HEALTH FINANCING GUIDANCE NO. 4

ALIGNING PUBLIC FINANCIAL MANAGEMENT AND HEALTH FINANCING

A PROCESS GUIDE FOR IDENTIFYING ISSUES AND FOSTERING DIALOGUE

World Health Organization
OECD
RESULTS FOR DEVELOPMENT

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Aligning public financial management and health financing: a process guide for identifying issues and fostering dialogue

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Preface

This guide was commissioned by the World Health Organization (WHO) and jointly prepared by Results for Development (R4D) and WHO under the auspices of WHO's Department of Health Systems Governance and Financing, Health Financing Unit. It is part of the Collaborative Agenda on Fiscal Space, Public Financial Management and Health Financing Policy. Preliminary drafts were presented at the second Collaborative Agenda meeting in Montreux, Switzerland, in April 2016.

This document offers guidance to help health and finance authorities at the country level engage in productive dialogue, assess alignment between a country's public financial management (PFM) system and health financing system, and work toward a joint policy roadmap to improve alignment. It builds on a paper[1] that considers how PFM and health financing systems can be better aligned in support of universal health coverage (UHC), provides a framework for examining common challenges and offers strategies for addressing those challenges.

These resources can be helpful to an array of stakeholders who are engaged in efforts to move toward UHC by bringing PFM and health financing systems into better alignment:

- **health policymakers** who are working to ensure more efficient spending and increased allocation to priority populations, programmes and services;
- **public budget officials** who are charged with ensuring that expenditures in the health sector are transparent and accountable;
- **health providers** who need more flexible financing arrangements so they can better align their resources with population needs; and
- **external partners and donors** who aim to promote a sustainable transition to UHC.

Sinit Mehtsun (R4D) led the development of the guide, with contributions from Cheryl Cashin (R4D), Danielle Bloom (R4D), Elina Dale (WHO) and Susan Sparkes (WHO). The guide builds on a survey of budget officials by the Organisation for Economic Co-operation and Development (OECD) Joint Network on Fiscal Sustainability of Health Systems on budgeting practices for health, which includes direct input from Camila Vammalle, Chris James and Ana María Ruiz of the OECD. The survey was modified with input from Christoph Kurowski (World Bank) and Ajay Tandon (World Bank). Hélène Barroy (WHO), Joseph Kutzin (WHO) and Maximillian Mapunda (WHO) provided input, as did Sheila O'Dougherty (Abt Associates), Mariam Ally (Ministry of Health, Tanzania), Gemini Mtei (consultant, Tanzania), Maude Ruest Archambault (World Bank) and Hnin Hnin Pyne (World Bank). This work was done under the guidance of Agnès Soucat (Director, Health Systems Governance and Financing, WHO).

Financial support was provided by the UK Department for International Development (Program for Improving Countries' Health Financing Systems to Accelerate Progress towards Universal Health Coverage) and the Ministry of Health and Welfare of the Republic of Korea (Tripartite Program on Strengthening Health Financing Systems for Universal Health Coverage). For more information, please go to www.who.int/health_financing.

[1] Cashin C, Bloom D, Sparkes S, Barroy H, Kutzin J, O'Dougherty S. Aligning public financial management and health financing: sustaining progress toward universal health coverage. Geneva: World Health Organization; 2017.

Introduction

In recent years, many countries have adopted universal health coverage (UHC) as a national policy priority and have committed to directing government funding toward that goal. Ensuring sustainable progress toward UHC means that a country's public health financing system must routinely generate sufficient, and largely domestic, resources to achieve health sector objectives within its macroeconomic and fiscal context. It is not only the level of government health spending that matters for sustaining health systems that can meet UHC goals, but also the efficient and equitable use of those funds. Public budget revenues, as well as the public financing systems that manage those funding flows, therefore play a crucial role in directing money efficiently, equitably and effectively toward UHC goals and other health priorities.

The public financial management (PFM) system is the set of rules and institutions, policies and processes that govern the use of public funds. Since public budget funds form the cornerstone of sustainable financing for UHC in most countries,[2] PFM rules and institutions greatly affect the level and allocation of public health funding, the flexibility with which funds can be used, the effectiveness of spending and the way health sector results are accounted for. The PFM system provides the health sector with a domestic, integrated platform to manage resources coming from all sources and across national and subnational entities. While there are international standards that govern financial management systems—including for accounting, reporting and controls—these systems still need to be flexible enough to address country-specific needs, including those of the health sector and other social sectors.

PFM improvements in general are typically beneficial to the health sector. But the health sector faces some specific challenges that require more flexibility than PFM systems sometimes offer, including the ability to direct funds to where interventions and services are needed and to ensure equity while creating incentives for efficiency and quality. PFM systems do not always align with these health financing objectives.

Even when PFM reforms support health financing objectives, misalignments can occur due to incomplete implementation, poor communication or operational challenges such as poor-quality multiyear budgeting and incomplete transition toward programme-based budgeting. Misalignments can also be inadvertently introduced through new PFM policies that make it difficult to change pooling and purchasing arrangements as planned. In some cases, the health sector does not actively engage in policy dialogue and articulate its needs or does not take advantage of new or existing flexibilities.

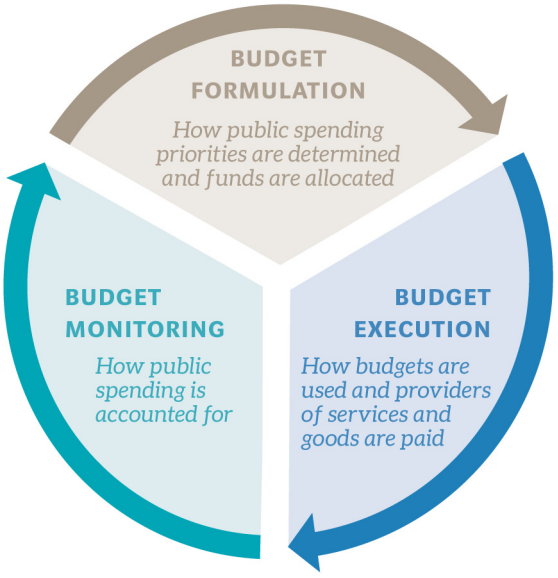
Other misalignments can occur due to differences in policy objectives and the architecture of the PFM system itself. For example, a PFM objective of fiscal decentralization can be directly at odds with a health sector objective to increase national pooling of health funds to improve financial risk protection and equity. Particularly in countries where the PFM system continues to focus on input-based line-item budgets, PFM rules can constrain options for meeting health financing objectives related to purchasing.

[2] Kutzin J, Yip W, Cashin C. Alternative financing strategies for universal health coverage. In: Scheffler R, editor. World scientific handbook of global health economics and public policy. Volume I: the economics of health and health systems. World Scientific—Imperial College Press; 2016.

The public financial management system

The PFM system provides sectors with a platform for managing resources from all sources and across national and subnational levels. (See Fig. 1.)

FIG. 1 THE PUBLIC FINANCIAL MANAGEMENT SYSTEM[3]



Public finance processes are typically structured around the annual budget cycle, which is meant to ensure that public expenditure is well planned, executed and accounted for. A standard budget cycle includes three distinct stages: budget formulation, budget execution and budget monitoring. Budget formulation involves making macroeconomic projections to help determine what level of total government expenditure will be feasible and how much of the total expenditure will be allocated to each of the line (sector) ministries based on strategies and policy priorities. This step also involves negotiation at different levels, including with individual ministries, and subsequently developing and approving final budgets. Budget execution involves the release of funds to line ministries or departments/agencies according to the approved budget and making payments for goods and services. It is during this stage that government agencies make payments to health care providers (both public and private) for covered services. Budget monitoring involves ensuring that spending agencies and entities comply with laws and regulations, implement good financial management systems with reliable financial reports and internal controls and audits, and achieve budgetary objectives. Health authorities should engage at each step of the PFM process to ensure alignment with sector priorities and effective and efficient use of public resources.

The PFM system has an underlying mandate to help maintain a sustainable fiscal position for the country and allocate resources equitably, ensure quality and efficient delivery of publicly funded goods and services, maintain

[3] Cashin et al.

transparency and accountability, and ensure compliance and oversight. Good PFM systems balance fiscal discipline with the need to meet government policy objectives, including for the health sector.

Many countries have initiated long-term reforms to "modernize" their PFM system in line with international best practices and with a view to strengthening transparency, accountability and predictability as well as improving alignment between expenditure and government priorities. New approaches to budgeting have also been developed and piloted in the health sector.[4]

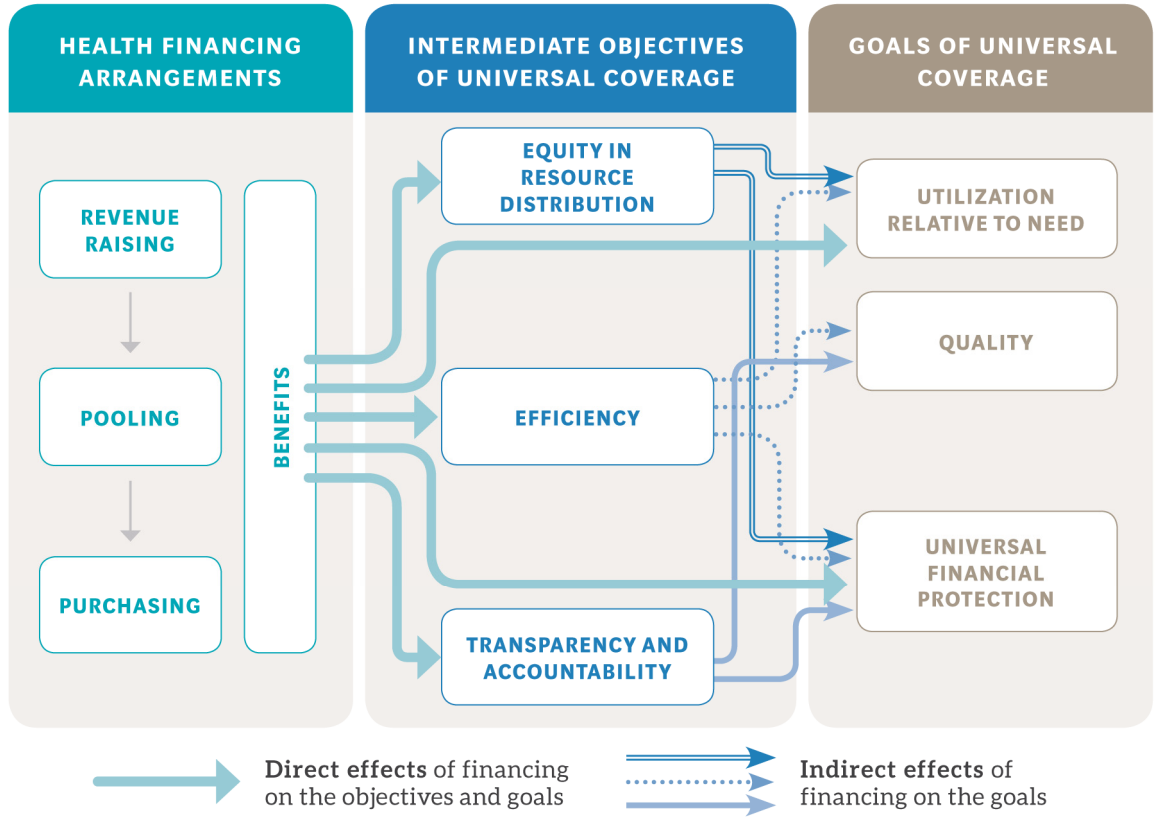
[4] Robinson M, Last D. A basic model for performance-based budgeting. Washington (DC): International Monetary Fund, Fiscal Affairs Department; 2009.

The health financing system

The health financing system is the set of policies and supporting arrangements that govern the resources and economic incentives of the health system. The health financing system has the following functions that support UHC goals (as shown in Fig. 2):

- **raising revenue** efficiently and equitably from stable sources;
- **pooling risk** to protect individuals from financial risk associated with their health care needs and
- ensure equity;
- **strategic purchasing** of health services on behalf of a population to ensure efficiency, quality and value for money;
- **stewardship**, including governance of health financing agencies and regulation of markets; and
- **benefit design and rationing policies**, including measures such as patient cost sharing (through user fees or copayments), service exclusions and waiting lists.[5]

FIG. 2 THE HEALTH FINANCING SYSTEM[6]



Source: Kutzin (2013)

[5] Kutzin J. A descriptive framework for country-level analysis of health care financing arrangements. Health Policy. 2001;56:171–204.
[6] Cashin et al.

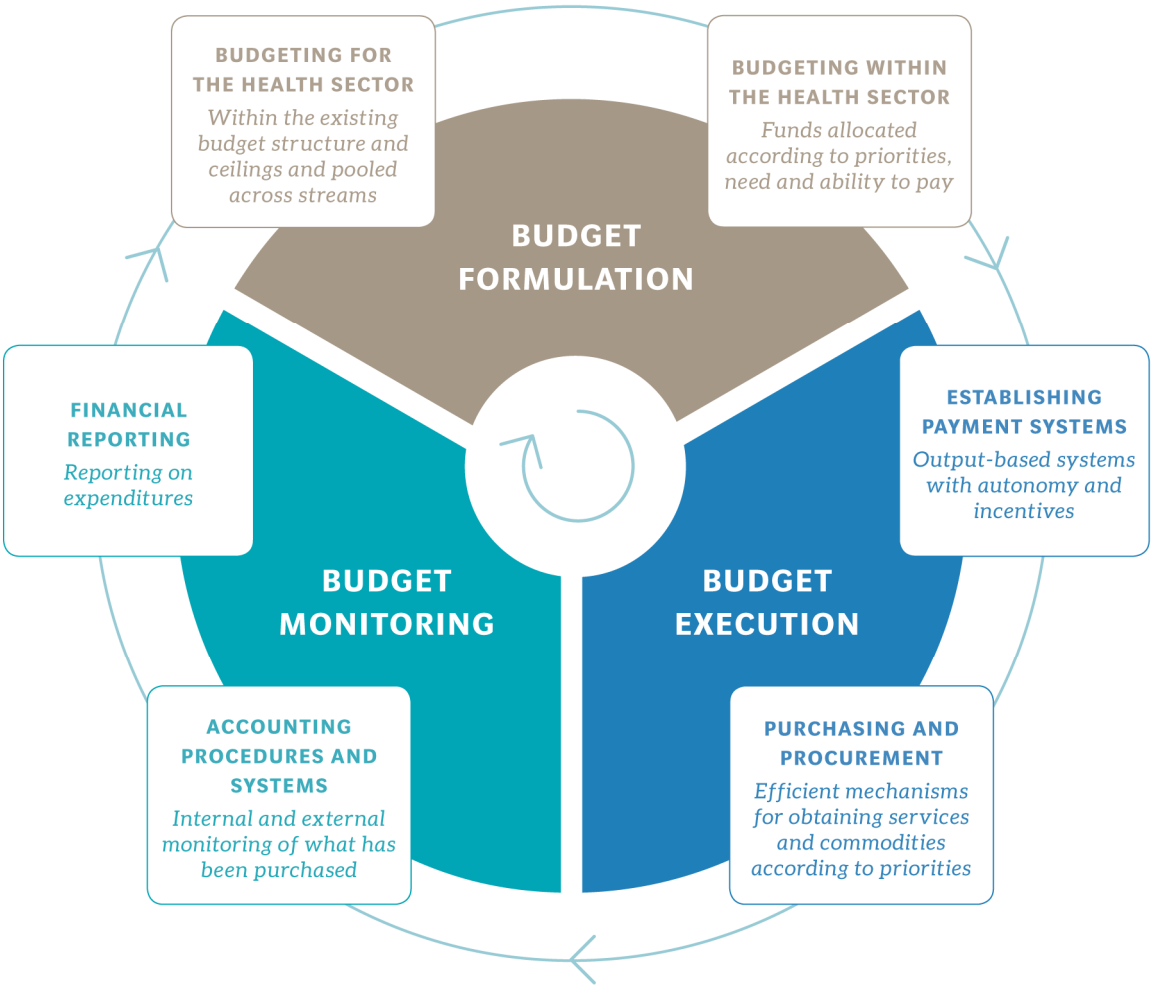
There may be significant potential to make better use of public funds for health by examining and improving the alignment between the PFM system, the budgeting process and health financing objectives to reduce inefficiencies and underabsorption of public funds in the health sector.

When the PFM system and health financing system are working in harmony, they can reinforce one another's objectives and make the following results possible:

- **Health sector policies and priorities are reflected in the budget.** Health budget allocation is sufficient and stable enough to meet health sector objectives and commitments.
- **Funds are directed to health sector priorities.** Funds can be pooled, allocated and disbursed across populations, geographic areas and time to respond to health needs and ensure equity and financial protection for target populations.
- **Funds are used effectively and efficiently to deliver high-value services.** Funds are directed to priority populations, interventions and services, and payment to providers is based on service outputs and performance. Disbursements are predictable, and flexibility in purchasing and provider payment ensures efficiency and value for money.
- **Funds are accounted for against priorities.** The ministry of health and ministry of finance are both accountable for the proper use of public funds and effective delivery of health interventions, goods and services.

Alignment between the PFM system and health financing system can lead to a single, integrated cycle, as depicted in Fig. 3.

FIG. 3 INTEGRATED HEALTH SECTOR FINANCIAL MANAGEMENT[7]



[7] Ibid.

The purpose of this guide

This guide provides countries with an illustrative process for diagnosing misalignments between health financing policies and PFM systems, identifying the main obstacles and determining actions that can improve alignment.

Specifically, this guide can be used to:

- structure a collaborative process to assess alignment between government budgeting processes and health sector objectives and inform a roadmap for better alignment related to specific reforms as well as more generally;
- promote constructive dialogue between senior budget officials and health policy-makers;
- build the capacity of the ministry of health to engage in informed dialogue with the ministry of finance on issues of PFM rules, the budget process and alignment with health financing policy; and
- contribute to the global knowledge base on health budgeting practices and alignment with health sector objectives.

This guide provides a framework for health and finance policy-makers at the national and/or subnational levels to work together to assess how well their health budgeting practices and financial rules are aligning with current or planned health financing policies to reach the common objectives of accountable and effective delivery of publicly funded health interventions, goods and services.

The assessment process answers these overarching questions about health financing systems, budgeting practices and PFM systems:

- Do they make it possible to allocate sufficient funds to the health sector to meet sector objectives and fulfill strategic plans, given the current and future demographic and macro-fiscal realities of the country?
- Do they make it possible to direct funds to priority populations, interventions and services at every step of the budget cycle (through pooling and purchasing arrangements)?
- Do they make it possible to demonstrate that public spending on health has reached priority populations, programmes and services and has met stated objectives in the budget reporting and accountability systems?

When this guide can be useful

PFM reforms and health financing reforms can reinforce one another to achieve more effective and efficient use of public funds for health, better financial accountability and greater transparency. But the flexibility needed for pooling and purchasing mechanisms can be challenging to implement in input-based, line-item PFM systems. Reforms to the PFM system and the health financing system sometimes happen in parallel, and when health financing reforms are discussed and planned without regard to the PFM system, they can face obstacles during implementation. For example, plans to establish a national health insurance system may require funds to be pooled from different sources into a single account or may require that health budgets be formed at the national rather than subnational level. Either scenario might lead to PFM challenges. If a country enacts health financing policies that introduce output-based payment to health providers (such as capitation payment for primary health care or case-based payment for hospital services), budgets will need to be formed and executed so payments can be released to providers in this way.

As PFM and health financing reforms are undertaken, a well-informed dialogue between the ministry of health and the ministry of finance is essential to ensure that the two systems are working in harmony. This guide can serve as an entry point for that dialogue, creating a structured approach for health, finance and other stakeholders (such as local government districts/zones and consumers) to discuss any underlying issues before

implementing system changes that might affect the health financing system or PFM system. It can be useful in the following situations:

- when planned health financing reforms (such as payment to health providers for service outputs and results or holistic, system-level changes that seek to make progress towards UHC) will change how health funds flow through the system and policy-makers want to anticipate how those changes will affect or be affected by the PFM system;
- when policy-makers want to ensure that planned PFM reforms (such as broad fiscal decentralization) do not inadvertently introduce obstacles to current or planned health financing policy;
- when health financing policies face implementation challenges because of weaknesses in the PFM system or rules that limit flexibility; and
- when policy objectives include improving the quality of health spending and reducing inefficiencies by directing funds to frontline service providers and linking payments to service outputs and results.

Countries that are planning health financing or PFM improvements need to understand the PFM system and any ongoing reforms in order to frame and guide dialogue between the ministry of health and the ministry of finance. For example, Tanzania's Health Financing Strategy calls for a single national health insurance system and a shift to output-based payment for health providers. The success of the proposed reforms will depend in large part on whether the PFM system will allow a change in how health budgets are formed, the way funds flow through the system and how funds reach health providers. In Tanzania, the process guide was used to frame a discussion among the main health sector stakeholders about budget formulation and execution in relation to implementation of the national health financing strategy and movement toward a single national health insurance system. (See Box 1.) Myanmar, which introduced key policies in 2011 to improve service delivery and reduce out-of-pocket spending, is using the assessment process to foster a better understanding of health financing reforms for UHC and their linkages with governmentwide PFM reforms. (See Box 2.)

Box 1 Tanzania (mainland): Identifying key health financing policy areas

Tanzania faces a unique set of challenges in aligning the health financing system and PFM system. In the budget formulation process, PFM rigidities impede better matching of health sector plans and budgets. Planning, budget structure and processes are based on inputs rather than on service outputs; this makes it difficult to define health programmes and service outputs (such as priority maternal and child health services and minimum benefit packages) and is not consistent with health sector objectives and strategic plans.

As Tanzania moves toward a single national health insurance system, it may face challenges in pooling funds across multiple revenue sources and addressing fragmentation in the health sector at both the national level and service delivery level. A 2014–2015 public expenditure review found that an increasing number of development partners were dropping from the basket funding a mechanism that pools nonearmarked resources from various development partners to support the implementation of a health sector strategic plan. Nonbasket funds as a share of total foreign funds have increased to 82%, with a corresponding decrease in the share of basket funds. This type of fragmentation can also lead to different PFM rules for different funding sources, which greatly increases the administrative burden on clinical staff and decreases efficiency. At the local government authority (LGA) level in Tanzania, funding for health comprises government block grants, donor basket and nonbasket funds, local government funds, the National Health Insurance Fund, the Community Health Fund, private sources and unclassified sources. Different rules for different funding sources and expenditure caps at the line-item level reduce the flexibility to allocate payments received across budget line items.

In Tanzania, the process guide was used to guide discussions among the main stakeholders that went step by step through various aspects of budget formulation and execution as they related to the establishment of the single national health insurance system and a minimum benefit package.

Box 2 Myanmar: Linking health financing and PFM reforms

In Myanmar, the Ministry of Health is taking steps to improve service delivery readiness nationwide, especially at the front lines of service delivery, in support of UHC. As part of this reform, the government has committed to strengthening health financing functions, including exploring innovative financing for health, risk pooling options and efficiency gains through improvements in procurement and increased allocation to public health and primary care. These reforms will require aligning the PFM system and health financing system, given the significant increase in the overall health budget, with more funds flowing to the front lines of service delivery and with health financing reforms being considered.

Through initial small consultative meetings with stakeholders, facilitated by an in-country international partner, a small team from the Ministry of Health completed relevant sections of the draft process guide and validated the findings with frontline health service providers.

Although the process is still within the ministry, it has supported a greater understanding of health financing reforms for UHC and the linkages with PFM reforms taking place across the government. The benchmarks for discussion and the alignment continua (described below) have helped the ministry identify areas with the greatest potential for significant improvement before entering into dialogue with the Ministry of Finance.

Table 1 summarizes the conditions for effective health financing policy implementation, the PFM functions that underpin each health financing function, common PFM challenges that can arise, and benchmarks for close alignment between PFM systems and health financing policy. It can serve as a starting point for dialogue between the ministry of health and ministry of finance about improving alignment between the PFM and health financing systems.[8]

[8] Although other frameworks and approaches for assessing PFM systems are available, most notably the Public Expenditure and Financial Accountability (PEFA) framework, they do not address the specific PFM requirements of the health sector and typically do not shed light on alignment of health financing and PFM policy.

TABLE 1	HEALTH FINANCING AND PFM FUNCTIONS: CONDITIONS AND CHALLENGES[9]			
HEALTH FINANCING FUNCTIONS	**PFM FUNCTIONS**	**IMPLEMENTATION CONDITIONS**	**COMMON PFM CHALLENGES**	**COUNTRY EXAMPLES**
Revenue raising				
> Estimates of resource needs to achieve policy priorities given macro-fiscal realities > Revenue streams from both health-specific and general government sources > How funds are allocated to the health sector	> Policy/ strategy > Revenue projection > Budget formulation > Budget classification	> Sufficient and stable resources to meet stated health sector objectives > Appropriate and predictable timing and harmonization of health revenue streams	**Misalignments in policy:** > Budget ceilings for the sector that do not reflect political commitments > Budget classification based on facility and line item rather than on objectives, programmes and services **Implementation challenges:** > Poor revenue forecasting and fragmented revenue sources (including donors and private out-of-pocket payments), leading to unrealistic or unclear total envelope and ad hoc adjustments > Poor tax administration and collection, leading to missed revenue targets and budget shortfalls > Weak link between policy and budget formulation	> **Myanmar.** Lack of credibility in the budget leads to misalignment of policy priorities and spending as the budget is significantly remade during the year.
Pooling				
> Accumulation of funds across funding streams > Accumulation of funds within the health sector (across geographic areas, administrative levels, etc.)	> Budget formulation	> Mandate and mechanism to accumulate and redistribute funds according to need and ability to pay	**Misalignments in policy:** > Fiscal decentralization whereby budgets are formulated at different administrative levels with no mandate or mechanism to transfer funds between budgets > Different budget formulation processes and pooling arrangements for different revenue streams (e.g., social health insurance, donor funds, out-of-pocket payments) > Parts of the health budget (such as health worker salaries) determined and paid directly by the ministry of finance or the treasury **Implementation challenges:** > Donor funds that are fragmented and poorly integrated with domestic resources	> **Malawi.** More than 70% of health sector spending is donor funded, creating transparency issues related to funding for health and coordination of resource flows. > **Tajikistan.** Highly inequitable government health spending under fiscal decentralization, with no mandate or mechanism to reallocate health funds

[9] Cashin et al.

Health financing functions	PFM functions	Implementation conditions	Common PFM challenges	Country examples
Purchasing (provider payment)				
> What to purchase and with what funds > How to purchase and what payment mechanisms to use within the health sector allocation > Monitoring what has been purchased	> Budget formulation > Budget execution and payment > Accounting and reporting	> Mandate to purchase services for the population (benefits package, essential services) > Stable, timely and predictable funding to enter into contracts with providers > Flexibility within the structure of the budget to make payments according to service outputs and performance > Mechanisms and incentives to improve efficiency and quality > Provider autonomy to make management decisions and respond to incentives > Standard accounting procedures, financial reporting, internal controls and auditing	**Misalignments in policy:** > Difficulty matching health spending to needs and priorities: • Budgets are classified, formed and disbursed based on inputs, with the health facility as the budget unit • Different purchasing arrangements and accounting for different revenue streams (health budget, health insurance fund, donor funds) > Lack of provider autonomy to respond to incentives in output-oriented payment > Obstacles to engaging with the private sector > Government procurement rules reduce flexibility and ability to match inputs with need **Implementation challenges:** > Delays in release of funds, making it difficult to enter into credible contracts with providers > Poor information systems and monitoring capacity	> **Ghana.** Delays in transfers of earmarked taxes to the National Health Insurance Authority interrupted contracts with providers and resulted in providers threatening to pull out of the scheme. > **Malaysia.** The traditional budget system makes it nearly impossible for the Ministry of Health to purchase services from private primary care providers to close access gaps and reduce waiting times. > **Mongolia.** Budget law requires output-based payment to be paid through health facilities' line-item budgets that impose rigidities on reallocation of funds at all levels of the system. > **Tanzania.** Health facilities have their own bank accounts as a part of decentralization but little authority to use funds without approval.

How this guide is organized

This guide offers steps for examining alignment between the PFM system and health financing policy objectives at each stage of the budget cycle, as well as a series of templates that countries can use to document the current situation and assess how well current practices align with good practices. The guide is designed so that sections can be modified to fit specific country needs. Summary tables, output tables and continua that appear in the body of this guide can be filled directly or copied and pasted into another document.

Assessment modules

This guide is organized into six assessment modules that correspond to the steps in the health budget cycle, each with accompanying summary tables, output tables and alignment continua. The process is not intended to be prescriptive or strictly linear; countries can use the guidance selectively and adapt it to their needs and the needs of their different regions or institutions at different points in time.

MODULE 1	MODULE 2	MODULE 3
LAYING THE GROUNDWORK This module establishes objectives for the assessment process from the perspective of both health policy-makers and budget officials. It also lays a foundation for the rest of the process by describing current policy initiatives and key issues and challenges related to health financing policy, the budget process and the PFM system.	**HEALTH BUDGET FORMULATION** This module identifies decision-making and coordination mechanisms used in the budget formulation process, the budget classification system and the approach to allocating funds to and within the health sector.	**HEALTH BUDGET EXECUTION AND PROVIDER PAYMENT** This module documents how resources flow through the system, including how budgets are executed and health providers are paid.
MODULE 4	**MODULE 5**	**MODULE 6**
BUDGET ACCOUNTING AND REPORTING This module identifies the accountability mechanisms in place to assess the efficiency, effectiveness, quality or equity of budget fund use.	**FISCAL SUSTAINABILITY** This module assesses whether funds are treated in a way that promotes fiscal sustainability over the medium and long term.	**OPTIONS FOR ACHIEVING BETTER ALIGNMENT BETWEEN PFM AND HEALTH** This module identifies options for enhancing alignment between the health financing system and PFM system to achieve stated policy objectives.

Summary tables and sample questions

Each module includes summary tables that can be used to document the current situation and identify potential bottlenecks. The annex includes templates with sample questions that can be helpful in generating information for the corresponding summary tables.

SUMMARY TABLES	CORRESPONDING SAMPLE QUESTIONS IN THE ANNEX
Summary Table 1.1 Current policy initiatives, key issues and challenges	1.1.1, 1.1.2
Summary Table 1.2a Sources of funding for the health sector	1.2.1
Summary Table 1.2b Earmarked revenue sources for the health sector	1.2.2
Summary Table 1.2c Sample health sector funds flow map	1.2.3
Summary Table 1.2d Coverage arrangements	1.2.4
Summary Table 1.3 Level of fiscal decentralization in the health sector	1.3
Summary Table 2.1 Budget preparation process and classification system	2.1.1, 2.1.2, 2.1.3
Summary Table 2.2 Description of budget allocation to the health sector	2.2.1, 2.2.2, 2.2.3
Summary Table 2.3 Description of budget allocation within the health sector	2.3
Summary Table 2.4 Allocation of donor resources	2.4
Summary Table 3.1 Budget execution process	3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.1.5, 3.1.6
Summary Table 3.2a Purchasing and provider payment arrangements	3.2.1
Summary Table 3.2b Provider autonomy	3.2.2
Summary Table 4.1 Budget monitoring process	4.1.1, 4.1.2
Summary Table 4.2 Accountability mechanisms	4.2.1, 4.2.2, 4.2.3, 4.2.4
Summary Table 5.1 Fiscal sustainability measures	5.1

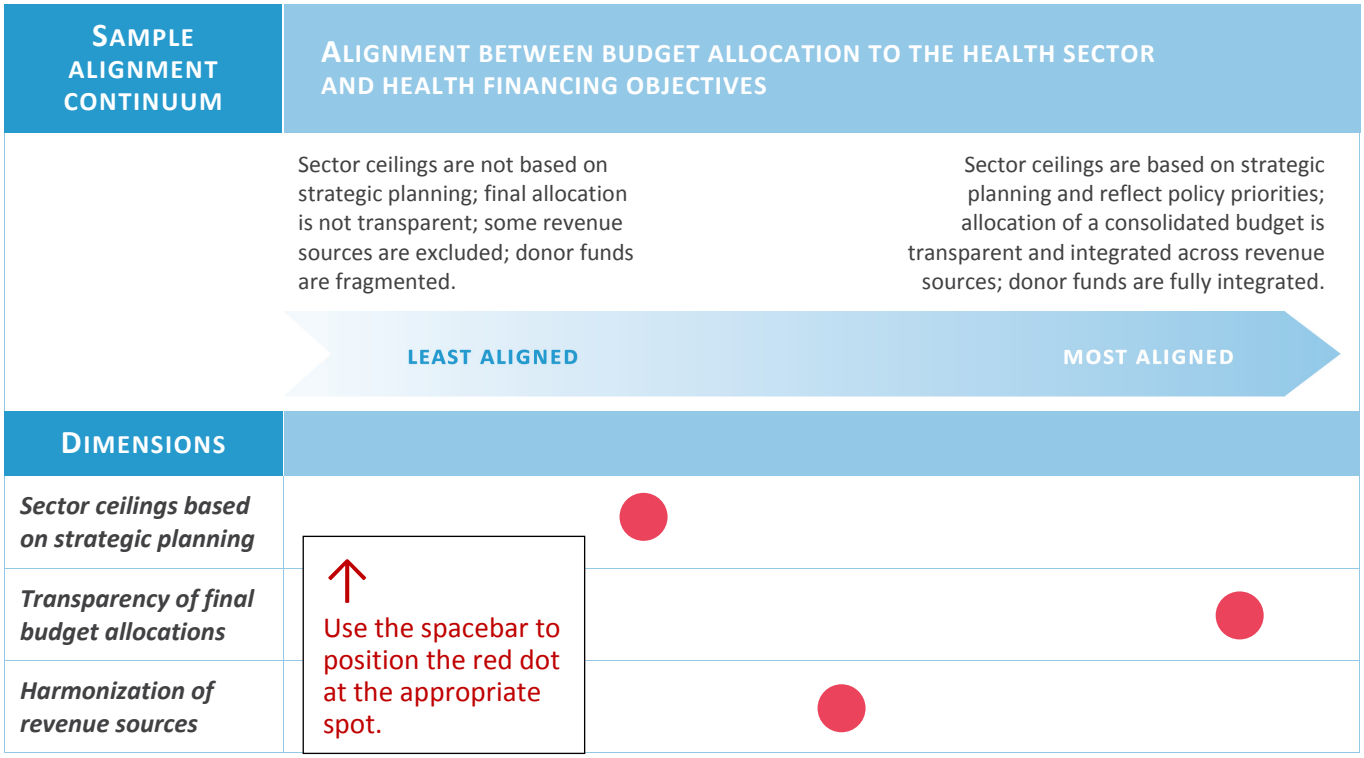
Assessment tables and alignment continua

At the end of each module are an assessment table and an alignment continuum. The assessment table can be used to evaluate the country's progress at each stage of the budget cycle and note key bottlenecks that should be addressed.

The alignment continuum provides a way to identify where a country falls along various dimensions of a continuum of alignment. For instance, alignment between budget allocation to the health sector and health financing objectives includes three dimensions:

- the degree to which sector budget ceilings are based on strategic planning;
- how transparent final budget allocation is; and
- how well all revenue sources (including donor funds) are harmonized in generating sector budget ceilings

Stakeholders can identify where a country falls along each dimension of a continuum (as denoted by a red dot in this guide) by discussing how the country is performing relative to defined good and poor practices.



ASSESSMENT TABLES AND ALIGNMENT CONTINUA	
Module 2	
Assessment Table 2	Budget formulation practices
Alignment Continuum 2.1	Alignment between budget formulation and classification and health financing objectives
Alignment Continuum 2.2	Alignment between budget allocation to the health sector and health financing objectives
Module 3	
Assessment Table 3	Budget execution and purchasing/provider payment
Alignment Continuum 3.1	Alignment between budget execution and health financing objectives
Alignment Continuum 3.2	Alignment between purchasing/provider payment and health financing objectives
Module 4	
Assessment Table 4	Budget monitoring
Alignment Continuum 4.1	Alignment between budget monitoring and health financing objectives
Module 5	
Assessment Table 5	Fiscal sustainability practices

Final output tables and roadmap

The guide provides a set of final output tables that can be used to identify areas where it is most critical to improve alignment between the PFM system and health financing objectives and to assess options for improvement. These final output tables can be used to further guide dialogue among the relevant stakeholders and to develop a roadmap of required steps to improve alignment.

FINAL OUTPUT TABLES AND ROADMAP	
Module 6	
Final Output Table 6.1	Priority areas to address for achieving better alignment between the PFM system and health financing system
PFM system and health financing system	Proposed solutions for achieving better alignment between the PFM system and health financing system
Final Output Table 6.2	Roadmap for achieving better alignment between the PFM system and health financing system

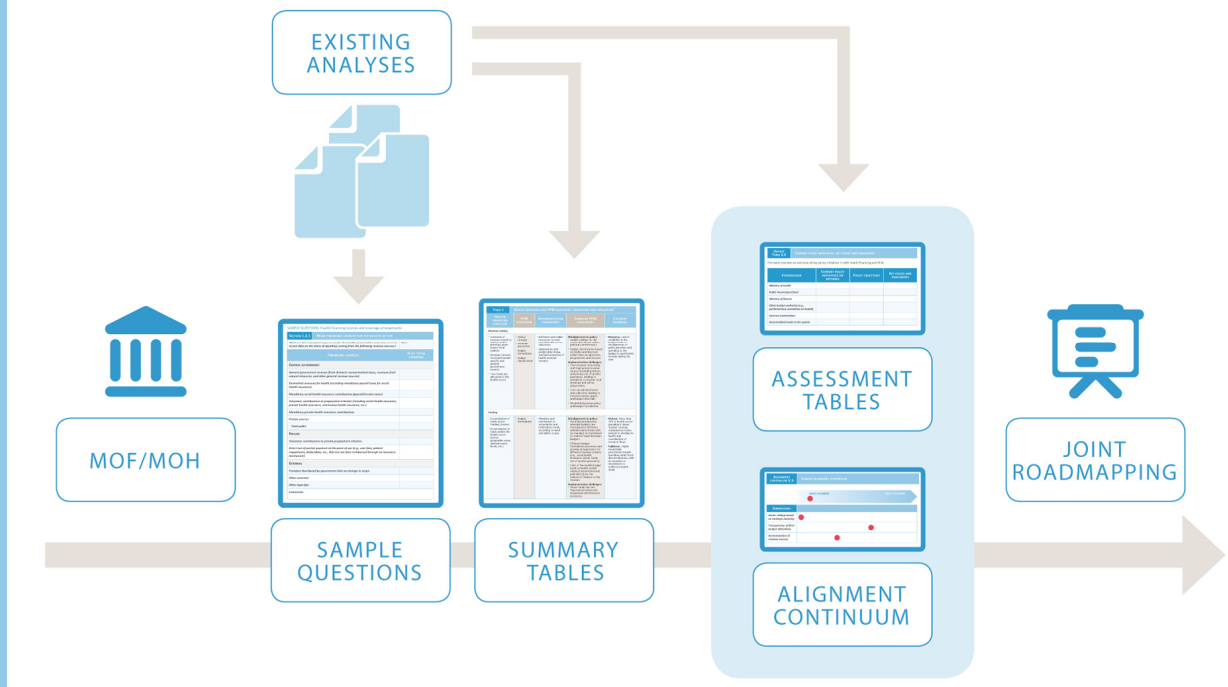
How the assessment process is structured

The assessment process focuses on key health financing policies and challenges that arise when these policies are not aligned with the PFM system.

The assessment process detailed in this guide is not intended to replace existing assessments; rather, it is meant to augment them and examine in greater detail the alignment between the PFM and health financing functions, given policy objectives and fiscal resource constraints. The assessment process draws on available policy or legal documents, secondary data, stakeholder interviews and expert opinion. No additional quantitative data collection is required, although the process may identify the need for additional data to support the identification, development and implementation of new policies or refinements to existing ones.

Fig. 4 shows how the answers to the sample questions can be combined with existing information to generate assessment tables that compare the current situation with benchmarks and place it along a continuum of alignment between the PFM system and health financing system.

FIG. 4 **POSSIBLE STEPS IN THE ASSESSMENT PROCESS**



The assessment can be carried out under the overall direction of a strategic-level steering committee, with the specific steps in each module carried out by a technical **Working Group**. Support from a neutral **Facilitator** (a health financing or PFM expert with knowledge of institutional arrangements in the country) and an **Analytical Team** that independently collects information, conducts stakeholder interviews, and synthesizes and analyzes the results for interpretation by the **Working Group** can be useful. The **Working Group** or **Analytical Team** can draw from existing multisector **Working Groups** that would ideally include both health policy-makers and budget authorities. The questions posed in the guide should be answered by multiple stakeholders, including a balance of health and budget officials, either through individual interviews, small consultative meetings or a larger facilitated meeting.

The process is meant to be country led, organic and flexible. Most countries will choose to apply only a subset of the guide to address the particular issues they are facing. A sample structure of the assessment process is illustrated in Table 2. The actual process will depend on existing relationships among stakeholders.

The final output of the process may be a policy roadmap for removing obstacles and better aligning the PFM system and health financing system in a way that helps achieve shared objectives.

TABLE 2 SAMPLE STRUCTURE OF THE ASSESSMENT PROCESS

MODULE	COMPONENT	ACTIVITIES	TIME NEEDED	OUTPUTS	RESPONSIBLE PARTY
Module 1: Laying the groundwork	**Data collection and analysis**				
	Identify key health financing policy issues	Identifying which aspects of health financing policy are most critical to how funds flow through the PFM system. Assembling background data and key documents to identify current policy initiatives and key issues and challenges for both health financing policy and the budgeting process / PFM system.	2–4 weeks	Summary Tables 1.1, 1.2a, 1.2b 1.2c, 1.2d, 1.3	**Analytical Team**
	Small group consultations or joint "kickoff workshop"				
	Plan the assessment	Holding small group consultations or a joint "kickoff workshop" to validate the objectives of the assessment process from the perspectives of both health policy-makers and budget officials.	1–2 days		**Working Group** with **Facilitator**

TABLE 2	SAMPLE STRUCTURE OF THE ASSESSMENT PROCESS (CONTINUED)				
MODULES	**COMPONENT**	**ACTIVITIES**	**TIME NEEDED**	**OUTPUTS**	**RESPONSIBLE PARTY**
Data collection and analysis					
Module 2: Health budget formulation	Complete the assessment exercise	Using the questions and output tables in Modules 2–5 to compile information from relevant documents and stakeholder interviews about the current processes at each stage of the budget cycle and to assess the current situation against benchmarks for alignment between PFM systems and health financing objectives.	1–2 months	Summary Tables 2.1, 2.2, 2.3, 2.4 Assessment Table 2.5 Alignment Continua 2.1, 2.2	**Analytical Team** with input from the **Working Group**
Module 3: Budget execution and provider payment				Summary Tables 3.1, 3.2a, 3.2b Assessment Table 3.3 Alignment Continua 3.1, 3.2	
Module 4: Budget accounting and reporting				Summary Tables 4.1, 4.2 Assessment Table 4.3 Alignment Continuum 4.1	
Module 5: Fiscal sustainability				Summary Table 5.1 Assessment Table 5.2	
Module 6: Identifying options for achieving better alignment between PFM and health	Compile information from the assessment	Using the questions and output tables in Modules 1–6 to assess the information against benchmarks on alignment of the PFM system and health financing policy objectives.	1–2 weeks	Draft Final Output Tables 6.1, 6.2	**Analytical Team**
	Validation and consultation to reach consensus on key issues				
	Analyze and interpret the results of the assessment	Compiling information and convening to reach consensus on interpreting elements of the assessment.		Validated Final Output Tables 6.1, 6.2	**Analytical Team**, with input from **Facilitator**
	Workshop: developing options to enhance alignment				
	Develop options to enhance alignment	Discussing and agreeing on options to enhance PFM and health financing policy alignment, better coordinate existing health policies with existing PFM requirements and develop policy reforms in both areas as part of an implementation roadmap.	1–2 weeks		**Working Group**, with input from **Facilitator** and **Analytical Team**

Several countries that implemented a draft version of this assessment process have contributed valuable experience and guidance on addressing specific health financing policies or challenges.

The entry point for the assessment will depend on the practical realities on the ground. The process can be initiated through targeted consultative meetings with stakeholders or through an initial "kickoff workshop." In the first joint meeting or the initial consultations, the **Facilitator** will guide the **Working Group** or stakeholders in reviewing the current health system and PFM context and identifying broad areas of misalignment that could be addressed using the process guide, given the stated policy objectives. These initial discussions can help inform roles and responsibilities within the assessment process and the timeline. In some countries, the process may start on a smaller scale, with just internal consultations within the ministry of health as an exercise to better prepare for dialogue with the ministry of finance. Box 3 offers tips on how to structure the initial consultations and the kickoff workshop.

Box 3 Tips for structuring consultations and/or a kickoff workshop

- Identify and receive feedback on key areas of current or planned health financing policy in which implementation is or will likely be affected by the PFM system, such as plans to improve pooling of funds or introduce output-based payment for health providers.
- Orient stakeholders to the purpose and structure of this guide and how it can help them identify priorities for improving alignment between the PFM system and health financing policy.
- Include stakeholders from the ministry of health and ministry of finance as well as other bodies, such as a national health insurance authority. Depending on the country context, it may also be helpful to include other stakeholders, such as development partners. In some countries, however, the process may start on a smaller scale, with just internal consultations within the ministry of health as an exercise to better prepare for dialogue with the ministry of finance.
- Provide a concise overview of this guide and PFM and health financing policy priorities as background for using the modules. Emphasize relevance to ongoing policy priorities (such as single national health insurance on the health financing side or decentralization and programme-based budgeting on the PFM side).
- Establish a consistent vocabulary/lexicon for the discussion.
- Emphasize that the guide can be useful when considering specific reforms as well as for viewing the PFM and health financing landscape more holistically. Create opportunities for participants to share the status of policy developments in their country, in a way that allows discussion topics to build on one another.
- Demonstrate how the questions, output tables and alignment continua are connected and how they feed into the intermediate and final outputs of the process.
- Promote a sense of ownership among the participants, many of whom will be essential to the data collection process.

Laying the groundwork

In this module, the **Analytical Team** assembles background documents on key policy directions for both health financing and the PFM system. This information will be critical to identifying key areas of alignment between the PFM system and health financing policy as well as obstacles. The **Working Group** will use this information to reach consensus on the objectives of the assessment process.

The important background information includes:

- main sources of funding for the health sector, their basic policy objectives and how funds flow through the system;
- coverage arrangements and their institutional characteristics related to pooling and purchasing; and
- fiscal decentralization in the health sector, encompassing both financing and delivery.

SECTION 1.1 CURRENT POLICY INITIATIVES

In this section, the **Analytical Team** assembles information on current policy initiatives and key issues and challenges for both health financing policy and the budgeting process and PFM system.

SUMMARY TABLE 1.1 **CURRENT POLICY INITIATIVES, KEY ISSUES AND CHALLENGES**

This table provides an overview of key policy initiatives in both health financing and PFM. (Corresponding sample questions in the annex: 1.1.1 and 1.1.2)

STAKEHOLDER	CURRENT POLICY INITIATIVES OR REFORMS	POLICY OBJECTIVES	KEY ISSUES AND CHALLENGES
Ministry of health			
Public insurer/purchaser			
Ministry of finance			
Other budget authority (e.g., parliamentary committee on health)			
External stakeholders			
Decentralized levels in the system			

SECTION 1.2 HEALTH FINANCING SOURCES AND COVERAGE ARRANGEMENTS

Next, the **Analytical Team** maps the main sources of financing for the health sector and the different coverage and pooling arrangements. This helps trace funds from the main sources of financing to the managing agencies responsible for pooling and purchasing, and then to providers. The resulting output tables provide a clearer picture of any fragmentation in health financing that may stem from multiple revenue sources and different pooling and purchasing arrangements from parallel budgeting processes. They also help identify mechanisms for redistribution of funds across pools (i.e., transfers across economic status).

SUMMARY TABLE 1.2A **SOURCES OF FUNDING FOR THE HEALTH SECTOR**

This table helps reveal possible fragmentation in funding sources and the need for a PFM mechanism to unify pooling arrangements or redistribute funds across pools to improve equity and/or harmonize purchasing arrangements. (Corresponding sample questions in the annex: 1.2.1)

SOURCE	NATIONAL (%)	SUBNATIONAL (%)	TOTAL (%)
Government/compulsory sources (i.e., public)			
General government revenue			
Social health insurance contributions			
Earmarked revenue for health (other than social health insurance contributions)			
Other mandatory health insurance contributions			
Total public			
Private/voluntary sources			
Voluntary contributions to private prepayment schemes			
Direct out-of-pocket payment at the point of use			
Total private			
External			
Transfers distributed by government from foreign origin (i.e., on-budget external funding for health)			
Direct foreign transfers (i.e., off-budget external funding for health)			
Other external			
Total external			

SUMMARY TABLE 1.2B — EARMARKED REVENUE SOURCES FOR THE HEALTH SECTOR

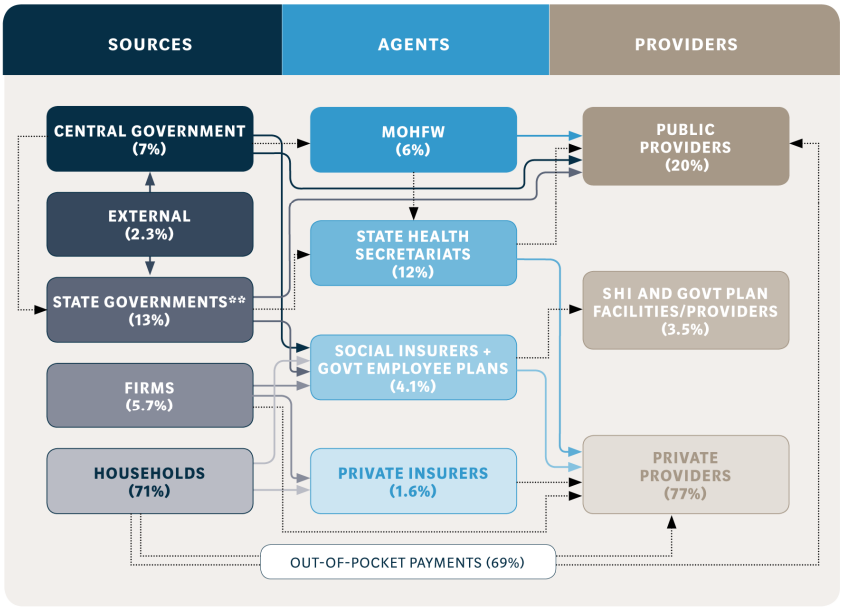
This table helps identify earmarked funding sources for the health sector and determine whether they are integrated with general budget revenues and other funding sources. (Corresponding sample questions in the annex: 1.2.2)

CHARACTERISTIC OF EARMARKING FOR HEALTH	CURRENT SITUATION	KEY ISSUES AND CHALLENGES
Policies for earmarking for health		
Revenue sources for earmarks for health		
Expenditure purpose for earmarks for health		
Implementation arrangements for earmarks for health		
Results/experiences with earmarks for health		

SUMMARY TABLE 1.2C — SAMPLE HEALTH SECTOR FUNDS FLOW MAP

This diagram maps how resources are transferred from different sources to different agents. (Corresponding sample questions in the annex: 1.2.3)

MAIN ACTORS AND FUNDS FLOWS IN THE INDIAN HEALTH SYSTEM (2005)[10]



[10] La Forgia G, Nagpal S. Government-sponsored health insurance in India: are you covered? Directions in Development. Washington (DC): World Bank; 2012.

SUMMARY TABLE 1.2D	COVERAGE ARRANGEMENTS

This table helps reveal fragmentation in pooling and the possible need for PFM changes that improve cross-subsidization (transfers across regions) or promote higher levels of aggregation. (Corresponding sample questions in the annex: 1.2.4)

INSURANCE COVERAGE ARRANGEMENT	% OF POPULATION	# OF POOLS	CROSS-SUBSIDIZATION MECHANISM(S)
Government-funded coverage with automatic entitlement			
Social/compulsory/ mandatory health insurance			
Mandatory private health insurance			
Voluntary private (commercial or nonprofit) health insurance			
Other voluntary coverage (e.g., community-based, civil society or nongovernmental)			
Employer-provided coverage			
Other coverage arrangements			
No coverage (no pool)			
Other			

SECTION 1.3 FISCAL DECENTRALIZATION

Decentralization involves defining roles and responsibilities among different levels of governments for fiscal functions (including planning and budget preparation, budget execution, revenue generation, intergovernmental allocation of budgetary resources, and public sector borrowing). In countries with a high degree of fiscal decentralization for both raising revenues and setting priorities for expenditures without an equity-based mechanism for redistribution, pooling is more fragmented, which often has negative effects on equity and financial protection. Many countries find that decentralization laws can be in conflict with a movement toward national health insurance systems or other efforts to improve pooling of health funds or establishing national provider payment policies.

In this section, the **Analytical Team** describes the level of fiscal decentralization in health budgeting and expenditure to identify potential bottlenecks to health resource generation, pooling or purchasing that should be examined in greater detail in subsequent sections.

SUMMARY TABLE 1.3 **LEVEL OF FISCAL DECENTRALIZATION IN THE HEALTH SECTOR**

This table documents the level of decentralization for each fiscal function. (Corresponding sample questions in the annex: 1.3)

FISCAL FUNCTION	COMPLETELY CENTRALIZED	SOME SUBNATIONAL AUTHORITY	COMPLETE SUBNATIONAL AUTHORITY	HEALTH CARE PROVIDER
Revenue generation				
Planning and budget preparation				
Allocation of off-budget revenue streams (i.e., social health insurance)				
Allocation of funds to the health sector				
Allocation of funds within the health sector				
Budget execution				
Payment of service providers				
Allocation of inputs to produce health services				
Human resources				

Once Summary Tables 1.1 through 1.3 are completed, representatives from the health sector and budgeting authorities can meet in a workshop or in small consultative sessions to discuss how to engage in more productive policy dialogue. They should agree on the key policy issues for discussion and the objectives of the assessment process.

The workshop or consultative meetings will provide the opportunity to:

- identify current reforms or policy initiatives in both health financing and the PFM system, as well as key issues and challenges;
- map the current health financing and service delivery structure to identify how funds flow to frontline providers and what health financing policy changes are needed to address funds flow through the system; and
- agree on the objectives and scope of the assessment process.

Once the priority issues and questions have emerged more clearly, the **Analytical Team** should work with the **Working Group** to define the scope of the assessment process and the specific questions to be answered. (See Box 4 for an example from Malawi.)

BOX 4 **MALAWI: A PARTICIPATORY PROCESS TO LAUNCH THE ASSESSMENT PROCESS**

Malawi is instituting numerous policy changes that span both PFM and health financing policy: decentralized management of health services, programme-based budgeting and a four-pronged health reform strategy that includes national health insurance, establishing a health fund, refining existing service delivery contracting arrangements and reforming central hospitals in line with decentralization. The government will face challenges in coordinating these interrelated policy directions and the supporting technical inputs. If the policies are well aligned, they may be able to help improve the efficiency and effectiveness of health spending.

Representatives from the Ministry of Health and Ministry of Finance, with support from partners on the ground, determined that implementing the process guide would be a good way to identify potential bottlenecks to advancing these policies. These representatives decided to bring together a broader set of government and donor stakeholders for a launch meeting to orient them to the guide. Participating entities included the Ministry of Health, Ministry of Finance, National Local Government Finance Committee, District Health Offices, Kamuzu Central Hospital, National Audit Office, World Bank and the UK Department for International Development (DFID). The meeting, facilitated by an international partner, focused on providing an overview of PFM and health financing; introducing a conceptual framework; clarifying existing policy objectives, cross-cutting issues and bottlenecks; reviewing the process guide and related questions; discussing how the guide could be adapted to the Malawian context; and determining an approach to data collection.

Formulating the health budget

In this module, the **Analytical Team** documents the decision-making and coordination mechanisms used in the budget formulation process, the budget classification system and the approach used to allocate funds to and within the health sector.

The objective is to identify:

- obstacles to ensuring that health sector budget allocation is appropriate for reaching adequate stated policy objectives and reflects stated priorities for health relative to other sectors; and
- obstacles to directing budget funds to priority populations.

SECTION 2.1 BUDGET PREPARATION PROCESS

The process for forming budgets and setting spending priorities will determine whether policy priorities are reflected in final budget allocations. The budget process gives specific responsibilities to designated organizations and individuals, to be carried out within a given timetable. This process is normally established and controlled by a legal and regulatory framework and often guided by fiscal space assessments.

SUMMARY TABLE 2.1 **BUDGET PREPARATION PROCESS AND CLASSIFICATION SYSTEM**

This table helps assess whether the budget process facilitates linkages between stated priorities and budget allocation for health. (Corresponding sample questions in the annex: 2.1.1, 2.1.2 and 2.1.3)

CHARACTERISTIC OF THE BUDGET PROCESS	CURRENT SITUATION	KEY ISSUES AND CHALLENGES
Relationship between policy, the legislative process, and the budget and approval process		
Role of the MTEF,[11] MTFF[12] and fiscal rules		
Role of the health information system data used to inform the budget process		
Engagement of health sector officials early in the budget process		
Budget classification system and its role in budget formation		
Role of programme-based budgeting		
Link between policy priorities and budget programmes, targets and allocations		

[11] Medium Term Expenditure Framework
[12] Medium Term Fiscal Framework

SECTION 2.2 BUDGET ALLOCATION TO THE HEALTH SECTOR

Budget allocation to the health sector can be based on a top-down budget-setting framework that determines sector targets or ceilings using current macroeconomic and fiscal policy constraints or can be determined in some other way. The main concerns are whether the allocation to health reflects the priority placed on health relative to other spending priorities, and whether strategies and operational plans can be adequately funded.

SUMMARY TABLE 2.2 **DESCRIPTION OF BUDGET ALLOCATION TO THE HEALTH SECTOR**

This table helps determine whether allocation to health matches stated priorities relative to other sectors. (Corresponding sample questions in the annex: 2.2.1, 2.2.2 and 2.2.3)

CHARACTERISTIC OF THE BUDGET FORMULATION PROCESS	CURRENT SITUATION	KEY ISSUES AND CHALLENGES
Transparency of national health sector budget ceiling		
Link between health sector budget ceiling and policy priorities		
Transparency of subnational health sector budget ceilings		
Equity and adequacy of subnational health sector budget ceilings		
Role of earmarked revenue in national and subnational health sector budget ceilings		

SECTION 2.3 BUDGET ALLOCATION WITHIN THE HEALTH SECTOR

In this section, the **Analytical Team** describes how allocation of public funds is made within the health sector and ultimately reaches priority populations, programmes and services.

SUMMARY TABLE 2.3 **DESCRIPTION OF ALLOCATION WITHIN THE HEALTH SECTOR**

This table helps characterize budget allocation within the health sector. (Corresponding sample questions in the annex: 2.3)

CHARACTERISTIC OF THE BUDGET FORMULATION PROCESS	CURRENT SITUATION	KEY ISSUES AND CHALLENGES
Basis of budgets within the health sector		
Integration/fragmentation in the health budget		
Allocation of health budgets across geographic levels		
Allocation of health budgets across administrative levels		
Allocation of health budgets across service delivery levels		
Type of budget classification (e.g., input- or programme-based budget)		

SECTION 2.4 ALLOCATION OF DEVELOPMENT ASSISTANCE FOR HEALTH

Donor funds are often not integrated with the government budget, with much international donor funding channeled directly to programmes or facilities (and some of it potentially not reaching priority populations, interventions and services). This exacerbates existing fragmentation in pooling of health funds and can put pressure on domestic PFM systems. This section is useful for countries that receive a significant amount of donor funding earmarked for health or direct financing of health programmes and facilities by international donors.

SUMMARY TABLE 2.4 **ALLOCATION OF DONOR RESOURCES**

This table helps assess whether donor resources for health are transparently accounted for in the total government budget for health. (Corresponding sample questions in the annex: 2.4)

CHARACTERISTIC OF THE ROLE OF DONOR FUNDS IN THE BUDGET FORMULATION PROCESS	CURRENT SITUATION	KEY ISSUES AND CHALLENGES
Government management of donor resources		
Allocation of general development grants to health		
Integration of donor resources into the overall budget and health budget ceiling		
Effect of donor resources on allocation to the health sector		
Effect of donor resources on allocation within the health sector		
Role of results-based financing		

SECTION 2.5 ASSESSMENT OF HEALTH BUDGET FORMULATION

In this section, the **Analytical Team** assesses how decision-making and coordination mechanisms are used in the budget formulation process, the budget classification system and the approach to allocating funds to and within the health sector.

ASSESSMENT TABLE 2.5 **BUDGET FORMULATION PRACTICES**

This table helps assess whether budget allocation to the health sector is sufficient and is directed to priority populations, programmes and services.

GOOD PRACTICE	PROGRESS	BOTTLENECKS
Stated health need reflects stated budget priorities		
Sufficient and stable resources to meet stated health sector objectives		
Multi-year perspective in fiscal planning, expenditure policy and measurement		
Health sector ceilings based on strategic planning and transparent priority setting across sectors		
Funds pooled and then allocated across populations using mechanisms that allow the transfer of funds between administrative levels and health revenue sources (i.e., social health insurance) according to health need		
Budgets classified and formed based on population health needs and the resources required to meet those needs		

USING THE ALIGNMENT CONTINUA

Each position along the alignment continuum reflects a number of dimensions. Using the spacebar, position the red dot where a country falls along the continuum for each dimension. The position can be determined based on discussion and a common understanding among stakeholders about how the country is performing relative to good practices. This discussion can be supported by the completed descriptive tables above and/or by working through an adapted version of the suggested questions for each module.

ALIGNMENT CONTINUUM 2.1	ALIGNMENT BETWEEN BUDGET FORMULATION AND CLASSIFICATION AND HEALTH FINANCING OBJECTIVES
	Administrative and economic classification only; budgets are formed based on input-based line items rather than objectives, activities and outputs. — Budgets are formed based on programmes related to priority populations, programs and services.
	LEAST ALIGNED — MOST ALIGNED
DIMENSIONS	
Budget classification system by revenue source	

ALIGNMENT CONTINUUM 2.2	ALIGNMENT BETWEEN BUDGET ALLOCATION TO THE HEALTH SECTOR AND HEALTH FINANCING OBJECTIVES
	Sector ceilings are not based on strategic planning; final allocation is not transparent; some revenue sources are excluded; donor funds are fragmented. — Sector ceilings are based on strategic planning and reflect policy priorities; allocation of a consolidated budget is transparent and integrated across revenue sources; donor funds are fully integrated.
	LEAST ALIGNED — MOST ALIGNED
DIMENSIONS	
Sector ceilings based on strategic planning	
Transparency of final budget allocations	
Harmonization of revenue sources	

Budget execution and provider payment

In this module, the **Analytical Team** documents key aspects of budget execution, including rules for the release of funds (such as treasury system or procurement rules), reallocation within budgets, and the nature of payment and funds flow to frontline service providers. This module places particular emphasis on understanding how health providers are paid because paying health providers for outputs rather than inputs is one of the most important ways to improve health financing and the use of public funds for health. Because it is difficult to predict which providers will deliver exactly which services, and because of the need to create incentives for quality and efficiency, most countries eventually move away from provider payment through input-based budgets capped at the health facility level. The team also identifies potential bottlenecks to channeling funds to priority populations, programmes and services and implementing effective incentive-based purchasing strategies.

SECTION 3.1 BUDGET EXECUTION PROCESS

In this section, the **Analytical Team** documents key aspects of budget execution, including rules for the release of funds (such as treasury system or procurement rules), flexibility for reallocation within budgets, and expenditure tracking and reporting. The team also identifies potential bottlenecks to channeling funds to priority populations, programmes and services.

SUMMARY TABLE 3.1 **BUDGET EXECUTION PROCESS**

This table documents who has authority to make spending decisions once budgets are finalized, how funds are allocated across expenditure items and flexibility in spending. (Corresponding sample questions in the annex: 3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.1.5 and 3.1.6)

CHARACTERISTIC OF THE BUDGET EXECUTION PROCESS	CURRENT SITUATION	KEY ISSUES AND CHALLENGES
Decentralization of budget execution authority at different levels (agencies, providers, etc.)		
Expenditure tracking and accounting systems		
Budget execution of multiple revenue sources		
Budget execution flexibility		
Authority for pharmaceutical procurement		
Programme budget execution flexibility		
Contracting arrangements		
Authority for expenditure of earmarked revenues		
Flexibility of expenditure for earmarked revenues		
Authority for expenditure of donor funds		
Flexibility of expenditure of donor funds		

SECTION 3.2 PURCHASING AND PROVIDER PAYMENT ARRANGEMENTS

In this section, the **Analytical Team** documents health purchasing arrangements and the nature of payment and funds flow to frontline service providers. The team also identifies potential bottlenecks to implementing effective incentive-based purchasing strategies.

There is no ideal payment method, and every method has strengths and weaknesses and can produce unintended consequences. But all payment methods can be useful at particular times and in particular contexts to address specific obstacles to increasing efficiency, equity or access or to enable specific service delivery improvements. This section examines how funds flow to frontline public health care providers and the mechanisms used to pay for health care services.

SUMMARY TABLE 3.2A **PURCHASING AND PROVIDER PAYMENT ARRANGEMENTS**

This table documents how funds are allocated across expenditure items and the purchasing and provider payment arrangements used. (Corresponding sample questions in the annex: 3.2.1)

CHARACTERISTIC OF PURCHASING AND PROVIDER PAYMENT	CURRENT SITUATION	KEY ISSUES AND CHALLENGES
Main public purchasers		
Public purchasers contracting with private providers		
Private purchasers/insurers and public providers		
Method of payment for primary care		
Method of payment for outpatient specialty services		
Method of payment for inpatient services		
Processes for transfer of funds		
Bank accounts and rules for accessing funds		
Rules related to cash management		
Rules related to payment caps, expenditure overruns and surpluses at the provider level		

SUMMARY TABLE 3.2B	PROVIDER AUTONOMY

This table documents who has authority to make spending decisions at the provider level. (Corresponding sample questions in the annex: 3.2.2)

ASPECT OF PROVIDER AUTONOMY	CURRENT SITUATION	KEY ISSUES AND CHALLENGES
Legal status of public hospitals		
Legal status of public outpatient diagnostic centers		
Legal status of public primary care providers		
Autonomy over budgeting and financial management		
Autonomy over allocating funds internally		
Autonomy over service mix		
Autonomy over staffing levels and personnel compensation (salary and bonus)		
Autonomy over equipment purchases and physical assets		
Autonomy over use of surpluses		

SECTION 3.3 ASSESSMENT OF HEALTH BUDGET EXECUTION AND PURCHASING/PROVIDER PAYMENT

In this section, the **Analytical Team** assesses how resources flow through the system, including how budgets are executed and health providers are paid.

ASSESSMENT TABLE 3 — **BUDGET EXECUTION AND PURCHASING/PROVIDER PAYMENT**

This table helps assess key aspects of the health budget execution process.

GOOD PRACTICE	PROGRESS	BOTTLENECKS
Funds are released in a way that directly links them to what the government is promising to buy.		
Funds are received in a way that can be flexibly allocated to what the government promises to buy.		
Funds are used to obtain optimal value related to what the government promises to purchase for the least cost.		
A mechanism exists for providers and/or the health sector to retain and reinvest savings and efficiency gains in the current year and from year to year.		

USING THE ALIGNMENT CONTINUA

Each position along the alignment continuum reflects a number of dimensions. Using the spacebar, position the red dot where a country falls along the continuum for each dimension. The position can be determined based on discussion and a common understanding among stakeholders about how the country is performing relative to good practices. This discussion can be supported by the completed descriptive tables above and/or by working through an adapted version of the suggested questions for each module.

ALIGNMENT CONTINUUM 3.1	ALIGNMENT BETWEEN BUDGET EXECUTION AND HEALTH FINANCING OBJECTIVES
	Budget execution is managed centrally; little flexibility to reallocate expenditure during the year; providers are paid based on inputs; health facilities have no bank accounts and no authority to manage budgets or hold cash. — Budget execution is decentralized; flexibility exists to reallocate expenditure during the year; all health facilities have bank accounts and authority to manage budgets and hold cash.
	LEAST ALIGNED — MOST ALIGNED
DIMENSIONS	
Level at which budget execution is managed	
Flexibility to reallocate funds across facilities and across line items throughout the year	
Facility-level authority to manage budgets and hold cash	

ALIGNMENT CONTINUUM 3.2	ALIGNMENT BETWEEN PURCHASING / PROVIDER PAYMENT AND HEALTH FINANCING OBJECTIVES	
	Health providers are paid based on inputs through line-item budgets; it is difficult or impossible for public purchaser to contract private providers; public providers have no autonomy for internal resource allocation; efficiency gains are considered unexecuted budget and are returned to the treasury.	Health providers are paid through output-oriented payment systems; public providers have flexibility for internal resource allocation; public purchaser can contract fairly with both public and private providers; providers and/or health sector retain and reinvest efficiency gains.
	LEAST ALIGNED	MOST ALIGNED
DIMENSIONS		
Providers are paid based on inputs or outputs.	●	
It is possible to contract fairly with private providers.	●	
Public providers have autonomy for internal resource allocation.	●	
Efficiency gains are retained/reinvested by providers and/or the health sector.	●	

Budget accounting and reporting

In this module, the **Analytical Team** documents the accountability mechanisms in place to monitor the budget, including autonomous social health insurance funds, and assesses whether funds are used appropriately for the intended purposes and bring the intended results related to health sector objectives and commitments to priority populations, programmes and services. The team also identifies potential obstacles to accountability for expenditures on priority populations, programmes and services.

SECTION 4.1 PROCESS OF BUDGET MONITORING

This section documents the process used to monitor the budget, information systems and flows, as well as audit processes.

SUMMARY TABLE 4.1 **BUDGET MONITORING PROCESS**

This table documents the process used to monitor the budget. (Corresponding sample questions in the annex: 4.1.1 and 4.1.2)

CHARACTERISTIC OF BUDGET MONITORING PROCESS	CURRENT SITUATION	KEY ISSUES AND CHALLENGES
How budget execution is monitored (responsible institution and information flows)		
Main indicators monitored for budget execution		
Consequences for underspending or overspending budgets		
Budget audit processes		
Process for monitoring programme budgets		
Relationship between targets and policy objectives		
Evaluation of actual spending		

SECTION 4.2 ACCOUNTABILITY

This section examines how spending agencies in the health sector are held accountable for meeting objectives.

SUMMARY TABLE 4.2 **ACCOUNTABILITY MECHANISMS**

This table documents how spending agencies are held accountable for meeting objectives. (Corresponding sample questions in the annex: 4.2.1, 4.2.2, 4.2.3 and 4.2.4)

CHARACTERISTIC OF ACCOUNTABILITY MECHANISMS	CURRENT SITUATION	KEY ISSUES AND CHALLENGES
Process and indicators tracked for effective use of budget funds		
How monitoring outputs are used		
Process and indicators tracked for effective use of programme budget funds		
Process and indicators tracked for effective use of earmarked funds		
Process and indicators tracked for effective use of donor funds		
Types of information used to hold spending units accountable		

SECTION 4.3 ASSESSMENT OF HEALTH BUDGET MONITORING

In this section, the **Analytical Team** assesses the accountability mechanisms in place to assess the efficiency, effectiveness, quality or equity of budget fund use.

ASSESSMENT TABLE 4.3	BUDGET MONITORING

This table documents the accountability mechanisms in place for monitoring the budget.

GOOD PRACTICE	PROGRESS	BOTTLENECKS
Funds can be traced and linked to expenditure on populations, programmes and services with accountability measures.		

USING THE ALIGNMENT CONTINUA

Each position along the alignment continuum reflects a number of dimensions. Using the spacebar, position the red dot where a country falls along the continuum for each dimension. The position can be determined based on discussion and a common understanding among stakeholders about how the country is performing relative to good practices. This discussion can be supported by the completed descriptive tables above and/or by working through an adapted version of the suggested questions for each module.

ALIGNMENT CONTINUUM 4.1	ALIGNMENT BETWEEN BUDGET MONITORING AND HEALTH FINANCING OBJECTIVES
	Budget execution is monitored only against expenditure on input-based line items; no accountability for achieving health sector objectives (e.g., no link to results) or mechanisms to protect against overruns/accountability. — Budget execution is monitored against health sector objectives (e.g., programme targets), and accountability mechanisms are in place at each level.
	LEAST ALIGNED — MOST ALIGNED
DIMENSIONS	
Criteria against which budget execution is monitored	
Accountability for achieving objectives	

Fiscal sustainability

This module examines existing mechanisms that are effective in ensuring fiscal sustainability of health expenditure over the medium and long term, including efforts to estimate resource requirements for and budget impacts of new proposals, revenue and expenditure projections, and mechanisms to bring resources into alignment with available revenue.

SECTION 5.1 FISCAL SUSTAINABILITY MECHANISMS

This section describes efforts to estimate resource requirements for and budget impacts of new proposals, revenue and expenditure projections, and mechanisms to bring resources into alignment with available revenue.

SUMMARY TABLE 5.1 **FISCAL SUSTAINABILITY MEASURES**

This table documents existing mechanisms for ensuring fiscal sustainability. (Corresponding sample questions in the annex: 5.1)

FISCAL SUSTAINABILITY MEASURE	CURRENT SITUATION	KEY ISSUES AND CHALLENGES
Commitment to maintaining balance between revenues and expenditures across health sector agencies, subsystems and providers		
Mechanisms to estimate resource requirements and budget impacts of new proposals		
Projections of health revenues and expenditures		
Mechanisms to keep expenditures in line with revenues ("commitment controls")		
Policies related to off-budget funds accumulating reserves and incurring debt		

SECTION 5.2 ASSESSMENT OF FISCAL SUSTAINABILITY MECHANISMS

In this section, the **Analytical Team** assesses whether funds are treated in a way that promotes fiscal sustainability over the medium and long term.

ASSESSMENT TABLE 5 — **FISCAL SUSTAINABILITY PRACTICES**

This table assesses existing mechanisms for ensuring fiscal sustainability.

GOOD PRACTICE	PROGRESS	BOTTLENECKS
Expenditures do not regularly exceed revenues		
Analysis completed regularly to project revenues and expenditures		
Well-functioning commitment controls in place		

Options for improving alignment between PFM and health

In this module, the **Working Group** considers options to improve alignment between the PFM system and health financing system in order to achieve policy objectives.

The ways that countries have tried to address inconsistencies among their PFM system, health budgeting practices and health financing policy commonly fall into three main categories (as shown in Table 4):

- general improvements in the implementation of PFM reforms;
- specific PFM mechanisms for the health sector; and
- extrabudgetary funds and transactions.

(These are not recommendations; rather, they reflect country experience.)

TABLE 4 WAYS THAT COUNTRIES TRY TO IMPROVE ALIGNMENT BETWEEN THE PFM SYSTEM AND HEALTH FINANCING SYSTEM[13]

GENERAL IMPROVEMENTS IN THE IMPLEMENTATION OF PFM REFORMS	SPECIFIC PFM MECHANISMS FOR THE HEALTH SECTOR	EXTRABUDGETARY FUNDS AND TRANSACTIONS
> Incremental PFM process improvements and making better use of existing flexibilities > General improvements in information and analysis	> Earmarking for health (to improve revenue raising) > Formula-based budget allocations for health (to improve pooling) > Intergovernmental fiscal transfers specific to health (to improve pooling) > Output-based provider payment (to improve purchasing) > Autonomy for health providers (to improve purchasing)	> Extrabudgetary funds (e.g., quasi-independent purchasing agency) > Donor-funded results-based financing schemes

Making general improvements in the implementation of PFM reforms is usually a long-term endeavor and largely falls outside the control of the health sector, although the sector can at times take the lead in adopting or piloting new approaches. The feasibility and value of the other two types of measures depend on the particular country context. In most countries, some combination of approaches is necessary to improve alignment between the PFM system and health financing policy objectives.

[13] Cashin et al.

As countries have worked to reform their PFM system, some have taken specific measures to address the needs of health financing and budgeting, such as making pooling of health funds possible within the context of fiscal decentralization or allowing specific health purchasing strategies and output-based payment systems.

In countries where the specific health financing needs cannot be accommodated within the budget rules, extrabudgetary funds managed by quasi-autonomous agencies, such as national health insurance funds, sometimes assume responsibility for all or part of the health pooling and purchasing functions. Some countries have such entrenched PFM challenges that they turn to schemes that bypass the public system almost entirely. One approach that has been promoted by the donor community is results-based financing (RBF) schemes that use extrabudgetary transactions to send funds directly to frontline health providers in the form of performance incentives. Although donor-funded RBF programmes can at times bypass PFM rigidities in the short term, there are often questions of sustainability and whether this mechanism can bring about deeper changes in health financing systems over the long term.

SECTION 6.1 OPTIONS FOR IMPROVING ALIGNMENT BETWEEN THE PFM SYSTEM AND HEALTH FINANCING SYSTEM

This section identifies options for enhancing alignment between the health financing system and PFM system to achieve stated policy objectives.

At this point, the **Working Group** will have a relatively clear picture of the current alignment challenges. In a workshop format, the **Facilitator**, together with the **Analytical Team**, will present options to the **Working Group** for enhancing alignment based on the goals of the health financing and PFM reforms. The group should consider the assessment results against options for improvement that are feasible in the short term, as well as more extensive improvements that may be feasible only over the longer term. The group should also identify contextual factors that are critical to improving alignment between the PFM system and health financing system and make recommendations for the way forward. For example, if line-item budget rigidities are interfering with the health financing policy objective of paying health providers based on service outputs and results, a short-term option may be to consolidate and reduce line items to increase flexibility. A longer-term solution may be to introduce programme-based budgeting or other PFM flexibilities that allow direct payment to providers for outputs.

FINAL OUTPUT TABLE 6.1	PRIORITY AREAS TO ADDRESS TO ACHIEVE BETTER ALIGNMENT BETWEEN THE PFM SYSTEM AND HEALTH FINANCING SYSTEM

This table describes options for enhancing alignment between the health financing system and PFM system.

WHAT IS WORKING WELL AND SHOULD BE MAINTAINED?

WHAT IS NOT WORKING WELL AND SHOULD BE CHANGED OR DISCONTINUED?

CONTEXTUAL FACTORS TO CONSIDER IN DECISION-MAKING

FINAL OUTPUT TABLE 6.2 | **PROPOSED SOLUTIONS FOR ACHIEVING BETTER ALIGNMENT BETWEEN THE PFM SYSTEM AND HEALTH FINANCING SYSTEM**

This table identifies short-term and longer-term solutions for addressing key PFM bottlenecks and lists contextual factors to consider when implementing the solutions.

KEY PFM BOTTLENECK	SHORT-TERM FEASIBLE SOLUTION FOR IMPROVEMENT	LONGER-TERM SOLUTION FOR IMPROVEMENT	CONTEXTUAL FACTORS TO CONSIDER

SECTION 6.2 ROADMAP FOR IMPROVING ALIGNMENT BETWEEN THE PFM SYSTEM AND HEALTH FINANCING SYSTEM

This section includes a table that maps the short-, medium- and long-term steps for implementing the proposed solutions for improving alignment between the PFM system and health financing system.

FINAL OUTPUT TABLE 6.3 | **ROADMAP FOR ACHIEVING BETTER ALIGNMENT BETWEEN THE PFM SYSTEM AND HEALTH FINANCING SYSTEM**

This table describes reform options for enhancing alignment between the PFM system and health financing system.

PROPOSED SOLUTION		CURRENT STATUS		CHANGES THAT NEED TO HAPPEN		
				SHORT TERM	MEDIUM TERM	LONG TERM
	→		→			
	→		→			
	→		→			
	→		→			
	→		→			

Annex: Templates

This annex contains templates for all of the output tables introduced earlier in the guide. They can be adapted to the needs of a particular country, region or institution at different points in time. They might be useful in their entirety, or specific sections may be more useful at particular times.

MODULE 1	MODULE 2	MODULE 3
LAYING THE GROUNDWORK This module establishes objectives for the assessment process from the perspective of both health policy-makers and budget officials. It also lays a foundation for the rest of the process by describing current policy initiatives and key issues and challenges related to health financing policy, the budget process and the PFM system.	**HEALTH BUDGET FORMULATION** This module identifies decision-making and coordination mechanisms used in the budget formulation process, the budget classification system and the approach to allocating funds to and within the health sector.	**HEALTH BUDGET EXECUTION AND PROVIDER PAYMENT** This module documents how resources flow through the system, including how budgets are executed and health providers are paid.
MODULE 4	**MODULE 5**	**MODULE 6**
BUDGET ACCOUNTING AND REPORTING This module identifies the accountability mechanisms in place to assess the efficiency, effectiveness, quality or equity of budget fund use.	**FISCAL SUSTAINABILITY** This module assesses whether funds are treated in a way that promotes fiscal sustainability over the medium and long term.	**OPTIONS FOR ACHIEVING BETTER ALIGNMENT BETWEEN PFM AND HEALTH** This module identifies options for enhancing alignment between the health financing system and PFM system to achieve stated policy objectives.

The sample questions provided are only suggestions, and the **Analytical Team** may choose to fill in the output tables directly or answer only a subset of the sample questions. The questions should be answered by multiple stakeholders, including a balance of health and budget officials, through individual interviews or focus groups or in a facilitated meeting format.

The **Analytical Team** may use a subset of the following sample questions that are relevant to the country context in order to complete the output tables in this module. Some of this information may be available through other assessments conducted in the country (i.e., MTEFs, resources tracking studies or funds flow studies).

SAMPLE QUESTIONS: Policy initiatives, key issues and challenges, and objectives for the assessment exercise

SAMPLE QUESTIONS 1.1.1	HEALTH FINANCING POLICY CONTEXT (corresponds to Summary Table 1.1)
What are the main health sector objectives articulated by the government and the key public programmes that are working toward them?	
Are there estimates of the resources required to meet the objectives or commitments to the population? Please describe.	
Describe the major policy directions in health financing or any planned reforms (including the timeframe).	
What are the specific objectives of these policy changes?	
Which major stakeholders are involved in the policy design and implementation?	
Has there been any direct dialogue (i.e., working group meetings, formal/informal discussions) with the ministry of finance or other budgeting officials on these polices? If yes, please describe. If no, please describe any obstacles.	
What are the issues and challenges related to these health financing policies?	

SAMPLE QUESTIONS 1.1.2	PUBLIC FINANCIAL MANAGEMENT POLICY CONTEXT (corresponds to Summary Table 1.1)
Describe the major administrative procedures and policy directions in the government budgeting processes or PFM system or any planned reforms.	
For planned reforms, what are the objectives of these policy changes?	
Which major stakeholders are involved in the policy design and implementation?	
Has there been any direct dialogue with the ministry of health or another health sector agency on these polices? If yes, please describe. If no, please describe any obstacles.	
What are the issues and challenges related to government budgeting and public financial management?	
To what extent are some of the PFM challenges related to broader civil service rules that apply across sectors?	
What are the objectives of this assessment for improving budgeting practices or the PFM system?	
Are there any flexibilities in the budget law or other policy documents that are not fully being taken advantage of by the health sector?	
Are there any restrictions in the budget law or other policy documents related to the funds flow from the national treasury to the MOH and local governments?	
Are financial rules that govern the management of public funds adequate? Are they up to date?	
Do financial rules at the decentralized level reflect the reality in subnational and rural areas?	

SAMPLE QUESTIONS: Health financing sources and coverage arrangements

SAMPLE QUESTIONS 1.2.1	MAIN FINANCING SOURCES FOR THE HEALTH SECTOR (corresponds to Summary Table 1.2a)	
	What are the main financing sources for the health system? (Use estimates or most recent data on the share of spending coming from the following financing sources.)	*Year:*
	FINANCING SOURCES	**% OF TOTAL SPENDING**
	CENTRAL GOVERNMENT	
	General government revenue (from domestic nonearmarked taxes, revenues from natural resources, and other general revenue sources)	
	Earmarked revenues for health (excluding mandatory payroll taxes for social health insurance)	
	Mandatory social health insurance contributions (payroll/income taxes)	
	Voluntary contributions to prepayment schemes (including social health insurance, private health insurance, community health insurance, etc.)	
	Mandatory private health insurance contributions	
	Private sources	
	Total public	
	PRIVATE	
	Voluntary contributions to private prepayment schemes	
	Direct out-of-pocket payment at the point of use (e.g., user fees, patient copayments, deductibles, etc., that are not later reimbursed through an insurance mechanism)	
	Total private	
	EXTERNAL	
	Transfers distributed by government that are foreign in origin	
	Other external:	
	Other (specify):	
	Total external	
	Comments:	

SAMPLE QUESTIONS 1.2.2	EARMARKED REVENUE SOURCES FOR THE HEALTH SECTOR (corresponds to Summary Table 1.2b)

Do any laws mandate earmarking of revenues or expenditures for health? If yes, are these laws enforced? By whom?

Are all or a portion of any of these revenue sources earmarked for health?

- ☐ Income (personal or corporate, including payroll tax and/or contribution rate)
- ☐ General consumption (VAT, sales tax)
- ☐ Sales of alcohol
- ☐ Sales of tobacco
- ☐ Sales of other specific consumption goods
  Specify:
- ☐ Earmarked share of total central government spending
- ☐ Earmarked share of subnational level total government spending
- ☐ Earmarked central-level transfers to the subnational level for health
- ☐ Development aid or other earmarked external sources
- ☐ Other
  Specify:

Was a new tax introduced or an existing tax increased to earmark for health, or was a portion of an existing tax newly allocated to the health sector?

What is the total tax rate and/or flat amount of revenue collected?

What proportion of that amount is earmarked for health?

Describe how earmarked funds are collected. Are they collected by the administering agency? Or are they collected through the treasury system and kept on budget or transferred to an off-budget fund?

Are earmarked revenues pooled with general revenue sources?

Does earmarking affect the stability, predictability and sustainability of public funds for the health sector?

Does earmarking affect the flexibility of how funds can be allocated? Spent?

Has the earmarking created any challenges for the ministry of health's budgeting processes and/or the ministry of finance's governmentwide budgeting?

Why was earmarking considered as an option for health sector revenue generation, and how consequential has it been (i.e., has there been broad public support)?

SAMPLE QUESTIONS 1.2.3	FUNDS FLOWS IN THE HEALTH SYSTEM (corresponds to Summary Table 1.2c)

Diagram how resources are transferred from different sources to different agents (e.g., the process of transferring resources from central to subnational governments, from central and/or subnational governments to social health insurance agent(s), and from external sources)?

Create a separate diagram showing funds flows between revenue sources, financing agents and health care providers and paste it here:

SAMPLE QUESTIONS 1.2.4	COVERAGE ARRANGEMENTS AND POOLING AND PURCHASING AGENCIES (corresponds to Summary Table 1.2.d)

Describe all of the different coverage arrangements in the country and the pooling and purchasing agencies for each. Please note whether the pooling and purchasing agencies are different and whether they are managed at the central or subnational level. The table below is a sample.

COVERAGE ARRANGEMENT	POOLING AGENCY OR AGENCIES	PURCHASING AGENCY OR AGENCIES (IF DIFFERENT FROM THE POOLING AGENCY)	% OF POPULATION COVERED
Government-funded coverage with automatic entitlement (e.g., based on residence, citizenship, poverty status, etc.)			
Social/compulsory/mandatory health insurance (i.e., with entitlement depending on a specific contribution made by or on behalf of covered persons)			
Mandatory private health insurance			
Voluntary private (commercial or nonprofit) health insurance			
Other voluntary coverage (e.g., community-based or nongovernmental)			

Employer-provided services			
Other coverage arrangements			
No coverage			
Other			

Comments:

Describe any transfers to equalize revenue or risk across different schemes or pools (e.g., from central or subnational governments to compulsory/social health insurance agencies, transfers across geographic areas or transfers between schemes). Describe the mechanisms or PFM rules that make these transfers possible.

Comments:

SAMPLE QUESTIONS: Impact of fiscal decentralization in health

SAMPLE QUESTIONS 1.3	LEVEL OF DECENTRALIZATION IN HEALTH SECTOR REVENUE GENERATION AND EXPENDITURE (corresponds to Summary Table 1.3)

Which government agency has primary authority to determine funding levels for health at the subnational level?

In general, what share of public revenue is raised at the subnational level and stays at that level? If this occurs at more than one level, describe by level.

Are there are any legal/regulatory revenue-raising restrictions on local governments?

Is there a mechanism for intergovernmental fiscal transfers across subnational levels of government? In general or specifically for health budgeting? Please describe. If this occurs at more than one level, describe by level.

Are funds collected separately through other sources at decentralized levels that are off budget and/or in kind (e.g., money in a national health insurance agency or funds raised at the district level through district taxes that are not part of a national budget)? If so, are they reported centrally? Please describe.

How much responsibility do subnational levels of government have for determining budget allocation to the health sector?

Are there specific budgetary targets or ceilings for health expenditure from subnational government budgets? If yes, describe how they are set and enforced.
How much responsibility do subnational levels of government have for determining allocation of funds within the health sector?
How much responsibility do subnational levels of government have for budget execution and paying frontline service providers and insurers?
How does fiscal decentralization in the health sector compare to general fiscal decentralization across all sectors (about the same, more/less decentralized revenue responsibility, more/less decentralized expenditure authority)?
Are staff who perform finance tasks within the MOH at local levels of government properly trained as accountants? Do MOH staff have access to in-service training at all levels?
Comments:

The **Analytical Team** may use a subset of the following sample questions that are relevant to the country context in order to complete the output tables in this module. Some of this information may be available through other assessments conducted in the country (i.e., MTEFs, resources tracking studies, or funds flow studies).

SAMPLE QUESTIONS: Budget preparation process and classification system

SAMPLE QUESTIONS 2.1.1	BUDGET PREPARATION PROCESS (corresponds to Summary Table 2.1)
What are the main steps and respective timelines in the budget preparation process?	
What legislation governs the budget preparation process? What are the key points of this legislation?	
Is there a formal coordination mechanism for the budget preparation process? If yes, please describe.	
Are health information system data and other data and analytical studies used to inform the budget process?	
Is there institutionalized coordination between the planning process and the budgeting process? If yes, which major stakeholders are involved?	
Is there consultation between central level and implementers? is there a planning and finance committee that reviews proposals, etc.?	
Is there an annual corporate plan? A microplan?	
Is there a process to formally review expenditure policies and programme prioritization?	
Are final priorities decided based more on political pressure or the needs and expectations of citizens?	
What share of the budget is discretionary (i.e., not already accounted for by earmarks, other legislated expenditures and debt payments)	
At what stage does the health sector become involved in the process?	

How closely does annual expenditure meet what is budgeted for year on year? How significant are last-minute and in-year adjustments? Is the budget process generally viewed as credible and realistic?

SAMPLE QUESTIONS 2.1.2	BUDGET CLASSIFICATION SYSTEM (corresponds to Summary Table 2.1)

What is the national budget classification system based on? (Check all that apply.)

- ☐ Implementing institutions (organizational or administrative)
- ☐ Functions
- ☐ Cost elements / input line items (economic)
- ☐ Programmes (groups of activities related to objectives)

How is budget classification used to form both ministry and service provider budgets?

Is there separate budgeting for vertical programmes?

If programme-based budgeting is <u>not</u> being used:

Are there plans to pilot programme-based budgeting? If yes, please describe.

If programme-based budgeting is not currently being used as the active form of budget classification, are other performance dimensions in place? If yes, what are they and how effective are they?

SAMPLE QUESTIONS 2.1.3	PROGRAMME-BASED BUDGETING (corresponds to Summary Table 2.1)

If programme-based budgeting is in use, what is it used for? (Check all that apply.)

- ☐ All public budgeting
- ☐ Budgeting for only some sectors
- ☐ Budgeting in the health sector

Do budget programmes determine the way money flows through the system, or do funds still flow by line item?

How are budget programmes and subprogrammes structured? What are the programmes and subprogrammes for health?

What other elements are included as part of the budget? Check all that apply.

- ☐ Formula-based allocation
- ☐ Administrative categories
- ☐ Functional categories
- ☐ Economic categories
- ☐ Activities
- ☐ Outcome-based targets
- ☐ Output-based targets
- ☐ Other
  Specify:

Are appropriations made on a programme basis? If not, how are they made?

Is allocation from the national level to other administrative levels made according to programme designations? If not, how is allocation made?

How are targets currently set, what data are used in the target-setting process and which stakeholders are involved?

Do targets or indicators align with those in key health sector policies or strategic plans?

Is past performance used to adjust targets for the current year? Are there rewards and/or penalties for meeting or not meeting targets?

Are indicators and targets focused on results that are attributable to the unit producing the related output or outcome? If not, what are they related to?

How are salaries dealt with in the programme budget?

SAMPLE QUESTIONS: Budget allocation to the health sector

SAMPLE QUESTIONS 2.2.1	NATIONAL HEALTH SECTOR BUDGET TARGETS OR CEILING (corresponds to Summary Table 2.2)
	Describe any specific targets or ceilings for the national health budget and how they are set (for the health sector as a whole, specific spending agencies within the sector, programmes, disease areas, categories of health facilities, specific health facilities or another expenditure category).
	Is there legislation that mandates targets or ceilings for the health sector? If yes, to what extent are these laws binding or consequential? What happens if spending goes under or over the mandated targets or ceiling? Does this refer to budgetary and social health insurance spending?
	What information or criteria are used to set targets or ceilings?
	Are revenues from all sources included in the health sector ceiling? If not, which are excluded?
	If budget targets or ceilings are not set for the health sector, how are final budget allocations decided?
	Are parts of the health budget (such as health worker salaries) determined outside of the budget allocation process? Please explain.
	Are particular targets or ceilings set according to the growth rate of central government-budgeted health expenditure, GDP or some other metric?

SAMPLE QUESTIONS 2.2.2	SUBNATIONAL HEALTH SECTOR BUDGET TARGETS OR CEILING (corresponds to Summary Table 2.2)
	Describe any specific targets or ceilings for subnational health budgets and how they are set (for the health sector as a whole, specific spending agencies within the sector, programmes, disease areas, categories of health facilities, specific health facilities or another expenditure category).
	Is there a formula for budget allocation to subnational levels? If yes, please describe.
	Describe any mechanisms for equalizing health budgets across subnational units.

SAMPLE QUESTIONS 2.2.3	ALLOCATION OF EARMARKED REVENUE SOURCES (corresponds to Summary Table 2.2)
Are any specific health sector programmes or activities funded by earmarked revenues (e.g., public education campaigns, social health insurance, disease-specific services)?	
What share of the health sector programme or activities funding is contributed by the earmarked revenue?	
Is the earmarked revenue included as part of a consolidated budget allocation process?	
How does the earmark affect the total allocation of funds to the health sector? Is it additive (increasing the entire allocation), or are there offsets in other parts of the budget because of the earmarked revenue?	

SAMPLE QUESTIONS: Budget allocation within the health sector

SAMPLE QUESTIONS 2.3	ALLOCATION OF THE BUDGET WITHIN THE PUBLIC HEALTH SECTOR (corresponds to Summary Table 2.3)
What is the unit of budgeting in the health sector? (Check all that apply.)	
☐ Health programmes ☐ Health care functions (e.g., curative care, medical goods, preventive care) ☐ Specific diseases (e.g., HIV, malaria, cancer) ☐ Individual health facilities (e.g., hospitals, health centers, diagnostic facilities) ☐ Other Specify:	
How are budgetary requirements estimated?	
How are bottom-up estimates of budgetary requirements reconciled with the health sector budget ceiling?	
Are any parts of the health sector budget considered to be nondiscretionary (guaranteed allocations or protected from budget cuts), such as salaries?	
Are there separate budgets for recurrent costs and investment?	

How is health budget allocation made between different geographic, administrative and service delivery levels? Are any resource allocation formulas used?
Are any policy or prioritization decisions made on allocation of health budget (e.g., portion to outpatient vs. inpatient care)?
How are final budgets determined and approved? Is this process done by parliament or some other authority? Does this require separate legislative approval? Is the government actively involved in defining health expenditure levels?
If there is a social insurance agency or other off-budget health sector institution, how is the budget developed and what is the relationship with other funds budgeted for health?
Do social health insurance funds finance the full costs of health care? If not, what is the process for approving full funding levels? Is there effective coordination between entities and clear division of functions (i.e., social health insurance agency, MOH)?
What is the process of approving health expenditures in off-budget social health insurance agencies?
Does the social health insurance agency receive an allocation from the central or subnational budgets? If yes, how is this allocation determined?

SAMPLE QUESTIONS: Allocation of development assistance for health

SAMPLE QUESTIONS 2.4	ALLOCATION OF DEVELOPMENT ASSISTANCE FOR HEALTH (corresponds to Summary Table 2.4)
How are general development assistance grants allocated to health?	
Does the government have an explicit policy for managing development assistance for health?	
Where is the development assistance management function located in the government?	
Does the development assistance management unit (or other unit) keep a database of incoming aid flows for health?	

Does the government have full information on the amount of funds committed and disbursed by international institutions and the projects that are financed?
Are development partners involved in any stage of the health budgeting process? If yes, how?
What percentage of development assistance for health is channeled via government or nongovernment agencies?
How well are donor funds that are not channeled via the government integrated with the government budget or planning processes (i.e., MTEF)? For example, are funds that do not flow centrally included in planning?
How does donor funding (both to the government and directly to nongovernmental agencies and providers) affect the total allocation of funds to the health sector? Is it additive (increasing the entire allocation), or are there offsets in other parts of the budget because of the donor revenue?
How does donor funding affect the total allocation of funds within the health sector?
Is any portion of donor funds allocated to results-based financing (RBF) within health? If yes, describe.
If yes, are RBF funds integrated with government revenues for planning and budgeting purposes? If so, how?
Are any donor funds integrated into health budgets at the local government level? If yes, describe.
Are any donor funds integrated into health budgets at the programme level? If yes, describe.
Are any donor funds integrated into health budgets at the health facility level? If yes, describe.
Are there any issues with donor funds going directly to individuals?

The **Analytical Team** may use a subset of the following sample questions that are relevant to the country context in order to complete the output tables in this module. Some of this information may be available through other assessments conducted in the country (i.e., MTEFs, resources tracking studies, or funds flow studies).

SAMPLE QUESTIONS: Process of budget execution

SAMPLE QUESTIONS 3.1.1	PROCESS OF BUDGET EXECUTION (corresponds to Summary Table 3.1)
	Describe the budget execution process.
	How does budget legislation affect the budget execution process?
	Which health budget execution decisions are made at the national level? Subnational level? Service provider level?
	What are the approval processes for expenditure decisions at different administrative levels?
	What are the responsibilities for budget execution in different types of health facilities? How is expenditure information aggregated and sent upward to reporting levels?
	Who is responsible for pharmaceutical procurement? For other health care commodities? How are responsibilities split across levels of the system?
	Are there issues related to bulk procurement, including across countries?
	Are regional health departments or providers responsible for independently procuring pharmaceutical products?
	Does the MOH have access to foreign currency for procurement of pharmaceuticals or medical devices/supplies? If not, are these commodities procured locally? Please describe.
	Do all spending bodies use common standards in the areas of procurement and payroll management?
	How are pharmaceutical prices determined?

For drugs and commodities, how are stock and expenditure payment arrears managed?
Is there a transparent competition and complaints mechanism for procurement?

SAMPLE QUESTIONS 3.1.2	PUBLIC EXPENDITURE TRACKING (corresponds to Summary Table 3.1)
What are the expenditure tracking systems at each administrative level? Are they electronic or paper-based?	
Is the budget execution system supported by a modern accounting framework and IT infrastructure at each level?	
Does the chart of accounts align with the budget classification system (PEFA)?	
How effective are internal controls for nonpayroll expenditure?	
Are there multiple execution processes, authority centers and tracking processes for multiple health revenue sources? Does this happen holistically so providers retain the ability to spend rationally and direct resources to priority populations, programmes and services?	
Are there complementary systems to measure nonfinancial results at different levels of the system?	
How are recurrent and capital expenditures managed?	
Are there resources in any health budget that don't show up anywhere but are spent on programmes (e.g., for health agencies, donor funds, local governments and providers)?	

SAMPLE QUESTIONS 3.1.3	AUTONOMY AND FLEXIBILITY IN BUDGET EXECUTION (corresponds to Summary Table 3.1)
How much authority do the different types and levels of public health facilities have to manage their own budgets?	

Which types and levels of health facilities have their own bank accounts?
Do health facilities with bank accounts have the authority to access and use the funds in these accounts?
How much authority do budget managers have to reallocate budget expenditures during the year at different administrative levels?
Can unspent budget funds be carried over to the next year? If yes, what is the mechanism and at what level are funds retained (health sector, programme, facility, etc.)
Do different types and levels of health facilities have the authority to enter into contracts with public and private suppliers?

SAMPLE QUESTIONS 3.1.4	**PROGRAMME-BASED BUDGET EXECUTION** (corresponds to Summary Table 3.1)

Please answer the following questions if your country uses or is piloting programme-based budgeting. Otherwise, skip to section 3.1.5.

Has programme-based budgeting increased in-year flexibility in budget execution? If yes, how?
Do programme managers have the authority to adjust budgets in-year? If so, what is the process?
Are managers held accountable for aligning budget execution with defined programme results or targets?
What controls (e.g., caps) are used to ensure that programme funds are not diverted to other programme areas during budget execution?
Do performance budgets give managers additional flexibility to determine how funds are spent?
Can funds left over from previous years be kept as programme savings in the new allocation process (i.e., in a fund), or are they carried over into the current budget?

SAMPLE QUESTIONS 3.1.5	EXPENDITURE OF EARMARKED FUNDS (corresponds to Summary Table 3.1)
Which agencies have authority to make decisions about the use of earmarked revenues allocated to health? Describe the rules on how these funds can be spent.	
What is the process for making transfers to the health sector? What institutions are involved?	
Are transfers made on time and in full?	
If earmarked revenues are not fully spent in one year, can they be carried over to the next? If yes, what is the mechanism (e.g., reserve fund for health insurance agency)?	

SAMPLE QUESTIONS 3.1.6	EXPENDITURE OF DONOR FUNDS (corresponds to Summary Table 3.1)
How much authority for managing expenditure of donor funds resides with the central government? With subnational levels of government? Specific health agencies? Programme managers? Health facilities?	
Is donor spending flexible? Can it be allocated to the country's priorities at the outset and be reallocated as needed throughout the year?	
If a portion of donor funds is allocated to a results-based financing (RBF) project in health, does this add flexibility to input-based line item systems? For example, do RBF funds have their own line in government budgets that can be allocated to priorities? And do they get combined with general revenue at any level?	
Do donor funds have parallel procurement systems? Do they have parallel results capture systems? Are results independently accounted for and/or reported into the government system at any point? At what level?	

SAMPLE QUESTIONS: Purchasing and provider payment arrangements

SAMPLE QUESTIONS 3.2.1	PURCHASING AND PROVIDER PAYMENT (corresponds to Summary Table 3.2a)
Which public agency or agencies purchase services from public health care providers?	

Do public purchasing agencies purchase services from private health care providers?

Describe how payments are made to different types and levels of health care providers (public/private, hospitals, outpatient specialty providers, primary care providers).

What Is the primary basis for payment to different types and levels of health care providers?

- ☐ Line-item budgets
- ☐ Global budgets
- ☐ Population-based payment
- ☐ Volume of services delivered
- ☐ Other (may include a combination of output- and input-based mechanisms)
  Specify:

Are there caps on total revenue that different types and levels of health providers can earn from government sources? If yes, describe how they are set.

How are payments disbursed and tracked? Do providers actually hold funds?

How are payments transferred to and received by providers? What are the administrative requirements to request and receive funds?

If providers receive funds from multiple sources, can these funds be managed in an integrated way or are there separate accounts, funds flows, accounting systems, etc.?

Are payments to providers from different sources consistent and predictable?

Are overruns incurred by providers compensated? If yes, how?

What are the policies related to cash management? Which health facilities hold cash?

SAMPLE QUESTIONS 3.2.2 — PROVIDER AUTONOMY
(corresponds to Summary Table 3.2b)

What is the legal status of most hospitals?

☐ Totally autonomous ☐ Semiautonomous ☐ Nonautonomous

What is the legal status of most public outpatient and diagnostic centers?

☐ Totally autonomous ☐ Semiautonomous ☐ Nonautonomous

What is the legal status of most public primary care providers?

☐ Totally autonomous ☐ Semiautonomous ☐ Nonautonomous

Who mainly oversees outpatient specialty and diagnostic centers?

Who mainly oversees public primary care providers?

How much autonomy do public providers have to make the following types of decisions?

HEALTH PROVIDER AUTONOMY AND DECISION-MAKING AUTHORITY	HOSPITALS	OUTPATIENT SPECIALTY AND DIAGNOSTIC CENTERS	PRIMARY CARE PROVIDERS	OTHER PROVIDERS
Budgeting and financial management	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:
Allocating funds internally	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:
Service mix	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:
Staffing levels (staff mix, hiring, firing)	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:
Personnel compensation: salary level and bonuses	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:
Personnel compensation: bonuses only	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:

Recurrent input use (types and amounts of medicines and other supplies)	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:
Equipment purchases	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:
Physical assets (renovation, new premises, etc.)	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:
Use of surplus income	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:	☐ No autonomy ☐ Full autonomy ☐ Limited autonomy Specify:

The **Analytical Team** may use a subset of the following sample questions that are relevant to the country context in order to complete the output tables in this module. Some of this information may be available through other assessments conducted in the country (i.e., MTEFs, resources tracking studies, or funds flow studies).

SAMPLE QUESTIONS: The budget monitoring process

SAMPLE QUESTIONS 4.1.1	PROCESS OF BUDGET MONITORING (corresponds to Summary Table 4.1)
	Is a mechanism in place to monitor budget execution in health (e.g., regular reporting on spending by relevant institutions to avoid overspending or underspending)? If yes, please describe.
	Which institution or agency has the main responsibility for monitoring the health budget?
	How does the budget legislation affect budget monitoring?
	What data and information are used for budget monitoring? Which data are automated? What analysis is done?
	What is the reporting cycle? How long does it take for budget reports to be aggregated and reconciled?
	Do monitoring agencies receive information regularly for timely monitoring? If not, what are the reasons for the delays?
	If the budget is underspent, are savings retained by the health sector? Does underspending result in lower budget allocation the next year?
	If the budget is overspent, is the excess deducted from the next year's budget allocations?
	Are there penalties for underspending or overspending?
	What is the audit process? Is there an internal and external audit? How frequent is it? Which institution(s) conducts the external audits?
	Are processes in place to evaluate actual use of budget funds? If yes, do the results affect the allocation of resources in the health sector?

SAMPLE QUESTIONS 4.1.2	PROCESS OF BUDGET MONITORING PROGRAMME BUDGETS (corresponds to Summary Table 4.1)

Please answer the following questions if your country uses or is piloting programme-based budgeting. Otherwise, skip to Section 4.2.

Does the accounting framework permit reporting according to programmes? How are targets set? Are there links in the accounting system between subprogrammes and outputs, indicators and targets?

Are there systems that allow for monitoring budget execution at the programme level? Please describe.

Are any nonfinancial systems used to collect data against targets? What are these systems, and how are data combined for reporting purposes?

Are performance monitoring targets aligned with the strategic priorities outlined in the MTEF?

Is there a programme audit that assesses progress against targets?

What is the audit process? Is there an internal and an external audit? How frequent are they? Which institution(s) conducts the external audit?

Has programme-based budgeting had an impact on transparency?

SAMPLE QUESTIONS: Accountability

SAMPLE QUESTIONS 4.2.1	ACCOUNTABILITY MEASURES FOR EFFECTIVE USE OF BUDGET FUNDS (corresponds to Summary Table 4.2)

Which indicators are tracked to assess how effectively budget funds for health are used? What are the data sources and flows?

What information in addition to financial information is used to hold spending units accountable for achieving results?

How are the results of the assessment used?

SAMPLE QUESTIONS 4.2.2	ACCOUNTABILITY FOR EFFECTIVE USE OF PROGRAMME BUDGETS (corresponds to Summary Table 4.2)

Please answer the following questions if your country uses or is piloting programme-based budgeting.

Are results produced by the entity that is held accountable for them? Are there issues with attribution? If more than one funding stream (e.g., government or donor) accounts for health funds in the programme budget, how are results tracked across resources? And at what level are results monitored (e.g., facility, district, national)?

Do the results and targets set across levels of the system adhere to a logical framework? How effective is this framework at determining levels of resource allocations? Are there challenges with creating and monitoring results?

SAMPLE QUESTIONS 4.2.3	ACCOUNTABILITY FOR EFFECTIVE USE OF EARMARKED FUNDS (corresponds to Summary Table 4.2)

Please answer the following questions if your country has any earmarked revenue sources for health.

How are revenues and expenditures reported for earmarked funds?

What are the accountability arrangements for the use of earmarked funds?

Which agency or institution is responsible for assessing how effectively earmarked funds for health are used?

What indicators are tracked to assess how effectively earmarked funds for health are used? What are the data sources and flows?

How are the results of the assessment used?

SAMPLE QUESTIONS 4.2.4	ACCOUNTABILITY FOR THE EFFECTIVE USE OF DONOR FUNDS (corresponds to Summary Table 4.2)

Are accounting and reporting systems for donor funds integrated with government budget monitoring systems, or are they parallel? Please describe.

Are donors required to inform the government about spending? If so, how is this information used and by whom?
What are the accountability arrangements for the use of donor funds?
Which agency or institution is responsible for assessing how effectively donor funds for health are used?
Which indicators are tracked to assess how effectively donor funds for health are used? What are the data sources and flows?
How are the results of the assessment used?

The **Analytical Team** may use a subset of the following sample questions that are relevant to the country context in order to complete the output tables in this module. Some of this information may be available through other assessments conducted in the country (i.e., MTEFs, resources tracking studies, or funds flow studies).

SAMPLE QUESTIONS: Fiscal sustainability

SAMPLE QUESTIONS 5.1	MECHANISMS TO ESTIMATE RESOURCE REQUIREMENTS AND BUDGET IMPACTS (corresponds to Summary Table 5.1)
	Do expenditures regularly exceed revenues in any health sector agency, subsystem (e.g., social health insurance system) or health care providers? Please describe.
	What mechanisms are in place to estimate resource requirements for new proposals in the different health spending agencies at the national and subnational levels (e.g., MOH, social health insurance agency)?
	Does the central budget authority receive economic evaluations (cost/benefit or cost-effectiveness analysis, financial protection analysis, consumer satisfaction surveys) of the expected health benefits from new policy proposals suggested by the MOH?
	Are fiscal projections of actual resources in line with policy priorities and future needs?
	What cost containment strategies ensure that publicly funded health expenditure stays within the allocated amounts?
	Which agency has the main responsibility for proposing measures to readjust health expenditures in order to stay within the approved limit or to limit overruns?
	What happens if expenditures exceed targeted levels?
	Are expenditures typically below targeted levels? Describe the magnitude of underspending and the causes.
	Are off-budget public health insurance agencies or other public health purchasers allowed to accumulate debt?
	Are public providers allowed to accumulate debt?

Are off-budget public health insurance agencies allowed to accumulate reserves? Can surpluses be accumulated? If yes, explain the rules governing how these surpluses can be used.
If your government is using programme-based budgeting, how has this affected the sustainability, stability and efficiency of your system?

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