

Strategizing national health in the 21st century: a handbook
Chapter 8

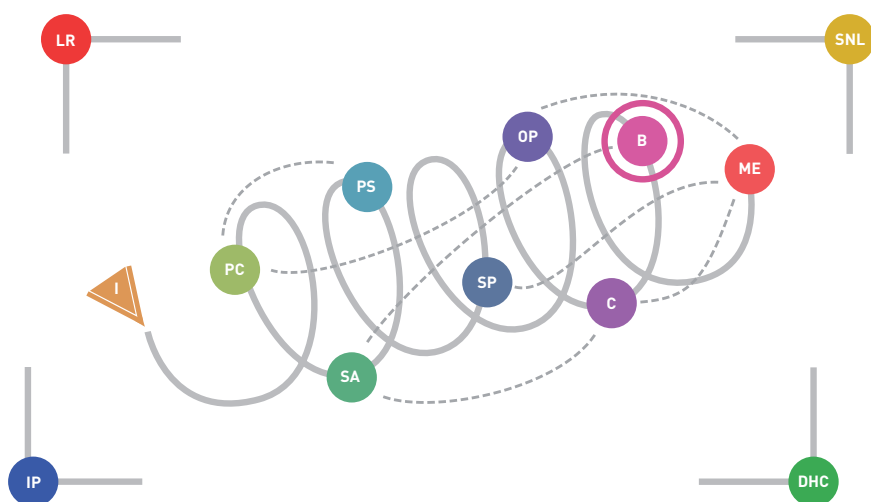
Budgeting for health

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Karin Stenberg





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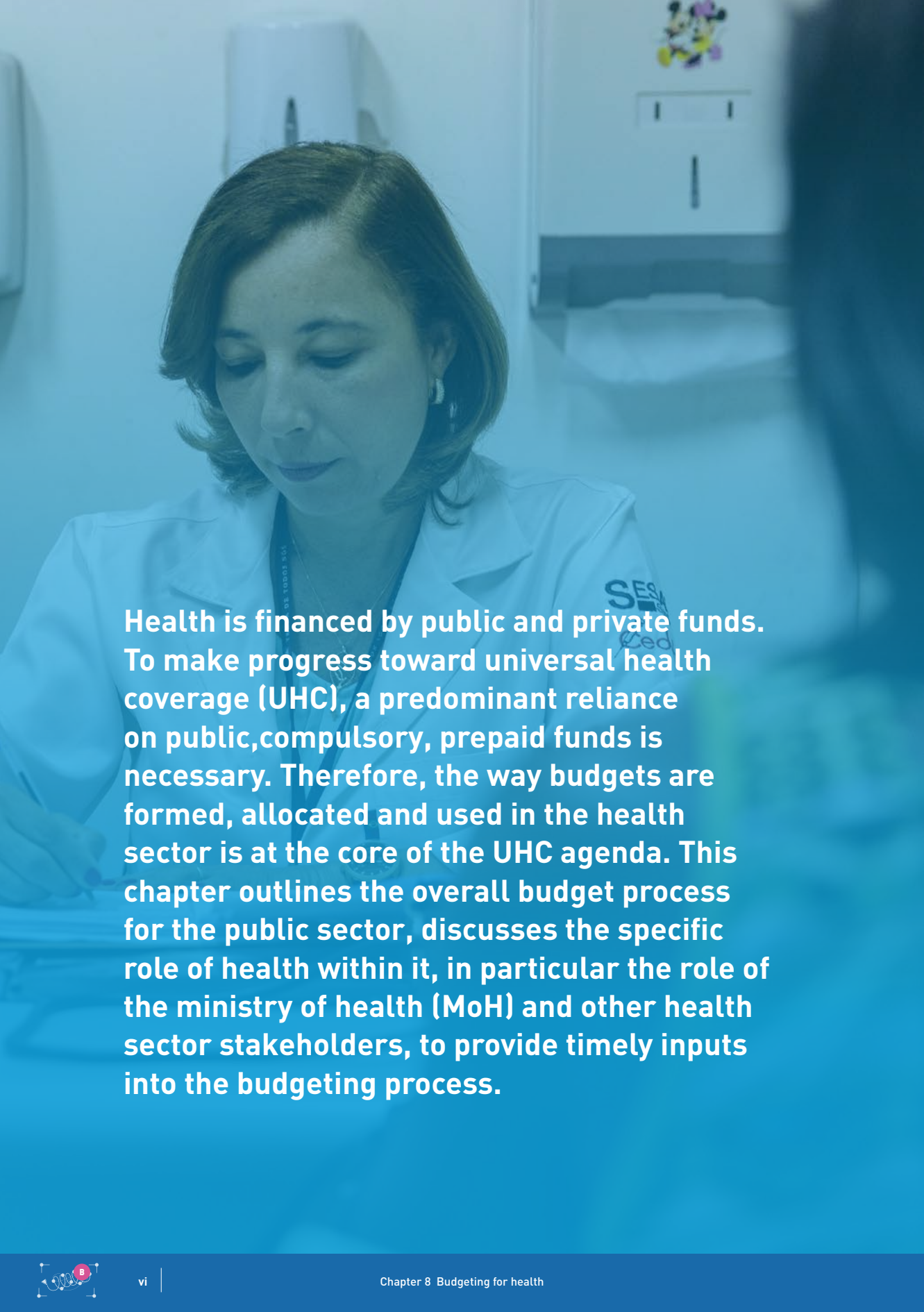
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Overview

Engaging in budget preparation, understanding guiding principles of budgeting as well as the political dynamics that enable the budget elaboration and approval process, is essential for health planners and managers. In many countries, the consequences of not doing so means that health policy-making, planning, costing and budgeting take place independently of each other, leading to a misalignment between health priorities and allocation and use of resources.



Health is financed by public and private funds. To make progress toward universal health coverage (UHC), a predominant reliance on public, compulsory, prepaid funds is necessary. Therefore, the way budgets are formed, allocated and used in the health sector is at the core of the UHC agenda. This chapter outlines the overall budget process for the public sector, discusses the specific role of health within it, in particular the role of the ministry of health (MoH) and other health sector stakeholders, to provide timely inputs into the budgeting process.

Summary

What is meant by budgeting for health?

Budgeting is related to the process of defining the allocation of resources to produce the best outputs given the level of revenues. A health budget, typically included in the general government budget, is more than a simple accounting instrument to present revenues and expenses – rather, it is a crucial orienting text, declaring key financial objectives of the country and its real commitment to implementing its health policies and strategies. While every implementing health organization develops a budget, in this chapter we discuss the national government budgeting process, which includes inputs from a wide range of health sector stakeholders.

Why is it important to understand the health budgeting process?

For those who seek to influence resource allocation in country, a good understanding of the guiding principles of budgeting as well as the political dynamics that enable the budget elaboration and approval process is essential. In many countries, a lack of understanding of budgeting issues results in delinked processes such that health policy-making, planning, costing and budgeting take place independently of each other. This leads to a misalignment between the health sector priorities outlined in overall strategic plans and policies and the funds that are

ultimately allocated to the health sector through the budgeting process. This misalignment has negative consequences: resources are not used as intended, and accountability is weakened. On the other hand, a good understanding of the budget process and engagement by MoH and other health sector stakeholders at the right time during the budget cycle will increase the chances that the final resource allocation matches planned health sector needs.

When does the budgeting process take place?

The budgeting process starts with a preparation/formulation stage of budget proposals, which includes a negotiation phase between MoH and ministry of finance (MoF) and ends up with parliamentary review and approval. In many countries the fiscal year follows the 12-month calendar year, beginning on 1 January; in some countries, the fiscal year may start at a different date (e.g. 1 October in the United States of America, 1 July in Australia and New Zealand). In a given year, there are three cycles potentially taking place at the same time: the implementation of the current budget, which essentially takes place throughout the year, at any given time; budget preparation for the next year; and audit or review of the previous year.

Who are the people involved and engaged in the health budgeting process, in particular the budget preparation phase?

Ministries of budget/finance and related entities are the leading agents for budget development. Ministries of health play a critical role to prepare, present and negotiate credible, priority-oriented budget proposals for the sector. Civil society and the general public can seek to influence health budget definition by engaging with the executive or the legislature.

How does the budgeting process work from the point of view of national health policy/strategy/plan (NHPSP) stakeholders?

The budget cycle starts with the government planning for the use of the coming year's resources. To allow this to be done in accordance with health priorities, health planning stakeholders have to engage strategically in this process and be prepared to support it. This chapter takes the reader through the steps of the budget cycle and some practical issues for the health community to consider.

Anything else to consider?

- ▶ decentralized environment;
- ▶ fragile environment;
- ▶ highly aid-dependent context.



8.1 What is meant by budgeting for health?

Some key concepts

8.1.1 What is a budget?

Narrowly defined, the budget is the government's forecast of revenue and planned expenditure, usually provided on an annual basis. A health budget is the portion of the national budget allocated to the health sector, including all ministries and agencies involved in health-related activities. A health budget is more than a simple accounting instrument to present revenues and expenses – rather, it is a crucial orienting text, declaring the country's key financial objectives and its real commitment to implementing its health policies and strategies.

8.1.2 Public financial management

Public financial management (PFM) rules govern how budgets are formulated, funds disbursed and accounted for. This is centrally important to UHC because PFM is the interface that helps ensure that increases in public spending translate into expanded health coverage.

National health authorities should aim to effectively engage with national budgetary authorities to foster credible, priority-oriented health budgets, and ensure efficient fund flows and budget execution in order to ultimately strengthen accountability.

8.1.3 Medium-term expenditure framework (MTEF)

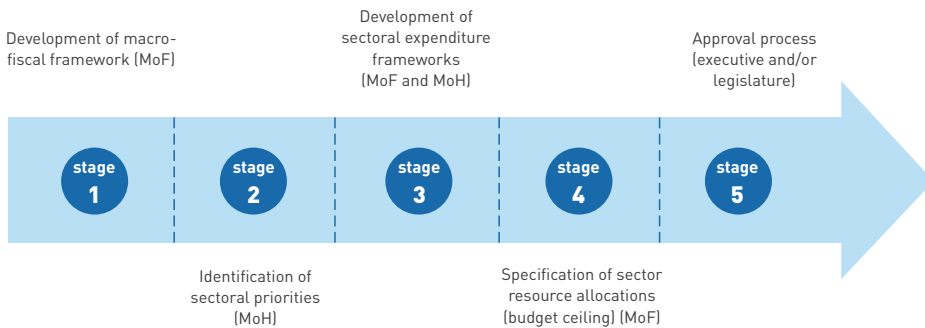
An MTEF is a comprehensive, government-wide spending plan that is expected to link policy priorities to expenditure allocations within a fiscal framework (linked to macroeconomic and revenue forecasts), usually over a three-year forward-planning horizon. Mid-term budgeting can help connect revenue forecasts, sectoral allocations and health policy priorities, and strengthen the overall quality and credibility of annual budget envelopes.

In order to do that well, governments need to be able to generate robust forecasts of forward macroeconomic conditions and revenue flows, as well as of the forward cost of existing and new policies. While the former is usually the responsibility of the central government,¹ the latter can only be done well using the specialized knowledge at sector level. Some countries have also initiated the development of sector/health-specific MTEF (see Fig. 8.1) that fit into the overall framework, which can help define more credible annual allocations.

A health budget allocates national funds to the health sector, declares key financial objectives of the country, and represents a commitment to health policy and strategy implementation.

¹ This is exercised through the introduction of good macroeconomic models and mechanisms to consult on forecasts with stakeholders such as the central bank, the revenue authority and independent research agencies.

Fig. 8.1 Key stages of a comprehensive MTEF¹



8.1.4 Line-item budgeting for health

Line-item budgeting has been the norm in many countries, in which the budget information is organized according to the types of expenses or cost categories. For health, these generally focus on staff, supplies (operational costs), and capital investment/equipment, all of which can be characterized as inputs for health systems. Providers receive a fixed amount for a specified period to cover specific input expenses (e.g. personnel, medicines, utilities).

The existence of many line items is a way for the legislature to retain control, but provides little flexibility to operationalize and manage health funds because the expenditure must follow strictly defined budget lines. In many countries, line-item budgeting has been a major deterrent to a functioning health purchasing system, which would require setting up appropriate payment mechanisms to enable funds flow to the right services and maximize efficient use of public funds.

8.1.5 Performance budgeting

“Performance budgeting”, “performance-based budgeting”, “programme-based budgeting” and “budgeting for results” are similar terms, with a common unifying feature: they are all concerned with introducing performance information into budget processes. The Organisation for Economic Co-operation and Development (OECD) has defined performance budgeting as a form of budgeting that links allocated funds to measurable results.² These alternative budget classifications present advantages for managing funds through increased autonomy for funds managers. Specifically for the health sector, it ensures that funds flow to the priority services and enables the purchasing of health services to be operational. By making explicit the purposes and results of budget spending, budget managers can also be held to account by the legislature and citizens.

Line-item budgeting is a way to manage budget information according to the types of expenses or cost categories. While this approach aims to increase transparency and accountability, it may often in fact restrict flexibility and lead to inefficient resource allocation.

8.1.6 Fiscal space and fiscal space for health

Fiscal space is typically defined as “the availability of budgetary room that allows a government to provide resources for a given desired purpose without any prejudice to the sustainability of a government’s financial position”.³ Tandon and Cashin’s conceptual framework to assess fiscal space for health in countries include factors such as macroeconomic conditions, the extent to which health is re-prioritized within the government budget, whether new earmarked funds for health have been introduced, the amount of external aid and increased efficiency of existing government health outlays.⁴

Health planning stakeholders have variable influence over these five factors. Some are directly outside of their control, such as the macroeconomic conditions. Others are in the direct domain of the health sector and therefore require particular attention from health planning stakeholders – namely the efficiency of current

health expenditures and the amount of external aid for health. Furthermore, there are those factors which are not directly in the hands of health planning stakeholders but for which the health sector can play an important role in terms of advocacy – namely the prioritization of health within the overall government budget, and whether there are efforts to introduce new earmarked funds specifically for health.

Fiscal space for health analysis could be better mainstreamed and systematized into the budgeting process in many countries to enhance budgeting decisions. Health planning stakeholders would do well by leveraging the fiscal space analysis to take a closer look at the political and institutional enabling factors which can actually support improved formulation, allocation and use of health budgeted resources.⁵ A better use of existing public resources toward UHC helps expand the fiscal room for the sector.

Line-item budgeting is a way to manage budget information according to the types of expenses or cost categories; however, this budgeting system does not provide the required flexibility to operationalize health plans and maintain a well-run health purchasing system.



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8.1.7 Strategic purchasing

Purchasing involves three sets of decisions: identifying services to be purchased, choosing service providers based on certain criteria, and determining the modalities of payments to providers.

As one of the generic sub-functions of health financing,^{II} purchasing refers to the allocation of resources to health service providers. Purchasing involves three sets of decisions, namely:

1. **identifying the interventions** or services to be purchased, taking into account population needs, national health priorities and cost-effectiveness;
2. **choosing service providers** based on criteria such as service quality, efficiency and equity;
3. **determining how services** will be purchased, including contractual arrangements and provider payment mechanisms.⁶

Purchasing is undertaken by a purchasing organization which can be, for example, an insurance scheme, a MoH, or an autonomous agency. Purchasing should not be confused with procurement, which generally only refers to buying medicines and other medical supplies.

There is a growing consensus, backed by efforts being made by countries, to move away from a passive approach to purchasing (no selection of providers, no performance monitoring, no effort to influence prices, quantity, or quality of care) to an active or strategic one.

Strategic purchasing with general budget revenues involves linking the transfer of funds to providers, and, at least in part, to information on aspects of their performance and the health needs of the population they serve.

^{II} Health financing functions include: revenue raising, resource pooling and strategic purchasing.

8.2 Why is it important to understand the health budgeting process?

During the budgeting process, health planning stakeholders and managers will inevitably be requested by MoF to provide information on sectoral priorities and an associated price tag. Understanding the guiding principles of budgeting as well as the political dynamics that enable the budget elaboration and approval processes is essential to make the case for health. In many countries, a lack of understanding of these budget-related issues results in delinked processes such that health policy-making, planning, costing and budgeting take place independently of each other. This leads to a misalignment between the health sector priorities outlined in overall strategic plans and policies and the funds that are ultimately allocated to the health sector through the budgeting process. This misalignment has negative consequences: resources are not used as intended, and accountability is weakened (see Box 8.1). On the other hand, a good understanding of the budget process and solid engagement by MoH and other health sector stakeholders at the right time during the budget cycle will increase the chances that the final resource allocation matches planned health sector needs.

In reality, the allocation of resources to different institutions and purposes is essentially a politi-

cal, rather than a purely technocratic process.^{III}

After having analysed needs and determined the most equitable and efficient policies and plans, health planning stakeholders must proactively engage in this politically-influenced process, as it determines the details of the national health budget, which impacts on effectiveness and efficiency of public spending for health. How health managers will be able to spend their money largely depends on what the budget allocation is. Not only is the budget envelope amount relevant, but so too is how that total amount is structured, how it flows into the system, timing of disbursements and how it will enable health financing to function in practice and to purchase the needed health services.

Understanding and influencing the budget formulation for the health sector is also a matter of efficiency and equity, two key health policy objectives linked to UHC, a principle increasingly enshrined in many countries' NHPSPs. How a budget is formulated and allocated, including to lower levels of government, has a direct impact on how well and how efficiently funds can and will be used. Supporting a fair distribution of resources across populations and/or geographical areas is likely to have a direct impact on health sector outputs.⁷

Understanding the guiding principles of the health budgeting process minimizes the chance of misalignment between health sector priorities outlined in strategic plans and the funds that are allocated to the health sector.

^{III} For more information, please see Chapter 4 "Priority-setting for national health policies, strategies and plans" in this handbook.

Box 8.1

Côte d'Ivoire: understanding the root causes for misalignment between health planning and budgeting⁸

Several factors can explain the misalignment between health planning and budgeting at both central and decentralized levels in the Ivorian context.

At central level, first, there is a noticeable lack of a general framework and aligned calendar between health planning and budgeting. There is no specific mechanism to align the budget formulation and national health planning processes. Operational plans are often developed for the ongoing year, while the budget is formulated for the next year. In addition, there is no alignment on the objectives and goals between the two documents. The budget elaboration is solely driven by the logic of facility-based funding through inputs, while the existing strategy sets a different approach through well-identified programmes and expected results. Also, when the programme-based budgeting process was introduced, it was used more as a means to reflect externally financed programmes than to fit with nationally defined priorities as set out in the NHPSP. Finally, weaknesses also resulted from the fact that the processes were relatively top-down, without considering local sector needs in a post-war context.

8.3 When does the budgeting process take place?

8.3.1 Budget cycle steps – a brief overview

The various public finance processes are structured around the budget cycle. This annual cycle aims to ensure that public expenditure is well planned, executed and accounted for. A standard budget cycle incorporates four distinct stages:

- (a) budget definition and formulation;
- (b) budget negotiation and approval;
- (c) budget execution;
- (d) budget reporting, auditing and evaluation.

The MoH is expected to translate government policy goals (as described in the NHPSP) into cost^{IV} estimates to fit into the suggested budget ceiling for the sector. The budget ceiling is given by the MoF based on its revenue forecast outlining the country's macroeconomic prospects in the medium term.

The MoF and MoH engage in negotiations over these requests which culminate in the formulation of a formal health budget proposal that is supposed to typically reflect revenue and expenditure plans for the budget period (most often one year). The budget proposal (which includes the health budget component) is typically presented for budget approval to parliament, which can propose amendments, before formal adoption.

Budget execution, or spending, consists of a set of processes that lead to effective fund flows/transfers from the treasury to the MoH, and onwards to sub-recipients (for example, districts, health providers, etc). The principal issues that the MoH will be faced with during the budget execution phase are the actual delivery/purchase of health services by those on the front line (e.g. health service providers) and the financial management function that supports the former.

Budget evaluation refers to internal and external control processes which are designed to ensure compliance with predefined targets and procedures. Governments also have accounting and reporting procedures which help keep records of financial and/or non-financial flows;⁹ these need to be respected and cross-checked.

An important point to note here is the issue of budget amendments that can be passed by parliament during the course of the fiscal year. This can happen when, for example, budgetary resources are lower than expected and overall spending needs to be reduced. Negotiations will determine whether the health-specific budget will be maintained or changed. It is often at this stage of budget renegotiation that the prime minister or president may play a key role in arbitrating between different priorities and sectors. Health leaders need to maintain a sufficient level of advocacy to ensure that the sector remains a budget priority throughout the year.

A standard budget cycle incorporates four distinct stages: budget definition and formulation; budget negotiation and approval; budget execution; and budget reporting, auditing and evaluation.

^{IV} See Chapter 7 "Estimating cost implications of a national health policy, strategy or plan" in this handbook.

8.3.2 Fiscal vs. calendar year

Not all countries use the calendar year to determine a fiscal year; either way, the budget steps remain the same.

Some countries' budget cycles, referred to as fiscal years, follow the calendar year and others do not. A fiscal year refers to a consecutive 12-month period which may or may not follow the January to December calendar. That being said, the most common fiscal year countries use is the calendar year. Other commonly used fiscal years are 1 July of one year to 30 June of the following calendar year and 1 April of one year to 31 March of the following calendar year.¹⁰ Fig. 8.2 depicts the budget cycle steps according to a fiscal year which is identical to the calendar year.

Fig. 8.2 Budget steps during a fiscal year starting on 1 January



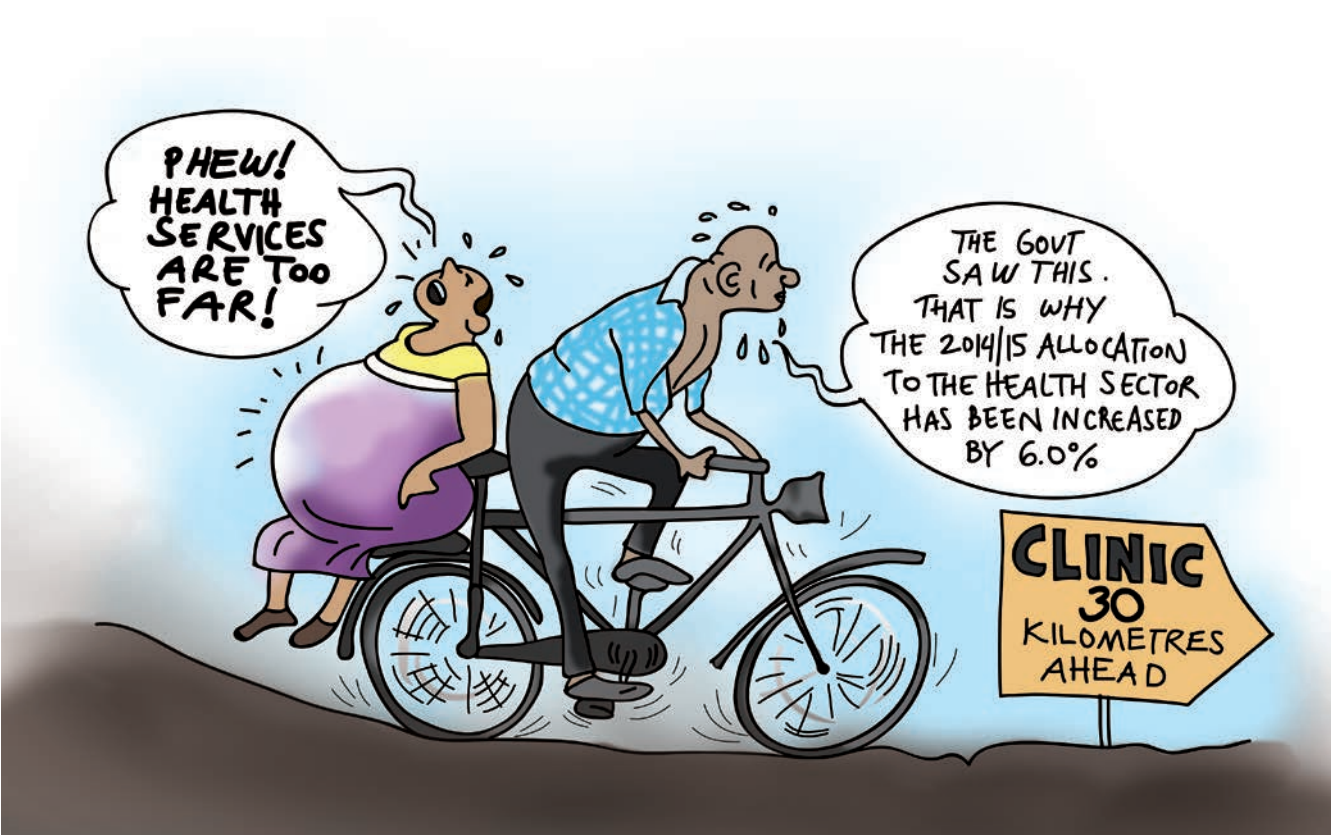


Fig. 8.3 How important is budget prioritization for health?¹¹

8.4 Who are the people involved and engaged in the health budgeting process?

Roles of different stakeholders

8.4.1 MoH: engaging in health budget formulation and execution

(a) MoH's role in health budget formulation

Developing robust health budget envelopes requires strong engagement by health ministries with national budget decision-makers

– first, because progress toward UHC is often associated with increased public funding for health, and secondly, because the latter also demands a functioning public finance system to align revenues with services and to manage

The Ministry of Health (MoH) must engage strongly with national budget decision-makers during health budget formulation. Credible, well-defined expenditure forecasts and systematized costing and priority-setting exercises can put MoH in a sound negotiating position with the Ministry of Finance.

expenditure better. Thus, the dialogue with MoF/treasury must involve not just the level of funding but also the PFM rules that govern their use (forming budgets, distributing them, expenditure management, reporting).

In particular, the MoH's role in the process of budget formulation boils down to three key inputs.

- (i) Analysis of expenditure forecasts against expected revenues; the aim here is to estimate the potential for increased health spending. Institutionalizing fiscal space for health analysis within MoH will be an important step in this direction;
- (ii) Drafting of credible, well-defined health budget proposals; systematizing costing and priority-setting exercises within the defined envelope;
- (iii) Engaging in budget negotiations and advocating for a sound health budget allocation.

(b) MoH's role in health budget execution

The budget execution stage is a pivotal process for all ministries including health, as it is the one which enables the actual implementation of NHPSP activities. MoH's key role here is one of supervision, support, and oversight of budget execution as this is often the deciding factor for implementation rates – poor technical and administrative support and oversight capacity generally results in a low health budget execution rate, and in more unused fiscal margins. Evidence shows that fiscal space expansion for the health sector is largely possible simply by

increasing effectiveness in government health spending.¹²

For purposes of health budget execution, MoH's role includes understanding PFM systems, and in particular, expenditure rules and regulations. In many countries, MoH's capacities require strengthening in this area, as expenditure management is often not well known or understood by those who do not have specialist skills in public finance. For example, in many countries, the MoH is not the final decision-making authority on spending (MoF is). This means that payment requests for services already rendered end up with the MoF (see Box 8.2). If the expenditure is not in line with expenditure rules, MoF may decide not to pay, especially in a circumstance where funds are not sufficient to cover all payment requests coming in from all sectors. Another challenge linked to a lack of understanding of the PFM system is the funds disbursement schedule. In many countries, it does not necessarily follow the needs of sector plans; instead, funds may be disbursed only at specific times of the year in specific amounts. Health ministries should take this into consideration when planning activities and health budgets for more effective implementation.¹³

Early engagement on the part of MoH with the MoF can provide better understanding of the financial management rules and the system within which expenditures must happen. Closer cooperation and inclusion of MoF representatives in key MoH consultations can help both sides better understand each others' needs and challenges.



Box 8.2

Low execution levels of the health budget: where does the problem lie?¹⁴

In many countries, health budgets are poorly executed, but little is known about the underlying causes of under-execution. A detailed analysis of the Democratic Republic of the Congo context reveals that the responsibilities lie on many fronts; many weaknesses and delays at both MoH and MoF explain low execution of the health budget envelope, with one major systemic bottleneck being the fact that the MoF still holds the final spending decision-making authority above all line ministries.

A closer look at the budget execution process in the Democratic Republic of the Congo in recent years demonstrated that the principal impediments were:

- (i) MoH's estimation of necessary resources for health was finalized too late; the calculations have been of varying quality over the years;
- (ii) MoF releases funds directly to those who are expecting payment from MoH (final spending decision-making authority is with MoF) and often does not do so in a timely manner.

Over 2011–2013, MoH's forecasted necessary resources on equipment, services, and other discretionary expenditure respectively came to 14%, 21%, and 59% of the funds finally requested from the Treasury, evincing an unambiguous disconnect between the estimation of resource needs and actual resources used. It was, however, noted that the MoH's estimation of necessary resources were more in line with funds spent for personnel expenditure (94%).

On the MoF side, monies paid out directly to suppliers/service providers on behalf of MoH came to only 55% for goods and equipment and 40% for construction. This implies that roughly half of MoH's suppliers received late payments. In addition, when the budget cycle closed at year end, these late payments remained as arrears in MoH's name and needed to be transferred to the following year's budget.

All in all, the bottlenecks are clearly systemic in nature and imply weaknesses on various fronts and a need for a more comprehensive, long-term reform in government processes and government capacity.

A core element of effective health budget execution and expenditure management is strategic purchasing,¹⁵ referring to the arrangements in

place, and mechanisms used, to allocate funds to health service providers. MoH is the entity that must think through and design how health

services should be purchased, in harmonization with existing PFM rules. This MoH task of improving the strategic purchasing of health services is central to strengthening health system

performance and progressing towards UHC, as it determines the way services are funded and providers incentivized (see Table 8.1).

Table 8.1 What can health planners do/help to foster PFM and health financing system alignment?

PUBLIC FINANCE CYCLE	TYPE OF ACTIONS /SUPPORT NEEDED FROM HEALTH PLANNERS
Mid-term budget planning	Elaboration of robust health MTEF
	Systematized fiscal space for health assessment
	Investment case for health sector to support budget prioritization
Budget formulation and negotiation	Elaboration of sound annual sectoral envelopes
	Refined budget structure
	Costing for specific policy change (provider payment mechanisms, benefit package)
Execution process	Good understanding of PFM rules Harmonizing PFM rules and health purchasing arrangements
Reporting, auditing, evaluating	Unified reporting and auditing system, and financial management information system
	Institutionalized public expenditure for health assessments and national health accounts, with a particular focus on public expenditure

8.4.2 Role of civil society organizations (CSOs) in the health budgeting process

Civil society engagement in the budget process should be welcomed and encouraged by government, parliament and other stakeholders.

Other stakeholders such as CSOs and the general public can seek to influence the budget by engaging the executive or the legislature in various ways: analysing budget proposals from the angle of grassroots needs, advocating for more transparency in budget processes, and taking part in local budget-setting processes.^V

The reality is that, in most cases, time for budget negotiations is short and budget sessions are not long enough to make the process as participatory and effective as it should be. Nevertheless, MoH can play its part in encouraging and ensuring more citizen and CSO involvement by producing or endorsing best-practice documents on citizen/CSO engagement in budgeting and collaborating with civil society to get nuanced citizen feedback (beneficiary assessment surveys, citizen scorecards, opinion polls, etc.) for planning, budgeting, and monitoring.^{VI}

Civil society engagement in the budget process should thus not only be welcomed but also encouraged by government, parliament, and other stakeholders. Several countries report low legislative capacity to analyse budgets, and thus they are dependent on line ministries as well as civil society, academia, and other bodies to support their study of the budget. An example from Mexico demonstrates that

civil society engagement with legislatures on budget analyses can be cardinal even if it is not easy, does not happen overnight, and is mostly characterized – at least in the initial stages – by building up relationships and credibility with government and parliament (Box 8.3).

Even in fragile settings, case studies from Asia and Africa demonstrate that systematized citizen assessments of budget proposals can indeed be conducted and can add great value to the budget formulation process. More importantly, they have the potential to strengthen overall governance and accountability practices between citizens and public authorities.¹⁶

A few countries have moved a step further by introducing a “participatory budget”, in which citizens are involved in budget priority-setting processes at local levels. The example of the Democratic Republic of the Congo shows the interesting lessons learned (Box 8.4).

Once the budget is formally presented to the legislature, public hearings and debates may also create space for civil society to express itself on specific issues and/or the budget as a whole. Often legislative committees engage in discussions with civil society and other stakeholders before voting.

^V Beyond the preparation phase, citizens and civil society platforms can also play an active role in the oversight phase. Good practices in country experience include: citizens’ report cards and social accountability mechanisms.

^{VI} In the Philippines, for example, the government obliges departments and agencies to consult and partner with CSOs when preparing agency budget proposals in the budget preparation stage.

Box 8.3

Civil society participation in health budgeting: the case of Mexico¹⁷

In Mexico, the NGO FUNDAR (Centre for Research and Analysis) monitors public policies in social sectors, especially health. One of the policies it has been monitoring for many years is the Seguro Popular (SP – People’s Insurance) programme as it is one of the most important health policy programmes for those who would otherwise be uninsured. The SP is thus Mexico’s solution to right-to-health legislation and is endowed with a generous budget. FUNDAR spent many years concentrating on research and analysis of the SP’s policies, and learning how to package and present its analysis for legislators and other CSOs.

Health policy in Mexico is decentralized; the federal government transfers up to 85% of allocated health resources to the state authorities for SP services. In several states, decentralized budget information is unavailable and there is little transparency as to which agency or entity is actually implementing SP services. The consequences at health service delivery level are dire, with constant shortages of medicines, high out-of-pocket payments by households, and low investment in health infrastructure. In addition, the SP has proven to be a “golden egg” for many states, with its large budget, large flexibility in spending,

and little oversight and control. Opposition politicians have criticized it bitterly, stating that it has not lived up to expectations.

Through its budget analysis work, FUNDAR first gained credibility and built trust with various legislators and state-level civil society actors. Over several years, FUNDAR began to make suggestions to modify Mexico’s article on social protection spending to become more transparent – this involved meeting with the executive and the legislative branches, mainly the Health Committee and the Budget and Public Accounts Committee. The suggestions were not taken into consideration in the following budget decrees but after much perseverance, seven amendments, all influenced by FUNDAR, were incorporated into the 2012 Federal Budget Decree. These amendments touched at the heart of accountability and transparency issues and, at least in theory, seek to improve expenditure control and evaluation of the SP budget, and increase the legislature’s capacity to supervise spending via the National Audit Office. The lesson to be learned here is that influencing national budgets is a long-term process and both civil society and parliamentarians, as well government, and ultimately the population, can greatly benefit.

Box 8.4

Participatory budget: lessons from pilot experiences in the Democratic Republic of the Congo¹⁸

Rural and urban citizens' recent participation in the formulation and management of local budgets has helped to strengthen governance in the Democratic Republic of the Congo. How does participatory budgeting work in practice? The local authority presents its budget to the public, specifying the share of the budget to be allocated to local investment. Through a process of dialogue, community members are able to choose for themselves which priorities should be addressed and funded under the local budget. The population is also involved in monitoring the implementation of the activities selected through this participatory process. Using mobile phones, which most Congolese now own, stakeholders in the

Participatory Budgeting Project can easily obtain, from wherever they happen to be, useful information on the date, time, and place of meetings. They can also find out what was decided at meetings, vote by SMS (short message service) and, importantly, monitor and evaluate the decisions made through voting – all while going about their daily lives. This participatory approach has enabled the decentralized territorial entities involved in the pilot project to improve local governance through social accountability, effective participation of citizens in the management of public affairs and citizen monitoring of public investments.

8.5 How does the budgeting process work from the point of view of NHPSP stakeholders?

Fig. 8.4 Aligning budget and strategic priorities: a core challenge¹⁹



The budget cycle starts with the government planning for the use of the coming year's resources. To allow this to be done in accordance with

health policy priorities, health planners have to engage strategically in the process and be prepared to support it.

8.5.1 Budget formulation

The macroeconomic projections, calculated usually by a macroeconomic unit in the MoF, enables the budget office within the MoF to determine the global level of expenditure that can be allowed without adverse macroeconomic implications, given expected revenues and a safe level of deficit.

In many countries, the prime minister or the president and/or the cabinet will be directly involved in budget formulation and preparation, especially in influencing the main strategic orientations and modalities of implementation.

The initial formulation of the national budget happens within the budget office of the MoF, with input from the various sectors. The degree of openness and interaction with the other sectors is very specific to each country, and this process will determine how long it takes to come up with a budget (weeks or months). The MoF will certainly request clear, transparent, and concrete information from its own individual departments or from other ministries directly. Some MoFs issue budget circulars to give instructions to line ministries, with the indicative aggregate spending ceiling stated for each ministry. This circular will also include information on how to prepare spending estimates in a way that will be consistent with macroeconomic objectives. It will spell out the economic assumptions to be adopted on wage levels, the exchange rate and price levels (and preferably differentiated price levels for different economic categories of goods and services).

MoH negotiations could be with the budget office directly or with an individual from a different MoF department assigned to the health sector. The MoF must accommodate various government

priorities and make decisions on trade-offs in order for budget expenditure totals to tally up to what is available with the country's fiscal space. There will also be negotiations between central-level management MoH and the district-level budget holders.

In reality, a lot of the budgeting processes make use of historical budgeting, i.e. the budget is based on last year's allocations. Unless there are major changes to the economic situation or government priorities (e.g. the 2014 Ebola crisis in West Africa), the broad contours of the budget should be generally known. They will be a combination of critical projections on economic growth, inflation, demography, revenue (all of this information should be included in the pre-budget statement) and overarching fiscal goals. Budgeted funds are often tied up with the fixed costs of staff and infrastructure, leaving limited flexibility, and perhaps even reduced budgetary scope for key patient treatment inputs, such as medicines and other disposable items.

The MoH can bring itself into a strong negotiating position by having its costed plan and plan of negotiation ready before the MoF begins calling on the different sectors for information. Normally, simply requesting an increase in funds for the health sector will not be adequate to convince a finance ministry that is dealing with several competing priorities. A costed plan is a prerequisite to negotiations with the MoF; however, in addition, specific information such as, for example, who are the ultimate beneficiaries of this plan, what are the expected health outcomes, and if necessary, how this will affect the country's economy and government goals as a whole, should be deliberated upon beforehand, calculated and analysed, for dis-

It is important to keep in mind that the MoF must accommodate various government priorities and make decisions on trade-off. MoH thus must come with a solid evidence base and arguments which have been thought through carefully to make the case for health.

cussion with the MoF. This is a critical stage for engaging in the budgeting process, including budget advocacy and negotiating with various stakeholders. Working hand in hand with civil society organizations and think-tanks can be useful here, especially in specific areas of expertise (Box 8.3).

Once budget negotiations have been finalized, the cabinet endorses the proposals for inclusion in the budget that will go to parliament.²⁰



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Box 8.5

Key steps of Liberia’s budgeting process²¹

Using the illustrative example of Liberia helps us understand in practice how budget preparation involves a large range of stakeholders at each and every step of the process.

In Liberia, the MoF leads planning and budgeting process. The MoF calculates revenue projections and then disseminates this information to the respective line ministries, sometimes in the form of a workshop. The line ministries are then responsible for submitting budget proposals, following which budget hearings, debate, and revisions of the original revenue projections take place between MoF and the line ministries. The

MoF must accommodate various government priorities and make decisions on trade-offs in order for budget expenditure totals to add up to what is available with the country’s fiscal space. There will also be negotiations between central-level management MoH and the district-level budget holders.

The process culminates in a draft budget which the MoH officially submits to the President and the Parliament. Once the Parliament has adopted the national budget, the line ministries are supposed to adjust their internal budgets according to final budget allocations.



Box 8.6

The budget preparation process in Ghana²²

The budget process in Ghana is an annual event which includes top-down setting of ceilings and broad priorities and bottom-up prioritization and allocation. Key steps in the process are listed below.

1. A request for inputs from the general public, including civil society and private sector groups.
2. An update of the macroeconomic framework, including overall expenditure ceilings and the distribution of government and donor funds.
3. An early policy review by ministries, departments and agencies, including costing of objectives, policies and activities.
4. Cross-sectoral meetings to identify: areas of overlap and duplication in outcomes, objectives and key outputs; areas where collaboration and coordination are required in the planning and implementation of activities; and comments and feedback on prioritization of objectives.
5. Review and finalization of ceilings in view of predicted cost forecasts.
6. Final ceilings are approved by Cabinet.
7. Development of more detailed first-year operational plans. These are developed bottom-up including regional and district plans, reflecting the policy direction and priorities set out in the NHPSP.
8. Discussion of operational plans in policy and technical hearings with the Ministry of Finance and Economic Planning. After finalization the Ministry consolidates the national budget.
9. Final allocation of ceilings between cost centres and objectives.

8.5.2 Budget approval or enactment

The budget is said to be “enacted” when it is brought to the legislature for discussion and subsequent passing into law. The (budget) appropriations committee usually has the power to vote on financial issues here as the leading legislative body making spending recommendations and decisions on behalf of the legislature. In the budget approval stage, public hearings and debates may take place on specific parts of the budget and/or the budget on the whole, with specific legislative committees (or subcommittees) engaging in discussions of specific topics. Here, the health committee (which may be organized as a subcommittee of the appropriations committee, or a separate standing committee)^{VII} will be active in studying the health sections of the overall budget and preparing an analysis and response, often in the form of amendments. It is here that the MoH has the vital opportunity to liaise with the legislature and support the technical analyses and cross-verification with the costed health plan. During this stage of the budget cycle, media attention to the country’s budget is high and this forum can be used to bring attention to specific issues, in partnership with advocacy organizations and civil society.

8.5.3 Budget execution

This stage of the budget cycle includes the actual implementation of the planned budget, which rarely is executed exactly as the budget dictates. The decisive issue is whether unplanned spending is adequately justified by policy decisions, changes in macroeconomic projections, or other reasons, and is well documented.

In many countries, budget implementation and oversight capacity is weak, which exacerbates

problems of a poor budget system, and thus budget execution that is further away from the planned budget. For the MoH, and any line ministry for that matter, it is essential that its own sector costing and MTEF work has made explicit where funds should go and for which activities. This can help in a situation where the budget is unclear or where reporting systems do not provide adequate information to monitor expenditure.

8.5.4 Budget evaluation

Budget evaluation and oversight for the full national budget is usually undertaken by a supreme audit institution (SAI). Its mandate is to monitor public spending against stated budgets and spending targets, and ensure accordance with relevant laws and regulations. SAIs are among the most important agencies for ensuring that money is spent in the appropriate way, in the way it was intended.

Increasingly, SAIs are tasked with auditing the efficiency of fund utilization, examining value for money, and assessing performance of public services.²³ Normally, the task of following up on and enforcing audit results and recommendations is within the remit of the legislature. Ideally, the legislature and the SAI (and where relevant, with civil society organizations) should collaborate closely to ensure that SAI findings are acted upon.

Specifically for the health sector, health budget execution can be evaluated during periodic sector reviews. This would fall within the health policy and planning cycle and is separate from national-level budget audits, although health-specific audits can and will certainly be undertaken by a country’s SAI.

^{VII} Not all health-related committees in a legislature will have influence over the budget. The exact committee or body which has a health mandate and influence over the budget will differ in each country.

The budget enactment process is a vital time for the MoH to liaise with the legislature health committees and support budget analysis and cross-verification with the costed health plan.

The supreme audit institution’s (SAI) mandate is to monitor public spending against stated budgets and spending targets and ensure accordance with relevant laws and regulations.

8.6 Important operational issues for health planning stakeholders to consider during the health budgeting process

8.6.1 Legal considerations

Although the precise legal framework for government budgeting varies from country to country, it is usually spelled out in some form or other, be it through a law or decree or regulatory directive or other means. Health planning stakeholders should be aware of how to source information relevant to the budget and where to position their technical inputs and influence.

The constitution is at the top of the legal hierarchy. Although it usually deals only with broad principles, the constitution may clarify three important aspects:

1. the relative powers of the executive and legislative branches with respect to public finance;
2. the definition of the financial relations between national and sub-national levels of government; and
3. the requirement, for example, in common law systems, that all public funds be spent only under the authority of a law.

The organic law is usually the main vehicle for establishing principles of public financial management. This may take the form of a single law that guides budget formulation, approval, execution, control, and auditing, or there may be several general laws covering specific areas of public finance management that may also relate to national and sub-national levels of government. The organic budget law also gives to the government, or the minister responsible

for public finance, the authority to issue detailed regulations and instructions.

The constitution, the budget organic law, and financial regulations are permanent and form the legal framework within which the annual budget law/finance law, which includes the revenue and expenditure estimates for a given year, is prepared, approved, executed and audited. The annual budget law can take different shapes depending on the system.

In the francophone and Latin American systems, the coverage of the annual budget law (budget or loi de finances in francophone countries and ley anual de presupuestos in Latin America) is rather far-reaching, since it stipulates the amount and details of revenue and expenditure, the balance amounts, any new tax legislation measures and any permitted changes to spending. Brazil, for example, has minimum health spending thresholds in place at municipal, state and federal levels of government that require a certain percentage of the annual budget be dedicated to health services.²⁴ Under the common law system, only revenue and expenditure estimates need to be presented to the parliament. By contrast, the annual budget in many transition economies has often been rather summary in format as no detailed legislation stipulates the contrary: prior to any recent reforms, budget estimates were presented in aggregate format, by budgetary institution – typically only the major supervisory institutions and not their subordinate units – and broken down only by broad “functions”.²⁵

The legal framework that impacts budget formulation and execution is made up of the constitution, organic budget law, and financial regulations.

8.6.2 How can countries introduce and effectively undertake multi-year budgeting?

MTEFs in the health sector were borne out of the need to ensure financial affordability and operational feasibility of health policy proposals.

Since the mid-1980s, budgeting reforms world-wide have been concerned in a significant way with engineering a shift from planning and approving budgets for one year at a time to a multiyear perspective to improve predictability and sustainability in sector funding. The need to ensure the financial affordability and operational feasibility of policy proposals has been a major factor behind the introduction of medium-term perspectives. Given that the disconnect between health policy-making, planning, and budgetary processes was recognized as a common factor of several countries' governance, the health MTEF has increasingly come to be regarded as a central element of public expenditure management reform programmes (see Box 8.7).

Box 8.7

Introducing health MTEF in Africa: the case of Malawi and the Democratic Republic of the Congo

Malawi²⁶

In 1993, a Budget Management Review in Malawi revealed real weaknesses in the country's budgeting system; it especially highlighted the fact that both sector-specific as well as overall spending objectives of the government were unclear. In 1995, the World Bank assisted in introducing the MTEF process in Malawi in four sectors, including health, in response to the review's findings. The first year of implementation focused very much on adequately costing sector-specific priorities to reflect the sector strategic plans. All of the other sectors joined in the following year, with the MoF providing overall guidance and management. After the initial years of implementation, it was clear that the Budget Division needed more staff and provisions were made for an increase in personnel. The MTEF in Malawi was seen as a process to support improved decision-making and to better link policies, priorities, resources, and budgets. It has involved both a top-down and bottom-up joint approach – top-down meaning a macroeconomic analysis looking at total revenue and allocation of budget ceilings to different sectors. At the same time, a bottom-up approach at sector level consisted of formulating a sector strategy and breaking the strategy down into activities and costs. In Malawi, a special emphasis was

given to involving a wide range of stakeholders in the design and implementation of the process and presenting the budgeting process as a management tool for all sectors. With the MTEF work, the MoF has taken on a less controlling role and is more of a supervisor of performance, ensuring accountability and transparency in resource use. An evaluation in early 2014 demonstrated good improvement for Malawi's budget credibility and stronger links between policies and budgets. However, significant improvements were still necessary for budget execution and control as well as accounting procedures.

Democratic Republic of the Congo²⁷

From 2011 the Research and Planning Division at the Ministry of Public Health (MoPH) has run a programme to improve the budget process via a results-oriented management concept that uses the MTEF as a tool. Since 2012, the national MoPH and provincial ministries have compiled a national and provincial MTEF each year. This tool is featured in the roadmap for government expenditure reform initiated by the Ministry of Economy and Finance, making the health sector a trailblazer for a reform to be extended to all other sectors. The benefits are twofold. First, results-based management practices are picked up by provincial planning and budgeting teams. These teams will play a central role in allocations of resources for health. Second, the tool makes it easier to develop arguments in defence of the health budget when choices are being made for the annual budget. In 2014, sound arguments helped the MoPH obtain a 20% increase in

the budget initially announced for non-wage expenditure. This represents an additional USD 10 million in the health allocation.

However, the unpredictability of external resources and uncertainty surrounding decentralization makes the medium-term budget process an especially delicate exercise that often has little link to macroeconomic realities. The MTEFs in the Democratic Republic of the Congo are developed using incomplete and patchy data: the provinces have no clear idea of the domestic and external resources that they will receive the following year. Therefore, MTEFs are hardly ever used to manage resources and are more of a theoretical exercise. The MoPH's efforts to improve the budget process are hampered by the uncertainty surrounding decentralization and the fragmentation of external financing. Recent efforts by the MoPH to strengthen their financing strategy should enable the government to set out its official vision of the health financing and decentralization architecture, which will improve the budget process.

To date, MTEFs have seen a mixed impact on increased budgetary predictability for health ministries, but there is some evidence that they have led to budget reallocations to the sector.²⁸ It is a common observation that the quality of forward spending estimates, as well as revenue forecast, is generally poor. For the former, they tend to consist far too frequently of the proposed budget for the first year of a multiyear framework, followed by inflation adjusted projections of cost for the later years: multiyear incrementalism, in other words. On the latter, revenue projections are sometimes

judged as unrealistic and do not allow for adequate strategic planning.

The process and quality of health and overall MTEF need strengthening in most countries, more specifically:

- ▶ more realistic resource scenarios;
- ▶ better alignment of MTEF ceilings with annual sector allocations;
- ▶ more support to MoH for developing sound health expenditure scenarios;
- ▶ more participatory processes.

Box 8.8

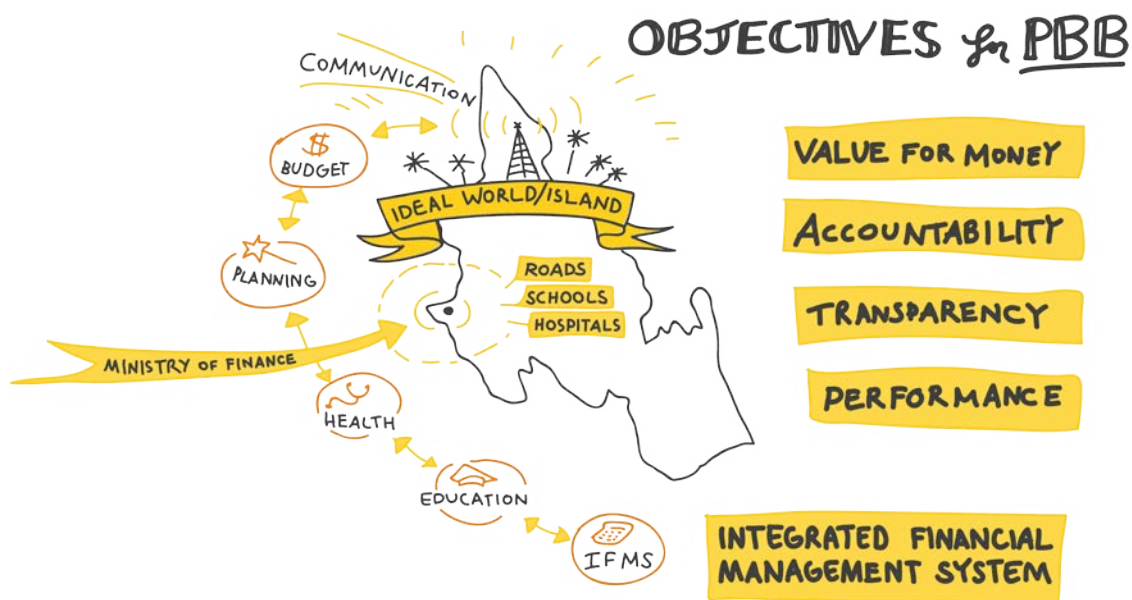
Barriers to medium-term budgeting²⁹

Legacy systems in francophone and anglophone countries in Africa may affect the implementation of standard reforms such as a medium-term budgeting. While francophone systems have budget control benefits and offer some mechanisms that are not out of keeping with a medium-term perspective (such as allowing for capital programming to have a multiyear legal basis in the financial laws), they also present important challenges. The central control over spending ministries discourages spending agencies from taking strategic responsibility for better spending and the budget format does not help either. With a strong emphasis on law in francophone systems, the lack of legal provisions for modern budget management mechanisms such as MTEFs and programme budgeting mean that reforms to these effects have very little impact. On the plus side, the requirement to adhere to the West African

Economic and Monetary Union directives, however, has driven successful reforms of key parts of the PFM systems.

In anglophone Africa, the United Kingdom-based financial management tradition can clash with the constitutional form of modern states. The role of parliament in undermining comprehensive, medium-term budgeting that is affordable and effective is among the key concerns. In anglophone countries the strong legal emphasis on the accountability of the spending agency (in this case, MoH) accounting officers in turn undermines a strong finance ministry mandated to run a disciplined budget process. The weak role of parliaments and inadequate capacity for medium-term forecasting, particularly at sector level, further affects the impact of these reforms.

Fig. 8.5 Introducing performance-based budgeting: from concept to practice³⁰



8.6.3 How can countries move from a line-item to a programme-based budget?

Many countries are progressively moving away from activity-based or line-item budgeting towards a system that is more focused on outputs and places emphasis on results. The shift from traditional budgeting to alternative budgeting methods with results and performance at its focus is noted to be more useful as a policy or decision-making tool. It assures elected and administrative officials of what is being

accomplished with the money, as opposed to merely showing that it has been used for the purchase of approved input.³¹ At the end of the budget cycle, a review of performance is supposed to help planners allocate and spend more effectively toward the set targets in the following years (see Box 8.9). In moving towards performance budgeting, countries adopt a system of planning, budgeting and evaluation

The move towards performance-based budgeting creates a system that emphasizes the relationship between money budgeted and results expected. However, caveats include the increased risk of new budget silos and initial confusion in weak PFM systems.

that emphasizes the relationship between money budgeted and results expected.

However, there are caveats. While performance-based budgeting seems to have been effective to better inform resource allocation decisions and in supporting higher quality of negotiation processes between MoF and line ministries like health, systematic evidence has been lacking on the actual effects on health sector performance. Performance-based budgeting requires considerable budget management capacity within the spending institutions. Providing more autonomy to such institutions (such as MoH) would require that accountability systems are in place and functioning to ensure that more flexibility indeed leads to better sector results.

However, in weak PFM systems, the introduction of an alternative budget classification is likely to create more confusion and to reduce accountability, at least initially. Budgets may therefore need to be presented using several different formats in a transition phase.

Specifically for the health sector, the introduction of programme budgets can increase risks of creating new silos (programme budgets are often disease-specific vertical programmes). Modifying the budget structure will not be sufficient to drive flows to expected results. Just as equally important as budget structure are personnel management and structure of government that provide incentives and accountability for improved health sector performance.



Box 8.9

From line-item to programme budgeting: the case of the Republic of Korea³²

The Republic of Korea's budget system revealed that the most problematic feature of the budget classification system was that it placed primacy on classifications by organization (ministries and agencies) and, most of all, by budget account. As a result, programme or activity level expenditures were fragmented over different accounts. Conversely, even when a programme or activity was funded solely through a single budget account, it took considerable cross-checking to verify that there are no other expenses in another account. The opacity of spending information for programmes or activities was compounded by the fact that there were more than 6000 activities. Thus the solution demanded that the budget classification system be simplified in order to make the spending information more transparent and accessible. Furthermore, this streamlining of the classification system should be accompanied by greater discretion granted to spending ministries like health. This would also allow the budget office and the legislature to concentrate on the broader resource allocation decisions while harnessing the expertise of front-line managers in spending within their sectors, in order to raise the efficiency of lower-level spending decisions.

With this general direction in mind, the Government decided on several basic principles for restructuring its line-item budget into a programme budget:

1. a programme cannot span multiple ministries;
2. all activities that have the same policy objective must be grouped under a single programme, regardless of revenue source;
3. programmes must be clearly differentiated from one another both in policy objective and programme name.

Further guidelines have been set to ensure that the programme classification matches that of the National Fiscal Management Plan (NFMP – the country's MTEF) and that the final number of activities is reduced to a level that is practical for resource allocation decision-making. Additionally, the Government decided that all indirect costs (salaries, facility maintenance, etc.) for each ministry would be aggregated into a separate programme, as would simple transfers among different budget accounts, rather than trying to distribute such costs or transfers into other programmes.

8.6.4 When and how should countries assess fiscal space for health?

The move towards performance-based budgeting creates a system that emphasizes the relationship between money budgeted and results expected. However, caveats include the increased risk of new budget silos and initial confusion in weak PFM systems.

The quest for fiscal space for health should be mainstreamed into the budgeting process (see Fig. 8.6 and Box 8.10). Situating fiscal space for health analysis in the overall budget forecast process is essential. It is likely that the analysis will be best placed at the medium-term budget formulation stage. It is a critical moment, largely unexploited, which should allow aligning realistic revenue forecasts with government priorities and associated expenditure ceilings. Sector-specific fiscal space assessment, if conducted prior to and as a support for the elaboration of a sound MTEF, will maximize impact on change. With such an assessment, health planners will bring useful technical value and support for exploring the actual potential fiscal space, rather than focusing on historical frameworks and ceilings.

A more realistic sense of the actual potential fiscal space for health can also aid health ministries to better plan for a possible reduction of resource allocations to health during the year – which can happen in times of financial difficulty due to fluctuations in external aid, a reduction in domestic resources, or other reasons. In such circumstances, NHPSP implementation can be deeply undermined if potential resource reductions are not adequately planned for and taken into account from the very beginning.

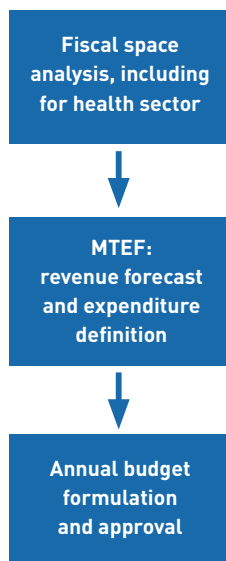
Box 8.10

Taking stock of fiscal space for health: main lessons from assessments in developing countries³³

Lessons from country evidence have shown that in contexts with very limited public spending for health (all standards included), fiscal space for health projections have helped to identify feasible scenarios for expanding resource availability on both the revenue generation and the expenditure side. They signalled existing margins from clearly untapped resources (e.g. taxation, mineral resources), from misalignment with government priorities and international commitments (e.g. low health prioritization) and from effectiveness and efficiency-related losses (e.g. low execution, skewed allocations, technical inefficiencies).

In more advanced countries (i.e. higher revenues and health prioritization within the budget envelope), evidence has shown that further gains are likely to derive from the expenditure side through improved management of the existing health budget envelope. In the short and medium term, a strategic combination of improved execution and modified allocation within the budget envelope is likely to drive fiscal space expansion for the sector. In such contexts, successful country experiences have focused on how to align an existing budget envelope with the UHC goals (i.e. reduce inequalities in service use and spending), rather than delaying or derailing the sequence of their reform process and expecting sizeable gains from the resource side.

Fig. 8.6 Positioning fiscal space for health analysis in the budgeting process³⁴



8.6.5 How can the necessary data be collected?

Accessing and effectively using quality budget and financial data is critical for health planners and managers, especially to drive future investment decisions. In many countries, MoH and other stakeholders cannot rely on good quality budget and financial data, for the following reasons:

- ▶ lack of access to and use of data by relevant MoH units;
- ▶ poor classification of public expenditure for health;
- ▶ weak financial management reporting and consolidation systems within MoH and across ministries.

Over the past decade, the systematized production of national health accounts has helped to monitor overall health expenditure from different sources at country level and to provide globally a systematic description of the financial flows related to the consumption of health care goods and services (see Box 8.11). MoH is encouraged to make use of health accounts outputs in a more systematic manner to further inform health planning and budgeting. There is also a need to institutionalize and systematize public expenditure assessments, as well as national health accounts, within MoH to strengthen their ability to inform and influence budget

Good quality budget and financial data are essential to inform health planning and budgeting. Expenditure assessments should thus be institutionalized, not the least because countries are encouraged to move towards a dominant reliance on public expenditure to make progress towards UHC.

decision-makers. As countries are encouraged to move toward a dominant reliance on public expenditure to make progress toward UHC,³⁵ more efforts shall be put on strengthening production and effective policy use of good quality public expenditure for health data. In doing so, three main aspects can be annually monitored:

1. how much is allocated to the health sector compared to the overall budget;
2. how much of the allocated budget is actually executed;
3. reasons for under or over-spending.

Box 8.11

Role of national health accounts in informing budget formulation and expenditure tracking³⁶

Health accounts cover actual expenditure and not budgets or commitments. Health accounts track health expenditure from all sources (including nongovernmental) to different types of providers (for example, hospitals vs providers of ancillary services) and different uses (for example, inpatient vs outpatient care or curative care vs preventive care).

Health accounts address five basic questions.

1. Where do resources come from (through which financing mechanisms have the revenues/resources been pooled)?
2. Who is managing those resources and under which financing arrangements do people get access to health care goods and services?

3. What kinds of goods and services are consumed?
4. Which health care providers deliver these goods and services?
5. Who benefits from the expenditures (by age, gender, regions, diseases)?

A new System of Health Accounts was issued in 2011 to allow comparison across countries and to accommodate a number of changes and improvements.

8.6.6 How should countries understand and influence the political economy of budgeting for health?

Overall, the budget elaboration process is a site for contestation of power and resources, and therefore not just an outcome of economic rationality. It is above all a political exercise (Box 8.12). Central to health planners is the acknowledgement that the budget preparation phase is fundamentally political, because it is about making real policy choices based on societal preferences and linking them to practical health sector strategies.

In order to understand the political economy of the budgeting process, it is necessary to understand the accompanying processes of health policy and planning.³⁷

- ▶ The process of allocating resources to different goals, priorities or institutions is essentially a political, rather than purely technocratic one. In addition to analysing health needs, health planning stakeholders should pay

sufficient attention to understanding political processes pertaining to budgeting prior to and during the budget formulation process.

- ▶ The process of budget allocation does not occur in isolation from macroeconomic and revenue issues, and efficiency/effectiveness concerns in the use of funds for health and in the other sectors. A holistic understanding of public expenditure systems – and the institutional cultures that condition them – is important in order to formulate strategies for change and improvement (i.e. an increased allocation to health).
- ▶ It should never be automatically assumed that health allocations translate accurately into spending. What money actually gets spent by whom, on what items and for what purpose is often determined during the process of budget execution, which in itself implies political, financial and technical interactions within a large range of interests and powers.

The budget process is fundamentally a political exercise, an acknowledgment that must be understood by health planning stakeholders.



Box 8.12

The politics of budget formulations³⁸

To guarantee meaningful change in budget allocations, it is recommended to have information about the following:

- (a) the formal structure of roles and responsibilities within the budget process;
- (b) the formal rules governing decision-making, political choice and accountability within the public expenditure management system;
- (c) the networks of stakeholder power and influence (outside the formal allocation of roles and responsibilities), which influence the outcomes of the budget process;
- (d) incentives for action (covert as well as overt) affecting the decision-making of politicians and officials during budget formulation and execution;
- (e) the latitude for independent discretionary action of bureaucrats at all levels of the budget execution process;
- (f) the norms and values prevailing in key institutions within the budget formulation and execution process.

The experience of budget initiatives with social/health goals suggests a number of broad lessons that can help guide practice, including the following: Firstly, budget processes which are successful in relation to social/health goals often involve a broad range of actors with different positions and skills – including NGOs, researchers, parliamentarians, members of political parties, technocrats and members of the social groups in question themselves. Secondly, many successful social initiatives on the budget process in developing countries have benefited from donor support. Sometimes this has been through support to civil society groups, sometimes through support to building capacity in government, and sometimes through the provision of extra resources (e.g. through Heavily Indebted Poor Countries debt relief). Thirdly, successful initiatives (such as the participatory budgeting movement in Brazil, or the gender budget initiative in South Africa) are often facets of a broader popular political movement or project. Where governments have particularly strong frameworks of policy goals, or other frameworks for accountability (such as constitutional provisions related to economic and social rights), the space for pro-poor engagement in the budget process is stronger.

8.6.7 Looking beyond budget: importance of public finance systems for health financing and UHC

From a public finance perspective, the key objectives of PFM are to maintain sustainable fiscal discipline, ensure strategic and effective allocation of resources and the efficient delivery of public services. On the other hand, health financing is typically characterized by functions that guide the collection, allocation and pooling of resources, as well as the purchasing of services, with the ultimate goal being universal health coverage (UHC). Fostering mutual understanding and further alignment between PFM and health financing systems is critical, and health planning stakeholders have a critical role to play here.

PFM systems shape the level and allocation of public funding (budget formulation), the effectiveness of spending (budget execution) and the flexibility in which funds can be used (pooling, sub-national PFM arrangements, purchasing). While PFM is sometimes considered a bottleneck for effective health spending due to rigidities in the way budgets are formulated and executed, PFM rules also provide the sector with a domestic, integrated platform to manage resources irrespective of their sources (i.e. a core attribute of pooling) and their levels (i.e. across national and sub-national entities).

From a PFM perspective, health is perceived as one of the spending sectors that deliver key public services and goods but overall lacks a good understanding of the PFM roles and rules for public sector effectiveness and financial accountability. In some countries, health is seen as a sector with less capacity, vis-à-vis other sectors, to adequately formulate its priorities

and needs and define credible budgets. Often, actual health sector spending is far from initially defined targets. In most low-income countries, actual health spending is typically lower than budget allocations, which ultimately reflects the sector's difficulties to plan, commit and disburse according to national PFM rules. The perception of lack of measurable, immediate health outputs of public resources tends to also reinforce a common perception of the sector's ineffectiveness and inefficiencies.

Overall, health has been both a distorting and innovating sector for PFM systems. Over the past two decades, the health sector has sometimes generated the development of parallel PFM systems to secure investments and limit fiduciary risks for external investments. Earmarked allocations and parallel budgeting, pooling procurement, reporting arrangements have become a strong attribute of the sector's development aid. At the same time, several low- and middle-income countries have also embarked on alternative health financing reforms that have been mutually beneficial for both the sector and PFM as a whole, through, for example, the development of sectoral MTEFs, the strengthening of domestic procurement mechanisms, the tracking of resources and expenditures up to the sub-national levels, a sound management of domestic pooled funds, the introduction of purchasing agents and strategic payment mechanisms to control expenditure and expand coverage at the same time. In this respect, the health sector can help leverage domestic PFM efforts.

The key objectives of public finance systems are to maintain sustainable fiscal discipline, ensure strategic allocation of resources and efficiently deliver public services.

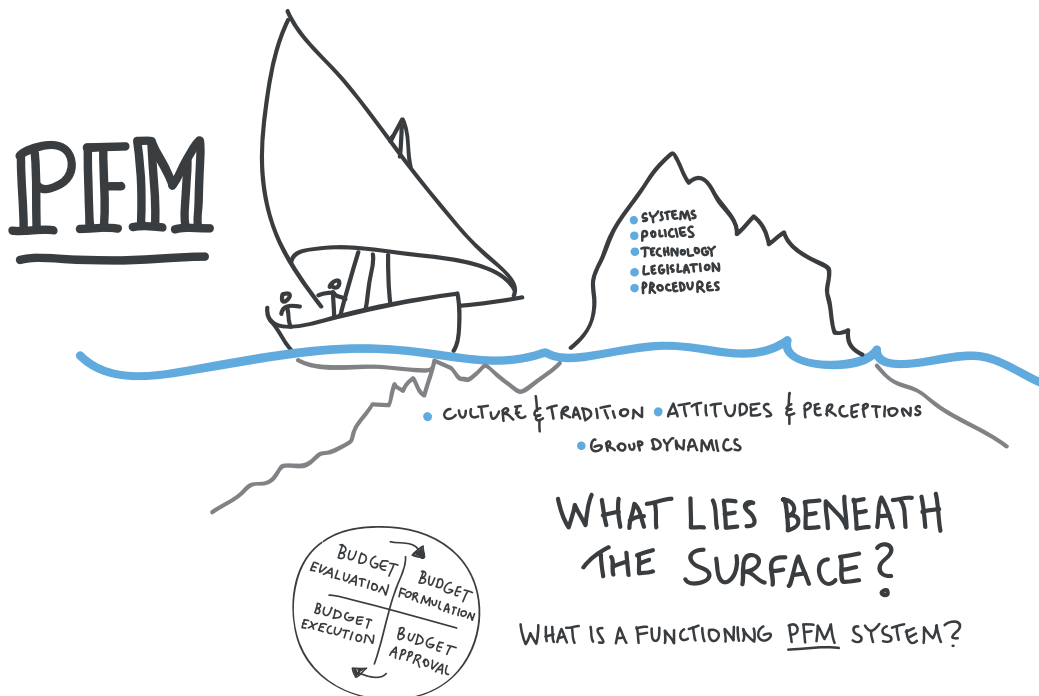


Fig. 8.7 What does it mean to have a functioning PFM system?

8.7 What if...?

This section outlines budgeting issues in specific settings such as decentralized contexts, highly donor-dependent countries, and fragile states.

Fiscal decentralization involves shifting some responsibilities for expenditures and/or revenues to lower levels of government; this can have an impact on health sector funding, as well as how funds flow to the health system.

8.7.1 What if your country is decentralized?

If health is a mandate for a decentralized entity, the full health policy and planning cycles may fall under a decentralized authority. Fiscal decentralization involves shifting some responsibilities for expenditures and/or revenues to lower levels of government; this can have an impact on health sector funding, as well

as how funds flow to the health system. In particular, it is important to clarify where local governments can determine the allocation of health expenditures themselves versus those where the centre mandates expenditures and decentralized entities simply execute those health expenditures.

For health planners, it is critical to understand at which level revenue and expenditure decisions are taken (see Box 8.13). Decentralization can make health budgeting processes more complex in that sense, even more so in contexts with weak governance systems. In addition, care must be taken to avoid new inefficiencies due to decentralization, such as separate procurement by each region when it would make most sense to procure together as a single purchaser.

Three main challenges have been observed across decentralized countries or those in the process of decentralization.

- (a) Resource mobilization mechanisms can end up being competing and fragmented, leading to inefficiencies in collection and pooling efforts;
- (b) Health sector priorities (often set at national level) may be misaligned with sub-national-level budgets and spending targets (e.g. health can de-prioritized in sub-national budgets);
- (c) Financial record management is more complex, with resulting poor national consolidation of financial data and limited financial accountability.

A well-managed decentralization process will have in place institutional arrangements for coordination, planning, budgeting, financial reporting, and implementation across government ministries/institutions as well as between the different administrative levels of the country. These coordination bodies are important mechanisms for MoH and health planning stakeholders to discuss specific budget-related issues linked to specific rules (e.g. the design of fiscal transfers) as well as review budget execution against sector priorities.³⁹

Box 8.13

Caveats in a decentralized setting: the case of Zambia⁴⁰

The catch in decentralized settings comes when the decentralization process is not prepared adequately or does not function as it should. This might mean that some structures and responsibilities are decentralized but not others, limiting the empowerment truly given to local district managers and communities, and also limiting its benefits. An example of the problems that may arise in such a situation can be seen in Zambia, where an evaluation of decentralization after about a decade of implementation found that health districts had only a moderate range of choice over expenditures, user fees, contracting, targeting and governance. Their choices were even more limited over salaries and allowances and they had no control over additional major sources of revenue, like local taxes. Health system performance indicators also showed no major change compared to before decentralization, suggesting that the expected advantages for the health system did not come into play. This is a particularly difficult situation, since expectations are often raised with the introduction of a decentralization policy but cannot be matched with action on the ground when not adequately implemented. This situation is usually linked to power and decision-making in some areas still being held centrally, leading to tensions between top-down central-level policy decisions and more locally driven agendas.

The central planning authority should give strong guidance as to the methodologies to be used for costing, budgeting, and expenditure tracking – without it, a diverse and heterogeneous set of data from the various decentralized structures will make aggregating countrywide data and producing national estimates very difficult. For example, an additional layer of analysis must be conducted for national health accounts data in countries with highly decentralized health financing systems with little central-level guidance or authority. Getting comparable and consistent figures is often a challenge that may necessitate external expertise. Many countries may not have the time or resources to make this extra effort. At a global level, there is a definitive drive to establish centralized District Health Information Software (DHIS2) and Hospital Management Information Systems to strengthen consistency in reporting.

Finally, an issue which can arise in a decentralized setting is a relative lack of reporting and transparency on money flows. Often, it is the central level that is held to closer scrutiny and is subject to political pressures on the funds it allocates and disburses to decentralized authorities. After that, as Box 8.3 illustrates in the case of Mexico, access to regional or district budget and expenditure data may be considerably more difficult. Low levels of transparency at regional or district levels may reflect a lack of accountability to the population on matters related to health budgets and expenditures. This would imply that the advantages and added value of a decentralized system close to population needs are not being leveraged and that budget-related problems have simply been relocated from central to decentralized level. As Box 8.3 also demonstrates, civil society groups can be key partners of the government and population to

ensure better accountability and transparency at lower levels of the health system and advocate for the objectives of decentralization to be fulfilled.

Some questions to consider for costing and budgeting in decentralized settings

What does decentralization actually mean in practice in your country? How far are structures, responsibilities, and budgets actually decentralized?

- ▶ The more power and authority actually vested in local authorities, the more scope there is for rational costing and budgeting that is close to the real needs of the local population.

Does the central level authority need to aggregate costing and budgeting nationally?

- ▶ If so, guidance and templates from a central authority would be useful and necessary to reduce the burden and error margins of reformatting and restructuring in order to compare and aggregate. In addition, technical support from a central authority might be recommended.
- ▶ The central-level authority should take into account revenue generation at different levels for more accurate fiscal space projections.

How transparent are health system costs, budgets, and expenditures reported at decentralized level?

- ▶ A low level of transparency may indicate a lack of accountability to the population coming under the decentralized authority and a subsequent lost opportunity to leverage the planning and budgeting advantages of being close to the population.

Box 8.14

Budgeting and health expenditure management in a decentralized state: Nigeria⁴¹

Nigeria is a federal state with three tiers of government, namely, the federal government, 36 state governments, and 774 local governments. The principal actors in the Nigerian public health sector are the Federal MoH (FMoH), the 36 State Ministries of Health (SMoH), the 774 Local Government Authorities (LGA) Departments of Health, and the authorities of the Federal Capital Territory, as well as various government parastatals and training and research institutions that are concerned with health matters.

The FMoH, the SMoH, and the LGA Departments of Health are responsible for planning and managing health spending in their respective jurisdictions. Public expenditure streams for the three levels of government are largely uncoordinated. Federal, state, and local allocation and expenditure decisions are taken independently, and the federal government has no constitutional power to compel other tiers of government to spend in accordance with national priorities.

The complexity of fiscal transfers and financial flows in Nigeria between federal, state, and local agencies makes it difficult for the govern-

ment to reconcile and track resource flows across the different levels and agencies of the health system. In general, the absence of accurate and detailed records on budgets and expenditures indicates that government administrations at all levels do not have the means to ensure that health resources are distributed equitably, efficiently, and effectively.

A further complication to Nigeria's decentralized setting came with the creation in thirty states only, of a new agency, the State Primary Health Care Development Agency. This agency is now responsible for primary health care in the state and is tasked to bring all primary care facilities and staffing under its control. In the 30 states where this Agency exists, the LGA Health Authorities are also under its direct control, creating much confusion as to the delineation of tasks and funding mechanisms.

This example from Nigeria demonstrates that decentralization does not always solve existing problems; in fact, when not organized and managed properly, decentralization can create unintended hurdles.

8.7.2 What if your country is heavily dependent on aid?

Budget transparency is a key principle of the Paris Declaration on Aid Effectiveness (2005), whereby donors and recipient countries agreed that greater budget transparency is necessary to ensure that resources are allocated towards effective poverty reduction strategies. The Accra Agenda for Action (2008) and the Busan Partnership Agreement (2011) also included additional commitments for donors to provide timely information on aid flows to recipient governments, such that country budgets can rely on predictable financial flows.

However, in reality, countries that rely more heavily on donor funds are especially vulnerable to the unpredictability of external funds. Donor dependence is a tricky concept as the definition as to what constitutes dependence is not clear – in particular whether dependence is more an issue of influence rather than an amount or share of the budget provided through external assistance. Nevertheless, it is acknowledged that external fund inflows may not only be positive. Donor grants may be earmarked and there may be a lack of reliable projections for future planning years.⁴² In addition, there are indications that increases in development assistance is not necessarily associated and matched with an increase in government health spending from domestic sources.⁴³

A review of 16 highly aid-dependent countries (countries with an Open Budget Index [OBI] aid dependency index averaging more than 10% over the years 2000 to 2006) revealed that although the presence of donors can promote reforms to strengthen budget transparency, the effects may be offset by other characteristics of donor activity, such as fragmentation and limited use of aid modalities for broader government support and pooled sector funding.⁴⁴

The 2012 Open Budget Survey Report measures the state of budget transparency, budget participation and budget oversight in 100 countries. One of the principal findings was that budget transparency in low-income countries is affected by the choice of aid modalities (i.e. the ways in which aid is provided) and the type of donor interventions, rather than the overall level of aid dependence. In short, the greater the proportion of aid channelled through recipient country budget systems, the more those systems will be strengthened and the more likely they are to become transparent.

“Rather than being linked to the level of overall aid dependence, the transparency is more correlated with an index of donor engagement which tries to capture the quality rather than the quantity of donor flow.”⁴⁵

The effect is not just from the amount of aid and the modalities, but also from the number of donors present. The greater the number of donors there are, the greater the fragmentation. In many countries, health remains the most fragmented sector, thus complicating sector-wide planning.

The most common budget-related challenges in aid-dependent countries include:

- ▶ problems with predictability of donor funds and alignment, harmonization, and coordination with sector strategies and sector strategy budgets;
- ▶ a disconnect between the pledged and actually disbursed monies from donors to aid-dependent countries;
- ▶ the timing of fund release – this impacts on budget credibility and ability to implement activities;
- ▶ donor conditionalities tied to specific funds. Overcoming some of the above-mentioned challenges involves constant dialogue with donors on these issues. It can help considerably to gather and document evidence demonstrating the kinds of difficulties encountered by the budget-related challenges, including implementation delays or lack of implementation altogether.

Common budget-related challenges for aid-dependent countries are the limited predictability of donor funds, the disconnect between pledged and disbursed donor monies, the timing of fund release which may be in line with need, and donor conditionalities tied to specific funds.



8.7.3 What if fragmentation and/or fragility is an issue in your country?

Fragile or post-conflict states will have a reduced tax base and limited revenue generation compared to other countries, translating into an increasing reliance on informal payments and on donor funding. In addition, the transition from short-term emergency relief to longer-term development means a shift in funding models for the health sector – usually, there is some government takeover of basic services with heavy donor assistance. In most cases, this will be accompanied by the continued presence of emergency services as well, creating several parallel funding streams for different types and levels of services that necessitate strong steering capacity and management by the MoH. This is – almost by definition of a fragile state – rarely existent, which makes rational planning and budgeting extremely complex and challenging. (See, for example, Box 8.15).

Private expenditure, remittances from abroad, and aid inflows end up attaining larger totals than expected for health in fragile state situations. Estimates from Afghanistan, Liberia, and the Darfur region of Sudan demonstrate that private health spending soars when public financing is largely absent.^{VIII} High levels of private spending means that only those with money can pay to have access to health services.

A good basis for policy dialogue during the national health planning process would be a basic estimation of the total future resource envelope to be expected for health. Due to the uncertainty of estimations, various scenarios can be developed, i.e. low levels of financing vs high levels of financing. If possible, a special study examining the level of private expenditure would be warranted, given the weight of private expenditure in the health sector.

Box 8.15

Health accounts in a conflict-affected or emergency setting

In conflict-affected countries the health accounts activities remain logistically and methodologically challenging because of the inherent insecurity, governance and institutional weaknesses. Usually government investments are very limited, out-of-pocket expenditures may increase and the access to health care services and goods is limited, which may lead to an increase of risk-taking behaviour and impoverishment. These countries rely heavily on international aid for health care provision but at the same time the absorptive capacity in the recipient government institutions may be very low. The health accounts in post-conflict settings usually focus on resource tracking of external funds. It is important to validate the health accounts results internally (with the data authorities and stakeholders), but also to cross-check the data with other sources (donor reports and international databases) as well as analyse the data, comparing them with general economic and health indicators. The findings from health accounts reports can help improve donor accountability and coordination, ensure more equitable distribution of development aid, and lead to better reallocation of health care funds.

^{VIII} More information can be found in Chapter 13 “Strategizing in distressed health contexts” in this handbook.





8.8 Conclusion

A health budget should be viewed as a crucial sectoral orienting text, declaring key financial objectives and its real commitment to implementing health policies and strategies.

During the budgeting process, health planning stakeholders and managers will need to understand the guiding principles of budgeting as well as the political dynamics that enable the budget elaboration and approval processes; not doing so will be a huge missed opportunity to make the case for health. If MoH and other health sector stakeholders are actively and knowledgeably engaged with MoF and others during the budget cycle, resource allocation will more likely match planned health sector needs, and execution is more likely to follow allocations.

The various public finance processes are structured around the budget cycle. In this chapter, the four distinct budget cycle stages (budget definition and formulation, budget negotiation and approval, budget execution and budget reporting, auditing and evaluation) are elabo-

rated upon, with an emphasis on health sector stakeholders' specific role in each, possible entry points for engagement, and particular issues to consider when doing so.

In essence, developing robust health budget envelopes requires strong engagement by health ministries with national budget decision-makers, to make the standpoint of the health sector clear, comprehensible and compelling. This requires MoH and planning stakeholders to think through the operational details and costs of health sector needs and how health services should be purchased within the framework of existing PFM rules.

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