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Research Article

From Stumbling Block to Enabler: The Role of Public Financial Management in Health Service Delivery in Tanzania and Zambia

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Abstract—The way governments manage resources through the budget cycle has important implications for health policy and whether governments achieve societal objectives such as efficiency, equity, quality, and accountability. Studies found a positive association between health service delivery outcomes and good governance of public finance; however, the mechanisms through which public financial management affects service delivery remain underexplored. This article maps the three stages of the budget cycle to common performance criteria used in health service delivery. It applies this approach to experiences in Tanzania and Zambia. The findings point to a number of stumbling blocks, including the lack of flexibility to provide additional resources for unexpected demand for care, misalignment between budgeting and planning, fragmented funding sources, rigid internal controls, insufficient budget provision leading to arrears, and a budget evaluation system that is excessively compliance driven and gives inadequate attention to issues of equity, quality, and efficiency in service delivery.

INTRODUCTION

Public financial management (PFM) relates to how governments manage resources through the budget cycle. This makes PFM a key vehicle through which governments implement policy—including health policy—and achieve their economic and societal objectives.¹ Thus far, the associations between budget formulation and approval, budget execution, and budget evaluation and health service delivery have not been examined. A discussion of how these elements of the budget cycle affect health service delivery is thus important.

The World Health Organization defines health service delivery as the “immediate output of the inputs into a health system” (p. 2).² Health service delivery depends on

Keywords: budget management, facility management, health systems, performance budgeting, program budgeting, public expenditure management, public financial management, service delivery

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numerous aspects, including government and private financing, infrastructure, human resources, management practices, and organizational culture, to name a few. PFM, or the processes through which public funds are managed, plays an important role in service delivery because it sets the framework for how public funds are used to finance the provision of health care. As such, PFM influences how service delivery contributes to health system objectives of efficiency, equity, quality, and accountability and ultimately to better health status and financial protection.³

The three overarching objectives of public financial management are aggregate fiscal discipline, operational (or technical) efficiency, and allocative efficiency.⁴ Aggregate fiscal discipline is about governments prudently balancing aggregate revenues and expenditures, which is important to ensure sustainable and predictable revenue streams for service delivery. Operational and allocative efficiency pertain to operating at minimal cost and allocating funds in accordance to government priorities. These are also common objectives in health service delivery. If implemented well, public financial management can enhance efficiency and quality health service delivery, and it can help keep providers accountable. Public financial management, through its budgeting modality, can, for example, impact operational efficiency in hospitals. A hospital budget that is defined based on the number of beds will set different incentives for efficiency in resource use and health service delivery than an output-oriented budget that rewards hospitals for better quality care. Similarly, weak budgetary controls and accounting can create bottlenecks and leakages and contribute to inefficient provision of services. In such cases, PFM becomes a stumbling block for the provision of health services.^{5,6}

Several governments in East and Southern Africa have strengthened various components of their PFM systems, including planning and budgeting systems, budget execution, and accounting and reporting. These reforms have been evaluated in public expenditure and financial accountability (PEFA) assessments. A review of the latest PEFA assessments shows that by and large PFM systems in countries in East and Southern Africa perform reasonably well.⁷ South Africa has the best PFM system, followed by Rwanda and Ethiopia, whereas the Comoros, Madagascar, and Zimbabwe have the weakest PFM systems based on a composite rating of 28 dimensions across the PFM spectrum including the formulation, execution, and evaluation of the budget. Higher income countries in the region tend to perform better on most PFM dimensions, particularly in credibility and comprehensiveness of the budget, budget execution, and accounting and reporting.

Well-functioning PFM systems are essential for good governance of public finance and health service delivery. In countries with good governance, health spending was found to have a significant effect on reducing infant and child mortality.⁸ Welham et al.⁹ use average scores from PEFA assessments as a proxy for PFM quality to regress PFM quality on health outcomes. The PEFA dimensions included in the proxy were budget reliability, transparency, management of assets and liabilities, policy-based fiscal strategy and budgeting, predictability and control in budget execution, accounting and reporting, external scrutiny, and audit. Controlling for gross domestic product per capita, female literacy, and HIV prevalence, they find that a one-point improvement in the PEFA score is associated with a 20% fall in under-five mortality, a 17% fall in infant mortality, and a 2% increase in life expectancy at birth. More detailed qualitative analysis would be needed to show how the different PFM dimensions affect health service delivery and outcomes.

Although this has been recommended by different studies, the mechanisms through which PFM affects health service delivery have rarely been examined.^{5,10,11} A World Bank study shows conceptually how PFM can affect health financing and service delivery.¹² The report also examines supply- and demand-side barriers in service delivery, including physical barriers to care, as well as issues associated with availability of inputs and the budget process. Chakraborty et al.⁵ and Cashin et al.⁶ discuss at a theoretical level how public financial management reform and health financing are aligned. They conclude that synergies between PFM and health financing contribute to better results for health financing reforms. Conversely, when alignment is weak, such as in PFM environments that excessively emphasize expenditure control, this threatens the ability of health financing reforms to sustain policy objectives. There is, however, insufficient analysis on how PFM could advance service delivery. More practical advice on this was provided by guidance manuals on the PFM and sector ministry intersection by the Swedish International Development Cooperation¹³ and the German Gesellschaft für Internationale Zusammenarbeit.¹⁴ Both of these manuals outline various PFM reforms such as the introduction of a medium-term expenditure framework and financial management information systems and describe how they are likely to be important for service delivery. Still, a recent literature review on PFM in health suggests that "the overall evidence in this field appears to be patchy" (p. 28),⁵ with many hypotheses remaining largely underexplored and insufficient evidence to identify causal effects.

This article maps the three stages of the PFM budget cycle to common performance criteria used in health service delivery. The analysis uses experience from Tanzania¹⁵ and Zambia¹⁶ to show how deficiencies in the PFM environment can create stumbling blocks for health service delivery and to explore how PFM can act as an enabling instrument in improving health. Evidence from other countries is presented to help interpret findings from these two countries.

MATERIALS AND METHODS

This article uses qualitative methods, a systematic review of the literature, and two country case studies to examine the connections between the PFM dimensions and health service delivery. The literature was identified through a Boolean search strategy using the term PFM, or a synonym thereof, in combination with “service delivery” and “health.” A manual review of titles and abstracts found 12 relevant studies of sufficient quality.

The review of the literature has two purposes. It provides a conceptual discussion of the theory on how the budget cycle relates to the provision of health services, and it identifies current evidence on the link between PFM and service delivery. Because the literature does not show how the various dynamics actually play out at the country level, this article subsequently explores these dynamics through case studies from Tanzania and Zambia. These two countries were selected because of new information on their public financial management that has been collected in public expenditure reviews by the World Bank. Furthermore, the characteristics of the health systems in Tanzania and Zambia

make them interesting cases for comparison. Though the two countries provide valuable insight, a sample of two is small and does not suggest that findings have external validity. Rather, the two countries are used illustratively to show how various PFM interventions can affect service delivery at the facility level. Findings from the country case studies were compared to evidence identified in the literature review.

HOW PUBLIC FINANCIAL MANAGEMENT RELATES TO SERVICE DELIVERY

The nature of the budget cycle has been discussed extensively in the literature.^{4,6,12,17} The three stages in the budget cycle are linked to service delivery as follows: (1) budget formulation: how public spending priorities in health are determined and included in the budget, approved, and funds allocated to health activities; (2) budget execution: how budgets are used to finance the provision of health services; and (3) budget evaluation: how the implementation of the budget is evaluated and used to inform the next budget allocation. Others have visualized the budget cycle in four or seven stages.^{1,7,18} The authors chose a shorter, three-stage version to simplify and make points more clearly. Together these three budget stages affect how well a health system can deliver services efficiently, equitably, of high quality, and by keeping managers accountable.^{3,6} Figure 1 shows this relationship. A more detailed discussion of the three stages and their relation to service delivery goals is provided below.

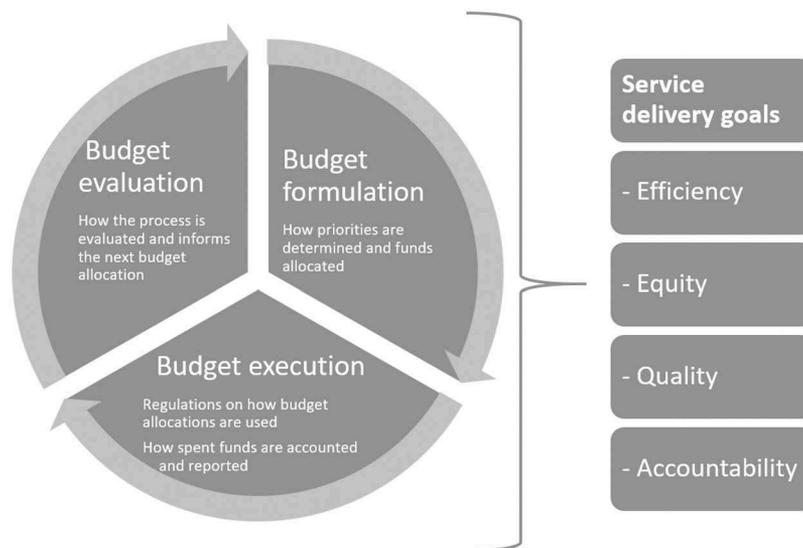


FIGURE 1. From PFM to Service Delivery Goals: A Conceptual Framework. Based on Andrews et al.¹ and Cashin et al.⁶

Budget Formulation

Fiscal discipline governs budget formulation and puts pressure on the sectors to formulate their budgets in a responsible way that reduces the fiscal risk for the government. During the budget formulation process, health facility managers develop their activity plans against the budget ceilings provided by the government and in alignment with sector priorities. All plans are then submitted to the higher administrative level where they are compiled for annual budget proposals. Plans are often extended beyond the next fiscal year to allow for a multiyear perspective. The structure of the budget proposals is classified against the chart of accounts of government. Most proposals show economic classification (e.g., salaries, pharmaceuticals) and administrative classification (such as the Ministry of Health), but some go beyond to include information on activities or specific functions or programs such as primary health care. Governments in East and Southern Africa predominantly classify their budgets as line items by economic classifications. Other budgeting methods in health include activity budgets, which disburse based on the number of activities provided; program or performance budgets, which reimburse for a specific performance agreement; or global budgets for hospitals, which provide a fixed amount to hospitals to cover the aggregate costs of delivering a set of services. In many countries, governments tend to use a mix of these budgeting methods in health.

The budget formulation process aims to enhance allocative and operational efficiency; however, it can lead to inefficient health service delivery when there is a disconnect between planning and actual needs; for example, because of unexpected higher demand for health care. Equity and health service quality may be negatively affected if the necessary budgetary provisions are not made to treat lower income groups or to ensure the availability of medical supplies. And budget formulation does not keep health facility managers accountable if future planning is not informed by an evaluation of past performance.

Budget Execution

Once the budget is enacted, health facilities are given the mandate to execute the budget according to plan and with financial discipline. Spending guidelines govern the mechanisms by which health budgets are executed. Guidelines specify who has to sign off on spending requests, what funds can be used for, and what flexibility facility managers have in moving funds across line items. The execution of the budget is subject to internal controls that are enforced through the government's financial management information system. PFM rules require

all financial transactions to be captured by the accounting system, which is fundamental for accountability in budget execution. In an input-based budget, the execution is to pay for the planned line items such as salaries and medical material. This also applies for output-based budgets, but facility managers have more flexibility to reallocate funds to deliver specific outputs.

Though budget execution rules introduce some financial discipline, they can also limit health service delivery performance. Line item budgets, for example, can lead to inefficient service delivery when facility managers are prohibited from reallocating funds across line items to finance overruns in wage expenditures to respond to unexpected needs. In addition, health budgets may arrive late in the year, which can lead to arrears to suppliers or to charging unofficial fees to patients, which may affect equity in access.

Budget Evaluation

At the end of the budget cycle, governments are required to send their annual financial reports to independent agencies for external audit and accountability processes.¹ Budget evaluation is the stage where the government examines how effectively funds have been used to achieve policy objectives, which is important to inform budget allocations for the subsequent year. However, budget evaluation processes tend to be focused on financial compliance rather than how efficiently and of what quality services were delivered. In addition, budget evaluation processes tend to not assess equity in access to inform future allocations.

A caveat needs to be made on how health facilities can manage funding. Health services are delivered by health providers owned by central and local governments and, in some countries, the private or voluntary sectors who contract with government. This means that the degree of financial autonomy given to a health facility as well as the maturity of the PFM system affect how health facilities process and manage their budget. Introducing these different levels of budget management would be beyond the scope of this article, which focuses on the experiences of public health facilities in Tanzania and Zambia.

RESULTS FROM COUNTRY CASES

This section uses the above framework (Figure 1) to examine how the three stages in the budget cycle affect efficiency, equity, quality, and accountability in health service delivery in Tanzania and Zambia. Table 1 summarizes possible stumbling blocks that can be created during the budget cycle and maps them against the four goals in health service delivery.

Budget cycle	Health service delivery objectives			
	Efficiency	Equity	Quality	Accountability
Budget formulation	Budget system rigidities slow down additional allocations to finance unexpected demand for care Budget ceilings can lead to cuts without prioritizing health activities Fragmented funding sources undermine effective planning	Budgets are developed with insufficient attention to equity	Budgets are developed with insufficient attention to service quality	Facility managers are not kept accountable for financial management
Budget execution	Rigid internal controls limit flexibility in budget execution Insufficient budget provisions lead to arrears and price increases	Budgets that are insufficiently funded can compromise equity	Budgets that are insufficiently funded can compromise service quality Slow and irregular cash releases can compromise service quality	Lacking financial accountability undermines the foundation for autonomy
Budget evaluation	Budget evaluation that inadequately informs the next budget cycle compromises efficiency	Budget evaluation tends to be compliance driven and gives inadequate attention to equity	Budget evaluation tends to be compliance driven and gives inadequate attention to quality	Lack of integrity in capturing and reporting transactions undermines budget evaluation and accountability

TABLE 1. Mapping PFM to Health Service Delivery: An Overview of Challenges

Efficiency

The efficiency of health service delivery is impacted by all three stages of the budget cycle, including budget formulation, execution, and evaluation.

Budget System Rigidities Slow Down Additional Allocations to Finance Unexpected Demand for Care

During the budget formulation process, health facilities plan their activities to treat the expected need for services by patients. In Tanzania and Zambia, the government releases funds against the budget, and health facilities are expected to implement activities as outlined in their plans. However, demand for health services can change; for example, if there is a spike in disease incidence. Often countries have a contingency budget line to finance such unexpected demand. Responding to an increased demand for care would require a swift adjustment to the total finances allocated to health and a change to the purpose for which funds can be used. This process, however, can be cumbersome and slow, because supplementary budgets may be required that

will need to be ratified by the legislature, as shown by the following example.

One example of a disease spike is the cholera outbreak in Zambia between September and December 2017, when 547 cholera cases were reported.¹⁹ This resulted in an unanticipated increase in patients who had not been budgeted for and for which Zambia did not have a contingency budget line available. The onset of cholera required additional resources to finance surveillance, health education, chlorine distribution, contact tracing, and environmental health monitoring. However, supplementary budgets require legislative approval and are usually not passed more than once a year in Zambia. This restriction can become a stumbling block. It makes facilities slow to react to emerging needs, which undermines their operational efficiency. Expenditure caps at the program level, rather than the facility level, could address this issue but are in practice difficult to manage because this could lead to large unwarranted expenditure inequities across facilities. To respond to the crisis, the Zambian government relied on extensive assistance from the international community

and the Zambian army, in part due to financing needs but also because of budget rigidities that slowed down the provision of additional funds to finance cholera treatment.

Budget Ceilings Can Lead to Cuts without Prioritizing Health Activities, Population Groups, or Expected Outputs and Outcomes

Planning is a bottom-up exercise in both countries. Health facilities develop plans to deliver activities to their population and achieve specific outputs and outcomes such as vaccination coverage. Facilities submit their plans to the district authorities where they get collated and then passed on to the legislative for approval. In Tanzania, however, facility plans tend to be too aspirational. During legislative enactment, the proposed plans were adjusted by administrators to be within budget ceilings that were set *after* the planning stage and without adequate consultation with the health sector about priorities. Once actual budget ceilings were established, health facilities were not given the chance to prioritize their plans adequately. The resulting misalignment between planning and budgeting undermines the purpose of bottom-up planning. It is also inefficient because administrators who are unfamiliar with the resource needs in health facilities decide on their behalf.^{20,21} In Tanzania, the situation has improved somewhat in recent years in part due to efforts in making indicative budget ceilings more realistic and by discouraging wish-list proposals from facilities. Similarly, in Kenya, the misalignment between planning and budgeting was found to weaken prioritization of activities in the health sector, and the integration of these processes through information technology investments would strengthen the policy orientation of the budget.²²

Fragmented Funding Sources Undermine Effective Planning

Health facilities in Tanzania and Zambia receive funds from several sources, including budgetary allocations from the government; results-based financing (RBF) and basket fund allocations from donors provided directly to facilities; user fees paid by patients, which are retained by facilities; as well as revenues from health insurance when facilities are reimbursed for treating insured patients. These funding sources have their own protocols on how funds can be used. For example, in Tanzania, health facilities must follow guidance notes on resource use for RBF funds, protocols for the use of user fees and health insurance reimbursements, and a negative list on the use of basket fund resources. The negative list identifies all items that may not be purchased with basket funds. This undermines effective planning,

facility management, and efficiency, because the various protocols are insufficiently coordinated at the facility level and lead to rigidity in the use of funds. An unforeseen shortfall of funds from one source cannot easily be replaced with another during budget execution. This has been found to affect drug availability in health facilities and the adequate provision of medical supplies to provide care. Anecdotal evidence suggests that facilities take a pragmatic approach and use RBF funds for investments and salary top-ups because they cannot use other resources such as basket funds for these expenses. In Tanzania, the problem is partially addressed through investments in information systems and consolidated facility plans that should provide better oversight until purchasing reforms are implemented. Other countries attempted to mitigate fragmentation through sector-wide approaches. A review of Sector Wide Approach (SWAPs) concluded that they contributed in harmonizing development assistance but were only modestly successful in improving efficiency in resource use through using joint financing modalities.²³ Fragmented funding can also create adverse financial incentives. If patients, health insurance, and RBF all pay providers a fee for specific services, then some procedures can become “cash cows” for providers, which may cause providers to deliver more of these services and contribute to growing expenditures.

Rigid Internal Controls Limit Flexibility in Budget Execution

Health facility managers in Zambia and Tanzania do not have the necessary autonomy to reallocate funds to changing needs such as to finance higher drug expenditures during the year. This limits their ability to allocate funds effectively. The execution process of line item budgets entails controls that ensure that funds can only be requested against items in the budget that were previously committed to and approved by the legislature. For example, commitment control would ensure that funds allocated for utilities are actually spent on utilities and not diverted to other items such as goods and services or wages. Tanzania has recently introduced a program-based budget classification at the local government level that disburses the budget against programs like primary health care and preventative care. However, during budget execution, the commitment control still applies to inputs and activities instead of outputs. Similarly, in Zambia, program budgets have been introduced and are reported against, but execution continues to enforce strict line item control. Inefficiencies in service delivery arise because facilities are bound by

original activity plans and thus unable to adjust to changing priorities in service delivery in an output- or program-based budget.

In both countries, high levels of control during execution mean that the Ministry of Finance lacks confidence in the prudence of spending units. In both countries, the program or output budget reforms are therefore not effectively utilized. Strict line item–based ex ante commitment control would not be necessary, and facilities could instead report against line items after expenditure has been concluded. In Tanzania, an enabling factor was that line item control was aggregated to allow for greater flexibility within that budget line for health facilities. Further, automatic virement (transfer from one part of a budget to another) for limited budgets is permitted (e.g., up to 10% between budget lines). This approach did not fully address the problem of insufficient flexibility imposed by the rigorous line item commitment control, but it removed some of the inflexibility by allowing for shifting some of the funds.

Insufficient Budget Provisions Lead to Arrears and Price Increases

Arrears in the health sector are a concern in Tanzania and Zambia and affect efficiency. They are most common in non-wage recurrent expenditures but can also accrue for wages and salaries, which make up the larger share of the budget. In Zambia, multiyear framework contracts were signed with suppliers but not captured in the financial management system. Contracts have, however, frequently exceeded budgeted amounts, and budgets have been released with delays such that suppliers were not paid on time. This has resulted in a significant buildup of arrears. By 2015, Zambia had 30 million USD of accumulated arrears for drugs and pharmaceutical supplies, corresponding to about 7% of general government health expenditures. A subsequent depreciation of the kwacha against the USD further worsened the fiscal implications of arrears (denominated in USD). Arrears can lead to a price increase because suppliers adjust prices to accommodate for risks of late payment. In Zambia, suppliers refused to deliver drugs until arrears were settled. Thereafter, suppliers built in a risk premium and increased prices, which negatively affects efficient use of funds. Efficiency in service delivery was undermined because it required more resources to deliver care. Higher prices also led to periodical drug shortages in health facilities. In Tanzania, arrears affected efficiency through late payment penalties.^{21,24} Arrears are problematic in other countries too, including in Malawi, where the public expenditure review identified arrears due to poor financial management.^{25,26}

Equity

Equity in service delivery is mostly affected by budget planning.

Budgets Are Developed with Insufficient Attention to Equity

Tanzania recently introduced an output orientation to the traditionally input-oriented budget. Zambia has been using multiyear program budgets. However, budget formulation is insufficiently informed by equity criteria. Relevant factors such as disease burden, poverty rates, and changes in population density are not adequately taken into consideration during the budget development stage, which contributes to inequalities over the years. In Zambia, annual non-wage budgetary allocations were guided by a formula to account for inequalities; however, non-wage government spending covered only 16% of total expenditure. The formula consisted of a deprivation index that estimated relative need based on several factors including population size and density, disease burden, and various poverty proxies. However, the formula was not updated over time and was ineffective in addressing equity. The physician-to-population ratio for the top quintile is about five times that for the bottom quintile, compared with around 3.5 times for nurses and midwives.²⁷ Furthermore, the formula did not extend to lower levels of local government and adjust for inequities within districts, which can be higher than inequities across districts. Adjusting the full budget, including human resources by area-specific equity criteria, would provide greater budgets to facilities in disadvantaged areas that generally find it problematic to attract staff to work there.

Quality

The quality of health service delivery was found to be impacted through deficiencies in the budgeting and execution processes.

Budgets That Are Insufficiently Funded Compromise Service Quality

In Zambia and Tanzania, the credibility of the budget, which is the degree to which budgets were honored, was found to be inadequate and the government disbursed funds late in the year. If budget appropriations are not honored, this has important implications for facilities' abilities to deliver quality health services. Though wages are usually paid, budgetary allocations for nonsalary recurrent expenditures or capital expenditures fare worse. The quality of health care suffers if facility managers do not have the necessary funds available to pay for medical material, pharmaceuticals, and facility maintenance.

And staff cannot work effectively if they lack the necessary medical supplies to provide care. Stock-outs cause patients to purchase their own medical supplies and medicines from pharmacies, which can reduce equity in access to care. In Zambia, delays in salary payments negatively affected the morale among staff and encouraged absenteeism and moonlighting in the private sector. In Tanzania, about 14% of health staff are absent and the rate is much higher among medical doctors.²⁸ Similarly, in Zambia, the caseload is extremely low, with one to two patients per doctor per day,¹⁶ suggesting that doctors are absent. The absence of health staff affects service quality and can cause delays in treatment. In Uganda, absenteeism among health staff has resulted in an increase in emergency caesarean sections, with complications and worse outcomes.²⁹

Accountability

Accountability of service delivery permeates through the full budget cycle. The case studies point to accountability issues in budget execution and evaluation.

Facility Managers Are Not Held Accountable for Financial Management

In Tanzania and Zambia, health facility managers plan their activities and district health authorities manage the financing of these health activities. Facility managers thus are accountable for the delivery of services but not for financial management, which creates an accountability gap. Facility managers may not know whether they are within budget with their activities, which makes it difficult to hold them accountable. Facilities are also not kept accountable to the population they serve because they can argue that resources from the district are slow to arrive and insufficient. Similarly, district authorities are responsible for managing health funds but they are not responsible for how health services are delivered and for health outcomes. To address this accountability gap, donor basket fund allocations and performance financing schemes are now disbursed directly to health facilities in Tanzania. Increased financial responsibility for facility managers has been accompanied by capacity building in financial management at the facility level to align processes and incentives. The effectiveness of this policy shift has not been evaluated yet because direct disbursement to facilities was only introduced in early 2018. But it will provide increased financial autonomy to health facilities.

Financial Accountability Provides the Foundation for Autonomy

Confidence in payment and reporting during budget execution is necessary to keep managers financially accountable and

provide decentralized services in health facilities. In Zambia, for example, financial accountability of facility managers is weak. More than 55% of funds spent at the district level cannot be mapped against budgets or spending categories, and facility managers and district authorities have not been kept accountable for the missing 45%. Unsurprisingly, this has been a stumbling block in the effort to reduce control measures and give more financial autonomy to facility managers. In Tanzania, however, significant investments in information systems were made that have strengthened financial management. These investments were fundamental for channeling funds directly to facilities and giving them more spending autonomy. Because financial information systems were only established in late 2017, the impact on service delivery remains to be seen. This makes capacity building in financial management and control an enabling factor for increased spending autonomy in health facilities.

Budget Evaluation Focuses on Compliance and Gives Inadequate Attention to Performance

The budget evaluation phase should ensure accountability and value for money in financial activities.¹ In Tanzania and Zambia, budget evaluation has tended to be compliance driven, with inadequate attention to value-for-money measures, equity, and quality. As a result, performance indicators on efficiency and equity in service delivery and quality of care are not used to inform budgetary decisions for the next year. Public expenditure and financial accountability assessments in Tanzania and Zambia point this out and emphasize that even when value-for-money audits are done, results are not used in the next budget formulation process and they are not communicated back to providers. This has affected service delivery because providers do not receive the necessary information and resources to adjust their performance and improve equity, quality, and efficiency. As long as governments face high fiduciary risks, performance audits are unlikely to be prioritized. Though this area is largely understudied, limited evidence from the Middle East and North Africa regions suggests that performance management information and internal audit can help strengthening service delivery.³⁰

DISCUSSION AND CONCLUSIONS

The way in which public funds are planned and managed has important implications for health service delivery. Yet, there is limited evidence on how financial management affects health service delivery, and some pathways about how the budget cycle affects service delivery remain underexplored. The budget formulation, execution, and evaluation processes

can create stumbling blocks that affect service delivery. These stumbling blocks stem from the lack of flexibility to provide additional resources for unexpected demand for care, late budget ceilings that do not allow for prioritization of health activities and volumes, fragmented funding sources that undermine effective planning, rigid internal controls that limit facility autonomy during implementation, insufficient budget provision that can lead to arrears, and budget evaluation practices that are compliance driven and give inadequate attention to issues of equity, quality, efficiency, and accountability in service delivery.

Examples from Tanzania and Zambia show that PFM can become an enabling factor for efficient service delivery by providing adequate budget ceilings up front and discouraging wish list-based planning to reduce the need for arbitrary cuts later in the budget cycle, as well as information technology investments that capture planning, budgeting, execution, and accounting and reporting requirements from government and donors. PFM is not equity or quality oriented on its own, but PFM can make it easier for facility managers to ensure equity and quality of service provision by including these objectives in the budget formulae and moving away from historic budgeting. Stricter control, greater compliance, more rigorous monitoring, and strong accountability for the use of resources are all critical enabling factors.

Framing the discussion around both PFM and service delivery objectives shows that there are terminology differences between PFM and health financing. PFM tends to be framed around the budget cycle, whereas health financing discusses revenues, pooling, and purchasing of health services. This gap in terminology also needs to be overcome to facilitate a dialogue and show how a well-managed budget can contribute to improved health service delivery.

This analysis was limited to two countries and the findings do not necessarily provide external validity. Future research could examine additional countries and address questions of the effects on service delivery of channeling funds directly to facilities and holding them accountable; the role of performance management in facilities with spending autonomy; the sequencing of public financial management reforms at the facility level to introduce autonomy and performance measures; conditions for effective performance audits; and how arrears affect service delivery. Analysis on these financial management issues could inform the current discussion on budgetary reforms in health, including moving from line item budgeting to different types of performance-based budgeting, and help ensure that financing mechanisms set the necessary incentives to improve health care performance.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflict of interest was reported by the authors.

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