HEALTH FINANCING WORKING PAPER NO 14

LEVERAGING PUBLIC FINANCIAL MANAGEMENT FOR BETTER HEALTH IN AFRICA

Key bottlenecks and opportunities for reform

World Health Organization

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ABBREVIATIONS

AOP	Annual Operations Plans
AMP	Aid management platform
AfDB	The African Development Bank
CHAG	Christian Health Association of Ghana
CAO	Chief Accounting Officer
CABRI	Collaborative African Budget Reform Initiative
CHF	Community Health Fund
DFID	Department for International Development
DHFF	Direct Health Facility Financing
FFARS	Facility Financial Accounting and Reporting System
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HMIS	Health Management Information System
IGFT	Intergovernmental fiscal transfers
IPSAS	International Public Sector Accounting Standards
IFMS	Integrated Financial Management System
IPSAS	International Public Sector Accounting Standards
IPPS	Integrated personnel and payment systems
MCHSS	Making Country Health Systems Stronger programme
MTEF	Mid-term expenditure frameworks
MOH	Ministry of Health
MOF	Ministry of Finance
NGO	Non-governmental organisations
OECD	The Organisation for Economic Co-operation and Development
OTIMS	Online Transfer Information System
PDIA	Problem-driven iterative adaptation
PFM	Public Financial Management
PIU	Project Implementation Unit
PEFA	Public Expenditure and Financial Accountability
PBF	Performance-based financing
P4P	Pay-for-performance
RBF	Results-based financing
SNA	Subnational authorities
UNAIDS	The Joint United Nations Programme on HIV and AIDS
USAID	The United States Agency for International Development
UHC	Universal Health Coverage

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1 PREAMBLE

1.1 EXECUTIVE SUMMARY

Public Financial Management (PFM) is at the core of the Universal Health Coverage (UHC) response. Given the scarcity of publicly available literature on PFM issues in health, the main aim of this WHO report is to take stock of common PFM challenges affecting health spending in the African Region, with a view to improve the current understanding of the problem. Building on WHO on-going case studies and policy activities, this report also seeks to distil lessons learned from the effectiveness and appropriateness of existing PFM reforms in the health sector in order to enable African countries to accelerate and tailor their PFM response, and ultimately better support progress towards UHC.

PFM reform matters for health

A robust PFM system is integral in enabling progress towards UHC. Subject to a country's available resources, this involves optimising not just how public funds for health are raised, but also how they are allocated, managed, and accounted for throughout the PFM system. Core PFM requirements include having reliable budgets that are aligned with sector needs; executed according to plans in a flexible manner; and transparently accounted for. The health financing reforms initiated in many African countries since the mid-2000s have revitalised interest in PFM for the sector. By placing public funds at the core of health financing, the movement towards UHC has transformed PFM into a central issue for sector results in the African Region.

Historically, PFM challenges affected health expenditure through chronic bottlenecks at all steps of the budget cycle in the African Region. Health budgeting was often disconnected from sector planning and costing processes, resulting in misaligned budget allocations. Weaknesses in health budgeting, combined with inefficiencies in expenditure management, previously translated into misspending, under spending, or both. In cases where accounting and auditing systems were in place, they rarely ensured accountability for sector performance. While each national health system has its own unique funding and management arrangement, the complexity in funding flows – as well as in service delivery mechanisms – often contributed to some common PFM challenges for the health sector in African countries.

To strengthen efficiency and accountability in the use of public resources, African countries have initiated general PFM reforms since the late 1990s. In most countries, a relatively standard package of interventions has been introduced, including multi-year expenditure frameworks, budget structure reforms, and computerised financial management systems. These were complemented by parallel efforts to strengthen basic PFM processes, such as the overall quality of budget formulation, execution and reporting practices. In most African countries, ev-

idence highlights some benefits of these reforms, with some advances in credibility of budgets, resource management and overall accountability of public funds. The health sector has benefited from these general improvements. However, results are heterogeneous across African countries and, in many instances, fundamental PFM obstacles have remained in the sector.

Slow progress towards better budget formulation in health

As a result of these reforms, the quality of budget formulation in the health sector has improved in several African countries over the past two decades. Health budgets are better anticipated and prepared due to overall improvements in budgeting practices (e.g. better revenue forecasts) and specific actions in the health sector (e.g. stronger links between health planning and budgeting). However, the structure of most health budgets remains input dominated. This report estimates that only 18 of 41 African countries had introduced some form of programmatic classification to present their health budgets in 2017, while only one country in the Region uses programmes as the unit for budget appropriation in health.

This continues to impede flexibility when using financial resources and the ability to re-allocate funds, contributing to waste as well as under-use of resources in the sector. It also limits the ability to link budget allocations with sector outputs, hampering accountability efforts. Institutionalising the transformation of budget structures could accelerate efficiency in health spending, especially if accompanied by simplified expenditure controls and necessary capacity development in financial management up to front-line levels.

In addition, badly defined health programme budgets can create unnecessary complexities, overlaps and duplications in resource management and reporting. In the 18 African countries that have initiated this transition, more careful attention is needed in terms of how the health budgetary programmes are designed (e.g., programmes' formulation, number, structure, targets) and implemented to make sure the reform (a) enables a more explicit link between public resources and expected outputs; (b) translates into more flexibility in resource management; and (c) generates good performance information that could ultimately contribute to better allocation decisions in the sector.

Persistent budget execution issues in health

Despite efforts to simplify overall expenditure management procedures and devolution of spending authority from Finance to Health ministries, budget execution remains a fundamental blockage for health in many African countries. This report estimates that 13 of 26 African countries have an average of more than 15% under-spending of their annual health budget allocations. The analysis presented in this report shows a deteriorating trend, with most budget execution rates in health decreasing between 2008 and 2016 across African countries. Health as a sector appears systemically more exposed to under-execution than overall government spending in the Region.

While each country situation is unique with context-specific explanations, this report helps decipher some of the commonly observed root causes of under-spending in health with the view to support countries in their own identification processes. Some factors (such as issues with revenue forecasts) are directly attributable to the Ministry of Finance (MOF).

However, other problems further downstream in the expenditure process can also affect budget utilisation, some of which are directly attributable to MOH capacities and preparedness for budget implementation (e.g. reliability and timeliness of cash requests). Building on the proposed categorisation, countries should be able to unpack the root causes of under-spending in their own contexts and prioritise corrective actions from bottom to top. Changing the game in health budget execution will often require simplifying the provision and management of public resources at sub-national levels, for example through direct digital payments to health facilities.

Limited accountability towards results

While budget accounting and reporting is stronger in many African countries due to measures such as introducing computerised financial management systems and a standard set of accounting rules, accountability towards sector performance remains limited in health. The complexity of the Integrated Financial Management Systems (IFMS, initially introduced for expenditure control) has presented challenges for adaptation at sub-national levels.

To address the remaining fragmentation in reporting systems, introducing performance monitoring frameworks as part of budget structure reforms represents an important opportunity to streamline both financial and technical accountability. As this approach monitors outputs and expenditures in a single consolidated framework, countries and development partners should further explore this option for better alignment in reporting and overall accountability.

Beyond the necessary measure of upgrading and streamlining information systems, this transition implies a profound change in MOH's function and mindset, by placing the relationship between injected resources and expected sector results at the core of a renewed dialogue between finance, health, and – where applicable – local governments.

Change in the focus and process of PFM reform in health

We call to revisit the focus and process of PFM reforms in the health sector. PFM reforms should be defined and implemented in a way that supports, not undermines, actions to move towards UHC. African governments are in a critical position to ensure that PFM systems fit the requirements to enable progress towards UHC and should seize the momentum to revisit the reform agenda. In the past, the scope of generic PFM reforms did not systematically address priority sector issues; therefore, shifting focus to interventions that better fit sector needs is justified.

Whilst moving towards a predominant reliance on public funds for UHC, the health sector has a vital role in ensuring that PFM systems enable resources to reach frontline health facilities adequately, and that they can be used and managed in a suitable, flexible manner while strengthening accountability for results. Achieving this will involve refining several operational aspects of local PFM systems in the Region that are further delineated in this report (e.g., direct release of funds to facilities, access to bank accounts, and flexible accounting systems). From a process standpoint, PFM reforms in the health sector should be better grounded in clearly identified bottlenecks. To improve policy consistency and effectiveness, PFM reforms should also be better coordinated with other critical reforms affecting health expenditure (e.g. strategic purchasing reforms, political and fiscal decentralisation).

PFM action framework for health ministries

Ultimately, this report delivers a PFM action framework for health ministries in the African Region. To enhance interaction between health and finance authorities, this report suggests three distinct areas of possible engagement for health ministries, namely: (1) Be actively aware and up to date on general PFM reforms (e.g., monitoring multi-year budgeting approaches that increase predictability in health financing); (2) Contribute to designing and implementing PFM reforms applicable to health (e.g., defining budgetary programmes in health to align budget allocation with sectors); and (3) Lead policy development for health specific PFM interventions (e.g., designing regulatory frameworks for financial autonomy of health facilities, in collaboration with finance authorities and local governments).

Action framework for health engagement in PFM reform

Overall recommendations:

1. Ministries of Health should (1) be actively aware and up to date on general PFM reforms; (2) contribute to designing and implementing PFM reforms applicable to health; and (3) lead policy development for health specific PFM interventions (e.g., designing regulatory frameworks for financial autonomy of health facilities, in collaboration with finance authorities and local governments).
2. In order to solve PFM challenges in the health sector, the focus and process of PFM reform should be adapted to give more attention to local-level challenges;
3. Institutionalising well-defined budget structure reforms in health should be accelerated through enhanced coordination between finance and health authorities;
4. Better understanding the root causes of budget under-execution in health is a key priority to define and implement corrective actions with the view to optimise the use of resources; and
5. Countries and development partners should prioritise the strengthening of PFM capacities in the health sector – from top to bottom.

1.2 RÉSUMÉ EXÉCUTIF EN FRANÇAIS

La Gestion des Finances Publiques (GFP) est au cœur de la réponse vers la Couverture Santé Universelle (CSU). En l'absence de connaissances solides et facilement accessibles sur les questions de GFP en santé, l'objectif principal de ce rapport de l'OMS est de faire le bilan des problèmes communs de GFP affectant la dépense de santé dans la Région africaine, avec l'objectif d'améliorer la compréhension actuelle du problème. En s'appuyant sur les études de cas et activités de politique de l'OMS, ce rapport cherche aussi à tirer les leçons quant à l'efficacité et la pertinence des réponses politiques apportées en matière de GFP dans le secteur de la santé. Cela pourra permettre au final aux pays africains d'accélérer et ajuster leur réponse concernant la GFP aux besoins du secteur de la santé et donc d'apporter un meilleur soutien au progrès vers la CSU.

Les réformes de GFP sont importantes pour la santé

Un solide système de GFP fait partie intégrante de la progression vers la CSU. Progresser vers la CSU avec les ressources disponibles dans un pays donné implique une optimisation de la façon de lever des fonds mais aussi de la manière dont ceux-ci sont alloués, gérés et comptabilisés dans le système de GFP. Les exigences fondamentales incluent de disposer d'un budget fiable, aligné sur les besoins du secteur, exécuté selon les plans et de manière flexible, comptabilisé de façon transparente. Les réformes du financement de la santé initiées dans de nombreux pays africains depuis le milieu des années 2000 ont ravivé l'intérêt pour la GFP. En plaçant les fonds publics au cœur de la réponse du financement de la santé, l'évolution vers la CSU a transformé la GFP en une question centrale pour les résultats du secteur dans la région.

Historiquement, les difficultés liées à la GFP ont affecté les dépenses de santé par la présence chronique de goulets d'étranglement à toutes les étapes du cycle budgétaire. La budgétisation en santé a souvent été déconnectée des processus de planification et d'estimation des coûts dans le secteur, résultant en un non alignement des allocations budgétaires. Les insuffisances concernant la budgétisation combinées à des inefficiences dans la gestion de la dépense, se sont traduites, dans le passé, par des dépenses erronées et/ou insuffisantes dans le secteur. Dans les cas où les systèmes de comptabilité et d'audit sont en place, ils ont rarement garanti une redevabilité de la performance du secteur. Bien que chaque système de santé national soit financé et géré de manière unique, la complexité des flux de financement - et des mécanismes de prestation de services - a souvent contribué à certains problèmes caractéristiques de la GFP auxquels est confronté le secteur de la santé dans les pays africains.

Pour renforcer une utilisation efficiente des ressources publiques et la redevabilité dans la gestion de celles-ci, les pays africains ont engagé des réformes de leurs systèmes de GFP depuis la fin des années 1990. Dans la plupart des pays, un ensemble relativement standard d'interventions a été mis en place, notamment des cadres de dépenses à moyen terme, des réformes de la structure budgétaire et des systèmes de gestion financière informatisés. Ces réformes ont été par des efforts parallèles visant à renforcer les processus de base de la GFP, tels que les pratiques de formulation budgétaire, d'exécution et de reportage. Le secteur de la santé a bénéficié de ces améliorations générales. Cependant, les résultats sont hétérogènes à travers les pays africains et, dans de nombreux cas, des obstacles fondamentaux à la GFP demeurent dans le secteur.

Lents progrès vers une meilleure formulation des budgets en santé

En conséquence de ces réformes, la qualité de la formulation budgétaires s'est améliorée dans le secteur de la santé dans plusieurs pays africains au cours des deux dernières décennies. Les budgets de santé sont mieux anticipés et préparés, en raison d'améliorations générales des pratiques de budgétisation (par exemple une meilleure prévision des revenus) et d'actions spécifiques prises dans le secteur de la santé (par exemple des liens plus forts entre la planification et la budgétisation en santé). Cependant, la structure de la plupart des budgets de santé reste dominée par les intrants. Ce rapport estime que seuls 18 sur 41 pays africains ont introduit certaines formes de classification programmatique pour présenter leur budget santé en 2017, alors que seulement un pays de la Région utilise le programme comme unité de crédit budgétaire dans la santé.

Une utilisation flexible des ressources financières s'en trouve donc entravée tout comme la capacité de réaffecter les fonds à mesure que les besoins de santé évoluent, conduisant à un gaspillage et/ou à une sous-utilisation de ressources dans le secteur. Cela limite également la possibilité de lier les allocations budgétaires avec les résultats du secteur, entravant les efforts de redevabilité. Institutionnaliser la transformation des structures budgétaires permettrait d'accélérer une utilisation efficiente des dépenses de santé, si cela est accompagné par une simplification des contrôles de la dépense et un développement nécessaire des capacités en gestion financière jusqu'aux premières lignes.

De surcroit, des budgets programmes mal définis peuvent créer des complexités non nécessaires et des duplications dans la gestion et le reportage des ressources. Dans les 18 pays africains qui ont initié cette transition, une plus grande attention est nécessaire quant à la définition (par exemple, la formulation, le nombre, la structure et les cibles des programmes) et la mise en œuvre des programmes budgétaires en santé, pour s'assurer que la réforme (a) permet un lien plus explicite entre les ressources publiques et les résultats attendues, (b) se traduit par une plus grande flexibilité dans la gestion des ressources et, (c) fournit une information sur la performance qui pourra en définitive servir à des prendre des décisions d'allocation en santé plus éclairées.

Des problèmes persistents en matière d'exécution des budgets de santé

En dépit des efforts déployés pour simplifier les processus de gestion de la dépense et le transfert de l'autorité de la dépense vers le secteur, l'exécution budgétaire dans le domaine de la santé reste un sérieux blocage et ce, dans plusieurs pays africains. Ce rapport estime que 13 des 26 pays africains affichent chaque année une sous-exécution de leurs allocations budgétaires en santé de plus de 15% en moyenne. L'analyse présentée dans ce rapport montre une tendance à la détérioration dans les pays africains, avec une diminution de la plupart des taux d'exécution budgétaire dans la santé entre 2008 et 2016. Le secteur de la santé semble systématiquement plus exposé que la dépense générale gouvernementale. Même si la situation de chaque pays est unique et s'explique en fonction du contexte, ce rapport aide à déchiffrer certaines des causes profondes observées en matière de sous-exécution en santé, avec l'idée d'aider les pays dans leur propre processus d'identification. Certains facteurs (tels que les problèmes liés à la prévision de revenus) sont directement attribuable au Ministère des Finances. Cependant, d'autres problèmes plus en aval de la chaîne de la dépense peut aussi affecter l'utilisation budgétaire, certains directement attribuables aux capacités et à la préparation du Ministère de la Santé

(par exemple, la fiabilité et la ponctualité des demandes de trésorerie). S'appuyant sur la catégorisation proposée, les pays devront être capables de décortiquer les causes profondes de la sous-exécution dans leurs propres contextes et de prioriser des actions correctrices, du bas en haut de la hiérarchie. Changer la donne en matière d'exécution budgétaire en santé exigera souvent de simplifier la fourniture et la gestion des ressources publiques aux niveau infranationaux, par exemple à travers des paiements digitaux directement adressés aux formations sanitaires.

Une redevabilité des résultats limitée

Alors que la comptabilité et l'établissement de rapports budgétaires ont été renforcés dans les pays africains, particulièrement grâce à l'introduction de systèmes de gestion financière informatisés et à la mise en place d'un ensemble standard de règles comptables, la redevabilité sur les performances du secteur de la santé reste limitée. Les Systèmes intégrés de gestion financière (SIGF) présentent souvent des défis complexes pour une adaptation à l'échelle infranationale, y compris dans les infrastructures sanitaires. Pour venir à bout de la fragmentation dans les systèmes de reportage financier, l'introduction de cadre de suivi de la performance dans le cadre des réformes de structure budgétaire représente une opportunité importante pour consolider l'information sur la performance financière et opérationnelle.

Comme cette approche assure le suivi des résultats et des dépenses dans un seul cadre cohérent, les pays et les partenaires au développement doivent explorer cette option pour un meilleur alignement dans le reportage et la redevabilité. Au-delà la nécessaire mise à jour des systèmes d'information, cette transition implique un profond changement dans la fonction et l'état d'esprit du Ministère de la santé. Ils doivent placer la relation entre les ressources injectées et les résultats attendus du secteur au centre d'un dialogue renouvelé entre finances, santé et, quand cela est le cas, les gouvernements locaux.

Changement dans le contenu et le processus des réformes de GFP

Nous appelons à revisiter le contenu et le processus des réformes de GFP dans le secteur de la santé. Les réformes de GFP doivent être définies et mises en œuvre pour qu'elles apportent un soutien à la CSU, et non à son affaiblissement. Les pays africains sont dans une position critique pour garantir une réponse des systèmes de GFP aux exigences permettant de progresser vers la CSU. Les autorités concernées doivent saisir cette occasion pour revoir le programme de réforme. Le contenu des réformes de GFP n'a pas systématiquement pris en considération les problèmes prioritaires du secteur dans le passé, justifiant alors un recentrage sur les interventions qui répondent mieux aux besoins du secteur. Les réformes devraient porter plus d'attention sur le renforcement de la gestion financière et de l'autonomie aux niveaux locaux, c'est-à-dire pour les formations sanitaires. Tout en s'orientant vers une prédominance des fonds publics pour la CSU, le secteur de la santé a un rôle vital à jouer pour s'assurer que les systèmes de GFP permettent que les ressources nécessaires soient bien attribuées aux structures sanitaires de première ligne et qu'elles soient gérées de manière appropriée, flexible. Atteindre cela impliquera de revoir plusieurs aspects opérationnels des systèmes locaux de GFP dans la région qui sont décortiqués dans ce rapport (par exemple le transfert de fonds direct aux structures sanitaires, l'accès aux comptes bancaires, et des systèmes de comptabilité flexibles). D'un point de vue du processus, les réformes de GFP dans le secteur de la santé devront être plus ancrées dans des goulets d'étranglement clairement identifiés. Afin d'améliorer

la cohérence et l'efficacité des politiques, les réformes de GFP doivent être mieux coordonnées avec les autres réformes critiques affectant la dépense de santé (par exemple, les réformes d'achat stratégique, la décentralisation politique et fiscale).

Action framework for health engagement in PFM reform

Cadre d'action GFP pour les ministères de la Santé

Enfin, ce rapport présente un cadre d'action en matière de GFP pour les ministères de la Santé dans la Région africain. Pour améliorer l'interaction entre les autorités finance et santé, ce rapport suggère trois domaines d'engagement possibles pour les Ministères de la Santé, en particulier : (1) Un intérêt (et un suivi) des réformes génériques de GFP qui améliorent les prévisibilité et durabilité du financement de la santé (par exemple les approches de budgétisation pluriannuelles) ; (2) Un rôle pro-actif dans la définition et la mise en œuvre des réformes de GFP qui affectent directement la dépense de santé (par exemple la définition des programmes budgétaires de santé) ; (3) Une fonction directe d'élaboration et des mise en œuvre d'interventions de GFP spécifiques à la santé, y compris avec et pour les niveaux infranationaux du gouvernement (par exemple, la flexibilité dans la gestion financière et l'autonomie des formations sanitaires de première ligne).

Recommandations générales:

1. Les Ministères de la Santé doivent prendre une part plus active dans l'élaboration et la mise en œuvre des réformes de GFP de sorte à ce que les réformes répondent mieux aux besoins du secteur;
2. Afin de résoudre les défis de la GFP dans le secteur de la santé, le focus et les processus des réformes GFP doivent être adaptés afin de donner plus d'attention aux défis locaux;
3. L'institutionnalisation des réformes de structure budgétaire en santé doit être accélérée à travers une coordination renforcée entre les autorités financières et de santé;
4. Une meilleure compréhension des causes profondes de la sous-exécution budgétaire en santé est une priorité clé afin de définir et mettre en œuvre des actions correctrices afin d'optimiser l'utilisation des ressources;
5. Les pays et les partenaires au développement doivent prioriser le renforcement des capacités de GFP dans le secteur de la santé – de haut en bas.

1.3 INTRODUCTION

Background and framing

No country has made significant progress towards Universal Health Coverage (UHC) without relying on public funds as a dominant share of financing health. Public funds are essential to ensuring protection against financial hardship that may result from the use of health services [1, 2]. Framing progress towards UHC in this way logically positions the budget and its underling rules and practices at the centre of the UHC agenda. Therefore, Public Financial Management (PFM) – the set of rules that govern how public funds are allocated, used and monitored – is increasingly being recognised as a central pillar for ensuring UHC across countries of the world [3-5]. In principle, PFM aims to support the effective and efficient use of public resources as well as financial accountability and transparency across Government sectors.

The quality of PFM systems in health is one of the necessary enabling factors for health financing reform implementation [7]. PFM rules and practices affect health financing at the level and allocation of public funding (budget formulation), the effectiveness of spending (budget execution), and the flexibility with which public funds can be used (subnational spending and payment arrangements). It also influences accountability and transparency of spending (accounting and reporting - Fig. 1) [3]. Effective implementation of health financing reforms will therefore largely depend on strengthening and tailoring both cross-sector PFM reforms and those specific to the health sector in relation to budget planning.[1]

If public resources are not disbursed in a timely manner using appropriate allocation or payment mechanisms, PFM poses fundamental challenges for the delivery of health services and is detrimental to the overall country response to the health needs of its population. A lack of flexibility in relation to resource management can also introduce inefficiencies in the health system, since funds cannot move to where they are needed most, and/or lead to an underspending of health budgets. This results in a loss of fiscal space available for the sector [6].

African countries have embarked in a long-term cross-sector PFM reform agenda since the 1990s. The gradual introduction of a standard package of interventions including: multi-year expenditure frameworks, budget formulation reforms, and computerised financial management systems, aimed to transform PFM systems in the Region. As a result of these reforms, evidence suggests that PFM systems have indeed improved over time in several countries. However, Public Expenditure and Financial Accountability (PEFA) scores – that assess the performance of PFM systems – remain heterogeneous across countries of the Region [10-13]. There are, in addition, core remaining blockages for basic PFM processes (e.g., execution practices), which have led some members of the PFM expert community to recommend countries "get the basics right" before engaging in more sophisticated approaches [14].

Report objectives and methods

[1] Ultimately, high quality PFM systems are anticipated to positively affect health systems' outputs through a number of mechanisms [8, 9]. These mechanisms include greater public spending efficiency (both in terms of allocation and operation) as a result of more transparent and accountable government approaches, greater stability and reliability of health funding for timely service delivery, and greater fiscal discipline (where budgets are realistic and executed in a timely fashion).

In the health sector, the scarce literature indicates systemic PFM weaknesses at different steps of the budget cycle, from budget formulation to execution and reporting [3;4]. In the absence of sector-specific stocktaking, evidence is lacking on the exact scope of the PFM challenges for health, their root causes, and the effectiveness and appropriateness of current policy responses to address these challenges. There is also a lack of clarity on how health stakeholders could be more appropriately engaged in this agenda.

Against this backdrop, the main aim of this report is to identify and analyse the nature, extent, and causes of PFM issues affecting health expenditure in the African Region, with a view to improving the understanding of the problem.[2] In addition, this report seeks to distil lessons learned from the effectiveness and appropriateness of existing PFM reforms for the health sector in the Region, to enable countries to tailor the PFM response to the health sector's needs and so to better support progress towards UHC.

The analysis was conducted in four steps. The methods and key steps in this analysis are outlined in Tab. 1. The first steps involved collecting and analysing country data on budget classifications in health from 41 African countries, consolidated into a database. This country mapping of health budget classifications – which provides an overview of the types of budget classifications used to present recurrent health expenditure in country's budget – served to evaluate the transition to programme-based budgets in health.[3]

It also involved consolidating public expenditure data on health from various primary sources, such as country Ministries of Finance and secondary sources (such as the PEFA). A dataset (2008-2016) was constructed, including expenditure data for 33 African countries, which was then used to estimate the level of budget execution in health. These first steps enabled WHO to provide an overview of budget formulation and execution practices in the health sector across the African Region.

Table 1: Methods and key steps in the analysis

1)	Cross-country data collection and analysis: Country mapping of budget classifications in health covering 41 countries for 2017, and dataset of budget execution in health covering 33 countries for 2008-2016
2)	Rapid evidence assessment on PFM reform implementation across sectors and in health specifically in the Region
3)	Country deep-dive assessments: PFM bottlenecks assessments in the health sector and budget structure analyses (Burkina Faso, Cameroon, Cote d'Ivoire, Democratic Republic of the Congo (DRC), Gabon, Ghana, Kenya, Nigeria, Senegal, South Africa, United Republic of Tanzania, Uganda)
4)	Country, Regional, and global consultations for validation of findings and consensus on key recommendations.

[2] For the purposes of this report, the African Region includes countries within the WHO African Region: Algeria; Angola; Benin; Botswana; Burkina Faso; Burundi; Cameroon; Cabo Verde; Central African Republic; Chad; Comoros; Congo; Côte d'Ivoire; Democratic Republic of the Congo; Equatorial Guinea; Eritrea; Ethiopia; Gabon; Gambia; Ghana; Guinea; Guinea-Bissau; Kenya; Lesotho; Liberia; Madagascar; Malawi; Mali; Mauritania; Mauritius; Mozambique; Namibia; Niger; Nigeria; Rwanda; Sao Tome and Principe; Sene.g.al; Seychelles; Sierra Leone; South Africa; South Sudan; Swaziland; Togo; Uganda; United Republic of Tanzania; Zambia; and Zimbabwe.

[3] The country mapping data are available here.

The second step consisted of assessing published evidence. In the absence of publicly available literature on PFM issues in health for low-and-middle income countries and the African Region specifically, authors contacted topic experts to collect additional resources. The evidence used in this analysis mostly consisted of grey literature, such as development partners' assessment of domestic financial management systems.

In addition to an assessment of available evidence, the report builds on recent and on-going country reviews and policy dialogue activities undertaken by WHO in relation to sector wise PFM reforms in the Region since 2015 (Box 1). PFM bottleneck assessments in the health sector were done in Cameroon and the DRC (implemented jointly with the World Bank), Gabon, Senegal, and Tanzania in 2016-2017, and are being undertaken in 2019 in Côte d'Ivoire, Kenya and Nigeria. Deep-dive analyses on budget formulation issues in health were completed in Burkina Faso [15] and Gabon in 2018, and are on-going in Ghana and Uganda. Country findings from these reviews have been directly used to support the analysis in this report.

Box. 1: WHO work on PFM - building the knowledge base for health stakeholders

Why is WHO engaged in this agenda? Countries making progress towards UHC are doing so by placing great importance on public funds being the dominant share of health financing. Framing health financing in this way puts the budget at the core of the UHC agenda. WHO is committed to supporting countries in designing and implementing appropriate PFM reforms in the health sector. In line with this, WHO initiated a programme of work in 2014 to support MOH reform efforts , the core objectives of which are to: 1) frame and conceptualise the importance of PFM in the context of UHC; 2) develop the knowledge-base on what constitutes an effective policy response to ensure a PFM enabling environment towards UHC; and 3) provide technical support to countries and strengthen health sector's technical capacities for effective PFM reform design and implementation in health.

Conceptual guidance: the first steps of the programme of work consisted of bringing clarity on key concepts and definitions, and framing the PFM agenda in the context of health financing reforms. It highlighted the importance of having robust PFM systems to create an enabling environment for UHC. The flagship product "Aligning PFM and health financing" developed by WHO and Results for Development sheds light on the possible disconnect between PFM reforms (e.g. the introduction of rigid execution rules) and the need for more flexible response to enhance appropriate use of public money in the health sector. Since 2018, WHO has shifted focus towards budgeting issues, since the quality of budget formulation is increasingly acknowledged as a key factor for effective and efficient health spending. "Budget matters for health" summarizes key issues associated with the formulation and classification of budgets in health.

Technical convening: As part of this programme of work, WHO convened a series of global conferences with partner agencies on public finance management and health financing policy under the "Collaborative agenda on fiscal space, public financial management and health financing". Three meetings have been organised by WHO since 2014, with the aim of ensuring a gradual shift towards implementation of adequate PFM reforms in the health sector. At regional level, WHO in collaboration with Health Harmonization in Africa partners, organized a high-level conference with finance and health representatives from 50 African countries in 2018, with the view to enhance the understanding of key PFM bottlenecks in health and discuss possible corrective actions.

Production of global goods: WHO developed an on-line repository of health budgets that gives access to open source information on finance laws and related budget documents applicable to the health sector for more than 100 countries. It is a one-stop shop for researchers and policy-makers interested in the analysis and monitoring of health budgets. In addition, WHO has carried out a country mapping exercise of health budget classifications. This on-line product provides an overview of the types of budget classifications used to present recurrent health expenditure in more than 100 countries, for those interested in monitoring budget reforms in the health sector.

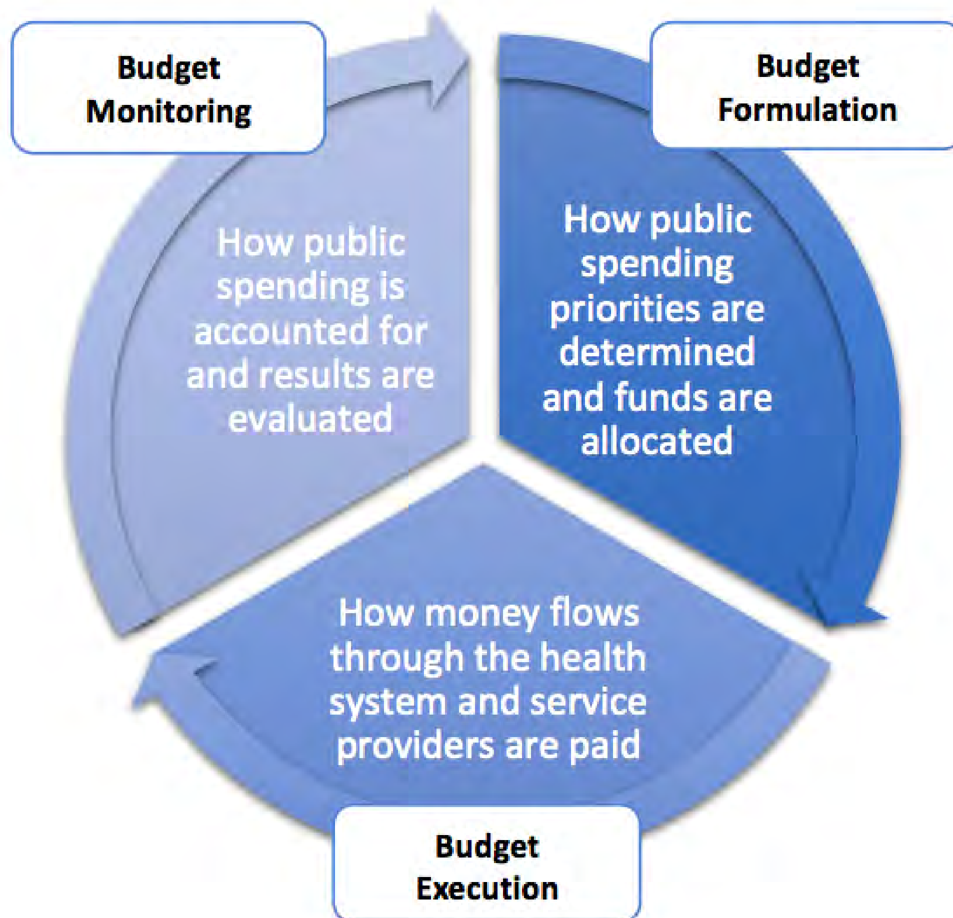
Country support work: WHO is supporting countries in conducting PFM bottleneck assessments to identify weaknesses in PFM functions and processes affecting health spending. In addition, country assessments are being carried out on the transition towards programme-based budgeting in the health sector to better capture the process and outputs of the reform in health. Building on country findings, policy dialogue and technical assistance are provided to a select group of countries interested in refining budget reforms in health.

Training and capacity building: PFM is an integral part of WHO's annual face-to-face global health financing training courses, which is delivered in both English and French. In addition, a series of webinars on budget issues in health will be conducted in 2019. This series will be available for all key stakeholders interested in tailoring budget practices for better health spending towards UHC. The WHO eLearning course on health financing policy will soon also contain a PFM module.

As a final step, PFM-related consultations were organised with multiple topic experts from the Collaborative African Budget Reform Initiative (CABRI), the International Budget Partnership (IBP), the World Bank, and independent experts (January-September 2018). This report also benefited from the input of country officials from African countries present during the 'Public Financial Management for Sustainable Financing for Health in Africa' conference organised in Nairobi by WHO and the African Development Bank (AfDB), in Nairobi, Kenya (September 25-28 2018).

To organise the findings of this analysis in a structured and easy to understand manner, this report follows the budget cycle approach developed by Cashin et al (2017) [3] that maps the three main stages of a budget cycle – budget formulation, budget execution, and budget reporting – and then links these key stages with health financing goals. Consequently, Chapter 2 of this report is dedicated to highlighting key challenges and lessons learned from policy responses related to budget formulation in the health sector. Chapter 3 addresses the budget execution phase, looking first at challenges then reviewing policy responses implemented in countries of the Region. Chapter 4 explores budget reporting issues in the health sector. Chapter 5 sets out crosscutting issues, focusing on the scope and process of PFM reform needed for health and the role of the Ministry of Health (MOH) in this reform process. Chapter 6 summarises key recommendations for health policy-makers.

Figure 1: Mapping the budget cycle and health financing functions.



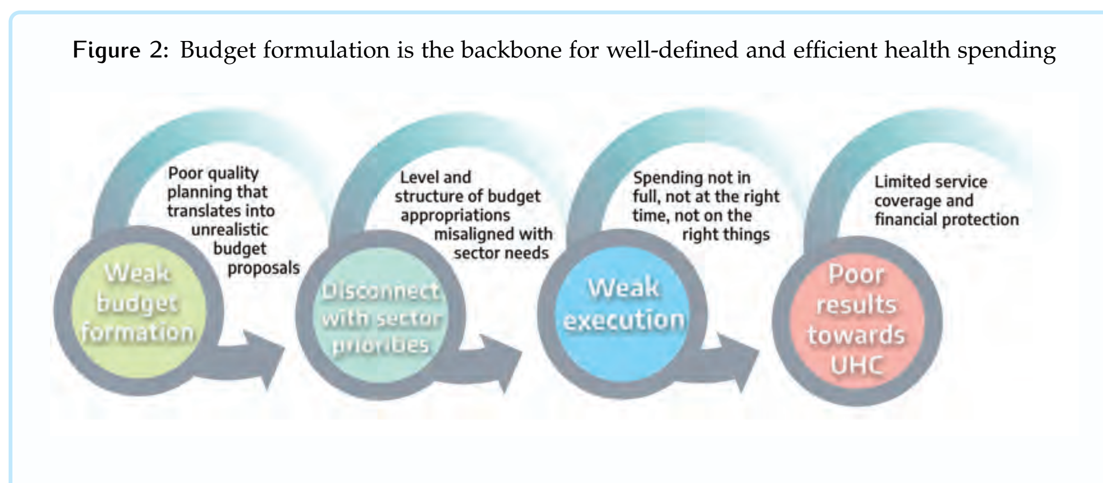
Source: Adapted from Cashin et al, 2017 [3].

2 BUDGET FORMULATION

2.1 KEY ISSUES IN HEALTH

While the level of public funding matters for UHC, the strategic allocation of public resources is crucial for achieving successful results [3, 17]. Budget formulation is the backbone of well-defined and efficient health spending, with each step of the budget cycle relying on the success of this strategic planning phase.[4] Budget formulation provides a tool and a process for health and finance professionals to facilitate priority setting and define what can be achieved in the sector with projected resources. Poorly formulated and estimated budgets create a vicious cycle, undermining downstream efforts [16].

Figure 2: Budget formulation is the backbone for well-defined and efficient health spending



Consequently, challenges that arise during budget execution and reporting are often partially linked to problems that occurred in the earliest stages of budget preparation (Fig. 2). Low-quality budget proposals in health often result from poor and uncoordinated planning and priority-setting mechanisms, inappropriate costing and misaligned structure [4]. These main parameters are further detailed in the section below.

Poor budget credibility in health is often the result of weak priority setting and costing approaches in the Region, as observed elsewhere.[5] Health ministries often face challenges in

[4] The budget formulation or development phase consists in setting up the fiscal targets of a given fiscal year and the level of government expenditures compatible with these targets. It often includes the production of pre-statement budgets led by the executive branch of government, that are further reviewed and approved by the legislature.
[5] Budget credibility or reliability describes the ability of governments to accurately and consistently meet their expenditures and revenue targets. According to PEFA, it means that the budget is "*realistic and implemented as intended*"'.

prioritising sector needs and estimating their costs for various technical (e.g., uncertainty in health needs) and capacity reasons. Lack of explicit priority-setting mechanisms, inappropriate costing techniques, as well as poor information systems, contribute to disconnects between budget allocations and needs [4]. A frequent disconnect between costing and budgeting lead to inconsistencies and misunderstandings between the finance and health authorities. While costing health sector plans provides a useful framework for long-term planning and resource mobilisation (including from external sources), costing for annual sector budget proposals should be done against projected public resource envelopes to be meaningful and implementable [18].

Budget misalignments are frequently attributed to inappropriate health budget structures. Health budgets have traditionally been organised as input-based budgets in the Region – i.e., they have been based on the detailed inputs needed to deliver health services at facilities, such as human resources or pharmaceuticals [7, 19]. Under each section, detailed inputs are included such as fuel for ambulances or stationery for facilities to guide budget appropriations [19] (Fig. 3). Inflexible input-based budgets have major recognised limitations in general, and for the health sector in particular. While such budgeting approaches may help to ensure a basic level of control and may prevent misappropriation of funds where there is weak financial accountability, it is generally accepted that input-based budgets create rigidities and constrain effective matching of budget to sector priorities and outputs, in turn leading to waste of resources and lack of accountability in terms of actual results [7].[6] In particular, the inflexibility problem comes in during the execution phase, when health facilities have to spend against detailed proposed line items, with little consideration of actual needs and limited manoeuvrability to shift funds across lines [20].

Certain types of public expenditures for health are programmed separately, creating more fragmentation in health budget formulation. Personnel expenditure – which makes up the bulk of health spending in many African countries [6] – is often protected in a separate funding pool and paid according to civil service rules and pay scales which are determined outside of the MOH. In most countries, health authorities have neither the information nor the power to influence staff regulation and spending [22].[7]

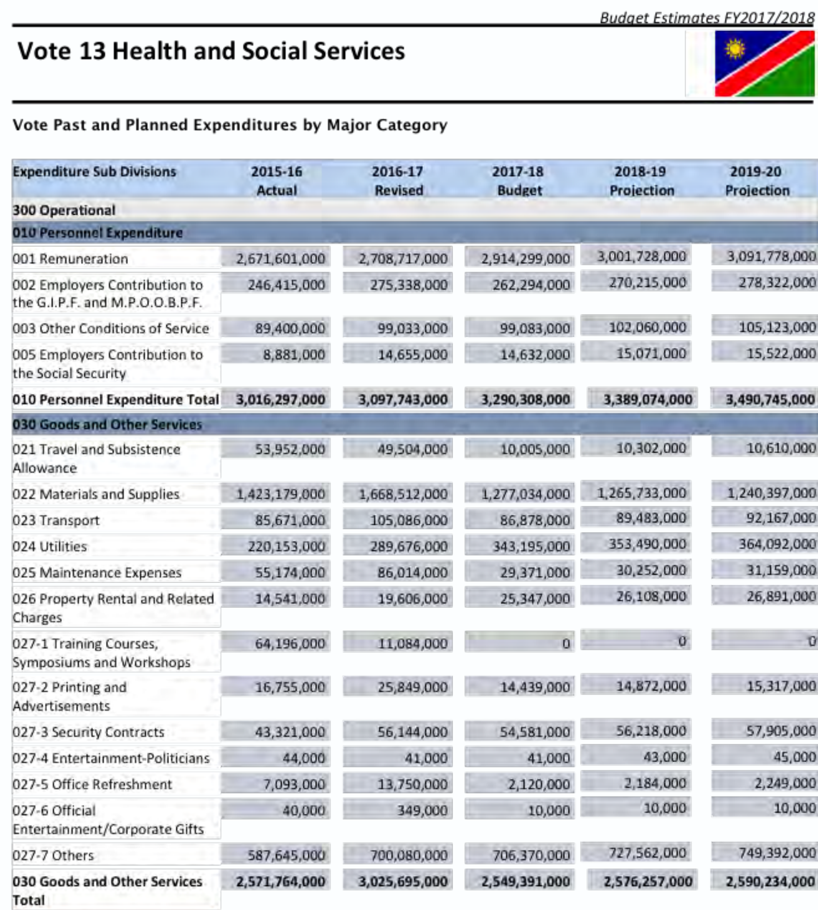
Capital expenditure is also often typically separated, sometimes included as part of 'development budgets', from recurrent expenditures and is often managed by a separate ministry, such as the Ministry of Planning, with limited coordination with operational priorities. Medicines may also be procured and managed centrally, and may be provided in kind to health facilities rather than being purchased from budget transfers or the facility's own revenues. This may result in less flexibility in the planning and allocation of resources for the sector as a whole.

The multiple sources of funds, schemes, and funding flows in health pose specific challenges for budgeting, because they are often not pooled and are subject to different allocation rules [25]. Several assessments have underlined the fragmentation in funding flows as a core feature of health financing in the Region, posing challenges to appropriate budgeting. In one study of 12 francophone African countries, an average of 23 discrete and generally uncoordinated financing streams per country was identified [26]. Different rules often apply to the

[6] These types of budgets provide constraints in accountability for value for money, because they do not permit scrutiny into what priorities were focused on in terms of spending.

[7] In addition, this separation can result in a serious mismatch between salaries and other recurrent costs leaving facilities with staff but no funding for direct patient care, creating substantial inefficiencies and poor service delivery.

Figure 3: An example of an input-based budget for health (extract), Namibia



Budget Estimates FY2017/2018

Vote 13 Health and Social Services

Vote Past and Planned Expenditures by Major Category

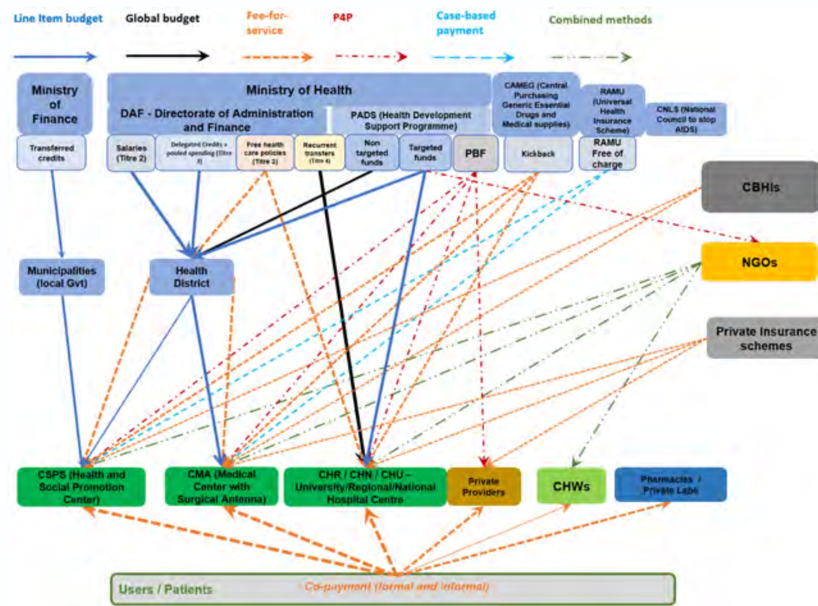
Expenditure Sub Divisions	2015-16 Actual	2016-17 Revised	2017-18 Budget	2018-19 Projection	2019-20 Projection
300 Operational					
010 Personnel Expenditure					
001 Remuneration	2,671,601,000	2,708,717,000	2,914,299,000	3,001,728,000	3,091,778,000
002 Employers Contribution to the G.I.P.F. and M.P.O.O.B.P.F.	246,415,000	275,338,000	262,294,000	270,215,000	278,322,000
003 Other Conditions of Service	89,400,000	99,033,000	99,083,000	102,060,000	105,123,000
005 Employers Contribution to the Social Security	8,881,000	14,655,000	14,632,000	15,071,000	15,522,000
010 Personnel Expenditure Total	**3,016,297,000**	**3,097,743,000**	**3,290,308,000**	**3,389,074,000**	**3,490,745,000**
030 Goods and Other Services					
021 Travel and Subsistence Allowance	53,952,000	49,504,000	10,005,000	10,302,000	10,610,000
022 Materials and Supplies	1,423,179,000	1,668,512,000	1,277,034,000	1,265,733,000	1,240,397,000
023 Transport	85,671,000	105,086,000	86,878,000	89,483,000	92,167,000
024 Utilities	220,153,000	289,676,000	343,195,000	353,490,000	364,092,000
025 Maintenance Expenses	55,174,000	86,014,000	29,371,000	30,252,000	31,159,000
026 Property Rental and Related Charges	14,541,000	19,606,000	25,347,000	26,108,000	26,891,000
027-1 Training Courses, Symposiums and Workshops	64,196,000	11,084,000	0	0	0
027-2 Printing and Advertisements	16,755,000	25,849,000	14,439,000	14,872,000	15,317,000
027-3 Security Contracts	43,321,000	56,144,000	54,581,000	56,218,000	57,905,000
027-4 Entertainment-Politicians	44,000	41,000	41,000	43,000	45,000
027-5 Office Refreshment	7,093,000	13,750,000	2,120,000	2,184,000	2,249,000
027-6 Official Entertainment/Corporate Gifts	40,000	349,000	10,000	10,000	10,000
027-7 Others	587,645,000	700,080,000	706,370,000	727,562,000	749,392,000
030 Goods and Other Services Total	**2,571,764,000**	**3,025,695,000**	**2,549,391,000**	**2,576,257,000**	**2,590,234,000**

Source: Ministry of Finance, Namibia [21]

separate elements of funding, including inflexibilities through restrictions on the planning and use of these funding sources (e.g., earmarked funds for certain purposes or commodities) [20;27]. As described in Fig. 4 for Burkina Faso, the multiple funding sources have their own rules for resource use up to frontline users, which is conducive to undermines effective planning and management of resources.

Fragmented budgeting processes are further exacerbated by a high dependency on external aid associated with multiple financial management arrangements. Major vertical programmes require separate planning and budgeting processes, making it more difficult to develop integrated plans and budgets to improve the full range of health services. Several joint donor reviews of financial management arrangements in African countries identified the existence of multiple separate bank accounts for specific programmes.

Figure 4: Mapping of domestic funding flows in the health sector, Burkina Faso



Source: [28]

These accounts reflect the large number of standalone activities, many of which are managed through a dedicated Project Implementation Unit (PIU), and are subject to a variety of budgeting and financial management rules [29]. A joint financial management review, conducted by the AfDB, the European Union, GFATM, and the World Bank, identified 26 parallel entities implementing health sector support projects in Burundi for example [29]. The large number of independent organisations and related financial management systems introduces significant challenges to effective sector oversight, as even on budget funds frequently require separate management following specific procedures.[8]

Shortfalls in the budget negotiation and approval process weaken the quality budget-making process in health. While health is often recognised as a top priority by African governments, health ministries struggle to make the case and to translate commitments into voted allocations, in the absence of strong negotiation skills, limited influence, as well as poor implementation of budgeting rules and calendars. Power relations, informal behaviours, information gaps, fail-

[8] External funding provided off budget and as goods in kind or donated assets also create specific challenges to the budgeting and management of health resources. For example, medicines may be provided in kind by externally funded programmes. Not only do medicines provided in this way make it more difficult to factor supplies into comprehensive health sector budgets, but there may also be associated costs that are not budgeted for. In addition to goods in kind, many health facilities in African countries rely heavily on donated medical equipment, which typically comes with significant installation, operating, and maintenance costs that may not be adequately covered by the donor. WHO estimates that the purchase costs of medical equipment only represent about 20% of the total costs incurred during the life of the equipment. Poor reporting of the existence and condition of donated assets can result in inadequate budget provision for maintenance, or inequitable allocation of capital funds.

ure to follow rules and calendars, and influence by other actors outside of the health sector all seem to have an impact on eventual budget decisions for health [30, 31].

The recent formalisation of budget conferences in several African countries, such as in Côte d'Ivoire, Mozambique or Uganda, has certainly been a step towards a more systematic dialogue around budget preparation, securing more consistent involvement of health stakeholders. The implementation of budget conferences varies across African countries, however, health or social sectors are often bypassed at these events and there is a range of informal practices that typically continue to govern allocation decisions in several countries in the African Region [31].

2.2 LESSONS FROM POLICY RESPONSES

Several aspects of the health budgeting processes have been strengthened across countries of the African Region. The health sector has benefited from improvements in general budgeting processes (e.g. multi-year budgeting), as well as from specific actions taken in health. This section briefly highlights general changes in budgeting practices, and then focuses on major changes directly affecting the budgeting of health expenditure. As the introduction of programmatic classifications has been an important change for the health sector's budgeting to better align resources with sector priorities, the section provides an overview of the effectiveness of this reform in the Region.

In several African countries, budgeting on a multi-year basis may have improved predictability in the health sector's resource envelope. The usefulness of an MTEF, which is typically introduced to control fiscal sustainability and improve resource predictability, lies in the extent to which it is used as a guide for preparing annual budgets, providing a realistic indication of future revenues and how revenues will be allocated to the sector in, usually, the coming 2-3 years [34]. While the approach may have improved predictability in some countries, there is a number of recognised weaknesses in its use: poor quality revenue forecasts, widespread incremental changes within the MTEF (and a corresponding lack of strategic reprioritisation), limited political enforcement (e.g., failure to use the year 2 figures from the previous year's MTEF as a basis for the following year's budget), and limited engagement of sectors (including health) in integrating sector plans.

In several countries, for example, the MTEF was not sufficiently considered during budget negotiations and the variance between the amount projected in the MTEF and the eventual budget allocation for the sector was substantial [18, 19, 35, 36]. Several African countries have now integrated MTEF within their budget planning process, which is done through a multi-year planning approach. Budgets are now approved for 3 years, and variations between the planned and allocated envelope for the sector have been effectively reduced in several countries (e.g. in Burkina Faso, Ghana).

Various mechanisms, such as Annual Operations Plans (AOPs) linking financial inputs and operational outputs, have been introduced in several African countries to create a more explicit linkage between plans and budgets in the health sector [37, 38]. In Kenya for example,

AOPs were introduced to create an explicit linkage between the planning and budgeting processes for the health sector, although challenges remain in using this approach to inform the actual budgeting process. The institutionalised dialogue between finance and health authorities that is also happening in several countries of the Region (including in Côte d'Ivoire, Gabon, Kenya, Mozambique, and Uganda) through forming joint committees may also have smoothed communications and mutual understanding and requirements, while the actual benefits in terms of better budget alignment still need to materialise, in the absence of actual decision power of these committees [37].

Figure 5: Countries with programme classification in health budgets (percent of regional sample, 2017 or earliest available year)

Source: WHO Country Mapping of Health Budget Classifications, authors' calculations [39]. The bars indicate the number of countries with a programme classification in their health budgets (as per the health sections of the approved national Finance Law). EMR=Easter Mediterranean Region; AMR=Americas Region; AFR=African Region; EUR = European Region; WP/SEAR=Western Pacific & Southeast Asian Region.

While an estimated 18 (44%) of 41 African countries have introduced some forms of programmatic classification to present their 2017 health budgets, most keep an input-based approach. Though health has often been a pilot sector for budget structure reforms, the Region demonstrates slow reform institutionalisation in comparison to the other Regions of the world (Fig. 5).[9] The introduction of programmatic classifications in budget formulation means that budgets are presented and approved by a set of 'programmes' articulated around policy goals and outputs. If execution of funds follows a similar output-based logic, whereby funds are released by programmes and not by line items, there are several benefits from a health financing perspective: 1) stronger linkages between budget allocations and sector priorities; 2) support for output-oriented provider payment systems; and 3) incentives for performance-oriented accountability and transparency [7].

Countries of the Region are at different stages of implementing budget structure reforms, most facing challenges with the transformation of expenditure management processes. Out of 18 countries that have introduced forms of programmatic classification to present health budgets, only six have institutionalized the reform. Only in Burkina Faso, Gabon, Ghana, Kenya, Mauritius and South Africa, the health section of the Finance Law is approved by the legislature by programmes. Despite a change in budget formulation, execution continues to be processed by inputs, because ex-ante controls are not relaxed and ultimately money is not disbursed based on 'programme' logic [40, 41] in most of these countries. South Africa is the only country in the Region where budget releases are based on programmes for the sector

[9] The country mapping data are available here.

[29].[10] For the other countries, programmatic classifications are done as a pilot effort but have not led to actual changes in resource allocation.

A change in budget formulation is often an opportunity to boost performance monitoring and accountability against achievement of specific targets for sector results, that it has not been fully exploited so far. The introduction of performance monitoring frameworks, as direct companions to programme budgets, represents a great opportunity for the health sector to consolidate financial and technical performance information into a single framework. While traditional budgets focus on ensuring that appropriations are targeted to the approved line-items, well-aligned output budgets emphasise accountability for sector results [42]. The quality of performance monitoring frameworks obviously matters. Good practices inform how essential it is to set the right number of performance targets that are reliable, comparable, and aligned with existing information systems of the sector. South Africa is most advanced in this respect for the Region (See Tab. 3 in Annex).

Programme budget is not a panacea for all countries. When badly defined and introduced in weak accountability contexts, it can create more complexities in resource management and reduce accountability. The implementation of major budget reforms without ensuring basic PFM elements can leave systems vulnerable to fraud or abuse, which has been confirmed in several contexts such as Cameroon and Mozambique (Box 2).

Box. 2: Introduction of programme budgets in weak accountability contexts- the example of Mozambique

The Government of Mozambique first began a serious effort to modernise its PFM systems in 1996 with the introduction of a medium-term fiscal framework and an integrated financial management system. The government entered a second phase of reform in 2006, when it introduced programme budget reforms. However, programmes were used primarily as planning tools and could not be mapped to allocations.

At the same time, although reform efforts proceeded rapidly, they were introduced within a context of weak controls. While the new financial management system was expected to alleviate this problem, administrators failed to collect data on compliance with internal controls. After several years of implementation, problems became difficult to ignore [44].

Although programme budgets sought to link allocations to sector plans, money was reportedly misspent during execution, thus reducing spending on strategic priorities. External controls, meanwhile, reflected the input-based budget structure. Rather than tracking whether the funds were spent on approved priorities, external audits and the Parliament focused on whether the money was spent on the specific goods and services that were budgeted.

These failures were blamed for a public finance crisis in 2016, which saw widespread reports of the misuse of funds and an overall lack of transparency in spending by the government [11].

[10] Within a structured framework of delegated authority, fund managers should be provided with the financial flexibility to execute and ultimately make necessary reallocations within the programme envelope in order to procure the best mix of inputs to produce desired service outputs, respond to changing needs in the sector, and increase efficiency to extend coverage. The shift from line-item to programme-based budgeting is not sufficient unless the underlying degree of flexibility is provided to move funds between budget lines, expenditure categories and costs centres, and the level at which this flexibility operates is clearly defined and effectively delegated (for example, to central fund managers and health facilities).

3 BUDGET EXECUTION

3.1 KEY ISSUES IN HEALTH

Budget execution is often cumbersome and slow in many African countries, due to multiple ex-ante controls and a high degree of centralisation in the MOF, directly affecting effectiveness of expenditure in sectors such as health.[11] For the Region, budget execution is reported as the weakest component of the budget cycle.[12] Country evidence shows that there are risks for loss at all steps of the expenditure chain in health [6]. The section below provides an overview of the problem and unpacks its root causes.

Under spending in health is a recurring issue in African countries. This report estimates that 13 (50%) of 26 African countries had an average of more than 15% under spending of their health budget allocations yearly between 2008 and 2016 (Fig. 8). Health budget execution, according to this report's estimates, is systemically lower than execution for overall government allocations (Fig. 9). In addition, our estimates from 30 countries indicate that the situation is not improving in African countries. Budget execution seems to have deteriorated in health over the past 15 years (Fig. 10), with large in-country variations over the years.[13]

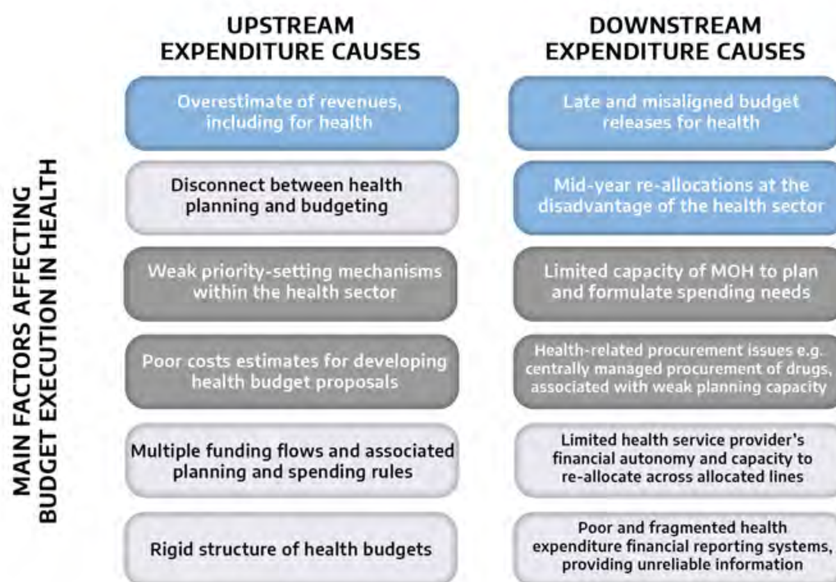
While under spending is often attributed to low absorption capacities of MOH, there is actually a myriad of commonly observed root causes in the Region involving both finance and health duties. While some factors are directly attributable to cash and expenditure management issues overseen by finance authorities (further described below), there are other problems that can be directly addressed within MOH, such as credibility of budget proposals or timeliness of cash requests. Fig. 6 summarises some of the commonly observed root causes for both upstream expenditure (i.e., before the release of funds) and down-stream expenditure (i.e., during and after the actual execution period) and map them to finance and health responsibilities.

[11] In strict terms, budget execution refers to the release and use of funds and generally includes a series of steps, including the commitment of funds, verification of activities, and authorisation of payments.

[12] A review of PFM assessments in 31 African countries found that PEFA scores are higher upstream in the budget cycle (at budget formulation) than they are downstream in the cycle (at budget execution and reporting) [13].

[13] In certain situations, limited execution of certain lines won't be necessarily associated with poor sector performance. Limited execution might instead signal the actual shift of resources towards unplanned or emerging priority needs. In addition, in an input-budget setting, the need to plan and authorise spending by detailed inputs may create an artefact that does not reflect how money is actually used in practice, and/or needed at lower levels of government (for example, at a district, facility, and implementing agency level).

Figure 6: Under-spending in health is a multi-faceted problem



Areas highlighted in blue mostly pertain to finance duties; areas highlighted in dark grey mostly pertain to health duties; areas highlighted in light grey fall to both parties – at the nexus of coordination between health and finance.

Weaknesses in the cash management systems – ubiquitous in the Region – are a first major cause of under spending in health. Common challenges observed in budget execution in the African Region are liquidity problems alongside late, inconsistent, or insufficient disbursements of funds [3, 41, 46, 47]. In many countries, only a portion of allocations reached their destination because of liquidity problems [48]. Beyond revenue issues, this is often a result of cash budgeting practices in which the total amount of releases is matched to the revenues raised in the previous month, and therefore can result in unexpected shortfalls in line ministry funding [49].

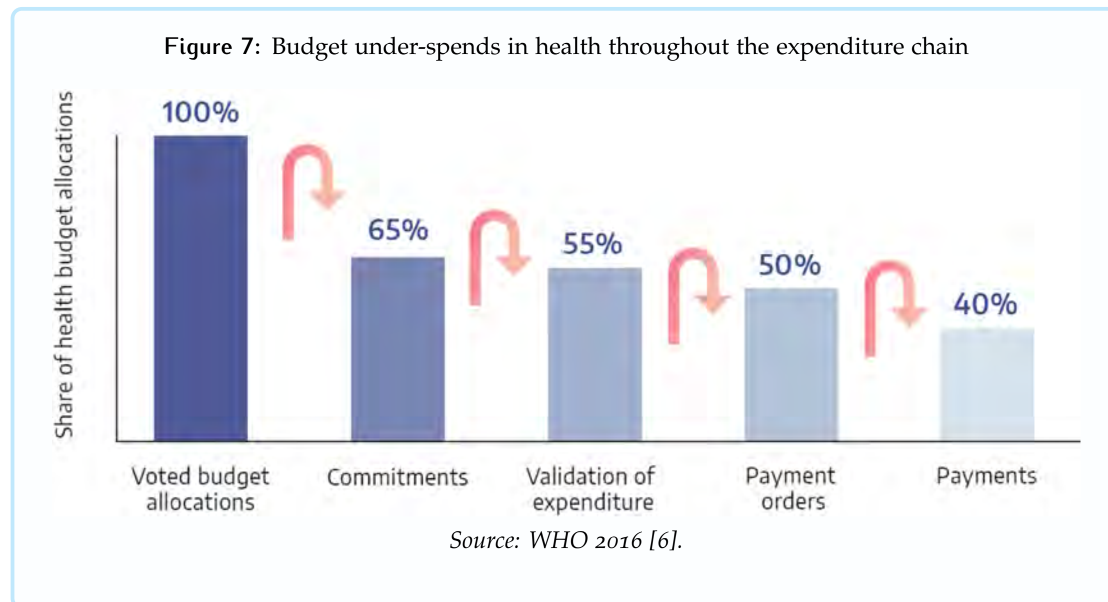
Cash budgeting typically distorts the prioritisation of different components in the health sector budget and leads to unpredictable, irregular, and reduced flow of funds (sometimes with a surge of funding towards the end of the financial year). In addition, weaknesses at different steps of the expenditure chain may also partly explain under-execution in health, with some of weaknesses directly pertaining to MOH capacities (Fig. 7) . The stylised example in Fig. 7 highlights possible losses from commitments to final payments, where only 65% of the approved budget allocations for health was committed, 55% validated and approved for payment, and 50% requested for actual payment, which led to only 40% of the initial allocation being actually paid to providers.

Other execution challenges result from issues upstream in the budget rules and structure. Technical challenges arise in many African contexts, when budget formulation and associated rules for spending prevent reallocation between budget lines and constrain execution. Input-based budget rules preclude the shifting of health expenditures to respond to service needs over the course of the year [3] (see Chapter 2). The execution process of these budget types entails controls that ensure that funds can only be requested against items as specified and approved in the initial health budget [20]. This is often a major cause of under spending because some budget lines become obsolete, as health needs evolve (e.g. reduction in seasonal malaria prevalence) or new needs emerge (e.g. outbreaks) (Box 3).

Another important issue is the fact that execution differs by nature of expense, with discretionary expenditure – at the core of health service delivery – being more fragile to low execution. When funds are in short supply, nondiscretionary spending i.e. salary expenditure, has most often the first claim on available funding, leading to limited resources available for operating costs generally at health facility level [50]. Shortfalls can have a disproportionate impact on non-salary recurrent spending and components of capital projects that can be delayed. In the DRC between 2011 and 2015, the execution rate for staff costs was 94%, while the execution rate for non-staff expenditure was just 32% [24]. In Senegal, the average execution rate for grants for 2012-2015 was 99%, while the rate for the more administratively complex capital expenditures was just 64% [36] [22]. Similar differences are seen in the execution of Tanzania's development and recurrent budgets for health. Here, delays in disbursements to Regional units were blamed on a failure to produce timely reports that are required for the release of development funds [51].

Another commonly observed difficulty in the health expenditure chain in the African Region is the ineffective transfer of funds to local health facilities. Several studies in African countries have found that facilities often receive a very tiny portion of the total health budget (in general less than 10%) [52]. Furthermore, for several PFM-related reasons (for example, de-

Figure 7: Budget under-spends in health throughout the expenditure chain



Source: WHO 2016 [6].

lays in disbursement, blockage at district level and physically accessing transfer funds) many health facilities do not even effectively receive or are able to use public transfers that are specifically intended for their use. Where district health offices manage facility funds, often only a very small proportion of each facility's budget is provided as a cash advance. While this avoids the payment challenge, it is not in line with the principle of empowering frontline staff, and often affects utilization of resources.[14]

[14] Facility health workers often have to make physical journeys to district capitals to collect salaries and facility funds, or to report expenditure, resulting in absence from the facility and incurrence of costs. The lack of bank accounts, due to weak bank systems (or lack of legal authorisation) poses a common challenge in remote areas in several countries [53].

Box. 3: Root causes of DRC MOH acute budget under spending

The DRC example is helpful for understanding the multiple factors that result in under-execution of health budgets. The situation is explained by causes linked on one hand to weaknesses in planning and budgeting process at the MOH level (e.g., weak capacity for needs assessment, delays in preparation of budget proposals, and lack of formalised budget preparation process) and expenditure and cash management issues, with multiple manual ex-ante controls centralised by finance, leading to systemic delays and errors.

The table below highlights the budget implementation rate for health and for the overall budget for the DRC for the years 2011-2015. While the low overall implementation rate suggests a need for substantial strengthening, in all but 2 years the overall absorption of the health budget was significantly lower than that of the overall budget [54].

During budget preparation in the DRC, sector work plans and budget documents have in the past been delivered late and are of variable quality. In particular, health authorities have systematically overestimated allocations from external resources. In 2013 for instance, the health ministry's forecasted budget needs for equipment, services, and other discretionary expenditure came to 59% of the funds ultimately requested from the health ministry [4]. This was linked to delays in issuing quarterly Budget Commitment Plans by the central budget office. Other issues, including errors in preparation of budgets and delays in receiving the Minister of Public Health's approval of the sector plans, point to capacity and organisational problems within the Ministry of Public Health, as well as the lack of a formalised budget preparation process and structure [24].

Systemic expenditure management issues have further hampered budget execution. Validation of expenditures remains a highly manual process managed by the Ministry of Budget. Long delays in validation have resulted in expenditures being charged to the next quarter and a loss of quarterly transfer for the Ministry of Public Health. Once validated, the Ministry of Finance processes a purchase order through a similarly manual process, which can take 2-3 months, again resulting in the loss of quarterly transfers for the Ministry of Public Health. Payment is also frequently delayed further by errors in the authorisation of payments and bank transfers [24]. Transactional data also suggests that the time profile of budget releases is often erratic for MOH's resources, with releases grouped in the last quarter of the fiscal year [24].

Budget implementation rates, DRC

Year	Execution rate of overall budget (%)	Execution rate of health budget (%)
2011	71.7	73.0
2012	72.3	27.5
2013	69.2	71.5
2014	62.9	40.4
2015	70.2	62.0

Source: MOF, DRC

Figure 8: Health budget execution in African countries, average % of health budget allocations (2008-2016)

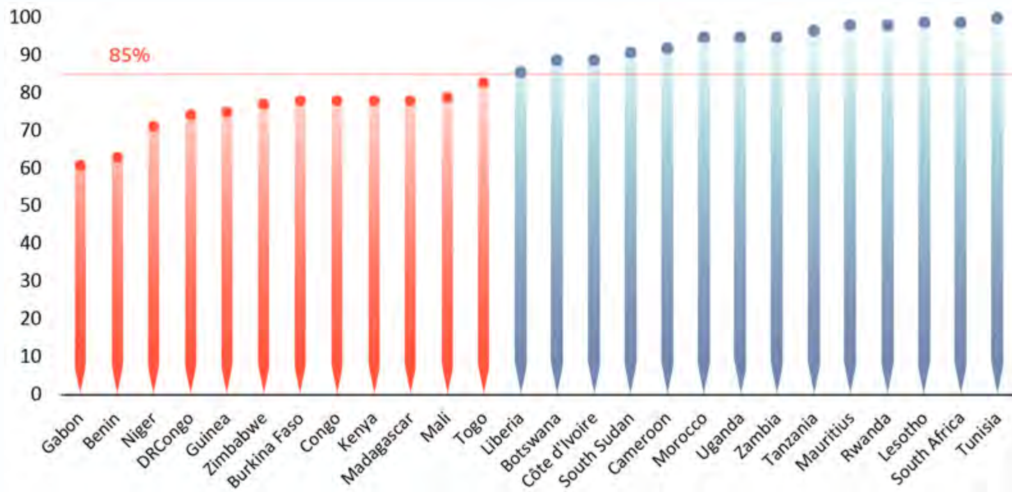
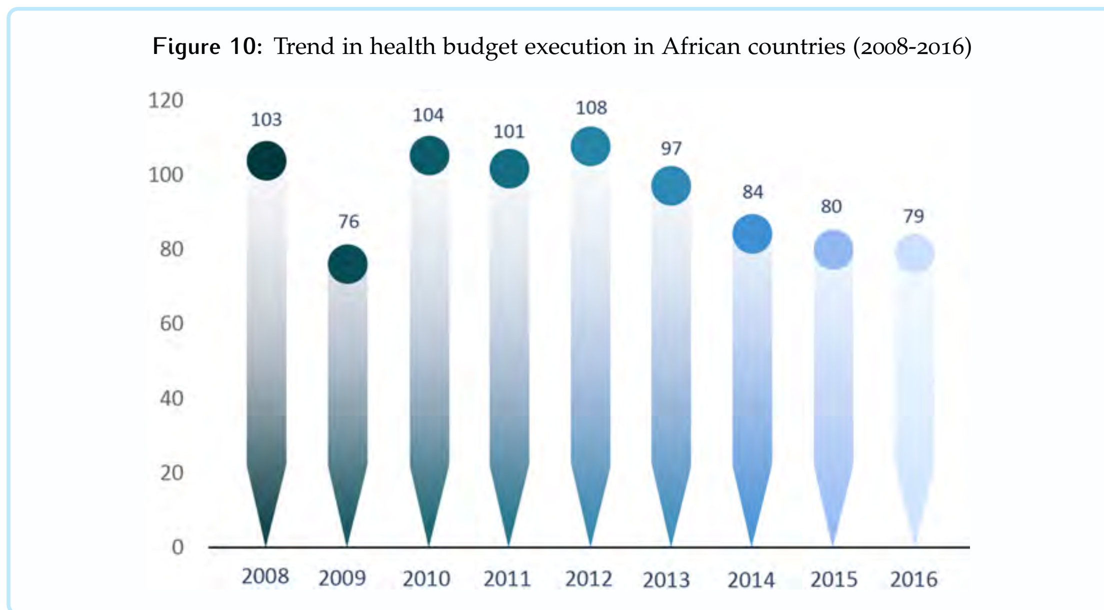


Figure 9: Overall government and health budget execution in African countries (2008-2016)

Figure 10: Trend in health budget execution in African countries (2008-2016)



Source: PEFA and country expenditure reports, authors' calculations

Note: country list for figures 8 and 9: Benin (PEFA), Botswana (PEFA & MOF), Burkina Faso (PEFA), Cameroon (PEFA & MOF), Congo (PEFA), DRC (PEFA & MOF), Côte d'Ivoire (PEFA & MOF), Gabon (PEFA & MOF), Guinea (PEFA), Kenya (PEFA), Lesotho (PEFA), Liberia (PEFA), Madagascar (PEFA), Mali PEFA), Mauritius (PEFA), Morocco, Niger (PEFA & MOF), Rwanda (PEFA), South Africa (PEFA & MOF), South Sudan (PEFA & MOF), United Republic of Tanzania (PEFA & MOF), Togo (PEFA), Tunisia (PEFA), Uganda (PEFA & MOF), Zambia (PEFA & MOF), Zimbabwe (PEFA & MOF). Country list for 10: Benin, Botswana, Burkina Faso, Cameroon, Congo, DRC, Côte d'Ivoire, Gabon, Gambia, Guinea, Kenya, Lesotho, Liberia, Madagascar, Mali, Mauritania, Mauritius, Morocco, Niger, Rwanda, Sierra Leone, South Africa, South Sudan, United Republic of Tanzania, Togo, Tunisia, Uganda, Zambia, Zimbabwe.

3.2 LESSONS FROM POLICY RESPONSES

Several PFM interventions have been introduced in African countries over the past two decades to improve overall budget execution with variable levels of success. The section briefly highlights general changes in expenditure management, and then focuses on specific interventions implemented in the health sector, such as strategic purchasing, that could have contributed to better budget execution in the sector, while at the same time serving the efficiency, quality and equity agendas.

Reforms to address budget execution have often included a package of standard PFM interventions across African countries. They generally included clarifying budget execution procedures, reducing the number of interventions by financial controllers, upgrading the computerisation of expenditure process through Integrated Financial Management Systems (IFMIS), strengthening overall cash management, introducing accrual accounting [55].[15] A key policy across African countries that directly affected health expenditure consisted of 'devolving' spending authority and expenditure control from MOF to sector ministries, bringing commitments process closer to sector decision.[16]

While no stocktaking of the reform has been undertaken for the Region so far, preliminary evidence seems to suggest some implementation bottlenecks where (from Burkina Faso, DRC, to Gabon, or Mozambique) controls seem to continue to be very much administered by finance agents (that are often seconded to sector ministries) with limited involvement or formalised dialogue with technical units of ministries of health in particular [13, 56].

Upstream reforms, such as those related to budget formulation, may have also helped in some contexts but improvements in budget execution are not automatic. Measures such as introducing a medium-term fiscal budget framework; improving the definition and formulation of budget policies and programmes; or enhancing the size or management of contingency reserves have helped reduce the gap between what was initially planned and what is actually spent in several contexts [55]. Specifically, a change in budget formulation can facilitate budget implementation given the supposedly flexible use within 'programme envelopes', but it is not automatic.

Where change remains presentational, it does not link or automatically lead to changes in how money is disbursed, and therefore it rarely impacts on budget execution. In the case of Gabon for example, and similarly the first years of programme budget introduction in Kenya, there was an observed decrease in budget execution in health, following the introduction of programme budgets in health (Tab. 2).[17] Beyond drop in general revenues, main explanatory factors lie in the lack of relaxing of ex-ante controls and the inability to have programmes that

[15] Accrual accounting and budgeting provides a comprehensive picture of accounting assets and liabilities that a Government controls, and is preferable to a narrower, cash-based accounting and budgeting approach.

[16] This process has the potential to strengthen the budget execution process by simplifying procedures and should give sector ministries stronger incentives to manage their budgets effectively.

[17] Gabon's budgetary programmes for the MOH included the following: 1) support to the health system and in policymaking; 2) prevention and health security; 3) supply and access to health services; and 4) funds for HIV/AIDS programmes.

properly function as 'programme envelopes' – i.e. providing the ability to re-allocate across different lines within the same budgetary pool.[18]

Table 2: Falling of health budget execution rates following transition to programme budget in Gabon

Year	Approved budget for MOH (CFA francs, in millions)	MOH expenditure (CFA francs, in millions)	MOH's budget execution rate (%)
2012	123.6	87.5	71
2013	14.6	101.4	69
2014	125.2	69.3	61
2015	98.9	38.7	61
2016	56.9	33.9	60

Source: MOH, Republic of Gabon.

Shifting to 'strategic purchasing' of health services has not yet been fully exploited in African countries to improve budget execution.[19] Strategic purchasing can help to prioritise spending better and, potentially, improve budget execution by directing resources to where they are most needed. In several African countries, multiple provider payment systems have complicated the shift to strategic purchasing, by limiting the ability to pool resources and, frequently, by instituting a number of conflicting incentives [62]. Fragmented purchasing systems make it difficult to implement a unified set of payment rules, and so may increase the overall administrative burden, particularly on health facilities [21] (Box 4).[20] Some PFM rules have also undermined the incentive structure that strategic purchasing seeks to create in some countries. For example, rules that require that any savings must be returned to the central budget, particularly if the savings cannot be reallocated within the year by operational units to other budget lines, eliminate the incentive to provide more effective and efficient spending in the sector [3].

[18] Most countries that have transitioned formulation of budgets to programmes have indeed kept budget releases controlled by line-items, thereby hindering potential benefits of the reform for health sector spending.

[19] Strategic purchasing is an approach that transfers funds to providers (health facilities) based, at least in part, on information about providers' performance or the health needs of the population they serve.

[20] Conversely, attempts to mitigate fragmented fund flows can become a step or path to broader pooling and purchasing reforms, especially if both payment and information systems are unified or harmonised ensuring efficiency gains and consistent or complementary incentives at facility and individual client level.

Box. 4: Burkina Faso: multiple payment arrangements and the passive purchasing of health services

In Burkina Faso, multiple provider payment mechanisms are in place, with inconsistent incentives to the delivery of services at different levels of the health system.

Burkina Faso's health financing system is characterised by a high level of fragmentation. A 2014 study identified no fewer than 23 separate health financing schemes [26]. This is largely attributed to the large number of free and subsidised policies in place. Subsidies are funded by a variety of sources, including the state budget, international partners, non-governmental organisations (NGOs), private and community insurance funds, and households [22]. The result is a highly fragmented pooling of resources that hinders financial risk sharing and highlights the complexity of health sector purchasing in Burkina Faso. The state is the main purchaser of health care in the country, channelling just over half (53%) of health expenditures.

Funds flow largely via line-item payments based on historical spending, although the government's ongoing budget reform efforts are expected to result in changes to the purchasing and procurement system. Personnel costs, which cover civil servants' salaries, are governed by the 2015 Act No. 081-2015/CNT on the General Statute of the State Civil Service. Salaries levels are, therefore, largely determined outside of the Ministry of Health. However, there is scope to incorporate performance top-ups to civil service salaries.

Grants and transfers may be delivered as global budgets, while vertical programmes such as the state-subsidised maternal-and-child-health programme are paid via case-based payments. The nascent social health insurer is experimenting with a combination of capitation and case-mix payments in three districts. Community-based health insurance, private insurers, and patients rely heavily on fee-for-service, with the organised insurers generally having some controls over overall spending. A review of expenditure flows finds that approximately two thirds of payments to the sector are line-item payments, and one third are case-based payments with results.

While the multiplicity of payment and procurement mechanisms illustrates a trend to experimentation and learning-by-doing that is required for any major reform, care should be taken to prioritise a system that will harmonise and coordinate the multiple different streams. The current purchasing system shows an overall lack of coherence and homogeneity that increases administrative costs while undermining the efficiency goals of the case-mix and performance payments [22].

Source: [22].

As part of their strategic purchasing reforms, several African countries have introduced flexible financing models that allow more financial autonomy to health service providers, while providing performance-oriented bonuses to reward service use or quality, mostly at primary care level [63]. These experiences are well known in many African countries, under the categories of performance-based financing (PBF) or results-based financing (RBF). While reviews of experience show mixed results in terms of sector outputs [64-66], these 'pilots' have led to a range of innovations in the use of resources in the sector with, in some contexts, improvements in levels of budget execution, especially at local levels. In Burundi, Côte d'Ivoire, DRC, Rwanda, Senegal, Zambia or Zimbabwe,[21] where this approach is being implemented, resources provided to health facilities - mostly from external resources - are managed directly by facility managers and disbursed according to performance logic, on the basis of a range of predefined sector targets. In these contexts, the major change lies in the fact that facilities were allowed to directly receive funds, while districts or other sub-national levels were typically in charge. In addition, there was significant flexibility in the use of funds, based on quarterly adjustable plans. In general, evidence shows good disbursement rates.

[21] For more details on RBF experiences in African countries see here.

The institutionalisation of such mechanisms has often encountered difficulties, and the development from a 'pilot' to a domestically rooted response requires PFM intervention. In the African countries where they have been implemented, these initiatives have often been designed and developed by the health sector without sufficient collaboration with the finance authorities. The passage entails institutionalised change at both local and central levels. At central level, the integration into budget formulation has been addressed by some countries; Burundi [67] and Rwanda, for example, have included specific budget lines into budget laws securing direct funding for facilities through this mechanism. A similar effort was made in Tanzania to integrate these funds into the budget. A dedicated budget line was introduced to capture these flows under the development budget starting in 2017, although not at the same level of granularity as there is for other activities in the government budget [68]. At local level, institutionalising RBF also means revising regulatory frameworks to allow facilities to access, receive – assuming they have access to banking services – and use funds in a flexible manner. This would, most likely, also require adjustments in reporting system and calendar. This challenge has not yet been taken on board in most African countries where the approach has been developed.

"*Direct facility financing*" is being explored by a few African countries, beyond results-based financing approaches, to enhance access to and effective use of resources for health facilities. Simplifying delivery chains of funds is key to improving budget execution in health. To do this, key local level PFM blockages must be addressed to ensure that resources are equitably allocated in line with needs, and that resources flow to frontline facilities in full and on a timely and predictable basis and that the management and use of resources at facility level is effective. Introduction of direct payments by MOF to districts or facilities removes intermediary steps, although they need to be accompanied by other financial management and reporting reforms, including capacity building.

In Zambia, government funds for the provinces and districts used to be channelled through the MOH and were recorded as "imprest" (advances), with detailed expenditure being recorded when the retirement reports were received. Since 2015, funds have been sent directly by MOF to provinces and districts, with fewer delays. In Uganda, the operational funds for health facilities were channelled through the local government, resulting in delays. Since the financial year 2014-2015, MOF has been implementing 'straight through processing' – a measure that sends funds directly to health facilities, thereby making funds available in a timely manner. In Tanzania, operating costs for facilities are channelled through councils, which have contributed to delays in receipt of funds by facilities. Since 2017, the government has been shifting to direct facility transfers from the health basket fund (Box 5).

Box. 5: Key features of Tanzania's Direct Health Facility Financing (DHFF)

The Government of the United Republic of Tanzania introduced DHFF in 2017 including a shift to output-based payment (PHC per capita payment system) for development partner (DP) investments in the health basket fund (HBF). DHFF HBF joined DHFF for other revenue streams and funds flows including community health fund (CHF), results-based financing (RBF), national health insurance fund (NHIF) for civil servants, other DP funding, and user fees. Related systems strengthening consists of inclusion of health facilities in LGA Chart of Accounts, opening or transferring facility bank accounts to government bank, and implementation of cross-sectoral, interoperable systems extended to facility level including planning and budgeting (PlanRep) and Facility Financial Accounting and Reporting System (FFARS). Key relevant features include:

- Payments are made directly from MOF to health facility bank accounts.
- The system is being introduced countrywide to all LGA dispensaries, health centers and hospital meeting certain preconditions, including establishment of a health Facility Governing Committee and availability of HMIS data, an active bank account and annual facility health plan.
- DHFF refers to all funding streams flowing through facility bank accounts. A focus is integration or harmonization on the purchaser side by unified purchasing framework and payment systems to reduce fragmentation and conflicting incentives for HBF, CHF, and RBF as well as integrating or harmonizing information systems, and on the provider side by unified DHFF management using PlanRep to plan and budget, FFARS to account and report, harmonizing spending guidelines and procurement processes, and increasing facility governing committee and community involvement.
- An essential component is to have good collaboration between the Ministry of Finance, the President's Office for Regional and Local Government and MOH.
- In the first step of direct facility financing for health basket funds the pool or formula for programme allocation by type of service or institution did not change, but the share for dispensaries and health centers (45%-50%) was shifted to output-based payment.
- DHFF for health basket funds also includes a shift to output-based payment specifically Primary Health Care per capita payment system for dispensaries and health centres. The budget neutral formula-based system consists of a base rate or flat fee per facility adjusted for policy objectives or cost differentials. The adjustors comprise three factors: facility utilisation reflecting performance (60%); distance of the individual dispensary/health centre from the nearest fully functional hospital reflecting equity (20%); and service population reflecting need and converting to a per capita payment system (20%).
- The reform represents a shift of health facility planning, budgeting, reporting, and management from councils to the facilities themselves. National planning and budgeting guidelines have been updated and include a financial management module. Facilities prepare their annual plans and budgets by means of a standard template which is then entered into the Government's redesigned 'PlanRep' system which has been converted to a web-based system, standardised across the sector, extended to the facility level, and made interoperable with other basic management systems including LGA and facility accounting systems, and revenue collection system.
- Along with the nationwide star rating system for facility performance, DHFF enables funding to be targeted to improve performance.
- Facility financial management has been strengthened by the introduction of a web-based system FFARS for all health facilities and schools in Tanzania (about 7000 health facilities and 20000 schools). FFARS includes all facility revenue and expenses from all funds flows and many basic financial management functions are strengthened by this system including accounting, reporting, procurement, cash management and bank reconciliation, and internal controls. There is both automated and manual versions of FFARS and facilities can transition from manual to automated version as IT infrastructure and connectivity improve. Health centres have recruited health accountants to support financial management both at the health centre and at the dispensaries in the local area.
- Facilities use DHFF for drugs and are allowed to procure medicines directly from central Medical Stores Department (MSD) and when outside through mechanisms such as prime vendors when MSD is unable to supply it, and Regional framework contracts have been established.
- DHFF systems and processes have been immediately institutionalized although significant external funding is being provided to support the development and introduction of the DHFF system through a strong and supportive donor collaboration including both budget support and technical assistance.

Source: Tanzania Sector Wide Approach reference documents 2017.

As a complement, the use of mobile and digital technology is being explored to make money available to health facilities more rapidly and more easily, and, ultimately, to also improve budget execution. The health sector is making increasing use of mobile and other digital platforms to support and improve delivery of health services in African countries, but there has been little use of the technology in the financial management of the sector. There are clear opportunities for governments to use digitalisation of payments to support more reliable and efficient resource flows and transactions, and to improve accountability [69]. Digitalisation of payments is likely to be especially relevant to the health sector where receipts and payments may be distributed over a wide geographical area, including remote locations with limited if any conventional banking facilities.

4 BUDGET MONITORING AND ACCOUNTABILITY

4.1 KEY ISSUES IN HEALTH

While overall financial transparency is reported to have dropped in Africa, multiple funding flows cause even more complex and overlapping reporting relationships and management systems in the health sector. In the African Region, health budget transparency and accountability is hindered by complexity of funding flows and reporting mechanisms. Weaknesses in the underlying information system for financial management also make it very difficult to monitor the actual use of funds in the sector. The section briefly reviews core issues for budget monitoring in health, and then highlights some of the emerging good practices in this field.

Box. 6: Decline in budget transparency in Africa in 2017

Budget transparency is reported to have decreased in 2017 in Africa, according to the Open Budget Survey 2017 [71]. This survey, published yearly, assesses budget transparency based on the amount and timeliness of budget information governments are making publicly available. Each country is given a yearly score between 0 and 100 that determines it's ranking on the Open Budget Index.

According to the results of the Open Budget Survey 2017, many governments around the world are making less information available about how they raise and spend public money. After 10 years of steady progress by countries, the 2017 survey shows a modest decline in average global budget transparency scores, from 45 in 2015 to 43 in 2017 for the 102 countries that were surveyed in both rounds (scores are out of a possible 100). This is in stark contrast to the average increase of roughly two points documented among comparable countries in each round of the survey between 2008 and 2015.

The reversal of transparency gains is particularly discouraging given roughly three-quarters of the countries assessed do not publish sufficient budget information (defined as a score of 61 or higher), seriously undermining the ability of citizens worldwide to hold their government accountable for using public funds efficiently and effectively. Declines in budget transparency were most dramatic in Sub-Saharan Africa, where the average budget transparency scores fell by 11 points between 2015 and 2017.

Source: [72].

Fragmentation in reporting systems is a systemic weakness of health expenditure across the Region. The situation is enrooted in the multiplicity of funding flows and their associated rules for financial management and reporting (see Chapter 2). For instance, in South Africa in recent years at least six financial systems were being used simultaneously to report on health expenditure [70]. The accounting system was cash-based, with payroll and logistics information kept in standalone systems, none of which could be integrated to facilitate data analysis and reporting for health [3]. In several other African countries, the fragmentation and proliferation of financial management rules, manuals, tracking systems (e.g. in Uganda, they include:

IFMS, Online Transfer Information System [OTIMS], Aid management platform [AMP] and the Integrated Personnel and Payment Systems [IPPS]) has also been noted as limiting both transparency and accountability in the sector [29]. The situation is often associated with the predominance of external funds to fund the sector's activities.

In most countries of the Region, there is no performance-oriented accountability consolidated with financial information, which is now needed. While financial transparency is essential, accountability towards health outputs is critical for monitoring outputs in the sector. Most countries miss the opportunity of consolidating operational and financial performance information into one framework and keep the two separately monitored. Health sector financial reports are typically produced in silos, separated from the performance and activity data in systems such as Health Management Information Systems (HMIS), and from human resources and medicine stock-control systems. Different professional cadres – including health data specialists, human resources officers, pharmacists, economists and accountants – often work in isolation from each other, producing separate and potentially misaligned data and reports. Some countries of the Region have introduced performance-based management approaches that aim to link results with expenditures [40]. However, the design and effectiveness of these approaches vary largely across countries of the Region.[22]

External audit reports do not provide a comprehensive picture of systemic weaknesses in health sector financial accountability. Reflecting the fragmented institutional and budget structures of many health sectors in the Region, multiple audit reports are produced for different audiences, making it difficult to identify key system weaknesses, monitor follow-up of recommendations across the sector, and design and prioritise reforms. Also, official external audit reports are often produced two or three years after the events to which they relate. Their findings become less helpful with the passage of time and result in poor follow-up of recommendations. Where the structure of financial oversight is weakened in this way, sector goals are again threatened. While most external audits focus on compliance with procedures and controls, sector performance audits have provided, in some African countries, a valuable resource but are often not followed through.[23]

4.2 LESSONS FROM POLICY RESPONSES

A recent contribution has been made to improving financial transparency and accountability, while strengthening overall financial reporting, by introducing a standard set of accounting

[22] In many African countries, approaches are typically both high-level – with indicators and targets disconnected from actual sector's activities, and yet complex – with no clear chain of results and link between inputs and outputs, often further complicated by the multiplicity of different performance frameworks used by donor-funded programmes. In addition, the structure of budget allocations operates as a constraint, whereby it is difficult to link achievement of results to inputs-based allocations. While budget documents may analyse resources across multiple dimensions, expenditure reporting is generally more limited, and is typically reported by inputs.

[23] For example, the National Audit Office in the United Republic of Tanzania conducted a primary health-care performance audit to review whether health centres are managed efficiently and whether their performance is appropriately considered when allocating resources [74]. The audit identified key issues and weaknesses and made a series of constructive recommendations [74]. However, follow-up was poor, partly because of the dilution of accountability roles between health ministry and local governments.

principles and requirements in some African countries. While many countries in the Region continue to use cash accounting for their financial reporting, the global benchmark is the set of International Public Sector Accounting Standards (IPSAS),[24] which is being implemented by a number of countries in the Region (including Nigeria, United Republic of Tanzania, and Zimbabwe) and is being considered by several others. While this is a highly technical reform led by MOF, and may involve a move to full accrual accounting, there are two particular areas of opportunity for the health sector. First, IPSAS should provide the impetus for much improved accounting for capital assets such as buildings and equipment. MOH should take the opportunity of IPSAS to draw up a full, computerised national inventory of publicly owned (including donated) health-sector assets and ensure that robust arrangements are in place for updating, monitoring, and reporting from the inventory. Second, IPSAS requires consolidated accounts, which will give a more comprehensive view of income and expenditure through MOH and attached institutions.

While primarily developed for expenditure control, the expanded use of an Integrated Financial Management System (IFMS) in African countries has represented an opportunity to facilitate better accountability, although adaptation at local levels remains a core challenge across countries. The IFMS categorises expenditure data according to a number of potentially relevant fields, such as funding source; programme (or sub programme); cost centre; activity; item (or sub-item). The development of budgets by administrative unit, input code, or programme is no longer an issue of 'either/or'. Multiple permutations are now possible and users can extract reports based on one or more of the fields indicated.[25] While IFMS may improve central government accounting, the complexity of such systems presents challenges for adaptation at district and health facility levels, and in general fragmentation of financial information, still remains [75].[26] Such systems may sometimes be too inflexible in the way they have been implemented to fully meet the needs of MOH, and significant financial management activities may take place using alternative systems (even excel spread sheets), which can lead to errors and misalignments.

The introduction of performance frameworks as part of budget structure reforms is representing a great opportunity to streamline both financial and technical accountability. If the support systems are in place or strengthened, streamlining and consolidating both types of performance information into one framework has proven effective. As noted in Chapter 2, in South Africa where funds are monitored through such an approach, there have been clear

[24] More information is available at: https://www.ipsasb.org/

[25] The extensive coding allows reports to be generated on any of the fields. In general, as well as routine budget code fields for spending unit, economic classification and source of funds, the central government IFMS includes, where it exists, a programmatic field that structures budget lines around objectives, targets, and activities. The effective use of such programme fields requires not only careful thought and design upfront in selecting annual targets, but also striking a balance between detail and flexibility, in reporting expenditure accurately, and in identifying core users of the data who provide the necessary feedback loop to ensure the data is relevant and reliable.

[26] In Zambia, the district health offices that directly manage health facility's resources are not on the government's central accounting system; there are no immediate plans to connect them with that system, a step that would require significant resources both for installation and also in terms of on-going capacity to operate and maintain the system. In view of the need for basic accounting tools to manage funds and to provide assurance for accountability, many of the district health offices are installing an alternative, less complex accounting system with financial support from donors. Similarly, in Namibia and Kenya, lack of flexibility in the use of IFMS led to the sub-national levels not using it as their main tool for reporting, leading to systemic inconsistencies. In the United Republic of Tanzania, where direct facility payments are being implemented, a web-based cashbook system is being developed for facility accounting and reporting [77].

improvements in terms of sector performance reporting and accountability. Similarly, in Burkina Faso, such an approach is being gradually implemented [15]. What is now required is a profound change in culture, putting the relationship between the injected resources and the achieved sector's results at the core of a renewed dialogue between finance and health. Sector resistance should be overcome to effectively enter in this new era that should directly serve an efficient, as well as accountable, path towards UHC.

5 CROSS-CUTTING ISSUES

5.1 FOCUS AND PROCESS OF PFM REFORMS IN THE HEALTH SECTOR

The focus of PFM interventions in health had not always been appropriate to ensure support to efficient service delivery in health. While several PFM reforms have brought general benefits (e.g., better quality of budget proposals in health), these reforms often clashed with sector reforms as a result of a lack of consultation and understanding of country health systems, as well as requirements to bring about more efficient and equitable health spending. Lack of flexibility and a 'one size fits all' reform approach has had limited influence on fixing practical issues of funding flows in the sector, including those related to inefficient and inequitable funds flow fragmentation [13]. Generic PFM reforms that have focused too much on central level interventions (such as the introduction of programme budget or setting up of single treasury account), have not translated to the expected effects at local levels. Changing the budget classification system and appropriation structure does not always result in changes at provider level. A country can have programme-based budgeting, but providers may still face budget execution rigidities. Joint strategic re-thinking is needed between health and finance authorities to design micro-level PFM reforms to fix these problems.

Often, there has been a disconnect between the PFM response and the critical issues in the sector, calling for revisions in reform process design. The imposition of reforms with little consideration for solving problems in the sector, particularly those directly related to delivering services to the population, have sometimes resulted in failure [28]. The design of future reforms should be guided by a systematic analysis of sector's needs. When analysing PFM blockages in the health sector, it is important to look not only at the rules for allocating but also the rules for expenditure and reporting, because a failure to distinguish between these different allocation rules may undermine the sector's efforts to promote more responsive expenditure systems. A better understanding of what is needed to authorise expenditure and what is needed for accounting and reporting, alongside internal controls, will certainly facilitate the introduction of more appropriate expenditure management and accountability practices in the sector.

Central level PFM reforms have often been given priority in the response, while local level obstacles are at the core of health service delivery. Local-level obstacles to PFM reform must be addressed to ensure that public resources are delivered promptly to the health facilities, and also better match payment to priority services with appropriate financial incentives to increase efficiency, equity, and quality. For devolved settings, this also means developing an equitable and easy-to-understand formula for allocating resources, devising an effective

system of financial transfers that supports poorer areas and priority needs, and ensuring that grants are always paid on time and in full. Health facilities in turn will need improved capacity for financial management, while MOH, MOF and their local counterparts must share data and guidance to facilitate the monitoring of health expenditure.

5.2 CHANGE IN ROLE AND MINDSET OF MOH

Various parts of MOH have not always been pro-actively engaged in the design and implementation of PFM reforms in African countries. While they are frequently considered to be the exclusive domain of budgeting authorities, PFM reforms are rarely effective without the active participation of the spending units and their associated planners. To support a better interaction between health and finance authorities, this report suggests three distinct areas of possible engagement for health ministries, that include: (1) be actively aware and up to date on general PFM reforms (e.g., monitoring multi-year budgeting approaches that increase predictability in health financing); (2) contribute to designing and implementing PFM reforms applicable to health (e.g., defining budgetary programmes in health to align budget allocation with sectors); and (3) lead policy development for health specific PFM interventions (e.g., designing regulatory frameworks for financial autonomy of health facilities, in collaboration with finance authorities and local governments) (Fig. 11). More details are provided in the section below.

MOH can be classified as an interested observer in a number of broad PFM reforms that aim to stabilise and better predict the macro-fiscal environment. While the health sector is not the central focus of general PFM reforms, it can benefit from the increased predictability of the resource envelope that stems from improvements to the quality of annual budget projections and the introduction of an integrated MTEF approach into annual budgeting. Health authorities should monitor the advancement of these reforms more carefully. MOH, like other spending ministries, benefits most when they complement these growing strengths by ensuring the quality of the costing and utilisation data when developing sector budget proposals. Health sector should also advocate, and support use of cross-sectoral public finance and Human Resource (HR) management systems strengthened, made interoperable and extended to facility level to enable improvements in management and service delivery (e.g. planning, budgeting, payroll and HR management, accounting, and reporting systems).

MOH should proactively participate in the design of PFM reforms that directly affects health expenditure. Even if it does not directly manage all of the public resources for the health sector, MOH has an overarching responsibility for public health, the delivery of effective health services, and the efficient use of health sector's resources. MOH has a direct role in strengthening and implementing PFM components for the health sector, such as the development of realistic and reliable proposals for the annual health sector budget. With the introduction of budget reform and the transition to programme budgets, MOH should play an important role in defining budgetary programmes. In the most effective reform cases, MOH officers have taken the lead in aligning the programmes' content with sector priorities and plans [15]. No one is best placed.

The health sector should have a leading policy role in a number of PFM interventions that are specific, and sometimes unique, to the health sector. Many PFM reforms should directly target sector-specific issues noted above and link with the health financing reforms focusing on pooling and purchasing aspects. For instance, interventions should aim to increase the spending autonomy of health facilities. MOH should take the lead in designing and developing appropriate regulatory frameworks and, in dialogue, to obtain the buy-in of the finance authorities.

These transitions are more significant than a series of mechanical shifts: they imply a shift in the role and mindset of MOH teams. When ministries transition from being traditional planners to being programmers, they no longer conceive budgets as a series of inputs. Rather, they focus instead on the sector's priorities and its expected outputs. This implies a critical shift in the logic of budget planning, as well as in the management of resources. Ministries may also often become direct managers with accountability for how resources are spent and with implications for internal management systems, or they may take a more regulatory, oversight, and coordinating role, which require different approaches and skills plus good data. As MOH is increasingly being held accountable for results, it is essential that it establishes appropriate measurements and design information systems to monitor them, and that financial information is used to inform future decisions on allocations. These shifts must be thought through and should be implemented in coordination with another important shift. This should take place when governments transfer responsibility for strategic purchasing of health services of benefit packages to insurance/purchasing funds [62], whereby MOH must transform from being direct service providers to being stewards, regulators of purchasers.

Capacity building is a crucial component of these PFM changes in health. Budget reform may bring about changes to the underlying process of managing a health system's expenditure. In addition to raising awareness of the changes to execution procedures, MOH – in addition to the other levels of the health system – often requires significant capacity building in terms of its internal budget, accounting, and monitoring functions. Sector budget officers must be trained to use established PFM policies effectively. MTEFs, IFMS, and performance results can be leveraged to better target allocations. Skills upgrading can lead to better developed and justified health-sector budgets that align with sector priorities. Increasing the legitimacy of the budget will also strengthen the sector's position in the highly political negotiation process. As noted previously, capacity upgrading on overall financial management should include, if not prioritise, front-line facilities.

5.3 SPECIFIC CONSIDERATIONS FOR DECENTRALISED SETTINGS

Health financing arrangements in decentralised contexts are often a source of budget fragmentation at the local level. Subnational authorities (SNA) receive resources from multiple sources, making it complex to prepare consolidated budget proposals, especially within nascent budgeting capacities.[27] Arrangements for allocating central government funds to lower

[27]These sources may include block grants that they are free to allocate to locally determined priorities and sectors; conditional grants that are ring-fenced for specific sectors (e.g., for health or education); other forms of intergovernmental

levels are fundamental to the overall planning of health sector resources; however, they vary widely across the Region.[28] Each type of arrangement presents different opportunities and challenges to MOF and MOH in ensuring the integrated planning, budgeting and reporting of 'health resources'. If local governments are not well prepared from a budgeting perspective, decentralisation can put results at risk. The rapid pace of fiscal decentralisation in Kenya, South Africa, and the DRC, owing to strong political pressures, created challenges for preparing realistic budgets at local level and maintaining appropriate funding to health service delivery [78].

While different approaches have been used to protect health sector priorities and make sure that money is available, appropriately distributed and used, under devolved settings, a practical step-by-step approach is needed to define appropriate financial arrangements. The first step is to devise, and revise, an equitable and easily understood resource allocation formula, which would apply to the entire SNA in the case of a block grant or to the health sector specifically in the case of a conditional health grant. The design of the IGFT– together with the corresponding provider payment system to purchase health services – can have a significant impact on the health spending's efficiency and equity.[29] IGFT rules and approaches are typically determined centrally by MOF. MOH needs to better understand the impact of IGFT design on the health sector and should work with MOF to mitigate potential problems that affect the needs of health services. Second, a structure of fiscal transfers should be devised to support poorer Regions and communities, possibly through equalisation grants, with other supplementary grants such as matching grants for health that can incentivise local health expenditures. Third, grants must be paid out in a timely manner and in full. For this to happen, a simplification of transfer mechanisms must apply up to frontline levels.

Unfinished transition towards decentralisation can create more confusion in health budgeting and spending roles. While practice aligns with frameworks in several African countries, in some others the transition is unfinished and the division of responsibility between central authorities and subnational authorities, and facilities is unclear, including for health budget development and spending. In Kenya , Nigeria, and South Africa which have adopted a fully devolved model, local levels of the health sector have broad authority to make independent decisions for spending financed by own revenue and unconditional grants, which comprise most of the overall funding sources. In Uganda and Burkina Faso, which are closer to de-

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fiscal transfers (IGFTs), such as equalisation grants; project funding or goods in kind from off-budget sources such as NGOs, or external donors; and also 'own source' revenues which they are authorised to collect locally (e.g., property taxes, market stall fees, and licence fees).

[28] For example, some approaches are as follows: a government's health budget may be mainly under the health ministry and flow through that ministry (e.g., Malawi); or held mainly under the health ministry but some funds flow directly from the finance ministry to sub-national governments or health facilities (e.g., Zambia and Uganda) in countries with direct facility financing; or the health budget is divided between the health ministry and sub-national governments but is earmarked at the national level as health (e.g., Tanzania); or it is split between the health ministry and sub-national governments, but at the sub-national level is merged with other sector funding as block grants and is not earmarked for health (e.g., Kenya).

[29] While transfers from central to lower levels may take multiple forms, earmarked grants for specific sectors – including health – may help protect sector's spending and reduce Regional inequalities. Own revenues are generally not prioritised for social sector and captured for other purposes. Prioritisation towards health is generally lower at local level than at the central level. In the DRC for instance, provincial budgets allocated an average of only 4% of their own resources to the health sector in 2010-2014. With the exception of Kenya and Nigeria, where most transfers are unconditional, in most African countries transfers are largely earmarked by the central government for specific sectors. In the DRC, for example, conditional grants are earmarked for health, education, and infrastructure spending. In South Africa, conditional parts of central grants are earmarked for specific health purposes.

concentration , subnational governments have less flexibility to make significant resource allocations decisions, with most transfers being earmarked for specific purposes. In practice, evidence from a study including 18 African countries shows that – even when local governments are effectively assigned the responsibility to finance and deliver health services on paper – in most countries they have little control over local health resources [79]. This lack of local government discretion is particularly true for the management of human resources and associated wage expenditures: it remains the norm for central authorities, including in Burkina Faso or the DRC, and the United Republic of Tanzania, to determine the number and composition of local sector staff positions, to determine the wage rates and allowances paid to local staff, and to control local hiring, firing and promotion.

Simplifying funding flows and budget transfer mechanisms to ensure that health facilities can receive and use funds in a timely and flexible manner should be an important area of collaboration between central finance, health authorities, and local entities in devolved contexts. One cause of delay in receipt of funds by facilities is the involvement of one or more intermediary institutional layers. By improving central government payment systems, it is possible for finance ministries to make direct payments to facilities, as is currently being implemented for some sources of funds in the United Republic of Tanzania (see Box 5 in Chapter 3).

Critical preconditions for such a reform include: 1) including facility codes in MOF Chart of Accounts so they exist in the system thus enabling gradual increases in transparency, autonomy and accountability; 2) ability of health facilities to have bank accounts; 3) improving planning, budgeting and financial management capacity at facilities (e.g., with a simple but standardised cash book, and with an accountant from a larger facility such as a health centre providing back-stopping support to smaller facilities in the same area); and 4) arranging for the finance ministry to share expenditure data with the Ministry of Health to support overall monitoring of health-sector resources.

Figure 11: Action framework for health engagement in PFM reform

6 KEY POLICY RECOMMENDATIONS

Below, we outline five key policy recommendations generated from this report that now need to be implemented across the African Region for countries to tailor their PFM response to the health sector's needs, and better support progress towards UHC.

1. **Ministries of Health should take a more active role in PFM reform design and implementation to make sure reforms better respond to sector's needs**

   While general PFM reforms have been led by finance authorities over the past two decades with generally limited involvement of health sector stakeholders, health has a significant role to play in making sure that PFM reforms are effective for responding to sector needs. To enhance interaction between health and finance authorities, this report suggests three distinct areas of possible engagement for health ministries, namely: 1) A strengthened interest in (and monitoring of) generic PFM reforms to improve predictability and sustainability in the financing of health (e.g., multi-year budgeting approaches); 2) A pro-active role in designing and implementing those PFM reforms that directly affect health expenditure (e.g., definition of relevant budgetary programmes for health); and 3) A direct design and implementation function for health-specific PFM interventions, including with or for subnational levels of government (e.g., financial management flexibility, transparency, autonomy and accountability of frontline providers).

2. **In order to solve PFM challenges in the health sector, the focus and process of PFM reform should be adapted to give more attention to local-level challenges**

   Carefully specifying a country's PFM bottlenecks in the health sector (e.g., limited access to funds for health facilities, mismatch between central budget and health needs, and rigidities in use of funds) is a necessary step towards defining tailored responses. PFM reforms should be better grounded in sector's specificities to enable a more effective response. They should also be better coordinated with other reforms affecting health spending (e.g. strategic purchasing reforms) to ensure consistency and to maximise effects. More careful attention should be given to local-level obstacles to ensure public resources are delivered promptly to the health facilities that need them. Frontline health facilities require transparent and equitable arrangements for receipt of resources, as well as tools and capacity to manage and account for the use of resources. Health facilities in turn will need improved capacity for financial management, while MOH, MOF and local counterparts must share data and guidance in order to facilitate monitoring of health expenditure.

3. **Institutionalising well-defined budget structure reforms in health should be accelerated through enhanced coordination between finance and health authorities**

Most African countries have not yet institutionalised budget structure reforms, creating disconnect between budget formulation and expenditure management. Building on country experiences and lessons learned, it is becoming increasingly clear that the health sector can incrementally accelerate implementation of budget reform in the Region. Priority interventions from a health sector perspective could consist of moving towards budgetary programmes that pool public resources according to key sector priority goals; increasing the spending flexibility of the sector's fund managers responsible for programme implementation; developing a framework to provide financial autonomy to frontline providers while strengthening their financial management capacity; strengthening and consolidating performance monitoring frameworks for better sector accountability; and using performance information to support future budget decisions for the sector. Giving priority to these budget reforms in health will also be likely to help reduce PFM distortions and the development of parallel systems as development partners push to limit fiduciary risks for their investments. However, badly defined budgetary programmes can be detrimental to the sector's spending. In countries that have initiated the transition, more focus is needed on defining and refining well-aligned programmes that can be operationalised.

4. **Better understanding the root causes of budget under-execution in health is a key priority to define and implement corrective actions with the view to optimise the use of resources**

   While many countries have introduced generic measures to improve budget execution, such as the devolving and simplifying of expenditure control to health authorities, a better understanding of the root causes of health under spending from both the health and finance sides is urgently needed in each country. Findings from this report should help countries decipher the different types of causes and lead the development of priority actions, involving expenditure and cash management systems as well as possible upstream reforms linked to how budget allocations are prepared, formulated and costed. This will require strengthening collaboration channels between health and finance.

5. **Countries and development partners should prioritise the strengthening of PFM capacities in the health sector – from top to bottom.**

   Engaging more effectively in the design and implementation of PFM reform requires an institutional and cultural shift in health ministries. These transitions are more significant than a series of mechanical shifts. PFM change is about people and behaviours. While most PFM reforms have been dominated by the introduction of new procedures, tools, and frameworks, more attention needs to be put on people's skills, responsibilities, accountabilities, motivation, and rewards. Transition from traditional planning by inputs to programming and being accountable for health results requires long-term upgrading of MOH staff at all levels, in which countries and development partners should invest. Capacity building on PFM for sector stakeholders has been an overlooked aspect of these reform processes and should be re-prioritised. To serve that goal, development partners are encouraged to mainstream the strengthening of PFM systems in their health sector operations to maximise the development of local capacities towards stronger PFM systems in health. Pilot operations have started to include some PFM components as part of their sector operations; they should be mainstreamed to become a systematic practice

for all new health sector operations developed by multilateral banks or bilateral partners in the Region.

Going forward, the reforms required will need input from a range of stakeholders, from top to bottom of health systems, and political commitment from both finance and health leadership. Political commitment will need to be backed by funding, resources, and technical expertise in African countries developing their PFM systems. The WHO's Department of Health Systems Financing and Governance and the WHO Regional Office for Africa Department for Health Systems – and all stakeholders involved in this area – are committed to pushing this agenda forward and support countries implement a tailored PFM response in support of their progress towards UHC.

7 ANNEX

Table 3: Quality performance monitoring framework of programme budget in health: the example of South Africa

Objective Statement	Performance Indicator	Actual Performance			Estimated performance	Medium-term targets		
		2017/18	2018/19	2019/20	2016/17	2013/14	2014/15	2015/16
Improve district governance and strengthen management and leadership of the district health system	Number of Districts with management structures in line with the National Guidelines	New Indicator	WISN process and normative guidelines for PHC facilities have been completed	The draft District Health Management Office structure and job profiles was finalised	Uniform structure for District Health Management approved	National Guidelines for District Health Management Structures approved	52 Districts audited against the approved guidelines	Implementation lan in place to arrive at 52 Districts with District Health Management structures in line with the National Guidelines
	Number of PHC facility committees assessed to determine functionality	New Indicator	Implementation plan approved and Monitoring and evaluation system developed	1588 PHC facility committees assessed to determine its functionality	1200 PHC facility committees assessed to determine its functionality	2000 PHC facility committees assessed to determine its functionality	2500 PHC facility committees assessed to determine its functionality	3400 PHC facility committees assessed to determine its functionality
Improve access to community based PHC services	Number of functional WBPHCOTs	1063 functional WBPHCOTs	1748 functional WBPHCOTs	2590 functional WBPHCOTs	2000 functional WBPHCOTs	2000 functional WBPHCOTs	2000 functional WBPHCOTs	2000 functional WBPHCOTs
Improve quality of services at primary health Care facilities	Number of primary health Care facilities in the 52 districts that qualify as Ideal Clinics	New Indicator	New Indicator	322 facilities qualifying as Ideal clinics	Additional 750 primary health Care facilities in the 52 districts qualify as Ideal Clinics	1000 primary health Care facilities in the 52 districts qualify as Ideal Clinics	1500 primary health Care facilities in the 52 districts qualify as Ideal Clinics	2823 primary health Care facilities in the 52 districts qualify as Ideal Clinics
Improve accessibility of Primary Health Services to people with physical disabilities	Proportion of PHC facilities accessible to people with physical disabilities	New Indicator	New Indicator	New Indicator	25% of PHC health facilities	35% of PHC facilities accessible to people with physical disabilities	50% of PHC facilities accessible to people with physical disabilities	70% (of 2823) of PHC facilities accessible to people with physical disabilities
Improve quality of services at District Hospitals through the Ideal District Hospitals Programme	Ideal District Hospital Framework	New Indicator	New Indicator	New Indicator	New Indicator Ideal District hospital framework drafted and presented to NDHSC	More than 75% of patients after AMI receive acetylsalicylic acid, betalockers and statins	Ideal District hospital framework Implemented at 25% of District Hospitals	

Source: Ministry of Health, South Africa

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