

ALIGNMENT OF PERFORMANCE-BASED FINANCING IN HEALTH WITH THE GOVERNMENT BUDGET

DISCUSSION PAPER

August 2021

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WORLD BANK GROUP
Health, Nutrition & Population

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A Principle-Based Approach

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Health, Nutrition, and Population (HNP) Discussion Paper

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Health, Nutrition, and Population (HNP) Discussion Paper

Alignment of Performance-Based Financing in Health with the Government Budget: A Principle-Based Approach

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This paper would not have been possible without the generous support from the Global Financing Facility.

Abstract: Performance-based financing (PBF) is the transfer of funds to health facilities so they can provide a pre-agreed set of services according to appropriate standards of quality and administration. These initiatives have introduced a wide set of reforms, including in provider autonomy, access to financial services, flexibility on the utilization of funds, a performance orientation on the budget allocation, and rigorous verification protocols. This tends to set PBF apart from the prevailing public financial management (PFM) systems that often remain input-based and thereby create a sustainability challenge. As long as the prevailing PFM system remains in parallel to the PBF, countries are likely to return to the legacy PFM system once PBF donor resources dry up.

This paper unpacks this problem. It develops a conceptual framework about how to think about aligning PBF principles with PFM structures; offers a set of diagnostic questions for an assessment; and helps guide an analyst through the process of developing a reform roadmap, taking into account country context. The paper also proposes a reform roadmap to be centered around the following four facility financing pillars: (i) provider autonomy, (ii) financial management capacity, (iii) output-oriented budget provisions, and (iv) a unified payment system. As a discussion paper, this work aims to solicit feedback on the proposed approach from the PBF and PFM community.

Keywords: Performance-based financing, public financial management, performance budgeting, reform process, unified payment system, provider autonomy.

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ACKNOWLEDGMENTS

The authors Moritz Piatti-Fünfkirchen (Senior Economist, World Bank), Sierd Hadley (Public Finance Research Fellow, ODI), and Benoit Mathivet (Senior Health Economist, World Bank) are grateful to the World Bank for publishing this report as an HNP Discussion Paper. Angelita Adajar Bombarda (Analyst, World Bank) provided excellent analytical support. The team is also grateful to Tigist Yimer and Fiona Mack for excellent administrative and editing support. Ernest Massiah provided management oversight for this cross-cutting, regional analytical task. The work would not have been possible without generous financial support from the Global Financing Facility (GFF).

The work has benefitted tremendously from multiple rounds of discussions and feedback of a core working group on the topic that include Ellen Van De Poel (Senior Economist and GFF Lead for Health Financing, GFF), Petra Vergeer (Senior Health Specialist and GFF Lead for Knowledge & Learning and RBF, GFF), Moulay Driss Zine Eddine El Idrissi (Lead Economist, World Bank), Opope Oyaka Tshivuila Matala (Senior Health Specialist, World Bank), Rwema Jean De Dieu Rusatira (Senior RBF Consultant, GFF), Tawab Hashemi (Senior Health Specialist, GFF), Alain-Desire Karibwami (Senior Health Specialist, GFF), Munirat Iyabode Ayoka Ogunlayi (Senior Health Specialist, GFF), Isidore Sieleunou (Senior Health Specialist, GFF), Ayodeji Oluwole Odutolu (Senior Health Specialist, GFF), Fedja Pivodic (Economist, World Bank), and Timothy Williamson (Senior Public Sector Specialist, World Bank).

The team also wishes to acknowledge conceptual inputs based on numerous discussions with Helene Barroy (Senior Public Finance Expert, WHO), Joe Kutzin (Unit Head, Health Financing, WHO), Federica Margini (Analyst, WHO), Gemini Mtei (Finance Team Lead, Tanzania, Abt Associates), and Sheila O'Dougherty (Senior Independent Consultant) for an upcoming policy note on financing facilities through government systems. As this is ongoing work, the current interpretations in this paper are that of the authors alone.

The work also benefitted greatly from a close collaboration with Ousmane Maurice Megnan Kolie (Senior Public Sector Specialist, World Bank) on a PBF workshop, where the team was able to collect invaluable feedback from an engaged audience. The team also thanks Celestin Adjalou Niamien (Senior Financial Management Specialist, World Bank) and Yohana Dukhan (Senior Health Economist, World Bank) from the Cameroon team, who were the first to pilot the quantitative approach and speak to its practicability and relevance for the policy dialogue.

PART I – INTRODUCTION

Performance-based financing (PBF) is the transfer of funds to health facilities, which will provide a pre-agreed set of services at appropriate standards of quality and administration.¹ PBF makes these transfers to facilities conditional on the verified delivery of services or results, with the aim of giving these facilities an incentive to improve the quality of their services. This is typically accompanied by granting health facilities greater autonomy over their budgets, including whether or not to top up staff salaries. As such, PBF tends to be a significant departure from an input-based public financial management (PFM) system, which continues to be the predominant budgeting modality across Africa and beyond. The intent of this paper is to provide the following:

- Conceptual clarity on how typical PBF and government public financial management processes differ
- An assessment framework to determine how well a PFM system reflects PBF principles in any given country
- Guidance on how to develop a reform roadmap taking into account country context

This discussion is presented against the backdrop of continued debate about the success and value for money of these schemes. On the one hand, there is evidence that PBF has led to improved performance in the health sector. Various evaluations have found that PBF has improved output measures of health system performance, such as increases in outreach activities, institutional births, the professionalism of the health workforce, and reductions in staff absenteeism. There has also been some evidence that PBF has contributed to progress in infant and under-five mortality, although a causal relationship has been more difficult to establish. On the other hand, there remain questions about the cost-effectiveness of PBF schemes, and some recent studies have suggested that the financial incentive mechanism may not be driving results. There have also been concerns about excessive costs of verification.²

Despite this ongoing debate, PBF has been popular with many development partners, as it allows for sending funds to the front line, is outcome-oriented, and introduces strong accountability mechanisms. The World Bank, with support from the Health Results Innovation Trust Fund (HRITF) and now the Global Financing Facility (GFF), is currently supporting PBF operations in 28 countries around the world, including 21 in Africa, where it has committed over US\$1.6 billion in financial support.³ However, there remains a risk to the sustainability of these investments. Most projects have operated in a pilot-based project modality and in parallel with existing government financial management processes. As a result, PBF mechanisms are frequently abandoned after the donor project closes and governments return to business as usual.⁴

This paper maps out the systemic differences between a typical PBF engagement and national PFM systems. This is, of necessity, general and at this point cannot take account of the substantial variations in how both PBF schemes and national PFM systems work from country to country. The discussion also doesn't apply to countries where PBF schemes are purposefully

¹ This paper takes a narrow definition of PBF and thus excludes demand-side schemes such as voucher programs.

² The literature is summarized in Renmans et al. (2016).

³ More information on the PBF portfolio can be found at RBFhealth.org.

⁴ Shroff, Bigdeli, and Meessen (2017) reviewed the factors that supported or hindered the scale-up of PBF in 10 countries, one of which was its alignment with PFM systems.

routed through extrabudgetary funds such as insurance mechanisms. This paper illustrates key issues that are likely to emerge while mainstreaming PBF into the government budget. Providing conceptual clarity around these differences between PBF and the national PFM system will help policy makers and practitioners identify how this may relate to their countries. This is necessary for a dialogue around the reform process on mainstreaming PBF principles into the budget, developing a roadmap, and providing clarity on where compromise may be necessary.

The paper first describes how facilities are placed in a typical PFM system, followed by a summary of how PBF schemes are generally designed, and the likely tensions between these two funding models. This is followed by a discussion of the challenges that must be overcome if PBF is to be mainstreamed into national PFM systems and what such a reform process may look like across country contexts. The paper offers a conceptual framework and diagnostic tools to identify where PFM processes reflect PBF principles to help develop a reform roadmap. As a discussion paper, this work aims to solicit feedback on the proposed approach from the PBF and PFM community.

Issues that go beyond public financial management and are outside the scope of this paper concern legal issues associated with provider autonomy, questions of human resource management and cost and cost-effectiveness, discussions on the cost of verification, and whether performance-based reform is necessary for motivation and if it is valid across contexts.

PART II – PUBLIC FINANCIAL MANAGEMENT AT THE FACILITY LEVEL

Health facilities operate within a country's general PFM framework. This system determines the way in which facilities receive budgetary allocations, can spend their funds, and are held accountable for the use of those funds. A typology for funding arrangements, though these are generally not mutually exclusive, is provided below.⁵

- 1. Systems with statutory funds or purchasing agency that operates outside the budget** (e.g., Ghana). Purchasing agencies that operate outside of the budget do not abide by general budget execution protocols, and revenues for such agencies are in part derived from user contributions. However, if they rely on large government transfers or subsidies, the payment of these subsidies is subject to budget execution protocols. As such, what matters most in this instance is whether transfers are timely and correspond to budget appropriations. How health policy is relevant, how the purchasing agencies spend money or reimburse service providers, or how service providers then use funds from insurance payments exclusively depends on the contractual arrangement between purchaser and provider, and not the PFM arrangements.
- 2. Fiscally decentralized countries** (e.g., Kenya and Pakistan). Budget execution in a federal government setting is twofold and concerns (i) how central government manages intergovernmental transfers, and (ii) how state budgets are spent. If state budgets rely heavily on revenue received from intergovernmental transfers, the ability of states to deliver health services will also depend on the timeliness and credibility of the intergovernmental transfer. Regular budget execution protocols apply to how budgets have been spent at the state level.
- 3. Countries that allocate public budgets to local government administration for service delivery** (e.g., Malawi and Zimbabwe). In many sub-Saharan countries, local government administrations have the mandate for health service delivery and own facilities at the local government level. As such, they are the lowest-level spending unit in government that executes the budget on behalf of service providers. Relevant questions for countries in such a setting relate to how providers benefit from budgets executed at the local government level, and what it means for accountability and their ability to manage.
- 4. Countries that allocate budgets directly to service providers** (e.g., Tanzania and Burkina Faso). If budgets are provided directly to providers, this changes the legislative discourse, as an explicit decision needs to be made directly on how much each provider should be allocated, and then the provider is directly responsible for the adequate execution of that budget. Tertiary or secondary care hospitals are often explicit budget holders, while primary care providers are less so.
- 5. Countries that rely on nongovernmental organization (NGO) contracting for delivery of a minimum benefits package** (e.g., Afghanistan and Somalia). In some

⁵ Piatti-Fünfkirchen et al. (forthcoming)

fragile country settings, there is insufficient government capacity to provide health services directly. Here government contracts with NGOs directly to provide services on behalf of the government. Budget execution in such cases relates to how well such contracts with service delivery–implementing NGOs are managed.

PFM systems work differently in different countries and even in different parts of the public sector within a given country.⁶ Therefore, for practitioners seeking to apply the findings presented here, it will be necessary to account for the specific context in which they intend to put them into practice. The public financial management system in any given country is governed by a range of legal instruments, including the national constitution and laws on public financial management, audit institutions, procurement, and local government, along with their associated regulations. This legislation sets out key dates in the budget calendar, rules about who can authorize spending (warrants), the level at which the legislature controls overall spending limits (appropriations), the powers of the finance ministry to amend the budget during the year (virements⁷ and supplementary budgets), and whether districts and facilities may carry over unspent funds into subsequent fiscal years. These rules constitute the basis for the control of public expenditures, guided by a number of overarching principles related to the comprehensiveness, universality, unity, annuality, and specificity of the budget.⁸

Most countries with a decentralized health service have laws establishing the roles and responsibilities of different levels of government in supporting or delivering services and on how they are to be funded. Some countries use unconditional intergovernmental transfers to fund local health services, while others mainly use conditional transfers.⁹ Some central governments (e.g., in Tanzania and Uganda) appropriate resources directly to local governments, which prevents the ministry of health from reallocating operational funds from one local government to another during the fiscal year without first returning to the legislature to seek approval to do so.

The systems for managing different kinds of spending also vary. Our focus here is on operational budgets, and specifically those paid in cash. Drugs, equipment, and other resources are also provided in-kind by higher levels of administration (such as national medical stores). Staffing tends to have additional controls and rules developed by the ministry of public service (or equivalent), including through district or regional service commissions. Capital budgets are also often managed by the central government or by the subnational levels directly, often following different protocols and requirements. These arrangements naturally limit the discretion available to facility managers.

⁶ There is an extensive literature that describes aspects of the PFM systems that vary between countries (including Andrews 2008; Lienert 2003 and 2005; and Pattanayak 2016). These differences become more pronounced for units operating closer to the front line of service delivery and also depend crucially on each country's colonial history.

⁷ A virement is an administrative transfer of budgetary funds.

⁸ Lienert and Yaker (2010) describe the common features and good practices in PFM legislation.

⁹ The nature of decentralization affects how the budget for facilities is decided and managed, not just because of the way in which resources are provided and authorized but also because the PFM system itself may vary from one subnational government to another in very devolved settings (Boex 2013). A general discussion of intergovernmental fiscal transfers is available in Boadway and Shah (2007).

The Budget Cycle

PFM processes can be summarized as a three-stage budget cycle, as follows: (i) the formulation of the budget (how spending priorities are determined, budgets approved, and funds allocated); (ii) the execution of the budget (how budgets are used to finance the provision of services); and (iii) budget evaluation (how the budget execution is assessed to inform the next budget allocation). These three stages of the budget cycle are, in turn, explained using a stylized picture of PFM in a low-income country¹⁰ that uses a district-based primary health care system. The description also focuses on the nonwage, recurrent funding aspect of PFM, which is what constitutes the operational budget. The aim is to describe how government systems allocate and exercise control over resources to health facilities and to highlight features of the PFM system that are likely to be important for mainstreaming PBF.

Budget Formulation

All spending agencies in the health sector are generally required to adhere to an overall strategy that is meant to guide the development of their plans. Budget ceilings are given to the lowest spending unit. This is sometimes the district rather than health facilities, in which case facilities receive in-kind goods and services instead of funds from the district to enable them to deliver services. When districts are the lowest spending unit, the ministry of health sets limits on how much they may spend per facility or per policy objective. The facilities then make plans for the year ahead within this ceiling, in alignment with the government's health sector strategy. Facilities often include all funding sources in their plans, including government budget funds, user fees, and various donor sources that may not be recorded in either the national or district budgets. The facility plans are then submitted to the higher administrative level, where they are coordinated, and a budget proposal is prepared to be submitted to the relevant authority for approval.

While the facility plans can take a multiyear perspective, the budget proposal is usually prepared annually to authorize spending for one fiscal year. The structure of the budget proposals is classified against the government's chart of accounts. Most budget proposals are structured by economic classifications (such as salaries or goods and services) and administrative classifications (units in government such as the ministry of health, the local government, or the AIDS commission), but some are further disaggregated by specific activities, functions, or programs (such as primary health care).¹¹ Facilities are usually given a fixed lump sum of funding to cover their operational costs, rather than a detailed breakdown of inputs. However, the classifications in the district-level budget proposals are used as the basis for control during budget execution, with the spending limits set by the legislature for the fiscal year providing overall limits, and the finance ministry setting further controls for in-year expenditure at a lower level of detail than the formal appropriation.

¹⁰ Most of these factors also hold true for francophone countries in Africa.

¹¹ Barroy et al. (2018) provide an overview of health budgets using a common distinction in PFM between line-item budgets (where the basis of control falls on administrative and economic classifications of spending) and program budgets (where the basis of control falls on administrative and program classifications, while using economic line items as additional information for financial reporting).

Budget Execution

Once the budget is enacted, facilities may execute their budgets in accordance with their plans. A set of organizational processes govern general resource management, including how funds are disbursed to facilities, where resources are banked, and the mechanisms by which various expenditure categories are executed. Wages and salaries are typically managed differently from goods and services, and paid directly by the finance ministry into the health workers' bank accounts.

In some low-income countries, the finance ministry operates a system of “cash rationing,” whereby the disbursement of the approved budgets for facilities depends on the level of funding that actually becomes available during the year.¹² This is usually done by restricting quarterly warrants that authorize ministries and local governments to spend their budgets at lower levels than were appropriated. This has become an essential tool for governments in low-income countries to maintain control over the overall budget to curb inflation, but it can make budgets—and therefore service delivery—unpredictable. This is a problem for input-based budgets and PBF alike.

Once the funding is released, the execution of the budget by districts or facilities is generally subject to a set of internal controls, including budgetary controls and ex-ante commitment controls that are enforced through the Financial Management Information System (FMIS).¹³ In most low-income countries in sub-Saharan Africa, the budget is structured on an input line-item basis, and execution enforces ex-ante spending control according to detailed budget estimates. Virement rules provide some flexibility on resource use but are generally restricted to specific spending categories, programs, or spending units. All transactions need to be captured by the accounting system, which means that the payment and accounting functions need to be integrated to ensure that what is reported accurately reflects the actual transaction. Toward the end of the year, limits are generally set to restrict the carryover of funds and spending commitments into the next fiscal year.

Facilities access their budget funding in a range of different ways, including through the district account, a cash imprest system,¹⁴ or the facility's own bank account. It is still common for facilities' funds to be held in the account of the districts that manage them. In a number of countries, facilities are allowed to open their own commercial bank accounts. This is sometimes accompanied by a change in the flow of funds, with the finance ministry providing the transfers directly to facilities instead of going through intermediaries.¹⁵ Most countries are now establishing a treasury single account, which is a unified structure of government bank accounts that enables governments to consolidate their cash balances and minimize short-term borrowing costs.

Budget Evaluation and Oversight

¹² Cash budgeting practices are described by Stasavage and Moyo (2000); Miller and Hadley (2016) identified these practices as a factor behind the unreliable funding flows in the health sector in a number of countries.

¹³ See Pattanayak (2016) for a useful description of different approaches to spending controls.

¹⁴ An imprest is a cash account that businesses use to pay for small, routine expenses. Funds contained in imprest are regularly replenished to maintain a fixed balance.

¹⁵ Examples of this practice include Kenya (Opwora 2009), Uganda (Barroy et al. 2018), and Tanzania (Kapologwe et al. 2019).

Audits and the verification of results play an important role in informing budget allocations for the subsequent budgetary cycle. Annual budget evaluations are usually carried out by an audit institution that assesses whether financial activities were carried out in compliance with the country's original budget law and in accordance with the rules set out in its PFM legislation. In addition, this body conducts specialized audits and performance audits on specific services and areas of spending, although these are not carried out annually. Under international standards, audit institutions are expected to be independent from the executive, with the auditors presenting their report directly to the legislature, though these arrangements vary from country to country.

Although the nonfinancial performance of health facilities is not generally considered to be part of the PFM system, it is usually evaluated by a district health team, which reports its findings to the ministry of health and other relevant central government departments. These reports can be expected to shape decisions about facilities' budgets and staffing.

PART III – WHAT CHANGES HAS PBF INTRODUCED AND HOW ARE THEY ALIGNED WITH THE PFM SYSTEM?

What Is PBF?

The idea behind PBF is agency theory, which is the idea that the interests of the principal (purchaser) and of the agent (provider) may be misaligned and that asymmetry of information leads to suboptimal outcomes.¹⁶ In practical terms, this means that the behavior of providers (health facilities and hospitals) may not reflect the objective of the purchaser (the government). For example, providers may lack motivation and therefore provide care that is inadequate in terms of quantity and/or quality, which the purchaser cannot observe and is unable to affect or penalize. Evidence from Public Expenditure Tracking Surveys (PETS) and the World Bank's Service Delivery Indicators suggest that such behavior is often widespread in the public health services of low- and middle-income countries.¹⁷

PBF is designed to counter these problems by providing for a contractual arrangement that aligns the interests of both parties by establishing a common set of objectives. Indicators are agreed upon to measure the performance of the provider. These usually include measures of quantity and quality of the services that they deliver. The provider is paid in accordance with the extent to which it has attained those objectives, based on a predetermined unit price, usually weighted by quality.¹⁸ Thus, rather than enforcing required activities, the provider has autonomy and decides which activities to carry out, while the purchaser monitors the provider's progress against outputs that are in the interest of both parties. There is typically an intermediary third party that oversees adherence to the rules and verifies performance measures.¹⁹

In terms of facility financing and financial management, PBF typically has a number of important features. Health providers are treated as autonomous budget holders with considerable flexibility to spend resources on different inputs. This allows them to respond positively to the incentives created by the PBF system. As autonomous budget holders they must have sufficient financial management capacity to ensure the integrity of public spending, including through effective accounting and reporting. Finally, the system offers payments against past performance, with these ex-post payments made on a quarterly basis.

A practical illustration of how PBF works at the facility level is drawn from the World Bank's toolkit for PBF and provided in Table 1.1 below. However, in most low-income countries, PBF is used for only some of the facility's expenditures. Input-based payments are used for staff salaries and some operational funding, while drugs and equipment are mainly provided in kind

¹⁶ Chalkley et al. (2016, 2) give a brief overview of PBF payment mechanisms from an economic perspective.

¹⁷ See Welham et al. (2017) for a review of Public Expenditure Tracking Surveys (PETS) in the health sector.

¹⁸ Shen et al. (2017) describe the setup for Zambia, for example, where indicators include institutional delivery by a skilled birth attendant, curative consultations, antenatal care (ANC) including prenatal and follow-up visits, and full immunization of children under one year old. Service areas that have been targeted for quality improvements include assessment of curative care, antenatal care, family planning, immunization, and supply chain management.

¹⁹ Exactly how these various elements are put together varies from country to country and even between different pilot projects within a single country. Renmans et al. (2016) have written that "every PBF scheme has different features, is implemented in a different context, triggers different mechanisms, and has different objectives." Chalkley et al. (2016) describe a range of different approaches that have been used in low- and middle-income countries, while Josephson et al. (2017) review differences in the quality checklists from PBF schemes in 28 low- and middle-income countries.

from district or central budgets. This brings in a final point for discussion in this paper: the need to consider the way the PBF system fits into the broader health financing landscape and the extent that this supports a unified set of financing, management, and incentive structures.

Table 1.1: A Simplified Example of How PBF Works at the Facility Level

Health facility revenues over the previous period	Number provided	Unit price (US\$)	Total earned (US\$)
Child fully vaccinated	60 [1]	2.00	120.00 [2]
Skilled birth attendance	60	18.00 [3]	1,080.00
Curative care	1,480	0.50	740.00
Curative care for the vulnerable patient (up to a maximum of 20% of curative consultations)	320	0.80	256.00
[A typical minimum package for a health center would contain 15 to 25 services.]	-	-	-
Subtotal revenues			2,196.00 [4]
Remoteness (equity) bonus	+20% [5]		439.00
Quality bonus	60% of 25% [6]		395.00
Total PBF subsidies			3,030.00 [7]
Other revenues (direct payments: out of pocket, insurance, etc.)			970.00
Total revenues			4,000.00 [8]
Health facility expenses			
		Fixed salaries staff	800.00
		Operational costs	350.00
		Drugs and consumables	1,000.00
		Outreach expenditures	250.00
		Repairs to the health facility	300.00
		Savings into health facility bank account	250.00
Subtotal expenses			2,950.00
		Bonuses to staff in the facility = total revenues – subtotal expenses	1,050.00
Total expenses			4,000.00 [9]

Source: Fritsche, Soeters, and Meessen 2014.

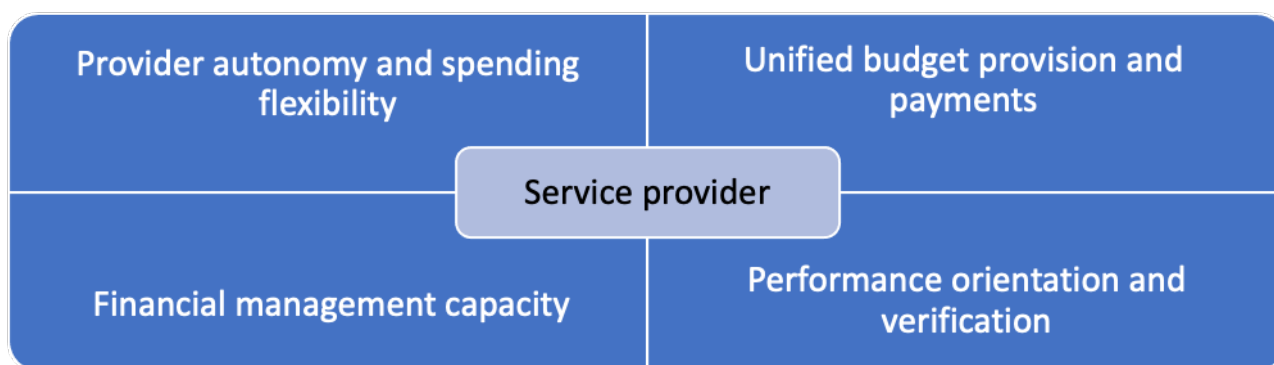
Notes:

1. A health facility fully immunizes 60 children in a quarter.
2. The health facility could earn US\$120 (60 at US\$2 per child fully immunized).
3. The health facility could earn US\$1,080 for 60 deliveries because each delivery earns US\$18. A typical minimum package of PBF services at a health center would contain 15–25 services.
4. This health facility would earn US\$2,196 as unadjusted subtotal for the services it produced over the past quarter.
5. The total amount would be adjusted for the remoteness or difficulty of the facility (equity bonus) because urban or peri-urban facilities could earn a disproportionate amount. In the example in Table 1.1 this particular facility would earn 20 percent more because of the difficulties it faces.
6. The total would also be adjusted by a quality score based on a checklist administered at the facility every quarter. This facility would earn 60 percent of what it would be entitled to because of the quality correction. The quality correction is a maximum of 25 percent of earnings from the past quarter [6]. This facility thus earns 60 percent of the 25 percent for its quality.
7. The funds earned (US\$3,030 in this example) are transferred to the bank account of the facility.
8. In this example, the health facility also has some other sources of cash revenue (US\$970), and these are added to the PBF earnings.
9. The health facility had US\$4,000 in income over the past quarter, and the expenses section illustrates how this could have been used. The income could be used for
 - (a) health facility operational costs, such as drugs and consumables, outreach expenses, and health facility maintenance and repair;
 - (b) performance bonuses for health workers (up to 50 percent) according to defined criteria; this facility decided to spend 26 percent of its total income on performance bonuses (34 percent of its PBF earnings; however, because of other sources of cash income, such funds are managed integrally); or
 - (c) savings, this health facility is saving not only to buy a motorcycle to facilitate community outreach but also to have a cash buffer.

How Do PBF Schemes Align with National PFM Systems

The introduction of PBF represents a significant change in the approach to financial management from focusing mainly on *how* funds are spent to focusing predominantly on *what* outputs are being delivered. The discussion above suggests that PBF requires provider autonomy and financial management capacity to complement the output orientation of payments. The design of an effective scheme must also consider how it relates to financing from other payment sources to minimize fragmentation (referred to as a unified payment system). These four “pillars” of facility financing²⁰ under PBF can present a challenge for integration into national PFM systems across the different phases of the budget cycle (Figure 1.1). Challenges may emerge due to a clash of principles (between the pillars here and the principles of good budgeting—comprehensiveness, universality, unity, annuality, and specificity) or from difficulties executing the PBF model in practice (such as when the finance ministry is unable to provide guarantees that funding for facilities will be transferred in full and on time).

Figure 1.1: Facility Financing Pillars under PBF



Source: Authors.

Giving Providers More Budget Autonomy

The concept of PBF requires that a health facility operate as a budget holder, with the ability to receive funds and the autonomy to decide the mix of inputs needed to deliver the contractually agreed services. There should also be enough flexibility in the use of funds to absorb ex-post payments that may vary from quarter to quarter, depending on a provider’s ability to meet the agreed-upon outcome goals. In contrast, under traditional input-based budgeting, allocations are subject to the annual budget law, which is usually enforced with varying degrees of rigidity and detail.

As discussed above, in a PBF system, facilities have reliable access to cash, either in a bank account or through some kind of cash imprest system, but some countries have stringent rules that restrict the use of commercial bank accounts by public sector organizations. Countries like Benin or Tanzania have made exceptions to their laws to allow these organizations to use commercial bank accounts; and in Uganda, facilities were asked to set up separate accounts for results-based financing (RBF) payments funded by donors. In general, however, this goes

²⁰ The discussion on facility financing pillars is based on conceptual discussions with Helene Barroy, Joe Kutzin, Federica Margini, Gemini Mtei, and Sheila O’Dougherty for an upcoming WHO/World Bank policy note on financing facilities through government systems. As this is ongoing work, the current interpretation is that of the authors alone.

against the PFM principle of “universality,” which requires that the facility’s budget must include all of its sources of revenue and all its expenditures. All resources should be linked to a common fund to be spent in accordance with the current priorities of the government.²¹ From a PFM perspective, routing funds through commercial banks that are not part of the treasury single account structure could lead to inefficiencies in budget management at the macro level—as the government would have to borrow to fund one entity’s spending while another entity is sitting on idle cash.

Authority to receive funding is accompanied by rules that restrict how funds are used. Many countries implement strict controls, with implications for how facilities can use their performance-based payments. Under PBF, facilities are able to use their funds to incentivize staff by providing them with salary top-ups in proportions that vary from country to country. However, governments tend to have civil service provisions that govern the management of the workforce, including strict establishment of budgetary controls. It is usually not possible to shift funds between budget categories for wages and other expenditures, and larger strategic hiring and firing decisions as well as salary adjustments are made at a central level.

The degree of (mis)alignment will vary between countries, depending on how the existing systems are governed. Continuing the example above, some countries permit facilities to receive additional allocations to allowances within an operational budget, including funds to hire health workers on contract. However, this degree of flexibility may not be possible in all contexts, and it will be particularly challenging for facilities if their budgets are controlled at the level of detailed line items instead of being less tightly earmarked.

Supporting Adequate Financial Management Capacity

Decentralizing responsibility for spending to providers involves the need to update the rules and systems for controlling and accounting for those funds, including the administrative coding of the chart of accounts. From a PFM perspective, decentralization of spending authority should not be problematic in itself, and many countries have made this move already, including in the education sector, where capitation grants are common. Some challenges during this process may include further decentralization of various accounting and reporting functions, including the deployment of the treasury system and the implementation of new banking arrangements. There are also common concerns about the capacity of providers (particularly smaller health facilities) to use these systems effectively and the administrative burden it creates for an already limited number of frontline staff.

Aligning the accounting and reporting mechanisms in PBF projects with a government FMIS, for example, can be difficult as an FMIS includes controls at the line-item level, which conflicts with the quarterly business plans and flexibility that are inherent in the PBF approach. Instead of using the FMIS to execute expenditures, several countries are compromising by posting their PBF transactions to the ledger after they have occurred, using the same chart of accounts, thus enabling all data to be captured in one place. However, this also means that other FMIS internal modules (such as budget preparation and payroll) cannot be used for PBF transactions. Furthermore, if transactions were routed through the FMIS, then the payment and reporting functions would be aligned, which would ensure integrity in reporting. If this is not done, costly forensic ex-post audits are needed to assess whether the reported expenditure reflects what actually happened.

²¹ Pattaro 2016.

Paying Facilities based on Their Performance

A fundamental difference between PBF and the traditional budgetary process is in the way facilities are paid. Under PBF, facilities receive funds after they provide their services, with the allocation being contingent on their performance and based on a fixed price per units delivered that is agreed in advance. During the traditional annual budget process, on the other hand, budget allotments are set at the beginning of the year, and funds are released periodically. As noted above, releases are made against the budget on the expectation that services will be delivered rather than based on the facility's actual performance during the previous quarter.

The use of an ex-post payment mechanism is already normal practice for independent suppliers of goods and services, but this is not usually the case for publicly owned facilities. Extending this principle to health facilities might result in a number of tensions. One relates to what is being bought and when. The traditional budget process provides an allocation for what will be delivered in the coming year. This is also true of commitments to pay suppliers, which must be budgeted for in advance. However, under PBF, the government may also need to pay for services that were delivered in previous fiscal years. This conflicts with the PFM principle of "annuality" in budget control. While there are precedents in Organisation for Economic Co-operation and Development (OECD) countries that legislate for multiyear contracts, such as social benefits, these kinds of rules are less common in low-income countries. Even if such rules were to be put in place, PBF schemes may be more difficult to manage in times of budget cuts, when resources decline from one fiscal year to the next.

The PFM principle of "annuality" requires all budgetary operations to be attached to one financial year to make it easier for the budgetary authority to monitor the executive body's activities.²² To update the annual budget, PFM processes would require a supplementary budget to be drawn up to reflect any significant changes, which in turn would require legislative approval rather than approval from the facility's governance committee. This can be cumbersome and is unlikely to be feasible on a quarterly basis, which is why performance grants to local governments have tended to be awarded on an annual basis. While it is possible to budget for better performance and plan to underexecute the budget to stay within legislated ceilings, this may lead to inefficient budget decisions overall and a loss of legitimacy for the outcomes the planned budget has committed to deliver. This risk will be greater if PBF budgets are appropriated to different local governments or districts, as any underexecuted funds in one district cannot then be used to compensate for overexecution in another district without having to return to the legislature with a request to amend budget ceilings.

There may also be practical difficulties embedding PBF in national PFM systems in which spending is controlled using monthly or quarterly cash rationing. If the finance ministry regularly reduces spending plans during the year because of reductions in the resources that it has available, then the agreed basis for funding facilities may not be honored and the PBF incentive system will break down. The facility may do what is required to receive a performance-based payment, but then the central government may need to reduce or hold back some of the payment due to a lack of funds. This represents a case of misalignment in practice, rather than in principle, between PBF and national PFM systems, and will be more likely to occur in countries where budgets lack reliability and where health spending is not a high political

²² Pattaro 2016.

priority.²³ A similar point could be made of the difficulties of completing a rigorous verification of performance indicators quickly enough to support a timely reimbursement of health facilities over the course of the year.

Rigorous verification of performance indicators is an essential aspect of PBF. This includes checking that the system isn't being gamed through false reporting. Budget evaluation is also an integral part of public financial management but is generally not done to the same level of detail. It is usually done by the supreme auditor institution (or delegated agents), which reports to the legislature or district council. While good practice in PFM would recommend performance audits, in practice, most countries lack sufficient capacity and financing, so most audits are compliance-driven and are intended to hold stakeholders accountable for wasteful or erroneous expenditure. In contrast, the verification of performance in PBF is carried out to justify disbursement of the next quarter's budget allocation. Verification can be done by internal audit agencies and counter verification by the external audit office to reduce cost, as was practiced in Tanzania.

It is also notable that granting more flexibility to health care providers to manage their own budgets has implications for budget oversight exercised by the legislature and district council. In any national PFM system, the legislature reviews budget proposals produced by the various health facilities. All government expenditure is subjected to rigorous compliance controls. The expenditure of PBF funds cannot be subject to these controls at the same level of detail because these expenditures may change within any given year as a result of the achievement or failure to achieve agreed outputs. This weakens the principle of "comprehensiveness" related to budget controls as well as the role of the legislature in overseeing the use of public funds.²⁴

Unified Payments Systems

In practice, the budgets of most PBF pilot projects are drawn up and managed by the ministry of health and operate alongside a range of other funding sources. As noted above, PBF projects tend to be restricted to operational funding, while also permitting facilities to top up staff pay. They do not cover the basic staff salaries and capital investments in a facility. They may not even cater for drugs purchases when these are distributed in-kind through a network of medical stores. Furthermore, in many lower-income country contexts, facilities receive considerable support directly from donor organizations and NGOs.

Ensuring that PBF systems are able to generate positive incentives to improve services requires that these funding flows be considered together. Input-based intergovernmental fiscal transfers are commonly provided to and through local governments to fund health service provision. Using both input-based and fee-for-service systems for the same type of expenditures fragments the provider payment mechanism. This raises longer-term questions about whether to integrate the two streams of funding and about the future role of intergovernmental fiscal transfers, though these are not explicitly PFM concerns. Mixed payment systems are commonplace in many countries. It is, however, necessary that they are purposefully designed and mutually reinforcing.

²³ See Mills (2018) and de Renzio (2009) for recent cross-country reviews of budget credibility or Simson and Welham (2014) for an explanation of the drivers of the lack of credibility in national budgets in Uganda, Tanzania, and Liberia.

²⁴ World Bank 1998.

More generally, consideration is needed for how to develop unified budgeting, execution, and reporting requirements across different streams of funding, as well as how to align the rules that govern fungibility of funds across different sources. This not only offers a basis for improving incentives, it also has the potential to reduce the administrative burden on facilities.

PART IV – DISCUSSION

Challenges with Mainstreaming PBF into National Systems

The introduction of PBF represents a fundamental change in how health services are financed and managed in low-income countries.²⁵ Whether adopting PBF is worthwhile is still a topic of debate, and any governments contemplating whether to adopt PBF will need to proceed with caution.²⁶ So far, the schemes adopted in most countries remain in their pilot phase and are heavily donor funded, with few having applied PBF nationwide. In this paper, we consider one challenge that must be resolved for more countries to choose to follow suit—the challenge of aligning PBF practices with national PFM systems.

Misalignment may be identified across the different “pillars” of facility financing and across the different parts of the PFM system. This paper has explored some common areas of misalignment that emerge from the decentralization of spending authority to a health provider and the shift from an input-based payment system to an output-based payment system (Table 1.2). It has also touched on the ways that PBF and the PFM system can support a more unified budget and payment system for health services.

Table 1.2: Typical Challenges in Aligning PBF with General Budget Management Processes

Typical PBF process	Typical PFM process	Discussion
Provider autonomy		
1 Facility is the spending unit	District is the spending unit	PBF requires facilities to manage their own funds. However, in most countries, the lowest cost center is at the district level, and facilities receive goods and services in-kind (or receive some funds as an advance). Some countries have introduced facilities as spending units in the chart of accounts (Tanzania) or created a conditional grant system that sends funds to facilities (Uganda).
2 Facilities have their own bank accounts	Country uses a treasury single account	PBF requires facilities to have financial sovereignty and to have access to banking services. This is often in conflict with the use of the treasury single account in PFM. Districts may have treasury subaccounts. Since nonwage recurrent spending is often small, the efficiency trade-off may be justified and therefore permit facility accounts if demonstrated with evidence to treasury. Use of mobile money or smart cards may also offer a feasible alternative.
3 Considerable flexibility over spending	Subject to annual budget law and enforced by ex-	Under PBF, facilities execute their budgets in accordance with their business plans and have flexibility to adjust to changing priorities with approval from their governance committees. Districts execute

²⁵ This discussion doesn’t apply to countries where PBF schemes are routed through extrabudgetary funds such as insurance mechanisms. This paper illustrates key issues that are likely to emerge when trying to mainstream PBF into the government budget.

²⁶ As well as the ongoing debates in the health financing community, it is worth noting that Schick (1998b) warned countries not to begin contracting within the public sector until there is greater confidence about adherence to contracts by the private sector.

	ante commitment control	their budgets in accordance with the annual budget law and are usually subject to ex-ante commitment control with varying degrees of rigidity. It may be possible to have a differentiated control strategy. In Pakistan, for example, there is a green corridor for low-value transactions, which extends greater flexibility at point of use.	
4	Salary top-ups possible	Predetermined budget for economic functions	Under PBF, facilities are able to incentivize staff by providing funds for salary top-ups. Usually, guidance is given on the limits. In contrast, the general budget usually cannot be used to fund top-up payments. Salaries are paid directly from central government.
Financial management capacity			
5	Quarterly business plan	Annual budget planning and formulation	Under PBF, facilities are required to produce quarterly business plans, under the guidance of a governance committee. This is in contrast to the PFM budget cycle, which works on the basis of an annual binding budget.
6	Budget approval	Budget approval	If PBF is integrated into the PFM budget, local budgets must be approved by the legislature at an aggregate level (e.g., there are PBF line items in the development budget). Legislative approval for the regular recurrent budget is more granular.
7	Accounting and reporting (manual)	Accounting and reporting (FMIS)	Separate accounting and reporting manuals and tools have been developed for PBF projects, whereas government expenditures are managed using the FMIS. The FMIS tends to be more rigorous with regard to integrating modules, the payment and reporting functions, and the planning and execution function. In some countries, PBF expenditure statements are posted to the FMIS ledger periodically.
Performance orientation			
8	Facilities get reimbursed against their performance	Districts request expenditures against the budget	Under PBF, the level of facility budgets depends on the facility's performance during the previous quarter. District budgets are subject to the annual budget law.
9	Rigorous verification*	Internal audit	Under PBF, to receive their funding, facilities must demonstrate progress against outputs as verified by a third party. Districts are subject to rigid internal controls with transactions being approved only if there are funds available in the appropriation and the budget.
10	External project audit*	External recurrent expenditure audit	As long as the PBF project goes through the budget, both scenarios are subject to external compliance audits. Under PBF, compliance is measured against project protocol, whereas for district budget expenditures, compliance is measured against the general government expenditure management protocol.

Source: Authors.

Notes: FMIS = Financial Management Information System.

* Could equally be mapped to financial management capacity

For PBF reforms to be sustainable, financial policy makers will need to find a way to overcome these areas of misalignment and integrate PBF into the processes of general government financial management. It is sometimes suggested that the introduction of program budgeting will support the necessary budget flexibility to align PBF into national systems. However, this may overstate the flexibility afforded by program budgeting and oversimplify the changes to facility financing that a PBF scheme requires.²⁷ It is also the case that program budgeting reforms are

²⁷ Shifting from line-item budgets to program budgets would not automatically resolve many of the areas of misalignment. In PFM, line-item budgets use administrative and economic classifications of spending, whereas

often only partly implemented. In countries like Ghana, Malawi, Zambia, and Zimbabwe, the program budget offers increased information on what funds are used for, but controls continue to be based mainly around economic line items (e.g., salaries, goods and services, etc.). Program budgeting may increase flexibility for program managers but make budget management at the facility level more rigid, as virement across programs is difficult. Program budgets do, however, offer an opportunity for alignment if the contractual relationship between the program and health facilities reflects facility financing principles.

There is no single solution to allow PBF schemes to be immediately integrated into national PFM systems, and compromises will have to be made in both PBF and PFM practices. For example, PFM systems could be reformed to give facilities more autonomy over their budgets as is required for PBF and to ensure that they have sufficient financial management capacity. Whether facilities should have dedicated bank accounts depends on the sophistication and reliability of the treasury single account and whether the efficiency loss from not consolidating idle balances is offset by the efficiency gains achieved by facilities handling their own finances. In environments where cash availability cannot be guaranteed through the treasury single account, transitional arrangements could be set up.

On the other hand, it is unlikely that the PBF practice of using quarterly business plans can be aligned with the PFM system, as the annual budget is the foundation of government budgeting, and supplementary budgets are too cumbersome to deliver on a quarterly basis if there are regular and large deviations between annual estimates and actual performance each quarter. While the PFM system might allow for some greater flexibility at the point of use, this is likely to be limited, especially between administrative units, spending categories, or high-value transactions. However, if more flexibility is granted in the PFM system, it might be possible for PBF transactions to be processed through an FMIS.

Developing a Reform Program

The degree of misalignment between PBF projects and national systems will vary from context to context as will the solutions for integrating PBF projects into the PFM system. Provider autonomy should not be a significant challenge in countries that fund NGOs to deliver health services as compared to those that deliver services through publicly owned facilities in the national or subnational budget. The way the PBF system is implemented in a federated country where subnational governments have significant authority over both health service delivery and PFM systems may also be very different than in a highly centralized system. Government PFM systems may not matter significantly for the integration of PBF into a national system if services are funded through a statutory fund like a health insurance scheme. Alignment questions will also vary by PFM context specificities. For example, a country with an advanced program budget structure may require different areas of reform than an input-oriented PFM system. Any attempts to integrate PBF into a national PFM system must, therefore, begin with a good understanding of how the existing health financing and financial management arrangements work.

program budgets use administrative and program classifications but use economic line items as additional information for financial reporting. Program-based budgeting is often used to support health financing. An output orientation in the budget can be provided through output, program, or performance budget modalities but is rarely implemented in practice. The deviations between planned and actual performance would still need to be accounted for in the same way as changes to spending plans, as discussed above.

Developing a credible alignment strategy for PBF must also acknowledge that reforms to the PFM system can be difficult to implement. Even after decades of international support to PFM reforms, there remain widespread weaknesses in national PFM systems. Reforms such as medium-term and program budgeting have often disappointed, as the old ways of working remain deeply entrenched in the government systems.²⁸ Seeking to reform PFM systems to implement the facility financing pillars for PBF must be tackled against that backdrop, and recognize the political and legal barriers to change and whether there is sufficient capacity to implement the new systems.²⁹ These factors are not necessarily all related to the public sector either. If the PBF is going to be used as a vehicle for donor harmonization, for example, there may be higher standards for financial management capacity than in other parts of the PFM system. Just as there are discussions about the cost of rigorous evaluation systems for PBF, there will be debates over which of the facility financing pillars are most important and how they could be adapted to fit with national PFM systems and intergovernmental fiscal relations. The process of the dialogue is, therefore, as important as the technical work needed to identify the areas of misalignment and design the PBF scheme.

Because of variations in context and in the space for reform in the PFM system, the precise approach to aligning PBF and PFM systems will be different in each country. To understand whether the PFM system can be adapted to fit the pillars of PBF or if these pillars could be delivered in a different way, reformers could look at the experiences with other reforms. For example, it will be worthwhile to analyze whether alignment with PFM was a challenge in attempts to introduce other purchasing mechanisms (e.g., per capita financing of primary health care) and how these challenges were overcome or not. There will also be value in understanding approaches to capitation grants in the education sector and performance-based payments for local government infrastructure services, as well as other related reforms.

At the same time, the pillars of facility financing in a PBF scheme are expected to be universal and the sequencing of their introduction can be guided by some basic principles. From a PFM perspective, there has long been a general consensus in the academic community that reforms should at least seek to establish effective basic functions before moving onto more advanced practices.³⁰ Planning for PBF implementation in national systems could draw from this view to suggest how to advance the different pillars of facility financing at different rates. For example, developing mechanisms to integrate spending and reporting at the facility level will build confidence that health facilities have the capacity to manage funds, which strengthens the argument for giving them more autonomy in the medium term. With more autonomy and spending flexibility, facility managers can be held directly accountable for the facility's results. This will pave the way for introducing performance-based budgeting as facilities will already meet the preconditions for financial control and management autonomy (see Box 1.1).

²⁸ Schiavo-Campo (2017) offers a general reflection on the challenges with introducing these advanced PFM practices, while the recent PEFA Secretariat (2021) report shows how most low- and middle-income countries have multiple weaknesses in their PFM systems when judged against accepted good practice.

²⁹ Andrews (2012) discusses the “space for change” across three dimensions: acceptance, authority, and ability, which he defines as follows: “(i) Is the solution acceptable given values and norms? [acceptance]; (ii) Can the solution be authorized given power structures? [authority]; (iii) Is the solution within current or foreseeable abilities to adopt and implement? [ability].”

³⁰ The role of sequencing in PFM is discussed extensively by Diamond (2013), and the importance of providing basics first is highlighted in the seminal work by Schick (1998a).

Box 1.1: Sequencing Considerations in the Reform Process

Some sequencing of PFM reform may be necessary in the process of mainstreaming PBF principles into the budget. The following aspects are potential sequencing considerations but should be seen as notional, depend on country context, and will likely require iteration:

- Facilities need to be recognized as individual spending units within the government PFM system. In countries where districts are the lowest level of spending agencies, this will require a significant policy shift in which spending authority is devolved to facilities, complete with the associated public financial management functions. New oversight structures and audit capacity may also be needed to ensure that the bank accounts and funds that are entrusted to facilities are being used appropriately.
- Building the public financial management capacity of facilities is a necessity. Facilities need to be able to plan, budget, receive funds, spend funds, account for funds, and report on their spending. Andrews and Campos (2003) discussed the balance between control and flexibility and concluded that confidence in accountability needs to be established before flexibility can be granted. Subsequently a stepwise approach can be taken. As integrating facilities' transactions into the FMIS is unlikely to be realistic, they could be posted to the ledger while being accounted for manually. Banking sector innovations such as smart cards or the m-pesa app that have a direct interface with the FMIS could be used to ensure the integrity of these transactions, which is a fundamental requirement for accountability.
- If facility financial management capacity has been built and the integrity of the financial reports can be assured, then some controls could be relaxed to give facilities more flexibility to execute their own budgets, while maintaining rigorous financial reporting on an input basis to ensure financial accountability.
- With autonomy, financial management capacity, and ability to use funds in a sufficiently flexible manner, an output or performance orientation can be introduced into the PFM system. Without these prerequisites, facilities would not be able to react to performance incentives.

Source: Authors.

Ultimately, these suggestions can only serve as general guidance for reformers. The final design of a PBF scheme and the route to implementation will vary. It will reflect the differences in context and authorizing environment and the different solutions and compromises that are made to integrate the facility financing pillars and PFM systems. It will also reflect many other design elements of the PBF scheme that were noted in the introduction but not covered in the paper—factors such as the cost of the scheme, the value of the payments, the organization of performance improvement support, and so forth. Nonetheless, the discussion has pointed to some general themes that should be noted in the development of future PBF projects.

Analytical Framework for Working Through These Issues Systematically

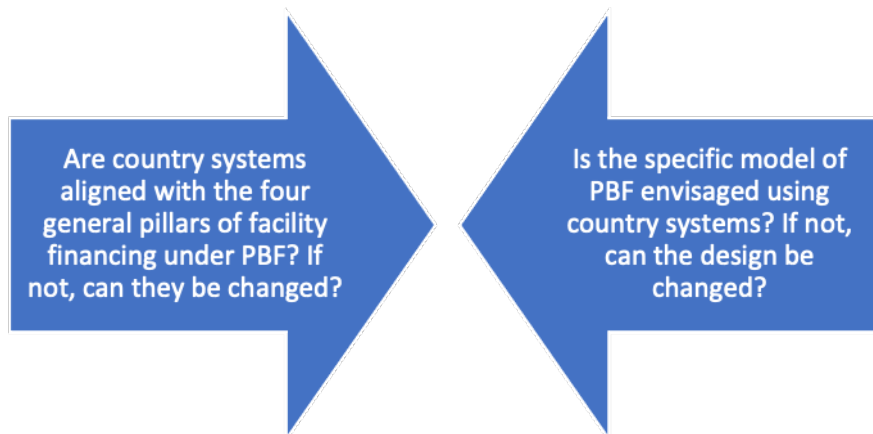
The final contribution of this paper is to draw together these different issues into a more structured analytical framework (Figure 1.2). As noted above, it is important to clearly identify how well the PFM system is set up to support PBF principles before committing to adopt PBF in

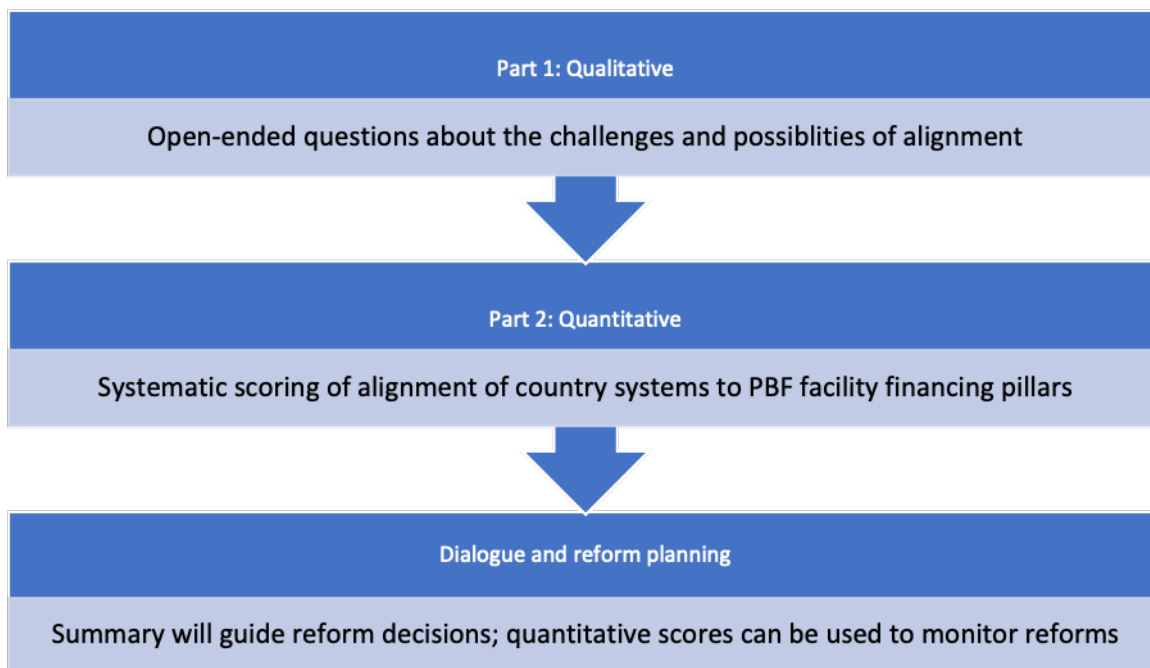
country systems. In Annex 1, we present a theoretical framework, a checklist of key questions, and a scoring methodology for important variables to support the design and monitoring of PBF reform plans. Once this has been assessed and determined, it will be possible to decide which aspects of PBF to adopt, to develop a roadmap for its implementation, and to choose the best indicators for measuring performance.

The framework is designed to capture the degree of alignment along two dimensions. The first asks whether national PFM systems can support the four pillars of facility financing in PBF from a general perspective. Where national systems would not support these pillars, the analysis and discussions should seek to understand the space for reforming PFM systems to support greater provider autonomy, financial management capacity, performance orientation, and harmonization of health budgets and payments across funding streams. The second dimension of alignment concerns the degree that the specific model of PBF being considered or used in a given country is integrated within national PFM systems. This will identify areas of the design where there are critical differences with the national PFM systems and begin to explore ways to close the gaps—or even to agree on aspects of the PBF scheme that cannot be taken forward as part of the national health system in the medium term.

The starting point of the analysis is based on general, open-ended questions that could guide initial analysis in a given country context. These look at how the facility financing pillars for PBF relate to the systems used at each of the three stages of the PFM cycle set out in Part 2. This is followed by a more systematic benchmarking of the country system against the four pillars, using an approach drawn from other popular institutional assessments such as the Public Expenditure and Financial Accountability Program (PEFA). Indicators are rated on a four-point scale from A to D (A is the best score on the metric), but could be tailored to reflect key concerns from the qualitative, open-ended questions. A summary assessment combines the qualitative analysis based on the more open-ended questions with a set of aggregated quantitative indicators drawn from the benchmarking exercise. This combination of qualitative and quantitative is intended to support a meaningful interpretation of the underlying analysis and to encourage discussion on the changes and compromises needed to deliver a more PBF scheme that could be taken to scale.

Figure 1.2: Summary of the New Diagnostic Approach





Source: Authors

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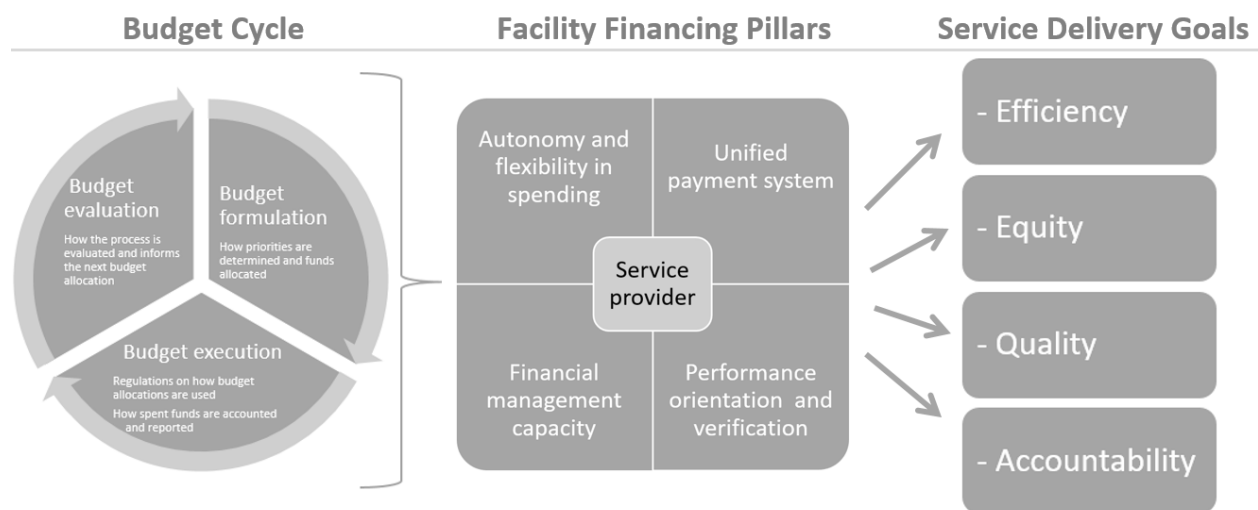
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ANNEX 1: DETERMINING HOW PBF CAN BE ALIGNED WITH A COUNTRY'S PFM SYSTEM

A conceptual framework was developed to identify the extent to which a country's PFM system could support the adoption of PBF. The methodology follows a simplified, three-stage budget cycle and focuses on key issues: (i) How priorities are determined and funds are allocated; (ii) the rules that govern the actual expenditure process; and (iii) how budget execution is evaluated and how it informs the subsequent budget allocation.³¹ This reflects the PFM environment within which health facilities must operate. Facilities deliver health services and are thus responsible for meeting the PBF service delivery goals (Figure 1A.1).

Figure 1A.1: How Public Financial Management Relates to the Pillars and Service Delivery Goals of Performance-Based Financing



Source: Based on Cashin et al. 2017 and Piatti-Fünfkirchen and Schneider 2018.

To explore the relationship between the budget cycle and the facility financing pillars, a number of questions can be asked, which should be tailored to the country context. Examples of such open-ended questions are provided in Table 1A.1.

³¹ Rajan, Barroy, and Stenberg 2016; Barroy et al. 2018; Piatti-Fünfkirchen and Schneider 2018; Cashin et al. 2017; and Chakraborty et al. 2010

Table 1A.1: Qualitative Questions to Ask by Budget Cycle

	Budget formulation	Budget execution	Budget evaluation
Provider autonomy and flexibility of spending	What is the legal status of facilities? What role do they play in planning and budgeting, and can they hold bank accounts and receive funds? If there is a budgetary program, what is their status within it?	How are funds released to facilities; what are banking arrangements; and do they have authority to spend? Are execution protocols sufficiently flexible to allow spending according to need? How is bulk procurement managed? How does spending and reporting relate to budgetary programs?	Are facilities responsible for financial management and accountable for the prudent use of funds
Financial management capacity	n.a.	Are FM protocols meaningful for facilities? Is there sufficient capacity and opportunity for training? Is there an FMIS in place for internal controls and should there be?	Do facilities produce adequate and timely financial reports for evaluation?
Performance orientation and verification	Does the budget formulation process reflect an adequate mix of capitation and output-based payments? Is this mix opportunistic or purposeful and does it set the right incentives?	Does the budget allocation process provide for a well-prioritized set of activities to ensure quality of services? Are budget provisions responsive to equity considerations?	Do facility budgets reflect output or performance measures? Is budget evaluation compliance and performance oriented?
Unified payment system	Is there a unified budget for all funding sources	Are execution protocols harmonized across funding sources?	Are budget evaluation processes harmonized across all facility revenue streams and do they lead to comprehensive recommendations?

Source: Authors

Notes: n.a. = Not applicable; FM = Financial management; FMIS = Financial Management Information System.

It is important to understand how these questions relate to service delivery goals (Figure 1A.1). If alignment across reform spaces is challenging, whether or not to pursue this further or engage in compromise should be driven by the extent to which this affects these goals. If mainstreaming of some PBF elements is challenging, but does not severely affect the system’s ability to deliver against these objectives, mainstreaming of this aspect may not be necessary (nor perhaps desirable). The qualitative assessment above should, therefore, carefully consider theoretical alignment but also the relevance to service delivery goals. Whether compromise should be struck will also depend on the cost of alignment (e.g., how does verification affect efficiency in service delivery).

The qualitative assessment may be supplemented by a quantitative approach to establish a baseline and provide a foundation for monitoring progress. Together, the qualitative and quantitative approach can form the basis for a roadmap for reform.

For the quantitative approach, a set of 29 criteria was developed to test how PFM processes support PBF principles. These criteria are detailed in Tables 1A.3 to 1A.6 and are presented in a matrix format in Table 1A.2. Each cell in the matrix is a composite of multiple assessment criteria.

Table 1A.2: Assessment Criteria for Testing How PFM Supports the PBF Pillars

PBF pillar	Budget formulation	Budget execution	Budget evaluation
Provider autonomy	Criteria 1–3 (D1)	Criteria 4–7 (D2)	Criteria 8 (D3)
Unified budget provision / payment system	Criteria 9 (D4)	Criteria 10–11 (D5)	Criteria 12 (D6)
Financial management capacity	Criteria 13 (D7)	Criteria 14–21 (D8)	Criteria 2–23 (D9)
Performance orientation and verification	Criteria 24 (D10)	Criteria 25–26 (D11)	Criteria 27–29 (D12)

Source: Adapted from Piatti-Fünfkirchen and Schneider 2018.

The criteria are assessed on a four-point scale from A to D. An A is the best available score on the metric. Definitions are provided for each score for each of the criteria in Tables 1A.2 to 1A.5.

The dimensions in the matrix are a composite of the assessment criteria. As shown in Table 1A.1, each dimension (such as budget formulation for provider autonomy) was derived from a set of assessment criteria (Tables 1A.2 to 1A.5). The assessment criteria were then aggregated into a single dimension score following OECD guidance for creating composite indicators.³² This method has also been used extensively in other diagnostic frameworks such PEFA

³² Nardo et al. 2005.

assessments.³³ For example, two criteria assessed with a B will translate into a single dimension score B, while two Bs and an A will translate into a B+.

Scoring can be used to benchmark and interpret findings. The various dimension scores pinpoint deficiencies and indicate what interventions may be required to support a PBF reform. The scoring is aimed to be as objective as possible, but some subjectivity invariably remains as the questions are mostly qualitative in nature.

The data for the assessment are derived from interviews with and information from stakeholders in district councils, district health managers, and managers of facilities of all types, including not-for-profit private providers. These data have been triangulated with administrative and government financial data. The initial scoring of the criteria should be done by the assessment team and confirmed by stakeholders from the ministry of health. A two-stage process can be used to adjust the criteria to the context of a given country. In the first stage, interviews are conducted with key informants from the ministries of finance and health and other stakeholders to find out how the budget works across the PFM cycle from the perspective of national-level decision makers. This would also help refine the questionnaires for downstream interviews. In the second stage, interviews are conducted with stakeholders from all of the different kinds of service providers to fill in the matrix. The districts and facilities chosen for the interviews should be selected according to best practices and based on qualitative research to maximize opportunities to learn.³⁴

The assessment of the extent of the alignment of PFM with the pillars of the PBF approach should include a discussion on how the level of alignment affects service delivery goals. The WHO defines health service delivery as the “immediate output of the inputs into a health system.”³⁵ Public finances, and the management thereof, are a key component in the production function of services. A discussion of how PFM supports providers would be incomplete without a discussion of the subsequent implications of actual service delivery. According to the WHO’s 2013 health financing framework,³⁶ service delivery goals that should be considered are equity, quality, efficiency, and accountability.

³³ PEFA 2018.

³⁴ Yin 2015.

³⁵ WHO 2008, 2.

³⁶ Kutzin 2013.

Table 1A.3: Scoring Scheme for Provider Budget Autonomy

PBF pillar	Budget stage	A	B	C	D
Provider autonomy	Budget formulation	1 - Facilities are recognized as autonomous spending entities with defined budgets.	Facilities have defined budgets for funding their basic operational activities.	Facilities do not receive formal budgets individually; instead their funds come from a pooled budget at the district council level with loosely defined drawing rights.	Budgets are not defined for each facility. They receive in-kind support instead.
		2 - Budget ceilings are communicated well in advance, allowing dispensaries/health facilities to plan effectively.	Providers are given notional but realistic budget ceilings before they prepare their annual work plans.	Facilities are told to assume a percentage increase from the previous year.	Facilities are given no budget ceilings, and their annual work plans constitute a wish list rather than a prioritized set of activities.
		3 - Facility plans are adequately reflected in final budgets.	Facility plans are mostly reflected in the district budget.	Districts consider facility plans during the development of the district budget proposal.	There are either no facility plans to consider in the district budget or they are ignored.
	Budget execution	4 - Facilities have authority to spend and to access financial services (bank accounts).	Facilities have authority to spend but limited access to financial services (e.g., because of physical distance)	Authority to spend is retained at the district level, which responds to facilities' requests.	Authority to spend is retained at district level with inadequate communication with facilities.
		5 - Facilities are allowed to receive funds from all sources, including the government budget.	Facilities are allowed to receive most funds (except funds from the government budget).	Facilities are allowed to receive funds from user fees and insurance payments.	Facilities are not allowed to receive funds, and all revenues are incorporated into a treasury single account.
		6 - Facilities are allowed to carry funds forward between fiscal years from all sources, including government budgets.	Facilities are allowed to retain funds from most sources (except the government budget).	Facilities are allowed to retain funds from user fees and insurance payments.	Facilities are not allowed to carry funds forward between fiscal years
		7 - Facilities have full flexibility to spend funds according to need.	Facilities have flexibility to adjust their nonwage recurrent spending.	Facilities have the flexibility to adjust their spending on nonwage and nondrug items.	Facilities either do not spend or are locked into an input-based line-item budget with complex virement procedures.
	Budget evaluation	8 - Facilities are fully responsible for the FM of all expenditure items and are assessed on compliance.	Facilities are responsible for nonwage expenditures and are assessed on compliance.	Districts are assessed on compliance but coordinate closely with facilities.	Districts are assessed on financial compliance, with insufficient attention given to facility management.

Source: Authors

Notes: FM = Financial management.

Table 1A.4: Scoring Scheme for a Unified Payment System

PBF pillar	Budget stage	A	B	C	D
Unified budget provision	Budget formulation	9 - There is a single unified budget for all funding sources (government, donors, insurance payments, and internally generated revenue) at the facility level.	Facility budgets include government, user fees (if any), and the majority of donor funding.	Facility budgets include government, user fees (if any), and some donor funding.	Facility budgets only include government funding.
	Budget execution	10 - Execution protocols are harmonized across all funding sources and are not a big challenge.	There is a manageable number of execution protocols for the different funding sources, causing insignificant delays.	Some execution protocols for the different funding sources cause significant delays.	There are too many execution protocols for the different funding sources, and this hinders service delivery.
		11 - Reporting requirements are harmonized across all funding sources.	Different funding sources require different reporting modalities, but this has only a limited effect on overall efficiency.	Different funding sources require different modalities of reporting, which negatively affects efficiency.	Different funding sources require different reporting modalities, which takes key facility staff away from their service delivery duties.
	Budget evaluation	12 - Budget evaluation processes are harmonized across all facility revenue streams and result in a unified set of recommendations.	Budget evaluation processes focus on government budget allocations and internally generated funds (fees, charges, insurance payments) but not external funds; however, they result in a set of unified recommendations.	Budget evaluation processes are fragmented, yet an effort is made to unify recommendations across sources.	Budget evaluation processes are fragmented by funding source and result in potentially conflicting recommendations.

Source: Authors

Table 1A.5: Scoring Scheme for Financial Management Capacity

PBF pillar	Budget stage	A	B	C	D
Financial management capacity	Budget formulation	13 - n.a.	n.a.	n.a.	n.a.
	Budget execution	14 - Clear and adequate financial management protocols are defined.	Basic but sufficient financial management protocols are defined.	Financial management protocols are district FM protocols, which relate well to facility needs.	Financial management protocols are the same as for districts, but these are inadequate for facility management.
		15 - Training materials cover facility FM protocols and are accessible to them.	Training materials cover facility FM protocols but are inaccessible to them.	Training materials cover district FM protocols, which are still relevant to the management of facilities.	Training materials cover district FM protocols but have limited relevance for facilities' requirements.
		16 - There are financial management systems in place for essential financial management needs	Financial management systems are in place in facilities but lack internet connectivity.	Financial management systems are manual but are consolidated at district level.	Financial management systems are either not in place or are unreliable for basic FM functions.
		17 - Facilities have adequate accounting capacity.	Facilities have some accounting capacity and receive good support from district administration.	Facilities have limited accounting capacity but receive compensating support from district administration.	Facilities have limited accounting capacity and receive insufficient support from district administration.
		18 - Facilities have adequate reporting processes in place that use the same accounting standards as general government PFM and are appended to the FMIS ledger.	Reporting processes follow government accounting standards but are not well integrated into the FMIS ledger.	Reporting processes are not well aligned with government accounting standards and are not integrated into the FMIS ledger.	There are few or no reporting processes.
		19 - Procurement processes involve all relevant parties (including health specialists) and actively control for quality.	Health specialists are not always involved in procurement processes.	Health specialists are hardly ever involved in procurement processes.	There are no provisions for health specialists to be involved in procurement, which results in poor quality of service delivery.
		20 - Facilities have no problem in executing the budget in accordance with given execution protocols.	Facilities mostly execute the budget in accordance with given execution protocols.	Facilities frequently bypass execution protocols to streamline processes.	Execution protocols are generally not followed because of excessive rigidities, which raises accountability concerns and the accumulation of arrears.
		21 - Facilities' FM systems (planning, budgeting, accounting, reporting) are well integrated into government PFM.	Facilities' FM systems require some manual adjustments but are mostly integrated into government PFM.	Facilities' FM systems are fragmented and require a lot of manual work to integrate them into government PFM.	Facilities' FM systems are not well integrated with government PFM systems.
	Budget evaluation	22 - Facilities have a clear, established process for capturing and reporting transactions for budget evaluation and accountability.	Facilities have a good process for capturing and reporting transactions, but there are some gaps.	Facilities have a process for capturing and reporting transactions, but it is not adequate.	Insufficient integrity in how facilities capture and report transactions undermines budget evaluation and accountability.
23 - Facilities produce financial reports in a systematic fashion.		Facilities produce partial financial reports, and there are some fiduciary concerns.	Facilities produce limited financial reports, and there are significant fiduciary concerns.	Facilities do not account or report on their use of resources.	

Source: Authors

Notes: n.a. = Not applicable; FM = Financial management; FMIS = Financial Management Information System.

Table 1A.6: Scoring Scheme for Strategic Budget Provisions and Verification

PBF pillar	Budget stage	A	B	C	D
Performance orientation / strategic purchasing	Budget formulation	24 - The budget formulation process reflects a careful mix of capitation and output-based payments.	The budget formulation process is based on capitation that provides a global budget to facilities.	The budget formulation process is historical and input-driven.	There are no facility-level budgets, and all support is in-kind.
	Budget execution	25 - The budget allocation process provides for a well-prioritized set of activities to ensure quality.	Activities are prioritized with some shortcomings.	There are significant shortcomings in prioritization during the budget preparation process.	There are major shortcomings in prioritization during the budget preparation process that negatively affect the quality of service delivery.
		26 - Budget allocations to facilities are responsive to equity considerations.	Budget allocations are input-based with some adjustment for equity.	Budgets allocations are historic and input-based with some attention to equity in historic allocations.	There is no semblance of equity in either current or past budgets.
	Budget evaluation	27 - Performance data are used to inform budget allocation decisions.	Facilities' budgets and purchasing are mostly based on their performance, with some historical considerations.	Facilities' budgets and purchasing are mostly historically based, with some performance considerations.	There is no strategic purchasing, with facilities' budgets being allocated on a historical basis and not on the basis of performance.
		28 - Budget evaluation is driven by compliance and performance and takes into account population needs.	Budget evaluation processes provide some guidance for making adjustments to meet population needs.	The budget is mostly compliance-driven.	Budget evaluation is entirely compliance-driven.
		29 - A reward/sanction system is in place to incentivize the efficient delivery of good quality services.	Some useful measures are in place to address inefficiencies or poor quality during facilities' performance evaluations.	Most budget evaluation is compliance-driven with limited attention given to efficiency or quality in performance reviews.	Budget evaluation is entirely compliance-driven.

Source: Authors

Performance-based financing (PBF) is the transfer of funds to health facilities so they can provide a pre-agreed set of services according to appropriate standards of quality and administration. These initiatives have introduced a wide set of reforms, including in provider autonomy, access to financial services, flexibility on the utilization of funds, a performance orientation on the budget allocation, and rigorous verification protocols. This tends to set PBF apart from the prevailing public financial management (PFM) systems that often remain input-based and thereby create a sustainability challenge. As long as the prevailing PFM system remains in parallel to the PBF, countries are likely to return to the legacy PFM system once PBF donor resources dry up.

This paper unpacks this problem. It develops a conceptual framework about how to think about aligning PBF principles with PFM structures; offers a set of diagnostic questions for an assessment; and helps guide an analyst through the process of developing a reform roadmap, taking into account country context. The paper also proposes a reform roadmap to be centered around the following four facility financing pillars: (i) provider autonomy, (ii) financial management capacity, (iii) output-oriented budget provisions, and (iv) a unified payment system. As a discussion paper, this work aims to solicit feedback on the proposed approach from the PBF and PFM community.

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