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# Report on the WHO Global Learning Event

Introducing programme-based budgeting in health:  
the devil is in the details



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# Background of the Global Learning Event

## Why PBB?

Programme-based budgeting (PBB) is a budgeting instrument to link budget allocations to outputs. Specifically, a PBB approach groups expenditures by policy objectives or outputs, usually through a three-tiered structure (programme goal, sub-programme, activity). PBB releases funds by programmatic envelopes and is accompanied by a performance-monitoring framework that focuses on output targets.

There are several reasons why making the shift from line-item budgeting (which typically classifies, releases, and controls expenditures by detailed line items) to PBB can be beneficial for health spending. Doing so can help to address rigidities associated with line-item budgeting and provide more flexibility in resource use; to direct funding to priority services (e.g., primary care); and to link resource allocation to outputs/targets. A shift to PBB also represents a way of purchasing health services within the existing public financial management (PFM) system without having to establish separate insurance-based arrangements. Finally, it can improve public transparency of health spending and accountability for obtaining results.

Over the past two decades, nearly all low and middle-income countries (LMICs) have initiated reforms to shift from input-based budgets to programme or output-based budgets, and health has often been a pilot sector for the introduction of these reforms. While some LMICs are more advanced in the reform processes and already operate using full-fledged PBB, most LMICs have faced design and implementation challenges in making this shift.

LMICs implementing PBB have encountered three main challenges, all with respect to budgetary programmes: 1) difficulties in design and formulation; 2) difficulties in financial management; and 3) difficulties in monitoring performance, from both a financial and a non-financial perspective.

## WHO work on PBB

Since 2017, the World Health Organization (WHO) and its partners have built a global knowledge-base to inform PBB reforms in the health sector. This has involved extensive technical consultations, in-depth country reviews, and the development of *How to make budgets work for health: A practical guide to designing, managing and monitoring programme budgets in the health sector* (2022). Having received several country requests to provide further technical support for the introduction or refinement of PBB in health, this Global Learning Event was an opportunity to share and review practical experiences of reforms in support of PBB in the health sector, with a focus on LMICs.

- **WHO guidance book:** *How to make budgets work for health: A practical guide to designing, managing and monitoring programme budgets in the health sector* <https://www.who.int/publications/item/9789240049666>
- **Country case-studies** on the introduction of PBB in health – developed by WHO, Organisation for Economic Co-operation and Development (OECD) and International Budget Partnership (IBP) <https://www.who.int/teams/health-systems-governance-and-financing/health-financing/policy/budgeting-in-health/programme-budgets-in-health-country-evidence>



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## Objectives of the Event and target audience

The Global Learning Event was designed as a technical deep-dive on PBB to

- Help frame and identify the key questions and considerations that PBB implementers need to reflect on when introducing or refining PBB in the health sector,
- Discuss good practices and see how trade-offs that emerge at each stage of the reform process can be addressed, and
- Identify remaining gaps in knowledge and needs for future reform support and cross-learning.

The event was primarily intended for ministry of health officials who are involved in the design and implementation of these reforms, while also being of interest to other actors, including finance authorities, planning ministries, and development partners wanting a better understanding of the requirements for this type of reform in the health sector.

The Global Learning Event was structured around the three challenges mentioned above, with an agenda block for each. Each block included a presentation on key questions, a presentation by a country representative, discussions in breakout groups, reporting in plenary from the breakout groups, and final reflections by a subject-matter expert. The event provided an opportunity to use peer learning to identify challenges and discuss ways to address or avoid them. The event thus complemented the guidance and case study-based learning provided in the above-mentioned WHO references.

## Participation

The Global Learning Event was attended by more than 300 unique participants, which included the organizers of the event (the background staff as well as the presenters). Approximately 75% of the external participants were country officials from LMICs (including representatives of ministries of health and finance) and the rest were representatives of international organizations.

## Presentations

A slide deck containing all presentations is available from this link

<https://docs.google.com/presentation/d/1SF1HR7gtZ9dS99lmFX84ceFEQwlrQoyY/export/pdf>

## Recordings

[https://bit.ly/PBB\\_event\\_220628](https://bit.ly/PBB_event_220628)

## Acknowledgements

This report was developed by the Event's organizing team, including Hélène Barroy (Senior Public Finance Expert, WHO), Linnea Mills (PFM and Governance consultant), Valérie Dossogne (Web Manager), and Joseph Kutzin (Team Head, Health Financing, WHO). WHO acknowledges funding support received from Gavi, the Vaccine Alliance for the Global Learning Event.







# Block 1:

## Designing programme-based budgets in health

The Global Learning Event's first block focused on how best to design budgetary programmes for health using a PBB approach. The most important issues are: 1) aligning the budgetary programme with health-sector spending priorities, 2) choosing how to incorporate disease-related activities into the PBB structure, and 3) incorporating primary care into PBB formulation.

### Key questions (Hélène Barroy, WHO)

To ensure PBB's design features are aligned with the health sector's spending priorities, consideration should be given to

- Ensuring the number of budgetary programmes is manageable. Countries should avoid establishing either a small number of very large programmes or a large number of very small programmes.
- Coherence of the type of budgetary programme (policy-oriented, service-focused, and/or support/administrative). Countries should ensure that the combination of budgetary programmes does not result in an overlap between funding providers for the same services. Preferably, staff costs should not be grouped under a separate administrative budgetary programme as that separation can reduce the flexibility to manage the budgetary programme's resources.
- Budgetary programme structure, to ensure that the programme structure provides a coherent chain of results (a theory of change) across the structure. A three-level structure (programme, sub-programme, activities) is generally advised.

When making decisions on how to incorporate disease-related activities into PBB, consideration should be given to

- Where in the budgetary-programme structure disease-related activities are to be included. While these activities can constitute budgetary programmes in themselves (a programme for HIV/AIDS, a programme for malaria, etc.), it is generally preferable to integrate disease-related activities either at the sub-programme level or at the activity level, to reduce fragmentation in how those services are funded, and ultimately delivered.
- How to track and assess progress in fighting diseases, and to include relevant disease-related indicators in PBB performance-monitoring frameworks.

When deciding how to include primary care within PBB formulation, consideration should be given to

- The pros and cons of formulating budgetary programmes based on the levels of care (e.g., for primary care, for secondary care, etc.). While doing so may help to prioritize primary care within budgets, this approach can also make it harder to fund service-delivery approaches that are integrated. One way to avoid this is to include primary care as a sub-programme within a broader programme.





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## Country presentation: South Africa (Mark Blecher, National Treasury, South Africa)

A representative of South Africa's National Treasury presented on factors influencing the design of PBB in that country, both at national and provincial levels. The country benefited from going through the PBB process at the central level, while learning about the need to secure buy-in from different institutions (e.g. provinces). South Africa operates health-related budgetary programmes at both national level (six programmes) and sub-national (provincial) level (eight programmes), all with sub-programmes. The type of budgetary programme used is mostly service-focused, with each programme including all related costs, including those for personnel. The government focused on establishing platforms that are integrated, avoiding those that are vertical. Budget appropriations are based on information from the programme level, allowing for maximum flexibility to shift resources across sub-programmes; a worthwhile trade-off compared with using the sub-programme level, which offers more detailed information. Most disease-related activities are included in the Communicable and Non-Communicable Diseases budgetary programme. At the provincial level, this translates into integrated services; there is also a vertical HIV sub-programme, but this is being phased out. South Africa's experience shows that disease-specific budgetary programmes can fragment the budget and should be integrated into other budgetary programmes. South Africa has chosen to channel its primary health care budget through its District Health Services budgetary sub-programmes, and to deliver those services through integrated service-delivery platforms (clinics, community health centres, community-based activities, district hospitals).

After the presentations, participants discussed budgetary-programme design considerations in smaller breakout groups. The table below shows the themes of the different breakout groups and the specific questions addressed.

<b>Breakout group 1: Generic features of PBB in health</b>
Q. What is the best process for generating the programmes? Is there an optimal number of budgetary programmes in health? Why? What are the trade-offs?
Q. What are the challenges when certain major inputs (e.g., personal, infrastructure) are kept outside of the budgetary programmes? How to deal with these challenges?
Q. What are the challenges when the PBB structure is not consistent across levels (e.g., central, sub-national, purchaser)? How to deal with these challenges?
Q. Can you share your experiences/knowledge of how a programme structure has facilitated a results chain? Is the goal/programme/sub-programme/activity structure adapted to most contexts?
<b>Breakout groups 2 and 3: Health programmes in PBB</b>
Q. At which level of the budgetary programme structure would you incorporate disease/health operational programmes, i.e., budgetary programme, sub-programme, activity? Why? What are the trade-offs?
Q. Can you share your experiences/knowledge of how the disease/health operational programme organizational structure has interacted with budgetary programme formulation?
Q. What are the challenges with formulating budgetary programmes when disease/health programmes are already in place? How can these be effectively managed?
<b>Breakout group 4: Primary care in PBB</b>
Q. At which level should primary care be integrated into the programme structure? As a budgetary programme, sub-programme, or activity? What are the trade-offs?
Q. Can you share your experiences/knowledge of how primary care budgetary programmes/activities interact with other programmes and services (e.g., maternal health) to limit duplication and fragmentation in the funding of service delivery?
Q. When primary care is delivered at various levels, how can PBB facilitate the coordination of providers? How can it incentivize referrals, or ensure a continuum of care?

Participants shared a variety of country experiences and broader insights, including the importance of health ministry officials having ownership of the budgetary programmes, and authority to design programmes in line with their objectives. Another insight regarding primary health care was that PBB structures should follow country-driven, rather than global, definitions of primary health care.

To conclude Block 1, reflections on the topic and presentations were given by Cheryl Cashin from Results for Development (R4D) who has lengthy experience working on health financing reforms. She shared some findings of the recent The Lancet Global Health Commission on financing primary health care, to which she was a key contributor, as well as reflections from a PBB perspective. A key insight concerned the importance of making health priorities, such as primary health care, visible in the budget to protect the funding for these priorities and how PBB as an approach can help to ensure that visibility.







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# Block 2:

## Managing programme-based budgets in health

The Global Learning Event's second block focused on how best to manage programme-based budgets in health. The most critical financial-management challenges are: 1) ensuring that PBB increases flexibility in spending; 2) enabling providers to be paid through the PBB structure and to access and use funds; and 3) ensuring effective disbursements and accounting for transfers in situations where a separate purchaser, such as a health insurance fund, exists.

### Key questions (Moritz Piatti, World Bank)

To ensure PBB increases flexibility in financial management, consideration should be given to

- The type and level of disbursement, with a “global budget” or a “lump sum” being the most conducive to flexible management by programme managers.
- The management of spending on human resources and administration. If a shift to PBB does not coincide with the removal of input-based or activity-based controls, then the introduction of PBB can increase financial rigidity instead of than promoting flexibility.

To make sure providers can be paid through a PBB structure, consideration should be given to

- Ensuring that contractual arrangements between programme managers and service providers are output oriented, as this approach can allow for direct purchasing of services through the budget.
- Fostering coherence in providers' financial management. The PBB structure must allow for flexibility. At the provider level, this is assured when each provider receives its money from one sub-programme only; receiving payments from several different sub-programmes will lead to fragmentation and increase rigidity.

Challenges that providers may encounter when accessing and using programme funds need to be considered, including

- A lack of capacity and/or authority. Providers must have the authority to receive and spend funds, and the capacity to account for how resources are spent. Related public financial management reforms that provide more autonomy to providers will be necessary to make PBB work for the health sector.
- Potential fragmentation, and inconsistency across levels of government, resulting from a budgetary-programme structure that is insufficiently aligned with the administrative structure, for example when providers must draw funds from several different sub-programmes.

With a separate purchaser, when disbursing and accounting for transfers, consideration should be given to

- The specifics of transfer disbursement and accounting, which depend on the level of purchaser autonomy.







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### **Country presentation: Zimbabwe (Norbert Machinjike, Ministry of Finance and Economic Development, Zimbabwe)**

A representative from the Zimbabwean Ministry of Finance presented on the experiences of implementing PBB in the context of a wider integrated results-based management reform. The presentation focused on the country's budgetary programme for primary health care and hospital care, highlighting that PBB made it possible to allocate resources directly to the level of care. Other advantages have been the clear allocation of costs, improved ability to monitor spending, clear lines of accountability, and improved budget deliberations through the ensuing legislative debates that have taken place. That said, the reform is still ongoing, and challenges remain regarding building capacity at the lower levels of care, and fully aligning the administrative systems with the PBB approach.

The ensuing breakout groups discussed targeted questions related to the financial management of budgetary programmes. The themes of the different groups and the specific questions addressed are shown in the table below.

<b>Breakout group 1: Flexible financial management</b>
Q. Should funds be released by programme/sub-programme, activity, or input level?
Q. How to manage administrative and HR spending?
Q. How to deal with possible input-related capping (e.g., for staff)?
Q. How to manage the workload of financial management staff?
<b>Breakout groups 2: Provider payment</b>
Q. How to encourage arrangements based on outputs in contracts between programme managers and service providers?
Q. Under PBB and output-based payment, how to improve service providers' financial management (e.g., planning, budgeting, procurement, accounting, and reporting)?
Q. What other types of reforms are needed to ensure flexibility and accountability (e.g., provider autonomy)?
<b>Breakout group 3: Financial fragmentation</b>
Q. What challenges may service providers encounter when accessing/using programme funds?
Q. How to minimize fragmentation (at the provider level) when financing from multiple budgetary programmes?
Q. How to adapt to multiple layers of national and local government responsibility (decentralized environments)?
<b>Breakout group 4: Transfers to social health insurance (SHI)</b>
Q. Is alignment between budget structures of a separate purchaser and the rest of the health sector's budget desirable?
Q. If a country has a purchaser with a high degree of autonomy, what are the ways to disburse and account for transfers given the PBB structure?
Q. In a context where the predominant health sector budget is managed based on inputs despite the PBB structure but there is also a separate purchaser with a high degree of autonomy, what are the potential issues and what are the ways of addressing them?

Participants offered various insights, including the importance of avoiding retaining purely input-based systems alongside PBB. Another insight was the importance of releasing funds at the higher, sub-programme, level to ensure flexibility while not foregoing adequate control. One way of handling this tradeoff is by managing the cost of contractual staff in a more flexible way than salaried staff. Additional insights related to the importance of having a well-functioning financial management information system (FMIS) to better handle the financial-management workload that is required in a PBB approach.

To conclude Block 2, Neil Cole from Collaborative Africa Budget Reform Initiative (CABRI) provided reflections, including stressing that managers of budgetary programmes should be granted autonomy, while being held accountable. The way to grant managers the necessary authority to manage, is for PBB appropriation to be conducted at the programme level (i.e., the highest level within the three-tiered structure). Also key is ensuring that the programme structure's sub-programme and activity levels have sufficient capacity to manage and account for funds.



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# Block 3: Performance monitoring with programme-based budgets in health

The Global Learning Event's third block focused on how to monitor performance in PBB. The main challenges in performance monitoring are: 1) how to align the PBB performance-monitoring framework with the country's health sector priorities and goals; 2) how to ensure the development of sound and feasible performance monitoring; and 3) how to ensure that a PBB performance framework is useful for accountability purposes.

## Key questions (Linnea Mills, Independent & Fahdi Dkhimi, WHO)

To ensure a PBB performance-monitoring framework aligns with the health sector's priorities and goals, consideration should be given to

- Developing a performance framework that establishes a hierarchy of goals and objectives which systematically links to annual budgets and multiannual budget frameworks while reflecting national and sectoral development plans. Such a hierarchy of goals should provide information about the assumed cause-and-effect relationships needed to achieve strategic goals and policy priorities.

To ensure the development of a sound and feasible performance-monitoring framework, consideration should be given to

- Finding good measurements, through performance indicators, that can identify whether the budgetary programmes' goals and objectives are attained. It is preferable to have a small set of targeted and strategic indicators; countries with long-term use of performance budgeting typically have, over time, scaled back the number of indicators they use.
- Addressing challenges related to the interoperability of data systems used for collecting and processing performance data. These systems are often separate, owned by different institutions (ministry of health vs ministry of finance), and were developed for different purposes (financial management vs health monitoring). Interoperability eases the implementation of the PBB performance-monitoring framework, but often is not considered a central issue.

To ensure that a PBB performance framework is useful for accountability, consideration should be given to

- Establishing baselines and targets for the performance indicators. Without targets it is difficult to assess the programme's achievements, and without baseline measurements it is impossible to know how ambitious the targets are, or the degree to which the results deviate from those targets. Both baselines and targets are needed for managers, politicians, and other stakeholders to be able to use a performance framework.







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### Country presentation: The Philippines (Omi Castanar, PBB consultant)

A PBB specialist from the Philippines presented on how that country established a BPP performance-monitoring framework in health, through various iterations, from 2007 onwards. Several years prior to adopting a PBB structure, the country developed a monitoring framework related to performance budgeting, with the inclusion of outcome indicators in the budget. This process taught important lessons about the number and use of indicators, ultimately showing three indicators per budgetary programme to be a manageable number in that context. With each indicator being linked to performance incentives, the indicators must focus on monitoring performance for which the Department of Health has budgetary influence. The Philippines' experience also showed the value of involving oversight agencies and budgetary programme managers in the choice of performance indicators, to ensure that the monitoring is useful for them. Finally, the country's experience highlights the importance of linking PBB performance-monitoring frameworks with the overall national performance framework so that it becomes part of a larger monitoring system.

The breakout groups that followed the presentations discussed a series of targeted questions pertaining to the challenges of designing, populating, and using the PBB performance-monitoring frameworks in the health sector. The themes and questions that were discussed are shown in the table below.

<b>Breakout group 1: Alignment with sector needs and priorities</b>
Q. How important is it to have a clear hierarchy of goals that links health budget programmes upwards with health sector objectives and national goals? What problems, if any, have you experienced in using PBB performance monitoring in the absence of interlinked goals across national, sectoral, and budget programme levels?
Q. When designing a PBB performance framework in the health sector, which actors need to be involved? Who should be in charge of coordinating the overall design process and who should give input and when? What useful lessons can you share about this process?
Q. What constitutes a good process for identifying the performance/result we want to monitor in PBB in health? What should the analytical process look like and who should lead this phase of the design process? What useful lessons can you share in this regard?
<b>Breakout groups 2: Sound and realistic PBB framework</b>
Q. What indicators have been (and are) used at which level of the programme budget structure in your country, and how have they been selected? How do we mitigate the risk of inappropriate reporting requirements (too many indicators, not at the right level of the PBB structure)?
Q. What strategies should be put in place to ensure timely collection and transmission of quality data for PBB performance appraisal? How do we deal with variability in data availability by programme or sub-programme?
Q. In your experience, what approach works to ensure financial information integrates well with information on activity and results? How well is the PBB information management system integrated and interoperable with other sectoral information management systems?
<b>Breakout group 3: Putting PBB framework to good use</b>
Q. Is PBB performance data actually used in the budget cycle in your country? Who are the main users? Is it linked to frameworks of accountability for ministry of health (MOH) and managers in the health system? Is it used by civil society?
Q. How do we avoid potential pitfalls in how performance information is used – such as perverse incentives for civil servants or providers to distort data, to set easy targets, to neglect aspects of performance that are not monitored?
Q. What would effective support look like for countries to develop competencies to present and explain performance data (e.g., data analytics and visualization skills) so that users of the data really understand performance and can use it for meaningful accountability?

One participant shared Kenya's experience of aligning the national performance-monitoring framework with the sub-national-level budgetary programme structure, resulting in a need for a platform for dialogue between the technical and political levels. Other participants shared insights on political economy aspects of PBB monitoring, for example how changes in leadership can affect both priority setting and performance monitoring, impeding continuity.

To conclude Block 3, Chris James from the OECD offered his reflections based, primarily, on experience from OECD countries. He stressed the need for realistic expectations about what PBB performance monitoring in health can achieve, and that this can take time and iteration to get right. PBB performance monitoring is primarily about obtaining information that can help improve knowledge about programmes' effectiveness; in turn, this information should be used for better engagement with the ministry of finance. Additionally, performance indicators should be carefully selected, and limited in number. The experience of OECD countries also shows that performance monitoring can be introduced incrementally, enabling capacity to be built and a culture of monitoring to be developed gradually (for example, by piloting the framework on parts of the health budget). From there, countries can gradually increase the scope and ambition of their performance monitoring, and link that monitoring to other good budgeting practices in health.









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# Event's key takeaways

## Technical guidance wrap-up

Hélène Barroy synthesized the learnings from the three blocks in a technical-guidance wrap-up. With respect to Block 1 (design of budget programmes in health), guidance can be summed up as follows:

- Weigh in generic design choices when introducing PBB in health – these choices all have direct implications for financial management of the budgetary programmes;
- Use a manageable number of budgetary programmes (typically, more than one, but not so many that they become fragmented);
- Define goals, outputs, and sub-programmes along a coherent results chain (like defining a logical framework throughout the budgetary programme structure);
- Align the budgetary programme structure with the service delivery system to ensure that funds flow to the prioritized services (making those services visible in the budget);
- Integrate disease-related activities into the sub-programme level or activity level to facilitate integrated service delivery, while considering the institutional interface of those programmes;
- Include all costs, including those for staff, within budgetary programmes, to ensure programme managers have the flexibility to handle all the programme-related resources;
- Use a common programme structure across all budgetary levels.

Regarding Block 2 (managing PBB in health), ways to foster flexible financial management conditions include:

- Disburse funds as “lump-sum” (or “global budget”) at sub-programme level to enable flexible management by programme managers;
- Promote flexibility in programme funds management for budget holders, shifting control from line items to outputs (“letting the manager manage”);
- Ensure budgetary-programme managers are accountable for programme outputs;
- Use the PBB structure to engage in output-oriented contracts with service providers;
- Define reforms complementary to PBB, to enhance provider autonomy alongside robust financial management;
- Staff norms/salary management and PBB – ensure reforms are consistent and aligned, and do not impede one another (e.g., staffing norms).



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Finally, for Block 3 (PBB performance monitoring in health), ways to achieve a useful output-oriented performance framework include:

- Align the performance-monitoring framework to PBB outputs;
- Focus on assessing outputs at the sub-programmes level, rather than programme outcomes. While outcomes may be helpful for senior-level leadership, managers at sub-programme-level will benefit more from a focus on outputs;
- Populate the performance-monitoring framework with a manageable number of indicators; start small and refine as the system matures;
- Avoid punitive accountability;
- Ensure the performance-monitoring framework is put to good use, and designed in a way that guides future budget allocations, while promoting public transparency;
- Harmonize – if not integrate – financial and non-financial performance. PBB is an opportunity to integrate those types of monitoring into a consolidated framework.

## Partners' roundtable

The last session was a partners' roundtable in which representatives from Public Expenditure and Financial Accountability (PEFA), the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund), Gavi, the Vaccine Alliance (Gavi), and the P4H network (P4H) shared their views on the importance of PBB, in the context of their respective organizational mandates.

Srinivas Guruzada from PEFA noted that the challenges faced by countries (particularly LMICs) while developing and implementing PBB in health may not be specific to that sector but rather to more general, and government-wide, problems with how budgets are planned and executed. In other words, for health sectors to be successful, countries must be successful, although health sectors can be the champions leading the way.

Michael Borowitz from The Global Fund stated that, although PBB presents new territory for that organization, shifting their focus to outputs is nevertheless the right way to go. He stressed the importance of enhancing budgetary programmes' visibility of outputs and results for different diseases.

Emmanuel Bor from Gavi highlighted PBB's capacity to improve efficiency and effectiveness in public spending on health, but warned of the risk of PBB being implemented in a "cosmetic" rather than a structural way. To avoid this, he stressed the importance of having key fundamentals in place prior to introducing PBB, including a credible budget, a robust strategy for the health sector with performance-monitoring measures intact, and reliable input-based budgeting processes.

Finally, Claude Meyer from P4H stated that PBB is part of P4H's mandate and consequently part of the collaborative network's workplan, with health-financing specialists in 18 countries available to assist with PBB implementation issues.

## Next steps

During the last session, participants were polled on which follow-up support actions to prioritize. Increased knowledge sharing of LMICs' experiences and setting up a community of practice topped the list of most-needed actions. WHO will take these inputs into consideration to shape the next steps of the learning agenda.

Joe Kutzin of WHO provided the Global Learning Event's closing remarks, stressing how PBB is integral to the wider health-financing agenda. Although not a panacea, PBB enables budgetary resources in health to be used more effectively, by removing PFM-related barriers, and it is important to understand in detail what this implies and requires.

For the next steps, WHO will 1) produce new case studies on PBB in health to continue the learning process; 2) continue providing ongoing country support, including a study tour (from Algeria to South Africa), and 3) conduct a scoping review on the inclusion of primary care into PBB structures.



