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Aligning Public Financial Management and Health Financing

Sustaining Progress Toward Universal Health Coverage

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World Health Organization

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Executive summary

In recent years, many countries have committed to universal health coverage (UHC) as a national policy priority. Since public funds are the cornerstone of sustainable financing for UHC in most countries, the public financial management (PFM) system – the institutions, policies and processes that govern the use of public funds – plays a key role. A strong PFM system can ensure higher and more predictable budget allocations, reduced fragmentation in revenue streams and funding flows, timely budget execution, and better financial accountability and transparency.

PFM improvements in general are typically beneficial to the health sector. But the health sector faces some specific challenges that require more flexibility than PFM systems sometimes offer, including the ability to direct funds to where interventions and services are needed and ensure equity while creating incentives for efficiency and quality. PFM systems do not always align with these health financing objectives.

Even when PFM reforms support health financing objectives, misalignments can occur due to operational issues or challenges in implementing PFM improvements, such as poor-quality multiyear budgeting and incomplete transition toward programme-based budgeting. Misalignments can also be inadvertently introduced through new PFM policies that make it difficult to change pooling and purchasing arrangements as planned. In some cases, the health sector does not actively engage in policy dialogue and articulate its needs or does not take advantage of new or existing flexibilities.

Other misalignments can occur due to differences in policy objectives and the architecture of the PFM system itself. For example, a PFM objective of fiscal decentralization can be directly at odds with a health sector objective to increase national pooling of health funds to improve financial risk protection and equity. Particularly in countries where the PFM system continues to focus on input-based line-item budgets, PFM rules can be at odds with health financing objectives related to purchasing.

This document outlines areas where the PFM system and PFM rules are crucial for the effective implementation of health financing policy in support of UHC and offers guidance for improving alignment. Many of the steps toward improving alignment between the PFM system and health financing policy are considered good PFM practices in general, such as more policy-based budgeting and programme-based budget classification. But specific measures may be called for to address the particular needs of health budgeting, such as allowing pooling of health funds across different revenue sources, providing mechanisms for intergovernmental transfers to improve equity, allowing payment of health care providers through output-based payment methods, and giving providers the flexibility to manage their resources and deliver services in a responsive way.

Improving alignment between the PFM system and health financing system requires ongoing dialogue between health and finance authorities and other entities, such as local governments. The PFM system should be considered when health financing policy is designed, and health financing policy objectives should be considered when decisions are made to implement PFM reforms. Through this coordinated approach, the goals of the PFM system and the health sector – efficient and effective use of public funds and fiscally sustainable progress toward UHC – can be jointly accounted for and collaboratively achieved.

Preface

This paper was commissioned by the World Health Organization (WHO) and jointly prepared by Results for Development Institute (R4D) and WHO under the auspices of WHO's Department of Health Systems Governance and Financing, Health Financing Unit. It is part of the Collaborative Agenda on Fiscal Space, Public Financial Management and Health Financing Policy. Preliminary drafts were presented at the first Collaborative Agenda meeting in Montreux, Switzerland, in December 2014 and at the second meeting in April 2016. It was motivated in part by work conducted by Cheryl Cashin of R4D and the World Bank on the macroeconomic, fiscal and public expenditure context of health financing policy.

The paper considers how public financial management (PFM) and health financing systems can be better aligned in support of universal health coverage (UHC). It provides a framework for examining common challenges and offers strategies for addressing those challenges. A companion process guide builds on the framework to help health and finance authorities at the country level engage in productive dialogue, assess alignment between a country's PFM system and health financing system, and work toward a joint policy roadmap to improve alignment.

These resources can be helpful to an array of stakeholders who are engaged in efforts to move toward UHC by bringing PFM and health financing systems into better alignment:

- **health policymakers** who are working to ensure more efficient spending and increased allocation to priority populations, programs and services;
- **public budget officials** who are charged with ensuring that expenditures in the health sector are transparent and accountable;
- **health providers** who need more flexible financing arrangements so they can better align their resources with population needs; and
- **external partners and donors** who aim to promote a sustainable transition to UHC.

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For more information, please go to www.who.int/health_financing.

Introduction

The global movement to expand universal health coverage (UHC) is well underway, with the World Health Assembly and the United Nations General Assembly calling on countries to "urgently and significantly scale up efforts to accelerate the transition toward universal access to affordable and quality healthcare services."[1] In September 2015, world leaders adopted the 2030 Agenda for Sustainable Development, which includes the goal of achieving UHC for all by 2030.[2]

Sustaining progress toward UHC requires that a country's health financing system routinely generate sufficient – and largely domestic – resources to expand and sustain access to high-quality health services with financial protection. Evidence and experience have shown that public resources are fundamental to ensuring efficient and equitable progress toward UHC,[3,4] so UHC requires significant fiscal commitment from governments.

Countries thus have the ongoing challenge of balancing fiscal restraint with expanded access to quality health services. Many have significantly increased government funding for the health sector even in the face of unfavorable macroeconomic and fiscal conditions. On average, total health spending doubled in real terms in low-income countries between 1995 and 2010 and increased by 80% in low- and middle-income countries.[5]

However, it is not only the amount of resources available for the health system that matters for enabling progress toward UHC. Funds must also be used equitably and efficiently. This means that government funding for health must flow through the system in a way that most efficiently provides effective coverage for the population with priority interventions and services. UHC is fundamentally about social equity, so pooling and redistributive mechanisms are needed to ensure financial protection and subsidies for the poor. These mechanisms can be challenging to implement in fragmented or highly decentralized systems. And when fiscal resources are limited, expenditures must be carefully managed to get the most value for the money – to cover the greatest number of people with the highest-quality services and the most protection possible against the potential impoverishing effects of paying out of pocket for health services. However, purchasing strategies that can help improve efficiency typically require flexibility to contract and pay health care providers for outputs, and they require up-front investments in capacity.[6] Finally, those allocating and managing public funds for health must be able to demonstrate that funds were used effectively and efficiently, and that they were used to purchase priority health services for the population. (See Fig. 1.)

Fig. 1 Sustainable financing for UHC

Thus, sustaining progress toward UHC has three main dimensions:

- **Sufficient financing.** Countries must dedicate enough resources to meet UHC goals within their macro-fiscal context.
- **Equitable and efficient use of resources.** Resources must be directed to priority populations, interventions and services – according to need and ability to pay – through pooling and purchasing arrangements.
- **Accountability.** Good financial management, timely budget reporting, internal controls, auditing and other accountability measures are needed to demonstrate that public spending on health meets equity, efficiency and sustainability goals in a transparent and accountable way.

Since public funds are the cornerstone of sustainable financing for UHC in most countries,[7] the public financial management (PFM) system – the institutions, policies and processes that govern the use of public funds – plays a key role. A strong PFM system can ensure higher and more predictable budget allocations, reduced fragmentation in revenue streams and funding flows, timely budget execution, and better financial accountability and transparency, including for the health sector. Ongoing, long-term general PFM reforms that have implications for health financing include the introduction of policy-based and multi-year budgeting and planning, the transition toward programme-based budgets, the consolidation of information, reporting and accounting systems, and the development of an integrated financial management system.

PFM reforms and health financing reforms can reinforce one another to achieve more effective and efficient use of public funds for health, better financial accountability and greater transparency. As a PFM system is modernized, the emphasis shifts from financial control through detailed financial regulations and line-item budgeting to greater flexibility in the use of funds to meet targets and achieve outcomes.[8] But misalignment between the PFM system and health financing system can create obstacles to effective implementation of health financing policy. Particularly in countries where the PFM system continues to focus on input-based line-item budgets, PFM rules can be at odds with health financing policy objectives. Some of these misalignments are caused by operational issues or challenges in the implementation of PFM improvements, such as poor-quality multi-year budgeting and incomplete transition toward programme-based budgeting. Misalignments can also be inadvertently introduced through new PFM policies that make it difficult to change pooling and purchasing arrangements as planned. In some cases, the health sector does not actively engage in policy dialogue and articulate its needs or does not take advantage of new or existing flexibilities. Other misalignments can occur due to differences in policy objectives and the architecture of the PFM system itself. For example, a PFM objective of fiscal decentralization can be directly at odds with a health sector objective to increase national pooling of health funds to improve financial risk protection and redistribution to improve equity.

As PFM and health financing reforms are undertaken, a well informed dialogue between the ministry of health and the ministry of finance is essential to ensure that the two systems are working in harmony. Even in places where public funds do not make up the majority of health funding, improving the capacity of national health authorities to engage more effectively with national finance authorities is crucial to ensuring effective health financing policy and accountability across the public and private health sectors.

Stronger dialogue between health and finance authorities can lead to:

- more productive engagement by health authorities in the budgeting process, ensuring that they know the rules and can take advantage of existing flexibilities;
- better understanding among health authorities of ongoing PFM reforms and their implications for the health sector;
- better understanding among finance authorities of health financing policies and objectives and the role of the PFM system in their implementation;

- greater capacity on the part of the ministry of health to communicate with finance authorities about needed adjustments to the PFM system; and
- better communication between health and finance authorities about revenue forecasts, sector needs, budget ceilings and adjustments and so forth.

This paper identifies key areas in which the PFM system affects the implementation of health financing policies in support of UHC, and it highlights areas where the PFM system can be out of alignment with health financing policy objectives. It also offers options for better alignment that are derived from the experience of countries that have used certain approaches successfully. The main objective is to support productive dialogue between the ministry of health and the ministry of finance to better harmonize the PFM system with health financing policy and thereby achieve UHC goals according to principles of good public-sector management.

Overview of public financial management and health financing systems

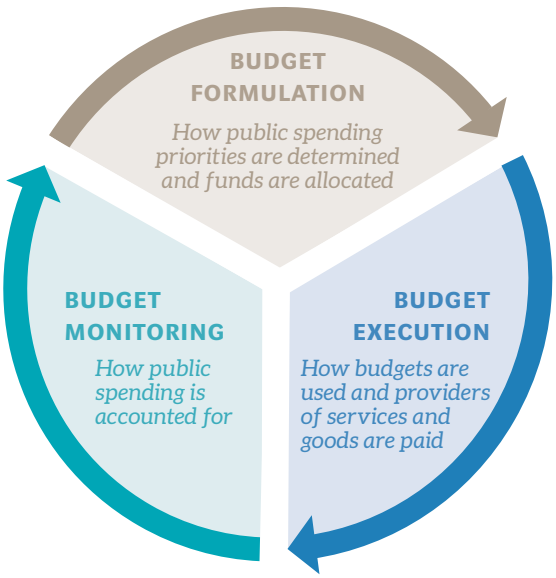
The PFM system is charged with ensuring that government resources are used effectively, efficiently and transparently. The health financing system has a similar mandate, with a specific focus on the health sector and with the further mandate to meet UHC goals.[9] Even though the PFM system and health financing system have different roles, some key components of their respective policy tools can work in the same direction toward more predictable financing, more effective and efficient use of funds, and greater transparency and sustainability.

The PFM system

The PFM system is the set of rules and institutions governing all processes related to public funds. (See Fig. 2.) It provides sectors with a platform for managing resources from all sources and across national and subnational levels.

Public finance processes are typically structured around the annual budget cycle, which is meant to ensure that public expenditure is well planned, executed and accounted for. A standard budget cycle includes three distinct stages: budget formulation, budget execution and budget monitoring. Budget formulation involves making macroeconomic projections to help determine what level of total government expenditure will be feasible and how much of the total expenditure will be allocated to each of the line (sector) ministries based on strategies and policy priorities. This step also involves negotiation at different levels, including with individual ministries. Budget execution involves the release of funds to line

Fig. 2 **The public financial management system**



Sources: Allen, Hemming and Potter (2013); Cangiano, Curristine and Lazare (2013); ACCA (2011); PEFA Secretariat (2016); Simson, Sharma and Aziz (2011); World Bank (2004)

ministries or departments/agencies according to the approved budget and making payments for goods and services. It is during this stage that government agencies make payments to health care providers (both public and private) for covered services. Budget monitoring involves ensuring that spending agencies and entities comply with laws and regulations, implement good financial management systems with reliable financial reports and internal controls and audits, and achieve budgetary objectives. Health authorities should engage at each step of the budget cycle to ensure alignment with sector priorities and effective and efficient use of public resources.

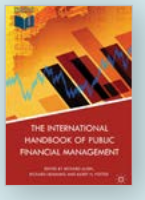
The PFM system has an underlying mandate to help maintain a sustainable fiscal position for the country and allocate resources effectively, ensure effective and efficient delivery of publicly funded goods and services, maintain transparency and accountability, and ensure compliance and oversight. Good PFM systems balance fiscal discipline with the need to meet government policy objectives, including for the health sector.

Many countries have initiated long-term reforms to transform their PFM system in accordance with international best practices and with a view to strengthening transparency, accountability and predictability as well as improving alignment between expenditure and government priorities. New approaches to budgeting have also been developed and piloted in the health sector.[10]

Helpful resources

Budgeting for Health (WHO)
http://who.int/healthsystems/publications/nhpsp-handbook-ch8/en/

Health Financing Policy (World Bank)
documents.worldbank.org/curated/en/394031467990348481/



International Handbook of Public Financial Management
www.palgrave.com/us/

IMF Guidelines for Public Expenditure Management
www.imf.org/external/pubs/ft/expend

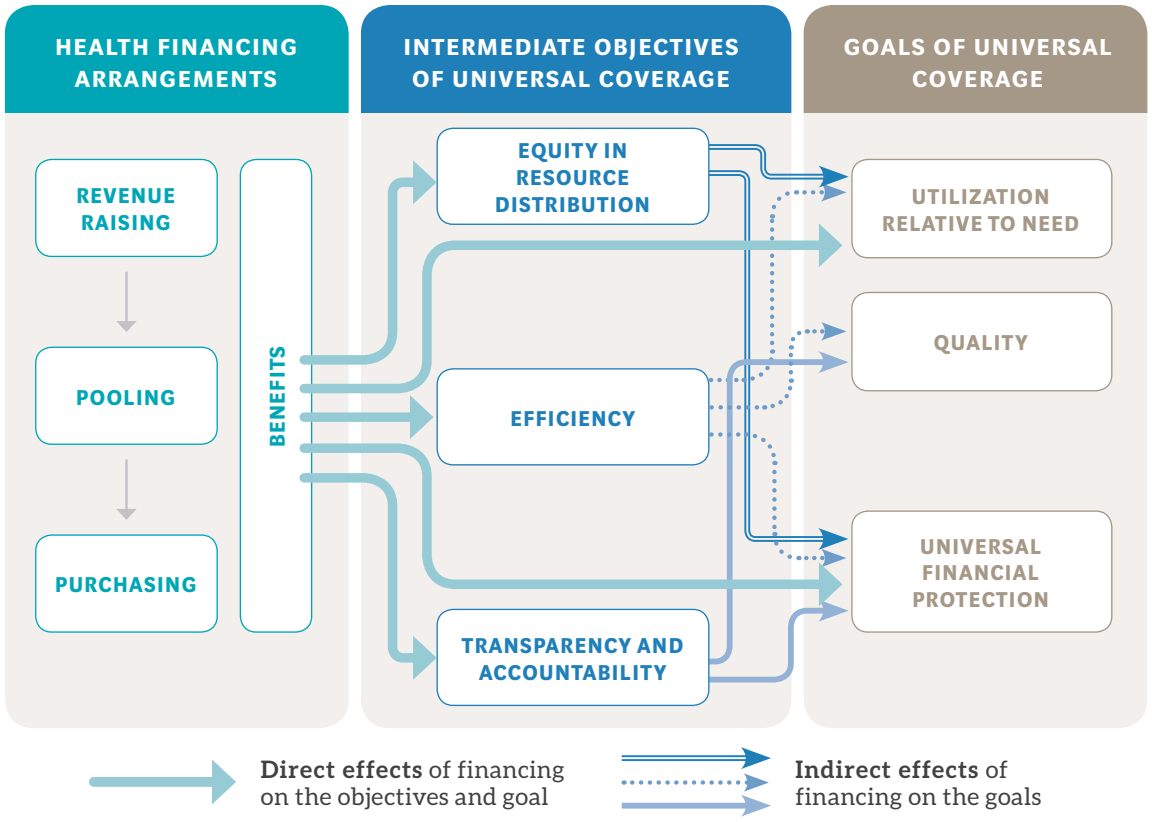
The health financing system

The health financing system is the set of policies and supporting arrangements that govern the resources and economic incentives of the health system. The health financing system has the following functions that support UHC goals (as shown in Fig. 3):

- **raising revenue** efficiently and equitably from stable sources;
- **pooling risk** to protect individuals from financial risk associated with their health care needs and ensure equity;
- **strategic purchasing** of health services on behalf of a population to ensure efficiency, quality and value for money;
- **stewardship**, including governance of health financing agencies and regulation of markets; and
- **benefit design and rationing policies**, including measures such as patient cost sharing (through user fees or copayments), service exclusions and waiting lists.[11]

These functions are needed to address the particular challenges of health financing and budgeting. These challenges are explained in further detail in a later section.

FIG. 3 **THE HEALTH FINANCING SYSTEM**



Source: Kutzin (2013)

AREAS OF MUTUAL REINFORCEMENT

When the PFM system and health financing system are working in harmony, they can reinforce one another's objectives and make the following results possible:

- **Health sector policies and priorities are reflected in the budget.** Health budget allocations are sufficient and stable enough to meet health sector objectives and commitments.
- **Funds are directed to health sector priorities.** Funds can be pooled, allocated and disbursed across populations, geographic areas and time to respond to health needs and ensure equity and financial protection for target populations.
- **Funds are used effectively and efficiently to deliver high-value services.** Funds are directed to priority populations, interventions and services, and payment to providers is based on service outputs and performance. Disbursements are predictable, and flexibility in purchasing and provider payment ensures efficiency and value for money.
- **Funds are accounted for against priorities.** The ministry of health and ministry of finance are both accountable for the proper use of public funds and effective delivery of health interventions, goods and services.

In general, a strong PFM system that provides predictability in the resource envelope, releases funds in a timely and flexible manner and supports effective financial accountability and transparency is critical for implementing health financing reforms. General improvements in the PFM system will therefore typically improve alignment between the PFM system and health financing system.

In particular, key PFM improvements that can benefit health financing include:

- **policy-based budget formulation** – more closely linking the policy and budget formulation processes
- **programme-based budget classification** – moving from input line items to budgets based on programmes.

Policy-based budget formulation

The PFM system and health financing system can be well aligned when the link is strong between overall government planning and budgeting and fiscal rules. Strengthening the quality of annual health budget proposals with well defined, achievable priorities aligned with costs estimates is a first critical step toward that goal.

One approach is to use a *medium-term expenditure framework* (MTEF), a comprehensive, government-wide spending plan that sets sector budget ceilings strategically to reflect policy priorities and can help ensure more stable and predictable sector revenue sources, including for health. An MTEF links policy priorities to macroeconomic and revenue forecasts, usually over a three- to five-year period.[12] Although expenditure allocations and budgets are approved on an annual basis, a medium-term outlook can help strengthen alignment between resources and policy. An MTEF enables the ministry of finance to budget more accurately against actual resource constraints, which leads to better planning and management of sector services and programmes. An MTEF therefore can provide health and finance authorities with better spending predictability.[13]

Some countries have found that an MTEF can help the budget better reflect stated health sector priorities when it is part of a comprehensive approach to improving the budget process. In Myanmar, when the new government came to power in 2011 and committed to a range of PFM reforms, including building a policy base for the budgeting process through a medium-term fiscal framework, higher priority in the budget was given to the social sector, including health. About 1% of government expenditure was allocated to health in 2011–12; in 2013–14, that share more than tripled to 3.6% with more policy-based budgeting.[14]

Programme-based budget classification

Another approach to strengthening the link between budgeting and policy is programme-based budgeting. This method classifies, organizes and releases the budget according to programmes with shared objectives instead of along administrative and input lines.[15] Programme-based budgeting also makes it possible to organize budgets around health services or groups of services (such as an essential services package or primary health care) rather than individual spending units (such as health facilities) and to purchase services with output-based payment. Performance-based budgeting often builds on programme-based budgeting by incorporating explicit goals and targets or other expectations. It aims to consider past performance in the budget development and appropriations process, with the goal of making allocation decisions that achieve measurable results. Programme-based budgeting may be combined with a treasury single account (a single account held by a country's central bank on behalf of the government) as a way to consolidate funds from across multiple sources for a single programme area.

Budget classification by programme can help clarify programme and policy objectives by defining the desired outputs; it can also improve monitoring, transparency and accountability for both PFM and health financing.[16] (See Box 1 .) Setting spending levels and controls at the level of the health programme (such as the primary health care programme) rather than the individual spending unit (such as the health facility) or narrow vertical programmes (such as tuberculosis or HIV/AIDS) can ensure more efficient allocations across levels of care and provide flexibility without compromising financial controls. Programme managers can reallocate operating expenditures to meet

objectives as needs change, and they can ensure that any efficiency gains lead to reinvestment in the programme or extending coverage rather than being lost to budget cuts in the next year. Input-based line-item budgets are still used within programmes and activities to guide implementation, but budgets are executed with more flexibility and funds can be reallocated across inputs to achieve programme objectives.

Box 1 Programme-based budgeting in Mozambique

Mozambique is a country where PFM reforms have had positive effects on health budgeting. The country began a series of PFM reforms in 2002, with the primary goal of establishing a financial management information system across the public sector.

While programme-based budgeting was rolled out in 2009 at the national level across sectors, it remains a planning concept that cannot be mapped to appropriations or execution and is not linked to management centers. However, the reform has prompted some sector ministries, such as health and education, to promote a separate, bottom-up process that adopts a more typical programme framework that aligns activities and responsibility centers, and it has helped improve coordination with development partners.[17] Budgeting laws were adjusted to create a medium-term budgeting instrument with universal classifiers.[18] The Ministry of Finance allocates the budget to the Ministry of Health, which distributes it to provincial health directorates or district administrations, where a capitation formula is applied.

There is some evidence that these reforms have led to more equitable allocation of resources for outpatient care across geographies and improved alignment in government and donor resource allocation.[19] The strengths of Mozambique's PFM system have led the country to become one of the top recipients of on-budget aid in Africa.[20] But despite generally good performance and high scores from the Public Expenditure and Financial Accountability (PEFA) programme and other assessments, structural problems persist.[21] For example, although funds now flow through a treasury single account, engagement by the national parliament and citizens in planning and monitoring is reportedly lacking.[22] Other issues have arisen due to poor integration between sectors and central agencies and between planning and budgeting institutions.

Helpful resources

Health Systems Financing: The Path to Universal Coverage (WHO)

http://www.who.int/whr/2010/en/

Raising Revenues for Health in Support of UHC (WHO)

www.who.int/health_financing/documents/revenue_raising/en/

Health Financing Country Diagnostic (WHO)

who.int/iris/bitstream/10665/204283/1/9789241510110_eng.pdf?ua=1

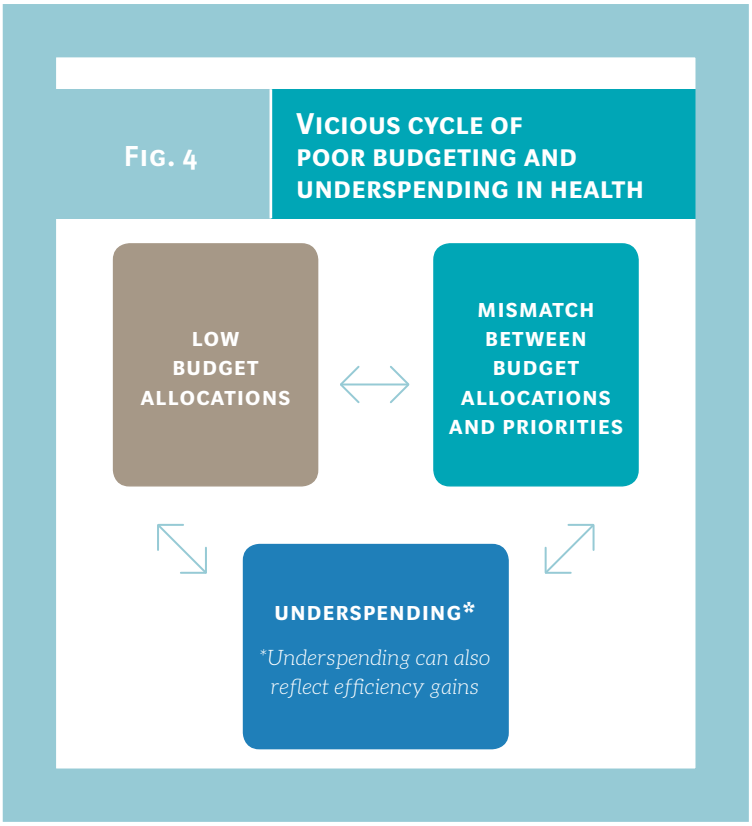
Good Practices in Health Financing (World Bank)

openknowledge.worldbank.org/

Misalignments between the PFM system and health financing system

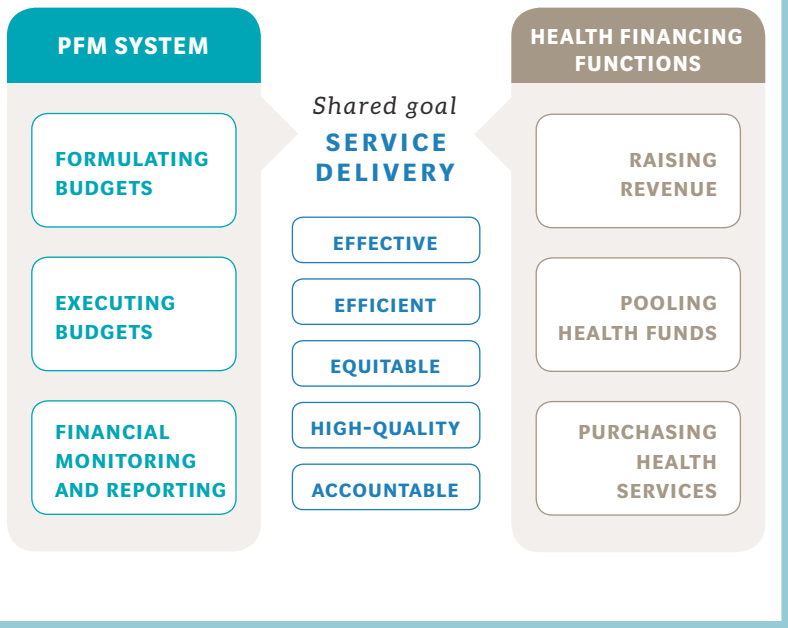
The health sector is critical to a country's efforts to achieve its broader development objectives, which are also the mandate of the ministry of finance. At the level of policy development or during the implementation phase, however, PFM and health financing reforms can misalign and go in different (sometimes contradictory) directions.

There also can be misunderstanding between health and finance authorities. Finance authorities sometimes have the impression that the health sector does not understand how PFM rules work and how those rules can help the public sector be more effective. The lack of measurable, immediate results from public spending on health can reinforce perceptions that the sector is ineffective and inefficient. In addition, health spending often deviates from budget targets because the volume, type and geographic distribution of needs are difficult to predict. In many low- and middle-income countries, actual spending is lower than budget allocations. Available data from sub-Saharan African countries indicate that between 10% and 30% of allocated health budgets go unspent.[23] This is sometimes attributed to low absorptive capacity and inefficiency, but the underspending often reflects difficulties in budgeting and disbursing funds according to national PFM rules and lack of flexibility to reallocate funds to areas with higher-than-anticipated needs. This situation can lead to the vicious cycle of low budget allocations, mismatch between budgets and priorities, and underspending. (See Fig. 4.)



These challenges can arise because of poor implementation of supportive PFM policies, lack of communication between health and finance authorities during policy development, or more fundamental differences in policy objectives and the PFM architecture itself. In the first case, PFM policies that are in alignment with health financing objectives, such as policy-based budgeting and programme-based budget classification, are implemented slowly or incompletely, or the health sector has not made adequate use of these reforms to effectively implement health financing policy. In the second case, countries embarking on improvements in their PFM system fail to consider health financing policies, especially when the health sector does not actively engage in policy dialogue and articulate its needs. This can lead to inadvertent misalignments that make it difficult to change pooling and purchasing arrangements as planned.[24] For example, fiscal decentralization reforms, when applied across the board, can be at odds with better pooling of health funds. In the third case, differing policy objectives and the PFM architecture itself lead to misalignment. For example, steps to introduce or refine treasury systems to strengthen financial control can limit options for paying health providers for outputs instead of inputs.

FIG. 5 **FUNCTIONS AND OBJECTIVES OF PFM AND HEALTH FINANCING SYSTEMS**



In many of these cases, the misalignment occurs and persists because the PFM system and health financing system are designed and operated in parallel. (See FIG. 5.)

SPECIFIC CHALLENGES OF THE HEALTH SECTOR

Specific challenges within the health sector require flexibility to manage the flow of funds and direct funds to where interventions and services are needed to ensure equity while creating incentives for efficiency and quality. Finance and health officials can differ in their views of the right balance between financial control and flexibility to achieve equity and other objectives. This can give rise to misalignment between PFM and health financing policy objectives.

One specific challenge in the health sector is the high degree of uncertainty associated with health needs. Unlike in other sectors, such as education, health needs vary across populations, over time and across geographic areas. (See BOX 2.)

Health needs are concentrated in a relatively small segment of the population: 20% of the population generally accounts for 80% of all health spending.[25] This uncertainty makes it necessary to "pool" risk across populations to protect individuals from financial hardship if they find themselves in the unlucky group that requires expensive health services. The failure of the private market to provide this insurance function equitably and efficiently is an important justification for government financing of the health sector.[26] Risk pooling is one of the most challenging aspects of the health sector and creates complicated public financing issues.

The uncertainty associated with health needs also creates challenges in allocating budgets to lower levels of the system and individual health providers. For example, while health needs can generally be predicted for large populations, it is difficult to predict the need for specific services, such as the number and location of obstetric emergencies or traumas from traffic accidents, in a given year – especially within smaller populations. If the unit of budgeting is small (such as the district or health facility), it can be difficult to match resources to needs in advance. Uncertainty at the population level can also include unpredictable health crises (such as the Ebola epidemic) and conflict situations.

In the health sector, unlike in other sectors, the use, cost and quality of services are greatly affected by the choices made by those who deliver and receive services. Individuals often do not know which services they need or the quality of care they are receiving (known as *information asymmetry*), so health providers make many of the decisions on service use. Sometimes providers make decisions in their own financial interest and drive up costs (known as the *agency problem*). Individuals can also make choices that drive up costs. For example, they might choose to bypass primary health care or seek treatment for simple conditions in more expensive hospitals.[27,28,29] Low or no payments at the point of service can encourage overuse (known as *moral hazard*) and lead to inefficiency on the part of both providers and consumers.

Box 2 Budgeting for health vs. budgeting for education

Despite available information on population projections and health needs, the health sector does not have a straightforward basis for budgeting, unlike sectors such as education. Budgeting for education is typically based on relatively firm information about individual needs.

For example, a 10-year-old child in the United States will most likely need to enter 5th grade, and the number of students in each cohort in each school in a given year is relatively easy to predict. Likewise, the inputs and cost of inputs in the education sector are relatively stable and predictable and not significantly influenced by individual teachers or students. This means budgeting at the district level or school/facility level can more accurately reflect resource needs in the education sector than in the health sector, which has much greater variability in terms of resource needs, who will seek care and what outcomes can be ensured over the long run.

Furthermore, defined metrics such as test scores and educational attainment are in place for most schools; these are more generally recognized as direct outcomes of system inputs. As a result, a much larger body of evidence is available on which to base budgeting and incentives at school and teacher level. While both sectors face challenges with respect to effective budgeting practices, the health sector must contend with much less predictability and a weaker evidence base.

These problems (collectively referred to as *market failures*) in the health system make budgeting at the level of the health facility or small administrative unit even more uncertain, and they create the need for incentives to encourage individuals and providers to make decisions that lead to more efficient service use and delivery. Service providers, in turn, should have some say in management decisions so they can internalize and respond to these incentives and meet the needs of the populations they serve (known as *provider autonomy*).

A further challenge is the complex nature of health services and service delivery. The traditional PFM view emphasizes inputs procured through the public system and services delivered in public institutions. That is how budgets are often created and disbursed. However, health services can be delivered by a wide range of public and private providers that combine inputs ranging from simple (such as bandages) to technologically advanced (such as computed tomography [CT] scans). These inputs can be procured through the government system or on the open market. Thus, public funding of health services does not necessarily mean delivery through public institutions; it means making services geographically and financially accessible through both public and private service providers using contracting and purchasing arrangements. (See Box 3.)

Finally, these complexities also can drive cost growth in the health sector that can be difficult to predict and manage. Although underspending on health is a challenge in many low- and middle-income countries, health spending typically outpaces economic growth, which eventually puts pressure on government budgets. Spending on health is also driven by rising incomes, new technologies and demographic changes.[36] It is therefore critical to understand the impact of new policies on costs, but this can also be difficult to predict.

Box 3 The "make or buy" decision

Countries that rely heavily on public funds to finance health services are faced with the decision of whether to "make" or "buy" health services – that is, whether to deliver services largely through a public provider network or to contract out to public and private providers. The best approach for a given country depends on the existing systems and service delivery mix, but many countries are moving toward a combination – a mixed health system.[30]

Many low-income countries, and some middle- and high-income countries, have health systems that are financed through the government budget and run by the ministry of health, with services delivered through a network of public providers. These national health services typically provide centralized financial allocations to the health sector; funds are then distributed downward to subnational levels and finally to providers through line-item budgets. Some health systems that rely on general government revenues and public service provision, such as those in Malaysia and Sri Lanka, perform well in general. Sri Lanka, for example, provides universal free access to its network of public health facilities. The level of financial protection is high, with few people forced into poverty by health expenditures, and out-of-pocket payments tend to be concentrated among wealthy households.[31] However, many other countries with such hierarchical budgetary arrangements struggle to secure adequate funds in the yearly budget process, and allocations are often based on inputs (such as hospital beds and staff) that reinforce historical patterns favoring large hospitals in wealthier urban areas. These systems are often characterized by chronic underfunding, inadequate supply and poor staffing distribution.[32]

Another common challenge is bottlenecks in funding flows and budget execution from the national to subnational levels and from there to frontline health providers. Lack of incentives for efficiency and quality, along with limited managerial autonomy in more rigid input-based budget systems, can also erode performance and public trust.[33] A parallel private sector often emerges to meet the demand for health services, which together with the chronic underfunding of public facilities often leads to high out-of-pocket payments for patients and weak financial protection.[34] In Brazil, for example, although the national health delivery system has improved health coverage and strengthened primary care, chronic underfunding has eroded quality and driven many patients to pay out of pocket for private providers or private insurance coverage. So in spite of the country's universal population coverage, out-of-pocket payments continue to account for more than half of total health expenditure.[35]

To address this issue, some countries (including Ghana, Indonesia, Mexico, Peru and Viet Nam, among many others) have introduced public insurance systems to inject additional resources into the health system as a means to provide financial protection against out-of-pocket fees. Many countries have also introduced a separation between the purchasers of services and providers. A separate purchasing entity can create opportunities to contract private providers, as well as semiautonomous public providers, and introduce new payment systems and other strategic purchasing approaches. While some of those countries initiated their new insurance programs with a payroll tax, the main funding source has remained general government budget revenues. By redirecting these budget funds to the new insurance agencies, countries have found a way to enable more strategic purchasing of services using general government revenues.

Countries with a large private health sector typically find it necessary to engage private providers to ensure access to UHC service entitlements. Contracting private providers through public coverage arrangements can also provide an important avenue for setting rules and ensuring greater efficiency, equity and access.

Many countries have implemented policy reforms that enable them to create risk pools for insurance, move funds to where population needs are greatest and improve purchasing to create incentives for efficiency and quality in service delivery.[37] Other approaches that have been used to encourage more efficient resource use in the health sector include separating financing, service provision and regulation into more autonomous organizational entities (sometimes called the *purchaser-provider split*), introducing market elements with contract-based competition in service provision, and expanding contracting of private providers using public funds.[38] These more complex institutional arrangements often require more flexible rules, particularly in regard to budgeting and the purchasing of health services.

Potential sources of misalignment

As countries plan health financing improvements to address the specific challenges of the health sector, it is important for health policy-makers to understand the PFM system and any ongoing reforms in order to frame and guide dialogue with the ministry of finance. It is also crucial for PFM specialists to be aware of health financing policies. (See Box 4.) Table 1 summarizes the conditions for effective health financing policy implementation, the PFM functions that underpin each health financing function, and common PFM challenges that can arise either because of implementation challenges or more fundamental misalignments in the PFM architecture and health financing policy objectives. This table can serve as a starting point to identify potential issues for discussion between the ministry of health and the ministry of finance as they work to improve alignment between the PFM system and health financing system.

Other frameworks and approaches to assessing PFM systems are available – most notably the Public Expenditure and Financial Accountability (PEFA) framework[39] – but they do not address the specific PFM requirements of the health sector and shed little light on issues of PFM and health financing policy alignment. (See Box 5.)

Box 4 PFM and health financing reforms in Malawi

A number of reforms have been proposed in Malawi to strengthen national health financing and PFM systems,[40] including the following:

- In line with the National Decentralization Policy, the Ministry of Health is decentralizing management of health services (including financial functions) as a way to improve quality, efficiency and access.
- In 2014, the Ministry of Health and two other pilot ministries implemented programme-based budgeting as part of an overall PFM Improvement Program. The goal is to improve efficiency by replacing line-item budgets with a structure that aligns budgets more closely with sector outcomes.
- A four-pronged health reform strategy was initiated in early 2015 and linked to a broader public-sector reform agenda: 1) establishing a health insurance scheme, 2) creating a Health Fund, 3) reviewing the public–private partnership between the government and the Christian Health Association of Malawi, and 4) reforming central hospitals in line with decentralization policies.

These initiatives have achieved positive results individually, but a key challenge for Malawi will be to coordinate them to improve the effectiveness, efficiency and equity of health spending.

Box 5 Frameworks for assessing PFM reforms

PEFA is an integrated monitoring framework to measure a country's general PFM performance at a specific point in time using quantitative indicators. The tool was created to provide reliable information on the performance of PFM systems, processes and institutions. The PEFA methodology can be reapplied to track changes over time.

The 2016 update includes 31 performance indicators grouped into seven "pillars of performance" (budget reliability, transparency of public finances, management of assets and liabilities, policy-based strategy and budgeting, predictability and control in budget execution, accounting and reporting, and external scrutiny and audit) that are considered essential to achieving the PFM outcomes of aggregate fiscal discipline, strategic allocation of resources, and efficient service delivery. While PEFA does not assess sector-specific PFM issues, it can expose challenges faced by the sectors, such as a disconnect between policy priorities and budget allocations.[41]

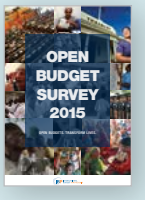
Other frameworks for assessing PFM systems include the Open Budget Index, which measures the transparency of budget systems and whether national governments give the public opportunities to participate in the budget process, and the International Monetary Fund's Code of Good Practices on Fiscal Transparency.[42,43]

The USAID Health Finance & Governance project has published a toolkit to help ministries of health work more effectively with ministries of finance. It includes tools to assess PFM performance, assess internal controls for the health sector, develop key performance indicators and assess the efficiency of resource use.[44]

Helpful resources

PEFA Framework
pefa.org/content/pefa-framework

IMF Code of Good Practices on Fiscal Transparency
www.imf.org/external/np/pp/2007/eng/051507c.pdf



Open Budget Survey and Index
www.internationalbudget.org/opening-budgets/open-budget-initiative/open-budget-survey/

USAID Health Finance & Governance toolkit
www.hfgproject.org/wp-content/uploads/2014/10/Introduction--A-Toolkit-for-Ministries-of-Health-to-Work-More-Effectively-With-Ministries-of-Finance.pdf

Table 1 **Health financing and PFM functions: conditions and challenges**

Health financing function	PFM functions	Implementation conditions	Common PFM challenges	Country examples
Revenue raising				
> Estimates of resource needs to achieve policy priorities given macro-fiscal realities > Revenue streams from both health-specific and general government sources > How funds are allocated to the health sector	> Policy/ strategy > Revenue projection > Budget formulation > Budget classification	> Sufficient and stable resources to meet stated health sector objectives > Appropriate and predictable timing and harmonization of health revenue streams	**Misalignments in policy:** > Budget ceilings for the sector that do not reflect political commitments > Budget classification based on facility and line item rather than on objectives, programmes and services **Implementation challenges:** > Poor revenue forecasting and fragmented revenue sources (including donors and private out-of-pocket payments), leading to unrealistic or unclear total envelope and ad hoc adjustments > Poor tax administration and collection, leading to missed revenue targets and budget shortfalls > Weak link between policy and budget formulation	> **Myanmar.** Lack of credibility in the budget leads to misalignment of policy priorities and spending as the budget is significantly remade during the year.
Pooling				
> Accumulation of funds across funding streams > Accumulation of funds within the health sector (across geographic areas, administrative levels, etc.)	> Budget formulation	> Mandate and mechanism to accumulate and redistribute funds according to need and ability to pay	**Misalignments in policy:** > Fiscal decentralization whereby budgets are formulated at different administrative levels with no mandate or mechanism to transfer funds between budgets > Different budget formulation processes and pooling arrangements for different revenue streams (e.g., social health insurance, donor funds, out-of-pocket payments) > Parts of the health budget (such as health worker salaries) determined and paid directly by the ministry of finance or the treasury **Implementation challenges:** > Donor funds that are fragmented and poorly integrated with domestic resources	> **Malawi.** More than 70% of health sector spending is donor funded, creating transparency issues related to funding for health and coordination of resource flows. > **Tajikistan.** Highly inequitable government health spending under fiscal decentralization, with no mandate or mechanism to reallocate health funds across regions.

Health financing function	PFM functions	Implementation conditions	Common PFM challenges	Country examples
Purchasing (provider payment)				
> What to purchase and with what funds > How to purchase and what payment mechanisms to use within the health sector allocation > Monitoring what has been purchased	> Budget formulation > Budget execution and payment > Accounting and reporting	> Mandate to purchase services for the population (benefits package, essential services) > Stable, timely and predictable funding to enter into contracts with providers > Flexibility within the structure of the budget to make payments according to service outputs and performance > Mechanisms and incentives to improve efficiency and quality > Provider autonomy to make management decisions and respond to incentives > Standard accounting procedures, financial reporting, internal controls and auditing	**Misalignments in policy:** > Difficulty matching health spending to needs and priorities: • Budgets are classified, formed and disbursed based on inputs, with the health facility as the budget unit • Different purchasing arrangements and accounting for different revenue streams (health budget, health insurance fund, donor funds) > Lack of provider autonomy to respond to incentives in output-oriented payment > Obstacles to engaging with the private sector > Government procurement rules reduce flexibility and ability to match inputs with need **Implementation challenges:** > Delays in release of funds, making it difficult to enter into credible contracts with providers > Poor information systems and monitoring capacity	> **Ghana.** Delays in transfers of earmarked taxes to the National Health Insurance Authority interrupted contracts with providers and resulted in providers threatening to pull out of the scheme. > **Malaysia.** The traditional budget system makes it nearly impossible for the Ministry of Health to purchase services from private primary care providers to close access gaps and reduce waiting times. > **Mongolia.** Budget law requires output-based payment to be paid through health facilities' line-item budgets that impose rigidities on reallocation of funds at all levels of the system. > **Tanzania.** Health facilities have their own bank accounts as a part of decentralization but little authority to use funds without approval.

Source: Adapted from Cashin (2016)

Misalignments in revenue raising

The health sector requires sufficient and stable resources to meet stated objectives, and funds must be raised equitably and efficiently. Allocations should also be developed within a medium-term fiscal framework and a medium-term expenditure framework to ensure sustainability. Budgets allocated for health may be inadequate due to unpredictable sector budget ceilings, budget allocations that are separate from policy objectives and planning, and budget classification by inputs. Although every sector faces these challenges when the link between policy and budgeting is weak, the consequences for the health sector can be more severe. Unpredictable budget envelopes and disbursements compound the already high level of uncertainty in resource needs, and the human consequences of budget shortfalls and commodity stock-outs can be high in terms of avoidable illness and death.

Unpredictable health sector budget ceilings

Poor revenue forecasting, fragmented revenue sources (including donors and private out-of-pocket payments) and weak tax administration can lead to unrealistic or unpredictable budget ceilings and ad hoc adjustments during the year for all sectors. The resulting unstable budget ceilings can compromise the integrity of the entire budget process. Poor revenue forecasting can be due to lack of medium-term budgeting practices as well as underuse of tools such as short- and long-term fiscal projections that examine revenue sources over time.[45]

Revenue for the health sector can also be unpredictable if it comes from fragmented sources and is recorded and reported in diverse ways across different parts of the system. Some revenue sources might not show up in the budget. For example, funds flowing into extrabudgetary social insurance agencies or fees collected from out-of-pocket payments might not appear in a consolidated budget that identifies a total allocation of public funds to the health sector.

Estimates of total available resources for health are further complicated by donor funding because donors do not always disburse all of the funds they commit; aid flows are more volatile overall than fiscal revenue and can decline during economic downturns, when they are needed most.[46] Leakages can also occur, making actual disbursements less than initial commitments. In Malawi, for example, loss of donor funds due to overhead and transaction costs averages about 19%.[47] Finally, donor funding and programme planning cycles are short-term in nature and often do not align with government planning or budget timelines. This affects a government's ability to understand the timing of budget resource flows, extrabudgetary resource flows and implementation cycles of international partners. The unpredictability and volatility of aid flows can weaken the credibility and effectiveness of the budget process.

Budget allocations that are separate from policy objectives and planning

Health sector budget allocations often do not reflect political commitments to health (even widely publicized political commitments), sector objectives or strategic and operational plans. The processes for determining top-down spending ceilings and bottom-up budget needs often happen in parallel, and ministries of health can find it difficult to influence budget ceilings determined by central budget authorities. Sometimes sector budgets are submitted too late to be considered when budget requirements across the system are determined, or sectors are given too little time to prepare comprehensive budgets if budget ceilings are disseminated late in the process. The ministry of finance or other central budgeting authorities also might not be adequately engaged in the process of setting national and sector objectives, which often happens in planning ministries and agencies.

In Mozambique, the annual budget process, headed by the General State Budget, is separate from the planning process, which is outlined in the Economic and Social Plan.[48] This separation makes it difficult to link objectives with annual expenditure plans and priorities. In addition, information about programme implementation is presented in a separate document from the budget and information on resource requirements, which makes it difficult to infer linkages between public expenditure and specific objectives. Reporting mechanisms are also often separate.[49]

This fragmentation results in weak ownership of the budget process among line ministries, which might have little incentive to fully participate in the central planning and budget cycle. In Kenya, for example, weak Ministry of Health stewardship and institutionalized separation between the planning and budgeting processes are two major causes of weak budget and health sector policy alignment.[50] Even less transparent in many countries are the in-year budget adjustments by the ministry of finance that take place outside of the formal priority-setting process and often put the health sector at a further disadvantage.[51] Without enough capacity to assess and define sector budgets in a strategic way, budget authorities often resort to across-the-board percentage decreases of sector budgets. This situation is exacerbated by centralized budgeting processes that give line ministries, including the ministry of health, little opportunity to provide input. Conflicts are resolved in an uncoordinated and ad hoc manner in which multiple stakeholders might promote their own agendas and exchange favors for votes.[52]

A major disconnect between national priorities and commitments from actual expenditure at the local level is common in highly decentralized contexts. In Indonesia, for example, despite the country's stated commitment to achieving 100% enrollment of the population in the national health insurance scheme by 2019 and a legislated earmark requiring 5% of the national budget and 10% of district budgets to be allocated to the health sector (not including government health worker salaries), total allocations for health have remained low by global standards – only 3% in 2013. Preliminary estimates suggest that the 5% central budget target was met for the first time in 2016.[53] There have been challenges in monitoring expenditures at the district level, along with a high degree of discretion on the allocation of health funds. The actual share of district spending going to health is well below the 10% target in many districts across the country.[54]

In practice, the process of budget formulation is sometimes reduced to incremental adjustments to the previous year's budget.[55] Revenues are not matched to policies and priorities, and they may not be adequate to meet the health sector's objectives. Decision-making focuses on changes to input items rather than on programmes as a whole, and the dialogue between the ministry of finance and ministry of health is not about achieving stated priorities but rather on whether to discontinue activities that are perceived to be lower priority. Limited scrutiny of existing policies results in a mismatch between policies and available resources.[56]

Even in countries that have a medium-term expenditure framework (MTEF), the approach has not necessarily led to better alignment of government policies, plans and budgets. (See Box 6.) Some people argue that countries have used the MTEF as a standardized prescriptive budgeting tool without adequately adapting it to the country context,[57,58,59] or that they have overlaid the MTEF on the existing budgeting process without adequately linking the two. In Armenia, for example, the MTEF is informed by policy priorities, but the budget process is driven primarily by detailed line-item budgets.[60] Budget allocations for health more closely mirror stated priorities, but budgets are not as results-oriented as they could be.

Box 6

Results-based budgeting for health in the Democratic Republic of Congo

In 2011, the Democratic Republic of Congo (DRC) initiated a programme to improve budgeting for health, using a results-oriented management approach that includes an MTEF.[61] Since 2012, the Ministry of Public Health and provincial ministries of health have compiled MTEFs each year. This approach is a featured element of the government's expenditure reform effort, making the health sector a trailblazer in instituting reforms that will be extended to all sectors. However, health MTEFs have been mostly a theoretical exercise so far.

The benefits of results-based management practices are twofold. First, they are adopted by provincial planning and budgeting teams, which will play a central role in future allocations of resources for health. Second, they make it easier to develop arguments in defense of the health budget when choices are being made for the annual budget. In 2014, sound arguments helped the DRC's Ministry of Public Health obtain a 20% increase in the initially announced budget for nonwage expenditure. This represented an additional US$ 10 million in the health allocation.

However, the unpredictability of external resources and uncertainty surrounding decentralization make the medium-term budget process an especially delicate exercise that often has little connection to macroeconomic realities. The MTEFs in the DRC are developed using incomplete data: the provinces have no clear idea of the domestic and external resources they will receive the following year. Therefore, the MTEFs are more of a theoretical exercise and are rarely used to manage resources.

Budget classification by inputs

Misalignments can occur when the budget classification system categorizes expenditures only by organizational unit (such as the health facility) and input-based line items rather than by programmes or services that work toward policy objectives. (See Box 7.) While this approach arguably can lead to greater predictability and control over the budget, the link between the budget and the services the government commits to making available is weak. This often results in a mismatch between budget allocations and spending needs. Input-based line-item budgets also typically lack the flexibility needed to shift expenditures based on service delivery needs that may change throughout the year. This can result in inefficiency and underspending of budgets. Also, when health sector budgets are based on individual facility line-item budgets, it can be difficult to distinguish between important allocations, such as between primary health care and tertiary services. Even in countries where primary health care is a stated top priority, allocations often remain low and difficult to track.

Misalignments can also occur between budget classifications in the health system and expenditure classifications in the chart of accounts (the list of all accounts and the system for classifying and recording transactions in the PFM or accounting system) if the latter (or some other consistent framework) is not used at all levels. This can constrain

Box 7 Budget classification systems

A budget classification system groups revenues into categories and groups expenditures into administrative, functional, programme-based and/or economic classifications.[62]

- **administrative classification**—the entity or entities responsible for managing the funds, such as the ministry of health or, at a lower level, health facilities and schools
- **functional classification**—types of expenditure based on intended purpose, such as health or education
- **programme-based classification**—types of expenditure based on sets of activities carried out to meet specific policy objectives
- **economic classification**—types of expenditure based on input, such as salaries or capital spending

the government's ability to maintain adequate accounting, recording and reporting and in turn reduce its decision-making control and overall accountability.[63] In the revenue forecasting phase, it can limit the government's ability to project resource needs based on an accurate picture of past use.

The movement toward programme-based budgeting is widespread and aims to address the shortcomings of input-based line-item budgeting, but country experience has been mixed. Programme-based budgeting often does not bring about improved alignment with health financing policy. For example, as of the end of 2012, more than 80% of African countries had introduced or were committed to introducing some sort of programme- or performance-based budgeting. None had a fully functioning system in place; Mauritius and South Africa each had a partially functioning system in place, while Ethiopia, Kenya, Liberia, Malawi, Mozambique, Namibia, Tanzania and Uganda had made some progress.[64,65]

One common impediment to effective programme-based budgeting is when programmes are simply laid over line-item budgets and countries do not actually budget or pay according to programme. Many countries in Africa use programme-based budgeting as a parallel exercise that translates the regular budget into a programme-based format, which is then evaluated against indicators and targets. The budget is submitted by all or a subset of ministries that are piloting this budgeting approach in addition to the regular budget, which still dictates how funds actually flow.[66] As a result, no benefits are achieved for health financing, particularly purchasing.

At the other extreme are programme-based budgets that remove all controls and can actually contain less information on planned expenditure and reduce transparency, as was the case with Kenya's first experience with programme-based budgeting in 2013. The budget included only three health programmes (Curative Health, Preventive and Promotive Health Care Services, and Disaster Management) and no subprogrammes. In subsequent years, the links to programme and subprogramme objectives, indicators and targets have improved somewhat.[67]

Misalignments in pooling of health funds

Universal health coverage implies that all individuals are able to access the services they need and the system provides protection for everyone against large (relative to household income), unpredictable financial risks. From a pooling perspective, this means both accumulating funds from the range of sources to harmonize funding streams and being able to cross-subsidize funds from wealthier to poorer populations and from people at low risk of illness (such as the young) to those with higher risk (such as the elderly). Pooling is also necessary across time because of the uncertainty about how health needs in a population will vary from one year to the next.

Effective pooling of public funds requires both a mandate and a fiscal mechanism (such as actual transfer and accumulation of funds in a purchasing agency, a resource allocation formula or an intergovernmental transfer regime) to accumulate funds for health based on the ability to pay and reallocate them according to need. But PFM rules can make it difficult to move funds based on need and fiscal capacity across geographic areas (because of fiscal decentralization), revenue sources (because of earmarking or institutional barriers), providers (because of health facility-based budgeting) and time (because budgets cannot be carried over from year to year). Many countries also face challenges with pooling across input budgets when some inputs – such as health worker salaries and physical capital – are paid directly by the ministry of finance or the national treasury.

Fiscal decentralization

Fiscal decentralization is the devolution of fiscal authority from the central government to local government agencies. Decentralization can also mean moving PFM and health financing responsibilities to lower levels (district, county, facility and provider) – including revenue raising, budgeting, forecasting health needs, and procuring drugs and commodities.[68] On the revenue side, fiscal decentralization is typically accompanied by revenue-sharing rules, which specify proportions of revenue that can be retained by local government units and the share that must be contributed back to the center for reallocation to regions with lower revenue-generating capacity.

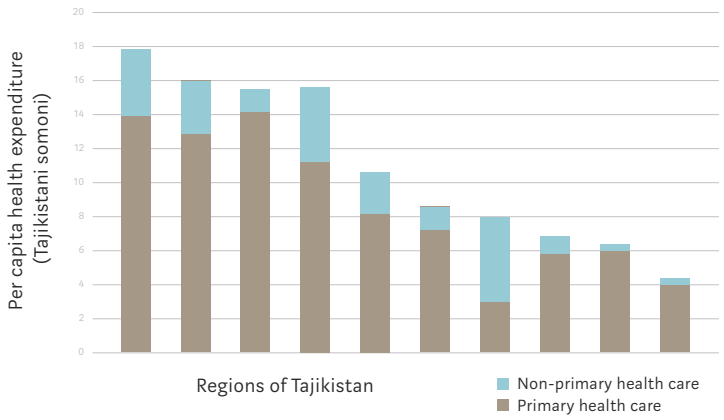
Fiscal decentralization can be at odds with efforts to increase pooling of health funds. In Peru, for example, efforts to improve pooling by channeling a larger share of health budgets through the national health insurance fund have met resistance from the Ministry of Finance because of concerns about financial control and going against decentralization policies.[69] Decentralization can be particularly problematic when there is no mandate or mechanism to transfer funds between budgets and revenue sources. In countries with a high degree of fiscal decentralization for collecting revenues and setting priorities for expenditures, pooling is more fragmented if there is not a strong equity-based mechanism for redistribution. This lessens equity and financial protection. In Tajikistan, for example, rapid devolution of both revenue and expenditure authority to local governments in the immediate post-Soviet period led to fragmented pooling across regions and generated a high degree of inequity, with per capita resources for health in the highest-spending region exceeding that of the lowest-spending region by more than 400%. (See Fig. 6.) In China, by contrast, strong central control over revenue raising and reallocation coupled with greater decentralization in expenditure decisions may have protected equity through "virtual pooling" at the geographic level while providing incentives for investment in health at the local level – with positive effects on health outcomes.[70]

Fragmented revenue streams

A common obstacle to effective pooling in low- and middle-income countries is the fragmentation of revenue streams, with general tax revenues collected and used through the budget system and largely disbursed as input budgets to maintain the health delivery infrastructure, and with other sources of revenue pooled in different accounts (such as local government accounts or an off-budget public insurance fund) and disbursed to providers directly as commodities, as budget top-ups or as direct payment for services.

Effective risk pooling and cross-subsidization can be a challenge when health coverage expands through multiple programmes or schemes. In Thailand, for example, the Universal Coverage (UC) Scheme has the largest risk pool, which effectively ensures cross-subsidization and equitable financial risk protection within that group. However, the per-beneficiary expenditure across Thailand's three insurance programmes is highly skewed because of the lack of redistribution among them (US$ 366 per beneficiary for the Civil Servant Scheme, US$ 97 for the UC Scheme and US$ 71 for the formal sector programme in 2011).[71]

Fig. 6 Inequity in health spending in Tajikistan (2007)



Source: Langenbrunner, Cashin and O'Dougherty (2009)

Some countries have attempted to improve redistribution and equity by integrating multiple programmes, but the results have been mixed. Turkey integrated its multiple insurance programmes and achieved highly equitable cross-subsidization.[72] Viet Nam integrated multiple programmes (including that for the formal sector and the Health Coverage for the Poor Program) but without a mandate or mechanism to pool the revenues for the different insured groups. So although all beneficiaries fall under the management of the same purchaser, Vietnam Social Security, the revenue available to cover services is highly inequitable across population groups.[73] (See Box 8.) Gabon is another example. Coverage schemes for civil servants, the private sector and the poor have been merged into an umbrella fund (CNAMGS). However, revenues have not been pooled, constraining the ability to effectively redistribute funds and sustain coverage for all population groups.[74]

Donor funds often flow in fragmented streams that are not integrated with the government budget, with much donor aid provided off-budget. This not only exacerbates existing fragmentation in pooling of health funds but can also put pressure on domestic PFM systems. In many low-income countries, external funding makes up a significant portion of health or subsector resources. A 2004 study examined donor funding records from 14 countries and found that 50% of donor funds were not recorded in the balance of payments or were provided as off-budget support.[75] The 2010 Tanzania public expenditure review found that although funding pooled with government funds (*basket funds*) made up the majority of development funds for health, more partners were delivering funds through off-budget channels. From 2006/07 to 2010/11, the amount of money flowing through off-budget channels nearly quadrupled in absolute terms.[76]

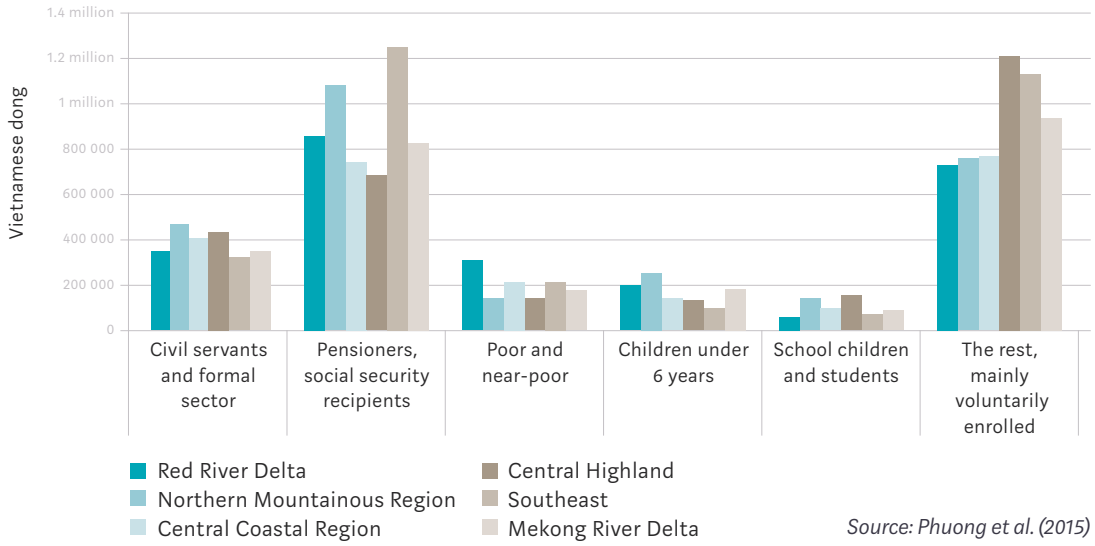
Off-budget donor funds are often allocated to programmes and projects that do not always contribute to reaching the country's priority populations, interventions and services. In Uganda, for example, development assistance for health has increased dramatically, surpassing the government's own expenditures on health, but primary health care and other priorities identified in Uganda's health sector strategic plan remain underfunded.[77]

Box 8 Pooling challenges across revenue sources in Viet Nam

Health insurance in Viet Nam is organized into a single pool, which covers 64% of the population. In practice, however, the country has 63 provincial pools that each cover populations ranging from 300,000 to 4.8 million people. The large number of membership categories – six – each covered by contributions from different revenue sources with different contribution rates, worsens the fragmentation because provinces maintain subpools for each of the six categories.[78]

The social health insurance agency pays district hospitals on a per capita basis to provide basic care to insured individuals. The capitation rates do not reflect health needs; rather, they are based on historic spending levels that are driven by available revenue. The figure below shows average capitation rates by region for the six membership categories. While there is one pool in principle, the fragmentation from the revenue sources flowing into the pool is perpetuated through the provider payment system.

Average capitation rates in Viet Nam by region (2011)



Source: Phuong et al. (2015)

Fragmented input budgets

Input budgets can also be fragmented, with certain parts of the health budget determined using different processes. For example, capital budgets are sometimes determined by a separate ministry, such as a ministry of planning, and not coordinated with operational priorities. In many low- and middle-income countries, most health workers are civil servants, so salary budgets are determined according to civil service rules and pay scales that are outside of the health budgeting process, and health workers receive their salary directly from the treasury. Although staffing allocations may be based on need, they are often tied to historical staffing patterns with an urban bias and other sources of inefficiency and inequity.[79] This dynamic can lead to accountability and oversight problems because of difficulties in coordinating across institutions. Holding any one person or entity ultimately responsible for meeting health sector objectives can be challenging.

Staff salaries and allowances account for 9% to 80% of total government health expenditure, with an average of 29% in Africa and more than 50% in the Eastern Mediterranean.[80] Maintaining control over public-sector wages is a key PFM challenge, but maintaining separate budgeting and salary payments keeps a large segment of health resources outside of pooling arrangements, where they cannot easily be moved to address variations in health need. The incentives of provider payment systems are weakened when salaries are not pooled with other health funds and these payment mechanisms are used only to pay for other nonsalary costs. Thailand has significantly improved pooling of health funds, but bringing government health worker salaries into the pool has proved challenging. (See Box 9.) Other health spending areas that may be included, planned and disbursed outside of the health sector budget include centralized procurement of some pharmaceuticals and other commodities, capital investment and training.

Box 9 Challenges with pooling salaries in Thailand

Launched in 2001, Thailand's Universal Coverage Scheme is managed by the National Health Security Office and covers 75% of the population.[81,82] The scheme is financed through a per capita allocation from the national budget that is calculated to cover the costs to public (and some private) providers of delivering services in the comprehensive benefits package, including staff salaries.

The plan to use the budget to pool and redistribute funding for salaries ran counter to civil service workforce rules, which mandate that civil service salaries be made in a separate government allocation and not be used for other purposes. In the first year of the scheme, the inclusion of salaries in the per capita allocation also led to financial deficits for provincial hospitals with a relatively high concentration of staff, while those with fewer staff received surplus funding. Using its authority to manage the budget during the three-year transitional period, the Ministry of Public Health removed salaries from the capitation-based allocation. Nonetheless, the share of salary funding being channeled through the scheme rather than the general budget process has been growing and has led to a slight improvement in the equitable distribution of human resources for health.

Misalignments in health purchasing

Strategic purchasing is widely used in health systems of all types to create the right incentives and manage health funds efficiently. Aligning financial incentives with the objectives of the health system requires flexibility to pay providers for service outputs and performance and to fine-tune incentives as health needs and objectives change.[83,84] Other strategic purchasing approaches include negotiating with pharmaceutical suppliers to manage drug costs, deliberately channeling resources to more cost-effective services, and building in incentives for both providers and patients to limit the use of high-cost and unnecessary services.

Strategic health purchasing requires institutional authority to make purchasing decisions, including the selection and design of provider payment systems, and enter into contracts with providers. It also requires flexibility to allocate funds to pay for outputs and outcomes, and well functioning information systems to design, implement and monitor purchasing mechanisms.[85] A large purchaser or multiple purchasers operating under a unified set of rules and regulations can exert influence over how health care resources are used and how providers deliver services. Systems with fragmented pooling typically also have fragmented purchasers, greatly weakening the ability to match

resources with health sector priorities and create appropriate incentives for providers. In countries with a single purchaser or a few large purchasers covering the entire population, the power to shape overall resource use in the health sector can be profound.[86]

Giving incentives to providers to be efficient and deliver high-quality, cost-effective services is not enough, however – providers also need enough autonomy and flexibility to respond to incentives. Line-item budgets reduce the opportunity for providers to combine inputs and services in the most efficient ways to respond to incentives and meet the health needs of the populations they serve.[87]

A number of challenges can make it difficult to align PFM rules with the institutional and technical requirements of strategic health purchasing:

- budgeting by health facility and inputs rather than by services
- different purchasing arrangements and accounting for different revenue streams
- lack of provider autonomy
- obstacles to engaging the private sector
- government procurement rules that limit flexibility
- delays in the release of funds
- poor information systems and monitoring capacity.

Budgeting by health facility and inputs

Input-based line-item budgeting poses challenges not only for raising revenue for health and ensuring that budgets match service needs but also for health purchasing. This type of budgeting often undervalues the management capabilities and flexibility that providers need in order to combine inputs into services, and it offers few opportunities to create incentives for the right services to be delivered in the right way and most efficiently. Systems in which the national treasury retains strict control over payment to health providers are even more inflexible.[88] In Mongolia, even though the Ministry of Health identified strategic purchasing – and, in particular, provider payment – as an important way to direct limited funds to priority services, strategic purchasing has been limited by the continued flow of all public funds through facility-based line-item budgets that are tightly managed by the national treasury. Some new output-oriented payment systems have been used in the social health insurance system, but it remains difficult to create incentives for providers because all funds are planned, disbursed and accounted for using input-based line-item budgets.[89] The lack of flexibility to reallocate budgets based on service needs was noted by providers in a health facility survey in Mongolia; some said lack of flexibility had a more negative impact on the quality and efficiency of service delivery than low budget levels.[90]

Furthermore, when the health facility is the unit of budgeting and facilities are paid by input line item, it is difficult to ensure that efficiency gains are retained by the health sector and reinvested in services. In Mongolia, when a provider is more efficient and spends less on one line item (such as electricity), the savings are returned to the treasury even if the provider has greater-than-expected need for another line item (such as medicines).[91]

Different purchasing arrangements and accounting for different revenue sources

Different revenue sources often come with their own purchasing agencies and approaches, and health care providers may receive payment in multiple ways that can create uncertain revenue streams with conflicting incentives. This, in turn, makes it difficult to match funds with services and achieve efficiency gains.[92] For example, when a provider receives funds through a line-item budget from the ministry of health as well as output-based payment from a national health insurance fund, any incentives for efficiency and productivity within the output-based payment system are muted. In addition, parallel purchasing, accounting and reporting systems often exist for donor funds, further complicating the incentive environment and adding administrative burden.

The lack of coordination among multiple funding sources can also limit the ability of policy-makers, purchasers and health providers to accurately record and report expenditures. For instance, health funding in Tanzania at the district level occurs through government block grants, donor basket and nonbasket funds, money from councils' own funds, the National Health Insurance Fund, the Community Health Fund, private sources and unclassified sources. This makes it difficult for policy-makers to know the total level of funding and payment to primary health care providers, and it limits the ability of purchasers to strategically allocate resources and create incentives for efficiency and quality.[93]

Lack of provider autonomy

The level of provider autonomy over financial, personnel, service delivery and other decisions affects providers' ability to respond to incentives by changing the mix of inputs and services they deliver. The more areas over which providers have decision rights, the more flexibility they have to respond to the incentives of purchasing and provider payment policies and the more powerful the incentives will be. Provider autonomy should also be accompanied by managerial capacity, access to information for making strategic decisions, and accountability.

In systems where providers have little management autonomy, the results of new purchasing and payment methods will be either diminished or perverse. For example, if the payment method – such as capitation – creates strong incentives for efficiency but providers do not have the flexibility to alter the mix of inputs they use (such as by shifting staffing), service quality can suffer. In Indonesia, the purchaser for the national health insurance system pays primary health care providers by capitation, but there are strict rules about how public providers can allocate those funds between staff payments and other operational costs. In addition, a provider that receives funds from multiple revenue streams must allocate and account for them separately. These financial rules greatly diminish the potential of the capitation payment system to encourage efficient use of resources and better service delivery.[94] Limited provider autonomy and flexibility to respond to new incentives has been a major factor in the failure of new health purchasing approaches to bring significant benefits in many countries.[95]

Greater provider autonomy at the primary care level has been shown to improve service delivery in many cases,[96] but excessive financial autonomy for hospitals without strategic purchasing in place can have a negative impact. In China and Viet Nam, for example, hospital autonomy policies have made public hospitals largely self-financing and the purchasing strategies of the health insurance agencies remain weak. The result has been increased supply of high-cost services relative to primary care, more out-of-pocket burden on patients and less efficiency overall.[97,98]

Obstacles to engaging the private sector

In many countries, a large share of health service use occurs in the private sector, and efforts to expand coverage must engage private providers to ensure access and respond to population demands. In South Africa, 70% of physicians are in the private sector but 68% of the population seeks care only in the public sector. For the country to implement its ambitious plans to establish a national health insurance system funded predominantly from general budget revenues, this imbalance must be addressed, and it may be necessary to allow public funds to be used to purchase services from private providers.[99] Even in countries where the private sector remains small, the growing demand for health services is creating a need to bring private providers into public health coverage.

PFM rules can create obstacles to contracting private providers using public funds or managing private funds in public facilities. If budgets are formed and disbursed using input-based line items, there may be no mechanism to allow public funds to flow to private providers. Even in countries where contracting with private providers using public funds is allowed, the rules often disadvantage the private sector. For example, public provider salaries are typically paid directly by the treasury, so this subsidy should be accounted for when setting payment rates for private providers. However, some PFM systems do not allow differential payment rates for the private sector or the system has insufficient revenue to pay higher rates. In Indonesia, the purchasing agency for the national health insurance scheme (BPJS-K) contracts with both public and private providers. BPJS-K pays the same payment rates to

both public and private hospitals, although public providers are highly subsidized by the government, which covers health worker salaries and investment costs through the line-item budget.[100] On the other hand, public providers who earn money privately on private wards in public facilities or through direct out-of-pocket payments from individuals may not have a mechanism for reporting that revenue.

Government procurement rules that limit flexibility

In many low- and middle-income countries, procurement of essential medicines, other health commodities, supplies and equipment remains centralized in the ministry of health or other central bodies, and procurement regulations are often outdated and cumbersome. This reduces the flexibility to obtain medicines and other supplies in the right quantity and at the right time to meet service delivery needs.[101] A well functioning procurement system benefits from both more centralized negotiation of multi-year purchase agreements (known as *framework agreements*) and more decentralized ordering and purchasing by providers to directly match supply with need.

In Chile, for example, the government negotiates multi-year agreements with suppliers for selected products under its e-procurement system, ChileCompra. All government agencies can order against these agreements using an electronic catalog, receiving the lower prices negotiated by ChileCompra and avoiding the costs and lead times associated with individual purchasing agreements.[102] With such framework agreements, health purchasers can include payment for medicines and other commodities in the rates they pay service providers, and providers can use the revenue to procure medicines efficiently under the prenegotiated agreements. Procurement rules in many countries limit the use of framework agreements, however, and they include other cumbersome provisions that limit flexibility and the ability to match supply with need at the service delivery level.

Delays in the release of funds

Many delays can happen during the budgeting process, resulting in the release of funds later in the year. This makes it even more difficult to match funds with health service needs. In Nepal, for example, more than half of the health budget was not received until the last four months of the year in 2012, which led to underspending and almost 20% of the budget not being used. The PFM rules themselves can also contribute to delays and difficulty absorbing funds. Nepal's District Health Offices were criticized for not being able to absorb funding, but they did not have adequate time to follow the necessary processes for expenditure accounting and approvals.[103]

Delays in the release of funds also make it difficult for the purchaser to enter into credible contracts with providers. This not only leaves providers without sufficient funds to meet service delivery needs, but it also weakens the purchaser's position in negotiating with providers and its ability to implement strategic payment systems. In Ghana's National Health Insurance Scheme, for example, chronic delays in the release of funds led to threats by service providers to pull out of the scheme. This would have curtailed access to services for the insured.[104]

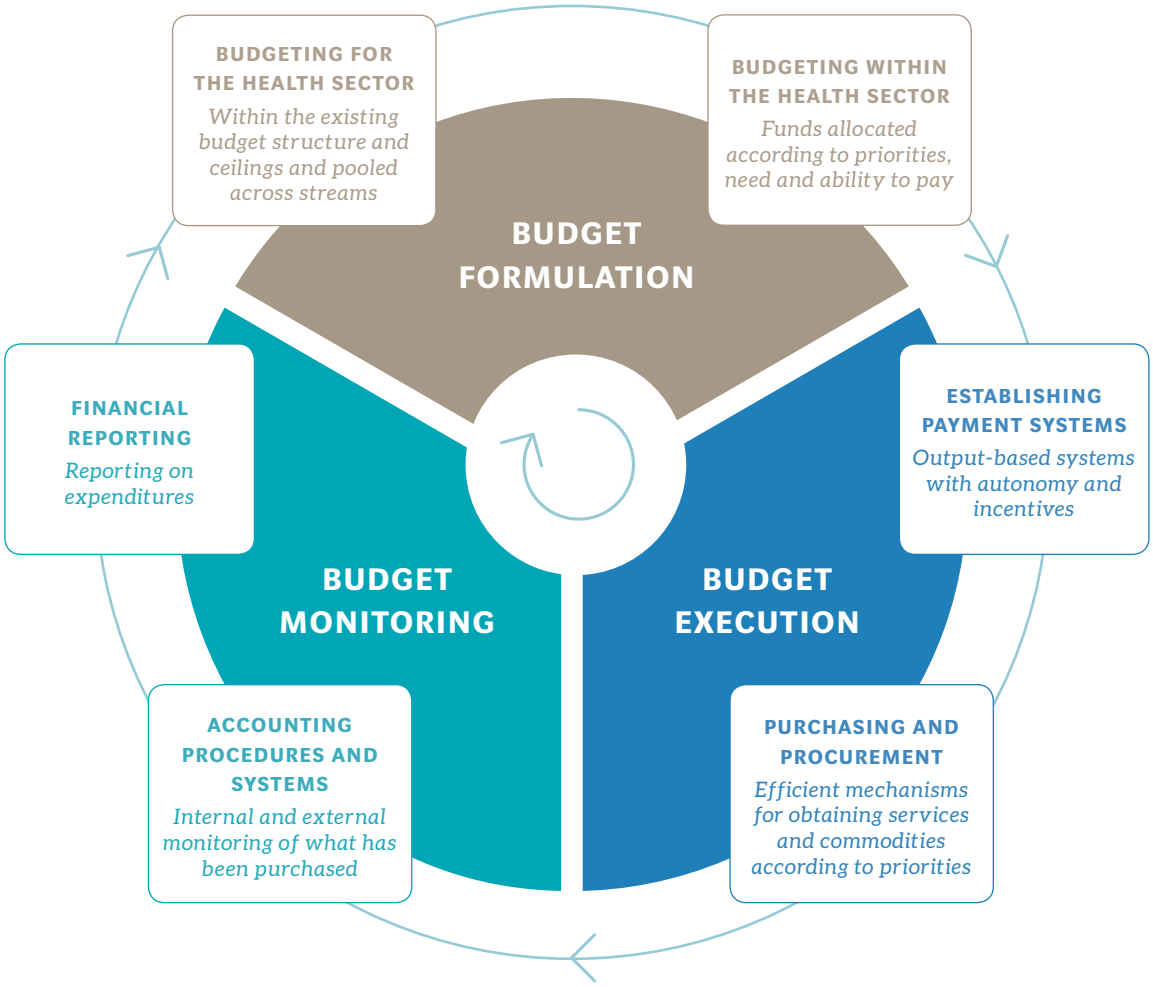
Poor information systems and monitoring capacity

Weaknesses in financial management information systems and fragmentation across the ministry of health and in the overall financing data architecture can make it difficult to monitor the use of funds and what services are actually being purchased with public funds. For example, before large-scale improvements were made in South Africa, the country had numerous information systems (including different financial management systems), a cash-based basic accounting system, a separate payroll system and a separate logistics systems. These systems could not be integrated, which made it difficult to aggregate and analyse data.[105] Poor financial management and monitoring systems are also often cited by ministries of finance as a reason to delay moving to output-based payment systems, which they think will make expenditures more difficult to track.[106]

Aligning the PFM system and health financing system

Alignment between the PFM system and health financing system can lead to a single, integrated cycle. (See Fig. 7.)

Fig. 7 **Integrated health sector financial management**



The most common ways that countries have tried to address inconsistencies among their PFM system, health budgeting practices and health financing policy fall into three main categories (as shown in Table 2):

- general improvements in the implementation of PFM reforms
- specific PFM mechanisms for the health sector
- extrabudgetary funds and transactions.

Table 2	Ways that countries try to improve alignment between the PFM system and health financing system

General improvements in the implementation of PFM reforms	Specific PFM mechanisms for the health sector	Extrabudgetary funds and transactions
Incremental PFM process improvements and making better use of existing flexibilities General improvements in information and analysis	Earmarking for health (to improve revenue raising) Formula-based budget allocations for health (to improve pooling) Intergovernmental fiscal transfers specific to health (to improve pooling) Output-based provider payment (to improve purchasing) Autonomy for health providers (to improve purchasing)	Extrabudgetary funds Donor-funded results-based financing schemes

These approaches are discussed here not as recommendations but rather as a way to examine country experience. Making general improvements in the implementation of PFM reforms is usually a long-term endeavor and largely outside of the control of the health sector, although the sector can at times take the lead in adopting or piloting new approaches. The feasibility and value of the other two types of measures depend on the particular country context.

As countries have worked to reform their PFM system, some have taken specific measures to address the needs of health financing and budgeting, such as making pooling of health funds possible within the context of fiscal decentralization or allowing specific health purchasing strategies and output-based payment systems. In countries where the specific health financing needs cannot be accommodated within the budget rules, extrabudgetary funds managed by quasi-autonomous agencies, such as national health insurance funds, sometimes assume responsibility for all or part of the health pooling and purchasing functions. Some countries have such entrenched PFM challenges that they turn to schemes that bypass the public system almost entirely. One approach that has been promoted by the donor community is results-based financing (RBF) schemes that use extrabudgetary transactions to send funds directly to front-line health providers in the form of performance incentives.

In most countries, some combination of approaches is necessary to improve alignment between the PFM system and health financing policy objectives. Regardless of the specific country context, all of the steps toward improving alignment between the PFM system and health financing system are intended to promote good financial management and ensure that effective services are purchased for the population in the most efficient way. The most important underlying steps are to establish a platform for ongoing dialogue between the health authorities and finance authorities, focus on improving service delivery and other common objectives, and generally improve transparency and accountability.

General improvements in the implementation of PFM reforms

Improving implementation of planned PFM reforms through incremental system and process improvements can lead to better alignment with the health financing system, especially when combined with better use of information and analysis to increase transparency and more informed dialogue between health and finance authorities.

Incremental system and process improvements

In many cases, basic system and process improvements or incremental steps toward greater budget flexibility can accelerate the process of implementing PFM reforms and generate substantial improvements in budgeting for health. Consolidating and reducing the number of budget line items, for example, can allow greater flexibility for expenditure reallocation within a smaller number of larger line items.

Because they are typically large in scope and involve structural changes, PFM reforms can be slow to be adopted in general and by a sector in particular. In this case, the health sector may underuse new approaches or existing flexibility in the PFM system. For example, sometimes programme-based budgeting is allowed within a country's PFM system but the health sector does not use it. This was the case in Mongolia, where the health sector was accustomed to estimating budgets based on historical input-based allocations to health facilities.[107] In some cases, however, the health sector has taken the lead in piloting reforms such as programme-based budgeting. In Peru, early efforts toward programme-based budgeting and budgeting were based on a methodology developed by the health sector.[108]

Finally, health and finance authorities have a shared interest in ensuring good financial management by all actors in the health and finance systems. While this is difficult to achieve and requires continuous system and management improvements, it is made easier by the increasing international standardization of basic financial management systems, including accounting, reporting, internal controls, internal auditing and external auditing, which in general do not vary as much as the country-specific health financing revenue-raising, pooling and purchasing arrangements they support.

Improved information and analysis

Better information and analysis can lead to improvements in transparency and accountability, better resource allocation and efficiency in the health sector, and greater trust in public services. In Mexico, the prices of publicly procured medicines can vary as much as 3 000% among public institutions, which indicates large inefficiencies and possibly corruption. The Mexican government formed a coordinating commission to increase transparency of procurement prices and create the opportunity for public agencies to jointly negotiate prices.[109] In Kyrgyzstan, formalizing copayments and publicizing entitlements and copayment requirements under the Mandatory Health Insurance system effectively reduced illegal out-of-pocket payments for health care.[110]

Better use of information and analysis can also contribute to more informed dialogue between the ministry of health and ministry of finance. For example, estimates of funding requirements that are based on an understanding of the macroeconomic and fiscal constraints are more credible to ministries of finance.[111] Helpful PFM tools and analytical approaches include fiscal sustainability reporting, demographic projections, and integrated investment and operational planning. Public expenditure reviews have been widely used to scrutinize public spending to identify sources of inefficiency, ineffective spending patterns or potential new sources of revenue.[112]

A transparent platform for dialogue on health financing policy – such as cross-sector working groups – can promote common understanding between health sector leaders and central budget authorities. In Tanzania, a PFM working group that includes representatives from the Ministry of Health ensures that improvements to the health financing system are being considered as part of ongoing strengthening of the PFM system.

Specific PFM mechanisms for the health sector

In some countries, general strengthening of the PFM system is not enough to address the needs of health financing, and specific PFM mechanisms may be required to ensure adequate revenue allocations, create a mandate and mechanisms for pooling of health funds, or allow flexibility for strategic purchasing.

Earmarking for health to protect or increase revenue

Many countries earmark revenue – from a specific tax or group of taxes – for health to ensure adequate funding, especially when the link between policy and budget formulation is weak. Some implement expenditure earmarking – mandating a specific destination for a proportion of general funds either to the health sector in general or to a specific health program, population or service.[113] Earmarking has recently become part of the dialogue on domestic resource mobilization for health, particularly as countries transition away from donor-supported global health programmes.

A review of country experience with earmarking for health suggests that the results of earmarking for health are highly context-specific and dependent on a country's political priorities and budget process.[114] In some cases, earmarking has been a tool to advance and sustain a national health priority. In Ghana, Estonia and the Philippines, earmarking for health has made it possible to launch or expand a national health insurance program – and in the case of South Africa, to mobilize an effective domestic response to the HIV/AIDS epidemic. Ghana, Estonia and the Philippines earmark a portion of revenue from the value-added tax (VAT), payroll tax and alcohol/tobacco taxes, respectively. South Africa generally does not favor revenue earmarking, but it uses some expenditure earmarks to help ensure that priorities are met in a highly decentralized context. (See Box 10.)

The review also found, however, that in most cases earmarking is unlikely to bring a significant and sustained increase in the priority placed on health in overall government spending. Budgets are fungible, and earmarking one revenue source is likely to result in offsets through cuts in other sources. This is the case, for example, in Gabon, where increases in earmarked revenues through mobile phone and monetary transfers taxes were offset by reductions in general budget revenues in the following years.[115] Furthermore, earmarking by definition introduces rigidity in the budget process, and the inefficiencies in some cases can be severe. Earmarking has been more effective when practices come closer to standard budget processes – that is, softer earmarks with broader expenditure purposes and more flexible revenue–expenditure links.

Formula-based budget allocations for health

In the absence of a single national pool for health funding, the key mechanisms for accumulating funds for health and spreading risk are transfers across government administrative levels, between the government budget and government health purchasers, and across multiple insurance programmes. Transfer mechanisms include PFM rules that allow funds to move across administrative levels and institutions (*intergovernmental fiscal transfers*) and technical formulas that inform them (*resource allocation formulas*).

In systems such as in the United Kingdom that are mostly centralized in terms of revenue raising but have varying degrees of expenditure authority at subnational levels, health funding is pooled at the national level and then redistributed geographically using a needs-based allocation formula.[116] In Denmark, a national 8% income tax earmarked for health is collected (and pooled) by the central government and then redistributed to five regions and 98 municipalities through a risk-adjusted capitation formula and some output-based payment.[117]

Box 10 Expenditure earmarking in South Africa

Expenditure earmarking is the practice of mandating specific destinations (such as programmes, populations or services) to which funds for the health sector should be directed. This is distinct from revenue earmarking, which instead dictates what proportion of a particular funding source – which might be generated from a diverse set of revenue bases, such as income, payroll and sales tax – should be allocated to the health sector generally or toward a health programme, population or service.

Expenditure earmarking is a regular and official part of the South African budget system.[118] Within the country's federal system, a high degree of autonomy is exercised at the provincial level with respect to planning and budgeting. This can make it difficult for the central government to ensure that funds are being spent for their intended purpose.

Expenditure earmarks in South Africa are flexible and can be subject to regular amendment and updates. Many line items in the Department of Health budget are earmarked for expenditures, with as much as 20% of the health budget spent through conditional grants to the provinces, with other allocations also earmarked. The largest and most influential expenditure earmark is for HIV; it is seen as instrumental to the country's response to the epidemic. As priorities evolve, the government is considering how to use the HIV/AIDS grant in a more flexible manner to finance overall primary health care and service delivery improvements.

In China, since the process of decentralization began in the 1980s, revenue-sharing rules have evolved from central control of 80% of all revenues to more complex formulas aimed at allowing financially weaker regions to retain a greater share of revenues and subsidies, and finally in the 1990s to centralization of all tax collection and reallocation.[119] Evidence from Organisation for Economic Co-operation and Development (OECD) countries also shows that revenue-sharing rules can help mitigate inequities associated with fragmented geographic pools from fiscal decentralization.[120]

In Colombia and Chile, use of an allocation formula as part of decentralization reforms was shown to help improve equity in resource allocation for health. In Colombia, 1993 laws on fiscal decentralization allowed for formula-based budgeting based on population and other indicators. Two formulas were put in place based on the source of funding: one for municipal funds (based on poverty, unmet needs, fiscal contributions from individuals, administrative efficiency and quality-of-life indicators) and the other for equal allocations across departments and municipalities (based on population and inflation). In Chile, reforms began in the 1980s, with a focus on primary health care decentralization that allocated intergovernmental transfers to the primary health care level and per capita allocation directly to municipalities, adjusted for rurality and poverty level. Chile also put in place the Municipal Common Fund to redistribute funds from wealthier to poorer municipalities.[121]

Resources can also be allocated across geographic areas by using a measure of how much the poor are likely to benefit from the spending (*benefit incidence*).[122] For instance, a recent study using benefit incidence analysis of capitation-based resource allocation for health in Mozambique found that while equity had improved in 2011, inequities were found in the distribution of utilization – that is, the neediest and poorest individuals did not always have the highest utilization levels. The study also found that donor funding was targeted more at the middle quintiles while the government was more successful at targeting those most in need.[123]

In health systems with more fragmented revenue sources, the benefits of pooling can be achieved through intergovernmental fiscal transfers. Japan, for example, has multiple insurance plans for different insured groups, but all plans must meet national standards, such as uniform benefits. Because the age distributions and risk profiles of enrollees vary across the plans and contribution rates are thus highly skewed, transfers are made from the central and local governments to the most disadvantaged plans, along with other tax-financed adjustments. These redistribution mechanisms have improved equity across plans and population groups and have helped keep down the growth rates of premiums overall. The contributions as a proportion of income, however, still vary more than threefold.[124]

In Germany, the national health insurance system includes 180 competing schemes, or "sickness funds." The system is funded by a mandatory payroll tax assessed from both employers and employees. Because of imbalances in revenues and expenditures across sickness funds due to the differing risk profiles of the populations they serve, a 2009 policy change required all money collected by the sickness funds to be pooled in a new central fund and then redistributed back to the sickness funds according to a risk-adjusted capitation formula.[125]

Output-based provider payment

Paying health providers for service outputs and performance rather than inputs is one of the most important ways to improve health financing and the effective use of public funds for health. Because it is difficult to predict which health care providers will deliver exactly which services, and because of the need to create incentives for quality and efficiency, most countries eventually move away from provider payment through input-based budgets capped at the health facility level.

The most commonly used output-based payment methods are:[126]

- **Capitation** (per capita). Providers are paid a fixed amount in advance to provide a defined package of services for each enrolled individual for a fixed period of time.
- **Case-based** (diagnosis-related groups). Hospitals are paid a fixed amount per admission or discharge depending on the patient and clinical characteristics, which may include department of admission/discharge, diagnosis and other factors.
- **Fee-for-service** (tariffs or fixed fee schedule). Providers are paid for each individual service delivered. Fees or tariffs are fixed in advance for each service or bundle of services.
- **Global budget**. Providers receive a fixed amount per specified period to cover aggregate expenditures for providing an agreed-upon set of services. The budget can be spent flexibly and is not tied to line items.
- **Per diem**. Hospitals are paid a fixed amount per day for each admitted patient. The per diem rate may vary by department, patient, clinical characteristics or other factors.

There is no ideal payment method, and every method has strengths and weaknesses and can produce unintended consequences. But all payment methods can be useful at particular times and in particular contexts to address specific obstacles to increasing efficiency, equity or access or to enable specific service delivery improvements. For example, fee-for-service payment can lead to cost escalation in many contexts, but the method can be useful if a key priority is to increase productivity or service use.[127]

The capitation and global budget payment methods inherently limit financial commitments to providers. The other methods can be open-ended and thereby pose risks to financial and budgetary control by the purchasing agency. For open-ended payment systems, some other form of expenditure control is required, such as global caps on health subsectors, a total cap on payments to all hospitals (as in Thailand and in some provinces in China[128,129]) or a cap on individual providers (as in Mongolia[130]). A payment system can also add commitment controls and remain "budget-neutral"[131] – that is, keep total payments to health providers within the limits of the purchaser's budget – by adjusting payment rates downward if volume increases too much. This approach requires robust monitoring and information systems, however.[132]

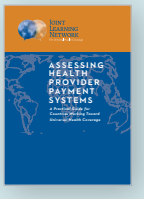
Autonomy for health providers

Health care providers should have enough autonomy to internalize incentives and make key decisions about allocating their internal resources. Health purchasing is more effective when providers have authority over key management decisions, such as staffing, physical assets, organizational structure, output mix and use of surplus revenue. Provider autonomy goes hand in hand with the shift to output-based provider payment systems.

In some systems, public providers can gain more management autonomy only when their legal status is changed and they become corporatized public entities or are privatized. In Mongolia, for example, most public providers continue to be constrained by line-item budget restrictions, but primary care providers (family group practices) were privatized in 1999 as part of health financing reforms and are now contracted with government funds and receive lump-sum capitation payments. Capitation payments are considered to be too low, but family group practices have been able to realize efficiency gains not seen among public providers because of their private status.[133]

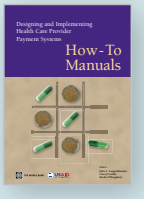
There is no ideal institutional arrangement that enables both effective purchasing and effective provision of health services in all settings. Rather, each country must take a different approach to ensure that the right incentives, rules and timing are in place to produce the desired results. A good starting point is reforms that consolidate funding flows and increase flexibility to allocate payments from line-item budgets to service providers. In Tanzania, for example, service providers receive various off-budget funds in facility bank accounts that can be released, with approval, and used to plan, budget, procure and manage funds flexibly to improve service delivery. This "micro-pool" improves purchasing even though it does not address broader pooling and financial risk protection problems.[134]

Helpful resources



Assessing Health Provider Payment Systems (JLN)

www.jointlearningnetwork.org/resources/assessing-health-provider-payment-systems-a-practical-guide-for-countries-w



Designing and Implementing Health Care Provider Payment Systems (World Bank/USAID)

elibrary.worldbank.org/doi/abs/10.1596/978-0-8213-7815-1

Extrabudgetary funds and transactions

Many countries are unable to achieve the necessary flexibility within their PFM system and opt to move certain health agencies, programmes or operations outside the government budget process through extrabudgetary funds or transactions, such as donor-funded RBF schemes.

Extrabudgetary funds

Extrabudgetary ("off-budget") funding arrangements can free some health financing functions from aspects of the government budgeting processes, salary scales and personnel rules and can carry over surpluses to the subsequent year. (See Box 11.) For example, many countries establish a quasi-autonomous health insurance fund to perform pooling and purchasing functions. Although this approach increases flexibility, especially in budget execution, it can also reduce the comprehensiveness and transparency of the national budget and possibly the ability of the government to manage the budget strategically and ensure good financial control.

Extrabudgetary funds are common in systems where earmarked revenues are managed by agencies through statutory funds. For example, the National Health Insurance Authority (NHIA) in Ghana manages the National Health Insurance Fund (NHIF), the statutory fund for the earmarked portion of the value-added tax and social security contributions that fund the National Health Insurance Scheme (NHIS).[135] Even in Thailand, where the UC Scheme is funded from general revenues, a quasi-autonomous agency (the National Health Security Office, or NHSO) manages the revenue flexibly after receiving a lump-sum budget allocation in an off-budget fund. The UC Scheme is funded by an annual negotiated per capita funding allocation (not an earmark) that is transferred to the NHSO in a lump sum through one grant line in the general budget. This allows flexibility to pay health care providers contracted through the UC Scheme, both public and private, using output-oriented payment systems such as capitation for primary care and case-based payment using diagnosis-related groups for inpatient cases.[136]

Box 11 Extrabudgetary funding arrangements

In practice, *extrabudgetary funding* refers to a diverse and often complex set of arrangements with different functions occurring on or off budget.[137]

- Off-budget *transactions* include all revenues, expenditures and financing transactions that are excluded from the budget.
- Off-budget *accounts* are the bank accounts into which extra-budgetary revenues and expenditures are paid and from which disbursements are made.
- Off-budget *entities* are organizational units that are engaged in extrabudgetary transactions, have their own bank accounts and financial management procedures, or have a legal status that is independent of government ministries and departments.

Extrabudgetary funds carry large fiduciary risks if they are completely outside of the PFM system, are not subject to basic PFM rules or have weak governance structures and institutions. They can also undermine the coherence of the health strategy. However, examples exist of extrabudgetary funds that are fully integrated into health strategies and budgeting and are under the PFM system up to the point of flexible disbursement to the managing agencies. In Ghana, the NHIF receives earmarked transfers for the NHIS as a line in the total government budget and the revenue is therefore part of the consolidated budget. The funds are controlled through the government's PFM system up to the point when they are released in a lump sum to the NHIF, after which they can be disbursed flexibly by the NHIA and used to pay health care providers that deliver services through a variety of output-based payment systems. The NHIF and NHIA have a transparent governance structure, including a board of directors that is accountable to Parliament.[138]

Nonetheless, extrabudgetary funds can be problematic from a fiscal oversight perspective; transparent financial rules, clear expected outcomes and strong monitoring (including fiscal risk oversight) are needed.

Results-based financing

Some countries have used donor-funded RBF programmes to channel a portion of payment to providers outside of the input-based budget based on performance targets. Such payments can be allocated flexibly by providers themselves. The RBF programmes thus introduce some output-based payment within a traditional budget system.

Under Argentina's Programa Sumar (formerly Plan Nacer), the national and provincial governments can link funding for Provincial Implementation Units (and, in turn, for provincial health providers) to results. To make this possible, the government has developed and implemented many mechanisms that were not previously common in the public sector, such as management and performance agreements, output-based payment rates, and monitoring, auditing and evaluation systems. Only about 1–3% of provincial health spending is through Programa Sumar, with the remainder flowing through input-based budgets, but even this relatively small amount of output-based payment is considered to have increased coverage of key maternal and child health services and improved health outcomes.[139]

Donor-funded RBF programmes raise questions of sustainability and whether this mechanism can bring about deeper changes in health financing systems over the long term. Many RBF programmes are outside the overall government process because the resources and the provider payments come directly from donors or their proxy management agencies. Some countries, such as Burundi and Rwanda, have incorporated RBF as a line item in health budgets that can be disbursed flexibly over time.[140] In Rwanda, the RBF programme is considered an important contributor to the government-wide movement toward linking funding to performance in contracts with departments and district councils.[141]

Conclusion

Many low- and middle-income countries must increase government health spending in order to achieve their UHC goals. But how money flows through the system to reach priority populations, interventions and services is also crucial.

Many countries can make better use of public funds for health and reduce inefficiencies by improving the alignment between the PFM system and health financing system, including the underlying budget processes and health financing objectives. This requires more productive and informed dialogue between the ministry of health and the ministry of finance, as well as a broader view of what constitutes and creates inefficiency. Inefficiencies in the management of the health sector itself must be addressed in order to reduce waste and increase the ability of the sector to absorb and effectively use additional funds. But some inefficiencies can also stem from the PFM system if it has been slow to modernize and has created rigidity, unpredictability and fragmentation of revenue sources.

For health expenditures to be more effective and efficient, the PFM system needs to be flexible enough to accommodate the particular requirements of the health sector. Mechanisms are needed to pool funds, protect individuals against financial risk and improve equity, given the variation and unpredictability in needs across geographic areas and over time. Purchasing and payment strategies that incorporate financial and other incentives for efficiency and quality are needed to bring more value for money in a sector where there is a high degree of uncertainty and where decisions made by providers and the population significantly affect resource use. These strategies require that purchasers have flexibility to pay for service outputs and performance, and they require that providers have flexibility to manage their resources and deliver services in a responsive way. At the same time, health policy-makers must demonstrate that they can manage funds effectively at all levels of the system and deliver on their commitments to the population. Policy-makers, programme implementers and providers must be willing to commit to clear, measurable goals for which they will be held accountable.

Improving alignment between the PFM system and health system requires ongoing dialogue between health and finance authorities and other entities, such as local governments. The PFM system should be considered when health financing policy is designed, and health financing policy objectives should be considered when decisions are made to modernize and improve the PFM system. Through this coordinated approach, the goals of both the health sector and the PFM system – efficient and effective use of public funds and fiscally sustainable progress toward UHC – can be jointly accounted for and collaboratively achieved.

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