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Improving Health Budget Execution: Learning from Country Experience

LOCAL HEALTH SYSTEM SUSTAINABILITY PROJECT

Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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Acronyms

APA	Annual Performance Agreement
COVID-19	Novel Coronavirus 2019
IBAS++	Integrated Budget and Accounting System
JLN	Joint Learning Network
KPI	Key Performance Indicator
LHSS	Local Health System Sustainability
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOF	Ministry of Finance
PEFA	Public Expenditure and Financial Accountability
PBB	Program-based Budgeting
PBMIS	Planning and Budgeting Management Information System
PFM	Public Financial Management
TA	Technical Assistance



1. Introduction

Poor budget execution—money not spent or not spent in alignment with national health priorities—leaves resources allocated to the health sector unused or not used where they can bring most benefit. It therefore undermines the ability of ministries of health (MOHs) to increase service and population coverage. Improving budget execution can increase the impact and overall level of resources used for health and can potentially free up additional resources for health, as it is often a pre-condition for ministries of finance (MOFs) to increase budget allocations.

Poor health budget execution is often attributed to low absorptive capacity of the health sector but may also be deeply rooted in a country’s public financial management (PFM) rules and processes. PFM systems may lack the flexibilities the health sector requires to encourage successful budget execution. In addition, both MOHs and MOFs may not utilize all the available PFM attributes or functionality, at the expense of service delivery and program results. Ultimately, root causes of poor budget execution are shared between the finance and health authorities.

While normative guidance for addressing these causes is well documented, practical advice for MOHs about how to adapt and implement this guidance to improve budget execution in their unique country environments is lacking. There are steps MOHs can pursue to improve budget execution while longer-term PFM reforms are undertaken, and MOHs in some countries have identified promising practices. Documenting and sharing these practices, with a focus on the practical steps involved, can benefit other countries that want to accelerate progress in health budget execution.

The [USAID-funded Local Health System Sustainability Project \(LHSS\)](#), in collaboration with the [Joint Learning Network for Universal Health Coverage \(JLN\)](#), launched the **Health Budget**

Execution Learning Exchange to understand and address poor health budget execution from the perspective of MOH practitioners. The aim was to identify and share promising practices to improve health budget execution while national efforts to strengthen general PFM systems are ongoing. The learning exchange was a time-limited, facilitated platform to share promising practices, jointly problem-solve, and generate lessons and solutions. Eight countries were selected to participate as learning partners based on their expression of interest.

- Learning partners**
- Bangladesh
 - Ghana
 - Kenya
 - Lao PDR
 - Liberia
 - Malaysia
 - Nigeria
 - Peru

The learning exchange meetings were followed by technical assistance (TA) to two participating countries—Lao PDR and Peru—to support teams to identify promising practices that they would like to adapt for their own countries, and to co-develop and agree on incremental implementation steps that teams could apply with LHSS support and carry forward after the end of the project activity.

This knowledge product presents key learnings from a review of the literature to identify examples of successful MOH efforts that have led to increased health budget execution, learning exchange meetings, and country-specific TA support. In the next section, we summarize the activity implementation process. This is followed by summaries of literature review findings and learning exchange outcomes on health budget execution; a shared vision of good health budget execution; and learning and promising practices in the areas of budget structure and processes and budget accountability. Next is a description of TA provided to two learning partners—Lao PDR and Peru—and, finally, a synthesis of key learning from the activity.

2. Activity Implementation Process

Literature review. The activity began with a literature review that examined normative guidance and country experience with efforts to improve health budget execution. The review yielded plentiful normative guidance on technical aspects of health budget execution, but little detail about practical steps countries could take to implement this guidance. Partners including the World Health Organization, the World Bank, and the Organization for Economic Cooperation and Development have been documenting the challenges and causes of weak PFM and its impact on country progress toward universal health coverage. This guidance was shared with learning partners and used to help develop a technical framework to guide the learning exchange. The most useful resources are listed at the end of this report.

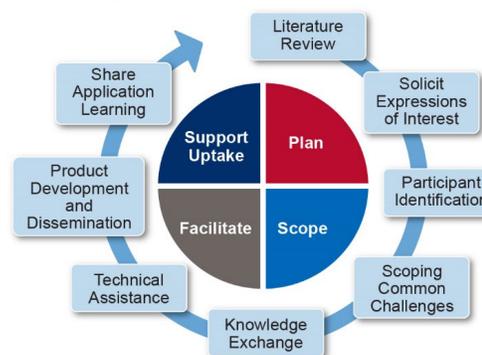
Learning exchange. LHSS built on lessons from previous JLN in-person learning exchanges to develop a virtual approach to facilitate cross-country dialogue and information sharing on common interests and learning needs. This represented a pivot from the original activity design, which called for in-country data collection and technical support for generating country case studies, to a virtual, demand-driven approach that could achieve activity objectives while adhering to COVID-19 restrictions.

Key steps in the learning exchange process included:

- Assess country interest by issuing an invitation for countries to submit expressions of interest and nominate teams of MOH officials to participate in meetings
- Gather country-specific information through a survey and scoping calls with the eight country teams on each country's health financing and PFM context
- Co-develop a technical framework, with country teams, using the literature review and information from the survey and scoping calls
- Use the technical framework, at a launch meeting, to establish a common understanding of key terms and agree on the focus of learning exchange meetings
- Facilitate two virtual meetings focused on topics prioritized by the countries

The TA process for Lao PDR and Peru. To support implementation of promising practices, LHSS built on the learning exchange to provide TA for implementation in two participating countries. Lao PDR and Peru expressed interest in a six-month TA and implementation support process. The key focus was identifying and beginning to implement first steps that could lead to improvement in budget execution. The first step enables both promising practice implementation and links to longer-term PFM or health financing reforms including strengthening pooling and purchasing arrangements. Without TA and its direct investment in the dynamics of implementation, it will be harder to implement and refine the promising practices as they can be complex, multi-faceted, and multi-layered at the country level.

Figure 1: Steps in the learning exchange





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Key steps in the TA process for both countries were:

- Collect additional information to better understand challenges in each country
- Analyze country information and normative guidance to prioritize promising practices
- Identify small incremental steps toward promising practices that country teams can implement with support from LHSS technical experts. Global experience of funds flow fragmentation and service provider management were entry points to help countries identify challenges impacting health budget execution as well as rapid improvement opportunities
- Implement TA through a combination of on-the-ground local consultant and remote international expertise



3. Understanding Good Health Budget Execution

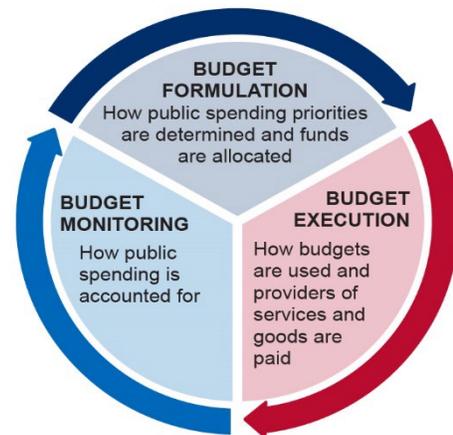
Health budget execution refers to the processes supporting the flow of funds from a government’s treasury to the MOH and other governmental health units, including service providers (sometimes called “spending units”). Budget execution forms part of the PFM function that supports the purchase of health goods and services (Figure 2). Health budget execution is a function of both government-wide PFM and health sector-specific processes and in addressing budget execution, MOHs are typically working within the health financing frameworks they have defined, while grappling with PFM frameworks that non-MOH actors have defined (Cashin et al. 2017).

There is broad consensus in the literature on what constitutes good health budget execution and what causes poor health budget execution. Characteristics of good budget execution go beyond a high year-end execution or spending rate to include:

- Good relationships between elements of the PFM cycle including budget formulation that is linked to national health priorities and budget monitoring
- Realistic budgets and no substantial differences (defined in the Public Expenditure and Financial Accountability (PEFA) framework as 15 percent or more¹) between budget enacted and budget implemented, except those required for legitimate purposes with modifications approved through established legal processes (PEFA 2016)
- Transparency in how the budget is spent to enable program results and control fraud and corruption (Allen and Tommasi 2001, Addison 2013)

Good budget execution is not easy to achieve. Budgets are rarely implemented exactly as approved and over- and under-spending are often observed to occur simultaneously (Allen and Tommasi 2001). Underspensing tends to be greatest in low- and middle-income countries and related largely to challenges around procurement and execution of donor funds (Dener and Saw Young 2013). MOHs may struggle to execute the budget if it is not a credible plan for the collection and use of public funds. Even where budgets are credible, deviations may arise from necessary policy adjustments, changing economic conditions, or because of inadequacies in the financial management and implementation of the programs to be financed with the budget (Simson and Welham 2014). The COVID-19 pandemic has also shown the necessity for flexibility, in even the most credible budgets, to respond to national emergencies.

Figure 2: Budget execution in the PFM cycle



Source: WHO (2017).

¹ A 15 percent deviation from the approved budget (i.e. spending at less than 85 percent or more than 115 percent) is considered inadequate and receives a D score in the PEFA methodology while a 5 percent deviation (i.e. spending at less than 95 percent or more than 105 percent) receives an A score.

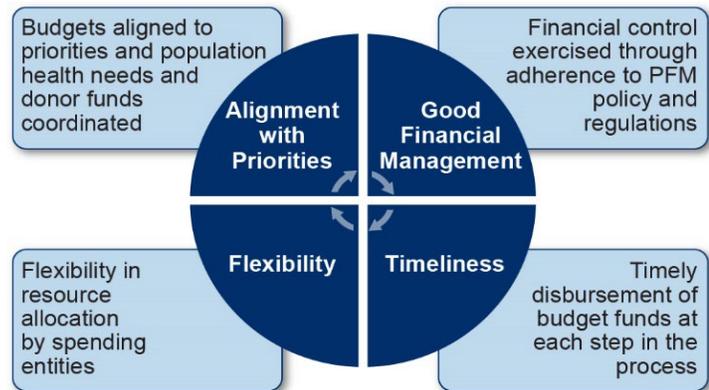


The literature describing country experiences shows that national health sectors face similar sector-specific challenges that lead to sub-optimal budget execution: for example, aligning health financing needs and approaches with national health priorities and PFM systems; lack of health financing and PFM capacity at all levels; fragmentation in the flow of funding; and balancing flexibility for spending agencies with appropriate levels of accountability (Cashin et al. 2017, Barroy et al. 2018). Funds flow fragmentation is a near universal issue that can exacerbate the impact of other technical, operational, and political issues on health budget execution. Domestic and development partner funds flow to health services through a variety of pooling and purchasing arrangements, characterized by different provider payment systems, PFM rules, and spending units. Understanding the consequences of fragmentation at the point-of-service or provider level can help identify entry points to improve budget execution.

3.1 Learning partners' shared vision for good health budget execution

LHSS used findings from the literature review to develop the technical framework that guided learning partner discussions. Many of the factors influencing budget execution that emerged from the literature review were also reflected in learning partners' own country experience. Learning partners agreed that good budget execution requires alignment of budgets to national priorities, sound financial management with controls exercised through adherence to PFM policy and regulations, flexibility for spending agencies to allocate resources to meet health priorities and emerging needs, and timely disbursement of budget funds at each step in the process. There can be a tension between some of these factors. For example, rigid spending rules designed to ensure strong financial management can prevent reallocation in response to changing needs. Figure 3 summarizes countries' consensus view of good budget execution.

Figure 3. Learning partners' shared vision for good budget execution



The partners further identified the four sets of factors, described below, that combine to create an enabling environment for good health budget execution, along with factors that are currently inhibiting their progress toward this enabling environment.

Legal and regulatory frameworks. Learning partners agreed that an enabling environment for good budget execution requires clear, fit-for-purpose PFM laws, accompanying guidelines to support the health sector's compliance with PFM laws, and capacity at the national and subnational levels to carry them out. Currently, however, health sectors face challenges that include rigid PFM laws and regulations that limit flexibility for spending institutions to use resources efficiently, as well as non-existent or inadequate guidelines.



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Text Box 1. Institutionalizing explicit processes for setting national health priorities: learning from country experience

A separate LHSS and JLN collaboration has explored country experiences with institutionalizing explicit priority setting in the health sector, to facilitate peer learning and sharing of promising practices. One area prioritized for learning by participating countries was how to ensure that priorities are linked to plans and budgets.

Priority-setting systems and processes. Priority-setting systems and processes that enable good budget execution were defined by the learning partners as those that ensure planning and budgeting are aligned and that budgets reflect priorities identified by a range of stakeholders through a consultative process. Currently, there are challenges with budget formulation processes that are cumbersome and de-linked from planning processes. These issues have also been identified in a separate LHSS Learning Exchange on Health Priority Setting (Text Box 1).

Budget structure, systems, and processes. Learning partners agreed that a program-based budget structure leads to better alignment of budgets with priorities and that automated processes facilitate timely release of funds. Program-based budgets strengthen health budget execution by setting out objectives and providing spending units with incentives, flexibility, and improved management processes to execute their budgets to achieve those objectives. Currently, however, several countries continue to formulate and execute budgets according to input-based line items rather than programs. A key rationale to shift to program-based budgeting (PBB) and payment is that it is very difficult to match input-based budgets to health service priorities. However, a shift to program-based budgets in budget formulation without a corresponding shift to program-based or lump-sum payment in budget execution can be confusing and counterproductive as input-based or line-item budget payment may not match the budget programs.

Accountability. Learning partners agreed on four key components of accountability for budget execution (Figure 4): clear expectations and goals for both financial management and program management; processes that integrate diverse stakeholders into health priority setting and budget formulation; information technology infrastructure that enables monitoring of spending against health priorities and PFM objectives (ideally linked with government-wide financial management systems); and clear consequences for spending units for not meeting defined objectives. Accountability for good budget execution requires appropriate roles and responsibilities across the national, subnational, and service provider levels. The partners also agreed that automated accounting and financial reporting is needed to facilitate in-time monitoring. In practice, however, most of the participating countries face inefficient manual monitoring systems with poor compliance and accountability and a lack of transparency.

Figure 4. Accountability for “good” health budget execution



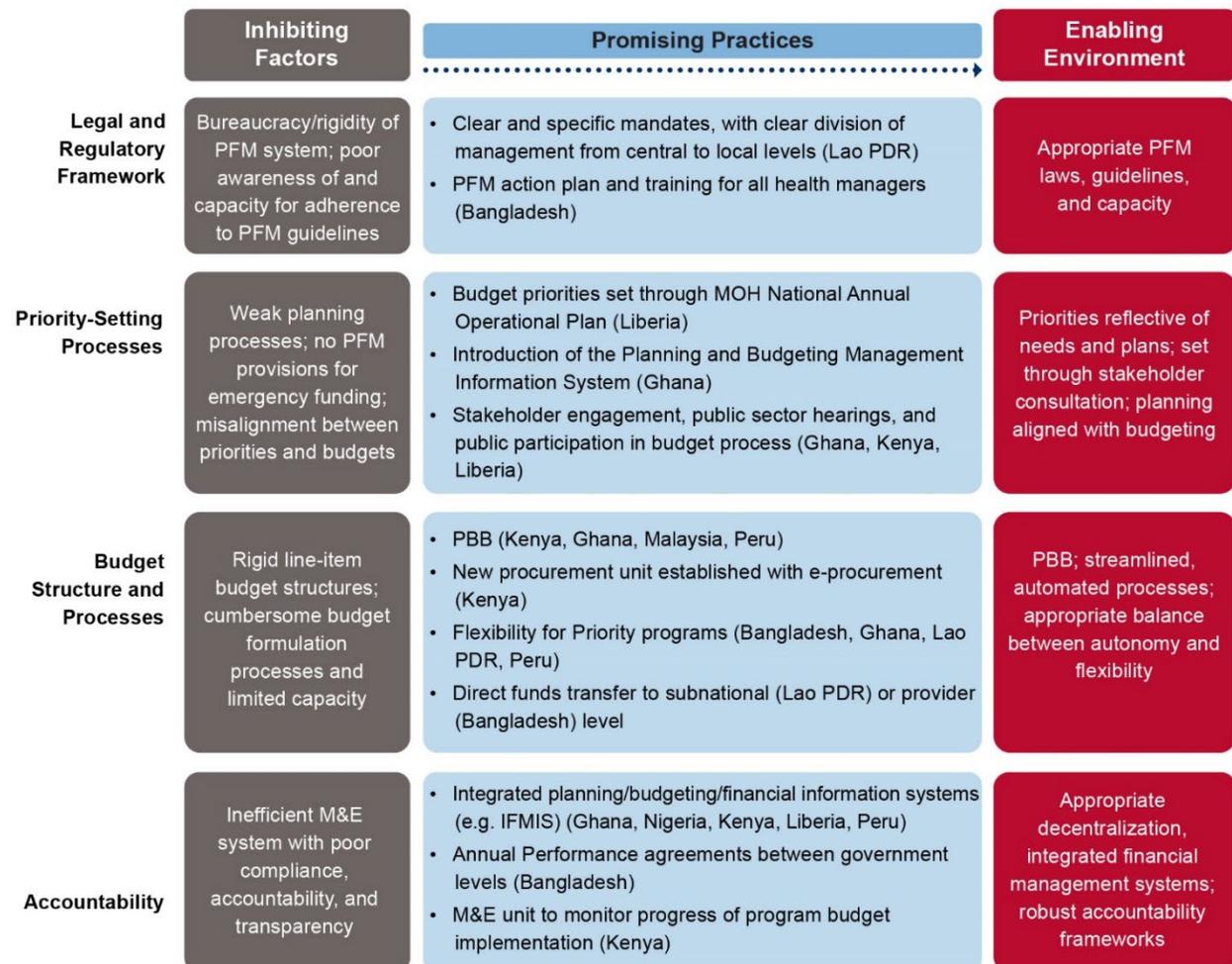


4. Promising practices

Building on this agreed framework, the learning partners shared promising practices to move beyond the challenges identified above and make progress toward an enabling environment for good health budget execution. For example, participants from Ghana, Kenya, and Liberia shared innovative ways to engage stakeholders in the priority-setting process to ensure priorities reflect the voices of a wide range of stakeholders. Participants from Bangladesh and Lao PDR shared good practices streamlining the flow of funds from the central to the subnational level, and Peru shared an example of strategic prepayment of health care providers under the national health insurance program. These practices are documented in the LHSS [blog series](#) on the learning exchange.

Figure 5 summarizes promising practices across the eight learning partner countries. This is followed by summaries of the learning from two learning exchanges focused on budget structure and processes, and accountability.

Figure 5. Summary of learning partners’ promising practices to move to an enabling environment for health budget execution



Note: M&E=monitoring and evaluation

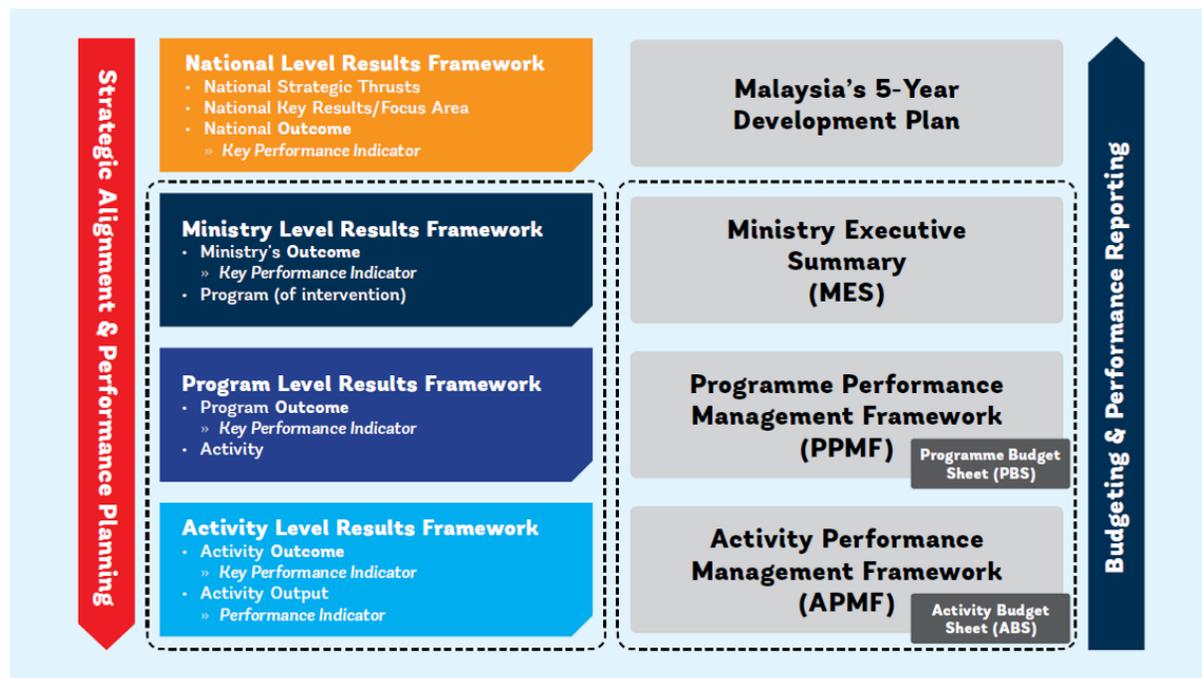


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Budget Structure. To move toward more flexible budget structures, some countries from the learning exchange have moved to PBB. Kenya has implemented PBB since 2000, first through a centralized system and subsequently through a devolved government system. Kenyan MOH representatives in the learning exchange explained that identifying key performance indicators (KPIs) and targets for programs are important, and that pre-requisites for PBB are good data and planning capacity for devolved spending units so that they can understand the KPIs set for their programs, plan the outputs that will be needed to achieve those KPIs, and understand the costs to budget the necessary resources. Surveys were conducted for key programs to understand baselines and set targets. In Kenya, PBB has helped to prevent programs becoming stalled due to a lack of resources because PBB ensures that all program costs are budgeted and funded. Malaysia has made incremental steps toward outcome-based budget formulation and execution since the 1970s with a full transition to outcome-based budgeting in 2013.² (See Text Box 2 for more details.)

Text Box 2. Promising Practice: Improving the Budget Structure through PBB in Malaysia

To strengthen alignment between the national strategy and program budgets, the Government of Malaysia used results frameworks (see Figure 6) and performance agreements to ensure that spending units understood the outcomes they had to achieve. The flexibility that PBB and its related budget execution provide has helped find savings while achieving health objectives. Malaysia invested gradually in an IT infrastructure, starting from manual Excel-based systems and moving toward the MyResults information system that maps all programs and program activities and their results frameworks.



Source: Malaysia Ministry of Health (2022)

² Different countries may use different terminology, but output-based or program-based budgeting all share a focus on linking budgets with results to ensure that resources are used to achieve health priorities.

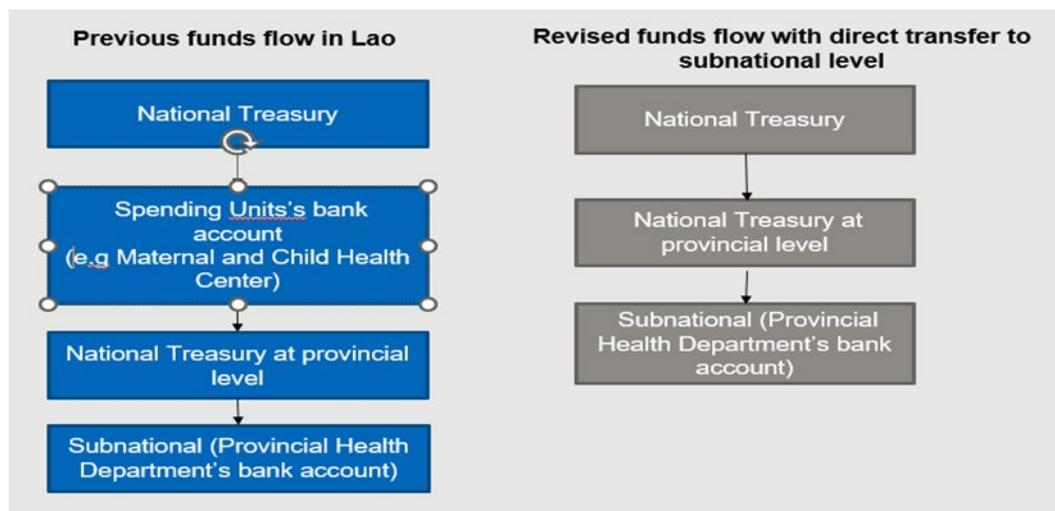


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Budget Processes. Simplifying disbursement of funds and strengthening procurement were prominent approaches to streamline cumbersome budget execution processes among the Learning Exchange countries (Text Box 3). In Kenya, a government-wide procurement unit and e-procurement system for goods and services have been established to fast-track purchases. In Nigeria, a Single Treasury Account system is used to pay salaries in a timely manner.

Text Box 3. Promising Practice: Streamlining Budget Processes through Direct Budget Transfers in Lao PDR

In Lao PDR, health budget funds for priority health programs are transferred directly to the subnational level, eliminating the need for funds to pass through the central MOH (see Figure 7). Direct transfers have helped to reduce delays in disbursements, enabling providers to purchase what they need in a timely manner. The Lao PDR example highlights that relinquishing some national-level controls to give more responsibility to subnational level spending units can improve financial management. At the same time, it requires efforts to strengthen the capacity of subnational level to plan and spend their budgets in compliance with the national PFM rules and, importantly, to report on their financial and technical performance so that the national level can understand challenges.



Source: Lao PDR Ministry of Health (2022)

Budget accountability. Promising practices were identified by Ghana and Bangladesh (Text Box 4), which have both introduced new systems that increase accountability for stronger health budget execution. The Bangladesh approach paired a communications tool with a measurement tool, linking the communication of health priorities with the system, tools, and capacity to measure and track those priorities. Ghana developed two new information systems and used them to integrate health data systems with financial management data systems to facilitate better monitoring of performance trends, budget planning, and budget advocacy for specific health priorities.



Text Box 4. Promising practices for budget accountability

Integrated Financial Management Systems to Monitor Budget Execution in Ghana

Ghana developed two new systems: the Planning and Budgeting Management Information System (PBMIS) and the Ghana Integrated Financial Management Information System and used them to integrate health data systems with financial management data systems to facilitate better monitoring of performance trends, budget planning, and budget advocacy for specific health priorities. The PBMIS is used to generate budget management and implementation reports to monitor budget execution and as a basis for negotiations with the MOF. Ghana invested in broad stakeholder engagement to obtain buy-in for the new system and strengthened the capacity of subnational spending units to use the PBMIS. The MOH ensured that the PBMIS was aligned with other health sector management systems (for example, District Health Information System 2 and Health Sector Scorecards) to compare budget execution with key output indicators, and developed an offline version to make the PBMIS more accessible in remote areas.

Using Performance Agreements to Strengthen Budget Execution in Bangladesh

Bangladesh introduced the Integrated Budget and Accounting System (IBAS++) and implemented Annual Performance Agreements (APAs). IBAS++ is a decentralized, automated system to support budget formulation, execution, and monitoring, and to track the implementation of government priorities. APAs are a results-oriented performance evaluation system that is used to establish, communicate and align with priorities and objectives. Results are measured by an automated system to objectively evaluate performance. APA implementation helped Bangladesh move toward a culture of accountability and transparency linked to the achievement of results rather than simply implementing required processes. The APAs and IBAS++ have improved quarterly monitoring and evaluation of health budgets, timeliness of health budget transfers and utilization, and government capacity to effectively decentralize fiscal responsibility by enabling subdistricts to use these systems.



5. Applying Promising Practices: Experience from TA in Peru and Lao PDR

At the end of the learning exchanges, learning partners identified their priorities for TA support, including promising practices that could potentially be adapted and advanced in their country contexts. The broad TA areas discussed across learning partners were: strengthening health sector PFM capacity, particularly at subnational levels; supporting transition to PBB; improving the use of health information systems; and enhancing engagement between MOHs and MOFs. LHSS provided TA to Peru and Lao PDR to select, adapt, and apply the promising practices shared by participating countries. The objective was to work with country teams to identify small implementation steps that they could implement with LHSS support and continue after the end of the activity.

A virtual kickoff meeting for TA support brought together Lao PDR and Peru for a workshop focused on factors that impact in-country implementation of promising practices to improve health budget execution

The workshop focused on two potential entry points to support country implementation of promising practices: the challenges arising from funds flow fragmentation and the opportunities to improve service provider financing and management.

The relationships across or within fragmented funds flows are usually productive places to focus budget execution strategies and sequencing. Different funds flows—for example, for salaries and recurrent costs or national or subnational funds—can have different management systems and processes for planning and budgeting, provider payment, procurement, accounting, financial reporting, or monitoring, exponentially multiplying the inefficiencies and administrative burden associated with less-than-optimal budget execution. Some of the resulting challenges and potential solutions that were discussed as part of the TA process are set out in Table 1.

Enhancing the role of service providers, for example by establishing public service providers as management entities rather than MOH or local government “spending units,” can improve PFM and budget execution by separating functions such as authorization and payment to increase transparency; improving plans and budgets; shifting to output-based payments with associated delegation of rights to determine the best mix of inputs and procure them; and enabling better accounting and reporting for service provider funds.

There is a powerful relationship between funds flow fragmentation complexities and service provider management opportunities as the impact of fragmented plans, budgets, payment, and administrative and financial management procedures is felt most acutely at the service provider level, where human resource shortages also tend to be the greatest.



Table 1. Problems stemming from fragmented funds flows and potential solutions discussed by Lao PDR and Peru

Problem	Potential solution
Separate flows for health worker salaries (usually general revenue direct from MOF) vs. non-salary recurrent costs for health service delivery (general revenue or payroll tax often through a health purchaser)	More pooling of funds, unifying provider payment systems across funds flows, changes in human resource allocation processes, or PBB encompassing both salary and non-salary costs
Separate flows for MOH input-based budgeting or payment vs. health purchaser PBB or payment to purchase a benefit package entitlement	More pooling of funds, unifying provider payment systems across funds flows, PBB, or harmonize PFM systems, rules, and practices
Separate flows for national level (MOH, MOF) vs. subnational funds with conflicting health financing or PFM systems, rules, or processes	More pooling of funds, unifying provider payment systems, or harmonize PFM systems, rules, and practices

5.1 Lao PDR

LHSS TA to the Department of Finance of the MOH of Lao PDR built on the promising practice described in Text Box 3, which aims to simplify funds flow from the National Treasury to the subnational level. The objectives agreed by LHSS and the Lao PDR country team during remote working sessions were to develop implementation steps and/or mitigation measures to protect against any unintended consequences of promising practice implementation, and to envision longer-term strengthening of health financing and PFM to improve budget execution. The first short-term implementation step is to use the health PFM guideline as a mechanism to strengthen health sector planning to ensure that provincial health departments improve their planning and program reporting to the central-level MOH. As provincial health departments take their guidance on health programming from the MOH, strengthening the national, provincial, and service provider planning process will serve to keep decision-making within the health sector, mitigate risks of losing control of funds, better match budgets to health priorities and plans, and improve both budget execution and management of service delivery

Remote assistance via four virtual meetings in May, July, August, and September 2022 helped Lao PDR to develop steps to improve MOH planning and program reporting

LHSS TA focused on supporting the MOH team to:

- Review the recently introduced reform to transfer funds for priority health programs directly from the National Treasury at the central level to the National Treasury at the provincial level, eliminating the transfer to the central-level MOH. The team examined the relative advantages of reducing PFM barriers and delays and the risk that the health sector would lose control of programming and oversight of funds.
- Consider revising the existing PFM guidelines for the health sector to incorporate the MOH planning process to clarify/codify MOH responsibility for health policy, priorities, and plans that drive budget formulation and execution and improve the balance between financial control and program and service delivery results and impact. The revisions would support



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clear, precise health plans that enable provincial health departments to prioritize funding for the right programs and services and standardize planning to speed up authorization and improve budget execution.

- Explore a gradual shift to PBB and/or program-based provider payment, with PFM systems and processes realigned to improve budget execution and the balance between financial control and program results. This longer-term approach of moving to PBB would mean delegating planning and budgeting responsibility to providers, with the national health programs aggregating the plans and budget as well as providing capacity-strengthening support to providers.

By the end of the TA progress, the Lao PDR Team agreed on a next step of initiating movement toward development of annual service provider-level plans to both improve facility management and mitigate the administrative burden of fragmented top-down vertical disease program planning. Greater involvement of the health providers will make them more visible and empower them to be vested in achieving national health priorities. It is expected that this first implementation step will ripple into broader reforms including program budgeting and purchasing health services through output-based payment.

5.2 Peru

LHSS support for Peru included remote sessions with an international PFM expert as well as in-country support through a local consultant.

Remote TA focused on implementation steps that encompass addressing fragmentation complexities and taking advantage of the opportunities inherent in improving service provider management. Peru funds flow fragmentation and associated differences in health

planning, budgeting, and provider payment exist both within MOH programs and across MOH general revenue and social health insurance/social security funds flows for health services. This fragmentation and lack of flexibility in standardized PFM rules, systems, and processes contribute to operational difficulties and capacity challenges at the subnational level that hinder budget execution.

A remote TA session on “Improving Budget Execution in Peru: Role of Health Facilities in Strengthening Subnational PFM, Health Purchasing and Service Delivery” used the example of direct facility financing in Tanzania (WHO 2020) to discuss improvements in health facility planning and accounting systems. Participants reflected on the benefits of involving facilities in planning and budgeting, and the potential to address funds flow fragmentation by harmonizing systems or possibly even moving general revenue funding towards output-based payment and contracting as has been done for social health insurance/social security.

Over eight months, LHSS’s local PFM consultant worked closely with a team of MOH technical officers to design an approach to strengthen subnational PFM capacity that could become part of an institutionalized improvement cycle with benefits for budget execution and PFM more broadly. The team began by developing and administering a rapid assessment to identify subnational and service provider-level PFM barriers or rigidities that can be incorporated into ongoing national PFM and health financing reform. The rapid assessment revealed that budget programming is seen as ineffective at defining and funding health priorities, requiring significant effort without providing value for the budget management process. Other challenges include

In-country TA helped the Peru MOH Budget Directorate to understand budget execution bottlenecks and address priority capacity needs in a sustainable way



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high levels of political turnover, insufficient budget management specialists at the regional level, and limited flexibility for service providers to modify budgets.

With LHSS support, the MOH team developed two official government documents that the MOH Budget Office will use to guide its ongoing work to improve budget execution:

1. A **Health Budget Management Guide** that summarizes the main rules and procedures for budget management within the framework of the national budget system of Peru. The guide aims to improve the effectiveness of multiyear budget programming, linking it to policy priorities and negotiation of additional funding for three-year periods. It will serve as a reference for the daily work of regional government officers and as reference and induction material for all incoming staff of regional public agencies and decentralized MOH bodies.
2. A **Capacity Strengthening Strategy for Budget Management** that establishes the objectives and main lines of action for improving the capacity of health budget managers, both at the national level and in regional governments, to improve the execution and quality of public spending on health.

LHSS-supported training and workshops focused on the responsibilities of the MOH Budget Directorate in projecting funding needs, establishing the parameters of resource use, and developing the regulatory framework that governs all regional budget executing units. The team mapped the sector budget management system and the factors, actors, and roles that influence performance—including government policies—to understand the implications of their decisions and the strategic and operational potential of the Department of Budget and regional governments. The junior budget specialists and senior health finance specialists who participated in the LHSS-supported training program have formed a multidisciplinary community of practice in the management of Financing for Universal Health Coverage (FICUS).

After the end of LHSS support, the MOH Budget Office plans to continue implementation of the capacity strengthening strategy by developing a certification process for budget management specialists. As a first implementation step, the team will advance a multiyear budget programming process, in consultation with regional governments, for the 2024 budget bill.



6. Conclusion

Improving health budget execution is a shared responsibility between MOHs and MOFs. There are steps that both ministries need to take across administrative levels, some independently and some collaboratively, to address issues such as: alignment of budgets with priorities, adherence to PFM policies and controls, and flexibility to accommodate shifting priorities. While government-wide PFM reforms can improve the enabling environment for health budget execution, solutions must be tailored for the needs and circumstances of the health sector, including health sector financing arrangements.

While the literature review and learning exchanges point to similar sector-specific challenges, there is no single approach or solution that all countries can adopt. Nevertheless, lessons can be drawn from learning partners' sharing of common challenges and promising practices, and experiences with TA to identify and support small steps to catalyze health budget execution improvements.

- Better health budget execution is a long-term commitment. Incremental steps can be more effective than approaches that propose broad reforms and can promote long-term engagement of country teams. Countries should **start with what they have**—their own promising practices—and build on these to create the right reforms step-by-step. This is particularly important as improving budget execution also requires improving other parts of the budget cycle.
- Learning partners in both this Health Budget Execution Learning Exchange and the separate LHSS Institutionalizing Explicit National Priority Setting for Health³ identified the importance of **linking national health priorities with health budgets and plans**. Good budget execution is not possible if budgets are not aligned with priorities and priorities are meaningless if they are not reflected in expenditures.
- An important prerequisite to identifying implementation steps is for countries to understand the **root causes** of poor budget execution and the misalignment of health, finance, and other stakeholders that can stand in the way of MOH action to address those root causes.
- Converting a promising practice to implementation in a dynamic country environment requires recognizing the depth and breadth of the technical, operational, and political considerations facing reforms or even small improvement interventions. **Beginning with a process to identify bottlenecks, such as a rapid assessment, or systematically examining relationships across or within fragmented funds flows** can help countries consider important factors, including how financing and service delivery functions are organized and the institutional structures, roles, and relationships across levels of government.
- Better health budget execution requires **capacity strengthening at all levels of the health system** to ensure that everyone involved in executing the budget understands the PFM guidelines, knows what they mean for the health sector, and is able to use the necessary tools, templates, and guidelines. Decentralization of fiscal responsibility can facilitate the implementation of reforms, but success is contingent on capacity strengthening.

³ Countries participating in the LHSS Institutionalizing Explicit Priority Setting for Health were: Bangladesh, Ethiopia, Lao PDR, Malaysia, Philippines, Rwanda, South Africa, and Thailand.



PROMISING PRACTICES TO IMPROVE MINISTRY OF HEALTH BUDGET EXECUTION: LEARNING FROM COUNTRY EXPERIENCE

- As capacity for health budget execution increases, **system enhancements that begin with small steps can be iteratively refined over time.** Implementing sustainable long-term reforms requires a gradual shift in mindset toward a culture of greater transparency and accountability for good health budget execution overall. Approaches that support countries to establish a dedicated team or community of practice of professionals engaged in budget execution processes can support long-term commitment and, ultimately, institutionalization of capacity strengthening and more effective practices.



7. Additional Resources

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Annex A: Learning Partner Teams

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Ghana	<p>Kwakye Kontor, Head of Planning and Budget, Ministry of Health (MOH)</p> <p>Ernest Owusu Sekyere, Senior Budget Officer in Charge of Health, Ministry of Finance</p> <p>Richard Agyeman-Badu, Deputy Director National Health Insurance Authority</p>
Kenya	<p>Robina Mwenesi, Senior Economist, Ministry of Health</p> <p>Isaiah Kiprono Byegon, Chief Economist, National Treasury and Planning, Ministry of Finance</p> <p>Evans Kisilu Muema, Economist, Department of Finance and Social-Economic Planning, County Government of Makueni</p>
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Malaysia	<p>Ms. Noor Azatol Azwa, Binti Hamidi, Finance Division, MOH</p> <p>Dr. Muhammed Anis Bin Abd Wahab, National Health Financing Section, MOH</p>
Nigeria	<p>Marcel Sati, Budget Formulation, Budget Office of the Federation</p> <p>Angus Ikpe, Budget Release, Federal Ministry of Health</p> <p>Chinyere Nduaka, Budget Execution, National Health Insurance Scheme</p>
Peru	<p>Felipe Cesar Meza Millan, Director General, Budget Office, MOH</p> <p>Augusto M. Portocarrero, Director General (Former), Budget Office, MOH</p> <p>Nelson Ugarte, Executive Director, Budget Office, MOH</p> <p>Segundo Montenegro, Executive Director (Former), Budget Office, MOH</p> <p>Orietta Soledad Ahumada, Economist, MOH</p> <p>Juan Carlos Haro, Industrial Engineer, MOH</p>