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FinHealth : PFM IN HEALTH TOOLKIT

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Acknowledgments

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The overall coordination and supervision of this task has been carried out by: ***Manoj Jain*** *(Country Focal Point, GGP- India ; Lead Governance Specialist ; and Task Team Leader of the Global Flagship - PFM in health) and* ***Tekabe Belay*** *(Program Leader and Co-TTL). The core team includes:* ***Paolo Belli*** *(Program Leader),* ***Srinivas Gurazada*** *(Senior Financial Management Specialist ; and Governance in sectors team lead),* ***Maxwell Bruku Dapaah*** *(Senior Financial Management Specialist),* ***David Waigwa Wachira*** *(Public Sector Specialist),* ***Frans Ronsholt*** *(Lead Consultant) and* ***Florence Claveranne*** *(Senior Consultant).*

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Inputs and suggestions have also been received from the country teams and the client governments that have conducted the pilot assessments of this toolkit by applying the evolving versions in their respective countries, namely (a) The Kyrgyz republic, (b) Lao People's Democratic Republic, (c) Guinea-Bissau and (d) Republic of Armenia. The draft was also shared widely for seeking inputs from development partners working under the aegis of Financial Management Technical Working Group (FMTWG) of UHC2030.

Final decision review was chaired by Adenike Sherifat Oyeyiola, Practice Manager (Governance Global Practice) and Feng Zhao, Practice Manager (Health, Nutrition & Population Global Practice)

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Abbreviations and Acronyms

COA	Chart of Accounts
EBF	Extra-budgetary Fund
FCA	Fragile and Conflict-affected
FMIS	Financial Management Information System
GDP	Gross Domestic Product
GHO	Global Health Observatory
GFSM	Government Finance Statistics Manual
IEG	Independent Evaluation Group
IFC	International Finance Corporation
IT	Information Technology
LGA	Local Government Authority
MOF	Ministry of Finance
MOH	Ministry of Health
MDAs	Ministries, Departments. and Agencies
MTBF	Medium-Term Budget Framework
MTEF	Medium-Term Expenditure Framework
NGO	Nongovernmental Organization
ODI	Overseas Development Institute
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-Pocket
PBB	Program-based Budgeting
PEFA	Public Expenditure and Financial Accountability
PFM	Public Finance Management
PHC	Primary Health Center
PIP	Public Investment Program
SAI	Supreme Audit Institution
SDG	Sustainable Development Goal
SDU	Service Delivery Unit
SHI	Social Health Insurance
SNG	Subnational Government
TSA	Treasury Single Account
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization

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PART A
INTRODUCTION TO THE TOOLKIT

Chapter 1 Background

1. **In promoting universal health coverage (UHC), the World Bank supports member countries' efforts to provide quality, affordable health care to everyone, regardless of their ability to pay, reducing financial risks associated with ill health and increasing equity.** The path to attaining UHC must be specific to each country; yet, whatever path countries take, the World Bank Group aims to help them all build healthier, more equitable societies, as well as improve their fiscal performance and country competitiveness. The World Bank's Health, Nutrition, and Population (HNP) strategy, therefore, aims to support and advise countries on achieving HNP results in ways that contribute to their overall fiscal sustainability, economic growth, and global competitiveness through improved transparency and accountability in the use of resources and the achievement of health results and good governance. The strategy recognizes the link between the achievement of results and the need to strengthen systems for fiscal sustainability, operational efficiency, fiscal transparency, and accountability—all elements of public financial management (PFM).

2. **Governance matters for the effectiveness of public resources in health service delivery.** According to the findings of a literature review on PFM and health service delivery conducted by the Overseas Development Institute (ODI) (Yevgeniy et al. 2016), one of the strongest and most consistent findings was the evidence that increasing public funding of health programs is likely more effective in better governed compared to poorly governed countries. There is also strong evidence of a positive relationship between various indicators of transparency and outcomes related to health service delivery.

3. **The evidence also shows that greater accountability and responsiveness play an important role.** Participatory initiatives such as participatory budgeting and community scorecards on health service delivery and fiscal decentralization in general were found to be positively related to good health and service delivery outcomes, especially in communities with sufficient local institutional capacity and accountability. The World Health Organization (WHO) has similarly conducted studies that show links between PFM and health financing and their links to UHC achievement at the country level (for example, WHO 2016).

4. **Studies by ODI, WHO, and several others support the view that when the PFM arrangements underpinning health service delivery systems are weak, there are no sustainable mechanisms for allocating resources to priorities or for ensuring that funds are used for their intended purposes in the most economical and efficient manner.** Institutional arrangements for service delivery in the health sector are inherently complex. This complexity is largely due to the multi-layered relationships, fragmented accountability, and complex resource flows and reporting arrangements. Typically, a central Ministry of Health (MOH) is charged with the overall responsibility for policy formulation and administration, so resources and reporting must flow between this center and the Ministry of Finance (MOF) on the one hand and between the center and decentralized authorities responsible for service delivery at regional, district, and local or community hospitals and health posts on the other hand. In such an environment, strong PFM systems could allow sufficient

and appropriate allocation of resources, smoothen fund flows, minimize opaqueness, and enhance transparency and accountability for results.

5. **Yet, progress in integrating PFM into the agenda of strengthening health systems has been slow, as has been the progress in achieving aid effectiveness and service delivery results.** A review by the Independent Evaluation Group (IEG) of the World Bank Group support to health financing for improving health system performance (World Bank/IEG 2014) found that collaboration across public sector and health teams as well as between the World Bank and the International Finance Corporation (IFC) was limited. An integrated approach that links health financing with public sector reforms is likely to be more effective than single-issue intervention. Such an approach includes reducing fragmentation in the pooling of funds, focusing on strategic purchasing, and considering potential adverse effects in the public sector context. Quite often, misunderstandings originate due to differences in the perception and perspectives between MOFs and MOHs regarding the importance of these issues and their relevance to service delivery outcomes.

6. **The 'FinHealth: PFM in Health Diagnostic Toolkit' (hereafter, 'the Toolkit')—as presented in the current document—aims to help country teams identify key challenges and opportunities associated with PFM arrangements in the health sector in client countries and programs. It also aims to propose possible ways to strengthen PFM arrangements for better planning and implementation of service delivery.** The Toolkit employs a problem-driven approach to identify and analyze the PFM and health finance bottlenecks or enablers that constrain or support service delivery results at the provider level. These factors are then traced along the service delivery chain to identify the systemic root causes that contribute to outcomes at the service provider level. The Toolkit is intended to assist countries in understanding if and how PFM issues are relevant to service delivery in the health sector in the particular country's context, and how to develop or customize possible solutions for the country. Considering the relative importance of the issues and challenges identified, as well as the possible practicality and sequencing of the solutions and/or interventions suggested, an action plan for the country could eventually be developed. Application of the Toolkit is aimed towards improving the efficiency of public spending in health to achieve better outcomes. Different analytical work will be required to assess whether the given budget for health is optimal in a given country context.

7. **To ensure an integrated approach, the review team should - whenever possible - link application of the Toolkit to ongoing interventions in the health sector, on PFM, and on governance in the country, as such work will provide insight into what the current challenges are ; and coordination will lead to complementary action plans.** Such ongoing work may include a Public Expenditure Management and Financial Accountability or a PEFA assessment, sectoral PFM work, a Public Expenditure Review, a Public Expenditure Tracking Survey, a Health Service Delivery Indicator Survey, a Health Financing System Assessment, or work on fiscal decentralization, among others.

8. **The Toolkit is also expected to help forge a common understanding of PFM issues in health among both PFM professionals and health professionals by contributing to a taxonomy or glossary that clarifies those links (see Annex 1).** Although the approach recognizes that the achievement of health outcomes could involve interaction of factors in multiple sectors, such as education and transport, as well as behavioral and cultural patterns, the Toolkit only addresses the issues that fall at the intersection of PFM, health financing, and health service delivery.

9. **The Toolkit evolved through a series of iterations since the first draft in 2016,** building on pilot study country assessments in Kyrgyz Republic, the Lao People's Democratic Republic, Guinea-Bissau, and Armenia.

PFM bottlenecks analysis and links to PEFA: Is this Toolkit delivering a PEFA framework for health?

The short answer: No.

The long answer: Perhaps the most commonly known framework used to evaluate generic PFM country systems is the Public Expenditure and Financial Accountability (PEFA) framework. The PEFA has 31 indicators divided into seven broad areas of activities, called 'pillars' (PEFA Secretariat 2016). The PEFA framework has been hugely successful in harmonizing approaches to PFM systems in developing countries and remains the most comprehensive assessment tool for PFM systems to date.

While widely known and used, and excellent for enhancing the understanding of PFM systems in developing countries, the framework has limitations especially when the intention is to help improve service delivery in a sector like health (Hadley and Miller 2016). PEFA (a) follows an approach of measuring a baseline across the government and is not specifically focused on a sector; (b) does not take a problem-driven approach of unpacking issues from a service delivery perspective; (c) focuses on the processes of the central government, and particularly from the perspective of the MOF, a focus that can mask problems in line ministries, local governments, and service delivery units (SDUs); and (d) does not adequately capture the underlying causes for poor PFM systems performance such as behavioral incentives and human resource skills and capacities.

Moreover, a PEFA assessment report does not necessarily include a detailed reform action plan. To develop a credible, practical, well-sequenced, and contextualized action plan, including one that also helps improve service delivery, a PEFA assessment needs to be supplemented by additional diagnostic work on underlying causes and by a political economy analysis of the country and its PFM stakeholders. Therefore, other diagnostic tools are needed to supplement PEFA assessments and especially for ensuring that the diagnostics unpack the real PFM bottlenecks which affect the service delivery level.[1]

The Toolkit takes a specific service delivery perspective to its analysis, includes factors such as human resource capacities, and integrates the development of an action plan. In a substantial number of PFM subjects, the Toolkit overlaps with PEFA and relevant cross-reference is therefore made to PEFA so that the PFM in Health review team may benefit from PEFA guidance on the subjects and refer to previous PEFA assessment findings in the country.

[1] Another widely used tool for analyzing health financing and public expenditure is the Public Expenditure Review (PER). The PER is one of the World Bank's core diagnostic tools for informing stakeholders about the efficiency, effectiveness, and equity of health expenditures in a country and their adequacy and sustainability relative to the country's health goals. The diagnostic tools review not only public spending but also private and donor spending. Moreover, the World Bank's Public Expenditure Tracking Surveys (PETSs) have been widely used in the social sectors (including health) for determining to what extent resources reach SDUs and for identifying resource leaks.

Chapter 2 Structure of the Toolkit

10. **The Toolkit is divided into three parts.** Part A—the present part—provides the background to as well as the structure and scope of the Toolkit, including elaboration of the links between UHC, health financing, and PFM systems. Part B explains the process of undertaking a diagnostic review of PFM in the health sector at the country level including the proposed format of the review report. Part C provides guidance on the technical content of the diagnostic review.

11. **The starting point of the diagnostic review is service delivery challenges viewed at the provider level, because this is where the consequences of service delivery bottlenecks are felt most.** Therefore, the diagnostic approach focuses specifically on the various kinds of challenges that health service providers and users face with respect to health service coverage (in Chapter 4 of Part A). Service delivery challenges are identified and reviewed from the providers' perspective, in both quantitative and qualitative terms, by making surveys and interview of service providers a core element of the diagnostic process. This 'problem-driven' approach departs from the traditional approach of a top-down PFM assessment and is relevant for diagnosing the service delivery bottlenecks along the PFM cycle.

12. **The secondary angle of viewing the impact of PFM is its interactions with health financing.** PFM systems are typically viewed through the stages of the budget cycle, while health financing focuses on adequacy of funding for health care, the extent of pooling of these funds, and the mechanisms used to pay providers. This is covered in Chapter 5 of Part A with two key questions in mind: 'Where and how should PFM and health financing align?' and 'What are the synergies between the two for improving service delivery and, ultimately, health outcomes?'

13. **These questions are further pursued in terms of the need for alignment of PFM reforms with the requirements for effective and efficient health service delivery, and what can be undertaken in the short to medium term to help improve service delivery.** The discussion also includes a section on the importance of dialogue between the MOF and MOH. This is also covered in Chapter 5.

14. **Supply-side challenges faced by the SDUs are discussed in Chapter 6 of Part A.** Identifying the most important ones from an SDU perspective is the main purpose of interviews at the SDU level and forms the basis for identifying related PFM bottlenecks, the easing of which could lead to improved service delivery.

15. **Guidance on how to undertake a diagnostic review of PFM in health at the country level is provided in Part B of the Toolkit.** This guidance includes a description of the stages of the review process, the institutions to cover and the PFM functions to investigate (with a list of key questions), and the proposed structure of the review report. These parts are supported by tools (in annexes) such as model terms of reference for the review team and a template for analysis of data from health care providers/SDUs.

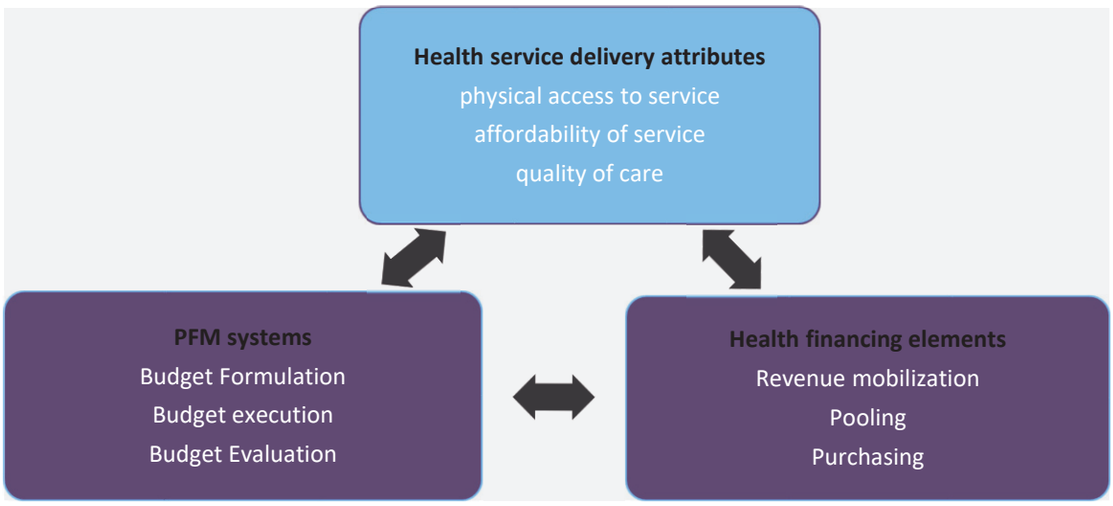
16. **Technical guidance on how to identify problems in PFM systems that affect health service delivery is provided in Part C.** The guidance discusses links between supply-side challenges, PFM systems, and other governance features, and offers guidance on how well-functioning PFM systems should be operating to support health service delivery. The guidance includes key performance questions to explore as well as needed background information and potential sources of information during field work.

17. **A glossary of definitions covering both PFM and health financing is included in the annexes.** It is a tool to facilitate common understanding of concepts among the PFM professionals, health care professionals, and health financing specialists who are likely to constitute the review teams and also be the users of the review reports. All literature referenced in the Toolkit is listed in Annex 7.

Chapter 3 Scope of the Toolkit

18. **The Toolkit draws on the three core areas and their respective main elements as illustrated in Figure 1,** health service delivery attributes, health financing elements, and PFM systems. These three aspects need to be closely coordinated to ensure that service delivery objectives/targets are commensurate with the health financing provided and that PFM systems enable the health sector to turn available financial resources into an appropriate mix of inputs needed for service delivery operations.

Figure 1: Scope of the Toolkit



19. **Building a physically accessible, reliable, quality health service delivery is a key component to achieve UHC according to Sustainable Development Goal (SDG) 3.8.**[2] Health service delivery requires resources which are financed through the health financing system and managed through PFM systems. Service delivery constraints identified at the provider level, therefore, constitute the basis on which PFM and health financing bottlenecks are analyzed. The three attributes of health service delivery are

- Physical access;
- Affordability; and
- Quality of care.

[2] SDG 3.8: Achieve universal health coverage, including financial risk protection; access to quality essential health care services; and access to safe, effective, quality, and affordable essential medicines and vaccines for all.

20. The three attributes and their links to PFM systems are discussed in Chapter 4.

21. **Health financing** includes the following three functions:

- **Resource mobilization.** This includes the way monies are raised to pay for health care system and delivery costs. The interest here is on the adequacy and sustainability of revenues raised in an efficient and equitable manner.

- **Pooling.** This includes the accumulation and management of financial resources to ensure that the financial risk of having to pay for health care is borne by all members of the pool and not just by the individuals who fall ill.

- **Purchasing.** This includes the method of paying providers for health services.

22. These aspects of health financing and their interaction with PFM systems are discussed in Chapter 5.

23. **PFM** is defined as the set of rules and processes that govern how public resources are allocated, spent, and accounted for. The coverage of PFM includes the central government budget and all lower levels of the government as well as the broader public sector, including state agencies, state-owned enterprises, and public-private partnerships. The key objectives of PFM are the following:

- **Aggregate fiscal discipline** that requires effective control of the total budget and management of fiscal risks to ensure fiscal sustainability.

- **Strategic allocation of resources** that involves planning and executing the budget in line with government priorities aimed at achieving policy objectives.

- **Efficient service delivery** that requires use of budgeted revenues to achieve the best levels of public services within the available resources.

24. **PFM systems are typically arranged in line with the budget cycle,** which entails the following:

- **Budget formulation.** Budgets are planned and prepared based on government fiscal policies, strategic plans/priorities, and macroeconomic and fiscal projections.

- **Budget execution.** Budgets are implemented within a system of effective standards, controls, and processes to ensure predictability in the availability of funds for service delivery and efficient use of the funds. Accounting and reporting require that accurate and reliable records be maintained and that information is produced and disseminated on time.

- **Budget evaluation.** Public finances—including budget outturns and output performance—are reviewed by the government itself and by an independent external auditor (usually the Supreme Audit Institution [SAI]), with follow-up actions on recommendations for the forthcoming budget cycle.

- PFM systems are the main focus of the Diagnostic Review as set out in Part C of the Toolkit.

25. **The Toolkit is focused on identifying bottlenecks in PFM systems, which affect service delivery, either directly or indirectly through the health financing system.** From a health sector perspective, PFM systems for strategic allocation of resources (also known as allocative efficiency) are an essential part of health financing, whereas efficiency in converting those resources into service delivery (also known as technical efficiency) is key to maximizing the level of health services that can be provided with the given resources. These links between health financing and PFM systems are discussed in Chapter 5. The aggregate fiscal discipline acts as a macro-level constraint under which the other two outcomes can be delivered. It affects both the level of resources that can potentially be made available to the health sector and PFM systems which also need to serve the purpose of ensuring aggregate fiscal discipline.

26. **The Toolkit takes into account the fact that service delivery results are shaped by many nonfinancial factors, including education and infrastructure, as well as behavioral and cultural patterns.** At the provider level, management and technical capacity are also critical determinants of the quality of service delivery. Improvement of health services, therefore, depends on a complex interplay of financial and nonfinancial factors that affect both service providers' and consumers' behavior. It is important to bear in mind that the Toolkit will only enable analysis of the issues that fall at the intersection of PFM, health financing, and service delivery.

27. **Moreover, country-specific factors—such as economy, culture, demography, and epidemiological context—lead to a wide array of health sector organizational and financing arrangements.** Accordingly, there can be no single explanation for challenges in service delivery just as there can be no single solution to fix them. The objective is to enable a thorough country review of all PFM elements that might be at play and lead to an understanding of whether and how these issues are relevant to the country's context and how solutions could be developed for the country.

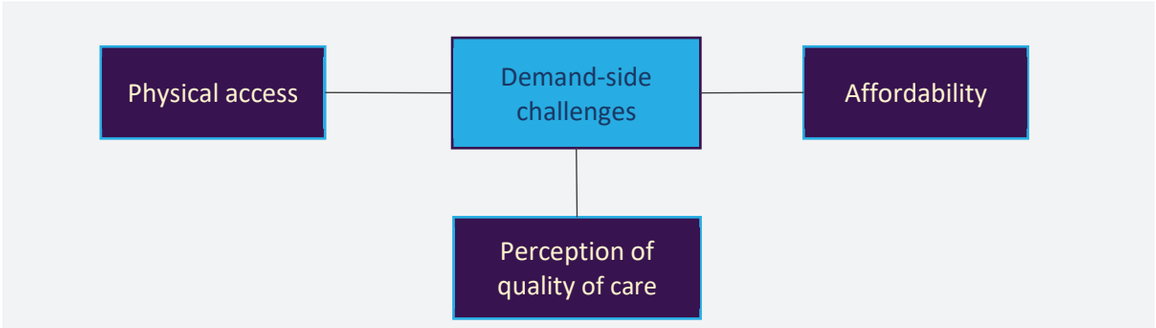
28. **The aim is to be descriptive of nonfinancial and country-specific factors to ensure consideration of the related issues and challenges when undertaking the analysis of PFM systems and how those systems impact health service delivery.** Depending upon the context and background of the health sector in the particular country, some issues may not be relevant and/or the severity or importance of the issues in the service delivery chain may differ.

Chapter 4 How Does PFM Affect Health Service Delivery?

29. **Both demand- and supply-driven factors affect the use of health services.** The present chapter covers the demand-side factors, that is, the three characteristics of health services which determine why people may or may not decide to use health care services when needed, including preventive and curative services.

30. **Demand-side barriers are the reason that patients may not use health care services when needed.** While cultural acceptability and individuals' awareness of available health services are also factors that determine demand for services, the Toolkit focuses on factors that determine the services provided and thus on factors that have a potential PFM/health finance cause. These factors have been identified as physical access, affordability, and perception of quality of care. Each of these factors play a role in the extent to which the health services are in demand.[3]

Figure 2: Demand-side Barriers



4.1 Physical Access

31. **Physical access is a fundamental issue in many low-income countries, where large sections of the population live in rural areas.** The need to travel substantial distances makes people less likely to use services that are far away from their homes or involve significant time and transport costs to access. Limited physical access also poses serious issues of equity, because the poorest people are more likely to live in remote areas.

32. **The way the health system is organized, which largely depends on government priorities and the way providers are compensated, is critical to address physical access bottlenecks.** For instance, the development of primary care and small or mobile units is likely to improve access to health care services. Countries may also invest in developing community health workers for basic

[3] While each of the three barriers are characteristics of the services provided and affects the extent of demand for the services by the population, in practice, the points of measuring the state of services vary, with physical access and affordability typically being measured by household perception (for example, through household surveys) and quality of services being measured by a range of supply-side elements (see Chapter 7).

curative and preventive services. Likewise, to encourage providers to deliver health care services in specific areas, governments may promote the development of specific purchaser-provider models, an approach described in Chapter 5.

33. **Investments to help address physical access issues are likely to improve service delivery through increased service coverage.** First, investments for building new health facilities may help strengthen the health care network, provided funds are adequately targeted and spent for their intended purposes. Second, the health sector benefits from investments made in infrastructure in other sectors such as transport, energy, water, and sanitation. The MOH is expected to base its own investment and allocation decisions on an analysis of the territorial coverage of such infrastructure and its investment decisions to improve health service coverage, therefore, need to consider synergies from complementary services and investments in other sectors to address accessibility barriers on a holistic basis.

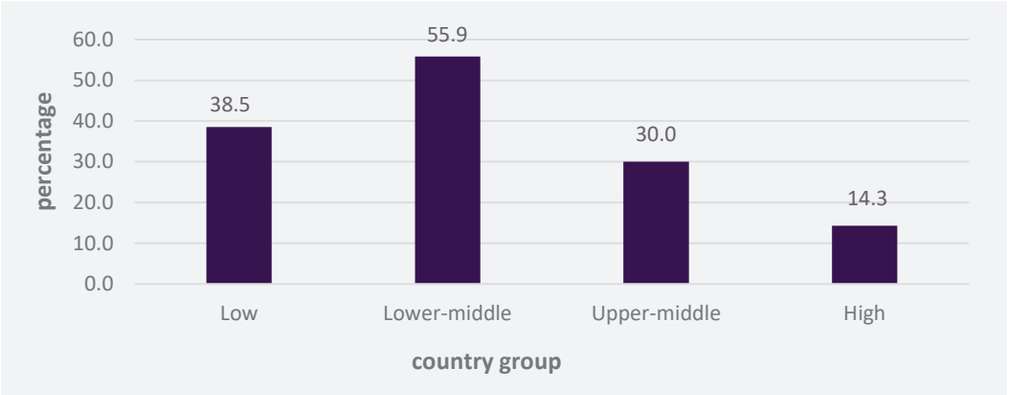
4.2 Affordability

34. **Making health services more physically accessible can have an impact on service use only if individuals can afford the services.** Health care services can be funded from different sources. They can be paid by the government, by health insurance funds (with contributions from members and/or employers), by external development partners, or directly by households at the time of service use (out-of-pocket [OOP] payments). OOP payments may include nonmedical costs (travel, food, or lodging expenses for the patient and his/her family) as well as medical costs, that is, the payments made by individuals to providers for the health care services. Some of these OOP costs are official, but others may be unofficial (including bribes and other charges). Affordability is a direct function of the OOP payments, which individuals will have to make when seeking health services, relative to the income or wealth of the household.

35. **The magnitude of OOP payments and the appropriate use of the generated revenue are affected by PFM systems in a country.** Legitimate direct charges by service providers must be transparent to any user, and the funds collected need to be accounted for and reported to the overseeing entities on a regular basis. Appropriate accounting and reporting systems need to be in place for the collection of revenue as well as the transfer or local use of the funds according to regulations. Incentive systems can facilitate collection and reporting of revenue by service providers. Internal controls, inspections and audits shall check that those systems are adhered to in a comprehensive and timely manner. Such oversight systems can contribute to identifying unofficial (i.e. illegal) payments, though usually other systems outside PFM functions - such as anti-corruption units - are needed to control the demand for bribes. The unofficial payments to providers can be substantial, particular in low-income countries where public resources for health services often are inadequate to ensure universal health care.

36. **The percentage of total resources dedicated to health sector that come from OOP payments varies across countries.** As of 2014, this percentage was significantly higher in low- and lower-middle-income countries (38.5 percent and 55.9 percent, respectively), where public resources are scarce, than in high-income countries (14.3 percent), (see Figure 3).

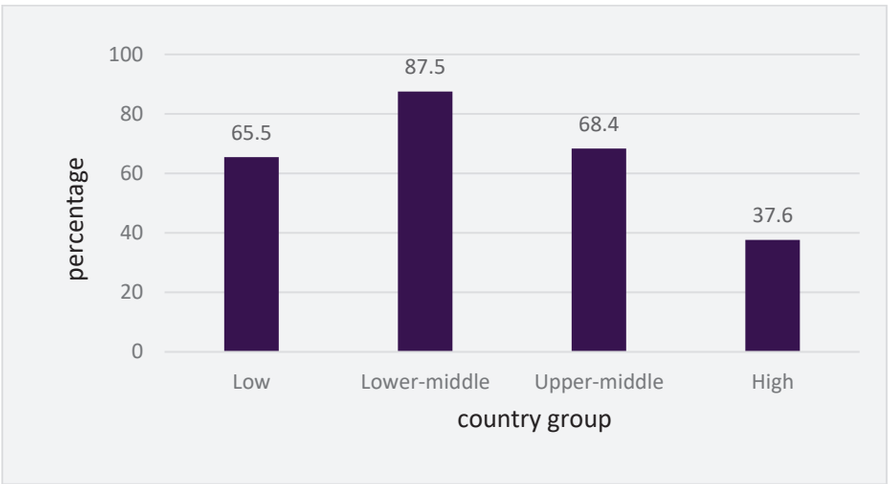
Figure 3: OOP Expenditure as a Percentage of Total Expenditure on Health (by Country Group, 2014)



Source: WHO (Global Health Observatory [GHO] Data Repository) 2016.

37. **In addition to OOP payments, private individuals and households also make prepayments in terms of insurance premiums and contributions to similar financial protection schemes.** As a portion of such total private expenditure on health, OOP expenses account for three-quarters in low- and middle-income countries, but about half that level in high-income countries (see Figure 4).

Figure 4: OOP Expenditure as a Percentage of Private Expenditure on Health (by Income Group, 2014)



Source: WHO (GHO Data Repository) 2016.

38. **The introduction of prepayment mechanisms aimed at improving financial protection is significantly affected by PFM systems.** One of the dimensions essential to UHC is the extent to which financial protection is provided, which is usually measured by the magnitude of OOP costs. The introduction of prepayment mechanisms allows the risk of incurring large OOP costs to be lowered. While the expansion of prepayment mechanisms offers better financial protection, the introduction of prepayment as a major financing system has a significant impact on PFM rules and practices, because it may imply new funding channels and processes. These issues are further discussed in detail in Chapter 5.

4.3 Perception of Quality of Care

39. **A household's perception of service quality is an important factor in determining whether the household will seek the services of a health service provider, choose an alternative service or**

choose not to seek any medical treatment at all. Such perceptions are subjective, highly qualitative and sometimes based on hearsay rather than actual experience and facts. Therefore, service quality is usually measured from the supply-side rather than through household surveys.

40. **It is the provision of quality of care - rather than household perception - which is affected by the availability and management of financial resources.** Consequently, quality of care is considered only from the supply-side in this Toolkit and discussed as a supply-side factor including its links to PFM systems in Chapter 6.

Chapter 5 Health Financing - Interactions and Synergies with PFM Systems

41. **As PFM systems in the health sector support resource mobilization for the sector and facilitate and control the flow of those resources to the service providers, no review of PFM systems in health can be undertaken without a thorough understanding of the health financing system and its links with PFM systems.** In this chapter, we discuss how PFM elements interact with health financing and its three functions of health financing, namely resource mobilization, pooling, and purchasing in Sections 5.1, 5.2, and 5.3, respectively. The chapter includes discussions of the related subject of fiscal decentralization and concludes with a discussion of the issue of alignment of health financing reforms and PFM reforms in Section 5.4.

42. **There are five key messages of this chapter:**

- Increasing resource mobilization for health depends amongst others on comprehensive sector planning and effective budget formulation systems.

- Whilst insufficient funding for the health sector is usually a major reason for inadequate service delivery, it is by no means the only reason, as the efficient use of available financial resources is equally important;

- Fragmentation of health sector funding is a major issue in many countries, which hinders pooling of resources for sharing of financial risk across population groups. Under a system with multiple sources of financing, a well-designed PFM system can help mitigate the ill-effects of fragmentation.

- Strategic purchasing of health services from providers can improve efficiency of public spending but requires that budget management systems focus on achievement of objectives/outputs rather than control of line-item inputs.

- Improving health service delivery through enhanced resource mobilization and greater efficiency in use of the sector's resources, therefore, requires coordination of broad PFM systems reforms with reforms of health financing systems, and thus close collaboration between ministries of finance and health.

5.1 Resource Mobilization

43. **Moving toward UHC requires more resources for the health sector.** The achievement of UHC implies significantly reducing OOP payments to guarantee financial protection. Studies show that this is highly correlated with a country's capacity to raise general revenue (Fan and Savedoff 2014), (also see the discussion under 'Affordability' in Section 4.2). Hence, the commitment to achieve UHC as part of the SDGs means increasing public spending on health care and is likely to impose stronger pressure on government budgets.

44. **Insufficient funds allocated to the health sector are not always the reason for poor service delivery.** In addition, there is no evidence that increased resources will always lead to better health results either. In fact, there is plenty of evidence that, for a given level of health funding, performance as measured by health outcomes varies greatly between countries as factors of allocative and technical efficiency are also at play. Nevertheless, it is understood that adequate financing is a necessary condition to produce the desired health service delivery.

45. **The impact of PFM systems on resource mobilization for health depends on the composition of sources for health financing.** For instance, where the dominant source of financing is a separately funded social health insurance (SHI) scheme (with its own earmarked contributions), the level of exposure of health sector resources to the general PFM system will be different from that in a system where the dominant source is general tax revenue (so that resource allocation for health is subject to the government's general budget allocation system). In the former case, PFM systems and governance arrangements in the SHI scheme would need to align with health financing objectives in the country to help facilitate improvement in service delivery. Similarly, a health system where the public sector is significantly involved in service provision and financing will have a higher level of exposure to country-level PFM rules than a system where the government is neither the major provider nor financier of health services.

46. **Mobilization of additional domestic resources for health requires creation of fiscal space.** Fiscal space is commonly defined as the budgetary room that allows a government to provide resources for public purposes without undermining fiscal sustainability.[4] At the macro-level, creation of fiscal space in the overall government resource envelope is an issue of economic growth and macro-fiscal policy, which will not be discussed here. Increasing fiscal space for the health sector within that overall resource envelope requires attention to (a) increasing the health budget allocation through reprioritization within the government budget so that allocation for health increases within the existing budget envelope; (b) mobilizing additional resources earmarked for the health sector such as taxes (for example, on pollution, tobacco, alcohol, and so on) or contributions to mandatory health insurance schemes; and (c) increasing the technical efficiency of public spending, including on health, so that more service outputs may be delivered out of a given budget. Each of these means is discussed in the following paragraphs.

47. **A further option for mobilization of additional resources for health is through earmarked external grants and loans.** This option is also discussed below as part of the section on earmarked funding.

Increasing the Health Budget Allocation through Reprioritization

48. **At the country level, the amount of public resources dedicated to financing the health sector is largely out of the direct control of the health sector itself.** It depends mostly on the level of economic development, the government's ability to generate higher domestic revenues, and the priority given to the health sector relative to other sectors. PFM systems play an important role in ensuring that allocations to the health sector are aligned with political priorities and based on realistic resource needs.

[4] A recent World Bank study (Tandon et al, 2018) describes the different variables likely to channel additional funds to the health sector, including *"conducive macroeconomic conditions such as economic growth and increases in overall government revenue that, in turn, might lead to increases in government spending for health; a re-prioritization of health within the government budget;" "an increase in health sector-specific resources, for example, through earmarked taxation; health sector-specific grants and foreign aid;" and "an increase in the efficiency of existing government health outlays."*

49. **The MOH's strategic sector plan is the starting point in determining the sector's resource needs.** The strategic plan is designed to document the overall vision, direction, focus, and priorities of the health sector over the medium term in the context of a country's current level of economic and human development outcomes. Such plans should ideally be costed and come with an accompanying financing strategy that determines how they will be funded. If well formulated, with a financing strategy and a phasing of the operational part, the strategic plan should form the basis for making the case for more resources from domestic sources to the health sector. Weaknesses in the health sector's own planning process do not strengthen the case for more resources, because incremental health sector budget estimates and unrealistic projections, which are not anchored in a detailed needs analysis and operational plans, will provide weak justification for increased resource allocation from the national budget.

50. **A strong case for additional resources for health—when challenged by the MOF—is made by formulating a budget that demonstrates the link between health spending and health service results.** A well-prepared budget shows how the resources allocated to the sector will be put to productive use by demonstrating how more allocation of resources will result in increased health services provided and eventually in improved health results. This may be done by presenting alternative health funding scenarios which demonstrate how different levels of resources will be able to change the level of health services and could be a feature of the longer-term sector strategy and also of the annual budget submission to the MOF, if proposals for funding above the issued ceilings—with proper justification—are allowed in such submissions. At the same time, budget proposals should have a medium-term view to take into account the future recurrent cost implications of capital investments and recognize that health results are likely to emerge after a time lag.

Revenue Earmarked for the Health Sector

51. **Dedicated revenue sources can help insulate health programs from fluctuations in budget allocation.** Five types of earmarked revenue sources for health are considered here, namely (a) earmarked taxes, (b) user fees and charges paid by patients at the SDUs and retained by the SDUs for funding expenses, (c) SHI schemes, (d) private or voluntary health insurance, and (e) external aid earmarked for the health sector. Each one of these is discussed in the following paragraphs.

52. **Earmarked taxation means that the proceeds of a specified tax are dedicated—in whole or in part—to health spending.** This is often handled through 'sin taxes' (taxes on pollution, tobacco, or alcohol) to emphasize public health promotion efforts and combat harmful practices. However, the relevance of such mechanisms is debated and is a matter of discussion between the MOH and MOF. The MOHs usually view such earmarking as a way to secure health spending and limit fluctuations in levels of fiscal resources. By contrast, the MOFs usually prefer to pool all resources in the general budget, which gives them full control over the levers, so they can better adjust the budget strategy to match economic cycles. In practice, earmarked revenues might have little impact on fiscal space for health, because an increase in earmarked resources may be offset by a decline in allocations from the rest of the general budget (WHO 2010).

53. **User fees and charges paid by patients at the SDUs for services obtained may be retained by the SDUs for funding expenses.** Such revenue constitutes part of households' direct OOP expenditures. If retained by the provider, the revenue can be used to improve health care quality (for example, to buy medicine, update the facility, or pay bonuses to medical staff). This provides an incentive mechanism for the SDUs and generates additional funding directly related to the demand for services at the individual SDU. Often, however, a share of the proceeds is required to be transferred to the MOF/Treasury as part of general revenue and is therefore not available to improve the quality of care or finance other costs of provision. Such sharing arrangements tend to

exist only with government providers, not with private providers. Whether retained or not, government SDUs should be required to follow normal accounting practices for the payments collected and the expenditure incurred from that revenue.

54. **SHI systems are generally characterized by independent or quasi-independent insurance funds, a reliance on mandatory earmarked payroll contributions (usually from individuals and employers), and a clear link between these contributions and the right to a defined package of health benefits.** In many countries, coverage has been progressively extended to subpopulations and then to the whole population. The state generally defines the main attributes of the system, although funds are generally non-profit and supervised by the government. The number of funds varies by country. Where there are multiple funds, mechanisms are often used to compensate for different risk profiles across funds, and administrative costs are generally higher. The payroll base acting as a funding mechanism of SHI systems insulates them from budgetary negotiations that may subject national health service systems to more variable funding (Gottret and Schieber 2016). A challenge from a PFM perspective is, however, to maintain adequate accounting, financial reporting, monitoring, and oversight of the extra-budgetary SHI funds, particularly when they are managed by autonomous agencies, which may be subject to separate laws and regulations with regard to PFM.

55. **Private or voluntary health insurance—including community-based health insurance schemes—often supplements publicly funded coverage.** Private health insurance is paid for by non-income-based premiums (not tax or social security contributions) and is usually found in high-income countries. Community-based schemes can be broadly defined as not-for-profit prepayment plans for health care that are controlled by a community that has voluntary membership. Voluntary health insurance is defined as any health insurance paid for by voluntary contributions. Although these types of coverage are distinct, most private health insurance markets are also voluntary—except in a few countries—as are community-based insurances. There are several roles that private/voluntary health insurance can play in a country's public or social coverage:

- Primary - as the main source of coverage for a population or subpopulation
- Duplicate - covering the same services or benefits as public coverage, but differing in the providers, time of access, quality, and amenities
- Complementary - covering cost-sharing under the public program
- Supplementary - for services not covered by the public program (Gottret and Schieber 2016)

56. **Earmarked external funding is a means of increasing health sector funding, which has been very important to improving health results in many low-income countries.** While the impact on results of external financing relative to domestic financing cannot be easily determined, the main results which health systems in Sub-Saharan Africa have achieved, over the last two decades, are in the areas of prevention and control of HIV; tuberculosis; and malaria and reproductive, child, and maternal health, which are also the areas where external financing has focused.

57. **External financing, however, comes with drawbacks on effectiveness and efficiency and is hardly sustainable in the long term.**[5] Despite its well-meaning intentions it can have adverse effects on the health budget. Though external funds may boost the government's overall resources, in some

[5] Foreign aid may likely give extra fiscal space to the health sector. WHO (2010) suggests that foreign aid will be indispensable to move away from OOP payments.

instances, it may not represent a net addition to the health sector's financing because it simply replaces ordinary budgetary allocations, even if the external funds are, in principle, earmarked for the sector. External funds may also force the sector to strive to balance national priorities with (different) priorities of external financiers. Donor funding which does not use country PFM systems can lead to parallel budgets or off-budget funding, thus affecting the overall fiscal management and pooling of resources needed for supporting government priorities.

58. **Health sector budget support is a form of external aid which is often seen as funding for the sector but in practice constitutes general government revenue.** While the conditions for release of sector budget support may be directly related to performance of the health sector in terms of outcome and output indicators or reform measures, the funds are released to the national Treasury and from there follows all government PFM systems, as they can then no longer be distinguished from other government revenues.

Decentralization of Health Financing

59. **The way the health budget is formed and executed is highly dependent on the way the health sector is organized and whether resources are managed directly by the central government, by provinces, by local governments, by national health insurance structures, or by private institutions.** Depending upon the country context, these arrangements could range from highly centralized to highly decentralized. Decentralization issues are discussed here in terms of the role that decentralization institutions might play in supporting providers in getting appropriate inputs rather than the type or levels of the organization.

60. **Greater decentralization to local authorities has the potential of better matching between government priorities and funds allocated down to the level of health facilities.** Local authorities are believed to have better knowledge of local needs and be more flexible than centralized planning and allocation systems. Besides, they may be able to generate additional fiscal space through local taxes and contributions. As decentralization increases the level of accountability, the likelihood of citizen's priority being reflected in the local budget increases. In addition, earmarked contributions to health are more likely to succeed in a decentralized environment than in a centralized one.

61. **The role of PFM systems is accentuated in a system of fiscal decentralization where budgetary allocation occurs at national and subnational levels.** As for health delivery challenges, the division of power among the different actors at the different levels of the government affects how resources are allocated and spent by the service providers.

62. **The potential for improving transparency and accountability in budget management is in theory high in a system of fiscal decentralization.** Appropriately designed fiscal decentralism can foster local resource mobilization and help bring such mobilization closer to the point of service delivery and increase the autonomy of providers to deliver services. In a regime that provides incentives for local revenue mobilization—such as allowing revenue collected to be retained at the local level—fiscal decentralization can support efforts to increase revenue mobilization at the local level. Where a decentralized government does not have the fiscal authority to raise or retain local revenue, however, operation of these fiscal entities adds to the administrative costs of the health system and competes with service providers for financial resources from the central government level.

63. **In reality, the local government, even in highly decentralized contexts, often has low revenue generating capacity.** This is particularly the case in developing countries. The local governments thus rely essentially on central government transfers and may also have little autonomy for adapting transferred funds to the local context. When dependent on central

government funding, the transparency and fairness of the territorial fund allocation systems become a key issue in the ability of local authorities to meet local needs for health services. The degree to which centrally determined service mandates are fully funded and whether this funding is fully transferred to the local authorities in connection with decentralizing the service mandate are also important. Rules-based and transparent formulas for vertical and horizontal allocation of budgetary resources from the central government to the local government play an important part in ensuring that the promised service standards are attainable with geographical equity.

64. **A decentralized system adds complexity to a health system, including its financing.** For resource mobilization, it may increase the potential to mobilize resources, and yet, it adds an additional layer of system of budget preparation and negotiation. At the same time, a decentralized system, with a fair amount of fiscal decentralization, would mean that the fight for mobilizing resources for health will be fought both at the national and subnational levels. For financial protection, it could increase the risk of ending up with several smaller pools. As such, it increases the risk of the subnational system's inability to provide financial protection. For purchasing of health services, a decentralized system would provide an opportunity for tailoring the system of payments to the needs of the local situation.

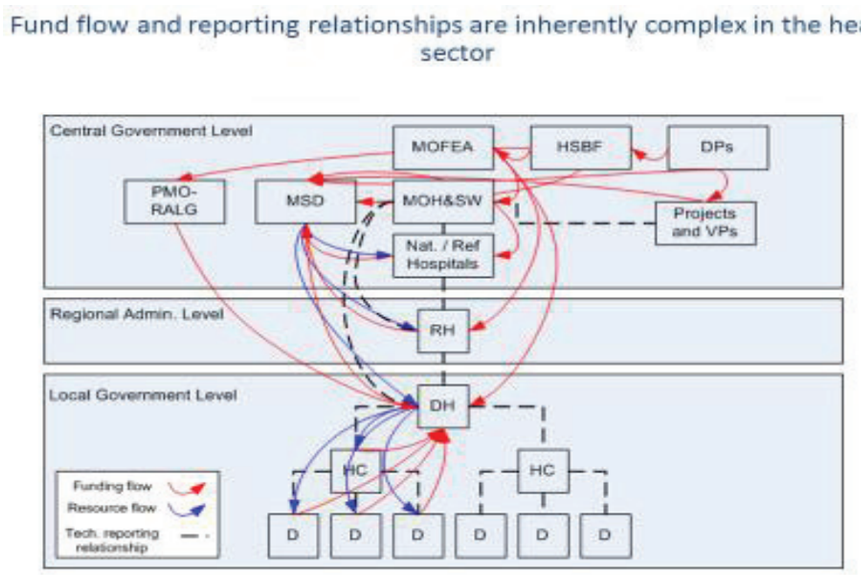
65. **Often, local governments have relatively low capacities to understand and implement the governance, PFM, and health financing systems as pronounced by centrally established laws and regulations.** This would imply a need to build the requisite capacity in these institutions at a local level as a precursor to allow for enhanced decentralization.

66. **Beyond theoretical considerations, there is little evidence that greater autonomy at the regional or local level will make funds flow more adequately to the service delivery points.** Local governments may have a better understanding of local health care needs, but this does not necessarily translate to a better process of allocating resources. They may not necessarily have the needed skills to allocate funds in a better and more orderly manner than a centralized system. Their decisions in allocating funds may be led by local political considerations that may not address the actual health needs of the population and may not be aligned with national priorities.

5.2 Pooling

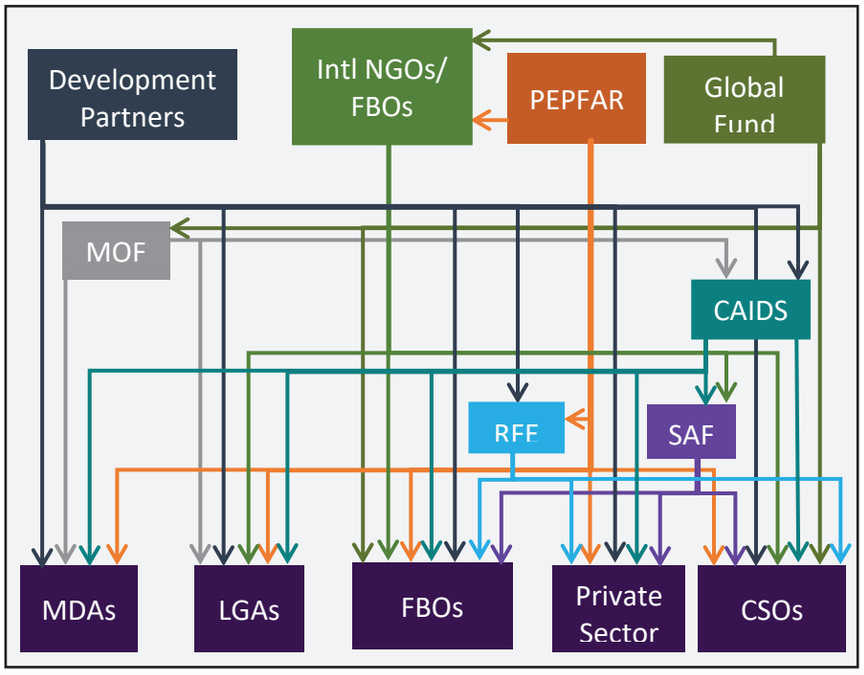
67. **Flow of funds arrangements in the health sector are inherently complex.** The complexity results from multiple sources of revenue for health service provision, leading to multi-layered relationships, diffused accountability, resource flows, and reporting arrangements between a typical central MOH (which is charged with the overall responsibility for policy formulation and administration) and decentralized authorities at the regional, district, local, or community hospitals or health posts that are responsible for service delivery (see examples in Figure 5 for a system with domestic resources only and Figure 6 with external aid through separate disbursement channels).

Figure 5: Example of Relationships and Fund Flows in the Health Sector



Source: Parminder Brar, World Bank (unpublished).
Note: MOFEA = Ministry of Finance and Economic Affairs; MOH&SW = Ministry of Health and Social Welfare; MSD = Medical Supplies Department; PMO = Prime Minister's Office; HSBF = Health Sector Basket Fund; RH = Regional Hospital; DH = District Hospital; HC = Health Center.

Figure 6: Schematic Fund Flows Example with Donor Funds



Source: Parminder Brar, World Bank (unpublished).
Note: Based on Parminder Brar, World Bank. Legend: CAIDS = Commission for AIDS; CSO = Civil society organization; FBO = Faith-based -organization; LGAs = Local government authorities; MDAs = Ministries, departments, and agencies; NGOs = Nongovernmental organizations; PEPFAR = President's Emergency Plan for AIDS Relief (U.S. President); RFE = Rapid Funding Envelope for HIV/AIDS; SAF = Social Action Fund.

68. **The share of public and private revenues for health varies according to country-specific health system arrangements, macroeconomic conditions, and political considerations.** In low-income countries, with limited potential for increasing tax revenue, the limited fiscal space is likely to shape institutional arrangements in health, resulting in a higher reliance on private spending such as OOP. Public expenditure is less likely to take over private expenditure, and the challenge from a health financing perspective is to channel private spending into some form of prepayment arrangement to strengthen financial protection for the poor and needy.

69. **Pooling helps improve financial protection by spreading risks.** The most effective way to deal with the financial risk of paying for health services is to share it, and the more people who share, the better the protection. Pooling implies that contributions are collected and pooled in public and/or private health funds to pay for services to providers on behalf of the people who are covered or insured. It offers the opportunity to cross-subsidize the poor from the rich, the ill from the healthy, and the old from the young. Pooling can have positive impact on the volume of services by removing some of the barriers to access health care services. On the supply side, pooling mechanisms encourage providers to accept every insured patient who arrives at their door because they are guaranteed more reliable revenues. Finally, pooling may encourage more efficient health practices (for example, more prevention services), which are likely to generate savings. Pooling is often combined with strategic purchasing (discussed in Section 5.3) in the health sector, and it results in better alignment of the health care spending with health priorities, while getting more people covered at the same time. Participation in a pool could be compulsory (automatic coverage or mandatory participation) or voluntary. The sources for the pool may vary, ranging from general revenues, to payroll taxes for state-funded systems, to premiums or voluntary contributions for private or community-based health insurance.

70. **One of the major challenges of many health systems is fragmentation of sector financing.** Fragmented financing limits the potential for pooling and sharing risks between the various elements of the society. Fragmentation usually happens because of the co-existing financing systems within the government including off-budget financing and earmarked (or ring-fenced) systems as well as contributions from two or more layers of government (see the discussion of revenue sources in Section 5.1). These co-existing systems are often managed by autonomous entities such as extra-budgetary government agencies, subnational government (SNG) entities, or state-owned enterprises. Uncoordinated or poorly coordinated budget planning and execution processes fragment an otherwise central pooling of resources at the national level.

71. **Effective pooling mechanisms require that all funds, irrespective of their sources, follow a single set of uniform procedures.** Fragmentation limits the beneficial effects of pooling because each source of funds usually has its own budgetary rules that govern how the funds can be spent and operate through separate bank accounts. Providers may have to use certain resources for financing certain activities or inputs. Likewise, each funding institution may require providers to follow a specific format for reporting under rigid spending rules, which limits the ability to keep the service delivery considerations in mind while exercising control. Thus, fragmentation is likely to increase administrative costs, waste, and duplication. This may imply the need for significant reforms in PFM systems to change the existing allocation and spending rules and align them with the objectives behind the pooling.

72. **A sound PFM framework that supports comprehensive, coordinated, and cohesive budget formulation across different levels of government and extra-budgetary funds (EBFs) should ameliorate such potential downside impacts of fragmentation.** Under such a system, a fiscal framework that underpins budget formulation could support a process where forecasting of revenues and expenditures is an exercise that involves all relevant bodies of the central and decentralized government including EBFs (such as an SHI fund). This could help provide the

preconditions for well-informed and rational decisions on government policies across all levels of the government.

73. **Under a system with multiple sources of financing, a well-designed PFM system can help mitigate the ill-effects of fragmentation.** For example, a PFM system can aim to bring together budgetary funds and EBFs (such as an SHI fund) through coherent planning and budget management processes to apply a set of rules and procedures which respond to service delivery challenges in the country. Similarly, collection of premiums through an SHI scheme may raise the following important PFM issues, which can be addressed by ensuring uniformity of PFM rules across all service providers:

- Unless the basis of accounting for both the government and the insurance fund are the same, there will be issues involving what accounting basis the SDUs should use for recording and accounting for the resources received from the insurance, for example, accrual versus cash basis, or use of different charts of accounts (COAs).

- There may also be issues involving what rules apply to the SDUs using funds received from the insurance fund. Given that the SDU is a government entity, will the SHI fund impose any fiscal rules other than those of the government?

- There may also be issues of accountability for the use of funds received from the SHI fund. How will the purchasers be held accountable for the use of funds received? Will the SAI have oversight over the insurance funds?

- There may also be conflicts in the way purchasing of services is arranged. Insurance funds may pay per service delivered, whereas the government may finance the SDUs through direct funding of some types of inputs. This may not support the tracking of funds for government programs against output targets.

74. **The complexity and fragmentation of the service delivery financing is further exacerbated when donor-specific financial management arrangements for implementing aid are introduced.** With the goal of reducing fiduciary risks, such arrangements are often parallel to country systems, following separate funds arrangements although sometimes funding similar government priorities. The proliferation of such donor-specific arrangements in the sector may not only contribute to undermining the use of country systems, especially where there is evidence that the country system or certain aspects thereof are good and can be relied upon, but they may also create opportunities for the misallocation of resources, 'double-dipping', and waste and misuse of public funds.

75. **An effort to address the inefficiencies associated with multiple financial management systems by external aid agencies is the Universal Health Care initiative (UHC2030)[6] initiative, which lays the foundations for effective donor coordination by promoting principles of harmonization and alignment that span the entire budget cycle.** The UHC2030 principles are likely to encourage an increase in health spending and a more efficient financial capacity to better target actual health needs and improve accountability.

5.3 Purchasing

76. **One way of improving the efficiency of spending in health is linking payments to providers to results achieved.** This involves using different types of payment systems that are employed to actively purchase targeted health services—often called strategic purchasing. It differs from passive

[6] Formerly International Health Partnership (IHP+) principles. IHP+ was replaced by UHC2030 in 2018.

purchasing, where budgets are allocated based on inputs such as salaries. Strategic purchasing aims at setting up a financing system based on incentives to change providers' behaviors to align their objectives with government priorities.

77. **Spending driven by strategic purchasing is likely to enhance efficiency.** It uses performance-based payments to incentivize providers for desired behavioral changes. Being based on results and performance to optimize the impact of available inputs, it contributes to greater technical efficiency and better service delivery.

78. **Setting up and managing strategic purchasing arrangements is a complex process.** It requires clarity in government priorities and an information system to track performance. It also requires the translating of priorities into multiyear budget documents to make sure that the reference framework for guiding annual budget formulation is the same for all government stakeholders.

79. **Most PFM systems are too rigid to allow improved spending based on strategic purchasing.** Performance-based payments systems are often in conflict with budget allocation and release systems based on line items, where allocations have weak links to the behavior/performance of providers. Strategic purchasing requires a flexible PFM system where payments, instead of being mere budgetary allocations, can encourage providers to behave in a way that promotes the strategic objective of the financier. The selection of payment method[7] depends on the objective of the purchaser in terms of volume of services, quality, and overall cost of care. PFM systems that accompany each of these payment systems need to be appropriately designed to ensure that objectives are correctly aligned, while at the same time ensuring adequate control and governance.

80. **PFM systems may be adapted to provide the flexibility required for improved purchasing arrangements.** Strategic purchasing requires effective accounting, control, and reporting systems to ensure compliance and help identify requirements for the following years' budgets. At the same time, control and reporting systems need to be adapted to the specifics of the chosen payment system. Service providers may be required to implement enhanced governance and accountability arrangements to mitigate risks that might arise from such arrangements, and that could potentially undermine service delivery.

81. **New monitoring systems may be needed to track performance.** Strategic purchasing arrangements require comprehensive and reliable information and data on consumers' and providers' behavior. If they are properly designed, cost accounting systems can help determine the appropriate costs for any particular standard service. These may be set up either in the public sector's service delivery channels or in the private sector, depending on the country context, and can help in monitoring costs and efficiency over a period of time. Such information is necessary to carefully define benefits packages, determine the relevant payment mechanism, and avoid creating perverse incentives that would put higher pressure on budgets.[8]

82. **Moving to output-based or results-based budgeting could help implement strategic purchasing.** Output-/results-based budgeting is likely to better reflect government priorities than

[7] There are several payment methods including fee-for-service, global budget, case based, capitation, and a combination, see Glossary of Definitions in Annex 1.

[8] The procurement strategy in the health sector needs to be aligned with purchasing arrangements. Providers need to get the necessary medical and non-medical supplies to support implementation of the purchasing arrangements, and procurement plans should be designed accordingly. Changes in the organization or management of procurement systems may also be needed to make sure that purchases of goods and services are consistent with health priorities or geographic specifics.

input-based budgeting and is more likely to provide clear information to providers about what is expected from them. Output-/results-based budgeting also encourages adequate reporting on providers' performance and promotes accountability. Allocating resources based on an aggregated set of expenditures usually gives providers more flexibility to reallocate funds within a particular set, while promoting accountability. Depending upon the country context, output-/results-based budgeting could possibly be combined with a program classification of the budget to better link fund allocation and management to service delivery targets.

5.4 Aligning PFM and Health Financing Reforms

83. **The issue of misalignment between health financing reforms and PFM concepts and rules is getting increasing attention from experts and development partners.** Misalignment is seen as an obstacle to improved service delivery and making progress toward UHC. The first section below describes how PFM and health financing functions can be leveraged to enhance their interaction for improved service delivery. It aims to identify the actions that could be taken, at the different steps of the budget process, to address existing challenges and get the full benefit of implementing good practices in PFM. The second section discusses the need for improved dialogue between the MOH and MOF on aligning PFM reforms with health sector needs.

Design PFM Systems to Better Support Health Sector Priorities and Financing Tools

84. **A sound and well-structured PFM system is likely to support health financing elements in encouraging better service delivery and progress toward SDG goals.** It is necessary to develop PFM practices that are fully consonant with and reinforce the objectives of the health financing mechanisms.

85. **Each country needs to develop a vision of its national PFM system and its health financing system that aligns the two systems well over the medium term.** While designing future reforms in health financing and/or in PFM, governments need to be cognizant of current misalignments between the two, whether this concerns planning, budgeting, fund flows, service delivery inputs, monitoring, control, or accountability, and need to take the necessary steps to remove the anomalies to improve service delivery. PFM systems should ideally help support the objectives of health financing systems, such as pooling and purchasing, by ensuring appropriate flexibility. Health financing reforms should be designed in a manner that is grounded in the current realities of the PFM environment (including governance systems, macro-fiscal control, and accountability) and is able to incentivize behaviors accordingly.

86. **Countries need to develop a long-term planning framework that enables the health sector to set up and implement its strategies for better service delivery.** Multiyear programming must guide the annual budget process to make sure that government priorities are reflected in the annual budgetary process on both the revenue and expenditure sides. Multiyear budgetary documents should include clear health objectives and indicators and be elaborated through the concerted participation of all stakeholders.

87. **Effective multiyear planning is likely to meet the expectations of both the MOH and MOF.** It is likely to reinforce the sense of common ownership on health policy. Combined with accurate macroeconomic forecasting, it supports the development of data collection and benchmarking to provide greater visibility on future expenses and help adjust the debt and fiscal strategy accordingly. In addition, it is likely to reduce fluctuations in resources and unexpected in-year budgetary adjustments, thus reinforcing budget credibility and the ability of health managers to engage in longer-term planning. Ideally, it could strengthen transparency by providing information on

government strategies and increasing scrutiny of the alignment of the budget process with the multiyear framework.

88. **To take into consideration health sector specifics, PFM systems may need to be suitably redesigned.** Moving to program-based budgeting (PBB) may prove to be key in aligning budget management and health financing with health sector priorities and providing more flexibility to providers, especially in countries which have the requisite capacity and skills to transition to PBB. The budget allocation needs to be done in an optimal manner that avoids wasteful expenditure and improves equity between territories or social groups.

89. **The existing PFM rules may need to be revised to make sure that providers are allocated predictable resources.** PFM systems need to take into account the service delivery perspective in the heath sector. Fluctuations between initial and final budget allocations during the budget preparation process as well as in-year budgetary reallocations should be kept to a minimum. Timely release of funds is essential to allow providers to purchase adequate drugs and supplies, recruit additional staff, and make investments. It is also likely to better support the implementation of purchasers' strategies for incentivizing workforce behavior. Finally, providers need more flexibility to adapt resources to changing needs and retain part of their unspent budget.

90. **A critical area of alignment between PFM and health relates to flexibility.** Health service delivery often happens in an unpredictable environment. Emergencies arise that require shifting of resources from one area previously considered a priority to another area demanding urgent attention. The decision to transfer resources, however, may be constrained if PFM rules are not flexible enough. Layers of approval and/or authorization from the MOF and sometimes from the legislature may slow down or even limit the transfer altogether. Appropriate flexibility to transfer funds between budget lines at the service provider level or at the health administration level is important, to not only ensure rapid attention to emergencies, but also ensure that health authorities have the latitude to ensure that funds are spent on whatever adds the most value to health service delivery.

Improved Dialogue between the Ministries of Finance and Health

91. **There are often contrarian perspectives between PFM professionals and health counterparts and, at times, between the MOH and MOF.** For the MOFs, continuous health spending and highly flexible PFM rules could make it difficult to achieve fiscal sustainability, control, and accountability. On the other hand, rigid PFM rules seemingly prevent flexible and effective use of health financing instruments to better adapt to evolving medical needs and priorities. Corruption scandals in the health sector undermine the mutual trust between these two ministries and development partners involved in the sector. This leads to a proliferation of parallel financial management arrangements[9] in an attempt to ensure central control and isolate external funds from corruption. This, in turn, undermines the sustainability of capacity building in PFM in health and increases the administrative costs of doing business in the health sector.

92. **Increased communication between the two ministries helps forge a common understanding of PFM issues in health.** The MOF needs to understand that the health sector requires specific financing instruments, such as pooling and purchasing, to target funds to priority programs, populations, or services. PFM techniques and practices should then play a supporting role

[9] "Understanding the costs and benefits of unharmonized and unaligned FM arrangements" (P157647)—a subtask under the PFM in Health Sector: Service Delivery Challenges and Solutions (P155193), which documents the issue for two countries (Kenya and Uganda).

to help deepen financial literacy and capacity. On the other side, the health sector should demonstrate value for money and respond to 'MOF focus on compliance' (Kanthor and Erickson 2013) by strengthening monitoring and expenditure tracking systems.

93. **The MOF and MOH can build on their common interest in addressing inefficiencies.** Redirecting wasteful expenditures to a productive purpose is likely to meet the objectives of both institutions. As a result, "making health systems more efficient and effective is likely to be one of the few ways of reconciling raising demand for health care and the public financing constraints." (OECD 2010)

94. **Developing synergies between the two ministries requires that they engage in an extensive dialogue.** Beyond the annual talks on budget and control over spending, this dialogue should include every PFM function and health financing. It is also critical for both ministries to share a common understanding of the priorities of the health sector, which implies that these priorities need to be jointly determined. The MOH has the knowledge, competence, and background required to articulate the country's health priorities in the short, medium, and long run. However, if the MOF is not adequately involved in this key process, there is little chance that multiyear planning will be reflected in the annual budget, and resources are likely to remain unpredictable, preventing health facilities from making the necessary decisions on investments. Increased coordination from the very early stages of the budget process is necessary to help build budget credibility and limit the risks of sudden freezing of funds.

95. **The dialogue between the two ministries should continue throughout the budgetary process.** Just as the MOF should participate in defining health sector priorities, the MOH should have a say in selecting an adequate allocation mechanism to make sure that it is aligned with government priorities and consistent with purchasing strategies. The need for increased interaction between these two ministries is indeed very similar on the health financing side. The MOF can provide assistance to the MOH in evaluating the administrative costs or the budgetary impact of purchasing policy reforms. It can also bring its expertise for setting up oversight mechanisms covering providers.

Chapter 6 Service delivery Challenges from a Provider Perspective

96. **Supply-side challenges are defined as the issues which limit the provision of health care services as seen from the perspective of the SDUs.** The focus of a Diagnostic Review of PFM in Health is to identify those supply-side challenges in the health sector and track their causes as they originate in PFM systems (see the methodological approach explained in Chapter 7). The focus is on issues that limit the availability of health care to the population at large, in particular provision of health care services as identified in UHC2030.

97. **Overutilization of health care services, especially hospital services, is also an issue but is not covered in any detail here.** Avoidable hospitalization and excessive hospital stays are major service delivery issues for a number of middle- and high-income countries. These could partly be because of incentives provided by poorly structured purchasing arrangements in these countries. For instance, in a country where hospitals are paid on a service package, which incentivizes stay in hospitals, there will be no way to get hospitals to reduce the length of stay of patients or refer them to primary service providers, which helps in reducing avoidable hospitalization. Extensive hospitalization may also be caused by lack of facilities for rehabilitation and long-term care after surgery.

98. **Some supply-side challenges are related to the health financing system.** Health financing and its interaction with PFM systems were discussed in Chapter 5. Health financing leads to supply-side challenges for the SDUs, the Diagnostic Review therefore investigates to what extent PFM processes facilitate resource mobilization for the health sector as well as pooling of the resources and strategic purchasing for effective and efficient service delivery.

99. **Other supply-side challenges concern the conversion of the financial resources for the sector into the physical inputs needed to deliver effective health care to the population.** Those physical inputs are categorized into three groups, staff (both medical and administrative); operational supplies (such as drugs, medical supplies, laboratory supplies , and so on); and infrastructure (such as buildings and related utility connections).

100. **The SDUs will often find themselves constrained in their ability to obtain funds for the most appropriate mix of inputs for service delivery because of various financial controls.** The demand for health services can be difficult to predict one year ahead, which is typically the lead time between preparing an annual budget and the actual implementation. Major disease outbreaks can occur abruptly, and the SDUs need to respond quickly. Budgets in many countries are based on economic line items at a very detailed level with the use of funds controlled at that level of detail. Getting approval for changes to the budget (virements) can take substantial time and may burden administrative staff unnecessarily, particularly where the SDUs are at the bottom of an administrative hierarchy with many layers. Even if the budget allocations align with service delivery needs, other lengthy control procedures may delay the process of acquiring the physical inputs needed (staff hiring and procurement rules). Such control procedures may apply to all types of inputs.

101. **In any PFM system, there is a need for adequate flexibility at the SDUs to respond quickly to demand for services on the one hand, while retaining requisite centrally instituted controls for ensuring macro-fiscal discipline and minimizing the opportunity for fraud and other leakage on the other hand.** While there may be a good reason to ensure that hiring of permanent staff and investment on infrastructure are well thought through because of their longer-term consequences, controls of other input acquisitions—such as minor purchases of operational supplies and maintenance required for equipment—should be allowed with a substantial degree of SDU autonomy and flexibility. In countries with credible annual budgets, stable medium-term budget allocations and a culture of financial compliance with the central finance agencies are much more likely to offer the SDUs (and other decentralized agencies) such flexibility than in countries where the opposite situation prevails.

102. **Nevertheless, it can be difficult for an administration to let go of a control culture where it has been ingrained for long periods, so controls may remain simply because they have always been there or, in some cases, because they provide opportunities for illicit rent seeking.** Examples of the slow pace of reducing controls include (a) a change from pre-audit of transactions to a modern internal audit function—of systems checks combined with external ex post audits—has been going on globally for decades, but pre-audit systems still remain in some countries and (b) program budgets have been introduced in many countries, but the expected improvements of budget flexibility for program managers have been forthcoming with significant delays, if at all. When the SDUs face bottlenecks in the flow and use of funds, it is important to determine to what extent a control feature serves genuine needs, whether it could be made less restrictive (for example, to make the control at a less detailed level), if not abandoning the control feature altogether.

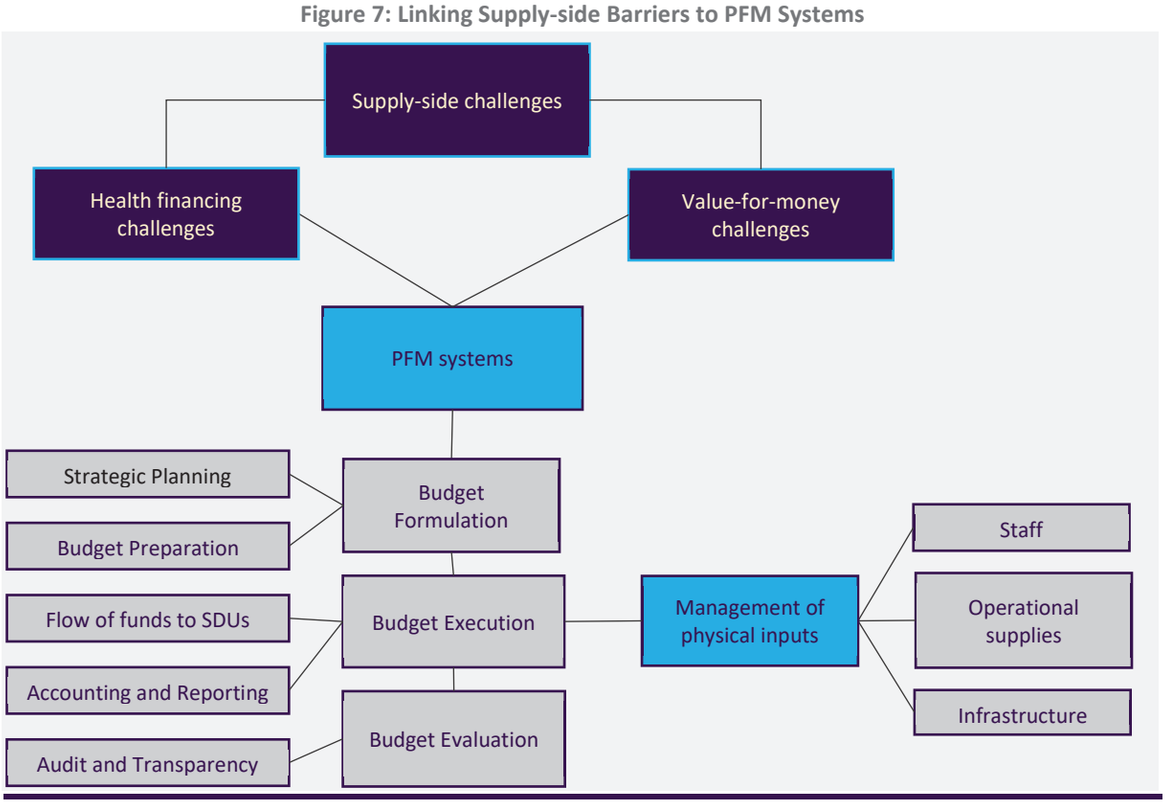
103. **Perceived levels of inefficiency and corruption in the health sector weaken the case for additional funding for health.**[10] The prevalent governance arrangements and the perception of health sector performance may affect the government's decision to enhance the sector's allocation. PFM reforms, coupled with larger governance reforms, could help address this perception and assist the MOH in developing a credible plan to showcase before the MOF. Reluctance to allocate more funds to the health sector is clear when basic structures to support effective resource management are lacking (for example, inadequate accountability, lack of monitoring, and results not being visible).

104. **Payroll and procurement of goods and services are the most common areas where corruption occurs.** Payroll is one of the largest expenditure items in health. Unfortunately, it is also one of the areas where largest governance issues are observed. The transparency and comprehensiveness of the public procurement system is another main determinant for the effective and efficient use of public resources.

105. **Improving efficiency in the use of resources requires comprehensive, reliable, and timely management information.** Financial Management Information Systems (FMISs) are central to generating such data. If designed well, they would apply to all spending units and all transactions. When reports from FMIS are made accessible to the public, the transparency of financial operations enabled by such systems can play a key role in holding accountable public officials and the government at large as well as in curbing fraud and corruption.

[10] WHO (2010) estimates that 20 percent to 40 percent of all health spending is wasted through inefficiency.

Figure 7: Linking Supply-side Barriers to PFM Systems



106. **Overcoming supply-side challenges—fully or partially—by resolving the related bottlenecks in PFM systems could provide enhanced resources for the health sector, and/or lead to improvements in allocative and/or technical efficiency.** Those efficiency gains mean that more or better distributed services may be delivered within the same resource envelope and can be as important to improved service delivery as an increase in the overall allocation of resources.

107. **The scope for achieving technical efficiency gains increases with the time horizon being considered.** Some expenditure items are difficult to cut or restructure in the short term, especially staff costs, and can crowd out spending on other inputs. Recurring operations and maintenance costs resulting from capital investments, which have not been carefully evaluated, might also crowd out spending on other inputs, limiting the available fiscal space for enhanced health service coverage.

108. **The abovementioned links between supply-side challenges and PFM systems determine the structure of the Diagnostic Review of PFM in Health and are illustrated in Figure 7.** A direct link between a specific supply-side challenge and a particular PFM systems element has not been attempted because there may be multiple PFM functions contributing to a specific supply-side challenge and multiple supply-side challenges affected by a particular PFM systems element.

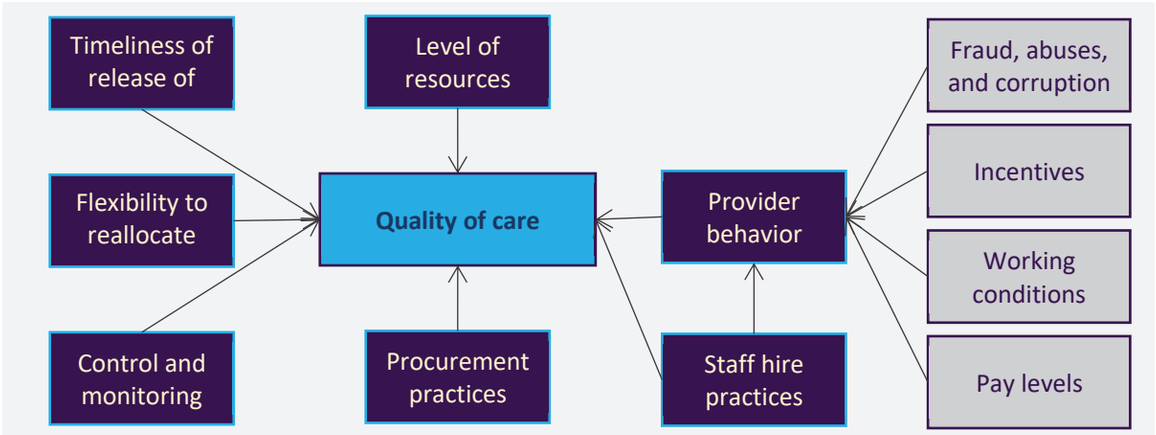
Quality of Care

109. **Quality of care is equally difficult to define and to measure.** There is no commonly accepted definition for this multifaceted concept, but health experts and organizations refer to the six elements of quality that have been identified by the Institute of Medicine in the United States: safety, effectiveness, patient centeredness, timeliness, efficiency, and equity. WHO notes that quality measurement for common aspects of health care (inputs, process, and outcomes) might be very disparate in terms of cost, time, and complexity, and as a result, some elements of quality lack evaluation (notably effectiveness and safety).

110. **Low quality may indeed adversely affect health outcomes.** Health outputs must be of sufficient quality to translate into actual improvements in health outcomes. Irrational treatment or prescribing may lead to medical errors and even induce negative outcomes as reputational risks crop up. The poorest are most likely to be affected by poor quality, because they have fewer alternatives for health services and have to make a choice between getting low-quality health care or forgoing medical treatment altogether.

111. **Reasons for poor quality of care are diverse—as illustrated in Figure 8.** Some of these supply-side challenges may not be linked to issues that are specifically financial in nature, for instance, inadequate initial and continuing professional training, absence of technical guidance, or mismanagement. These issues will not be discussed in the Toolkit because they do not fall within its scope. PFM-related causes of poor quality of care may be found not only in the lack of availability of resources and inputs but also in poor behavior among service providers.

Figure 8: Issues in Quality of Care



112. **Poor quality might result from insufficient funding.** Providers need to receive sufficient resources to recruit skilled health staff and purchase relevant drugs, necessary for providing adequate treatment. Availability of resources may also affect other quality elements such as safety, patient centeredness, or timeliness, potentially deterring individuals from seeking care and further affecting the level of services provided.

113. **The quality of care might be affected if providers are not allocated an adequate mix of inputs.** Poor budgeting and limited budget flexibility may prevent providers from reallocating funds according to their actual needs. As a result, they can choose not to spend the allocated budget, resulting in a lower production of outputs and in a likely cut in budget the following year, or they can spend allocated funds at the expense of effectiveness and efficiency.

114. **Delays in budget approval and releases of funds are likely to prevent inputs from being made available at the right time and in the right quantities for service delivery.** They may put off the launch of a procurement procedure, for example, resulting in a shortage of drugs or medical supplies. There is also a risk that staff recruitment will be delayed or that necessary maintenance work will not be undertaken on time. Likewise, the traditional rush to commit funds before the year's end might induce decisions driven by short-term considerations rather than by efforts to improve quality.

115. **Adequate compliance and performance monitoring are needed to encourage good practices.** Quality targets should occupy a larger part in the evaluation of providers' performance, even though they may be more complex to define. Similarly, more transparency is likely to

strengthen the ability of outside groups to track performance and encourage authorities to address quality issues. However, carrying out such monitoring implies that providers or the government are able to disclose information on quality of care by developing the relevant information systems.

116. **Procurement challenges and delays are likely to affect quality of care.** As mentioned earlier, inadequate drugs or medical supplies and late delivery all have an impact on the quality of care. Similarly, drugs may be ineffective or even detrimental to health if they have expired or have not been properly stored and handled. The growing prevalence of counterfeit drugs is also exploiting deficiencies in government regulation and supervision, procurement rules and procedures, pharmaceutical management, and supply logistics.

117. **Similarly, staff recruitment challenges are likely to affect the quality of care.** Medical staff should be recruited through open and transparent procedures which help ensure that the most competent individuals are hired. If the process of hiring is nontransparent, through personal connections and with little oversight, the likelihood is that less competent and motivated persons will be employed and that the quality of care will suffer.

118. **Quality of care is highly dependent on the incentive structures which providers face, as incentives shape their behavior.** Bad working conditions, low wages, or poor career prospects are each likely to deter health workers from working effectively. These issues are getting more and more attention from health experts. Studies show (Das and Hammer 2014) that the two key contributors to quality are competence/knowledge and effort. While competence is usually linked to training and, to some extent, other aspects of human resource management (see the paragraph 113), provider effort is often driven by incentives and motivation. Here, the way providers are paid—including linking payment with outputs—can incentivize providers. For instance, the lack of incentives could explain why poor quality may manifest itself in undertreatment, while perverse incentives could, on the contrary, foster overtreatment. Overall, improving both effort and attitude of health workers to improve the quality of health care services implies addressing the issue of incentives for providers and therefore, possibly, the service purchasing function (see Chapter 5).

PART B

THE PROCESS OF UNDERTAKING A DIAGNOSTIC REVIEW

Chapter 7 Diagnostic Approach to PFM in Health

7.1 Objectives of the Diagnostic Review

119. To effectively use the Toolkit, it is important to define the objectives which a diagnostic review aims to achieve when using this tool.

120. The key questions for the study are the following:

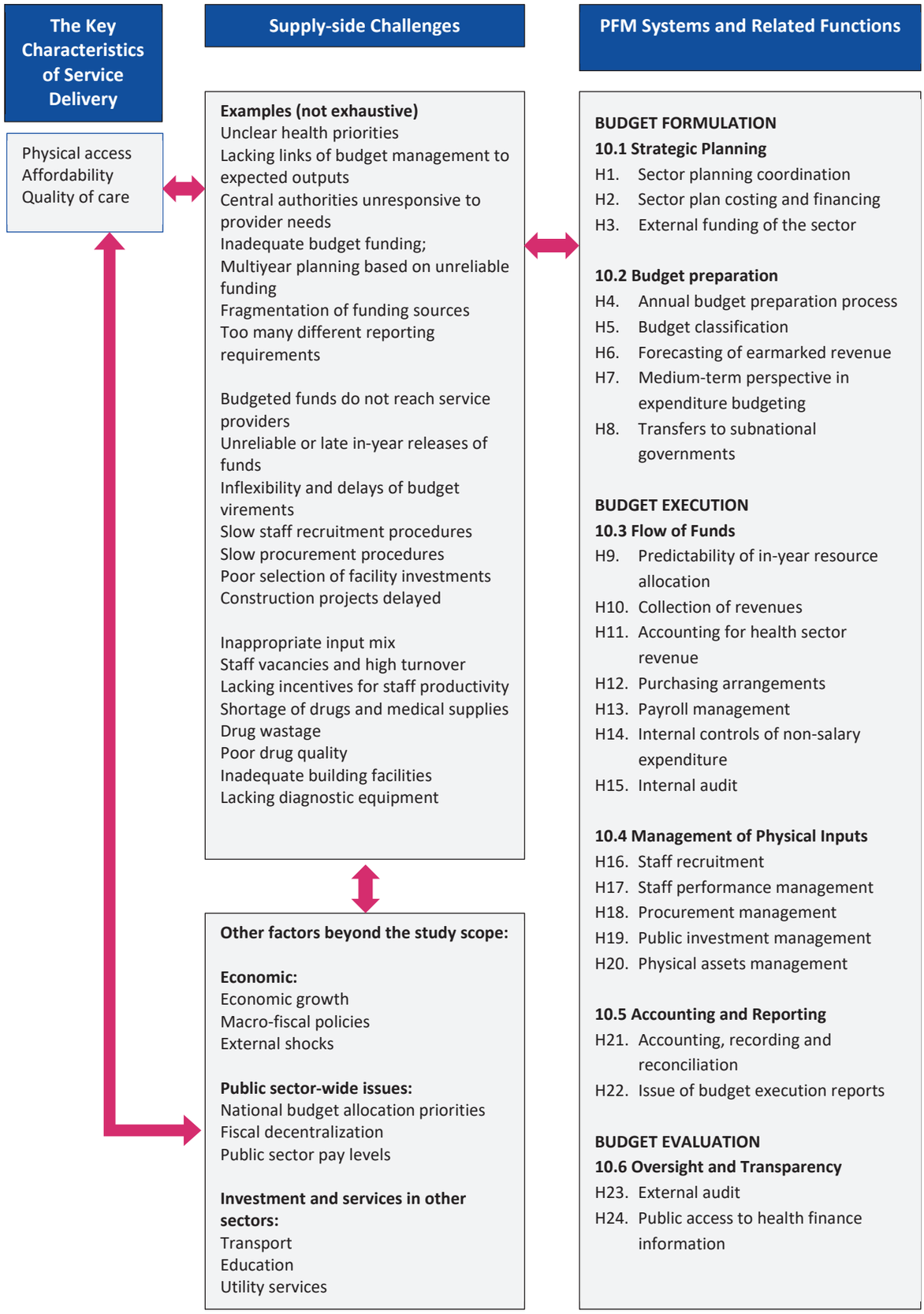
- What are the main PFM bottlenecks to service provision?
- How do PFM systems/reforms interact with health financing systems toward the achievement of UHC?
- How does the health sector maintain and leverage appropriate financial management and financial accountability arrangements to enhance progress toward achieving UHC?

7.2 Overview of the Diagnostic Approach

121. The links between UHC objectives and PFM systems are illustrated in the analytical framework in Figure 9. The contents of the four boxes in the figure are the following:

- The three attributes of UHC, which characterize the state of the health service system and reflect the current interface between service supply and demand for services, are shown in the left-hand column.
- The 'supply-side' challenges, which the health sector is facing in its pursuit of effectively and efficiently delivering services within available financial resources, are illustrated in the middle column—but only as examples as an exhaustive list is not possible.
- The factors which may influence both the supply-side challenges and the demand side directly—but go beyond the review of PFM bottlenecks to health services—are shown in the box at the bottom of the middle column.
- PFM systems, which may present bottlenecks to effective and efficient health service delivery, are listed in the right-hand column.

Figure 9: Analytical Framework Underpinning PFM in Health Service Delivery



Chapter 8 Stages of the Review

This section explains the sequence of steps that have to be taken to manage and undertake a Diagnostic Review of PFM in Health.

122. To identify the bottlenecks and their implications, the stages of the study commence with identifying the supply-side challenges in the middle column of Figure 9 and to go from there to PFM systems and the potential bottlenecks found there.

123. To answer the key questions in Section 7.1 a three-pronged approach to data collection is suggested.

- First, a review of recent studies undertaken in the country on the health sector, PFM, and governance issues.
- Second, a survey of a sample of health service providers to identify PFM-related challenges from the provider perspective.
- Third, a series of interviews with key institutions to track down the causes of challenges identified by providers and identify possible solutions.

124. The steps required to carry out this approach and prepare the related report are explained in more detail as follows:

Step 1: Determine management arrangements, diagnostic team, and time frame

- A team with skills in PFM, health finance, and health service delivery will be required to conduct the study (see sample terms of reference in Annex 2 for tasks and skill sets required). Recruit/mobilize the team, agree on peer reviewers, and establish support from the government focal point.

Step 2: Review of existing literature and documents

- This review should include health financing, fiduciary and PFM analytical work, other analytical work available on health service delivery, and other issues in the health sector of the country concerned. Examples of documents to review include health care laws; health finance laws; PFM laws and attendant regulations; procurement laws and regulations; and publicly available documents such as national development plan, health sector strategy, health ministry annual report, budget documentation, and (if existing) PEFA assessment report, sectoral PFM reports, Public Expenditure Management and Financial Accountability reports, PERs, Health Service Delivery Indicator Surveys, Health Financing System Assessments, and sector briefs, among others. Ongoing World Bank operations in the health sector, PFM, and governance in

the country will provide insight into what the current challenges are. Therefore, the review team should link application of the Toolkit to such ongoing work, whenever possible. Additionally, there could also be a comprehensive review of the strengths and weaknesses of the macro PFM arrangements and how health sector PFM arrangements compare with macro arrangements based on the existing information.

Step 3: Establish an overview of the status of the health sector in the country

- This would include the health status, disease challenges, institutional arrangements, and sector financing. If possible, the overview should include a flow of funds diagram (see examples in Figures 5 and 6 in Chapter 5 and the table in Annex 4 may assist in providing an overview of health financing). At this step in the process, the overview would be preliminary, with updates made during the data collection processes in the following stages. This preliminary overview would assist the team in selecting the institutions to cover by the diagnostic review (see Chapter 9) and select and refine the questions to ask during the field data collection task.

Step 4: Conduct surveys and interviews in-country with selected health providers

- The interviews should be conducted at various levels (including policy level and throughout the service delivery hierarchy) to ensure fair and proper representation of bottlenecks to service delivery. A sample of the SDUs should be identified, which are fairly representative of the service delivery arrangements in the country, to help generate information about the service delivery constraints that are faced by the sector. A questionnaire would need to be designed to suit the domain and service delivery level of the type of SDU/interviewee taking into context the environment—country, health sector, and imminent service delivery challenges. Questionnaires could differ by the type and levels of the SDUs selected in the sample—like interview with the central health ministry office in relation to an interview of a doctor working in a primary health center (PHC). All questions will need to be covered by the sample (selected to ensure complete information about the service delivery constrains to help unpack them during the analysis. Steps 2 and 4 will jointly allow the review team to identify the bottlenecks in PFM systems which affect effective and efficient service delivery.

Step 5: Identify possible root causes of the bottlenecks

- This concerns PFM bottlenecks which affect and impede service delivery as well as other issues of effectiveness and efficiency associated with PFM systems in the health sector.

Step 6: Conduct additional interviews with relevant officials

- The purpose is to track down the causes of challenges identified by providers and identify possible solutions, while at the same time filling the gaps in information identified through the review of recent studies. Interviews should be planned and data collected along the causal chain. Institutions to be interviewed will be based on the analysis in step 5. After collecting the additional information, fishbone diagrams (see Figure 10 for an example) should be used for a simplified presentation of tracing root causes of the bottlenecks.

Step 7: Draft the review report

- The report will be drafted in accordance with the structure proposed in Chapter 11 and the related guidance. Discuss the content of the draft report with various key stakeholders; review feedback, including from peer reviewers; and revise the report accordingly.

Step 8: Review the analysis and draft an action plan

- The action plan should consider the relative importance of the issues and challenges identified and possible practicality and sequencing of the solutions and/or interventions identified. The draft action plan will be finalized after discussions with all stakeholders.

Chapter 9 Institutional Coverage of the Diagnostic Review

125. **To provide a thorough understanding of how PFM affects health service delivery, all financial flows of funds and inputs in-kind for the benefit of health service delivery need to be considered during the review**, provided that these flows take place as part of public sector operations. This means that the flows to consider are those under the direct or indirect control of the government, whether at national/central or SNG level.

126. **Many institutions of very different nature are likely to be involved in the processes**, so it is important to consider the types of institutions the review may have to cover. The most important types of institutions are discussed here with suggestions to their inclusion.

127. **SDUs**—also referred to as health service providers—are at the center of the review as their delivery of services is what PFM systems are supposed to support. The SDUs at all levels should be covered, as long as they are under the control of the public sector. It may be necessary to interview private service providers in countries which mainly rely on the private sector to provide health services paid for by public funds, as it would otherwise be impossible to gauge the impact of flow of public funds on service delivery. Some SDUs may be managed by other government sectors than health—for example, military hospitals—and should be covered if they are open to the general public. As the number of SDUs in a country could be very large, it will be necessary to identify an appropriate sample of entities to visit and interview—the number of entities will depend on the size of the country and the different types of service providers, but a minimum of 20 entities should be surveyed to ensure that determination of bottlenecks from the service provider perspective is robust.

128. **MOH or equivalent**—the MOH and its departments are central to covering the macro and many meso level issues of the review. The review would cover deconcentrated offices operated by the MOH at regional or district level, which are separate from health offices under SNG, see paragraph 126, and those deconcentrated institutions would be covered by the review.

129. **Central finance agencies**—will typically include the MOF and its various departments some of which may have semiautonomous status such as an Accountant General's Department, a Procurement Authority, and a Revenue Authority. Also included in this category is a ministry or department of national planning (sometimes incorporated into the MOF), a ministry or department of human resources or personnel management, and an SAI. All of these institutions manage PFM systems that apply across all sectors including health. Interviewing a Revenue Authority or Department may only be relevant in case of issues with collection of revenue which is earmarked for the health sector—for example, mandatory contributions to a health insurance scheme, or a 'sin' tax earmarked for the sector.

130. **SNG—**central finance agencies, health departments, and other institutions may exist not only at the national or central government level but also at the SNG level. The existence and

importance of such institutions at the SNG level will depend on the structure of government in the country and thus on the degree of autonomy and resource generating capacity of the SNG. In some cases, there will be more than one SNG tier, as in large federal nations. The role of the SNG in provision of health services and contributions to health finance will determine to which extent the SNG should be included in the institutional coverage of the review.

131. **EBF and public corporations—**(sometimes referred to as state-owned enterprises)—EBFs and public corporations may play important roles in the flow of funds and materials for example, in terms of a national health insurance fund, or a national department for supply of pharmaceuticals and medical supplies. The SDUs—particularly national hospitals—may also operate as EBFs or public corporations. The institutions would all be under the government's control but may operate outside the government budget management processes with varying degrees of autonomy and own financing. General PFM systems do not always apply to them, as they may have different rules defined as part of their establishing legislation. While it may be relevant to interview medical training, research, and health sector regulatory institutions, it is considered beyond the scope of the diagnostic review to cover manufacturing public corporations which specialize in medical supplies.

132. **Development partners**—may have to be covered to the extent they provide financial support or in-kind supply of goods and services which are earmarked for the health sector, whether directly to public sector SDUs or through central government or SNG entities. One of the PFM functions covers integration of earmarked funding for health in the government's PFM systems. Budget support should not be covered as this method of support provides funding which—on receipt by the government—is no different from general tax revenue and by definition not earmarked.

133. **Private sector institutions**—in general, it is not envisaged that the review would cover private sector institutions, which includes for-profit businesses (notably providers of health services and supplies), NGOs, and other civil society organizations. There could be exceptions, however, such as private health service providers (as mentioned earlier), and useful information could be obtained from civil society organizations that focus specifically on issues of health service and financing.

Chapter 10 Structure of the Review Report

134. The proposed structure of the diagnostic review report is shown in Annex 3. Guidance notes to the content of each section are given below.

Section 1. EXECUTIVE SUMMARY

135. The summary needs to be concise and to the point within a maximum length of about three pages. It shall in particular draw on the conclusions about main PFM weaknesses affecting service delivery and the related policy recommendations according to Chapter 5.

Section 2. INTRODUCTION

136. The methodology should explain the list of recent studies identified and used for the review, the sampling of health service providers covered by the service provider survey, and the method of undertaking the survey, as well as the degree of response to the survey. The methodology should also explain the range of follow-up interviews undertaken with key stakeholders (listing the institutions covered and persons met in an annex).

Section 3. COUNTRY BACKGROUND INFORMATION

137. This section provides a description of the country situation with regard to the economic, social, and political context of the country and a description of the health sector and PFM systems. This part is purely descriptive and sets the stage for the systems review, analysis, and recommendations to be made in the other parts of the structure.

138. **Subsection 3.1 - 'Economic, Social, and Political Country Situation'** would describe the geographical country characteristics, population size, income level, public finances at the aggregate level, health status and disease prevalence, as well as climatic and political risks.

139. **Subsection 3.2 - 'The Health Sector'** should include description of the following:

- **Health Sector Goals, Priorities, and Service Delivery Approach** including details on goals and time-bound targets for health outcomes, health service outputs, disease control priorities, quality targets and benchmarks, and monitoring of quality of care.

- **Legal and Regulatory Arrangements of the Health Sector** with details such as what documents define the legal, statutory, or regulatory framework of health sector and what is legal framework for fiscal autonomy at decentralized levels relevant to the sector.

- **Institutional Arrangements of Health** details issues as follows: how is the health sector/department structured in the country? Is health administration and service

delivery decentralized? What are the layers of government, relationships, and oversight arrangements that exist in the health sector? What is the distribution of hospitals and PHC facilities in the country? Are health facilities within an acceptable radius of residents (using WHO standards) and not a barrier to services access? Are health SDUs outside the core government? To what extent are hospitals autonomous fiscally? To what extent do they receive subventions from the government? To what extent are supplies of drugs and medical supplies controlled by the government?

- **Health Financing and Pooling Arrangements** with details on the following: What are the main revenue resources and amounts for the sector (for example, use a table as in Annex 4)? How are they generated and collected? What is the trend of revenues over the past three years? Are all revenues held in one fund or are there multiple fund accounts (for example, revenue accounts, borrowed resources, extra-budgetary mechanisms such as National Health Insurance or sickness funds, donor-held accounts, contingency funds, and special funds)? What percentage of health care cost is OOP? How does this compare with the global standards? What proportion of the population forgoes services for financial reasons? What percentage of the population fall into poverty due to OOP? What proportion of the population is covered by health insurance or prepayment system? What are the current pooling arrangements (number, fund size, and benefits)? Are there cross-funding mechanisms across the pools or transfers from the government? What are the systems for purchasing health services in terms of purchasing entities, provider payment methods and provider selectivity etc. Include a flow of health funds diagram, according to Figure 9 in Part B.

- **Trends in Health Sector Resource Provision and Expenditure** with details on the following: What share of the central government budget is allocated to the health sector? What share of health spending is allocated to human resources, operational supplies, and capital expenditure, respectively? What are the existing purchasing arrangements?

- **Health Sector Reforms, Ongoing and Planned,** including the following: Are any alternatives to building new facilities to increase service coverage being considered? Are there any interventions in place to reduce OOP (medical and non-medical payments)?

140. **Subsection 3.3 - The National PFM system** would describe the following:

- **Legal and Regulatory Provisions for PFM:** What documents define the legal, statutory, or regulatory framework of PFM, including at the decentralized SNG level?

- **Institutional Arrangements for PFM:** What are the roles, responsibilities, and relative power of different actors in the budget execution process? Are there adequate numbers of staff with the requisite experience and qualifications to perform accounting functions? How about the availability of staff at decentralized locations? Is staff subject to a code of ethics? Include a description of the institutional and functional coverage of the FMIS, if any.

- **PFM Reforms, Ongoing and Planned:** Is there a comprehensive reform plan or a set of individual reforms ongoing or planned? Are there pending reforms to enlarge tax base or/and improve revenue collection? How is it expected to translate into

additional revenues? What PFM systems are receiving priority in the reform planning?

141. **Some of the data mentioned under Subsections 3.2 and 3.3 may be of particular relevance and importance to the review of a specific PFM function.** In that case, the review team should consider whether the data are more important for general overview of the country situation (and be presented in Section 3) or as evidence for conclusions on the performance of the PFM function (and be presented in Section 4).

Section 4. REVIEW OF PFM FUNCTIONS AFFECTING HEALTH SERVICE DELIVERY

142. **Review of the effectiveness and efficiency of PFM functions and related input functions as they relate to the health sector across all relevant institutions that contribute to service delivery, see institutional coverage in Chapter 9.** The review is focused on the 24 PFM or PFM-related functions. For each function, a set of essential questions are specified. These questions should, in principle, be answered for the SDUs covered by the review, whereas for other institutions only some of the functions and questions are relevant depending on the roles/mandates of those institutions and the kind of PFM bottleneck which the institution may contribute to. Overall, this section attempts to arrive at conclusions to five main PFM issues:

- Do PFM systems ensure that health financing resources reach the SDUs and other relevant spending units in the amounts planned (through budget releases, transfers, and purchasing operations, considering overhead cost at various organizational tiers)?

- Do PFM systems enable the SDUs and other spending units to use the resources effectively and efficiently for provision of quality services (timeliness, flexibility, and adequacy of spending/control procedures)?

- Is the use of funds accounted for in a comprehensive, timely, and transparent manner that promotes health priorities and spending efficiency (accounting systems, reporting, internal and external oversight, and public access to information)?

- Are the resources that are needed for planned health service delivery targets comprehensively and realistically costed, and are the sources of funding comprehensively and realistically estimated?

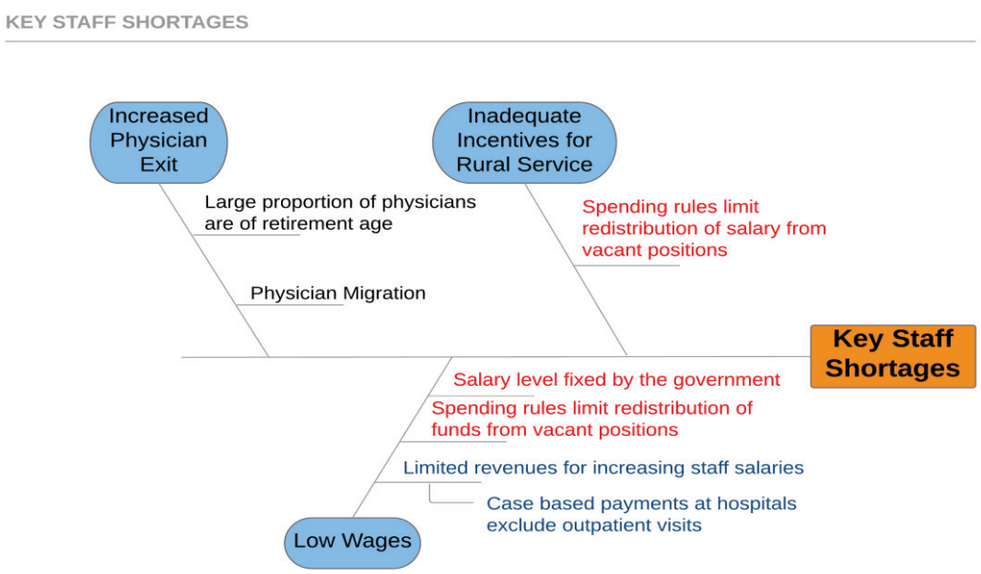
- Do PFM systems facilitate mobilizing health financing resources as planned (budgeted, collected, allocated, and reported)?

143. The review makes use of information from recently completed studies, service provider surveys, and follow-up interviews with key stakeholders within the institutional coverage.

144. **The analysis will lead to the construction of 'fish bone' diagrams which illustrate the links between supply-side challenges and root causes in PFM systems.**[11] An example of such a diagram is shown in Figure 10. The figures may be accompanied by analysis tables (see example in Annex 5) which allow a more detailed description of the identified constraints and causes than can usefully be inserted in a diagram.

145. **As the aim is to identify bottlenecks in the PFM systems and their root causes, the narrative and presentation of evidence may be kept brief for PFM functions that perform well.** However, review teams need to provide sufficient information under each function to demonstrate that the function has been adequately analyzed and to justify the conclusion that there are no significant issues, for example, based on the opinions expressed by the SDU management and other informants or documentary sources.

Figure 10: 'Fish Bone' Diagram Linking Health Service Supply-side Challenges to PFM Bottlenecks



Section 5. IMPACT OF PFM FUNCTIONS ON SERVICE DELIVERY AND POLICY RECOMMENDATIONS

146. By drawing on the information in Section 3 and the analysis in Section 4 of the review, the chapter discusses which of the PFM systems' weaknesses have the most profound impact on

- Physical access to service;
- Affordability of service;

[11] The fishbone (Ishikawa or cause and effect) diagram was developed by Kaoru Ishikawa in 1968 and has been widely used as a problem analysis framework and tool in quality management, quality control, and manufacturing. It has also been used in evaluations of the quality of health care, medical errors, and patient safety in health care institutions. More recently, the Ishikawa diagram has been used to analyze health system factors contributing to bottlenecks in the delivery of certain maternal health services. The fishbone diagram visually maps out the major underlying factors that contribute to a particular problem or outcome. The Fishbone Framework has been used in health systems research to identify such causal chains for a variety of service delivery constraints. In the Toolkit, the fishbone diagram is useful in identifying specific health financing and PFM issues that serve as contributory factors to important causes of health service delivery bottlenecks.

- Quality of service,
- Efficient use of health financing resources; and
- Accountability for service results.

147. **The aim is to identify the three to five most important PFM systems weaknesses which lead to service supply challenges and which will be technically and politically feasible to improve or reform in the short to medium term,** considering the existing implementation capacities or possible outside support. Feasibility of the reforms should in particular be considered in view of the following:

- To what extent the reform would be under full control of the health sector?
- Whether the reforms are foreseen in the ongoing, planned, and likely reforms of the health sector and PFM systems as described in Subsections 3.2.6 and 3.3.3?
- To what extent the MOF otherwise expresses interest in working with the health sector to implement the proposed policy recommendations?

148. The section will include a sense of how implementation of the recommendations will be sequenced or prioritized given the country context. In addition to the 3–5 priority issues to address, reforms may be proposed to address other PFM weaknesses of some—but less—importance. However, such additional reforms should be presented in a way that does not detract attention from the priority reforms a health ministry should seek to implement.

149. **Review teams need to be careful if they present recommendations for additional resources for the health sector.** Such recommendations may not be easy to push forward on the basis of a study based on the FinHealth Toolkit, unless the team has (a) made recommendations which will generate fiscal space for potential reallocation to areas within the sector of serious resource need or (b) identified specific gaps in the resource mobilization and allocation processes, for example, discrepancies between service targets and funding, or between budgeted resources for health and actual resources made available for spending. General calls for additional resources to health can be effectively addressed only by a process where the competing demands from all sectors are considered on equal terms, notably through the political allocation process in connection with the annual and medium-term budget negotiations, or through an overhaul of the health financing system. Such processes are not catered for in the Toolkit.

150. **The complexity of a reform is a main determinant of the effort and time frame required for successful design and implementation.** Reform complexity is largely a function of the reform's dependence on other preexisting and well-functioning PFM functions (the technical sequencing issue) and on the number and political power of stakeholders that need to be involved in and support the reform (the political economy). Effort and time frame also depend on the preexisting capacity to design and implement reforms. Such capacity is usually a function of the size and economic level of development of a country as well as the external support the country may be able to obtain. A few examples of typical reform recommendations are discussed in Annex 6 to highlight some of the issues that should be considered before a team proposes a recommendation and its sequencing.

PART C
TECHNICAL CONTENT OF THE DIAGNOSTIC REVIEW

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Chapter 11 How Do PFM Processes Affect Service Delivery?

151. **This chapter describes the 24 functions of the PFM system which the diagnostic review should cover in most cases.** These functions are listed in Figure 9 of Chapter 7. However, some functions may not be relevant in a particular country. Relevance will be determined partly by the organizational arrangements of the health sector (types of institutions involved) and the magnitude of funds flowing through each type of institution and partly by the initial findings from the review of existing/recent studies of the health sector in the country as well as interviews with SDUs.

152. **The PFM system functions are arranged according to the three stages of the budget cycle and their main components,** as illustrated in Figure 7 and the right-hand column of Figure 9. For each function, a table is provided with suggestions as to what questions to ask and whom to interview in the field. The format of the table is shown below with explanatory notes regarding each table field.

Function H [xx: title of function]
KEY DIAGNOSTIC QUESTIONS • [These questions should help conclude if this element of the PFM system is functioning appropriately or has a bottleneck that might affect service delivery. *These questions need to be understood and applied during the assessment with a service delivery bent of mind, and not necessarily from a supply/control side, to unpack the constraints/ issues which affect service delivery and find ways of addressing them.*]
BACKGROUND INFORMATION • [These questions should help in determining the coverage and importance of the sector institutions involved—for example, in terms of flow of funds. This may assist the review team in judging the relative importance of various bottlenecks.]
QUANTITATIVE DATA • [These data consist mainly of amounts, frequencies, classifications, dates, and time for which clear evidence should be available. While qualitative data will be equally important, quantitative data are usually easier to verify and thus more reliable.]
FIELD SOURCES OF INFORMATION • [Sources here are suggestions only. The list will not be exhaustive, and some sources may not be relevant in a particular country. Existing literature, studies, and so on are not included. However, a footnote is inserted where a function has an equivalent PEFA performance indicator, as relevant information from PEFA assessments is available for many countries. PEFA guidance on the function may also be useful to refer to.]

Budget Formulation

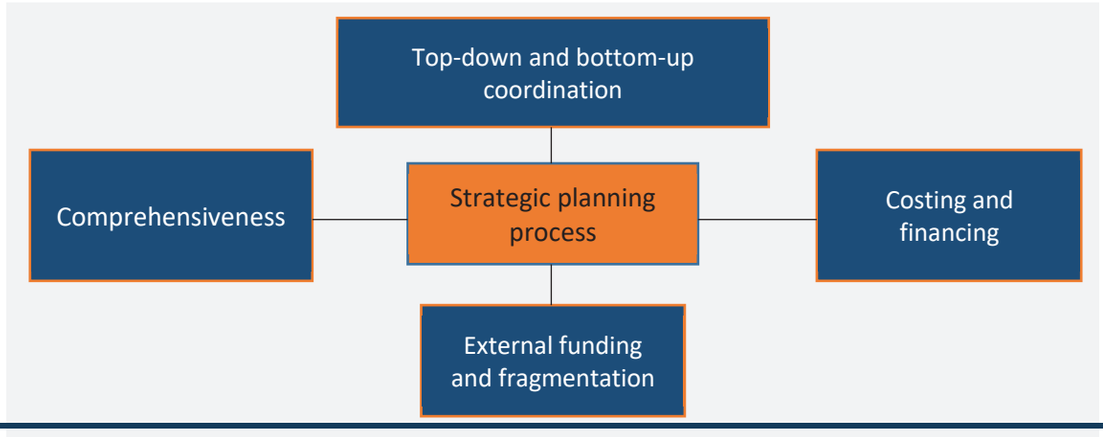
10.1 Strategic Planning

153. **The planning and budgeting functions of PFM systems are instrumental in ensuring adequate resources for the sector in line with political priorities and desired health results.** Health spending priorities should result from a health sector strategic plan and be reflected in multiyear budget planning that provides a realistic overview of the resources allocated to the health sector. It is a common weakness of strategic budgeting in many countries where national and sector plans or development strategies do not exist or, where they do exist, they represent unconstrained wish lists that are unhelpful in guiding budget decisions.

Function H1. Sector planning coordination

154. **The health sector's strategic planning process is the starting point for bringing together the issues of health results, organization of the sector, service delivery goals, resource mobilization, and resource utilization in terms of physical resources required.** The sector strategy would have a medium- to long-term horizon. While strategic planning can be considered a macro-level issue, it has profound implications for service delivery challenges at the SDU level in guiding the way SDUs are arranged as well as the service delivery targets and the resources that will be available to deliver on those targets.

Figure 11: Issues in Strategic Sector Planning



155. **For the sector strategic plan to be realistic and implementable, the planning process should combine a bottom-up and a top-down approach.** The plan should consider the needs identified at the SDU while the main priorities have to be determined at the national level in view of overall constraints on resource availability. Two-way communication between all stakeholders in the sector is therefore required.

Function H1. Sector planning coordination
KEY DIAGNOSTIC QUESTIONS • To what extent does the country have a comprehensive, unified, and up-to-date health sector plan covering at least the coming three years? • What are the systems for coordination and alignment between the MOH, EBFs, public corporations, SNG, and SDUs on medium-term and annual planning and implementation monitoring? Do all entities have multi-annual plans aligned with the national plan?

Function H1. Sector planning coordination
• Are senior management decisions, strategies, and plans disseminated/communicated to departmental and SDU staff? • Is there any established practice in the facilities that allows medical staff (doctors, nurses, and so on) to discuss priorities for facility development and share their needs and visions on the matter with managers and planners at higher-level institutions in the sector? • Are there programs and/or activities that cover two or more ministries (including health)? If yes, how are they coordinated?
BACKGROUND INFORMATION • Which organizational units are in charge of national planning and of health sector planning? • What EBFs and public corporations operate as part of the health sector? • What are their respective roles and annual turnover?
QUANTITATIVE DATA • Not applicable
FIELD SOURCES OF INFORMATION • Ministry of National Planning, MOH Planning Department, SNGs, SDUs, EBFs, and public corporations

Function H2. Sector plan costing and financing

156. **Implementation of the strategic plan is also dependent on all planned activities and investments being fully and realistically costed and accompanied by a realistic financing plan.** Costing needs to include all recurrent costs of the sector, including administrative costs, and be based on historic unit costs for various items and realistic projections taking into account inflation and planned public service pay developments. The health financing plan should consider all health financing schemes (that is, revenue sources) and set out how and at what administrative level funds are supposed to be pooled, including any cofinancing arrangements (for example, user fees and deductibles). The health financing component of the strategic plan has to tally with the existing health financing status (see the overview of the sources of financing and their relative importance as developed by the team on the basis of Annex 4) and align with the medium-term budget/expenditure framework (see review of Function H7. below). Minor difference between sector plans for financing and Medium-Term Budget Framework (MTBF)/Medium-Term Expenditure Framework (MTEF) estimates should be expected as comprehensive sector plans are often updated only every five years, whereas MTBF/MTEF estimates should be updated annually. The sector plan financing component and the related financial information mentioned will provide a picture of the degree of fragmentation of resources for the sector.

Function H2. Sector plan costing and financing[12]
KEY DIAGNOSTIC QUESTIONS • Is the sector plan fully costed and corresponding funding identified for all the services rendered by the sector? • Is the plan realistic and internally and externally coherent? What has been the performance against the plan so far?
BACKGROUND INFORMATION • Overview of health sector status as developed by the review team (see step 3 of the review process)
QUANTITATIVE DATA • Total recurrent and capital costs of the strategic plan for each year covered • Composition of financing of the plan for each year covered

[12] Corresponding PFA 2016 indicator PI-16.3.

Function H2. Sector plan costing and financing[12]
• Current actual composition of health sector financing • National budget allocation to health foreseen in the current MTBF or MTEF for corresponding years
FIELD SOURCES OF INFORMATION • Health sector strategic plan and most recent MTBF/MTEF documentation

Function H3. External funding of the sector

157. **Fragmentation in the health sector is in particular complicated by the introduction of parallel arrangements for implementing development assistance in most countries.** Development partners often cite weak fiduciary capacity as one of the bases for ring-fencing the implementation of their projects through arrangements such as project implementation units (PIUs) or the use of fiduciary agents, United Nations (UN) agencies, or NGOs. These arrangements are usually not aligned with the country's systems, nor are they harmonized among development partners. As a result, they can lead to considerable fragmentation at the implementation level, in direct conflict with the UHC2030[13] (former IHP+) principles that call for alignment and harmonization of health support at the country level.

158. **As a consequence of development-linked fragmentation, there may be coordination problems and duplication of PFM systems across all stages of planning and budget management.** There are countries where several audit reports are prepared by different development partners for their projects, separate accounting software is implemented to account for the use of resources, separate accounting procedures are used, and separate accounting and internal audit staff are used to ensure that project funds are used for intended purposes. Providers targeted for support by development partners are also subject to such arrangements when introduced. In some cases, such as in fragile and conflict-affected (FCA) states, the use of such arrangements is needed to help deliver programs, especially in the initial stages of state- and peace-building efforts. However, in most other cases, development partners need to at least harmonize their approaches with one another, assuming the country systems are weak. This will help improve the transparency of funding, for example, through joint audits, minimize double dipping, improve accountability for the use of resources, and minimize transaction costs. The review should highlight the implications of fragmentation on all relevant PFM functions when considering each function below.

Function H3. External funding of the sector
KEY DIAGNOSTIC QUESTIONS • To what extent are health sector interventions/projects financed by development partners aligned with (or directly based on) the government's health sector strategy/plan? • Are health funding by development partners reflected in the budget document (proposed and approved budget as well as budget execution reports)? • To what extent is there duplication or complementarity of development partners' health sector funding (even if under different project names)? • Are estimates of the value of in-kind support included in the strategic plan and budget documents? • To what extent are national/government PFM systems used for health sector interventions/projects financed by development partners (with regard to budget classification, budget preparation/approval, deposit in government bank accounts, release of funds to spending entities, procurement, reporting,

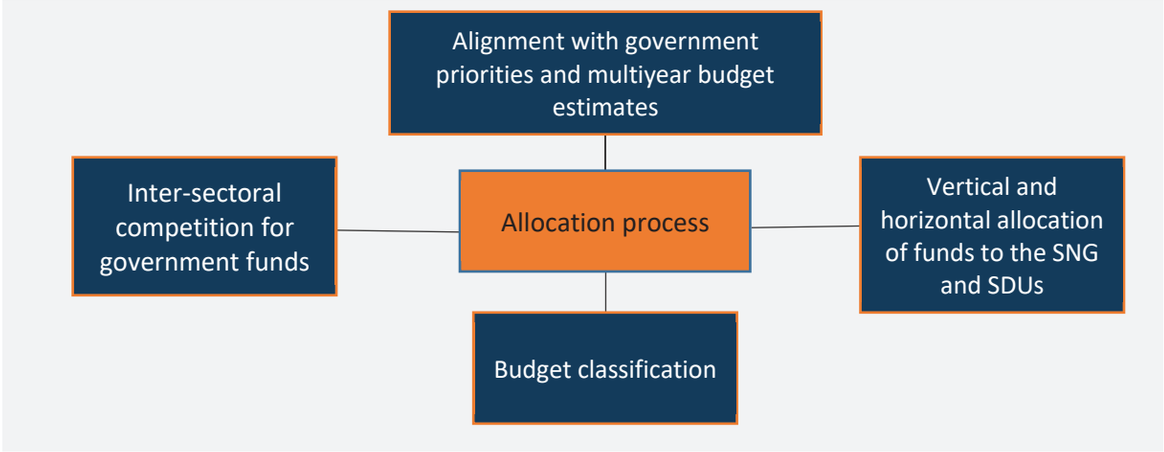
[13] In 2016, IHP+ was transformed into UHC2030 to respond to the health-related SDGs. UHC2030 expanded the scope to include health systems strengthening to achieve UHC.

Function H3. External funding of the sector
and auditing)?
BACKGROUND INFORMATION • What is the amount and nature of development partner support to the health sector? • Which development partners are providing this support? • What share of the budget is made up of development partner funding? • How much of the support is provided in-kind? • What are the policies and procedures that govern the flow of funds between development partner sources and health sector schemes? • How do the MOF and MOH prepare estimates for development partner-funded support to health?
QUANTITATIVE DATA • Development partner funding by agency and by government recipient institution.
FIELD SOURCES OF INFORMATION • The MOF, MOH, and development partners

10.2 Budget Preparation

159. **Government allocations to the health sector are linked to the PFM process and health financing arrangements.** When health services are directly provided by governments using salaried staff, resources are generally allocated according to the existing PFM processes resulting from the country's applicable regulations including on staff salaries, payroll management, and procurement. When health services are purchased from providers, however, the allocation process of resources to providers may depend on separate spending rules resulting from the specific arrangement between providers and purchasers. Strategic purchasing is discussed in detail in Chapter 5.3 and covered under PFM Function H13 below. The following focuses on the PFM process of allocating resources from the general national budget. Those processes may not cover earmarked financing instruments from which the resources are not managed through the national Treasury, for example, SHI managed by an autonomous agency or development partner funded health sector projects. Figure 10 illustrates four typical issues in the budget allocation process for the health sector (see also Chapter 5.1 section on Increasing the health budget allocation through reprioritization). Each of these issues is then discussed, followed by a proposed set of relevant questions to ask to conclude whether PFM systems and their application facilitate the resolution of those issues or alternatively give rise to bottlenecks for the health sector.

Figure 12: Issues in Budget Allocation



Function H4. Annual budget preparation process

160. **The budget preparation and elaboration process is essential for an effective allocation mechanism.** Government priorities should be adequately communicated to line ministries to guide budget preparation, and these priorities should be fully reflected in the annual appropriations allocated to the health sector. Although budget preparation is largely guided by the government's policy priorities, the process must be informed on the actual needs as revealed through a bottom-up review. While this is the ideal situation, macro-fiscal conditions set limitations on the overall resource envelope for allocation to the sectors. The MOF will therefore typically issue expenditure ceilings to each sector or line ministry within which the sector will have to plan its resource use. Often those ceilings are broken down into subceilings for salaries, capital investment, and other expenditures due to macro-fiscal policies. This further imposes rigidity on the health sector in deciding its resource use. The tension between priorities, local estimates of resource needs, and available budgetary resources then has to be resolved during the budget negotiation process.

161. **A well-prepared budget proposal, which is supported by evidence and accompanied by a detailed operational plan, is key to making the case for increased budgetary allocations.** In most jurisdictions, the MOF determines the health sector allocation in the national budget, taking into account competing priorities from all sectors of the economy. The budget negotiation process offers an opportunity for all sectors, including health, to make a case for increased allocation. The budget ceilings provided by MOF to spending entities or sectors should reflect their needs as negotiated through the budget negotiation process; however, like other ministries, the health ministry's expectations are not usually met by the budget ceiling. In addition, ceilings are sometimes unreliable and subject to several downward revisions before the budget document is finalized, a situation that does not bode well for planning. Decisions at the health ministry, leading to the allocation of resources to the health sector, need to be clear and logical to receive the requisite support from the MOF. Poorly supported budget proposals will weaken the case for extra resources.

162. **It is important that the roles of all participants in this budget preparation process are clearly defined and that each entity involved has sufficient time available to thoroughly prepare its contributions.** Legislation will typically define the roles and responsibilities, and an annual or generic budget preparation calendar should be available from the onset of the process with clear deadlines for each stage of the process.

Function H4. Annual budget preparation process[14]
KEY DIAGNOSTIC QUESTIONS • Does the annual budget calendar specify roles and contributions to the annual budget preparation process by all budget entities (MOH departments, SNGs, and SDUs)? • Is the calendar followed and giving enough time for each entity to fulfill its role? • Are budget circulars sufficiently comprehensive and clear for each entity to correctly complete its contributions to the overall process and its own budget? • Are annual budget ceilings issued, and what is the degree of breakdown/detail? • To what extent do they allow flexible use of funds within the ceilings and additional expenditure proposals?

[14] Corresponding PEFA 2016 indicator: PI-17 Budget preparation process.

Function H4. Annual budget preparation process[14]
• Are budget entities required to submit annual operational plans as part of their budget proposals—do they comply? And do they reflect realistic service delivery needs at program/activity levels? • Do SDUs prepare individual operational plans and budgets? If so, what information is given to SDUs in terms of results, output targets, and expenditure ceilings on which to base their planning? If not, how are plans and budgets established for each SDU? • How are SDU plans and budgets aggregated into plans and budgets for the health sector and its budget votes? Does the SDU consider alternate funding scenarios for determining relative priority needs ? • What feedback do budget entities receive after submission of the initial proposals to the MOF? What feedback do SDUs get from their overseeing LGA or MOH department? • When do entities receive final confirmation of the expenditure budgets for the year? • For the past three years, has the actual approved budget usually fallen above or below the ceiling? If so by what amount or percentage? How is any difference at the sector level passed on to SDUs? • What is the process and contribution from health sector institutions to in-year budget revisions?
BACKGROUND INFORMATION • Is the budget unified (for example, recurrent and capital or development budgets for health developed separately, by different ministries)? • Who consolidates the various health sector budgets and at what level?
QUANTITATIVE DATA • Dates/deadlines for each stage and participant of the budget preparation process • Initial ceilings issues to the health sector compared to the final approved budget allocations
FIELD SOURCES OF INFORMATION • The MOF, MOH, SNGs, and SDUs

Function H5. Budget classification

163. **Budget structure and classification determine whether expenditure can be linked with services delivered.** Classification systems used are shown in Figure 13. There are several different types of budgeting typically used by the MOHs depending on the classifications used to structure and control the budget.

Figure 13: Main Types of Budget Classification and Their Application in Health

Budget Classification	Application in Health
Economic	Classifies expenditure by economic categories (for example, salaries, goods, and services). To be consistent with the Government Finance Statistics Manual (GFSM) 2001 economic classification. Economic classifications are often associated with inputs-based or line-item budgets.
Administrative	Classifies expenditures by administrative entities (for example, agencies and health facilities) responsible for budget management
Functional	Categorizes expenditures by sector (for example, health and education). Within each sector, sub-functions of expenditure (for example, outpatient services and public health services) are further divided into classes (for example, outpatient services include general medical services, specialized medical services, dental services, and paramedical services). Categories have been predefined internationally for comparison.
Program	Classifies and groups expenditure by policy objectives or outputs for the sector (for example, maternal health, primary health care, and quality of care), irrespective of their economic nature. Unlike other classifications, it is meant to be country-specific. Activity-based classification (for example, provision of supplementary food) has also been introduced in some countries before—or supplementary to—larger budgetary programs, as an effort to group expenditure into coherent policy actions.

164. **Input-based allocation limits flexibility during budget execution and may make it harder for providers to adapt to changing health needs.** Input-based allocation is based on line items in the economic classification. This is the most common type of budgeting used in the health sector (also known as line-item budgeting), in which the budget is organized by type of expenditures, that is, wages, medicines and consumables, utilities, equipment, maintenance of facilities, and so on. Under line-item budgeting, a specific amount is allocated for a specific set of inputs. While line-item budgeting allows for detailed accountability and control, it does not allow for prioritization or flexibility in spending based on sectoral priorities or emerging needs. Health sector budgeting needs to be more flexible than many other sectors' budgeting. In other sectors, realistic forecasts can typically more easily be made based on assumptions that are more predictable. In the health sector, one must be prepared for major unexpected challenges such as an outbreak of a disease or a natural calamity that in turn triggers disease, and all of these point to the need for flexibility in the health sector budget. Furthermore, due to the rigidity inherent in line-item budgeting, this method of budgeting can become a hurdle, particularly for the health sector, when countries want to shift toward strategic purchasing, which requires flexible payment mechanisms.

165. **Another form of budgeting is Program Based Budgeting [15](PBB) , which links resources to specific programs.** PBB places an emphasis on results or outputs, thereby making the budget more oriented toward performance. Under PBB, it is easier to demonstrate value for money; since spending is linked with outputs, line ministries can show what has been achieved for every dollar spent. The performance review at the end of the budget cycle allows decision makers to allocate resources more effectively, based on the lessons learned from the previous fiscal year (known as performance-informed budgeting). In principle, program managers are supposed to have a high degree of flexibility in the use of resources allocated to the program to be held accountable for the results or outputs rather than for adherence to the budget for each line item. However, one should be aware that some countries have introduced PBB while simultaneously maintaining line-item budgeting and use the latter or both budget classifications for control purposes, which makes budget preparation and execution even more rigid than under pure line-item budgeting.

166. **However, PBB requires strengthened monitoring and governance arrangements.** It needs to be based on reliable forecasts to enhance the realism of budget allocation to the health sector. It also requires targets and indicators that are aligned with government priorities and improved reporting and monitoring systems. If it is not implemented properly, PBB can reduce transparency due to figures being too highly aggregated (for example, an economic classification that does not identify the different categories of expenditures) and due to a lack of appropriate information systems offering adequate detail. Likewise, while input-based budgets usually fit in fully with existing accounting and budget monitoring systems, moving to PBB requires significant changes in the financial control of the budget and execution of spending. If this is not properly done, it can lead to even more rigidity in

[15] also known as Program Budgeting or Output based budgeting

budget execution. For instance, some countries have introduced program-based allocation and control without increasing flexibility in input-based budget controls with the result that budgets have become even less flexible.

167. **PBB may lead to conflicts with budget allocation and control according to administrative classification.** All budgets must be allocated to an entity, whose manager must be responsible for the planning and use of resources available. If programs are not designed to align with administrative structures (such as MDAs), there is a potential conflict between managers of administrative units and program managers. While this may be relatively easy to avoid within one tier of the government, it becomes more complicated when autonomous SNG authorities are expected to be responsible for implementing major parts of national health programs.

168. **SDUs face additional administrative burdens if they receive funds from different sources which use different budget classification systems and COAs.** This is one of the problems with fragmentation. If budget allocations with different structure have to be reflected individually, it increases rigidity in the use of funds. COAs for financial reporting have to reflect the budget classification used for allocation, usually with some additional details. Keeping and reporting financial transactions with different subdivisions and coding for individual sources of funds leads to additional administrative work, often necessitating different accounting systems, and undermines consolidation of financial information.

Function H5. Budget classification[16]
KEY DIAGNOSTIC QUESTIONS • How are the health sector budgets classified for planning and control purposes? Does it help and aid service delivery? • Are budget classifications and COAs aligned across public institutions involved in the sector (central government, SNG, EBFs, and SDUs) and do they help in meeting the information required by the line managers/SDU heads who are responsible for service delivery? • What institutions constitute budget entities in the health sector? • Is program budgeting (or performance-based budgeting) used and aligned with the organization of the sector plan and with the structure of budget entities? If so, is each SDU covered by only one program? If by more than one program, how do SDUs obtain funding from the various programs and consolidate this into one plan and budget for the SDU? How is the accountability for achievement of results established? What is the learning for next year budget?
BACKGROUND INFORMATION • Budget classification, allocation, and control system as well as COA details for each source of funds available to SDUs
QUANTITATIVE DATA • n.a.
FIELD SOURCES OF INFORMATION • The MOF's Budget Department, MOH, SNG, EBFs, and SDUs

Function H6. Forecasting of earmarked revenue

169. **Just like budget allocations have to be well justified to be predictable, earmarked revenue which is transferred directly to the health sector has to be subjected to rigorous estimation process,** including firm and well-documented estimates of the impact of new or

[16] Corresponding PEFA 2016 indicator: PI-4 Budget classification.

changes to existing revenue measures such as sin taxes and user charges. For description of such types of earmarked revenue, see Chapter 5.1 section on 'Revenue earmarked for the health sector'. Often the proceeds from sin taxes are offset in general budget allocations, so poor (for example, overoptimistic) forecasting of such revenue can have a direct impact on the resources available for service delivery.

Function H6. Forecasting of earmarked revenue[17]
KEY DIAGNOSTIC QUESTIONS • Does the government prepare and document estimates of the fiscal impact of proposed changes to each earmarked health revenue measure for the budget year and the two following years? • Do SDUs prepare their own estimates of collection of OOP contributions for the coming budget year? If so, how are estimates consolidated?
BACKGROUND INFORMATION • Are any health insurance premiums collected by government institutions? At what rates and by whom are they collected? • What tax revenue measures are earmarked for the health sector, if any? • Who prepares budget estimates for the earmarked taxes? • How are they transferred from the collecting entity to the health sector? • How many and which type of SDU raise own revenue (through OOP payments for services and other income streams)? • What user charges are collected at SDUs?
QUANTITATIVE DATA • Amounts of earmarked taxes, SHI contributions, OOP payments, and other revenues for the health sector (see Annex 4)
FIELD SOURCES OF INFORMATION • The MOF, MOH, SDUs, and national revenue agency

Function H7. Medium-term perspective in expenditure budgeting

170. **Expenditure policy decisions have multiyear implications and should be aligned with the availability of resources with a medium-term perspective.** The resulting expenditure estimates must be consistent with the fiscal aggregates determined by the MOF, the projections of earmarked revenue (see H6 above), and ongoing expenditure policy requirements.

171. **The estimates for the outer years (following the upcoming budget year) in a medium-term budget are supposed to provide the basis for the future year's budget allocations at the ministry or sector level.** The medium-term budget estimates should be updated annually, building on the previous year's budget and estimates, through a process that is transparent and predictable. Expenditure policy proposals submitted to the government should be aligned with the policy objectives set out in approved and costed strategic plans (see H2 above).

172. **The preparation of medium-term estimates is intended to improve the predictability of budget allocations for sectors such as health (as well as strengthen fiscal discipline).** Medium-term estimates are usually disaggregated by high-level administrative, economic, and program or functional classification (see Function H5. above). The degree of breakdown determines whether the estimates constitute an MTBF which may show

[17] Corresponding PEFA 2016 indicator: PI-15.1 Fiscal impact of policy proposals.

allocations to sectors or line ministries with no or few further details, or a more detailed MTEF. The administrative classification should identify the relevant budget head of appropriation—for example, the ministry or department. To provide ministries and program managers with the flexibility to manage and respond to budgetary pressures within their expenditure ceilings, disaggregation by economic type may be limited to the main categories such as staff salaries, other recurrent charges, and capital investment, though sometimes, MTEFs are as detailed in breakdown as the annual budget estimates.

173. **As with the annual budget preparation process, multiyear expenditure estimates may be prepared under ceilings issued for each year to guide the estimates produced by the MOH and other budgetary entities in the sector.** This is to ensure that expenditure beyond the budget year is consistent with government fiscal policy and budgetary objectives. Such ceilings should be issued to ministries before the distribution of the first budget circular at the commencement of the annual budget preparation cycle.

174. **Predictability of resource availability is needed for firm multi-planning of activities and meeting expected health targets.** The MTBF/MTEF is supposed to be updated annually to reflect changing circumstances, both in terms of overall resource availability and sector challenges and priorities. It is therefore important for the planning in the health sector that the expenditure estimates in the last medium-term budget establish the basis for the current medium-term budget. This will be the case if variations in expenditure allocations between the corresponding years in each medium-term budget can be fully explained and quantified. If it is possible to reconcile and explain the differences, this shows that medium-term budgeting is operating as a dynamic process, with each subsequent budget building on its predecessor. It indicates that medium-term planning is embedded in the preparation of budgets and provides a means to strengthen fiscal discipline beyond a single year. It also enables the MOH to start early on the formulation of the next year's budget proposals, even before the annual MOF circular with budget ceilings has been received. Explanations of changes from the previous year's medium-term budget may include references to changes in macroeconomic conditions, revision of important variables and coefficients, and changes to government policy and expenditure priorities.

Function H7. Medium-term perspective in expenditure budgeting[18]
KEY DIAGNOSTIC QUESTIONS • Are estimates of expenditure for the sector prepared as part of the government's annual budgeting process covering at least the budget year and the two following years? • Do these multiyear estimates cover all entities in the sector? What are the contributions to the process by SNGs and SDUs? • Are the estimates prepared under the guidance of multiyear budget ceilings for the sector, and what is degree of breakdown? Are multiyear ceilings passed on to SDUs? • To what extent is multiyear budget preparation determined by program/results-based considerations (nature and numerical share of expenditure)? • Are the ceilings aligned with the expenditure policy proposals and cost estimates of the sector plan? • To which extent do budget documents explain changes to estimates from the second year of the last medium-term budget and the first year of the current medium-term budget?
BACKGROUND INFORMATION • Description of the medium-term expenditure documentation in terms of institutional coverage, degree

[18] Corresponding PEFA 2016 indicator: PI-16 Medium-term perspective in expenditure budgeting.

Function H7. Medium-term perspective in expenditure budgeting[18]
of expenditure details, output targets, and health results • What is the format of the medium-term expenditure documentation (integrated part of budget submission to the legislature or freestanding document)? • When during the annual budget cycle and by whom is the MTBF/MTEF approved?
QUANTITATIVE DATA • Deviations in health expenditure for the same budget years between the current and the previous MTBF/MTEF estimates
FIELD SOURCES OF INFORMATION • The MOH, MOF, SNGs, and SDUs

Function H8. Transfers to subnational governments

175. **An adequate allocation formula is essential to make sure that resources flow to the appropriate targets.** Targeting must be of different kinds. Geographic targeting aims at reducing disparities between regions. The allocation formula might also give priority to one level of care over others to better balance the resources benefiting each level of care. Finally, allocation might be targeted toward specific health outputs to meet the population's needs. The allocation function is often based on norms or ratios, for instance, to pay for staffing according to certain staffing norms, an approach with the advantage of being both simple and stable. However, norms and ratios alone might not consider the actual health needs of the population, resulting in disparities in health outputs or waste.

176. **The allocations of the budget going to deconcentrated administrative units (for example, regional administrations under the central government or directly to regional hospitals) or to the SNG responsible for health services (typically, primary health care) usually constitute the main resources available for public health care.** While the allocations to entities under the central government are treated as those to other central budget entities, the allocations to SNGs are meant to support the delivery of services by LGAs, which are not able to mobilize the resources for those services out of their own revenue means. It is therefore essential that transparent, rules-based systems are applied to budgeting and the actual allocation of such conditional (earmarked) and unconditional (block grant) transfers. Transfers to support the SNG's expenditure can be made in the form of unconditional grants, where their final use is determined by the SNGs through their budgets, or through conditional grants to SNGs to implement selected service delivery and expenditure responsibilities—for example, by function or program, typically in accordance with an agreed-upon regulatory or policy standard. The overall level of grants (that is, the vertical allocation) will usually be determined by policy decisions at the central government's discretion or as part of constitutional negotiation processes. Every fiscal transfer from the central government to the relevant SNGs should be considered. If different formulas or criteria are used for different elements of the transfer, the overall assessment may be made on a value-based weighted average.

Function H8. Transfers to subnational governments[19]
KEY DIAGNOSTIC QUESTIONS • Are there transparent and rules-based systems for allocating budget transfers and any inputs in-kind (in general and for health services specifically) among SNGs (both vertical and horizontal)?

[19] Corresponding PEFA 2016 indicator: PI-7 Transfers to subnational governments.

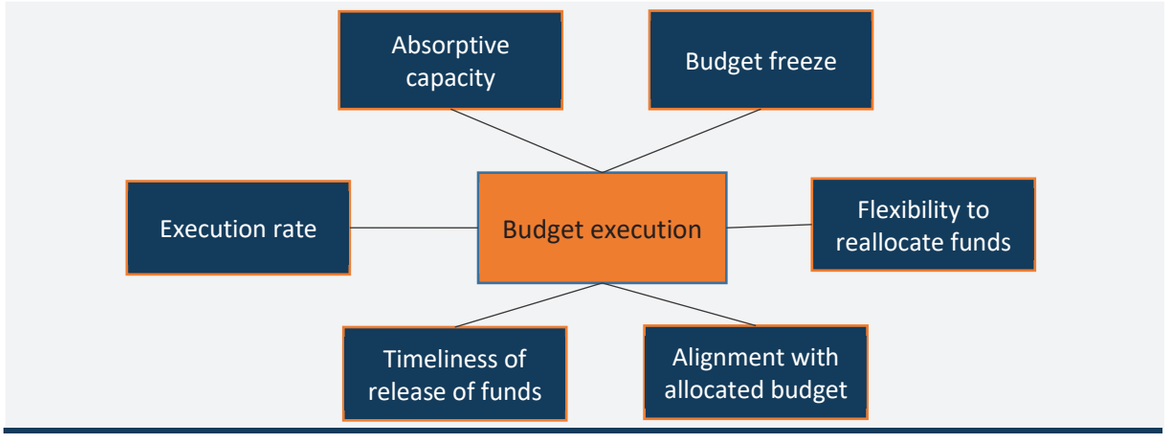
Function H8. Transfers to subnational governments[19]
• Are SNGs provided information/ceilings on estimated transfers from the central government for the upcoming budget year (and the following two years), and if so, how far ahead of the SNG budget submission deadline? • Is such information significantly changed and reissued after SNGs have approved their budgets? • Do SNGs submit their budget proposals to the central government for approval? • To what extent do actual transfers during the year reflect the information on transfers issued during budget preparation? • Does a timetable for the central government transfers to SNGs exist and how timely are actual transfers made? Does the delayed timing of transfer affect the service delivery?
BACKGROUND INFORMATION • What is the role of SNG in the health sector (more than one tier of SNG involved)? • Are SNGs bound by mandatory service delivery targets? • How independent are SNGs of the central government in terms of decision making, health sector budgeting, and financial resources? • What kinds of transfers are made from the central government to SNGs (both block grants and transfers earmarked for the health sector in general or for special programs)?
QUANTITATIVE DATA • Amounts allocated to SNGs from the central government (in total, block grants and earmarked transfers for health) • Amounts allocated by SNGs to health out of their own resources
FIELD SOURCES OF INFORMATION • The MOH, MOF, Ministry of Local Government, and SNG Health and Finance Departments

Budget Execution

10.3 Flow of Funds

177. **When the arrangements for flow of funds are weak, it may be unrealistic to expect good results on a sustainable basis because service delivery activities or priorities will remain unfunded, funded with significant delay, or inefficiently funded.** Adequate and timely fund flow is essential for service delivery. Even if funds are sufficient and have been adequately allocated, providers may face difficulties in implementing their budgets.

Figure 14: Issues in Budget Execution



Function H9. Predictability of in-year resource allocation

178. **The availability of resources can be affected by unexpected adjustments to the central government's allocations to the health sector.** During the budget year, the Treasury

might decide to freeze or reduce parts of the appropriations, either to balance a gap in revenue collections or for reallocating funds to emerging political priorities. When such interventions are recurring, they undermine budget credibility and discourage providers from committing funds to long-term projects or reforms, potentially affecting current or future service delivery performance. They can also reveal that earlier budget decisions have been based on unrealistic or inadequate assumptions, making it even more difficult for providers to get the expected level and mix of inputs.

179. **Delays in the budget execution process may constrain service delivery.** The late release of funds, due to cash management issues or inadequate procedures, may prevent providers from committing funds to planned operations. In low-income countries, providers might not manage any money themselves or may be required to obtain prior approval for expenses, potentially resulting in a longer decision-making process. Resulting delays in hiring new staff or in signing contracts with suppliers may prevent providers from providing the expected levels of service.

180. **Providers may not always have the capacity to utilize allocated funds.** Lack of capacity can result from a staff shortage or a lack of management skills. At the same time, a high spending rate does not mean that human resources and managerial capacity are sufficient. The absorptive capacity issue may be particularly salient when new external aid is granted to a country, with human resources being diverted from other activities to focus on implementing the donor's programs. Likewise, external aid flows are likely to 'consume' different amounts of a country's administrative capacity (Schieber et al. 2006). Donor-specific fiscal management arrangements can make the implementation of external aid projects even more complex while creating unnecessary duplication and additional opportunities for waste and misuse of funds. Some countries have adapted to the existence of competing external funds by minimizing the government budget allocation for health care providers.

181. **Budget execution may be affected by the limited flexibility to reallocate funds.** Providers may not be allowed to move funding across expenditure categories to adjust to changing service needs or to unexpected events. Limited flexibility—or cumbersome and time-consuming bureaucratic procedures—for such virements of funds might be detrimental to service delivery when it prevents health facilities from adjusting to fast-changing needs.

182. **Leakage and wasteful spending might take away resources from frontline delivery units.** Part of the allocated funds might never reach frontline delivery units. This may be due to negligence, poor organization of the budgetary process, lack of skills, lack of guidance on relevant good practices, poor communication between the various administrative layers, excessive administrative expenses, or poorly defined or overlapping responsibilities. It may also result from offenses such as corruption, fraud, or misappropriation. These shortcomings need to be addressed through increased accountability and adequate control and oversight systems.

183. **To manage budget execution, a cash flow forecast has to be prepared and updated throughout the budget in relation to actual inflows and outflows.** The consolidated government cash flow forecast is typically prepared during the budget preparation process

with inputs from each of the sectors or main budgetary entities. The forecast has to be updated regularly as actual revenue inflows, payment outflows, and financing of short-term cash flow gaps become known. A good cash flow plan is needed to allow issue of funds to the health sector, initially for making expenditure commitments (for example, hiring staff and entering contracts) and subsequently for making the corresponding payments.

184. **Where cash flow management and commitment control are ineffective, there is a high risk of generating expenditure arrears.** Effective use of FMIS across the budget cycle can reduce the risks. Expenditure arrears create frustration for the staff or contractors affected, leading to staff demotivation and contractors being less interested in government contracts—or bidding for them only at higher prices.

Function H9. Predictability of in-year resource allocation[20]
KEY DIAGNOSTIC QUESTIONS • Is an annual cash flow plan produced by the MOF? How often is it updated? • To what extent do the MOH, SNGs, and SDUs contribute to cash flow planning? • To what extent do SDUs (for example, which type of SDUs) have separate budgets which are protected against reallocation to other SDUs or other health sector agencies? • How often and with what horizon are funds released to each budget entity—and particularly to SDUs—for making expenditure commitments and for making payments, respectively? Does it adversely impact service delivery? • What flexibility do the MOH, SNGs, and SDUs have to transfer funds among budget lines within each entity's overall budget allocation? • What is the time frame for the approval of a virement request from an SDU? • How often are revised budgets introduced during the year and what is the extent of changes to the health sector allocations in that connection? Are such revisions disaggregated and passed on to SDUs? • To what extent are the original financial plans and budgets for health implemented as planned at the MOH/sector level (see quantitative data below) and at the SDU level?
BACKGROUND INFORMATION • What is the level of FMIS implementation in the country and what access do the MOH, SNGs and SDUs have to enter and review data in the system? • Can providers retain part of unspent allocated funds for spending after year-end? What rules apply? • What are the rules and procedures for budget virements?
QUANTITATIVE DATA • Percentage of the allocation for the health sector which was actually released in each of the past three years • The deviation between actual aggregate health sector expenditure as compared to sector plan estimates and compared to the central government approved budget • The compositional variance in actual versus budgeted expenditure for the same period, in total and by main economic expenditure items, by administrative and by programmatic classification
FIELD SOURCES OF INFORMATION • The MOH, MOF HQ and regional offices, SNG Health and Finance Departments, and SDU administrations

Function H10. Collection of revenues by health sector

185. **Effective collection of revenue in the health sector is important to ensure that planned resources are available both in amount and timeliness to enable the execution of the health sector budget.** This is particularly the case where earmarked revenue constitutes a significant share of overall resource mobilization for health compared to allocations from

[20] Corresponding PEFA 2016 indicator: PI-21 Predictability of in-year resource allocation.

the central government's general budget. The more fragmented the financing of the health sector is, the more complex such collection arrangement might be, involving, for example, the national revenue agency, an SHI scheme, external funds from development partners, and the collection of OOP payments by SDUs themselves. The process of collection of user fees by service delivery units and others in the health sector needs to be efficient, transparent and credible with an objective of providing sufficient and timely information to management to determine its allocation and ensure effectiveness in its usage.

Function H10. Collection of revenues by health sector[21]
KEY DIAGNOSTIC QUESTIONS • Are there clear and transparent pricing mechanisms for the fee-based key and additional services provided by the facilities? • How effective is the collection and recording of each revenue source earmarked for health (different systems for earmarked taxes, mandatory insurance contributions, and OOP payments)? • To what extent do SDUs receive in-kind private contributions? • Is there transparency and accountability in the collection and spending of earmarked revenue by all collecting organizations in the sector? Can the process be improved to provide better service delivery within the same resources?
BACKGROUND INFORMATION • Which revenue streams are collected by or for the health sector (other than allocations from the central budget)? • Which organizational units collect each of them? • What is the channel of revenue flow from the collecting organization to SDUs for each type of revenue?
QUANTITATIVE DATA • During each of the last three years, what was the deviation between actual aggregate health finance resources and sector plan estimates and the central government approved budget? • What was the compositional variance in actual versus planned/budgeted health finance resources for the same period, by type of funding?
FIELD SOURCES OF INFORMATION • The MOH, MOF, SDUs, SHI, and the national revenue agency

Function H11. Accounting for health sector revenues

186. **Effective and timely communication of collection of earmarked revenue for the health sector is necessary for both planning health expenditures and accountability purposes.** While Function H9. above dealt with allocations from the central government's general budget, funding of health care from other sources means that similar processes of communicating availability of funds to the sector and its spending entities is also important.

Function H11. Accounting for health sector revenues[22]
KEY DIAGNOSTIC QUESTIONS • How often are revenue collection reports produced (by each collecting entity and consolidated)? • What are the rules for SDUs keeping cash and are they complied with? • Are SDUs' own revenue streams retained at the SDU? To what extent are own revenue streams subject to budgetary controls from a higher institutional level? Does it help in improving service delivery? • Is there a regular and comprehensive reconciliation process of revenue collected, local expenditure made, and transfers of collections to the Treasury? • To what extent is expenditure held from the retained OOP revenue, reported to higher-level budget institutions, and included in the consolidated reporting by such institutions?

[21] Corresponding PEFA 2016 indicator: PI-3 Revenue outturn (for quantitative data).
[22] Corresponding PEFA 2016 indicator: PI-20 Accounting for revenue.

Function H11. Accounting for health sector revenues[22]
• How are private in-kind contributions reported—does reporting include monetary value, and if so, how is the value determined?
BACKGROUND INFORMATION • Who receives the revenue collection reports? • In what account is each type of revenue deposited (for example, treasury single accounts (TSAs) and subsequently transferred to? • To what extent is collected revenue kept at the entity?
QUANTITATIVE DATA • Same as for Function H10.
FIELD SOURCES OF INFORMATION • SDUs, MOH Finance/Accounts Department, internal auditors, MOF/Treasury, EBFs, SHI, and the national revenue agency

Function H12. Purchasing arrangements

187. **Efficiency of spending in health may be improved by linking funding of or remuneration of SDUs to policy objectives/results.** This involves using different types of payment systems that are employed to actively purchase targeted health services—this is often called 'strategic purchasing'. It differs from 'passive purchasing', where budgets are allocated based on inputs such as salary. For guidance on 'purchasing', refer to Chapter 5.3

Function H12. Purchasing arrangements
KEY DIAGNOSTIC QUESTIONS • How are public and private health service providers funded or remunerated for services provided? • To what extent are existing purchasing arrangements aligned with PFM legislation and regulations? Is any separate legal framework established to regulate how strategic health service purchasing shall take place? • Do the purchasing arrangements provide incentives to providers for achieving health system outcomes? • Is there any written guidance to assist purchasers in obtaining the best value for money? • Are resources allocated to purchasers stable enough to negotiate credible contracts with providers? • Are funds released to SDUs on time? • How do purchasers monitor the way purchasing arrangements are implemented? Do they have adequate information?
BACKGROUND INFORMATION • What types of SDUs provide health care? Are they public or private? • Which organizational unit(s) undertake(s) purchasing functions? • Which SDUs are receiving funds based on strategic purchasing arrangements (benefits packages)? Do they simultaneously receive funding on another basis (for example, input-based allocations)?
QUANTITATIVE DATA • Number of SDUs which are fully or partially funded from public resources—by public/private provider, type of care (for example, PHC/hospital), and geographical distribution • Share of SDU funding provided by strategic purchasing (broken down by type of SDU if possible)
FIELD SOURCES OF INFORMATION • The MOH Planning/Statistics Department, MOH Budget Department, SHI/EBFs and any other health service purchasers, SNGs, and SDUs

188. **The health sector's budget entities may be unable to absorb the funds allocated and released.** Under-execution is more common and an endemic problem in many low-income countries (Barroy et al. 2019). Cumbersome procedures for staff recruitment or procurement procedures for drugs and medical supplies may contribute to low absorption capacity. Inadequate numbers and skills of administrative staff may be another reason. In particular, under-execution of capital expenditure budgets is frequently observed and

indicates unrealistic planning of (often complex) infrastructure projects in relation to actual implementation capacities.

189. **Even if budgeted funds are fully released to the intended spending units on time, and the units have the capacity to absorb the funds, there are issues concerning the units staying within their means and spending in a manner that creates optimum value for money.** Internal control systems are established for that purpose and to check—among others—whether expenditure commitments are made against available budget allocations, whether staff recruitment and procurement follow the rules established to ensure competition and transparency, whether payments are made correctly with appropriate authorization, and whether all financial transactions are correctly recorded. While such controls serve the purpose of central fiscal control and accountability, they also need to be limited to what is strictly necessary and leave flexibility to service providers who may need to adjust budget estimates as service needs change. There is therefore a trade-off between central control and decentralized flexibility to consider (see the discussion in Chapter 6).

190. **Adequate monitoring, control, and oversight systems are required to help providers address waste and leakage and improve efficiency in operations.** However, adequate monitoring and control systems are complex to set up, as they require technical skills and expertise, adequate data capture and analysis systems to identify risks, and well-functioning follow-up processes. They also depend on the ability of the country to reinforce ethical standards among staff and to promote effective PFM and fiscal transparency as well as external scrutiny.

191. **Controls need to be carefully designed to function adequately and in ways that are commensurate with the risks.** They need to be comprehensive at all budget execution stages (commitment, validation, authorization, and payment) and to be carried out by well-trained staff. They also need to cover all types of PFM-related infringements in health care provision.

Function H13. Payroll management

192. **Improved payroll controls are likely to limit opportunity for leakages and corrupt practices.** Payroll controls require particular attention, since the payroll usually represents more than 50 percent of total budgeted expenditures in the health sector and because information systems can be very basic. The ability to reconcile payroll data using a human resource database and systematic consistency checks is likely to result in a more accurate monthly payroll. Segregation of duties in performing payroll checks can curtail corrupt practices. Timeliness in revisions of personnel records could enhance the quality of payroll processing. Such improved controls would also address the issue of late and retroactive payment adjustments, which can affect staff motivation.

193. **Reliable and timely payment of salaries is the basic requirement to maintain high morale and good performance.** Timely payment represents the core principle which substantiates employment contracts. It creates trust in the agreed terms of pay, as well as in the overall reliability of the organization and the system it represents, creating a climate of long-term security. This lets the employees focus on their jobs rather than on worrying

whether they will have their pay and their job tomorrow and what other elements of their organizations may turn out equally unreliable.

194. **Payroll controls also serve the purpose of overall fiscal discipline and can therefore lead to restrictions on and delays in hiring and promoting staff.** Controls should typically involve that the payroll is underpinned by a personnel database that provides a list of staff to be paid every pay period. This list should be verified against the approved establishment list, or other approved staff list on which budget allocations are based, as well as against individual personnel records or staff files. In this way, the controls would ensure that staff employment and promotion are undertaken within approved personnel budget allocations.

Function H13. Payroll management[23]
KEY DIAGNOSTIC QUESTIONS • To what extent are lists of approved staff positions, personnel databases, and payroll linked or integrated? • Are SDUs able to hire (temporary) staff without having centrally approved and vacant staff positions available? What are the employment restrictions for temporary staff (grades, employment period, and so on)? • How long does it take for newly appointed staff to receive salary and other payments (as from reporting to duty)? • To what extent are recurrent staff payments timely and with minimal retroactive adjustments? Does the staff payment structure (salary, overtime, allowances) help incentive staff performance? • To what extent do payroll preparation and payments include information technology (IT) systems, segregation of duties, and audit trails to data entries/changes? • Who enters payroll data (new positions, changes, variable benefits, and deductions) to the payroll system? What is the role of SDUs in data entry? What access does SDU management have to the payroll data? • Are SDU staff paid directly to their bank deposits or through checks or cash? Do they have to leave the duty station to collect payments?
BACKGROUND INFORMATION • Who prepares the payroll (central HR ministry/department, MOH, SNGs, and SDUs)? Is it one single payroll for the entire sector or is it fragmented? • Who make the actual payments of salaries and benefits (MOF/Treasury, MOH, SNGs, and SDUs)? • Are personnel and payroll preparation systems integrated into an FMIS or managed through stand-alone systems?
QUANTITATIVE DATA • Number of payrolls in the health sector • Number of staff in the health sector (on each payroll)
FIELD SOURCES OF INFORMATION • Central HR ministry/department, MOH, MOF/Treasury, SNGs, and SDUs

Function H14. Internal controls of non-salary expenditure

195. **Commitment control is a particularly difficult control element which aims to avoid the accumulation of payment arrears as a result of insufficient cash being available when payments fall due.** Payment arrears can undermine the government's future ability to attract qualified employees and suppliers at competitive prices. Commitment control subjects a planned expense to a budget check before a commitment can be initiated (for example, an employment contract or a contract for providing goods, services, and works). In

[23] Corresponding PEFA 2016 indicator: PI-23 Payroll control.

practice, it can be difficult to implement an effective commitment control system without negative repercussions for service delivery, especially in countries where budget reliability is low and short-term cash flow gaps are difficult to finance. In such cases of cash rationing, spending units may only be allowed to commit fractions of their respective annual budgets at a time. If procurement plans, fund releases for commitment, and cash flows are not well coordinated, a contract commitment may not be possible at the right time, and consequently, spending units may try to circumvent budget execution processes to fulfil their service provision mandate. Commitment controls for non-salary expenditure are usually different from the corresponding controls for the staff payments (for the latter, see H13 above).

196. **Internal control on non-salary expenditure includes—in addition to commitment control—a wide range of processes and types of payment across government,** including contract planning, contract award, verification of delivery, payment approval, and disbursement. This broad range of processes, with the many types of expenditure and the number of different people involved, increases the risk of incorrect and/or inconsistent application or circumvention of any procedures and controls that may be in place.

197. **Segregation of duties is a fundamental element of all internal controls to prevent an employee or group of employees from being in a position both to perpetrate and to conceal errors or fraud in the normal course of their duties.** The main incompatible responsibilities to be segregated are (a) authorization, (b) recording, (c) custody of assets, and (d) reconciliation or audit.

Function H14. Internal controls of non-salary expenditure[24]
KEY DIAGNOSTIC QUESTIONS • What are the financial controls for entering and executing contracts and other commitments? What is the process for SDUs to enter contracts and other commitments in the system? Are the controls effective? • Are payment control procedures effective and efficient as designed and implemented (sufficient budget control and segregation of duties without unnecessary control layers)? And do they constrain or undermine service delivery? • Is there a practice of transactions taking place outside the system (most often to circumvent budget controls)? • How significant are expenditure/payment arrears in the health sector? Are the arrears carried over to be paid from the following year's budget? To what extent do they originate from SDUs as opposed to LGAs, the MOH, or semiautonomous agencies such as a medical supplies agency? • Is there an effective system of tracking invoices and other payment obligations from the day they are due till payment has taken place? • To what extent does payment processing include IT systems, segregation of duties, audit trails to data entries/changes, and direct bank deposits? • Does SDU management have access to enter and/or review transactions in the IT system? If not, who undertakes that function and how do SDUs interact with the system?
BACKGROUND INFORMATION • What are the delays in the stages of the budget execution process (for example, commitments, verification, payment authorization, and disbursements)? • How are expenditure/payment arrears defined and monitored? • At what level do the payment arrears originate (MOH, SNG, SDU, and EBF), if any? • Is the control system computerized into an FMIS? And if so, is the system appropriately designed for

[24] Corresponding PEFA 2016 indicator: PI-25 Internal controls on non-salary expenditure.

Function H14. Internal controls of non-salary expenditure[24]
management of health sector commitments and payments?
QUANTITATIVE DATA • The stock of expenditure payment arrears in the health sector at the end of the last fiscal year
FIELD SOURCES OF INFORMATION • The MOH, MOF, SNGs, SHI/EBFs, and SDUs

Function H15. Internal audit

198. **Internal audit—if risk-based and well carried out—can help the health sector accomplish its objectives by identifying and addressing sources of inefficiency in service delivery.** It plays an important role in ensuring that the internal controls function as intended. Undertaking internal audit requires adequate independence of the auditors from operations while reporting to sector management. A good internal audit system focuses on reviewing systems and processes, rather than just compliance with rules and procedures in transactions, and makes recommendations for strengthening systems.

199. **Internal auditing often needs to be expanded and improved to better address inefficiencies.** Carrying out internal audit requires an adequate level of independence of the internal audit structures, development of a risk-based audit plan, and suitable strengthening of skills of internal audit staff. A good internal audit system would focus on reviewing the systems and processes rather than just transactions. Systematic follow-up on the internal audit findings and recommendations in the health sector is necessary to spread good practices, help health providers accomplish their objectives, and identify sources of inefficiencies. Internal audit also needs to be fully associated with budgetary reforms that are concerned with the move away from input-based budgeting. Such reforms may require new working practices of the department while making sure that increased autonomy and flexibility will effectively help providers get the adequate level and mix of inputs for better service delivery. This will also require suitably revising the methodology and approach of the internal audit department.

200. **High-quality performance audits are key to identifying deficiencies in health sector management and spreading awareness of good practices for future programs.** Performance and value-for-money audits report on the way the budget has been implemented and can identify bottlenecks in service delivery. They also provide feedback for discussions on future budgets. Such audit controls may be more difficult to implement than simpler audits, since they require multidisciplinary expertise and adequate indicators to measure the impact of operations on service delivery performance. Performance audit helps ensure that all parties involved are kept accountable for the efficient use of available resources. It encourages the government to assess and justify the relevance and effectiveness of health programs and to stop funding underperforming programs. Performance audits may be undertaken either by internal auditors or by external auditors (see Function H24.), who may also provide other specialized audits such as payroll/staff audits or procurement audits where special concerns may justify such interventions.

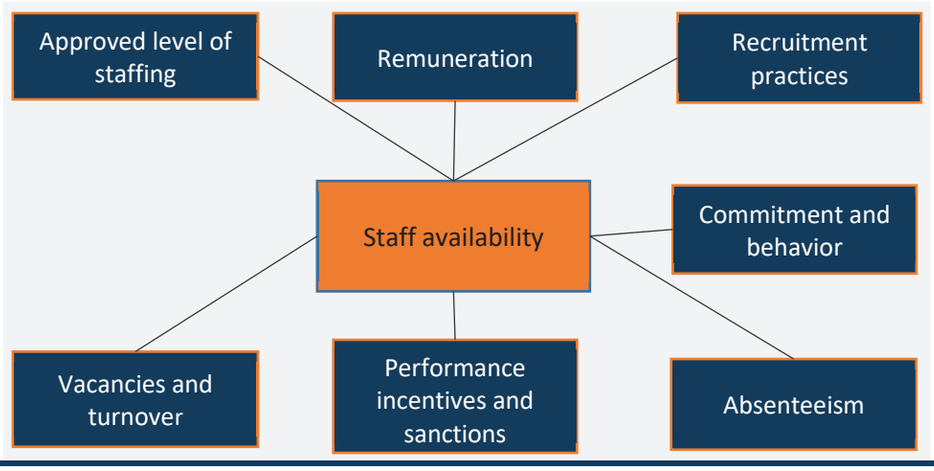
Function H15. Internal audit[25]
KEY DIAGNOSTIC QUESTIONS • How often does the internal audit function undertake financial, payroll, procurement, and performance audit at each type of institution in the sector? • To what extent is SDU management and administration burdened by the internal audit? • What management levels receive internal audit reports and how frequently? Does SDU management receive internal audit reports that cover SDUs? Is SDU management invited to discuss internal audit findings and proposed remedial measures? • To what extent—and how timely—does management (at all levels) respond to internal audit findings and recommendations? • Have any recent internal audit findings led to changes at the service delivery level? • Do Audit Committees exist in the health sector? Is the composition appropriate with independent members? Are they effective in considering various oversight reports relating to the sector?
BACKGROUND INFORMATION • What is the structure and capacity of the internal audit function in the sector? • Is there a Government-wide internal audit structure, which provides strategic direction and coordinates the internal audit function across ministries?
QUANTITATIVE DATA • Number of internal audit reports on (aspects of) the health sector issued during the past fiscal year
FIELD SOURCES OF INFORMATION • The MOH Finance and Budget Monitoring Departments, MOH Internal Audit Unit, SNG Internal Audit Units, and SDUs

10.4 Management of Physical Inputs

Staff

201. **Staffing issues are all the more important in the health sector, which is labor-intensive.** Moreover, the human factor is key to effectiveness in the relationship between health workers and patients. As a result, getting the appropriate level of skilled health staff is of tremendous importance for providers.

Figure 15: Issues in Staffing



Note: Links to staff 'behavior' are further elaborated in Figure 8.

[25] Corresponding PEFA 2016 indicator: PI-26 Internal audit.

202. **Human resources in the health sector involve three dimensions: availability, distribution, and performance.** Availability concerns the supply of qualified health workers, distribution concerns the recruitment and retention of health workers where their presence is most needed, and performance is defined by health worker productivity and the quality of care that health workers provide (WHO 2010). For the review, staff management issues are organized in two clusters of questions, the first concerning staff recruitment processes and the second concerning staff performance management.

Function H16. Staff recruitment

203. **The availability and coverage of health services can be affected by an inadequate level of staffing.** If providers are not allocated appropriate resources, they may not be able to recruit a sufficient number of suitably qualified health staff. Even when resources are sufficient to cover staff expenses, insufficient allocation of staff to providers may translate into inadequate distribution of resources among territories or levels of care. Basing the distribution of staff on historical resource use or on inadequate norms rather than on actual needs is not only likely to increase the risk of both understaffing and overstaffing but may also affect the skill levels of staff, enabling existing service delivery weaknesses to persist. Similarly, application of transparent and effective recruitment practices is important in ensuring that adequately skilled staff are hired.

204. **The best way to ensure merit-based appointments and to reduce risks of patronage and favoritism is to select candidates through open competition.** To find the most appropriate and capable individuals, all potential candidates should have equal opportunity to apply and their suitability for the post should be accessed through an open and fair competition. Competitive examination of candidates differs fundamentally from simple checks of eligibility. Limiting examinations to whether the person is certified to do the job or has achieved certain minimum qualifications does not ensure the selection of the best individual from several possible candidates. A necessary condition for competitive selection is that clear rules exist and are then implemented.

205. **Publicizing vacancies ensures that qualified candidates have an opportunity to apply.** This is a precondition for employing the most suitable and qualified staff. Achieving a sufficiently broad pool of qualified candidates is unlikely where information about vacancies is only available through personal connections, rather than through public channels such as websites, publications, employment and professional organizations, and so on. Moreover, even if vacancies are formally publicized, the way in which this is done may be limited or inaccurate and so may fail to ensure fair competition.

206. **Open and transparent appointment procedures are a key means of increasing the quality of appointments.** A transparent and accountable selection process ensures that choices of candidates are unbiased and objective, which in turn is necessary to hire the right people into the right posts. It also limits possibilities for discrimination and for offering jobs in exchange for personal favors. The minimum requirement for transparency is the involvement of a range of actors in the selection of candidates, so that subjective opinions are open to challenge.

207. **Hiring based on competence rather than personal favoritism is the foundation of a merit-based and professional medical staff.** Appointment systems may use diverse solutions for examining the professional qualities of the applicants. This can include safeguards against patronage and favoritism such as wide and transparent consultation and competitive selection. The ultimate indicator of the performance of the system is an estimation of how commonly appointments are guided by merit rather than by subjective factors such as personal connections, bribes, or political patronage.

Function H16. Staff recruitment
KEY DIAGNOSTIC QUESTIONS • Is allocation of approved staff positions based on rules-based and transparent criteria? • What are the top three barriers to staff recruitment? • Is information on staff vacancies always publicized in a timely and easily accessible manner? • How often are personal connections the key source of information about vacancies? • What are the legislative requirements for the actors to be involved in the selection process, for the selection criteria, and for keeping records of the decisions made? • Does the hiring process require candidates to submit a specified package of documents which shows the candidates' professional attainment and qualifications? • How often is selection based on competition? • What formal/informal procedures are used if there is more than one candidate for a certain position? • What is the extent of staff vacancies and staff turnover at SDUs, by nature of SDU and location?
BACKGROUND INFORMATION • What share of health spending is allocated to human resources (at the central budget level and at the SDU level)? • What is the extent of staff vacancies and staff turnover at SDUs, by nature of SDU and location?
QUANTITATIVE DATA • Number (and percentage) of staff vacancies by staff category and location
FIELD SOURCES OF INFORMATION • SDUs, the MOH Human Resource/Personnel Department

Function H17. Staff performance management

208. **Availability and commitment of health workers are related to appropriate levels of remuneration in the public sector.** Public sector remuneration regimes apply to all government employees, making it almost impossible to give differentiated treatment to health workers. Rigid public service rules can also prevent managers from introducing performance-based management and introducing significant variations in salary levels. Underpaid health staff are more likely to work two jobs to make ends meet. Low pay encourages medical personnel to prefer working for private practices or to go abroad. Constraints on the supply of staff can be even bigger in remote and rural areas, since health workers tend to prefer working in urban areas that offer more attractive professional opportunities and better quality of life for their families. Understaffing in rural areas is likely to further undermine equity in access to health care services, when the poorest portion of the population is concentrated in these areas. Financial incentives for working in remote areas constitute one possible solution to this problem.

209. **Behavior issues among health workers might affect the actual number of staff working/available at any given time.** High absenteeism, unusual turnover rates, or a significant number of idle workers might indeed translate into a decrease in the overall production of services. On the demand side, longer waiting lines (a quality measure) might also discourage people from using health care services, further affecting the level of health

coverage. Low levels of staff inputs can sometimes be improved by hiring contractual or temporary workers, although these alternatives can be costly and can harm service quality over the longer term. Providers in certain cases might also anticipate low staff productivity and therefore request more resources for staff than warranted.

210. **Improving service delivery implies designing and implementing tools to maintain adequate levels of staff and address behavior issues.** As mentioned earlier, public sector rules often hinder provision of such incentives. This is an area in which health financing tools can be more effectively developed to influence health workers' behavior in a desirable way. These health financing strategies and their relationship with existing PFM rules and practices are discussed in detail under strategic purchasing in Chapter 5.3 and under Function H12. Purchasing.

211. **Clear, accurate, and up-to-date job descriptions help employees know what is expected and to deliver accordingly.** The initial question is whether job descriptions even exist in written form. For those employees who do have job descriptions, the quality of this tool comprises several key dimensions. First, it is not enough for job descriptions to be in place, they need to be used in practice. Second, when workers have to refer to their job descriptions, they should find them helpful in most cases. Finally, job descriptions need to be regularly revised to make sure that they reflect current job responsibilities and priorities, to help evaluate performance, and to establish individual career development goals.

212. **It is impossible to improve the quality of services without having an effective way of monitoring it.** Tools for staff performance evaluation may vary and could be based on a variety of data sources and types of measures (indicators). However, any effective system should ultimately help motivate health workers to provide better services for their patients and help the facility as a service provider to achieve its strategic objectives. To achieve this, performance assessment needs several vital components: it must include some link between performance results and rewards, it must be sufficiently transparent with public disclosure of results, and it must be sufficiently interactive, involving employees and the management at all stages of the assessment (setting goals, discussing the process, and following up jointly on the outcomes).

213. **Health care must be safe for the patients, but it must also be supportive and fair to the medical staff.** Poor performance by doctors and nurses directly threatens patients and should not exist unrecognized under any circumstances. Timely detection of mistakes protects the patients in the short run, as well as in the longer term by providing doctors with feedback on how they should improve their approaches. However, mistakes sometimes occur even if staff are dedicated, and sanctions in such cases must be proportionate and fair, helping professionals, where possible, to continue their career and to improve. With the paramount importance of patient safety in mind, performance accountability systems should remain transparent, consistent, and fair to all sides.

214. **While high turnover can create substantial costs and disrupt operations, low turnover may signal both the lack of flexible and rounded skills, as well as 'rent seeking' behavior by those holding the same position for a long time.** Personnel turnover may be a serious problem for human resource management in health care for a range of reasons. High turnover creates direct and indirect costs for the facilities: management may need

time and resources to replace leaving workers, function through the transition, and reinvest in educating new employees. Indirect costs include low morale and dissatisfaction of the patients. On the other hand, low turnover may indicate that employees are not confident changing their jobs, potentially lacking comprehensive skills and knowledge. More dangerously, very low turnover can be a symptom of other hidden benefits enjoyed by remaining in same organizations: workers may have to 'invest' into their positions and these 'investments' may be lost if they resign.

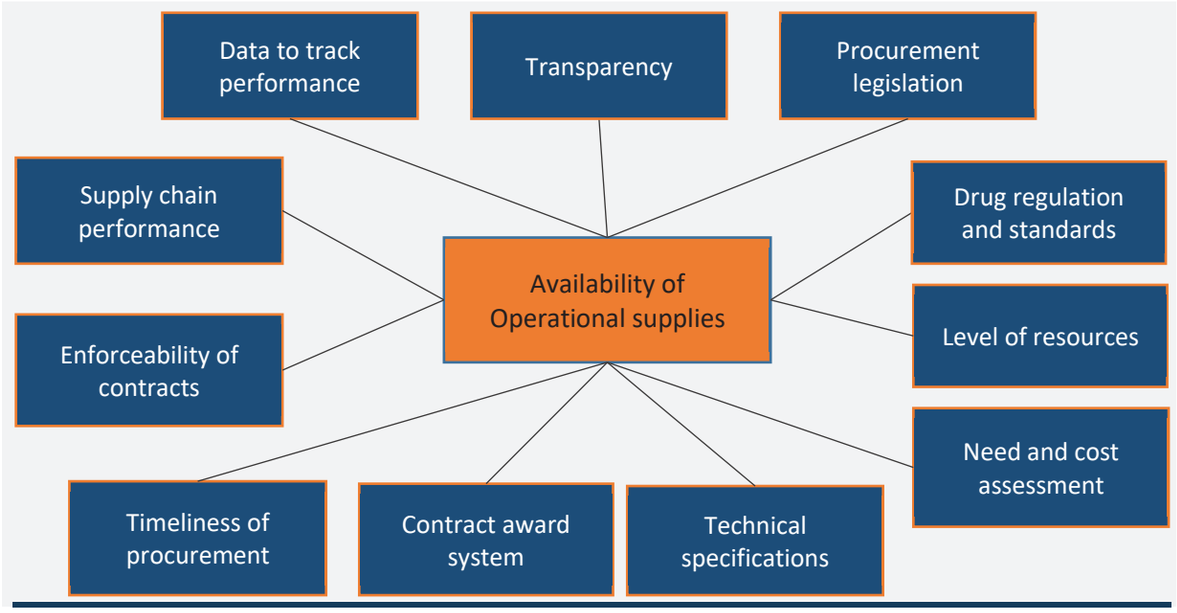
Function H17. Staff performance management
KEY DIAGNOSTIC QUESTIONS • What system of formal or informal staff performance assessment (if any) is in use? Does it include a clear record of results? • How explicit and objective are the criteria which are used for promotions? • To what extent are job descriptions prepared, updated, and useful? • What is the structure of remuneration of health workers? • What is the level of government pay for medical staff compared to the private sector? • To what extent does the system provide incentives for staff performance and remote locations? • To what extent is disciplinary action taken in case of poor performance or nonperformance, and what kind of action is involved?
BACKGROUND INFORMATION • What share of health spending is allocated to human resources (at central budget level and at SDU level)?
QUANTITATIVE DATA • Staff turnover rates by staff category and location • Level of absenteeism at SDUs
FIELD SOURCES OF INFORMATION • SDUs, MOH Human Resource/Personnel Department

Operational Supplies

215. **Operational supplies consist of a wide range of consumable items such as drugs, vaccines, dressings, syringes, laboratory consumables, vehicle/generator fuel, and so on.** It also includes small equipment items which are not large enough to qualify as capital expenditure or have a very limited life expectancy (typically less than a year). Operational inputs also include utilities such as water, electricity, and sewerage, which may be supplied from an SDU's own infrastructure (a water well and an electrical generator) or may be provided by a municipal utility service. In the latter case, standard procurement procedures (as discussed here) usually do not apply.

216. **Shortages of drugs and other operational supplies might result from insufficient funds or an inadequate allocation mechanism.** If the health sector is not getting enough resources or not getting adequate allocation for the needed inputs, it will not be able to purchase the desired level of physical inputs or else only be able to purchase them at the cost of poor quality. Unlike staffing, operational supplies are often considered as discretionary spending in the short term, so they are not protected against in-year budget fluctuations and are more likely to be affected by budget freezes and spending cuts.

Figure 16: Issues in Operational Supplies



217. **An inadequate mix of inputs is likely to affect the quantity or the quality of services.** Even if adequate levels of drugs and medical supplies are available to support health services delivery, they should be commensurate with the actual level of available staff. Health workers need to have at their disposal the adequate means to treat and operate on their patients. When staff resources are not available, it can result in waste or leakage if supplies or drugs cannot be used or stored.

Function H18. Procurement management

218. **Procurement planning is the starting point for ensuring that operational supplies are available at the right time and in appropriate proportions**. Procurement plans reflect the need for inputs and the related costs as well as the required timing of the supplies. Plans are often required as part of the budget submission to the MOF but may need to be adjusted as the final budget allocations are negotiated and approved.

219. **Appropriate planning is essential to make sure that providers will get the right quantity and quality of purchased drugs and supplies.** In particular, the steps of sourcing and defining needs require special attention to include adequate technical and operations specifications, consistent bidding documents, appropriate award criteria, and a sound assessment of time frame and expected costs. The rest of the procedure usually runs along the same lines. Teams need to be trained in negotiation and in drafting critical contract stipulations (for example, sanctions for delays and checks on the services actually provided and their quality) to facilitate the proper execution of contracts.

220. **Weaknesses in procurement processes affect the availability of drugs and other operational supplies for service delivery.** Weak processes can lead to supplies being missing, being inadequate to meet the needs, being delivered late or irregularly, failing to match what has been ordered, being expired or out of date, being maintained in improper conditions, or being lost or stolen. The list of the potential sources of these shortcomings is just as long and diverse, because bottlenecks may appear at virtually every step of the

procurement process. It should also be noted that lack of proper handling, storage facilities, and inventory management systems by the public health organization itself can lead to similar problems, after private suppliers have successfully delivered the ordered supplies (for inventory management, see Function H20. Public assets management)

221. **Effective procurement, regulatory, compliance, and enforcement systems promote transparency and value for money in the purchase of drugs and medical equipment for service delivery.** The cost and quality of health service delivery relies on many factors, including the price of drugs and medical supplies at the service provider level. Where procurement regulation and enforcement regimes are weak, service delivery issues could possibly include cartels, rigging of prices, and delivery of poor-quality pharmaceuticals and equipment. OOP payments may be directly affected by the high cost of drugs stemming from lack of competition or from artificial shortages created to gain rent from increased prices.

222. **Governments play a critical role, primarily in keeping the medical drug market in check, by containing drug prices or subjecting reimbursement to effectiveness criteria.** Drugs and pharmaceuticals are often governed by special regulations for prescribing, for dispensing, and sometimes for pricing. Regulations can also improve the efficiency of drug use in many ways: by the promotion of generics, establishment of essential drug lists, promotion of sound medical treatment protocols, and dissemination of quality checklists and good practices. As a result, the ability of providers to get the necessary drugs may not only depend on the effectiveness of procurement operations. There is therefore a need to mitigate perceived risks in the procurement of drugs, including corruption and collusion risks, by choosing appropriate procurement and purchasing arrangements to align accountabilities and responsibilities.

223. **A big issue is often the inability of the procurement units to use methods to evaluate competitive bids other than the lowest-bid award system.** This practice of awarding contracts to the lowest bidder is meant to ensure the least cost for completing a project or providing goods or services. The lowest-bid award system is praised for its ease of use and is often supported by budget managers. However, it may not result in the best value for money as it encourages contractors to overlook quality and to underestimate the actual costs potentially resulting in budget and time overruns, particularly where quality specifications of tender documents and contract performance monitoring systems are weak.

224. **There is a clear need to choose an appropriate method and organization of the procurement function.** Centralized procurement has it pros and cons. It is likely to be cost-efficient by avoiding duplication of efforts, mitigating the risks of corruption, and facilitating economies of scale and better contractual terms. However, centralized procurement may face the same weaknesses as decentralized systems if it is not sufficiently professional. It could even have more serious consequences due to the bulk quantity of materials potentially involved. Centralized procurement may also result in greater delays and is more likely to be out of touch with the actual needs of the service providers.

225. **Lack of availability of physical inputs can also stem from the existing purchasing/procurement legal framework and practices.** The absence of a legal framework

promoting transparency and fair competition is likely to yield many of the shortcomings mentioned earlier. Red tape and overcomplex procedural management may also increase the risk of fraud and corruption. The legal framework needs to be enforced effectively, which implies adequate administrative and judicial oversight protective of suppliers and of whistleblowers' rights. It may also require the existence of a fully independent competition authority with the powers and resources to investigate improper supplier practices, such as agreements or abusive behaviors distorting competition.

226. **The impact of procurement practices on service delivery may be difficult to measure without improved transparency.** Even if a procurement process is adequate from a compliance point of view, lack of data can make it difficult to track performance and to promote good practices. Similarly, adequate internal and external controls are essential to support effective procurement practices and help providers identify and address inefficiencies. Improved transparency is also likely to hold back improper practices and to encourage providers to benchmark their performance. Publishing the award of contracts paves the way for local communities to disclose inadequate procurement practices as well as excessive costs or inequities in the allocation of inputs. For that to happen, increased transparency must come with an effective complaint system that ensures prompt and impartial investigations.

Function H18. Procurement management[26]

KEY DIAGNOSTIC QUESTIONS

- Do annual procurement plans exist and if so, what is their scope? What is the level of detail of the plans (contract thresholds)? Which entities are covered by the plans? What is the role of SDUs in preparing and updating the plans?
- Are the procurement plans publicized? If so, when and through what means of publishing are they publicized?
- Do databases, records, and statistics on contracts (including procured items, value, and vendor) exist? What is the threshold for contracts to be included? Who has got access to view the data in the databases?
- Do vendors have to be registered in a government system before they may be asked to bid for supplies or services? Are there contract-size thresholds for that registration requirement? Do SDUs have direct access to the registration database?
- What is the extent of use of open competition, restricted competition, and direct negotiation for award of contracts that exceed the nationally established monetary threshold for small purchases (by value of contracts)?
- To what extent are contract award decisions made by an entity (committee) which is independent of the procurement planning and preparation office? Do SDUs have representation on tender evaluation and award committees?
- What is the extent to which information on bidding opportunities and contract awards are publicized in a timely and easily accessible manner?
- What is the extent of quality assurance systems in procurement and their use (including laboratory tests of pharmaceuticals)?
- What is the timeliness of procurement and distribution of drugs and medical supplies (reflected in overstocking, stock-outs, expired drugs, and so on at both the central procuring entity and SDU level)?
- What is the extent of active management (revisions, cancellations, and so on) of contracts based on contractors' performance to ensure continuing value for money?
- Is there a robust system for tracking and blacklisting poor-performing suppliers?
- Does a procurement complaints mechanism exist and operate satisfactorily?

[26] Corresponding PEFA 2016 indicator: PI-24 Procurement.

Function H18. Procurement management[26]
• Do independent tender oversight bodies exist and if so, what is the extent of their oversight (compliance with procedures, conflicts of interest, and so on)?
BACKGROUND INFORMATION • What share of central government budget is used for operational supplies and at the SDU level? • What are the thresholds for use of different procurement methods?
QUANTITATIVE DATA • Number and value of contracts entered under each method of procurement and by type of supply
FIELD SOURCES OF INFORMATION • The MOH Procurement Unit, SDUs, medical drugs/supplies agency, and the central procurement authority

Capital Investment

Function H19. Public investment management

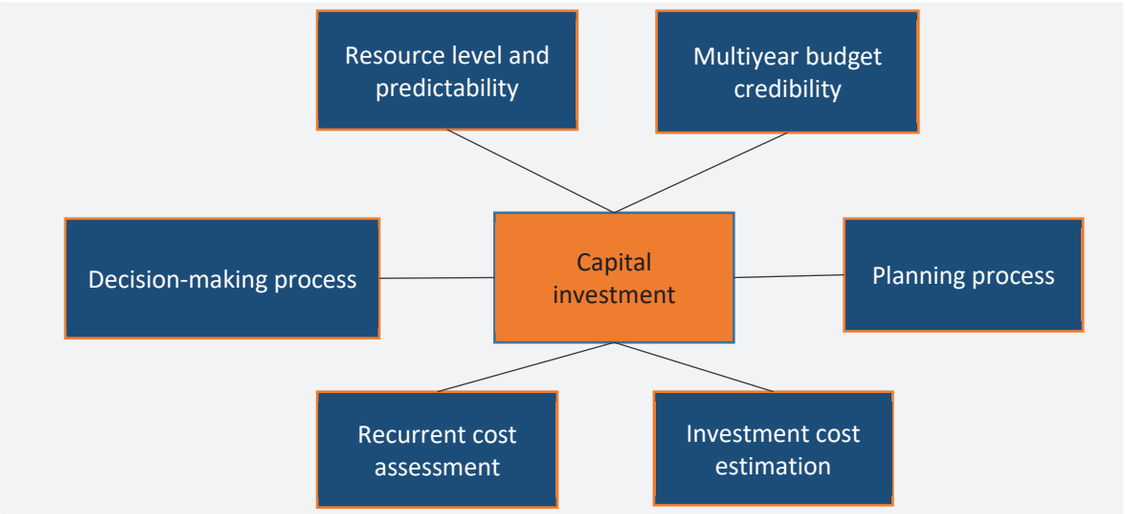
227. **Capital expenditure is essential to maintain or improve the performance of health service delivery.** Lack of necessary investments results in a lack of capacity, which in turn limits service coverage and results in poor quality health care. Outdated or poorly maintained buildings may also be costly to operate due to energy inefficiencies, frequent incidents such as water leakage, or other needs for maintenance.

228. **Capital investment planning and budgeting processes need to be closely linked to ensure that adequate funds are made available at the right time.** However, the complexity of some investment projects may make it difficult to ensure effective coordination between both processes. Building projects involve important preparatory work to decide which buildings should be updated, which ones should be replaced, where to build new facilities, and how they can address changing health needs or promote more efficient medical practices (for instance, outpatient models rather than overnight stays).

229. **Capital projects that require substantial investments typically take more than one fiscal year to complete and can have long-term expenditure implications.** This means that funds allocated for capital expenditures in the current budget will likely reflect decisions from the preceding year(s). In the absence of a clearly outlined capital investment strategy, investment decisions—such as construction of hospitals and PHCs—can be ad hoc and therefore run a high risk of (a) remaining incomplete (for example, if funding runs out or is not allocated beyond one following fiscal year), (b) not being allocated other resources in adequate amounts to provide services (for example, sufficient staff positions not being made available for new hospitals), and/or (c) being out of sync with broader health sector priorities (for example, inefficient resource allocation to new hospitals when the MOH's priority is the provision of frontline services).

230. **Investment projects spread over many years require multiyear financial planning to ensure adequate funding throughout the implementation period and provision of the inputs needed for operation thereafter.** This is often at odds with the legal framework and practices in annual budget management systems. A comprehensive sector strategic plan and a related MTEF are important elements in ensuring investment projects are successful.

Figure 17: Issues in Capital Investment Planning



231. **Capital investment planning may not always translate into effective capital spending, affecting the occupancy rate of health facilities.** As with staffing and drugs and supplies, providers need to be allocated enough funds to engage in building projects. Distribution of resources among territories or levels of care for capital spending may depend on the political weight of local authorities rather than reflect an ambition to support better service delivery. For that reason, a medium to long investment plan set out as part of an overall sector strategy is a valuable tool for presenting a clear and transparent vision of the anticipated development of facilities as a basis for the annual budgeting process.

232. **PFM systems need to include multiyear tools to support effective capital spending.** Multiyear programming—updated annually—is critical for keeping costs under control and enabling a comprehensive overview over the life span of a project. It also allows stakeholders in the ministries of finance and health to share information on project scope and jointly assess corresponding costs, and it encourages the implementation of adequate procedures for official project approval and reporting. Multiyear programming is likely to foster budget credibility and predictability of resources, provided that it is translated effectively in the annual budget. By providing predictable funding during project implementation, multiyear programming (see Function H7.) and commitment of funds will help avoid delays in implementation and contract payment arrears (see Function H14.).

233. **A realistic assessment of total costs allows projects to be fiscally sustainable in the short run as well as in the medium to long run.** One of the most common problems of capital spending is underestimating the associated maintenance and operating costs, a mistake that is likely to make the health facility budget unsustainable or crowd out other necessary expenses. Similarly, buildings need continuous investments in many different areas: new equipment, updated infrastructure, changing clinical technology or delivery models, compliance with safety regulations, improved energy efficiency, and improvements for patients' comfort, among other items. The variety of building-related choices to be made requires efficient decision-making and prioritization process to ensure optimal use of scarce resources.

Function H19. Public investment management[27]
KEY DIAGNOSTIC QUESTIONS • To what extent are capital expenditure allocations linked to national health sector strategies and strategic plans for individual entities? • Are investment project costs for the entire project implementation period estimated and submitted for inclusion in budget proposals? • Are recurrent cost implications following project completion estimated and submitted for the selection process? • What are the criteria for selection of investment projects for the upcoming budget year—are the criteria clear and transparent, and are they respected?
BACKGROUND INFORMATION • What is the level of capital expenditure? • What share of health spending is allocated to capital health expenditure (at the central budget level and at the SDU level)?
QUANTITATIVE DATA • Amount spent on capital investment in the health sector during the past fiscal year (by type of investment)
FIELD SOURCES OF INFORMATION • The MOH, Ministry of Planning or MOF Planning and Budget Departments, and SNGs

Function H20. Public assets management

234. **Lack of data and weakness in information systems are likely to increase the risk of capital misallocation.** A lack of updated and comprehensive records on nonfinancial assets, reflecting all significant events affecting the life span of an asset or its value, is likely to induce suboptimal use of available resources. Unnecessary capital expenses and disrepair or obsolescence are equally likely to take resources away from actual service delivery needs. Assets registries should be periodically reconciled with accounting records and physical surveys of assets to ensure updated and reliable information, ensure better investment planning, and identify potential malpractices or risks.

235. **Systems for disposal of fixed assets should ensure that assets are discarded, sold, or transferred only when they are no longer needed or uneconomical to maintain.** An effective asset disposal system ensures that there are clear criteria for deciding disposal and that the government obtains the best possible sales price when assets are sold. This may be achieved if asset valuations are up-to-date and transparent tender procedures are used in the disposal process.

236. **Inventories of operational supplies need to be well maintained to avoid losses and stock-outs.** Inventory registers should be accurate and up-to-date and provide adequate details such as expiry dates for drugs and vaccines. Inventory management should be subject to appropriate controls including segregation of duties (see Function H14. on internal controls).

[27] Corresponding PEFA 2016 indicator: PI-11 Public investment management.

Function H20. Public assets management[28]
KEY DIAGNOSTIC QUESTIONS • To what extent does the government maintain registers of its fixed assets in the health sector (for example, land, buildings, vehicles, medical equipment, and furniture)? • To what extent are age, usage, and valuation of assets included in the registers? • To what extent are management systems for inventories of drugs and medical supplies adequate to avoid stock-outs and loss (including physical damage, expired shelf-life, and theft)? Do the systems cover all SDU inventories? How do SDUs interact with the system to ensure that overall inventory records are correct and up-to-date? • What are the processes of monitoring and reporting on implementation of capital expenditure/investment projects? • What are the processes for updating the registers? What are the links to the accounting systems? • Are asset disposal systems adequate to avoid losses from fraud, undervaluation, and so on.
BACKGROUND INFORMATION • What legislation/regulations apply to the maintenance of assets registers and inventories? • Who keeps asset registers and who has access to view them or make changes? • What are the procedures for asset disposal? • What legislation/regulations apply to asset disposal?
QUANTITATIVE DATA • Value of health sector assets by type of asset and type of institution holding them
FIELD SOURCES OF INFORMATION • The MOH, SNGs, SDUs, MOF Asset Disposal Unit, public drug and medical supply agency, and central assets registers (for example, for land and buildings in ministries of lands, public works, and physical planning or similar)

10.5 Accounting and Reporting

Function H21. Accounting, recording, and reconciliation

237. **Accounting and financial reporting make up an important dimension of PFM, which helps enhance transparency and provides requisite, timely, and quality information for management reporting and evaluation of budget execution.** FMIS are central to the budget execution and monitoring processes, and if designed well, they should apply to all spending units and all transactions. Commitment and budget controls are usually embedded in FMIS, and purchase orders, payment vouchers, and checks may be issued directly by the system, ensuring that financial reports generated by FMIS have integrity.

238. **From a health sector perspective, the design and implementation of FMIS, and the associated rules and processes, have the potential to reduce time lags in bureaucratic processes, facilitate financial reporting, and enhance transparency.** Many countries have implemented FMIS for these reasons, but with varying degrees of coverage across the public sector. In a few countries, service providers are using such systems or at least interfacing with them to enable better budget execution and monitoring. Ideally, the design and implementation of such systems and associated processes and rules should align with the health sector objectives and therefore help improve service delivery. However, because these systems are driven by different objectives and considerations, this may often not be the case.

[28] Corresponding PEFA 2016 indicator: PI-12 Public asset management (dimensions 12.2 and 12.3).

Function H21. Accounting, recording, and reconciliation[29]
KEY DIAGNOSTIC QUESTIONS • Do all entities in the sector maintain up-to-date General Ledgers? • How often are bank statements reconciled with all differences explained? • How often are suspense accounts and advance accounts reconciled and cleared?
BACKGROUND INFORMATION • In which bank accounts are health sector funds kept? • Which organizational units control each type of bank account? • Is an FMIS in place and what PFM functions does it cover? •
QUANTITATIVE DATA • Dates of most recent account reconciliations and period covered by the reconciliation (for each account) • Annual turnover and actual balance in each account
FIELD SOURCES OF INFORMATION • The MOH Finance Department, SNGs, SDUs, PIUs and SHI/EBF management

Function H22. Financial reporting & Budget Execution Reports

239. **Information on budget execution that includes revenue and expenditure data is required to facilitate performance monitoring and, where necessary, to help identify action needed to maintain or adjust planned budget outturns.** Regular reporting is part of an effective monitoring and control system to ensure that budgets are executed as intended and that deviations from plans, if any, are highlighted for consideration by decision makers adjusting budget execution to better meet objectives and achieve desired outcomes.

240. **Comprehensive budget execution reports prepared regularly during the budget year serve mainly the government's internal purposes**—that is, they provide an overview of execution to support well-informed management decisions such as a budget revision or a supplementary budget.

241. **Annual reports for the health sector are critical for accountability and transparency.** Such reports support the government in ensuring that resources are allocated to strategic sector priorities. They provide a record of how resources were obtained and used, as a basis for comparison with plans and for accountability regarding the use of resources. Data from annual financial reports also provide a vital input in assessing the efficiency of service delivery.

242. **Budget execution reports are most useful if they include information on service delivery outputs and other activities of the reporting entities.** Comparing activities and service outputs to the commitment and disbursement of financial resources offers the best insight in effective budget execution and meeting output targets with budgeted resources. This requires that the full spectrum of health financing sources and arrangements are covered by the reports.

243. **Consolidation of reports is needed to ensure a full overview of implementation in the sector.** Information made available in separate reports from budget entities and other

[29] Corresponding to PEFA 2016 indicator PI-27 Financial data integrity.

public entities in the sector should be consolidated, but it may be difficult if such entities use different accounting standards and reporting formats.

244. **Financial reporting in health sector depends on the constitutional, legal and regulatory requirements.** In many countries international standards like IPSAS govern the requirements of financial statements. Where SDUs work on commercial basis, IFRS or other private sector financial reporting framework may be used. The requirements of whether or not the financial reports are prepared at sector-level, depends on the legal framework. Wherever, credible health sector level financial reports are issued, they serve as valuable tool in decision making for the government.

Function H22. Financial Reporting & Budget Execution Reports[30]
KEY DIAGNOSTIC QUESTIONS • Is there a requirement for health sector financial statements to be prepared? What standards are used for financial report preparation? • How often are in-year and end-year financial reports produced by each public entity of the sector (MOH departments, SNGs, SDUs, SHI/EBFs, and public corporations)? • Are SDUs required to issue different budget execution reports for each source of funding? • Are the Budget execution reports designed in a manner which is helpful in performing the program manager/line manager function? Does the report help in understanding the service delivery constraints ? • To what extent and by whom are the reports consolidated? What consolidation issues arise? Are any health financing sources or arrangements excluded from the consolidated reports? • Does consolidation include reporting by nongovernmental entities (NGOs, external development partners, and the private sector) in cash and in-kind? What consolidation issues arise? • Do the reports include comprehensive financial data (actual revenue and expenditure compared to estimates or approved budgets)? • Do annual reports compare financial and output data to the previous completed year? • Do the reports include quantitative service activity and/or output data? If so, what data are provided and how are they collected and processed? • Do the reports (particularly the end-year report) include a high-level qualitative and quantitative description and analysis of the activities and achievements of the entire sector for the reporting period? If so, how is that reporting disseminated and used within the government? • How is the accounting profession in the country governed?
BACKGROUND INFORMATION • Is there a standard format for annual reports issued by public institutions? • To whom does each entity submit its reports? • What accounting systems and standards are used by each type of public institution?
QUANTITATIVE DATA • Dates at which each entity in the health sector issued budget execution reports for the last completed fiscal year
FIELD SOURCES OF INFORMATION • The MOH, SHI/EBFs, SNGs, SDUs, PIUs, NGOs, MOF, Professional Accounting Organizations and SAI (regarding annual financial reports only)

Budget Evaluation

245. **Budget evaluation refers to the final stage of the budget cycle when there is an assessment of whether public resources have been used appropriately and effectively.** In addition to this accountability purpose, budget evaluation also provides feedback for

[30] Corresponding PEFA 2016 indicator: Combining PI-28 In-year budget reports and PI-29 Annual financial reports.

discussions on future budgets. Budget evaluation may include both an internal process of government, in which a central agency reviews financial reports and reports on activities and outputs, and an external audit function typically undertaken by the country's SAI.

10.6 Oversight and Transparency

Function H23. External audit

246. **While internal audit can be effective in assisting management of the audited entity, external audit is important for external accountability and transparency in the mobilization and use of public funds.** It may assure all stakeholders of effective and efficient financial management in accordance with all laws and regulations and of correct and comprehensive reporting of all financial operations. Exploiting the full potential of the SAI requires adherence to auditing standards, adequate coverage of systemic issues, and effective follow-up of the audit findings by the executives.

247. **Financial audits serve to enforce accountability and promote confidence in financial reporting.** In this regard, a financial audit provides assurance that management has presented a true and fair view of an organization's financial performance and position in accordance with well-defined rules and procedures. A rigorous audit process will, almost invariably, also identify areas where management may improve its control systems and processes. In particular, the audit function should review management information systems, payroll, procurement, and other systems supporting health service delivery.

248. **While compliance with controls in such systems is essential, there is also a need for service delivery results to be evaluated against performance benchmarks or output targets agreed during budget formulation.** Performance and value-for-money audits evaluate the way funds have been used to achieve the agreed-upon outputs and can identify bottlenecks in service delivery at all levels. Such audit may be more difficult to implement than simpler financial and compliance audits, since they require multidisciplinary expertise and adequate performance indicators to measure the impact of operations on service delivery (see also under Function H15. Internal audit).

Function H23. External audit[31]
KEY DIAGNOSTIC QUESTIONS • How often does SAI undertake financial, payroll, procurement, and performance audit at each type of institution in the sector? • To what extent is SDU management and administration burdened by SAI inquiries? • What management levels receive SAI reports and how timely? • To what extent—and how timely—does management respond to SAI findings and recommendations? • Have performance audits of health services been discussed by the legislature? Have those audit reports led to changes in what and how the health services are provided and how they are managed and funded? • What are the arrangements for audit of donor funded projects? If they are not audited by the SAI, how effective are arrangements?
BACKGROUND INFORMATION • Which of the institutions covered by the diagnostic review are audited by SAI? • Who audits the remaining institutions?

[31] Corresponding PEFA 2016 indicator: PI-30 External Audit.

Function H23. External audit[31]
QUANTITATIVE DATA • Dates of completion for the most recent audit of each type—including its institutional coverage • Dates of the management response to each audit report • Number of staff hours used by SDU to support auditors during the recent audit
FIELD SOURCES OF INFORMATION • SAI, MOH, LGA, and SDU management

Function H24. Public access to health finance information

249. **The range and relevance of information available to the public affects their ability to engage with the government and understand how public resources are being used.** It can contribute to better resource allocation by strengthening dialogue between the government and interested stakeholders and can also lead to improvements in service delivery. If the public is more aware of the trade-offs being made by the government in allocating scarce public resources, it can reduce pressure on the government to adopt unrealistic and unsustainable fiscal policy options.

250. **Transparency can help unmask existing bottlenecks, which prevent sustained improvements in service delivery.** Greater transparency can be provided through various means, such as publishing budget information, annual reports for the health sector, and the external audit of financial statements or performance audit reports. Such public access to information provides accountability to the users of the health system and the population at large and helps create political pressure for improvements of services as well as reveal waste and mismanagement. Public access is considered as availability without restriction, within a reasonable time, without a requirement to register, and free of charge, unless otherwise justified in relation to specific country circumstances.

Function H24. Public access to health finance information[32]

KEY DIAGNOSTIC QUESTIONS
• Are the following documents publicized by the government?
  ○ Health sector strategy/plan
  ○ Medium-term health sector budget
  ○ Annual budget proposal and approved budget for the health sector
  ○ In-year budget execution reports for the sector and for each entity
  ○ Annual reports for the sector, for individual entities
  ○ External audit reports covering health sector entities
• For each document: What is the delay in publishing each document—from document issue or end of reporting period?

BACKGROUND INFORMATION • For each document: Who publicizes it and through what media/means?
QUANTITATIVE DATA • The dates of issue of documents and dates of publication—and thus the publication delay—may not always be gleaned from the documents themselves and the website. Interviews with relevant institutions may be required.
FIELD SOURCES OF INFORMATION • Websites of the MOH, MOF, SAI, SDU management, and autonomous agencies in the sector

[32] Corresponding to PEFA 2016 indicator PI-9. Public Access to Fiscal Information.

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ANNEXES

Annex 1 Glossary of Definitions

This annex provides definitions to many technical terms used in the areas of health financing and PFM as reflected in the main body of the Toolkit. Terms are listed alphabetically, with cross-reference to closely related terms, and abbreviations are inserted if they are used elsewhere in the Toolkit.

Access to health care: The degree to which individuals are inhibited or facilitated in their ability to gain entry to and to receive care and services from the health care system. This could be physical, financial, or otherwise. Factors influencing this ability include geographic, architectural, transportation, and financial considerations, among others.

Accountability: The systems, procedures, and mechanisms designed to ensure that officials and institutions perform their duties and responsibilities while recognizing restraints on their power and authority. Accountability also refers to the processes that enable governments to be held responsible for their actions by their citizens, a central tenet of governance.

Accounting: The process of recording, classifying, and interpreting financial transactions that occur within an organization.

Accrual basis of accounting: An accounting method where revenues are recorded when they are earned and expenses are recorded when they are incurred. This concept differs from the cash basis of accounting, under which revenues are recorded when cash is received and expenses are recorded when cash is paid (see below).

Appropriation: Authority granted under a law (by the legislature to the executive) to spend public funds, up to a set limit, for a specified purpose. Annual appropriations are made through annual budget laws or, in some countries, separate appropriation acts consistent with the budget. Supplementary budgets/appropriations are sometimes granted subsequent to the annual law if the annual appropriation is insufficient to meet the specified purpose. Some countries use 'multiyear appropriations' which are those appropriations that expressly provide that they remain available for obligation for a definite period in excess of one fiscal year. The term 'standing appropriation' is sometimes used to define an authority extending beyond a single budget year under separate legislation (such as social security legislation). In most countries, agencies and departments require specific executive authorization ('apportionment, allotment, or warrant') to actually incur an obligation against an appropriation.

Arrears: Amounts that have not been paid or received by the date specified in a contract or within a normal commercial period. Payment (or expenditure) arrears may arise from nonpayment by government ministries/agencies in areas such as bills due from suppliers of goods and services, salaries due, transfers due, or debt service payments due. Tax arrears are taxes due to the government but not paid.

Assets: Property functioning as a store of value over which ownership rights are enforced by institutional units, individually or collectively, and from which economic benefits may be derived by holding them or using them over a period. 'Tangible' assets may either be financial (for example, cash, securities, loans, company shares, foreign reserves) or nonfinancial. 'Nonfinancial' assets include fixed assets (such as buildings, structures, vehicles, machinery and other equipment), inventories (for example, of pharmaceuticals and other medical supplies), valuables, land, and naturally occurring assets including mineral and energy resources. Assets may also be 'intangible' such as intellectual property rights and mineral exploitation licenses.

Audit: An independent review and examination of systems, records, and activities. The objective is to verify the accuracy and completeness of the entity's financial information, its compliance with laws, rules, and/or regulations governing its financial and other operations, and sometimes its performance in relation to established goals, objectives, and/or indicators. Audits are also used to evaluate internal controls, detect fraud, and identify potential improvements in processes and procedures. Audit is either internal or external (see definitions below).

Benefits package: A defined set of services and products. It can be aligned with a particular level of care (that is, primary, secondary, or tertiary health care services). Most schemes have a benefit package defining the sets of services that beneficiaries are entitled to. The benefits covered are a major driver of the overall cost of the scheme and its public acceptability.

Benchmarking: Methods and procedures for comparing an organization's processes and performance against best practices in the industry of profession. It is used as a means of improving performance. Process benchmarking is the study and comparisons of the processes and activities that turn inputs into outputs. Results benchmarking compares actual performance of organizations using performance indicators or measures.

Budget allocation: The amount of funds set aside in the government budget for transfer to a budget entity for a particular purpose according to the budget classification.

Budget authority: The legal authority to incur financial obligations that result in expenditures. It can also refer to a ministry, department, or unit of government that receives a budget through the government budget process and is accountable for that budget to the legislature. The latter may also be called a budget entity.

Budget cycle: A key process in any PFM system governed by the legal framework that can be organized into four components: budget planning, budget preparation, budget execution, and auditing. Reporting occurs throughout the four components.

Budget classification: Determines the manner in which the budget is recorded, presented, and reported and has a direct impact on the transparency and coherence of the budget. It is one of the fundamental building blocks of a sound budget management system. Classification is usually defined by one or more of the categories: administrative unit, nature of revenue and expenditure, government function, and expenditure program.

Budget entity: A ministry, department, or unit of government that receives a budget through the government budget process and is accountable for that budget to the legislature.

Budget examination: The process of reviewing budget requests from ministries and agencies by a staff member of a central Budget Department in the MOF, in which the budget request is analyzed, alternatives are developed, conclusions are reached, and recommendations are made.

Budget formulation: The steps and processes for preparing a government's budget, from preliminary analyses and forecasts, through submission of budget requests by ministries and other government bodies and the review and decision of the executive, to its official presentation to the legislature. It includes the following:

- **Budget planning**: The first component of the budget cycle, developing a short- to medium-term budget plan based on the established resource envelope. This component also includes the development of longer-term strategic plans and medium-term macroeconomic and macro-fiscal frameworks then linked to the budget plan. During budget planning, specific programs are defined at sectoral and activity levels to achieve national goals.

- **Budget preparation**: The second component of the budget cycle. It generally begins with a budget circular published by the agency responsible for budgeting (usually, the MOF), providing guidance for administrative and sectoral units on developing their budgets according to an approved budget plan, resulting in detailed budget estimates submitted to and negotiated with the MOF.

Budget: A document authorizing government officials to spend public funds within pre-agreed constraints, usually defined by time and budget classification (see above). The budget allocates resources and thereby expresses the policy priorities of the government. Such documents may include items directly related to the achievement of goals and objectives by the government as well as program descriptions and performance reporting.

Budgeting: The process by which an institution (for example, the central government, or a governmental organization) plans and estimates its future expenditures, revenues, borrowing, and other financial activities for a fixed period.

Budget Outturn: The actual amount achieved for the financial year, as opposed to (or compared with) the budgeted amount. Outturn can refer to total revenue, total expenditure, budget balance etc, as well as to sub-categories and individual budget lines.

Capital expenditure: Expenditure incurred for the acquisition of nonfinancial assets (see 'assets' above) of more than a minimum value, with an expected lifetime of more than one year. Capital expenditures are often recorded in a separate section (or capital account) of the budget or (in the case of 'dual budgeting') into an entirely separate budget for capital expenditures.

Cash basis of accounting: An accounting method in which revenues are recognized when cash is received and expenditures are recognized when cash is paid for services and/or goods.

Cash management: Management of cash inflows and outflows to maintain liquidity, so that the government is always in a position to meet its obligations as they become due. Government cash management deals with both collections (sources of funds) and disbursements (use of funds).

Central government: All units of government that exercise authority over the entire economic territory of a country. In general, the central government is responsible for those functions that affect the country as a whole, for example, national defense, conduct of relations with other countries and international organizations, establishment of legislative, executive, and judicial functions that cover the entire country. Delivery of public services, such as health care and education, may be a mandate of the central government but is often decentralized to or share with SNG. Nonmarket, nonprofit institutions controlled and mainly financed by the central government are included in the central government.

Chart of Accounts (COA): The basic building blocks of any accounting system, listing all accounts (categories) used in budgeting, recording, and reporting revenues, expenditures, assets, and liabilities. The COA includes codes that indicate key information, such as the department or unit responsible for the transaction, the program or purpose, and nature of the transaction. This is also referred to as accounts classification. For budget monitoring and control purposes, it should be aligned with the budget classification (see above).

Civil society: The nongovernmental and private sector organizations and institutions that manifest the interests and will of various public interest groups.

Claims: Statement for cost of services rendered by health care providers, hospitals, or facilities. Claims are prepared and submitted for payment as a part of the billing process by the provider or the plan member to the health care purchaser. Some systems, such as capitation or global budgeting, eliminate the need for claims.

Clinical audit: A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against set criteria. An audit can lead to the implementation of recommended changes.

Copay: A fixed payment defined in the insurance policy and paid at the point of service by the insured person each time a medical service is accessed. It represents a proportion of the actual cost of the service or product being obtained. Some form of insurance covers the remaining portion. Co-pay forms part of both OOP and 'cost sharing' (see these definitions).

Cost-benefit analysis: A type of economic analysis that includes measures in pecuniary units of costs and/or benefits (such as leisure time or environmental impacts) which do not necessarily have a market value. Cost-benefit analysis involves the application of three logical steps: (a) defining objectives and alternatives for accomplishing those objectives, (b) analyzing incremental changes with each alternative intervention versus without the respective alternative, and (c) comparing costs and benefits of the various alternatives.

Cost-effectiveness: The objective of achieving intended outcomes at the least costs. Cost-effectiveness analysis is thus a tool to determine how intended outputs or outcomes can be reached through various approaches and which approach represents the least economic costs.

Debt sustainability analysis: An assessment of the government's ability to make the fiscal policy adjustments (revenue collection and expenditures) needed to achieve solvency over the long term. A debt sustainability analysis looks at how the ratio of debt to gross domestic product (GDP) will change over time based on the outlook for the primary deficit, or fiscal deficit, and the interest rate-growth differential.

Debt: The outstanding amount that an institution owes to lenders at any given point in time. Thus, debt represents the cumulative total of all annual deficits, minus any annual surpluses, over past years.

Deductible: The additional amount of expenses that a health insurer will require to be paid before it will cover any expenses. Coinsurance reflects the proportion of cost that must be met out of pocket by the person who is covered.

Domestic resource mobilization (DRM): Involves generating funds from within the country, as opposed to external sources such as grants and loans from development partners.

Donor support: Grants and loans made through bilateral or multilateral channels for projects, direct budget support, or pooled funding mechanisms.

Earmarking: The practice of targeting new or existing streams of revenue for specific (health care) systems, programs, priorities, and/or populations.

Economic growth: An increase in the value of goods and services produced by the economy over a period. Economic growth provides a basis to increase general taxation and thus to increase fiscal space for the health sector and subsidize provision of care.

Efficiency: Refers to the production of as many good quality health services as possible with available resources or producing the desired level of service and quality with the minimum resources. Allocative efficiency involves allocating resources in a way that provides an optimal mix of goods and services and therefore maximizes benefits to society. Technical efficiency involves using the least amount of resources or the right combination of inputs to produce a desired mix of goods and services

Equity: Refers to the distribution of services among different groups. Equitable distribution refers to ensuring that all groups have fair and just access to needed resources and can achieve optimal outcomes

Expenditures: Government spending (outlays). Expenditures are made to fulfil a government obligation, generally by issuing a check or disbursing cash in physical or electronic forms. Expenditures may pay for obligations incurred in previous fiscal years or in the current year as permitted by law. Expenditures are often subdivided into capital and recurrent. Capital expenditures are those for the acquisition of assets with more than one year of useful life, while recurrent expenditures are those that must be repeated on a regular basis, such as wages, utilities, and so on.

External audit: A periodic or specific-purpose audit performed by an auditors independent of the audited entity, in accordance with laws or rules on the financial statements of a company, government entity, donor, or other legal entity or organization. See further under ‘audit’ above.

External revenue: Funds from development partners or other interests outside of a country, including ‘donor support’ and ‘private philanthropy’ (refer to these terms for more details).

Fee for service: Fee paid at the point of service outside of any formal pooling mechanism. This can include direct payments in the form of official sanctioned charges or unofficial (under the table) payments.

Fiscal deficit: The difference between annual revenues and expenditures, when expenditures exceed revenues. If revenue exceeds expenditure, there is a surplus. A deficit only reflects that fiscal year’s imbalance. Deficits are funded either disposal of assets or through borrowing.

Fiscal framework: A tool to establish medium-term fiscal targets with a focus on fiscal position, fiscal sustainability, and fiscal vulnerability. The fiscal framework is informed by the macroeconomic framework and includes revenue and expenditure projections disaggregated by various categories.

Fiscal space: The availability of budgetary room that allows the government to provide resources for a given desired purpose without jeopardizing the sustainability of a government’s financial position. Fiscal space can be enhanced through various revenue raising techniques, as well as by cutting expenditures, increasing technical efficiency, or borrowing.

Fiscal sustainability: The ability for government finances to be predictable, sufficient, and responsive to the need across time. It has four main characteristics: solvency (government ability to finance existing and probable future liabilities and obligations), growth (capacity of the government to sustain economic growth over a period), fairness (ability to provide net financial benefits to future generations), and stability (capacity of the government to finance future obligations without increasing the tax burden).

Fiscal vulnerability: A situation where the government is exposed to the possibility of failure to achieve its broad fiscal policy objectives. Large fiscal deficits, high levels of public debt, and volatile revenue streams are leading indicators that fiscal policy is vulnerable.

Financial Management Information System (FMIS): An information technology system which stores, organizes, and facilitates access to financial information. It supports the reliable collection and dissemination of information throughout the PFM cycle and provides decision makers with a set of tools to control, prioritize, and use public resources more effectively. Ideally, it stores financial information related to current and past year spending as well as the approved budgets for the current year, details on inflows and outflows of funds, and complete inventories of financial assets and liabilities. An FMIS may also be integrated with functions including asset controls, budget preparation, human resources, payroll, procurement, and other PFM subsystems as needed.

Financial protection: Refers to the financial burden an individual bears when accessing health services. The goal is to ensure that access to health services does not put people at risk of impoverishment and/or catastrophic health expenditure.

Financial reporting: The communication of financial information about the financial position, performance, and changes in financial position of an entity that is useful to a range of stakeholders in making economic decisions and performing oversight of the entity.

Fixed asset register: A list of fixed assets that belongs to an entity. Ideally, the register should show the date and cost of acquisition, its current value, usage, and other details for accounting (compute for depreciation), management, and taxation.

General taxation: Taxes levied on individuals and institutions for the general purpose of financing the government budget, usually in the form of income taxes, turnover taxes, and import/export taxes. Earmarked taxes deviate from general taxation by being raised to finance-specific public programs and activities.

Good governance: Governance that respects the democratic rights and interests of stakeholders while promoting government accountability, transparency, and efficient and effective delivery of public services and the rule of law.

Governance: The exercise of authority, involving the process and capacity to formulate, implement, and enforce laws and public policies and provide public services.

Gross domestic product (GDP): The market value of all finished goods and services produced within a country during a specific period. It includes all private and public consumption, government outlays, investments, and exports without imports. Real GDP, as opposed to nominal GDP, is adjusted to remove the effects of inflation. Per capita GDP is the GDP divided by the population of the country.

Health financing: The process of managing health sector funds to maximize efficiency, equity, sustainability, and accountability. Health financing has three basic functions: resource mobilization,

pooling, and purchasing. Financial management and improved alignment between health financing and PFM systems is crucial to achieving health sector goals.

Health insurance: Insurance as a concept guarantees benefits and protects the insured population from catastrophic health expenditure through some form of prepayment. Health insurance works best when risk pools are large and when the health risks associated with the covered population are diversified so that the healthy can subsidize the sick. Health insurance models are one way to describe how health financing systems are organized. Health insurance comprises a combination of various pooling, purchasing, and revenue collection arrangements used to ensure the provision of a defined benefits package. Some models of health insurance include the following:

- **Social health insurance**: Prepayment through employee payroll taxes and employer contributions or other premiums paid by the population to a quasi-independent fundholder or agency. Delivered through a largely publicly provided and administrated national system. Includes theoretically low fragmentation through larger national pools and a strong concept of social solidarity.

- **National health insurance**: Prepayment for the population through general or earmarked tax revenue and delivered through a largely publicly provided and administrated national system with theoretically low fragmentation. It is usually mandatory for all citizens.

- ***Mutuelles*/community-based health insurance**: Prepayment through premiums at the community level by community members to a community or association fundholder with varying arrangements for purchasing care. It can lead to fragmentation if there are no higher levels of pooling.

- **Private, voluntary health insurance**: Prepayment of premiums by employers who purchase coverage for employees or by individuals who pay for services delivered by private for profit or not-for-profit companies or providers on a voluntary basis. Unregulated private health insurance can lead to escalating costs, competition for healthy and wealthy populations (cream skimming) avoidance of sick, poor populations, and fragmentation between public and private systems. However, well-regulated private health insurance can improve competition and efficiency.

- **Mixed health insurance systems**: Contain elements of multiple models, for example, SHI for public sector employees in combination with private voluntary insurance for private sector employees, and forms of cross-subsidization for lower economic quintiles.

Health results: Achievement of targets for health outputs and outcomes. UHC (see below) is the overarching goal on the basis of which PFM and health financing bottlenecks are analyzed through the present toolkit.

Incentive: An economic signal that directs individuals (for example, health workers) or organizations (for example, health provider institutions) toward self-interested behavior. The incentives created by a provider payment system will affect provider decisions about the services they deliver, how they deliver them, and the mix of inputs they use for delivery.

Internal audit: Regular audits conducted by auditors employed by the audited entity (often in a specialized unit or department) and reporting directly to the head of the entity and/or its board. See further under ‘audit’ above.

Internal controls: Systems, policies, and procedures to ensure orderly, ethical, and efficient operations in accordance with the organization’s mission; to ensure compliance with laws and

regulations; and to reduce risks of waste, fraud, abuse, and mismanagement. The controls include, among others, segregation of duties within processes, appropriate authorization of transactions, safeguards over inventory and assets, efficiency of processes or operations, good record keeping and documentation, and reporting and use of the information.

Line item budgeting: Budgets classified and managed on the basis of cost of specific categories of inputs (for example, salaries, electricity, and fuel, goods, construction services). Line item budgets focus on the resources spent but do not provide information on the intended results. Also known as input budgeting.

Macroeconomic framework: Projections of the real, external, fiscal, and monetary sectors based on a set of macroeconomic goals and policy framework. The macroeconomic framework assesses domestic and global economic trends to estimate the resources that will be available to the government.

MDAs: MDAs are organizations and/or institutions that are primarily funded through a government's budget and are responsible for government operations, policies, and the provision of government services with those funds. They may additionally include those identified by any and all terms used to refer to government entities, including departments, offices, and so on.

Medium-Term Fiscal Framework (MTFF): The macro-fiscal framework draws on the macroeconomic and fiscal frameworks to estimate a resource envelope based on projected revenues and expenditures for three to five years. These revenue and expenditure amounts appear in the MTEF and annual budgets and are an integral part of the budgeting process and the PFM system. These may also be referred to as macro-fiscal frameworks.

Medium-Term Budget Framework (MTBF): A framework for integrating fiscal policy and budgeting over the medium term by linking aggregate fiscal forecasting to a disciplined process of maintaining detailed medium-term budget estimates by ministries that reflect existing government policies.

Medium-Term Expenditure Framework (MTEF): The expenditure portion of a Medium-Term Budget Framework and a critical tool during the budget preparation process that translates strategic objectives and priorities into financial figures over the medium term. It links the top-down resource envelope (what is affordable based on the aggregate expenditure ceiling established through the medium-term fiscal framework) to the bottom-up cost estimates prepared by spending agencies (what is needed). It provides a medium-term framework for policy makers to decide on program priorities and make political choices as the budget is being prepared.

Medium term, short term, and long term: In general PFM and governance practice, 'short term' refers to periods of one to two years, 'medium term' to periods of three to five years, and 'long term' to periods exceeding five years.

Organizational structure: A framework within which an organization arranges its lines of responsibility and authority, relationships, and communications among members and their rights and duties. Determines the manner and extent to which roles, power, and responsibilities are delegated, controlled, and coordinated.

Organization for Economic Co-operation and Development (OECD): The OECD is an international economic organization of 34 countries founded in 1961 to stimulate economic progress and global trade. It is a forum for countries committed to democracy and a market economy that offers a platform to compare policy experiences, seek answers to common problems, identify good practices, and coordinate domestic and international policies of its members.

Out-of-pocket (OOP) health expenditure: Includes the direct outlay of households at the time of service or supply, including gratuities and payments in kind, made to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services, whose primary intent is to contribute to the restoration or to the enhancement of the health status of individuals or population groups. The term is used interchangeably with direct payment. OOP includes 'fee for service', 'cost sharing', 'copay', and 'deductible' (refer to these terms for details).

Pooling: The accumulation and management of financial resources to ensure that the financial risk of having to pay for health care is borne by all members of the pool and not just by the individuals who fall ill.

Premium: The amount to be charged for a certain amount of insurance coverage. The premium depends on the benefits to be covered by insurance (the benefits package), the cost of those benefits, and estimates of the likelihood that the insured individual or group will use the benefits.

Primary health care: The provision of outpatient care, with a particular focus on ensuring the quality delivery of health interventions prioritized by countries and the global community against the highest disease burdens.

Private commercial sector contributions: Investment by the private sector (for example, in health infrastructure, supply chain management), including through public-private partnerships.

Private philanthropy: Donations given by private individuals or institutions either to local organizations or governments.

Private revenue: Funds from individuals or private institutions used for health care expenses either directly to providers as OOP or as contributions to SHI schemes.

Program budgeting: A type of budget process that groups revenues and expenditures by program, regardless of the number of budget institutions involved, and shifts the focus from resource input to service delivery outputs and objectives.

Progressive financing: A measure of equity. A financing mechanism (and its associated rate) that makes adjustments to lessen the proportional impact on those with less financial means, as opposed to 'regressive financing' (see below).

Public expenditure and financial accountability (PEFA): A multi-donor partnership of seven donor agencies and international financial institutions founded in 2001 to assess the conditions of country public expenditure, procurement, and financial accountability systems and develop a practical sequence for reforms and capacity development. Its flagship product is the PEFA Framework for assessing PFM systems, launched in 2005 and upgraded in 2016.

Public financial management (PFM) system: The national or SNG policies, procedures, and infrastructure for planning, directing, controlling, monitoring, and reporting on public financial resources intended to result in efficient and effective operations. It includes all phases of the budget cycle, including the preparation and execution of the budget, fund flows, internal controls and audit, procurement, monitoring and reporting arrangements, external audit, and parliamentary oversight as well as oversight of extra-budgetary operations and state-owned enterprises.

Public Investment Program (PIP): A phased, multiyear (typically three- to five-year) program for the entire government, or within an administrative unit or sector, to facilitate efficient and effective management of capital investments and improve management of donor financing.

Public procurement: The use of public funds by public entities for purchasing goods and services from domestic or international suppliers/contractors. It also relates to the processes applied for such transactions.

Purchaser: An entity that transfers pooled health care resources to providers to pay for services for a defined population. Purchasers can include health ministries, social insurance funds, private insurance funds, and other entities that manage health funds on behalf of the population.

Purchasing: The process of paying for providers for health services. There are three main ways to do this, often used in combination (see also 'provider payment' below):

1. The government provides budgets directly to its own health service providers (integration of purchasing and provision) using general revenue and/or insurance contributions.

2. An institutionally separate purchasing agency (for example, a health insurance fund or government authority) purchases services on behalf of the population (purchaser-provider split).

3. Individuals pay providers directly for services.

Provider: An individual or institution which is authorized to perform and be reimbursed for health care services. Providers may operate as part of a provider organization (such as a provider network or association of health care facilities)

Provider payment: The allocation of resources to a health care provider to deliver the covered package of health care goods, services, and interventions to the covered population. Payments can take the following forms:

- **Capitation (per capita) payment**: Providers are paid a fixed amount in advance to provide a defined package of services for each enrolled individual for a fixed period of time.

- **Diagnostic related groups (case-based payments)**: Hospitals are paid a fixed amount per admission or discharge depending on the patient and clinical characteristics, which may include department of admission, diagnosis, and other factors.

- **Fee for service (tariffs or fixed fee schedule)**: Providers are paid for each individual service delivered. Fees or tariffs are fixed in advance for each service or bundle of services; it may be paid from public funds or directly by the patient as OOP.

- **Global budget**: Providers receive a fixed amount for a specified period to cover aggregate expenditures to provide an agreed-upon set of services. The budget can be spent flexibly and is not tied to line items.

- **Line item budget**: Providers receive a fixed amount for a specified period to cover specific input expenses (for example, personnel, medicines, utilities). The budget in not flexible and expenditure must follow line items.

- **Per diem payment**: Payment of a fixed amount per day for each admitted patient (for example, to a hospital). The per diem rate may vary by department, patient, clinical characteristics, or other factors.

Redistribution: Transferring income from some individuals to others by means of a social mechanism. Examples include cross-subsidization of health care for the poor from contributions paid by wealthier population strata.

Regressive financing: A financing mechanism that is not adjusted to lessen the proportional impact on those with less financial means, that is, a measure of inequity.

Responsiveness: The extent to which a government reacts constructively and promptly to legitimate demands and changing conditions.

Results-based financing: An instrument to link financing to predetermined results, with payment made only upon verification that the agreed-upon results have actually been delivered.

Resource mobilization: The way monies are raised to pay for health care system and delivery costs. It comprises domestic revenue mobilization and external revenue.

Solidarity: Agreement among individuals with a common interest toward a social goal, such as providing UHC regardless of ability to pay.

Secondary health care: Medical care provided by a specialist or facility, usually upon referral by a primary care physician for cases that require focused knowledge and equipment.

State-owned enterprises: Enterprises that are resident in the country, which are controlled by government units or by other public corporations, and which charge economically significant prices for the goods and services they produce. Also known as 'public corporations'.

Strategic plan: A plan that covers an extended period (usually five years or more) and identifies national priorities and policies, with or without fiscal components. Sectoral or institutional strategic plans may be developed in line with a national strategic plan.

Supreme audit institution (SAI): A national organization that sets standards for audit work and generally undertakes and controls the external audit processes for the government.

Tertiary health care: Specialized consultative care, usually for in-patients referred by primary or secondary physicians.

Transparency: A form of accountability that is based on accessibility and openness of information. Transparency may be internal or external (public).

Treasury single account (TSA): A unified structure of linked government bank accounts for consolidating and managing the government's cash resources, thus minimizing borrowing costs.

Universal health coverage: The goal of ensuring access to quality essential health services (including prevention, promotion, treatment, and rehabilitation) for an entire population without risk of financial hardship or impoverishment, as per SDG 3.8. It requires determining who is covered in the population, for which services, and for what portion of the direct cost.

Value for money: The optimal use of resources to achieve the intended outcomes. It includes the elements of economy (minimizing the cost of resources used or required inputs), efficiency (the relationship between the output from goods or services and the resources to produce them), and effectiveness (the relationship between the intended and actual results of public spending).

Annex 2 Model Terms of Reference

STUDY OBJECTIVE

The objective of this study is to analyze PFM bottlenecks to health results in [country]. The study seeks to develop an understanding of links between health financing, PFM, and health sector results and to develop policy recommendations for reforming PFM systems that are most important in posing challenges to effective and efficient delivery of health services.

Specific responsibilities for this consultancy include, but are not limited to, collecting and analyzing data on PFM issues in the health sector as assigned by a Lead PFM Consultant and undertaking literature and in-country research on PFM and health financing.

BACKGROUND

Most of the resources for universal coverage (and the health sector in general) will/should come from public budgets. More resources for the health sector will not help achieve UHC goals if spending cannot be directed to priority populations, programs, and services. On the other hand, countries have limited fiscal resources, and growth in public health spending must be in alignment with the macroeconomic and fiscal capacity of the country and be fiscally sustainable. Therefore, optimizing how public funds for health are managed and flow through the system is critical for achieving UHC objectives within the available resource envelop. Harmonizing PFM systems with health financing functions to meet the objectives of effective delivery of services financed by the public budget with accountability can ensure that public funds available for health flow to and are effectively used for priority populations, programs, and services to meet UHC goals.

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

From a PFM perspective, health is one of the spending sectors that deliver key public services and goods, but overall it lacks a good understanding of the PFM roles and rules for public sector's effectiveness and financial accountability. Uncertainty of needs weakens the sector's ability to define credible ex ante budgets, and actual spending is likely to divert from initially defined 'targets'. In most low-income countries, actual 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 lack of measurable, immediate health outputs of public resources also tends to reinforce a common perception of the sector's ineffectiveness and inefficiencies.

PFM has been identified as a key bottleneck to health results in many countries. Over the past decade, [country] has embarked on broad financial management reforms with the support of the World Bank and other development partners, but results are slow and the implications for the health sector are largely unknown. Concurrently, health financing systems are under reforms with the view to shifting toward more dominant public financing of the sector. Recent political commitment toward UHC has provided additional incentives for the government to implement reforms on sound public finance management and financial accountability.

SCOPE OF WORK

The study is conducted in [country] to assess the main bottlenecks and opportunities for further health financing and PFM harmonization and to identify the key remedy actions to leverage sound financial management while moving toward UHC.

The key questions for the study are as follows:

- What are the main PFM and health financing bottlenecks to the achievement of health results?
- How do PFM systems/reforms enable the health financing implementation conditions toward UHC?
- How does the health sector maintain and leverage sound financial management and financial accountability to improve health results, including achieving UHC?

The proposed consultancy will specifically aim at

- Data collection and review of existing literature and documents (various PFM analytical work, other analytical work available on service delivery, health financing, and other issues in the health sector);
- Conducting surveys and interviews with selected health facilities on a representative sampling basis (minimum 20 facilities) to determine bottlenecks to service delivery;
- Conducting follow-up interviews with key stakeholders in PFM-related institutions to identify and analyze the root causes and issues associated with PFM systems, which affect and impede service delivery;
- Identifying key solutions to address the root causes of health financing and PFM problems affecting service delivery outcomes (efficiency and effectiveness); and
- Discussing the content of the draft report with various key stakeholders.

Specific guidance on how to best conduct this study is provided in the 'PFM in Health - Diagnostic Toolkit' issued by the World Bank 2019. The study shall follow this guidance.

The assignment will consist of a maximum of 25 working days from [date] to [date] for each expert in the study team:

- 5 days for collection and review of recent relevant studies in [country]
- 10 days for data collection through survey and interviews at selected health facilities and follow-up interviews with other key stakeholders
- 10 days for a draft report of initial findings on PFM bottlenecks and policy recommendations

DELIVERABLES/SPECIFIC OUTPUTS EXPECTED

- The consultant to deliver initial report by [date]
- A compilation of the data, information, and documents collected (Word documents and

Excel files if any)

- An analytical report showing casual chain of health results that emanate from

  (a) Diagnosis of the health PFM cycle;

  (b) Constraints and opportunities of current PFM and health financing reforms; and

  (c) Key remedy actions and intervention needs for further alignment between PFM and health financing systems toward UHC.

SELECTION CRITERIA FOR CONSULTANTS (OPTIONAL)

At least three experts are required for this assessment:

- **A PFM Consultant** with at least five years of experience in supporting PFM or public sector reforms or working on PFM issues in the public sector. The candidate should possess
  - A strong public sector focus for this position;
  - An advanced degree in public finance, accounting, public administration/management or equivalent;
  - Relevant professional public sector and PFM experience;
  - Ability to deal with analytical and strategic work; and
  - Interpersonal skills with the ability to work independently with partners and counterparts.
- **A Health Financing Specialist** with at least five years of relevant experience.
- **A Health Specialist** with a strong experience in health service delivery.

Jointly, the experts should cover the following knowledge and experience:

- Excellent understanding of the country's PFM system with work experience in financial management at a national or decentralized level
- Good knowledge of the health sector, with clear understanding of health financing functions and ongoing reform agenda toward UHC
- Ability to interact with government officials on complex technical issues within both the MOH and MOF
- Good analytical and writing skills in [language]
- Knowledge and operational experience in health financing—domestic revenue mobilization, risk pooling, and purchasing
- Knowledge of the various dimensions of the PFM cycle (budget formulation and execution, controls, accounting and reporting, and auditing and oversight of public finances) and experience in PFM reform (required)

- Ability to provide practical methodological and technical advice and guidance to ministry staff

- Willingness to travel and strong interpersonal skills with the ability to work independently with the clients

Annex 3 Table of Contents for a Diagnostic Review Report

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5. IMPACT OF PFM FUNCTIONS ON SERVICE DELIVERY AND POLICY RECOMMENDATIONS

Annex 4 Overview of Sources of Health Financing

Revenue Source	Amount	Amount as a Share of Total Government Health Expenditure	Amount as a Share of Total Country Health Expenditure
National government level			
Allocations from the general government budget (funded by domestic non-earmarked revenue)			
Earmarked revenues for health, including sin taxes but excluding SHI contributions			
Mandatory SHI contributions (for example, earmarked payroll taxes)[a]			
Mandatory private health insurance contributions			
Voluntary contributions to prepayment schemes (SHI, private, and community-based health insurance)			
Internally generated funds at SDUs (user fees, patient co-payments, and so on)			
SNG level			
Allocations from the general government budget (funded by domestic non-earmarked revenue)			
Earmarked revenues for health, including sin taxes but excluding SHI contributions			
Mandatory SHI contributions			

Revenue Source	Amount	Amount as a Share of Total Government Health Expenditure	Amount as a Share of Total Country Health Expenditure
Mandatory private health insurance contributions			
Voluntary contributions to prepayment schemes			
Internally generated funds at SDUs			
External/nongovernment financing			
Development assistance for health from bilateral and multilateral partners			
NGO contributions			
Other (please specify source)			

Note: a. Schemes may be financed by a mix of central or local government revenue, employee/employer contributions, social contributions, external donors, and so on. See the Revenues of Financing Schemes classification of SHA2011. Co-payments may differ across schemes, facility levels, providers, and services.

Annex 5 Analysis Sheet for Interviews at SDUs

Example for primary health care units

Service delivery constraint	Cause of constraint: Health financing	Cause of constraint: PFM	Cause of constraint: Other	General comments
Shortages of health workers (doctors and nurses) at health facilities, especially rural areas	• Low salaries • Inadequate financial incentive for rural service • Limited own revenues to increase staff salaries due to little income from user fee earnings at PHCs	• Salary levels fixed by government; facility managers have no means or ability to increase salaries • Spending rules do not allow distribution of savings from vacant staff positions to existing staff	• Rural service not attractive for doctors due to quality of life • Most doctors are at retirement age • Private hospitals compete for doctors and nurses	• Local government authority offers housing for staff at PHCs, even though it is not obliged
Stock-out of drugs procured by central medical supply		• Poor procurement planning • Actual population covered is larger than official statistics used to estimate required supply	• PHC does not have mandate to directly purchase drugs	
Limited ability to maintain buildings and equipment	• Difficulty in generating additional income from user fees (no drugs sold) • PHC relies on (unreliable) funding from local authorities for repairs	• Rules for use of capitation grants do not allow savings to pay for maintenance • Spending rules require unspent budget and social insurance funds for each line item to be returned		• Health facilities sometimes rely on unpaid repair and maintenance work by their own staff

Annex 6 Examples of PFM in Health Reform Recommendations

Recommendation A: Prepare a comprehensive and costed health sector strategy with operational and financing plans aligned with the government budget framework

The complexity and time horizon for implementing such a reform are highly dependent on the starting point for strategic planning and whether some of the preconditions for planning are in place already. Has some kind of strategic sector planning been undertaken in the past, and if so, what elements did such plans have and which ones were missing? In many countries, a strategic sector plan exists but costing and financing of plan implementation—and the prioritization of activities that follow from such constraints—have not been established, making the plans unrealistic. Costing of a plan is a technical exercise which can be completed by the MOH with some information sharing from all financial contributors to the sector, and so it is possible to complete within a relatively short time frame. Establishing the financing of the plan is a highly political process, which may drag on for a long period, depending on the political environment. Aligning the plan with the government budget assumes that a MTBF already exists, but this still leaves the questions of a case for a potential increased budgetary funding and the role of additional earmarked financing for the health sector. If those questions cannot be immediately answered, one way of proceeding toward completion of the strategic plan is to include alternative financing scenarios to the baseline funding plan and to show the associated consequences of each alternative on service delivery outputs and expected impact on health status. Conversion of the strategic plan into the annual budget plan will then have to be adjusted in line with the funding scenarios as and when decisions on financing options are made.

Recommendation B: Introduce appropriate record keeping and reporting of locally generated revenue at SDUs

Such a reform may be recommended where current record keeping and reporting are nonexistent, rudimentary, or fragmented across SDUs, thus hindering a complete picture of local health funding and spending on various inputs as well as undermining accountability. The reform may be implemented by the health sector itself, spearheaded by the MOH. Nevertheless, the reform would benefit from collaboration with the MOF in terms of ensuring alignment with the central government COA and collaboration with the SAI to ensure that the new system meets with approval by the external auditors. If health insurance agencies, LGAs, and development partners also provide funds directly to SDUs, and particularly if they demand co-payments from patients, those stakeholders also need to be consulted so that the system design may meet the needs of all parties and avoid operation of parallel recording and reporting systems at the SDUs. In a system where all funding is provided from the central government with the exception of fees paid by patients, the reform may be quite simple and be introduced within a time frame of possibly one year. However, the complexity of the reform and the time needed to design, test, and pilot a new system will increase with the number of stakeholders involved in using the new system. If the reform is accompanied by introduction of a new IT accounting system and requires staff training, the preparation and implementation of each of those elements will have to be considered in their own right and be given sufficient resources and time frame for completion.

Recommendation C: Introduce job descriptions for all SDU staff

This is a type of reform that may be implemented by the health sector largely on its own within a short-term perspective. The MOH may need to collaborate with the central government's ministry or department for personnel or human resource management to obtain templates for the job descriptions and to ensure that the descriptions will fulfill the needs of such a human resource department's requirements in relation to approval of positions, for example, ensuring that the qualifications and experience specified in each job description align with the staff grade—and thus with remuneration—usually determined at the central level. A challenge that requires a medium-term perspective is to ensure that staff performance is reviewed against the job description on a regular basis (for example, through annual discussions between the staff member and his/her manager) and that the job description is updated if needed.

Recommendation D: Create more flexibility for SDUs in the allocation of funds among expenditure items

Flexibility in use of funds at the SDU level has been raised as an issue several times in the Toolkit, to enhance the SDUs' ability to obtain the best possible input mix under changing health service demands during the year and avoid the need for bureaucratic procedures for in-year budget reallocations and virements. To design a reform, the review team would need to identify exactly where the controls imposed on SDUs originate from and what purpose they serve.

Budgetary controls would most often originate from the MOF's Budget Department through the MOH or directly to SDUs (the latter if, for example, hospitals constitute separate budget entities in the central government budget). However, budgetary controls could also originate from LGAs in charge of SDUs—with full or partial funding received from the central government through unconditional or sector earmarked block grants. The MOH may also have a role to play in the existing controls, so it would be important to investigate the flexibility the MOH has in budget reallocations and virement and whether the MOH allows this flexibility to be passed on to SDUs.

In principle, program budgeting should allow program managers to use the resources allocated to his/her program without restrictions. In practice, controls are still maintained at least for three main economic line items, namely, personnel expenditure, other recurrent expenditure, and capital investment due to long-term implications of most personnel and investment decisions. However, controls often remain at a much more detailed level and perhaps for good reason.

Flexibility in the use of budgetary resources works only where there is a culture of compliance with rules and regulations and budgetary resources are reliable. This particularly relates to committing funds (for example, issuing orders for supplies and services or hiring additional staff) when sufficient funds are available, having considered other expenditure commitments made—but not yet paid for—and other needs for the rest of the year. Otherwise, expenditure arrears may be created. Expenditure on utilities and rental of property are often a problem because the commitments are continuous. Therefore, the MOF may ring-fence such expenditure with budgetary controls at a more detailed level so that the funds are not diverted to other purposes. When the need arises for other expenditures to be enhanced, water and electricity bills are often not paid, particularly if the utility companies are state owned. This is one of the key concerns for many MOFs as the arrears to public enterprises lead to losses, which the MOF eventually will have to cover, or to utility supply problems due to cash flow problems of the utility companies.

Annex 7 Bibliography

Ablo, E, and R. Reinikka. 1998. "Do Budgets Really Matter? Evidence from Public Spending on Education and Health in Uganda. Evidence from Public Spending on Education and Health in Uganda." World Bank Policy Research Working Paper.

Adam, A., M. D. Delis, and P. Kammas. 2008. *Fiscal Decentralization and Public Sector Efficiency: Evidence from OECD Countries.*

Akin, John, Paul Hutchinson, and Koleman Strumpf. 2005. "Decentralisation and Government Provision of Public Goods: The Public Health Sector in Uganda." *The Journal of Development Studies* 41: pp. 1417–1443.

Allen, Richard, and Daniel Tommasi, eds. 2001. *Managing Public Expenditure: A Reference Book for Transition Countries.* OECD Publishing.

Barroy, Helene, Grace Kabaniha, Chantelle Boudreaux, Tim Cammack, and Nick Bain. 2019. *Leveraging Public Financial Management for Better Health in Africa.* WHO reference number: WHO/UHC/HGF/HFWorkingPaper/19.2.

Blanchet, N., R. Kidane, and M. Makinen, eds. 2015. *Universal Health Coverage Primary Health Care Self-Assessment Tool. Joint Learning Network for Universal Health Coverage Primary Health Care Initiative.*

Cashin, C., ed. 2015. *Assessing Health Provider Payment Systems: A Practical Guide for Countries Working Towards Universal Health Coverage. Joint Learning Network for Universal Health Coverage.*

Das, Jishnu, and Jeffrey Hammer. 2014. "Quality of Primary Care in Low-Income Countries: Facts and Economics." *Annual Review of Economics* 6: pp. 525–553.

Edward, A., B. Kumar, F. Kakar, A. S. Salehi, G. Burham, and D. H. Peters. 2011. "Configuring Balanced Scorecards for Measuring Health System Performance: Evidence from 5 Years' Evaluation in Afghanistan." *PLoS Med,* 8 (7): e1001066.

Fan, Victoria, and Savedoff William. 2014. "The Health Financing Transition: A Conceptual Framework and Empirical Evidence." Working Paper 358, Center for Global Development, Washington, DC.

Gottret, Pablo, and George Schieber. 2016. *Health Financing Revisited: A Practitioner's Guide*. World Bank.

Hadley, Sierd, and Mark Miller. 2016. "PEFA: What Is It Good For? The Role of PEFA Assessments in Public Financial Management Reforms." Discussion Paper, Overseas Development Institute.

Heller, P. 2005. "Understanding Fiscal Space." IMF Policy Paper, Fiscal Affairs Department.

Kanthor, J., and C. Erickson. 2013. *A Toolkit for Ministries of Health to Work More Effectively with Ministries of Finance.* Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.

Kutzin, J. 2001. “A Descriptive Framework for Country-level Analysis of Health Care Financing Arrangements.” *Health Policy* 56 (3): pp. 171–204.

———. 2013. “Health Financing for Universal Coverage and Health Systems Performance: Concepts and Implications for Policy.” *Bulletin, World Health Organization* 91 (8): pp. 602–611. doi: 10.2471/BLT.12.113985. PMCID: PMC3738310. PMID: 23940408

Langenbrunner, J., C. Cashin, and S. O’Dougherty, eds. 2009. *Designing and Implementing Health Care Provider Payment Systems: How-To Manuals.* Washington, DC: World Bank.

OECD (Organisation for Economic Co-operation and Development). 2010. *Value for Money in Health Spending.* Paris: OECD Publishing.

PEFA Secretariat. 2016. “PEFA Framework for Assessing Public Financial Management.” Washington, DC.

Schieber, George, Cristian Baeza, Daniel Kress, and Margaret Maier. 2006. “Financing Health Systems in the 21st Century.” Chapter 12. In *Disease Control Priorities in Developing Countries*, edited by Dean T. Jamison et al. Washington, DC: World Bank.

Tandon, Ajay, J. Cain, C. Kurowski, and I. Postolovska. 2018. “Intertemporal Dynamics of Public Financing for Universal Health Coverage: Accounting for Fiscal Space Across Countries” Discussion Paper. Washington DC: World BankUSAID (United States Agency for International Development). 2014. *Bureau of Economic Growth, Education, and the Environment: Guide to Public Financial Management.* USAID.

Wang, Hong, Kimberly Switlick, Christine Oritz, Catherine Connor, and Beatriz Zurita. 2010. *Africa Health Insurance Handbook: How to Make It Work.* Edited by C. Connor and H. Wang. Health Systems 20/20 Project, Abt. Associates Inc.

WHO (World Health Organization). 2007. *Everybody’s Business: Strengthening Health Systems to Improve Health Outcomes. WHO’s Framework for Action*. Geneva, Switzerland: WHO.

———. 2010. *The World Health Report - Health Systems Financing: The Path to Universal Coverage.* Geneva, Switzerland.

———. 2016. “Alignment Between Public Financial Management and Health Financing for Fiscally Sustainable UHC.”

World Bank. 2013. *Results-Based Financing for Health. Africa Health Forum Financing and Capacity for Results.* Washington, DC: World Bank.

———. 2014. *Core Health Financing System Assessment Protocol.*

World Bank/IEG (Independent Evaluation Group). 2014. *Support to Health Financing for Improving Health System Performance FY03–FY12*. Report No. E2014-0020. Washington, DC: World Bank.

Yevgeniy, Goryakin, Paul Revill, Andrew Mirelman, Rohan Sweeney, Jessica Ochalek, and Marc Suhrcke. 2016. *Public Financial Management and Health Service Delivery: A Literature Review.* Overseas Development Institute.