BUDGET MATTERS FOR HEALTH:

KEY FORMULATION AND CLASSIFICATION ISSUES

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Key Messages

- Robust public budgeting in the health sector is a necessary condition to enable the effective implementation of health financing reforms towards universal health coverage.
- Moving from input-based budgeting to health budgets that are formulated and executed on the basis of goal-oriented programmes can help build stronger linkages between budget allocations and sector priorities. This can also enable the implementation of strategic purchasing and incentivize accountability for sector performance.
- While budget classification reforms relate to overall fiscal management, health ministries have a critical role in defining the scope, content and coverage of budgetary programmes as a unique way to better align allocations with sector needs.
- The process, design and implementation of programme-based budgeting reforms in the health sector have varied greatly both between and within countries. Country budgets vary in terms of the relevance of budgetary programmes definition, their scope and structure, as well as the quality of performance monitoring frameworks.
- Despite past reform efforts, many countries plan health budgets by programmes but continue to spend by inputs. Several countries use hybrid or dual budget classification systems that mix health inputs, programmes and other classification methods, making it more complex to pool resources, spend and strategically purchase health services.
- Institutionalizing budget formulation changes alone is not enough. It should be coordinated with other elements of overall public financial management reform (e.g. multi-year budgeting, cash management, financial information and reporting systems) to ensure that changes in budget formulation are consistent with the rest of the financial management system.
- The interplay between budget classification systems and provider contracting and payment arrangements is a key issue from a health financing perspective. A change in budget formulation is likely to be one of the necessary conditions for implementing strategic purchasing of health services.
- The introduction of programme budgeting should be sequenced appropriately in the health sector, especially where basic public financial management foundations are not in place to safeguard against the misuse of public resources in the sector.

1. INTRODUCTION

No country has made significant progress towards universal health coverage (UHC) without relying on a dominant share of public funds to finance health *[1, 2]*. Framing the approach to health financing policy in this way places the health sector within the overall public budgeting system and underscores the crucial role that the budget plays, or should play, for UHC. Historically, the health financing dialogue has been largely driven by demands to raise revenues and find new sources of funds *[3]*, with much less discussion of overall public sector financial management and budgeting issues.

An understanding of the core principles of public budgeting is essential for those who have an active interest in health financing reforms. The budget is a primary instrument for strategic resource allocation *[4]*. Even in contexts where health insurance funds manage a core part of health expenditure, regular budgeting rules may continue to influence the flows of funds in health systems and the transfers to purchasing agencies and/or health facilities *[5]*.

However, there is limited understanding of public budgeting rules, processes and practices among health sector stakeholders. Beyond planning and budgeting units of health ministries, public budgeting is often perceived as complex, opaque, disconnected from health sector priorities, and handled directly by finance authorities. This perception, coupled with inherent health sector-specific challenges – e.g. uncertainty and difficulty in planning needs, poor quality cost estimates, fragmentation in funding sources and schemes – has contributed to low quality public budgeting processes in health in low- and- middle- income countries (LMICs) *[4, 6]*.

There is increased acceptance by governments that budget preparation is an important health sector concern. While countries differ in the size and scope of their budgeting challenges, more revenue for the health sector will not help achieve the UHC goals if well-functioning budgeting systems are not in place. Specifically, budget formulation – i.e. the way budget allocations are presented, organized and classified in budget laws and related documents – has a direct impact on actual spending and ultimately on the performance of the sector.

This policy brief aims to raise awareness on the role of public budgeting – specifically aspects of budget formulation – for non-PFM specialists working in health. As part of an overall WHO programme of work on Budgeting in Health, it will help clarify the characteristics and implications of various budgeting approaches for the health sector. It addresses the following main questions:

- What are the main budget classifications and how do they apply to health?
- What can a robust public budgeting system bring to the health sector?
- What do we know about the transition to programme-based budgeting in health?
- What are the key considerations and good practices to address health sector-specific challenges when reforming budget formulation?

2. DEFINING AND USING A COMMON TERMINOLOGY

Public budgeting is the process by which governments prepare and approve their strategic allocations of public resources (Box 1). From the perspective of public financial management (PFM), robust public budgeting serves several important functions: it sets expenditure ceilings, promotes fiscal discipline and financial accountability, and enhances efficiency in public spending *[7]*. The key features of a well-functioning budgeting system typically include: 1) multi-year programming; 2) policy-based allocation definition; 3) sector coordination for budget formulation; 4) realistic and credible estimates of costs; and 5) an open and transparent consultation process *[8]*.

The "health budget" – as defined in this paper – refers to allocations to Ministries of Health, their attached agencies and to other Ministries involved in the delivery of health-related expenditures.[1] Purchasing entities, if any, typically have various levels of institutional and financial autonomy. For instance, health insurance funds are often placed outside regular budget processes, with the intent to protect agencies' revenues and increase flexibility in resource use to purchase needed services. Such separate arrangements frequently follow different legal frameworks, and may have their own budgeting processes, expenditure classification and

1 Budgets from other ministries, such as finance, social affairs, defense, education, etc may also include health-related expenditure. Specific health programmes or activities can also be managed by, and integrated into, the budget of the President or Prime Minister's office or received transfers from ministries of finance or local governments. Thus, the budget of the health sector is in general broader than that of the Ministry of Health.

Box 1: Budget preparation process: role of ministries of finance and health

The annual budget is a key public policy document that sets out a government's intentions for raising revenue and using public resources to achieve national policy priorities. Every year, as part of the budget preparation process, finance authorities normally communicate budget ceilings to each ministry. Next, technical ministries, such as health, are expected, within an agreed calendar, to lead the preparation of budget proposals on the basis of their sector priorities. These proposals are then 1) negotiated with budget authorities in light of the fiscal framework and government priorities; 2) reviewed and adopted by the executive branch; and 3) submitted, in the form of a finance law for review and final approval by legislative authorities *[8, 9]*.

Some countries also use a multi-year approach, such as the medium-term expenditure framework (MTEF) *[10]*, to define a notional envelope for a 3-5-year period with the view to increase both strategic allocation across government priorities and predictability for each ministry's resource envelope on a medium-term basis. Despite their potential merits, MTEFs have often been of limited value to predict annual budgets for sectors *[11]*.

accounting requirements[2] *[4, 5]*. However, budget transfers and other subsidies from Ministries of Health, Finance, Social Affairs or local governments directed to purchasing entities generally continue to abide by the standard public budgeting, classification and accounting rules.

The classification and organization of a budget are centrally important issues when preparing sector budget proposals. Budget classifications serve to present and categorize public expenditure in the finance law and thereby "structure" the budget presentation. They provide a normative framework for both policy development and accountability *[14]*. If multiple classifications can be used to present budgets, what matters is the dominant classification(s) used for appropriation[3] – how money will be spent by the different bodies. The choice of budget classification(s) is therefore crucial for sectors. While budget execution rules influence how money flows to the health system, the choice of budget classifications often preempts the underlying rules for budget implementation and thereby plays a pivotal role in actual spending.

The "health budget" follows standard budget classifications. The overall structure of the budget, and thereby the use of classification(s), is typically defined by ministries of finance for all ministries/sectors building on internationally defined norms *[14, 15]*. Different classifications are needed for different purposes and at different levels. However, the issue is what type of classification is used for budget appropriation. **Table 1** summarizes the main types of budget classifications that can be used to formulate budgets and indicates how they apply to health.

While "programme-based" and "performance-based" budgeting are often conflated one with one another, introducing programme budgets is only one approach to performance-based budgeting *[16]*. In general terms, performance-based budgeting (PBB) links funding to the intended results, by making systematic use of performance information *[17]*. There are a number of PBB models, using different mechanisms to link funding to results *[18]*. The most basic form of PBB presents performance information in budget and other government documents. In this case, performance information does not play a role in allocation decisions, and so is often referred to as "presentational" PBB *[19]*. The second form is "performance-informed" budgeting, which takes into account performance results in the budget expenditure formulation *[17]*. Lastly, full performance budgeting typically aims at allocating resources based on results to be achieved. This form of performance budgeting is used only in a limited number of high-income countries *[18]*.

In the health sector, there is also often a lack of clarity on the differentiation

2 Social health insurance funds typically take the form of extra-budgetary entities "because for a security fund to exist, it must be separately organized from the other activities of government units, hold its assets and liabilities separately, and engage in financial transactions on its own account". See *[12]*. If improperly managed, extra-budgetary entities can undermine financial accountability and transparency and be problematic for fiscal discipline and debt reporting. However, there is increasing consensus around their potential benefits, by providing greater autonomy in funds management, within well-established governance and financial management systems. See 13.

3 In most countries, one dominant classification is used to present and appropriate budget. It happens, however, than two or more classifications (e.g. programmes and economic) are used for appropriations.

Table 1: Main types of budget classifications and their application in health

Budget classification	Application in health
Economic	Classifies expenditure by economic categories (e.g. salaries, goods, services). To be consistent with the Government Finance Statistics Manual (GFSM) 2001 economic classification *[12]*. Economic classifications are often associated with inputs-based or line-item budgets.
Administrative	Classifies expenditures by administrative entities (e.g. agencies, health facilities) responsible for budget management
Functional	Categorizes expenditures by sector (e.g. health, education). Within each sector, sub-functions of expenditure (e.g. outpatient services, public health services) are further divided into classes (e.g. outpatient services include general medical services, specialized medical services, dental services and paramedical services). Categories have been pre-defined internationally for purposes of comparison *[12]*.
Programme	Classifies and groups expenditure by policy objectives or outputs for the sector (e.g. maternal health, primary health care, quality of care), irrespective of their economic nature. Unlike other classifications, it is meant to be country-specific. Activity-based classification (e.g., provision of supplementary food) has also been introduced in some countries prior – or supplementary to – larger budgetary programmes, as an effort to group expenditure into coherent policy actions *[15]*.

Source: Authors

between budget classification systems – this paper's focus – and provider contracting and payment methods. Conceptually, as part of overall PFM systems, budget classification pertains to national and sub-national budgeting rules and provides the overall framework for the way regular budgets are presented, often executed and reported. Provider payment systems, which are situated within health financing policy, are linked to individual provider-level incentives and purchasing methods. Although the two issues are closely connected and influence each other *[16]*, in practice, they are distinct and often misaligned. If budgets can be created and spent based on outputs, such as programmes or services, most provider payment methods, including output-based approaches, are possible. If budgets can be formulated only on the basis of inputs and are executed using this same logic, the ability to create a performance-oriented payment system for providers can be difficult. In general, if salaries are separate from health service contracting and payment mechanisms and rely on line-item transfers, then the scope for "strategic purchasing" and efficiency in delivering services is constrained.

Box 2: "Budgetary programmes" and "health programmes"

The term "programmes" has a different meaning in the health sector as compared to its traditional definition in PFM.

In the health sector, the term "health programme" typically refers to a set of targeted interventions for specific diseases or groups, for example the immunization programme, the tuberculosis programme or the maternal and child health programme. Country "health programmes" often have multiple revenue sources, allocation arrangements, organizational structures and can be partly off-budget.

In budgetary terms, "programme" refers to a type of classification for expenditures. It becomes relevant when countries transition from input- to output-oriented budget formulation. Introducing programmatic classification aims to align budget formulation with national strategic plans. A well-defined budgetary programme typically cuts across sector-wide goals, and is not disease- or intervention-specific.

When defining budgetary programmes, countries use a variety of approaches. Some use a purely output-oriented approach (e.g., improved access to health services), or alternatively follow a functional logic (e.g., by level of care) and/or an organizational mandate-based approach (e.g., by entities) for defining the scope and coverage of the budgetary programmes. The budgetary programmes then operate following public expenditure management rules and are directly executed by "fund managers."

In general, when countries transition to programme-based budgets, disease- or intervention-specific activities are integrated in broader budgetary programmes, generally at the level of activities. For instance, immunization is often integrated as part of broader "public health or prevention" budgetary programmes, and can serve as an integrated activity as part of the overall sector goal of "prevention against health risks." A few countries, like Gabon, Peru and South Africa, have, however, inserted "disease-oriented" budgetary programmes to respond to specific priority needs (e.g., fight against HIV/Aids; malnutrition). The transformation to programme budgeting can also have direct implications for the organizational and administrative structure of the health sector that is often based on "health programmes".

Performance monitoring frameworks associated with the introduction of budgetary programmes generally provide useful information to monitor sector performance based on set goals. Monitoring information comes from sector and sub-sector routine information systems. The performance monitoring framework of budgetary programmes is a platform that can consolidate sub-sector performance information and expenditure monitoring. This is a critical step towards better alignment between programmatic and financial performance monitoring in the sector.

3. WHY IS BUDGETING IMPORTANT FOR THE HEALTH SECTOR AND UHC?

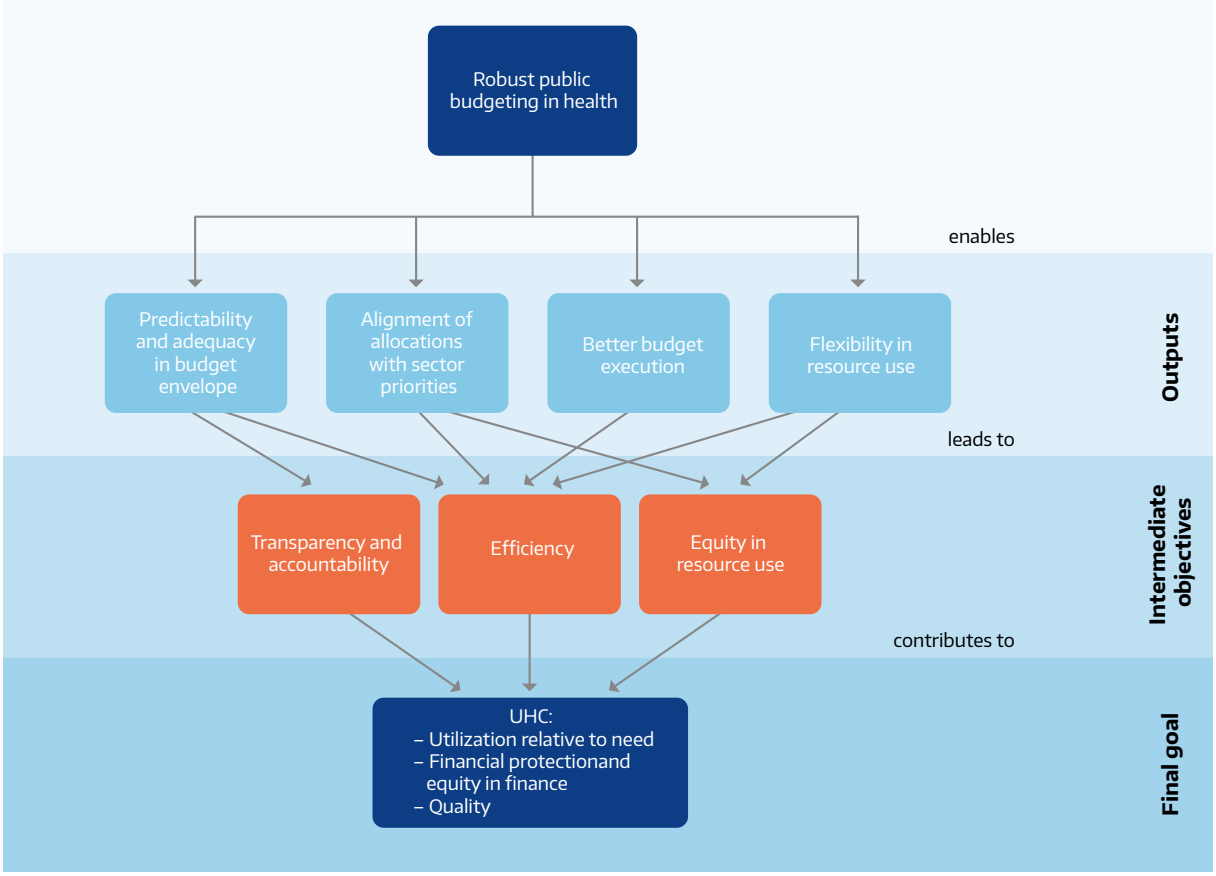
Because progress towards UHC relies on government spending, robust public budgeting[4] is a necessary precondition to facilitate this progress. While a number of macro-economic and health systems factors also influence performance towards the UHC goals, it is increasingly admitted that the quality of public budgeting in health is part of the necessary enabling factors towards UHC *[1, 9]*. *Figure 1* disentangles the key outputs that can come from strengthened budgeting systems in health (i.e. predictability, alignment, execution, flexibility), which can then lead or contribute to the intermediate goals of UHC (i.e. transparency and accountability, efficiency and equity in resource use).

Improving the quality of budgeting systems in the health sector can support the effective implementation of health financing reforms towards UHC in four main ways. Firstly, robust public budgeting in health, especially through the development of multi-year plans, is likely to improve *predictability* in the sector's resources, which in turn increases the likelihood that defined plans can be translated in policy actions on the ground. Secondly, proactive engagement of health ministries in the budgeting process can facilitate *alignment* of budget allocations with sector priorities, as laid out in national health strategies and plans. In doing so, allocative efficiency within the sector's resource envelope can be improved. Thirdly, if budgets are better defined, budget *execution* can improve, which means that underspending – a common issue in low income countries – can decrease in the sector (i.e. budget is implemented according to the plan, which is defined and articulated with national priorities). Fourthly, if the health budget is formulated according to goals and the execution rules align with this logic, it will allow a certain degree of spending *flexibility* and make budgets more responsive to sector needs. Ultimately, these "outputs" can support better transparency, accountability, efficiency and equity in the use of public resources – all directly contributing to progress towards UHC.

In the health sector, the influence of budgetary processes differs according to the way in which the health financing system is governed and funded. When health services are predominantly purchased through on-budget mechanisms funded from general revenues, the budget plays a critical role in resource pooling, allocation and use to directly provide needed services. In the absence of a provider/purchaser split or when health insurance entities represent only a tiny portion of public spending on health (e.g. for civil servants only), the budget of the Ministry of Health fulfills a quasi-monopolistic allocative and execution function for the sector. This is currently the case in most sub-

4 As noted in section 2, the key features of a well-functioning budgeting system typically include: 1) multi-year programming; 2) policy-based allocation definition; 3) sector coordination for budget formulation; 4) realistic and credible estimates of costs; and 5) an open and transparent consultation process.

Figure 1: Robust public budgeting: key enabling factor for UHC



Source: Authors, adapted from *[1]*

Saharan African countries and in purely tax-funded systems.

On the contrary, if purchasing entities play a dominant role in health spending the regular budget typically has a different mandate. First, in most cases, it keeps a controller role. The budget sets and authorizes the level (how much?), frequence and structure (how?) of transfers to purchasing entities – irrespective of their legal and institutional status –, and retains control and accountability mechanisms with respect to the budget transfers. Second, the budget plays a residual allocative function, and thereby directly allocates resources for the remaining on-budget programmes – often related to prevention and public health interventions – and authorizes spending according to existing delivery mechanisms. Regular budgeting and accounting rules apply.

4. WHAT DO WE KNOW IN THEORY AND PRACTICE ABOUT BUDGET STRUCTURE REFORMS IN THE HEALTH SECTOR?

4.1 RATIONALE AND MERITS OF REFORM

Input-based budgets – formulated on the basis of economic classification – have major limitations in general, and for the health sector in particular. No single budgeting system can suit the needs of all countries. However, there is a general consensus in the literature, as well as in country experiences *[4, 20, 21]*, that while input-based budgets can ensure a basic level of control and prevent misappropriation of funds where there is weak financial accountability, they create rigidities and constrain effective matching of budget and sector priorities *[22]*. There are clear limitations with being accountable for sector results while still allocating and monitoring resources based on detailed inputs at disaggregated levels, such as, in the health sector, fuel for ambulances, stationery for health facilities, or personnel training sessions *[9]*.

In light of these constraints, many countries have modified their regulatory and institutional frameworks to enable a change in the way budgets are formulated and executed. While countries have embarked on budgeting reforms for different reasons, in general they have been willing to move the focus away from inputs ("what does the money buy?") towards measurable results ("what can the sector/entity achieve with this money?") *[19]*. A primary objective of these reforms – and certainly a critical expectation for the health sector – is in general to foster alignment between resource allocation and public priorities and to make the budget, and the underlying rules for execution, more responsive to evolving needs *[23]*.

A programme structure has the potential to help clarify the logical framework that connects inputs/activities to outputs and wider policy goals. While it is theoretically possible to provide allocations to ministries and make them accountable for results without programmes,[5] the classification by objectives serves to promote policy-based allocation decisions. It is expected to make government activities more closely aligned with sector policy priorities, and thereby to contribute to better sector performance *[16]*. Ultimately, new budgeting models intend to enable future funding to be better linked to actual past performance (Figure 2) *[16]*.

Programme-based budgeting offers specific opportunities from a health financing perspective *[4, 24]*. While the potential for reform is clear in terms of improvements in fiscal management and accountability, the introduction of programmatic classifications could help in the health sector in at least

5 It is theoretically possible to have an input-oriented formulation of the budget, while controlling at an aggregate level to leave more flexibility at the individual line-item level.

Figure 2: Input-and programme-based budgets: stylized examples for health

	Input-based budget (recurrent expenditure)	Programme-based budget (example 1)	Programme-based budget (example 2)
1.	Compensation of personnel	Basic health services	Access to health services
2.	Goods and services	Secondary and specialized care	Health promotion and prevention
3.	Subsidies and transfers	Social subsidies	Support to priority population groups
4.	Consumption of capital	Governance	Administrative support

Box 3: Programme-based budgeting in health: opportunities for more aligned, efficient and accountable spending

Linking budget to priority spending. Budget formulation can create financial incentives to link resources with health sector priorities. Where budgets are presented on the basis of detailed inputs (such as salaries, travel, office supplies) and/or administrative units (such as facility X, hospital Y, university Z), it is difficult to make the link between spending and policy priorities. When budgets are formulated in terms of "pools of resources" (i.e. budgetary programmes), the link between spending and policy objectives should become clearer – assuming that budgetary programmes are well-defined, linked with policy priorities and do not create more fragmentation. In addition, by integrating vertical interventions into broader budgetary programmes, the development of budgetary programmes in health represents an opportunity to reconsider budget allocations according to broader sector-wide priorities, and to reduce fragmentation and overlaps caused by itemized spending on specific interventions.

Enabling strategic purchasing. There is a strong link between the way in which budgets are formulated and executed and the ability of a purchaser (i.e. an agent entitled to "purchase" health services) to move from passive to more strategic purchasing *[20]*. In several countries, line-item budgeting at ministry level has led to line-item payments and reporting at facility level. Even when countries have attempted to move away from line-item budgeting by introducing new approaches at ministry level, facilities continue to be paid and report back by inputs. From a provider's perspective, what matters is the capacity to reallocate across lines (staff, equipment), so long as the financial management capacities are in place, in order to deliver the needed services and to report by achieved outputs (e.g. service utilization) and not by set inputs. Planning and spending by budgetary programmes that are oriented to the achievement of specific outputs (e.g. access to quality curative services) can, if correctly implemented, present the purchaser with a larger choice of payment options and, ultimately, with incentives for better efficiency.

Supporting accountability for sector performance. In shifting the orientation of the health budget towards programmes, the sector is made accountable for delivering on stated sector objectives and not according to the use of given inputs. As part of programme budgeting reforms, countries have introduced performance monitoring frameworks that, if well defined (i.e. they have the right indicators, at the right level and tracked in the right way), help to monitor and evaluate sector performance according to the predefined goals or outputs. Ultimately, performance information should serve to inform future funding and reduce bias towards historical resource allocation patterns.

three ways: 1) to build stronger linkages between budget allocations and sector priorities; 2) to enable the implementation of strategic purchasing; and 3) to incentivize accountability for sector performance (Box 3).

4.2 CHALLENGES IN REFORM DESIGN AND IMPLEMENTATION

Most LMICs have faced serious challenges in reforming public budgeting. While programme-based budgeting reforms have a long history in high-income countries, and have shown some success (e.g., Australia, France, Netherlands, New Zealand, or Republic of Korea), the institutionalization process has generally been iterative, long and required high capacities *[21, 25, 26]*. In LMICs, programme budgeting has often been introduced in weak budgetary environments leading to challenges in both design (e.g. how to match budgetary programmes with sector priorities?) and implementation (e.g. how to align expenditure management with a programmatic logic?). As a result, and in spite of apparent conceptual merits, there is little evidence that budget structure reforms have effectively kept all their promises in terms of budget performance and accountability *[27]*.

In the health sector – a common pilot sector for budget reforms –, the design of budgetary programmes has been particularly challenging.[6] In the absence of clear guidance, the overall quality of programmes – in terms of coverage, scope, and structure – and of their associated performance monitoring frameworks has varied greatly both between and within countries (Box 4). As a result of relatively poor definition processes, several LMICs use hybrid health budget structures (i.e. inputs, such as health personnel or infrastructure, are presented at the same level as programmes), rendering execution very cumbersome *[31]*. In addition, while central budgets may have transitioned to a programme-based formulation, lower levels of government may continue to use other approaches to present and execute budgets. This evidence underscores the need for additional support and guidance in defining budgetary programmes in the sector.

As countries reform health financing systems, there has been a renewed interest to accelerate implementation of budgeting reforms. Emerging evidence suggests that budget classification reforms have often stopped at the formulation stage. While reforms have effectively had an impact on budget planning and formulation (i.e. the budget is presented and adopted using a programmatic logic) in a majority of countries, the process has often stopped there. "Fund managers" continue to receive funds by inputs, which affects the advancement of health financing reforms *[20, 32]*. The reasons for this pertain to both general expenditure management issues (e.g. outdated regulatory frameworks, misaligned financial information systems) and sector specific challenges (e.g. limited autonomy of funds managers/providers; capacity issues).

There is consensus among the PFM community on the need to properly "sequence" the transition towards programme budgets. There is a particular need to connect it with other segments of PFM reforms and strengthen the basic foundations of any PFM system (e.g. cleaning

6 While there is a lot of literature on the conditions for a successful implementation of programme-based budgeting for the overall government budget [*21, 24, 25, 28, 29, 30*].

Box 4: Programme-based budgeting in health: heterogeneity in programme definition

Country evidence suggests wide variation with respect to the following main characteristics:

Coverage and scope of health budgetary programmes:

- Do budgetary programmes cover comprehensively sector priorities?
- Are budgetary programmes aligned with sector priorities in their scope?
- Which types of expenditures are assigned to programmes?
- Are personnel expenditures treated separately?

Nature and structure of health budgetary programmes:

- Are budgetary programmes based on level of care, population groups or diseases, organizational mandate, or a mix of those?
- How are budgetary programmes structured and sub-categorized (by actions, sub-programmes, activities or inputs)?
- At which level are appropriations expected to happen (programme, or lower levels)?

Performance monitoring framework:

- What types of indicators and targets are in use (e.g. financial indicators, sector indicators)?
- Do they align with sector goals?
- At which level are they positioned (programme or lower levels)?
- Is performance information used to inform future allocation decisions?

Source: Authors

and simplifying budget coding), while introducing more sophisticated budgeting approaches[7] *[27, 35]*. Programme-based budgeting reforms need to be viewed as part of a continuum, as countries tend to shift from input-based to programme-based budgeting gradually, and some aspects of inputs-controlled systems remain in place, even after the introduction of programmes. Input controls continue to be important but not for budgetary allocations. Managers of programs still need to be able to control the inputs and activities. Also, there is a need for reports against inputs for budget review and analysis. Figure 3 below presents a stylized illustration of these varying experiences in the transition towards programme budgeting in the health sector, demonstrating the large spectrum between strict input-budgeting – as observed in Chad or the Lao People's Democratic Republic– and performance-driven programme budgeting that exists in Australia or the United Kingdom.

A set of practical considerations has emerged in relation to reform design and implementation in the health sector. While there is a lot of literature on the conditions for a successful implementation of programme-based budgeting for the overall government budget *[21, 24, 25, 28, 29]*, knowledge is more limited on how to address health sector-specific challenges of budget classification reforms *[30]*. From a rapid consultation of

7 In the context of growing scepticism on the ability of programme-based budgeting to keep its promises *29. , 33. 34. .*, several PFM experts argue that such reforms are not suitable for countries with low institutional capacities and weak financial accountability systems, where the approach could lead to misuse, fraud, and less transparency. In these situations, introducing some degree of flexibility to reallocate across inputs lines can be a recommended transition option.

experts and country counterparts organized in October 2017 by WHO, a consistent set of recommendations highlights the importance of strengthening technical and coordination capacities of health ministries to ensure pro-active engagement in the design of quality budgetary programmes (Box 5).

Figure 3: Input-and programme-based budgets: stylized examples for health

Input budgeting	Input budgeting with some flexibility and outcome indicators	Nascent program classification used for information only	Program budgeting in transition	Full program budgeting	Performance-driven program budgeting
· Presents expenditures by objects (inputs/ resources) · Detailed lines, typically based on economic & organizational classifications · Hierarchical controls with little managerial discretion · Reallocations have to receive MOF approval	· Broader lines (eg other charges, personnel emoluments) · Reallocations can be done within these broader lines · Contains performance indicators in the budget submission	· Budgets presented using program lines · These can be mixed with input and administrative lines · Programs typically are not well defined (too many or too few, program objectives are vague, weak performance indicators) · Expenditure controls remain at input level	· Budgets presented using program lines · These can be mixed with input and administrative lines · Still varying quality of programs · At least a portion of expenditures are managed at program level	· Budgets presented using program lines · Salaries included in the programs · Coherent, goal-driven programs · Certain inputs (eg salaries) can still be protected or capped · Expenditures are managed at program level · Performance indicators are presented but not used for resource allocation	· Budgets presented using program lines · Funds are allocated to various objectives (results) · Flexibility within programs · Results-oriented accountability
Example: Lao PDR, Greece	Example: United Republic of Tanzania	Example: Kenya, Kyrgyzstan	Example: Morocco, Peru	Example: France, South Africa	Example: Australia, UK

Note: Country examples focus on budgeting at the national level. Countries do not always fall neatly in these boxes, a country can be transitioning from (3) to (4), for example.
Source: Authors

Box 5: Implementation of budget classification reform in health: 10 key considerations for health ministries

1) **Ensure good understanding and clear definition of reform motivation** and expectations for the sector (e.g. better alignment with sector priorities, more flexibility in spending, capacity to pool resources and purchase services from the budget).

2) **Equip health authorities with the needed capacity and skills** to shift from classic planning by inputs to programming by outputs across the different levels of administration.

3) **Determine priority-setting mechanisms** to enable translation of national health priorities into budgetary programmes.

4) Ensure **continuous coordination mechanisms between health and finance**, and within health ministries, to reduce inconsistency in programming and secure alignment between reform goals and implementation.

5) **Sequence implementation of programme-based budgeting reform** and ensure that existing rules are known and used by health authorities, even during a transitory phase.

6) Consider from the start the **implications of programme-based budgeting for strategic purchasing**, making sure that programmatic classification simplifies, and makes more flexible, the choice of provider payment mechanisms.

7) Ensure that the reform **provides sufficient flexibility to programme directors** to manage funds according to an output logic, not ending with only a presentational change of budget documents.

8) Pay attention to the **design of the performance framework** to allow relevant monitoring and evaluation of expenditure **and be able to inform future allocation decisions**

9) **Tailor financial information systems** to the needs of performance monitoring without overloading health authorities with the tracking of unnecessary and fragmented information.

10) **Connect with and integrate programme-based budgeting reforms with other aspects of PFM agendas** (e.g. by revisiting the role of a multi-year spending framework); the effectiveness and consistency of the reform depends on the overall strength of the PFM underlying system.

5. CONCLUSION AND WAYS FORWARD

Growing evidence, including from WHO, shows that many PFM-related challenges have direct implications for health and the achievement of sector objectives. PFM, and particularly budgeting issues, have long been perceived as distinct from health sector concerns. However, problems related to the level and flow of public resources in health often stem from weaknesses in the overall PFM processes, in terms of both the original budgeting and subsequent execution practices. Serving as the backbone for the allocation and use of public resources, the formulation of a budget is centrally important for health policy-makers engaged in the design and implementation of health financing reforms towards UHC.

Pro-active engagement of health ministries in budgeting is essential to align sector priorities and budget allocations, and ensure appropriate and timely use of public resources. The budgeting functions of health ministries should be strengthened to enable this effective engagement. Robust public budgeting can support better predictability of the sector's resource envelope, facilitate alignment between resources and sector priorities, and improve execution. If the health budget is formulated according to goals and the execution rules allow a certain degree of spending flexibility, budgeting will also be able to support better achievement of results.

While budgeting reforms relate to overall fiscal management, health ministries have a critical role in defining the scope, content and coverage of budgetary programmes for the sector. The design of programme budgets in health has proved to be challenging, and ministries of health should pay specific attention to the definition of budgetary programmes to secure success in transition. Successful implementation of budgeting reforms will also critically depend on day-to-day collaboration between health and finance authorities at all steps of the reform process, from budgetary programme design to expenditure management and systems of reporting and financial information management.

From a health financing perspective, a key issue is the interplay between budget classification systems and provider contracting and payment methods. A change in budget formulation is likely to be one of the necessary preconditions for implementing strategic purchasing and moving towards more output-oriented contracts and payment mechanisms. Too often, the change in budget formulation does not translate into improved provider payment systems, as the two reforms tend to operate in different reform circles, with little connection with one another. These two reform processes and goals need to be better aligned, with one feeding into the other. Change in budget formulation should be accompanied and coordinated with other parts of PFM and health financing reforms (e.g. multi-year budgeting, financial information systems, facility's spending autonomy) to maximize coherence and impact.

WHO, in collaboration with a select group of partners involved in overall PFM reforms – namely the International Monetary Fund, the World Bank, OECD, the European Commission and the International Budget Partnership –, **is helping to address the "how to" gaps**. This includes identifying good country practices and lessons on designing and implementing budgetary programmes in the health sector. These efforts will aim at the implementation of budgeting reforms towards more sector relevance and effectiveness. They will support countries prioritize robust public budgeting systems as a core piece of their health financing reform agendas to make effective progress towards UHC.

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