World Health Organization

MEETING REPORT

WHO symposium on health financing for UHC

A closer look at fiscal space and public financial management issues in health

12–14 NOVEMBER, 2019
MONTREUX, SWITZERLAND

BACKGROUND AND OBJECTIVES

Public funds are central to financing progress towards universal health coverage (UHC) and ensuring coverage and financial protection. Consequently, mobilizing fiscal space through domestic revenues has risen in importance on the 2030 Agenda for Sustainable Development. Because weaknesses and rigidities in public financial management (PFM) systems often constrain the efficient use of such revenues, PFM reforms have now become central to the UHC agenda. Motivated by this, WHO's Department of Health Systems Governance and Financing convened a series of annual meetings in Montreux, Switzerland, on the links between fiscal space, PFM and health financing policy to share knowledge and provide guidance on country-related reforms.

The 1st Meeting of the Collaborative Agenda on Fiscal Space, PFM and Health Financing took place in December 2014. The meeting built upon existing efforts among partner agencies around these three key issues. A follow-up meeting was held in April 2016 where participants discussed key issues around enhancing productive dialogue as countries seek to move towards UHC. In November 2017, the 3rd Meeting of the Collaborative Agenda centered on practical issues countries face in implementing PFM policies and reforms to institutionalize and sustain progress towards UHC.

The 4th Meeting of the Collaborative Agenda took place on 12-14 November 2019. The meeting took a more granular approach towards PFM and fiscal space, focusing on specific health sector issues such as unpacking the links between overall fiscal space and health-specific measures, budget formulation and execution issues in health, and the interrelations with payment systems for health service providers.

The specific objectives of the meeting were to:

- provide participants with an update on conceptual developments on fiscal space;
- explore budget formulation and execution issues for the health sector;
- examine PFM reform from a health service provider perspective; and
- define a path forward with partners on fiscal space, PFM and health financing.

PARTICIPATION

105 delegates attended the Symposium. Delegates came from 12 countries, including Ghana, Indonesia, Kenya, Lao People's Democratic Republic, Nigeria, Peru, South Africa, Sri Lanka, United Republic of Tanzania, Ukraine, United States of America and Zambia.

In addition to representation from WHO headquarters, regions and country offices, a number of multilateral partner agencies, bilateral partners, non-governmental organization (NGOs) as well as foundations and academia participated in the meeting. These included Abt Associates, the Bill & Melinda Gates Foundation, the Center for Global Development (CGD), the Department for International Development (DFID) of the United Kingdom, the European Commission, Gavi, GIZ, The Global Fund to Fight AIDS, Tuberculosis and Malaria, the International Budget Partnership (IBP), the International Monetary Fund (IMF), Johns Hopkins University, the Norwegian Agency for Development Cooperation (Norad), the Organisation for Economic Co-operation and Development (OECD), Overseas Development Institute (ODI), Results for Development (R4D), Save the Children U.K., ThinkWell, the U.S. Department of the Treasury, the Wemos Foundation and the World Bank Group.

The full list of participants can be found in Annex 2.

Acknowledgements

This report was developed by Hélène Barroy, Sanhita Sapatnekar and Ronald Tamangan, under the guidance of Joe Kutzin and Agnès Soucat from the Health Systems Governance and Financing Department of WHO.

Funding Partners

WHO acknowledges funding support received from DFID under the Making Country Health Systems Stronger programme.

More Information

Background documents and presentations are available here:

https://www.who.int/news-room/events/detail/2019/11/12/default-calendar/collaborative-agenda-on-fiscal-space-pfm-and-health-financing-2019

INTRODUCTION

The WHO Director for Health Systems Governance and Financing welcomed participants to the Symposium, highlighting the ways in which the fiscal space and PFM agendas have evolved in the health sector since the 1st Meeting of the Collaborative Agenda in Montreux. When WHO initiated the Collaborative Agenda in 2013-2014, there was a critical need to define and agree on terminology, explain why PFM matters for heath and UHC, and clarify the role of the health sector in this area of work.

Since that time, the WHO and its partners have undertaken efforts to further investigate and frame the ideas that emanated from those initial discussions. Thanks to these collective efforts, there is now a growing recognition at the global level that PFM is crucial for UHC and that it is an enabling factor for health financing reform implementation.

For more information on this subject, please see:

https://www.who.int/activities/leveraging-public-financial-management-for-better-health

The time has now come to move forward once again and to explore ways to put fiscal space and PFM reforms into practice. Recent advancements in the fiscal space arena, such as the new IMF approach to assessing government-wide fiscal space, have also led to an evolution in framing. This is yet another argument for the need to strengthen fiscal dialogue between the health and finance sectors, especially as countries focus more on domestic resource mobilization.

The Director also noted that the PFM agenda has shifted toward better inclusion of these aspects into health financing reform implementation. At the country level, the agenda often involves two key efforts: first, strengthening the basic foundations of PFM systems to ensure robust budget preparation, execution and reporting in health and, second, tailoring PFM systems in more advanced settings to enable more flexible spending arrangements for health and better align with strategic purchasing reforms.

The Director welcomed the changing nature of the audience at the Montreux meetings as well, noting the addition of new participants from countries that had not been represented at the meetings previously and the growing number of practitioners working at the nexus of PFM issues and health financing or, more broadly, health system policy. The changing demographic of audience members reflected an increasing interest in the subject matter at global, regional and country levels, an interest that should be further reinforced by WHO and its partners. The informal community of practice that meets regularly in Montreux is a critical asset in the implementation of country reforms and stimulation of future research and collaboration on the topic.

KEYNOTE ADRESS

Highlights from the keynote address:

- The IMF's new strategy on social sector spending, which provides guidance to IMF staff on when and how to engage on social spending issues in the context of an increasing focus on inclusive growth.
- The scale of the Sustainable Development Goals (SDG) challenge and the need to overcome a funding gap that is estimated by the IMF to be very large in many countries, especially low-income countries.
- The need to meet those challenges through:
    - a stronger emphasis on enhancing tax capacity as well as on spending efficiency;
    - a whole of government and society approach; and
    - effective partnerships to ensure effectiveness in reform, including collaboration among development and technical partners such as the WHO, the World Bank, UNICEF and others.

The keynote address was given by a representative of the International Monetary Fund (IMF). The address highlighted ways in which the IMF has become increasingly engaged on social spending issues against the backdrop of an increased focus on inclusive growth. Over recent years, engagement has increased within the context of both fiscal surveillance and technical assistance programmes, especially in low-income countries where there is a need to enhance tax capacity and spending efficiency to close the SDG financing gap. The IMF now has a clear strategy in place to guide staff through the process of engagement which helps ensure consistency and fairness when policy advice is delivered. The strategy was developed through extensive consultation with development partners, academia and civil society.

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The strategy document is available here:

https://www.imf.org/en/Publications/Policy-Papers/Issues/2019/06/10/A-Strategy-for-IMF-Engagement-on-Social-Spending-46975

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IMF engagement is guided by an assessment of how macro-critical a specific social spending issue may be – meaning how critical that specific issue is to the achievement of macroeconomic stability – and consideration of that issue within the context of a programme. The existence of in-house expertise is another factor that guides IMF engagement. If fiscal sustainability, spending efficiency, spending adequacy, or a combination of these becomes a policy concern, a social spending issue can become a macro-critical one, thereby triggering IMF engagement.

To avoid the common stumbling blocks of engagement, such as competing priorities and misaligned work plans, early dialogue is essential. Early discussions can help align priorities and foster collaboration, both at headquarters and in the field. Also critical is establishing a stronger network of social spending counterparts across development and technical partners, including the WHO, the World Bank and UNICEF.

Following the keynote address, a clear consensus emerged among participants that the new IMF strategy on social spending represented a great opportunity for enhanced dialogue among IMF teams, country authorities and development partners engaged in policy dialogue for effective health financing implementation.

SUMMARY BY SUBTOPIC

MOVING TOWARDS DOMESTIC FUNDING:
Sustainable solutions for transitions

12 november 2019

Key messages:

- Sustainable transitions towards domestic resource mobilization include both financial and programmatic components.
- The main question is how overall outputs – not simply program outputs – can be sustained throughout the transition.
- Transitioning away from external financing for health should be perceived as an opportunity for countrywide reform, not as a threat.
- The PFM system can be a bottleneck in the process of transitioning.

This session introduced key issues related to a country's transition from external financing for health to domestic financing. The session was chaired by a representative of the World Bank who noted the steep decline in external financing that countries face as their income grows, a decline that often happens quite rapidly. The financial gap created by the decline is often too large for a government to overcome with its existing capacity to raise revenues. Even if the financial gap is small, a government's capacity to maintain the quality and coverage of programmes that were previously funded through external resources must still be considered. This suggests that transitions necessitate improvements in both financial capacity and programmatic capacity to sustain outputs while maintaining or expanding coverage.

To better understand this issue, session participants were given the opportunity to hear experiences from a panel of speakers, including representatives from Ghana[1], India, Lao People's Democratic Republic, and Sri Lanka. The experiences shared by the Ghanaian and Lao representatives echoed the statements of the session chair regarding domestic funding challenges in the wake of reductions in external aid. The Ghanaian representative highlighted the practical challenges posed by the co-financing requirements of donors, as amounts often largely exceed domestic fiscal capacities.

[1] Ghana has yet to transition away from external funding from the Global Fund but it is expected to begin doing so by 2023.

Other panelists underlined the ways in which PFM can be a bottleneck in the process of transitioning. For example, donor contributions often cut through the national budget and go directly to specific disease programmes, creating fragmentation in financial management systems. This is often the result of weak domestic systems that need to be consolidated as countries transition away from external funding.

Discussants agreed that transitions should be perceived as an opportunity for programmatic and institutional reforms. As opposed to being a threat to financial sustainability, transitions are an opportunity for countries to improve their PFM systems and their efficiency in spending. As responsibility for the funding of disease programmes shifts more towards domestic resources, maintaining an array of programmes with distinct, separate organizational arrangements is more likely to be unaffordable. Substantial gains are likely to emerge when searching for cross-programmatic efficiencies at the subfunctional level (e.g. in supply chain systems).

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Work by the WHO and UHC2030 related to this topic is available here:

https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/UHC2030_Working_Groups/2017_Transition_working_group_docs/UHC2030_Statement_on_sustainability_and_transition_Oct_2018.pdf

https://www.who.int/health_financing/documents/system-wide-approach/en/

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A NEW LOOK AT THE FISCAL SPACE FOR HEALTH

12 november 2019

Key messages:

- The IMF has put forward a new multi-indicator, dynamic approach to assess overall fiscal space.
- In health, there is a need to move away from a pillar-based approach and towards a country-focused budgetary framework.
- Budget reprioritization efforts must be contextualized to inform effective budget advocacy strategies.
- PFM improvements should be part of strategies to expand budgetary space for health.
- In practice, improved efficiency is not always linked to the expansion of budgetary space for health as savings may be deployed outside the health sector.

A representative of R4D with lengthy experience working on fiscal space for health chaired the session. The chair opened the session by highlighting previous fiscal space frameworks and the benefits of past approaches in bringing together health and finance perspectives. This was followed by an explanation on the ways in which the evolving global context has opened the door to refinements in the definition of fiscal space for health and its approach. Experience has shown that not all drivers contribute equally to the expansion of fiscal space for health, nor are all drivers under the purview of health authorities. The session featured representatives from the WHO and CGD who gave a presentation on the evolution of the thinking around fiscal space for health, especially in consideration of the current focus on domestic public resources for UHC.

A former IMF staff member, currently working with CGD, presented the new IMF approach for assessing overall fiscal space. Fiscal space is both forward-looking and dynamic (e.g. accounting for the impact of contingent liabilities in health). To allow for a consistent assessment of fiscal space across countries, the IMF has been developing and testing a new framework that assesses whether a country has room for discretionary fiscal policy without endangering market access and debt sustainability. Within this framework four types of country categorization are possible, namely: no fiscal space; fiscal space at risk; some fiscal space; or substantial fiscal space.

The IMF working paper on this subject is available here:

https://www.imf.org/en/Publications/Policy-Papers/Issues/2018/06/15/pp041118assessing-fiscal-space

he WHO, which recently initiated work in this field with partners, presented preliminary findings of the thinking to further refine the approach to operationalizing fiscal space for health expansion. The main rationale lies in the need for health stakeholders to define policy levers and clarify where ministries of health are best placed to engage in this agenda.

The budgetary process in creating fiscal space for health involves analysis of the level of public spending available through public revenues and domestic and foreign borrowing (which in turn are influenced by macro-drivers like economic growth), and the share of this allocated to health (i.e. budget reprioritization). PFM can also add to fiscal space for health. Poor PFM is bad for PFM but also for fiscal space for health (i.e. low budget execution) while good PFM enables fiscal space for health expansion. PFM should be viewed as a complementary way to provide more, or more flexible, resources for the sector. These three steps yield comprehensive budgetary space for health.

In the past, budget reprioritization has often been at the forefront of efforts by health ministries to engage in fiscal space for health, especially in the context of budget targets. Yet the analysis presented during the session suggests its limited effectiveness in expanding fiscal space for health, with growth in overall expenditure emerging as the critical driver of fiscal space for health expansion in most developing countries. Strengthening tax capacity remains the most effective strategy to enhance budgetary space for health.

Lastly, the WHO presenter noted that fiscal space for health assessments should be embedded in the multi-year budgeting cycle for better results through improved alignment. Reconnecting PFM and fiscal space for health can be made at the budget allocation and execution stages of the budget cycle.

There was clear acknowledgement from the audience that the terminology and key areas of engagement of health authorities need to be reconsidered, moving away from a traditional understanding of fiscal space for health. Budgetary space for health emerged as an alternative term to characterize the process of expanding budgetary resources for health within the budget cycle.

More information on work by the WHO on this topic is available here:

https://www.who.int/activities/fostering-fiscal-dialogue-between-finance-and-health

FISCAL DECENTRALIZATION AND HEALTH

12 november 2019

Key messages:

- A consensus is needed on the definition and basic concepts of decentralization in health.
- Fiscal decentralization can help sustain access to and coverage of health services.
- To secure results in the health sector in decentralized settings, conditional transfers linked to results is a possible response, as seen in several countries.
- Often decentralization does not trickle down to the health service provider level, thereby limiting the ability to use local funds.

This session began with an overview by a representative from the World Bank's Governance Global Practice on the definition and basic concepts of decentralization and the efficiency gains that decentralization, when done correctly, can bring. The example of Nepal, which moved from a unitary system to a federal system in 2005, was used to show how a constitution can link local mandates to the SDGs, and individual health outcomes to outputs and activities. Following the presentation, representatives from Argentina, Indonesia, Kenya and Nigeria engaged in a panel discussion.

In Argentina, the Programa Sumar, a conditional transfer scheme financed by provinces and linked to results, has been active since 2009. With a strong focus on results, the provinces do not ask for more fiscal resources but instead ask for a specific amount that is measured and tracked against specific indicators. The programme has resulted in net progress against predefined targets. The example from Indonesia showed the importance of such transfer mechanisms, as fiscal capacity at the subnational level often depends on natural resources or industry-based economies. Without transfer mechanisms across subnational governments, fragmentation hinders potential efficiency gains of decentralization.

Similarly, in Nigeria, local levels of governance have autonomy over how to spend money, though each level has a different fiscal capacity which is dependent upon natural resources, how income is earned, and local priorities. The impact of such a situation on the health sector is a geographical variation in quality and expenditure, with coordination (or lack thereof) emerging as a core issue. In 2014, a national health law was enacted to serve as a singular framework for coordination.

However, due to a lack of political will, it was not implemented until 2018. Today, appropriation is annual and mandatory at the national level and subnational levels co-finance their share. Delays at the subnational level are overcome by establishing co-financing requirements as a prerequisite for the release of central funds.

The panelist from Kenya highlighted an issue present in Kenya but common to other countries – fragmentation across grants. Providers and counties receive different types of grants, each existing as a separate silo and each with different sets of rules for utilization and reporting (e.g. conditional, unconditional, performance-based reporting or otherwise). In Kenya, there has been some noticeable stagnation in service coverage indicators following the start of the devolution process. In some ways, after decentralization, facilities lost autonomy as local counties started using facilities to generate revenues.

Discussants from ODI and the WHO flagged the significant variation in the amount of resources available to local units and the importance of properly designed intergovernmental transfers to secure funding as well as results. The WHO highlighted the fact that decentralization does not always reach the provider level, which is a core challenge as funds are often stuck at district level. The audience acknowledged this as a major bottleneck for effective health spending which should be addressed by increasing the autonomy of providers across levels.

DESIGNING PROGRAMME BUDGETS:
Key questions for health

13 november 2019

Key messages:

- Programme-based budgets in health can help align budget allocation with health sector policies and priorities, provide more flexibility in health expenditure management, and improve accountability by measuring resource use in relation to achieved results.
- The design of budgetary programmes will have a bearing on resource allocation, funding flows and monitoring and evaluation of outputs. The design is also a matter of formulation, structure and content.
- The devil is in the details: hybrid structures are likely to foster inefficiencies and financial fragmentation.
- An incremental stepwise reform process is needed for continuous refinement to align with evolving sector needs.

Following the chair's introduction, a WHO representative presented examples of challenging programme-based budgeting reforms in low- and middle-income countries (LMICs). Evidence showed that few LMICs (only 10 of 84 pilots) moved to full implementation, pointing to several design and implementation issues. The formulation, structure and content of budgetary programmes has a bearing on the design and effectiveness of the programmes.

Formulation refers to the title and naming of programmes, as well as their outputs, objectives, sublevels, and types of programmes (i.e. homogeneous or of mixed nature). Structure refers to the number of programmes and their size, as well as the hierarchy between programmes and sublevels. Content should ensure alignment with sector priorities and the incentives of provider payment mechanisms, including how managerial accountability is organized within the health ministry.

Three budget programme design challenges have been identified. First, some countries use hybrid designs, where input- and output-oriented programme lines are mixed and staffing costs are excluded from programme costs. This is a potential bottleneck for resource management as some inputs are managed separately. Second, some countries mix different programme categories together, for example having a few disease programmes, thematic programmes, and level of care programmes. Usually, ministries of finance employ five categories of programmes

(i.e. functional, level of care, disease, thematic, and organizational). This mixed structure often creates overlap and duplications, and creates complexities in resource management, especially at the provider level. Third, some countries have a disease-focused budget programme design, where disease responses are treated as separate budget programmes. This may result in financial fragmentation though this can sometimes be avoided if countries integrate the disease-focused programmes into budgets at the subprogramme or subactivity level, and/or include performance outputs and indicators within the performance monitoring framework of a programme budget.

The session presentations underlined the ongoing nature of programme-based budgeting reforms within Ghana, Peru and New Zealand. While often presented as a gold standard for programme-based budgets, the speaker from the OECD highlighted challenges in New Zealand with the definition and costing of outputs, especially at the regional level. In Peru, a programme-based budget was implemented as part of a government modernization drive, which was aimed at improved efficiency. However, its introduction was accompanied by the creation of several disease-oriented programmes and activities, generating fragmentation in funding streams and service delivery approaches. In the case of Ghana, budget programmes were designed around functions, with health service delivery divided into primary, secondary, tertiary and specialized care; the disease-focused elements of the budget programmes were embedded within activities.

Additional WHO material on programme-based budget implementation in health is available here:

https://www.who.int/health-topics/health-budget

IMPLEMENTING PROGRAMME BUDGETS IN HEALTH:
Links with provider payment systems

13 november 2019

Key messages:

- Budget structures must change as provider payment systems evolve to remove rigidities, improve accountability, and to create opportunities for more effective pooling arrangements and incentives for efficiency and quality.
- More provider autonomy is needed as an accompaniment to the reform process.
- In settings where there is weak governance or limited capacity, it may not be feasible to implement modern programme-based budgets and grant facilities autonomy. As a result, it may be difficult for purchasers to make use of output-based payments effectively.

The session was chaired by a representative of R4D who highlighted the disconnect between budget formulation and provider payment systems in some countries. The session unpacked the links between budget formulation and provider payment, identifying situations where they do and do not align.

A presentation by a WHO consultant helped frame the discussion, showing how programme-based budgeting systems and strategic purchasing can work together towards an effective output-based system. Despite its potential, budget systems can also sometimes impede reforms to provider payment systems. To ensure that funds flow smoothly from budgets to healthcare providers it is important to avoid funding fragmentation. Classifications for the budget systems and provider payment systems should be aligned at all stages, including those related to appropriation, contracts and provider payment mechanisms, and execution.

Several country examples were showcased throughout the presentation to illustrate best case scenarios, such as when the two reforms are closely aligned, and worst-case scenarios, when fragmented funding undermines both payment and programme budget reforms. For example, the Republic of Korea is home to a mature system, with full alignment and provider autonomy. South Africa is known for its mature programme-based budgetary system, though the country has yet to implement strategic purchasing. Ghana has not fully implemented programme-based budgeting though there is a special law to enable output-based payments; the country is still predominantly input-based when it comes to execution.

In the Philippines, programme-based budgeting has not yet been fully implemented and spending is currently confined to the central Department of Health. There is also a fragmented, input-based flow of funding to healthcare providers from local budgets.

Panelists from Armenia, the United Republic of Tanzania and Ukraine described the situation in their own countries, where each is in the process of aligning budget structure with payment systems. In Armenia, budgetary appropriations and budget execution are based on programmes and activities. However, the Treasury still exerts control over the activity level and the Ministry of Health (MoH) must approve all activity line changes, thereby introducing potential delays. In the Republic of Tanzania, public healthcare providers receive funds through a mix of line items (e.g. for salaries and health products) and direct funding, through reimbursement claims made to various health funds. Healthcare facilities can hold funds in their own bank accounts, reallocate funds across line items, and retain funds across financial years. In Ukraine, a semi-autonomous purchaser receives funds from the legislature through a programme budget line. Payment rates (i.e. capitation and case-based payments) to healthcare providers are approved by the Cabinet, even as providers maintain autonomy over their own bank accounts.

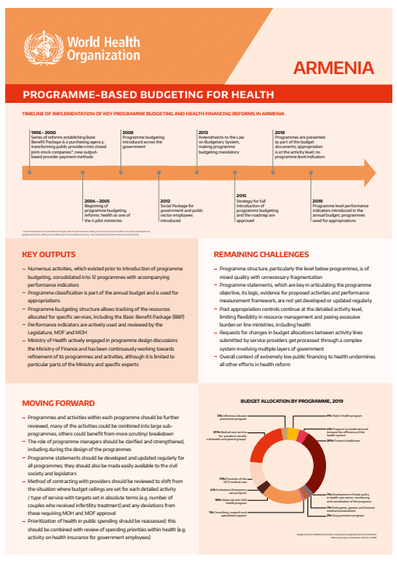
The session shed light on the critical relationship between budget structure and provider payment systems. There was a clear consensus among participants on the need to identify possible ways for countries to align their budget structure and, more broadly, PFM reforms with provider payment approaches.

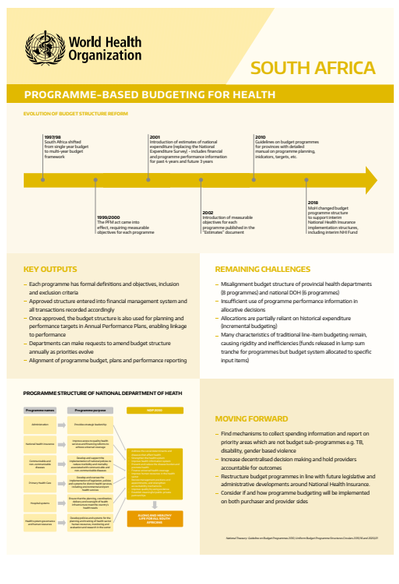
POSTER SESSION ON BUDGET STRUCTURE REFORM IN HEALTH

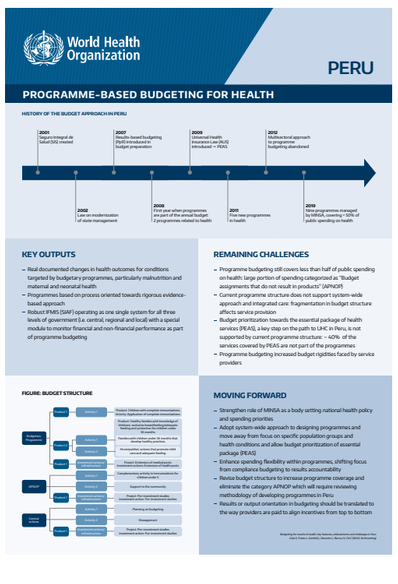
13 november 2019

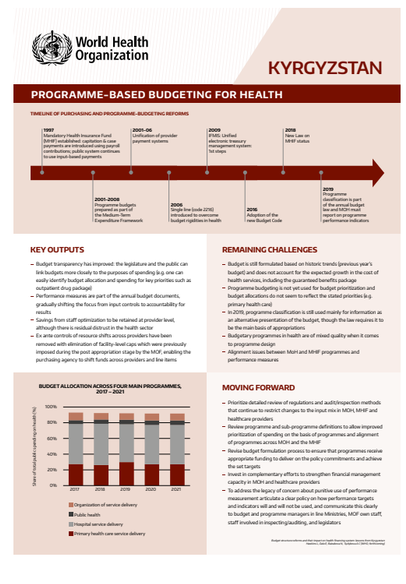
In the poster session, experts presented examples of programme-based budget structure reforms from eight different countries, including Armenia, Burkina Faso, Ghana, Kyrgyzstan, Mexico, Mongolia, Peru and South Africa. Presenters and participants discussed budget structure in terms of process, key outputs, remaining challenges and next steps.

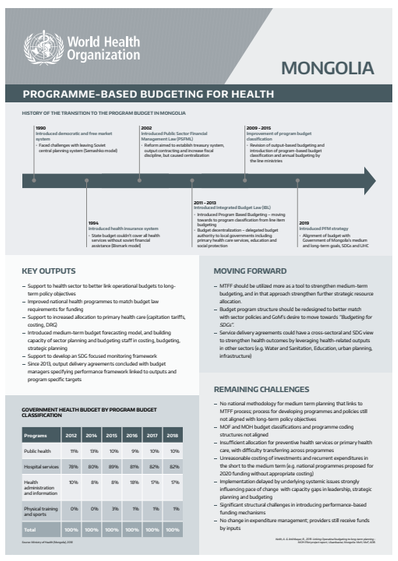
The posters were developed by the WHO between 2018 and 2019, in collaboration with local counterparts.

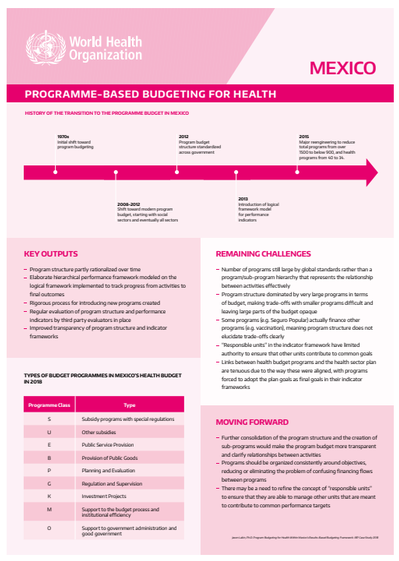


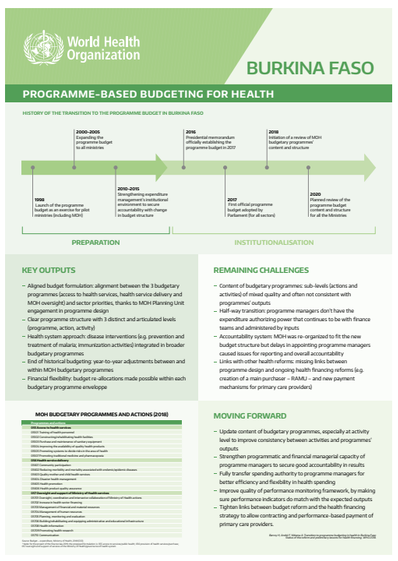


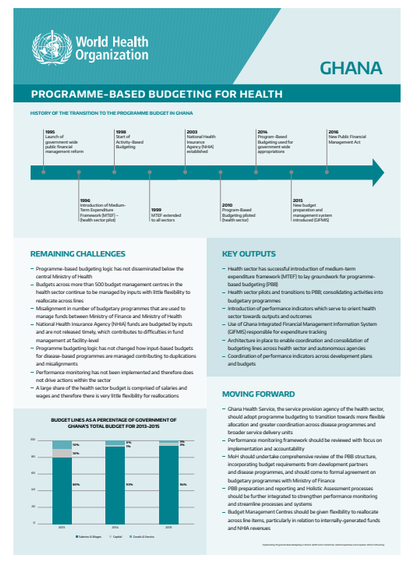












Electronic versions of all posters are available here:

https://www.who.int/news-room/events/detail/2019/11/12/default-calendar/collaborative-agenda-on-fiscal-space-pfm-and-health-financing-2019

EXECUTING HEALTH BUDGETS EFFECTIVELY:
what does that entail?

13 november 2019

Key messages:

- Budget execution largely impacts service delivery in health.
- Budget under-execution has multiple root causes pertaining to both finance and health issues.
- Rigid internal controls limit flexibility in budget execution. There is a challenge in balancing control with flexibility and these two objectives often exacerbate each other in the health sector.
- Ex ante commitment control at point of care may hinder effective expenditure management, as facilities may not have enough autonomy to respond to changing demands.

As part of this session, a representative from the World Bank delivered a presentation that framed the issue of budget execution from a health perspective. Building on ongoing work by the WHO and the World Bank, the presentation illustrated the critical links between budget execution and health service delivery. At its essence, budget execution is simply a matter of how health budgets are used, directed and controlled to finance health service delivery. Healthcare facilities are provided the mandate to execute the budget according to a pre-established plan. Once the budget is enacted, facilities are subject to financial discipline. In most cases, spending guidelines govern health budget execution. Such guidelines may specify who is able to sign off on spending requests, how funds are used, and what flexibility facility managers have in moving funds across line items. However, approved budgets may not always be released to the sector and its healthcare providers in its entirety or in a timely manner. In these situations, the nature of control and accountability should not be compromised, though the nature of control should differ based on the value and/or volume of transactions in health.

The session highlighted the core challenge of good budget execution systems, which is how to balance control with flexibility. Applying universal expenditure controls across all financial transactions will not meet these objectives. The inherent tension between control and flexibility in budget execution can, however, be managed effectively. It is important to recognize that some measures which are good for centralized fiscal control may reduce operational and managerial efficiency.

For example, input controls based on detailed economic line items may reduce operational efficiency by reducing the incentives healthcare facilities might receive if spending was related to outputs. Although tight ex ante commitment controls may lend themselves to prudent fiscal management, they may also limit the ability of healthcare providers to address changing demands. During the session, participants noted that high-value or high-volume transactions may be subjected to the full set of rigorous ex ante controls while relaxing controls for low-value or low-volume transactions, even though those transactions may still relate to important aspects of health service delivery.

In Zambia, programme budgets have been introduced and are regularly reported against. However, as representatives of the country described during the session, budget execution continues to enforce strict line item control. Inefficiencies in service delivery arise because healthcare facilities are bound by pre-established activity plans and healthcare facilities are unable to adjust to changing priorities in service delivery as part of an output-based or programme-based budget. In addition, the credibility of the budget was found to be inadequate and the government only disbursed funds late in the year. The execution process of line item budgets entails controls that ensure that funds can only be requested against items in the budget that were previously committed to and approved by the legislature. For example, commitment control ensures that funds allocated for utilities are actually spent on utilities and not diverted to other items, such as goods and services or wages.

In China, the management of budget execution and performance was strengthened through a joint effort by the health and finance ministries. The ministries supplement local government budgets as necessary and urge local governments to implement their budgets in a timely manner. By June each year, the rate of health budget funds executed should be more than 50 percent.

Overall, the session highlighted that challenges related to budget execution in health have multiple causes pertaining to both health and finance duties. A strategic dialogue should be put in place in countries where under-execution in health is most acute.

ACCOUNTING FOR HEALTH BUDGETS:
Concept and experiences

14 november 2019

Key messages:

- Transparency, oversight and public participation are the three key pillars of public budget accountability.
- More budget flexibility and more accountability are needed in health.
- Changes in budget structure can open the room for greater accountability and greater public participation in the budget process.
- Public accountability needs to be combined with patient and provider accountability.

The session, chaired by a Ministry of Finance representative from South Africa, opened with a presentation by a representative of the IBP who highlighted the three core pillars of public budget accountability: transparency, oversight and public participation. The presentation helped participants identify effective tools and processes to improve accountability in the use of public resources, starting with the understanding that more accountability leads to more flexibility. However, it's important to note that more accountability requirements may also create a push from the central level for more feedback. Accountability means every player must be willing to answer for their own actions and be open to the idea of sanctions if they fail to meet their commitments.

This implies budget accountability has several stages, including budget formulation (i.e prioritizing objectives and aligning the budget with priorities), budget allocation, budget execution, and the review stage, which allows auditors to submit the budget to post-execution controls.

Speakers during the session underlined the need for transparency, including clear links between operational plans and budgets; data on financial and non-financial performance and justifications for any deviations from agreed upon spending. Accountability must be both horizontal (i.e. oversight by formal actors such as the legislative branch or auditors) and vertical (i.e. public participation in government decision-making and oversight).

The critical role public participation can play was demonstrated through an example from Mexico, presented during the session by a WHO governance expert. Public participation around adolescent sexual and reproductive health in Mexico was one of the key drivers of change in the budgeting process, in addition to chang-

The last presenter of the session highlighted the opportunity to enhance accountability through the design of effective performance monitoring frameworks for programme budgets. An effective performance monitoring framework requires an integrated set of objectives and performance measures, as well as integrated funding. These should all be aligned with national, regional and sectoral planning and be included within an information management system that uses data for managerial and governance purposes (i.e. to manage service delivery and steer the system in the right direction). Clear, realistic and ambitious goals are a prerequisite for success. Output or outcome targets are not a goal in themselves; it is the overall impact that matters.

The discussant from the Global Fund further reinforced the importance of patient and provider accountability. True accountability can only be achieved when it crosses both horizontal and vertical lines. Generally, within the health sector, countries provide more data on budget formulation than on execution and often only by expenditure items. The discussant also noted that the role and capacity of regulators often needs to be enhanced.

Participants voiced their clear agreement that health budget accountability is an important topic that should be included under the Collaborative Agenda.

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More information about the ongoing work by UHC2030 and the WHO on the topic is available here:

https://www.who.int/activities/promoting-participatory-governance-social-participation-and-accountability

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[2] This is in line with the IBP's Open Budget Survey (OBS), a world's independent, comparative assessment of the three pillars of public budget accountability: transparency, oversight and public participation.

KEY CONCLUSIONS AND WAYS FORWARD:

1. The transition from external financing for health towards domestic resource mobilization should be more systematically researched and presented **as an opportunity for further country reforms** to address both programmatic and PFM-related issues.

2. **The links between fiscal space and PFM improvements** should be further explored, as a concept and in practice, as a complementary way to expand budgetary space for health.

3. **Studying the causes of budget de-prioritization** and reprioritization towards health would be an important input to inform future budget allocation decisions and advocacy strategies.

4. **The impact of fiscal decentralization on health coverage** should be thoroughly studied in targeted countries to consolidate evidence on potential risks for providers in accessing and using funds and to determine possible ways to address those barriers during the decentralization reform process.

5. **Consolidating evidence on budget structure reforms** is critical to allow stocktaking on the implementation of programme-based budgeting in the health sector and to provide tailored guidance to sector stakeholders in LMICs for necessary reform adjustments.

6. Unpacking the most commonly observed **root causes of budget under-execution** in health, by delineating both finance and health related issues, is critical to help address the issue as an urging priority.

7. **Ensuring that health budget accountability and transparency is embedded in the UHC** agenda and receives adequate study is essential for both credibility and financial sustainability reasons;

8. It is critical that the current collaborative approach to the Montreux agenda be maintained and even enhanced; one aspect of this will be to strengthening ties to the **informal "Community of Practice" to ensure harmonization in key messages and in country assessment approaches** for both the fiscal space and PFM work in the health sector.

ANNEX 1. AGENDA

Tuesday 12 november 2019

MAKING FISCAL SPACE WORK FOR HEALTH

1.1: Welcome and introduction	
9.00AM – 10.30AM	**WELCOME** **Agnès Soucat**, World Health Organization **KEYNOTE ADDRESS:** IMF renewed engagement on social spending **David Coady**, International Monetary Fund **PLENARY DISCUSSION** **INTRODUCTION:** Meeting objectives and agenda **Joe Kutzin**, World Health Organization
9.30AM – 11.00AM	COFFEE

1.2: Moving towards domestic funding: sustainable solutions for transitions	
11.00AM – 12.30AM	**CHAIR AND MODERATOR** **Toomas Palu**, World Bank Group **COUNTRY PANEL** **Kwabena Agyei-Mensah**, Chief Director, Ministry of Health, **GHANA** **Suphab Panyakeo**, Ministry of Health, Lao People's

	DEMOCRATIC REPUBLIC **Susie Perera**, Ministry of Health, Sri Lanka **Rajeev Sadanandan**, Health Systems Transformation Platform, **INDIA** **DISCUSSANTS** **Logan Brenzel**, The Bill & Melinda Gates Foundation **Joe Kutzin**, World Health Organization
12.30PM – 2.00PM	**LUNCH**

1.3: A new look at fiscal space for health	
2.00PM – 3.30PM	**CHAIR AND MODERATOR** **Cheryl Cashin**, Results for Development **ASSESSING FISCAL SPACE IN THE SDG ERA:** the new IMF approach **Sanjeev Gupta**, Center for Global Development **FISCAL SPACE FOR HEALTH:** key considerations for implementation **Helene Barroy**, World Health Organization **Jonathan Cylus**, European Observatory on Health Systems and Policies **DISCUSSANTS** **Abdo Yazbeck**, Johns Hopkins University **Jeremy Lauer**, World Health Organization
3.30PM – 4.00PM	**COFFEE**

1.4: Fiscal decentralization and health	
4.00PM – 5.30PM	**CHAIR AND MODERATOR** **David Coady**, International Monetary Fund **FISCAL DECENTRALIZATION:** key concepts and links with health expenditure **Serdar Yilmaz**, World Bank Group **COUNTRY PANEL** **Martin Sabignoso**, Independent Consultant, Argentina **Pak Pungkas**, Ministry of National Development Planning/BAPPENAS, Indonesia **Nneka Orji**, Federal Ministry of Health, Nigeria **DISCUSSANTS** **Wangari Ng'ang'a**, Office of the President, Kenya **Mark Miller**, Overseas Development Institute **Joe Kutzin**, World Health Organization

Wednesday 13 november 2019

ADDRESSING CHALLENGES IN HEALTH BUDGET FORMULATION AND EXECUTION

2.1: Designing programme budgets: key questions for health

9.00AM – 10.30AM	**CHAIR AND MODERATOR** **Loraine Hawkins,** The Health Foundation, UK **DESIGNING EFFECTIVE BUDGETARY PROGRAMMES IN HEALTH:** key issues for consideration **Hélène Barroy,** World Health Organization **COUNTRY EXPERIENCES WITH BUDGETARY PROGRAMME DESIGN IN HEALTH** **Andrew Blazey**, OECD (on New Zealand) **Lorena Prieto**, Independent Consultant, Peru **Daniel Osei**, Ministry of Health, Ghana **DISCUSSANT** **Chris James**, OECD
10.30AM – 11.00AM	**COFFEE**

2.2: Implementing programme budgets in health: links with provider payment?

11.00AM – 12.30PM	**CHAIR AND MODERATOR** **Cheryl Cashin,** Results for Development **UNPACKING THE LINKS BETWEEN BUDGET STRUCTURE AND PROVIDER PAYMENT REFORM** **Loraine Hawkins**, The Health Foundation, UK **COUNTRY INTERVENTIONS** **Elina Dale**, World Health Organization (on Armenia) **Gemini Mtei**, Abt Associates (Tanzania USAID/Public Sector Systems Strengthening Project) **Alona Goroshko**, National Health Service, Ukraine

	DISCUSSANT **Jack Langenbrunner,** USAID consultant (Indonesia)
12.30PM – 2.00PM	**LUNCH**

2.3: Poster session	
2.00PM – 3.30PM	**MOVING TOWARDS PROGRAMME BUDGETS IN THE HEALTH SECTOR:** deep-dive on low-and middle-income country challenges with design and implementation **COUNTRY CASE STUDIES POSTERS:** each presented and discussed by topic experts and country representatives: • Armenia • Burkina Faso • Ghana • Kyrgyzstan • Mexico • Mongolia • Peru • South Africa
3.30PM – 4.00PM	**COFFEE**

2.4: Executing health budgets effectively: what does that entail?	
4.00PM – 5.30PM	**CHAIR AND MODERATOR** **Sheila O'Dougherty**, Abt Associates (Tanzania USAID/-Public Sector Systems Strengthening Project) **BETWEEN CONTROL AND FLEXIBILITY:** framing the issue of budget execution from a health perspective **Moritz Piatti**, World Bank Group

COUNTRY PANEL: Improving budget execution in health: key practical lessons from better dialogue between health and finance authorities

Mumba Chanda, Ministry of Finance, Zambia

Patrick Banda, Ministry of Health, Zambia

Zhu Kun, Chinese Academy of Fiscal Sciences

DISCUSSANT

Philipp Krause, The Bill & Melinda Gates Foundation

Thursday 14 november 2019

BUDGET ACCOUNTABILITY IN HEALTH

3.1: Accounting for health budgets: concept and experiences

9.00AM – 10.30AM	**CHAIR AND MODERATOR** **Mark Blecher**, WHO **THE ROAD TO BUDGET TRANSPARENCY AND ACCOUNTABILITY IN HEALTH:** key concepts and country experiences **Jason Lakin**, International Budget Partnership **IMPROVING BUDGET ACCOUNTABILITY IN THE HEALTH SECTOR:** the role of government-civil society collaboration **Dheepa Rajan**, World Health Organization **PERFORMANCE FRAMEWORKS FOR PROGRAMME BUDGETS:** friend or foe for better accountability in health? **Maarten de Jong**, Vrije Universiteit Amsterdam and National Court of Audit, Netherlands **DISCUSSANT** **Michael Borowitz**, The Global Fund
10.30AM – 11.00AM	**COFFEE**

3.2: PFM reform: bridging health and finance perspectives

11.00AM – 12.30PM	**CHAIR AND MODERATOR** **Manoj Jain**, World Bank Group

	FIRESIDE CHAT: PFM AND HEALTH: towards a bold convergence? **Srinivas Gurazada**, World Bank Group **Sheila O'Dougherty**, Abt associates Tanzania **Jennifer Asman**, UNICEF **CONCLUDING REMARKS** **Agnès Soucat,** World Health Organization
12.30PM – 2.00PM	LUNCH
3.3: Wrapping-up	
2.00PM – 3.30PM	**CHAIR AND MODERATOR** **Joe Kutzin**, World Health Organization **PANEL:** Inputs from technical sessions **OPEN DISCUSSION ON WAYS FORWARD** **KEY MESSAGES AND CONCLUSION** **Agnès Soucat**, World Health Organization **Joe Kutzin**, World Health Organization

ANNEX 2. LIST OF PARTICIPANTS

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World Health Organization

Meeting Report

WHO symposium on health financing for UHC

A closer look at fiscal space and public financial management issues in health