapped the budgetary programmes according to the strategic objectives of the national health plan to ensure that the scope and content reflect core needs [99].

**These transitions are more significant than a series of mechanical shifts:** they imply a shift in the role and function of *Ministry of Health*. When ministries transition from being traditional planners to being programmers, they no longer conceive budgets as a series of inputs; rather, they focus instead on the sector’s priorities. This implies a critical shift in the logic of budget planning. Ministries may also often become direct managers with accountability for how resources are spent and with implications for internal management systems, or they may take a more regulatory, oversight and coordinating role which requires different approaches and skills plus good data. As ministries of health are increasingly being held accountable for results, it is essential that they establish appropriate measurements and design information systems to monitor them, and that financial information is used to inform future decisions on allocations. These shifts must be thought through and should be implemented in coordination with another important shift, namely: when governments transfer responsibility for service delivery to insurance/purchasing funds [100], health ministries must transform from being direct service providers to being regulators.

**Capacity-building is a crucial component of these reforms.** Budget reform may bring about changes to the underlying process of managing a health system’s expenditure. In addition to raising awareness of the changes to execution procedures, ministries of health – in addition to the other levels of the health sector – often require significant capacity-building in terms of their internal budget, accounting and monitoring functions. Sectoral budget officers must be trained to utilize established PFM policies effectively; MTEFs, IFMS and performance results can be leveraged to better target allocations. Skills upgrading can lead to better developed and justified health-sector budgets that align with sector priorities. Increasing the legitimacy of the budget will also strengthen the sector’s position in the highly political negotiation process.

<table>
<thead>
<tr>
<th>Table 4: Three areas for Ministry of Health engagement in PFM reforms</th>
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<tbody>
<tr>
<td><strong>PFM domain</strong></td>
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<tr>
<td>General PFM reforms</td>
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<tr>
<td>PFM reform directly applicable to the health sector</td>
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<tr>
<td>Health-specific PFM interventions</td>
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</table>
Box 6: Results-based financing (RBF) in health: key questions for public financial management

Performance-based financing (PBF) or pay-for-performance (P4P) is a form of incentive whereby health providers are, at least partially, funded on the basis of their performance in meeting targets or undertaking specific actions. This incentive is defined as fee-for-service-conditional-on-quality.

In many low- and middle-income countries PBF programmes are also often referred to as results-based financing (RBF), although RBF is an umbrella term for an instrument that links rewards with performance. RBF goes beyond PBF and includes conditional cash transfers, performance-based contracts and other incentives. In low- and middle-income countries, PBF initiatives are largely, or in many instances exclusively, supported through development aid.

Until recently, discussions on PBF tended to focus on whether it works or not – i.e. its effectiveness in improving utilization of services, quality of care and motivation of health workers. There has been a tendency to look at PBF as an isolated instrument and not in the context of larger health-financing reforms. There is typically very little discussion of the overall purchasing and provider payment systems of the countries where PBF is being implemented. There are no studies of what happens next if PBF is proven to be effective in improving certain indicators (such as skilled birth attendance) and key policy-makers and stakeholders are persuaded that it is a useful way forward. What are steps are necessary in budgetary processes to allow for a shift from rigid input-based budgeting to a form of payment based on results? How can PBF be truly integrated without contributing to fragmentation and becoming another vertical programme? What steps should be taken by donors and the government to reform health financing and PFM in order to allow providers to be paid according to results and not according to inputs?

Source: [101]

The health sector plays – or should play – a leading policy role in a number of PFM interventions that are specific, and sometimes unique, to the health sector. Many PFM reforms should directly target sector specific issues specificities noted above. For instance, interventions should aim to increase the spending autonomy of health facilities or to provide strategic financial incentives to health workers. While both these interventions interact with, and have implications for, the broader set of PFM rules and structures, the Ministry of Health will generally take – or should take – the lead in designing and developing appropriate regulatory frameworks and in dialogue to obtain the buy-in of the finance authorities. Some aspects of the health sector (e.g. the dispersed nature of the sector and its staff and facilities) have much in common with the education sector, and these two sectors can often benefit from working together in developing reforms with the Ministry of Finance.

As part of their health-specific PFM reforms, several countries have introduced flexible financing models that allow more financial autonomy to providers, while providing performance-oriented bonuses to reward service use and/or quality [101]. These experiences are well-known in many
African countries, under the categories of performance- or results-based financing (PBF or RBF). While reviews of experience show mixed results in terms of sector output [102]–[104], these “pilots” have led to a range of innovations in public finance. Revenues provided to health facilities – mostly from external resources – are managed directly by facility managers and disbursed according to a performance logic (i.e. on the basis of a range of predefined sector targets). However, sometimes these initiatives have been designed and developed by the health sector without sufficient collaboration with the finance ministry. Institutionalization of such mechanisms has often encountered PFM difficulties, and the passage from a “pilot” to a domestically-rooted response is often challenging (Box 5). In Burundi and Rwanda, however, specific budget lines have been incorporated into domestic budget laws and attest to the country’s willingness to provide more flexibility in the use of health-related resources. In the United Republic of Tanzania, a results-based financing pilot was initiated in 2015 in the Shinyanga, Mwanza, Pwani, Simiyu and Tabora regions. This was the first effort to provide financing to facilities directly. Further, the RBF introduced flexibility in the use of funds, including bonus payments to civil servants. Rather than following the annual budget cycle, RBF funds are guided by quarterly business plans. An effort was made to integrate these funds into the budget and a dedicated budget line was introduced to capture these flows under the development budget starting in 2017, although not at the same level of granularity as there is for other activities in the government budget [105].
In the context of health financing reforms, budget formulation reforms are crucial for the health sector. A programme structure has the potential to help clarify the logical framework that connects inputs and activities to outputs and wider policy goals. While it is theoretically possible to provide allocations to ministries and make them accountable for results without the programme structure, the classification by objectives serves to promote policy-based allocation decisions. It is expected to align government activities more closely with sector policy priorities and thereby contribute to better sector performance [16]. Ultimately, new budgeting models aim to enable future funding to be better linked to anticipated needs while also reflecting actual past performance. While the potential for reform is clear in terms of improvements in fiscal management and accountability, the introduction of programmatic classifications can help the health sector by 1) building stronger linkages between budget allocations and sector priorities, 2) enabling the implementation of strategic purchasing by offering more choices in provider payment arrangements, and 3) incentivizing accountability for sector performance [8].

Because of sector relevance, institutionalization of budget reforms in health should be prioritized by African governments. The development of health financing reforms in the context of efforts to achieve UHC has led in many African countries to renewed interest in accelerated budgeting reforms in the sector and has highlighted the urgent need to address bottlenecks in budgeting and expenditure management to ensure speedy reforms [4], [8], [30], [83]. While input-based budgeting remains in use globally to formulate health budgets, it is more common in Africa than in other regions (Figure 8). Only around 40% of African countries have institutionalized a form of programmatic classification to present their overall budgets and health budgets. The transition should be continued.

A change in budget formulation is an opportunity to boost performance monitoring against achievement of specific targets. Programme budgets are often accompanied by performance targets with specified time frames. Aligning the budget with programmatic or performance-based criteria introduces a fundamental
change in the budget’s accountability structures and facilitates more systematic monitoring and evaluation of performance. Figure 8 illustrates recent changes to the budget lines used in Kenya following budget reform. While traditional budgets focus on ensuring that appropriations are targeted to the approved line items, well-aligned output budgets emphasize accountability for sector results [32]. The revised budget structure published by Kenya emphasizes programmatic goals and increases flexibility in allocation decisions within the programme category. The flexibility of IFMIS allows for users within government to continue to analyse data by economic classification/line item, which may still be necessary in order to support ex-post analysis and to secure initial forms of accountability that may remain, while accounting expenditure in line with the predefined targets [107].

Figure 7: Change in the formulation of health budgets, Kenya

<table>
<thead>
<tr>
<th>INPUT-BASED BUDGET</th>
<th>2012/13 Budget Excerpt</th>
</tr>
</thead>
<tbody>
<tr>
<td>National AIDS Control Programme Headquaters</td>
<td>2012/13 Estimate</td>
</tr>
<tr>
<td>Basic Salaries – Permanent Employees</td>
<td>14,581,463.00</td>
</tr>
<tr>
<td>Personal Allowance – Paid as Part of Salaries</td>
<td>14,018,568.00</td>
</tr>
<tr>
<td>Personal Allowance – Paid as Reimbursements</td>
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<tr>
<td>Communication, Supplies and Services</td>
<td>60,149.00</td>
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<td>Domestic Travel and Subsistence, and other Transportation Costs</td>
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<tr>
<td>Printing, Advertising and Information Supplies and Services</td>
<td>353,372.00</td>
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<tr>
<td>Hospitality Supplies and Services</td>
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<tr>
<td>Specialised Materials and Supplies</td>
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<td>Office and General Supplies and Services</td>
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<td>Routine Maintenance – Other Assets</td>
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<tr>
<td>Purchase of Officer Furniture General Equipment</td>
<td>3,919.00</td>
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<td>Net Expenditure for SUBHEAD 01</td>
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<tr>
<th>PROGRAMME-BASED BUDGET</th>
<th>2016/17 Budget Excerpt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme</td>
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</tr>
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<td>Health Promotion</td>
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<tr>
<td>Preventive, Promotive, and RMNCAH</td>
<td>7,586,682,296.00</td>
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</tbody>
</table>

Source: Ministry of Finance, Kenya
Box 7: Structure and presentation of programme-based budgeting for health in South Africa

The South African Health Budget for 2017-2018 follows a programme structure as it has done for several years. The budget is divided into six programmes: 1) Administration; 2) National Health Insurance, Health Planning and Systems Enablement; 3) HIV and AIDS, Tuberculosis, and Maternal and Child Health; 4) Primary Health Care Services; 5) Hospitals, Tertiary Health Services and Human Resource Development; and 6) Health Regulation and Compliance Management.

These programmes are divided into subprogrammes. For instance, Programme 5 (Hospitals, Tertiary Health Services and Human Resource Development) includes the following eight subprogrammes: Programme management; Health facilities infrastructure management; Tertiary health care planning and policy; Hospital management; Human resources for health; Nursing services; Forensic chemistry laboratories; and Violence, trauma and EMS.

The functionality of these programmes is made possible because of key features of the budget document’s structure. First, the budget is structured primarily by programme and secondarily by both subprogramme and economic classification. Line items are present but are subordinated to the programme structure. Second, there is a structure of performance indicators with targets and timelines at both the programme level and also, in the majority of cases, at the subprogramme level. For instance, the indicator for the subprogramme Human resources for health is: “improve the quality of nursing-education and practice by ensuring that all 17 nursing colleges are accredited to offer the new nursing qualification by 2019-2020”.

Third, the 2017-2018 budget document provides extensive historical and future figures on expenditure by programme, subprogramme and economic classification, including the following: audited outcomes for the years 2013-2014, 2014-2015 and 2015-2016, indicating that audits also recognize the programme structure; the revised appropriation for 2016-2017; the average growth rate of the budget for the last five years; the average percentage of health in overall budget for the last five years; the 2017-2018 provision and projections for 2018-2019 and 2019-2020 (the MTEF); and the projected average growth rate of the budget for the MTEF period, and the projected percentage of the health for the MTEF period. The availability of these data makes it clear that the programme structure permeates not only the financial reporting system but also the audit process.

Fourth, the document contains a narrative which explains the function and objectives of all programmes and subprogrammes. Finally, the South African budget document includes historical and projected figures for employment by grade and by programme and subprogramme.

Source: The information presented here is based on the abridged health budget shared online by the National Treasury at http://www.treasury.gov.za/documents/national%20budget/default.aspx

Adopting programme budgets implies a shift in the entire budget cycle, but the biggest adjustment is the fundamental change required in how the sector approaches performance and results. Spending and being accountable to policy goals is a technical and behavioural challenge. As evidenced in several countries of the region that have made some critical steps towards institutionalizing a programme budget – such as Mauritius, South Africa and to a lesser extent Burkina Faso and Ethiopia – a careful combination of legal improvements, technical guidance, staff training and
upgrading of information systems is needed to secure an effective transition. In some cases, strong and continued personal involvement of planning unit directors, as in Burkina Faso, boosted interest in sector reform and enlisted health stakeholders’ support for the reform process (Box 9) [99]. The quality of performance monitoring frameworks also matters; it is essential to set the right number of performance targets that are reliable, comparable and build on existing monitoring systems of the sector.

While budget reforms generally require a long-term time frame to achieve institutionalization, there are several quick
### Box 8: Introduction of programme budgets in weak accountability systems: key lessons from Mozambique and Kenya

Lessons from failures when trying to introduce programme budgets in health can be instructive. The implementation of major budget reforms without ensuring basic PFM can leave systems vulnerable to fraud or abuse.

The Government of Mozambique first began a serious effort to modernize its PFM systems in 1996 with the introduction of a medium-term fiscal framework and an integrated financial management system. The government entered a second phase of reform in 2006 when it introduced programme budget reforms. However, programmes were used primarily as planning tools and could not be mapped to allocations. At the same time, although reform efforts proceeded rapidly, they were introduced within a context of weak controls. While the new financial management system was expected to alleviate this problem, administrators failed to collect data on compliance with internal controls. After several years of implementation, problems became difficult to ignore [108]. Although programme budgets sought to link allocations to sector plans, money was reportedly misspent during execution, thus reducing spending on strategic priorities. External controls, meanwhile, reflected the input-based budget structure. Rather than tracking whether the funds were spent on approved priorities, external audits and the Parliament focused on whether the money was spent on the specific goods and services that were budgeted. These failures were blamed for a public finance crisis in 2016, which saw widespread reports of the misuse of funds and an overall lack of transparency in spending by the government [109].

In Kenya, the first years after the switch saw a decline in budget transparency because of the high level of aggregation, confusion caused by incoherent narratives, and illogical indicators and targets [18], [32], [35].

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**Steps than are possible in the health sectors.**

In Burkina Faso, the institutionalization of the reforms of the budget structure took some 20 years (1998-2017) [87]. The other successful reforms, such as those in Mauritius [42] and South Africa [110], were generally decades in the making. For countries that have not yet started the transition or are stuck at the formulation stage, helpful lessons to move rapidly towards implementation in health include:

- integrating disease-specific interventions into broader, sector-wide budgetary activities or programmes;
- mapping the content and scope of budgetary programmes with national priorities;
- defining a clear management and accountability structure for budgetary programmes;
- ensuring that programmatic logic is connected with strategic purchasing and offers the potential for output-oriented payment arrangements at facility level.

**Recent experiences highlight the limitations of programme budgets when introduced in isolation and not accompanied by devolving authority to spending units.**

Budget reforms in African countries have often stopped at the formulation stage, and health expenditures continue to be spent by inputs in many settings. The reform must be
accompanied by a clear change in expenditure management and reporting. It is the health ministry’s responsibility to work with budget authorities to make sure these reforms are not simply presentational but that they permeate expenditure management. Within a structured framework of delegated authority, fund managers should be provided with the financial flexibility to execute and ultimately make necessary reallocations within the programme envelope in order to respond to changing needs in the sector. The shift from line-item to programme-based budgeting is not sufficient unless the underlying degree of flexibility is provided to move funds between budget lines, expenditure categories and costs centres, and the level at which this flexibility operates is clearly defined and effectively delegated (e.g. central fund managers, health facilities).

When initiating a change in annual budget formulation, the key is to work on improving consistency and alignment of budgetary structures across the sector. Several countries in the region, such as Burkina Faso, have made efforts to align the structure of the sector plan with multi-year and annual budgets, so that all three are now clearly focused on the same three broad budgetary programmes [99]. The next step includes mirroring budget formulation and expenditure and ensuring that new classifications are more than add-ons but

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**Box 9: Key factors for institutionalizing the programme budget in Burkina Faso**


Governance: setting up governance of the reform with involvement of the finance and other sectors – budget planning reform committee (in 2008), steering committee for implementation of the programme budget (from 2009) with implementation teams in each ministry and the creation of ministerial technical units for the programme budget.

Adaptation of management tools: adaptation of financial information systems to the new approach (review of the Integrated Expenditure System, or CID).

Capacity-building: production of a capacity-building plan for stakeholders, including in the sectors (2013), with the exception of programme officers (from the Ministry of Health) appointed after the training. Capacity-building activities targeted at the responsible financial officers and not the operational arm of the reform (e.g. budget programme directors).

Legal framework: a suitable legal and regulatory framework, including the transposition of directives of the West African Economic and Monetary Union (WAEMU) (2013-2016). Adoption of a presidential circular in 2016 announcing official transition to the programme budget in all ministries.

*Source: [99]*
actually drive funding flows. The final step consists in aligning performance monitoring frameworks, using the same program/sub programme/activity logic to monitor actual spending against set targets.

Performance-based approaches have been introduced in the sector, even without a change in budget formulation. In several countries of the continent, a performance-oriented approach has been introduced to manage public expenditure, serving to monitor achievements in sectors. Health has often been a lead pilot for these reforms. As a result, several countries are able to consolidate financial and sectoral information in one place and can connect the use of public resources with the achievement of results. This approach has been introduced in most States of the West African Economic and Monetary Union (WAEMU).
CHAPTER 3:  
A RENEWED CONTRACT BETWEEN HEALTH AND FINANCE FOR PFM REFORM ADAPATION

While the scope for Ministry of Health engagement in PFM reforms is becoming clearer, the path to achieving these reforms in health is an open question. An established literature underlines the importance of an appropriate sequence for introducing PFM reforms. It sets out a logical but overlapping progression of core financial compliance (an essential for an orderly PFM system): medium-term planning leading to a functional MTEF, followed by programme classification leading to programme and performance budgeting [11]. However, in several African countries, public finance systems contain some aspects of “advanced reforms” while still dealing with the basic PFM foundations [111]. It is essential that basic aspects of budget preparation, approval and execution are continuously strengthened, while introducing more advanced interventions.

It is becoming more obvious that there is no dichotomy between “fixing the basics” and transitioning towards more sophisticated budgeting approaches [112]. While caution is needed when relaxing ex-ante controls, the health sector has proved that successful reform implementation is possible by combining both basic and more advanced reform approaches. In Ethiopia, for instance, the PFM foundations have been strengthened in several sectors, including health, leading to more realistic and more reliable annual budget proposals for health, cleaned-up and simplified budget coding, more predictable cash management systems, and transparent and flexible procurement [113], [114], [115]. In parallel, the country has accelerated implementation of results-oriented PFM reforms in health by introducing multi-year financing plans, piloting programme budgets for the Ministry of Health, and improving accountability for sector results (Figure 10). Key is to be able to monitor effective implementation of both types of PFM interventions.

Sectoral PFM reform efforts should be grounded in stronger problem analysis. The imposition of reforms with little consideration for solving problems in a given sector have sometimes resulted in failure [116]. If a country aims to better direct money to priority health services and better respond to needs, change in budget formulation alone will hardly help. If ex-ante controls by inputs are not removed and local capacity, tools and
procedures are not strengthened, cost centres or fund holders (e.g. facilities, implementing agencies, programme managers) will not be able to spend money according to needs. In analysing PFM blockages in the health sector, it is important to look not only at the rules for “allocating” but also the rules for “expenditure and reporting” because a failure to distinguish those steps may undermine the sector’s efforts to promote more responsive expenditure systems. A better understanding of what is needed to authorize expenditure and what is needed for reporting and accounting will certainly facilitate expenditure management and accountability practices in the sector.

Calls to “do development differently” should be applied to PFM in order to promote reforms that are more attuned to local needs and realities and are more programmatic in their approach. This observation is often made but then promptly forgotten. In practical terms, it means that the PFM system is not a freely adaptable set of technical procedures. It is rarely capable of satisfying the requirements of optimal health financing regardless of their technical merit. Additionally, it requires PFM reforms to respond directly to the political context as well as the budgetary context. International best practice must give way not just to what is the “best fit” but to “the best political fit” [117]–[120].

A more problem-driven approach is relevant for solving PFM problems in the health sector. The approach of problem-driven iterative adaptation (PDIA) developed by Andrews and colleagues (Box 10) aims to solve particular PFM problems in a particular context by engaging broad sets of agents and skills and creating an “authorizing environment” for learning and feedback from lessons into new solutions. For the health sector, the implications of a more problem-driven approach are clear. First a careful specification of a country’s health system challenges (e.g. limited access to funds for health facilities, mismatch between central

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**Figure 11: Ethiopia’s pathways to strengthening PFM systems**

- Developing more realistic health budget proposals
- Simplifying and cleaning coding for health section
- Securing timely cash flow
- Enforcing program budgeting in health
- Reforming strategic purchasing function of health services
- Developing and using performance-oriented reporting systems to inform allocative decisions
Box 10: “Reforms as signals” and problem-driven iterative adaptation: application to the health sector

Two major reforms that have the potential to support UHC are Medium Term Expenditure Frameworks (MTEFs) and programme-based budgeting. Both have a long history in sub-Saharan Africa with very mixed outcomes. This is often attributed to the way in which these reforms are introduced – i.e. often with strong encouragement from the international community but without the timing and design being suitably adapted to the local context.

In 2013 Andrews [121] introduced the concept of “reforms as signals” i.e. reforms which are designed to garner short-term support (or sometimes respect) from the international community (and invariably promoted by it) but often lacking true government support. Andrews identifies the following characteristics of such reforms: they typically overlook contextual realities that determine how much change is possible; they emphasize “best international practice” interventions beyond the reach of developing countries; and they focus on narrow groups of champions that can seldom facilitate implementation and diffusion. In identifying why these reforms as signals have had little impact, his work points the way to a “politically savvy” approach to PFM reform.

Observing that decades of governance support (including PFM reform) have had relatively little impact in some countries, Andrews highlights the emptiness of reforms with no functionality or substance that have been developed as signals to the donor community and in response to demands for international best practice. He posits the idea of a more effective problem-driven (or context-driven) reform process (which is as relevant in health sector budgets as it is elsewhere) that responds directly to specific problems identified by government. He calls this organic approach “problem-driven iterative adaptation” (PDIA). As noted by ODI, this requires a clear emphasis on deep understanding of the local context in order to identify pathways for reform rather than top-down transmission of generic best practice to the local level [74].

This proposed approach resonates well with the health sector. While several PFM reforms led by the Ministry of Finance at central level have brought general benefits (e.g. cleaning up budget coding), they often clashed with other sector reforms as a result of a lack of consultation and understanding of country systems, as well as requirements to bring about more efficient and equitable spending. While budget formulation reforms, which require a very sophisticated process, have led to better alignment of budget allocations with sector needs, they may have been of little help when funds cannot reach and be used by facilities to respond to health needs. Lack of flexibility and a “one size fits all” reform approach has had limited influence on fixing practical issues of funding flows in the sector. Joint strategic thinking is needed between health and finance authorities to design micro-level reforms to fix these problems, by for example revising local legislation for facility financing.

budget and health needs, rigidities in use of funds at lower levels of government) is needed. These challenges then need to be prioritized and addressed step by step through an ongoing learning process and a wide support group (e.g. involving facility managers and programme managers, if any). Importantly, this approach is supportive of neither the imposition of international best practice nor blanket reforms (including
MTEF, programme-based budgeting, accrual accounting etc.) unless they agreed to be a specific response to a problem identified by government officials at various levels, suitably adapted, and with a credible, politically-supported theory of change.

A renewed contract is needed between health and finance. Advancements in PFM practices in the health sector depend on a combined response from finance and health, and a better mutual understanding of the needs and requirements of both sides. Despite the need for a strong relationship between the budgeting and sectoral authorities, the health sector often faces difficulty in actively engaging with the Ministry of Finance and other key partners. A lack of shared vocabulary can complicate communication, as can a belief that the technical nature of some health system concerns may not interest the finance authorities. While improving basic PFM levels is important for health, as for all sectors, health-sector specificities must be taken into consideration and responses tailored to sectoral needs when PFM responses are defined.

Because of the renewed interest for PFM in the context of health financing reforms, there is a need to capitalize on health sector advancement and to capture useful innovations that have arisen. In several countries, the health sector has introduced several innovations and is more advanced in PFM reform than other spending sectors. Some of the innovations are specific to health (e.g. introducing strategic purchasing approaches, improving financial management and the autonomy of facilities) while some are broader PFM reforms. Health has often been an effective pilot sector for programme budgets and MTEF, and in many countries sectors implement programme budgets even if the change is not fully institutionalized for the overall government budget. In Senegal, the Ministry of Health was among the three pilot sites when MTEF was introduced in 2006 – nearly 10 years before the MTEF was extended to all ministries in 2015 [26].

Among the key priorities for health-specific PFM interventions, improving local-level financial management is key. There is strong evidence of a positive correlation between local-level sectoral spending as a percentage of total sector expenditure and sector outcomes (e.g. an improved under-5 mortality rate) in both health and education [52]. The local level includes deconcentrated units of central government and is therefore independent of any particular political model or devolution arrangement. The health sector has a major stake in ensuring that PFM systems enable adequate resources to reach local frontline facilities. To do this, key local-level PFM blockages must be addressed to ensure that: resources are equitably allocated in line with need; resources flow to the local level in full and on a timely and predictable basis; and the management and use of resources at facility level is effective. Ministries of health need to work with ministries of finance and, where applicable, representatives of subnational structures, to ensure that the details of PFM reforms contribute to improving local health services.

Fiscal decentralization in the health sector should be implemented in a way that supports universal health coverage and does not undermine it. Different approaches can be used to protect health sector priorities and make sure that money is available, appropriately distributed and targeted. The first step is to devise – and revise – an equitable and easily understood resource
**Box 11: Implementing fiscal decentralization in the health sector of Tanzania**

The United Republic of Tanzania has more than 180 local government authorities (LGAs), each receiving its funds through multiple channels. According to the 2016 local government PEFA report [123], most of the funds allocated by the Treasury to the Council for primary health facilities are not disbursed directly to the facilities, although reforms are underway to change this (see Box 12). Rather, the Council incurs expenditure on behalf of the primary health facilities and transfers the procured items to the facilities. Funds disbursed to health facilities come either from the Health Basket Fund (a donor-financed pool) or the Health Sector Development Grant, using the guidelines in the respective programme documents. Hospitals, health centres and dispensaries also receive direct delivery of medicines from the central Medical Stores Department. Additionally, hospitals, health centres and dispensaries collect user fees which are retained at the facility level and used in accordance with the guidelines provided by the Council.

In order to strengthen equity, a resource allocation formula has been established which allocates health funds to LGAs on the basis of population (70%), number of poor residents (10%), direct medical vehicle route (10%) and under-five mortality (10%). This formula is published annually in the government’s budget guidelines but appears to be applied only to the goods and services element of the basket fund and to central government transfers. It does not apply to salaries. This is significant because a recent study [124] observed that, at the subnational level, salary payments [dominated by education and health] represented 78% of recurrent transfers and 55% of all LGA revenues, and this pattern has become more prominent over time. By 2013-2014, budgeted transfers for the running costs of health, water and primary and secondary education were 40% lower than four years previously at only TZS 10 700 (US$ 6) per capita. In other words, protection of salary budgets had come at the expense of running cost budgets, and an increasingly small share of the overall budget was therefore allocated using a needs-based allocation formula.

An element of bottom-up planning is achieved by the country’s Council Comprehensive Health Plan (CCHP) which begins with identification of health priorities at the grassroots level. In developing the CCHP, local staff are guided by centrally-determined policies and procedures, including some capping of individual budget lines. Some challenges have arisen because of the complexity of the guidelines and the difficulty of gathering and synthesizing the local data, although these illustrate well the issues that every country faces in balancing local needs and autonomy against national priorities and the need for quality control.

Allocation formula which would apply to the entire SNA in the case of a block grant or to the health sector specifically in the case of a conditional health grant. An immediate question is to what level the allocation should apply, with the option that it goes directly to the facility level, possibly in the form of a base allocation plus a performance or local-factor adjustment. Second, a structure of fiscal transfers should be devised to support poorer regions and communities, possibly through equalization grants, with other supplementary grants such as matching grants for health (which can incentivise local health expenditures). Third, grants must be paid out in a timely manner and in full. In
addition, when subnational governments are responsible for budgeting and managing health resources, central government can influence budgets by, for instance, making use of “non-negotiable” budget lines as in South Africa. Detailed local-level health budget guidelines may be drawn up by health ministries to communicate national priorities, provide technical guidance for budget development, ensure comparability between local areas, and enforce “red lines” [122].

Improving mechanisms for intergovernmental fiscal transfers is another priority to ensure continuous and timely funding of essential health services. The critical tool for transferring resources from central to subnational governments in a decentralized setting is the intergovernmental fiscal transfer (IGFT); the design of those transfers can have a significant impact on the health sector’s efficiency and equity. IGFT rules and approaches are typically determined centrally, particularly by the Ministry of Finance. Ministries of health need to understand the impact of IGFT design on the health sector and should work with ministries of finance to mitigate potential problems that affect the needs of the health sector. In order to improve the efficiency and effectiveness of health spending at the subnational level, one study analysed the three dimensions of IGFT design allocation, incentives and accountability – from a health sector perspective [125]. Drawing on that analysis, some general principles can be developed to influence the design of IGFTs that meet the accountability needs of finance ministries while also supporting health-sector goals (i.e. IGFT incentives should promote efficiency in order to fulfill the grantor’s objectives, and the IGFT should give transfer recipients autonomy in use of funds).

Simplifying funding flows and budget transfer mechanisms to ensure that health facilities can receive and utilize funds in a timely and flexible manner should be an important area of collaboration between finance and health authorities. One cause of delay in receipt of funds by facilities is the involvement of one or more intermediary institutional layers. By improving central government payment systems it is possible for finance ministries to make direct payments to facilities, as is currently being piloted for some sources of funds in the United Republic of Tanzania (Box 12). Critical preconditions for such a reform include: 1) improving financial management capacity at facilities (e.g. with a simple but standardized cash book, and with an accountant from a larger facility such as a health centre providing back-stopping support to smaller facilities in the same area), and 2) arranging for the finance ministry to share expenditure data with the Ministry of Health to support overall monitoring of health-sector resources.

The use of mobile/digital technology could be further explored to make money available to health facilities more rapidly and more easily. The health sector is making increasing use of mobile and other digital platforms to support and improve delivery of health services, but there has been little use of the technology in the financial management of the sector. There are clear opportunities for governments to use digitalization of payments to support more reliable and efficient resource flows and transactions, and to improve accountability [126]. In this regard, the health sector is an obvious and attractive sector for piloting such technology. Digitalization of payments is likely to be especially relevant to the health sector where receipts and payments may be distributed over a wide geographical area, including remote locations with limited
Box 12: Tanzania’s Direct Health Facility Financing – key features

The Government of the United Republic of Tanzania introduced Direct Health Facility Financing (DHFF) for some funding streams in 2017-2018 in order to ensure timely availability of funds, and to enhance performance, flexibility and local accountability in service delivery. Key features of the arrangements that are relevant to PFM include:

- Payments are made directly from the Ministry of Finance to health facility bank accounts.
- The system is being introduced countrywide to all facilities meeting certain preconditions, including establishment of a health Facility Governing Committee, as well as availability of HMIS data, an active bank account and an annual facility health plan.
- The introduction of DHFF is being phased by funding stream. It applies initially to basket funds, with the possibility of expanding to include, for instance, the Government’s funding for facilities’ non-staff running costs.
- It has been essential to have good collaboration between the Ministry of Finance, the President’s Office for Regional and Local Government and the Ministry of Health.
- District health funds are allocated to service levels on the basis of fixed percentage ranges – e.g. 20-25% of the district budget allocated to dispensaries.
- These budgets are distributed between facilities by applying a weighting (as a proxy for needs) to a fixed base rate per facility. The weighting comprises three factors: facility utilization (60%), distance of the individual dispensary/health centre from the nearest fully functional hospital (20%) and service population (20%).
- The reform represents a shift of health facility planning and management from councils to the facilities themselves. National planning guidelines have been updated and include a financial management module. Facilities prepare their annual plans by means of a standard template which is then entered into the government’s “Planrep” tool at district headquarters to be integrated into the district-level Comprehensive Community Health Plan.
- Along with the nationwide star rating system for facility performance, DHFF enables funding to be targeted to improve performance.
- Facility accounting has been strengthened by the introduction of a web-based cash book tool – the Facility Financial Accounting and Reporting System (FFARS) – for all facilities. Health centres have recruited health accountants to support financial management both at the health centre and at the dispensaries in the local area.
- Facilities are allowed to procure medicines when the central Medical Stores Department is unable to supply it, and regional framework contracts have been established.
- Significant external funding is being provided to support the development and introduction of the DHFF system.


if any conventional banking facilities. It is common for facility staff in the region to have to travel to district capitals to collect salaries and facility funds, or to report expenditure, and this can require them to be absent from the facility for several days. In addition to
facilitating government transfers of resources to facilities and staff, mobile money may have other applications in the health sector – for instance, in health insurance and savings schemes (such as Kenya’s M-Tiba e-wallet), in donor funds to pay for patients’ transport costs to access providers (e.g. the Freedom from Fistula Foundation in Kenya), or in transferring funds to a patient or to a health-care provider from family members working in towns and cities.

A significant contribution can be made to improving transparency and accountability in government financial reporting by introducing a standard set of accounting principles and requirements. While many countries continue to use cash accounting for their financial reporting, the global benchmark is the International Public Sector Accounting Standards (IPSAS) which have been, or are being, implemented by a number of countries in the region (e.g. Nigeria, United Republic of Tanzania, Zimbabwe) and are being considered by others. While this is a highly technical reform led by ministries of finance, there are two areas of opportunity for the health sector. First, IPSAS should provide the impetus for much improved accounting for capital assets such as buildings and equipment. Ministries of health should take the opportunity of IPSAS to draw up a full, computerized national inventory of publicly owned (including donated) health-sector assets and ensure that robust arrangements are in place for updating, monitoring and reporting from the inventory. Second, IPSAS requires consolidated accounts which will give a more comprehensive view of income and expenditure through ministries of health and their subsidiary institutions (such as medical stores that operate as subsidiary organizations under the health ministry).
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