Fiscal space, public finance management and health financing

A collaborative agenda

Montreux, Switzerland
9-11 December 2014

HEALTH SYSTEMS
GOVERNANCE &
FINANCING

World Health Organization

WHO Library Cataloguing-in-Publication Data

Fiscal space, public finance management and health financing policy: a collaborative agenda, Montreux, Switzerland, 9-11 December 2014.

1.Financial Management. 2.Health Policy. 3.Universal Coverage. 4.National Health Programs. I.World Health Organization.

ISBN 978 92 4 150850 6 (NLM classification: W 74)

AGREED COLLABORATIVE AGENDA: WORKSTREAMS AND PRIORITY ISSUES

Work-stream area	Priority issues
1) Health financing, fiscal sustainability, and public finance management: aligning for implementation	a) Improve communication between Ministries of Health and Finance to strengthen capacity and mutual understanding of health financing, fiscal sustainability, and public finance management concepts and practices, engaging with the public finance/PFM community and avoiding "reinventing the wheel". b) Improve alignment of health financing policy reforms (in particular desired changes to the way health services are purchased), and public finance concepts and management rules, including budget formulation, execution and accounting/financial reporting. c) Develop normative guidance, identify policy issues, and explore country experience with regard to key issues in PFM and the implementation of health financing and wider health system reforms
2) Benchmarking and targets, fiscal space, and health spending projections	a) Develop a more robust basis for health expenditure targets and benchmark health system and fiscal indicators, to ensure credibility and clear policy messages, consonant with internationally accepted norms b) Review different approaches to modelling and types of models used for fiscal space / health expenditure analysis and projections, and clarify the appropriate context for their respective uses
3) Integrating global health initiatives with health financing policy	a) Detail the issues arising from countries about to graduate from intensive support under various global health programmes and propose key issues for discussion amongst governments agencies, CSOs, and international partners b) Facilitate sharing and methodological harmonization of fiscal space and "investment case" analyses conducted by different agencies and programmes
4) Development of "health and budget officials" networks and improve understanding of health budgeting practices	a) Improve collaboration between health and budget officials to further understanding of issues with a view to improving health service delivery b) Improve understanding of budget practices and issues for health system reforms in different regional contexts c) Improve understanding of the political economy of budget practices in selected countries

Introduction

Public budget revenues are central to financing progress towards universal health coverage (UHC) in low and middle income countries (LMICs). Given the relatively small size of the formal sector in most LMICs, it is general budget revenues (mainly sourced from indirect taxes) rather than direct contributions for health coverage that must play the leading role. This is reflected in the growing number of cases of budget-funded coverage expansions in which the government either fully or largely covers the cost of contribution in LMICs such as Thailand, Mexico, Rwanda, China, Kyrgyzstan, Moldova, India, and elsewhere. While these countries have increased their public spending for health, they are not merely channelling larger amounts into existing supply-side budgets, because rigidities in public finance systems often constrain the efficient use of such revenues. Improving the capacity of national health authorities (typically represented by the Ministry of Health) to engage more effectively with national budgetary authorities (typically the Ministry of Finance)[1] is essential to make progress on critical issues related to both the level of funds to be provided and the flexibility with which such funds can be used – while concurrently ensuring accountability for the use of these funds.

Motivated by this experience, WHO's Department of Health Systems Governance and Financing convened a meeting on fiscal space, public finance management and health financing policy in December 2014, building on existing work and dialog on these issues with partner agencies in recent years. The aims of the meeting were to:

1) Identify priority issues and related products and processes as the basis for a jointly agreed work programme on fiscal policy, public finance management (PFM), and health financing for UHC; and

2) Generate technical inputs to improve the methodologies used for projections of fiscal space for health, including for the OneHealth Tool.

A number of partner agencies, foundations and initiatives participated in the meeting and agreed to be engaged in specific areas of follow-on work. These included the UK Department for International Development (DFID), the World Bank, Bill & Melinda Gates Foundation (BMGF), the Organization for Economic Cooperation and Development (OECD), the Global Fund to Fight AIDS, TB and Malaria, GAVI Alliance, UNAIDS, the US President's Emergency Plan for AIDS Relief (PEPFAR), the Collaborative Africa Budget Reform Initiative (CABRI), the Australia-Indonesia Partnership in Health Systems Strengthening (AIPHSS, funded by the Australian Department of Foreign Affairs and Trade (DFAT)), Save the Children Fund (UK), Results for Development Institute, the Health Finance and Governance Project funded by the US Agency for International Development (USAID) and managed by Abt Associates, and Oxford Policy Management. To ensure that the discussions and follow on work reflected country needs, several representatives of national health and finance ministries as well as other relevant government and other public agencies were present and participated actively

[1] While using the terms "Ministry of Health" (MOH) and "Ministry of Finance" (MOF) during the meeting, it is important to note that more broadly we are concerned with the issues arising between national health agencies and the authorities responsible for raising public funds, planning, and making budgetary allocation decisions. The actual names for each will vary across countries according to their specific institutional setup. In some countries, the health authorities and agencies may be a MOH, a Ministry of Social Affairs, a national health insurance fund, and so forth. The national finance and budget authorities may include the MOF, a separate Planning Agency, a "Ministry of Economy" or "Economic Planning", as well as higher levels of government such as the Presidential Administration or Prime Ministers' office, etc. Hereafter in the report, we use the term "MOH" for the health authorities and "MOF" as a short-hand for the wide array of national authorities responsible for fiscal policy, planning and execution/allocation of public spending, and expenditure reporting.

in the meeting. The countries represented in the meeting included the following: Burundi, Chile, Ghana, Indonesia, Korea, Lao PDR, the Netherlands, Philippines, South Africa, and Tanzania. The full list of participants in the meeting can be found in Appendix 1.

Participants discussed conceptual and practical issues with regard to fiscal policy, public finance management, and their relation to health financing for UHC. Time was also devoted to identifying common issues and challenges for disease-specific funders in transitioning to greater national funding and management of the services and interventions that they support, thereby increasing the probability of sustainability upon "graduation" or phase-out of aid. More specifically, the participants considered methods for improving projections of public funding for health, and identified critical topics for further work (the "collaborative agenda") that partner agencies may support on the interactions between health financing, fiscal policy and public sector financial management.

The report captures the main points of the presentations[2] and discussions and is organized according to the structure of the agenda for the first two days of the meeting (the agenda can be found in Appendix 2). The third day of the meeting involved reflections on the issues raised on days one and two; points from these reflections are integrated into the notes on the earlier sessions. The meeting concluded with the agreement on the priority issues, together with indicative "product areas" to take the work forward for the collaborative agenda. This is summarized in the table immediately after this section.

Prior to initiation or commissioning of follow-on work, and where deemed necessary, it is proposed to establish small teams to further develop and oversee progress on specific products. The types of outputs to be produced have not been fully specified, but are likely to include some a mix of the following:

- concept papers;
- issues papers;
- evidence/experience reviews;
- country case studies;
- country applied work, often as part of ongoing country support;
- capacity strengthening;
- information generation; and
- networks/meetings

The product areas highlighted in the following table are mostly topics, but in some instances, specific products or types of products were discussed during the meeting or in subsequent interactions with partners. To ensure both progress and coordination on the implementation of the collaborative agenda, it is necessary to establish a small multi-agency group that will be responsible for developing and maintaining an overall map of the planned activities in related areas.

[2] The presentations in pdf format can be found on the meeting webpage: http://www.who.int/health_financing/partner_agencies/Montreux/en/.

Detailed collaborative agenda on health financing policy, fiscal space and public finance management issues in support of UHC, with indicative product areas

Work-stream area	Priority issues	Indicative product areas
1) Health financing, fiscal sustainability, and public finance management: aligning for implementation	a) Improve communication between Ministries of Health and Finance to strengthen capacity and mutual understanding of health financing and public finance management concepts and practices, engaging with the public finance/PFM community and avoiding "reinventing the wheel".	i. Develop a lexicon/glossary of terms to help standardize language and terminology ii. Flesh out the concept of fiscal sustainability in the health sector iii. Issues paper: how to establish "rules of the game", including default decision-making processes, for dialog between health and finance authorities on a range of topics related to the budgeting cycle. iv. Identify existing / develop tools and good practices for diagnostics around relationship between public finance management and health financing systems and integrate in collaborative country engagement. v. Write papers on topics of earmarking, offsets, and the impact on overall prioritization of public spending; introduction of sin taxes, and predictable and sustainable levels of public spending on health – based on a review of positive and negative examples, identification of stated/perceived objectives, linking to non-financial indicators and incorporating a comprehensive public finance conceptual and implementation perspective, in particular looking at the interaction of any new revenues with existing revenues and expenditures (and a reminder to engage with the IMF on these issues)
	b) Improve alignment of health financing policy reforms (in particular desired changes to the way health services are purchased), and public finance concepts and management rules, including budget formulation, execution and accounting/financial reporting.	i. Develop options to address obstacles and improve alignment of health purchasing and public finance management (e.g. shift to output-based budgeting, or payment) based on case studies of practices (good and bad) related to budget formulation, provider payment, accounting and financial reporting, internal controls etc. in the context of existing PFM frameworks. ii. Analysis of issues and country experience with incorporation (or not) of personnel costs (salaries) into output-based payment systems iii. Issues paper and country cases distinguishing the role of social health insurance as a source of funds from the role of SHI agencies as an institutional approach to PFM constraints on the use of general budget revenues in pooling and purchasing reforms.

Work-stream area	Priority issues	Indicative product areas
		iv. Issues paper, country case studies and applied work highlighting challenges and opportunities posed by decentralization for health financing reform – PFM issues, interactions with SHI funds, etc. v. Case studies and applied country work to identify operational issues at provider level that constrain the ability to implement or benefit from a shift towards output-based payment methods, particularly in the public sector.
	c) Develop normative guidance, identify policy issues, and explore country experience with regard to key issues in PFM and the implementation of health financing and wider health system reforms	i. Normative paper on functional specification and needed capacities in health financing and service delivery (i.e. at what level – central, regional, district, sub-district, facility – are specific functions best performed) to support health policy response to fiscal and administrative decentralization ii. Conceptual and issues papers providing PFM perspective on elements of good practice in the health sector and major challenges at country level. iii. Papers and country studies on issues, challenges and opportunities for implementing pooling and purchasing reforms in the context of (a) decentralized governance; (b) getting balance right in terms of autonomy and accountability of providers; (c) fragmentation from separating pooling and purchasing arrangements by revenue stream; (d) establishment of purchasing agencies in a number of low & middle income countries, with a focus on implications for public finance policy development and implementation & health financing systems and progress in terms of UHC; and (e) the implications of different government financial rules for the disposition of efficiency gains in the health sector (i.e. retained and recycled vs. returned to Treasury).
2) Benchmarking and targets, fiscal space, and health spending projections	a) Develop a more robust basis for health expenditure targets and benchmark health system and fiscal indicators, to ensure credibility and clear policy messages, consonant with internationally accepted norms	i. Develop a paper proposing health expenditure targets & benchmark indicators based on a robust, evidence-based approach relating health expenditure indicators to achievement of UHC outcomes.

Work-stream area	Priority issues	Indicative product areas
	b) Review different approaches to modelling and types of models used for fiscal space / health expenditure analysis and projections, and clarify the appropriate context for their respective uses	i. Conduct a review of existing models (e.g. the World Bank's fiscal health fact sheets), clarifying the assumptions used, and provide guidance of their appropriate use in LIC/MICs (potentially develop a new model factoring in policy context e.g. decentralization, informality, incentives built into different payment mechanisms, launch of health insurance, sin taxes). ii. Review the fiscal space module in the OneHealth Tool and make improvements as needed. Review how to link projections into budget processes.
3) Integrating global health initiatives with health financing policy	a) Detail the issues arising from countries about to graduate from intensive support under various global health programmes and propose key issues for discussion amongst governments agencies, CSOs, and international partners	i. Identify a few countries that are supported by global health programmes, and conduct detailed joint sustainability reviews, including analyses of fiscal space / health expenditures (building on existing work where relevant) and opportunities to improve efficiency through consolidation and strengthening of underlying support systems (e.g. supply chain, health information). ii. Paper on advantages / disadvantages of global health programme-specific trust funds, and propose actions / policy options to improve alignment and reduce fragmentation/duplication with domestic health/public finance management systems
	b) Facilitate sharing and methodological harmonization of fiscal space and "investment case" analyses conducted by different agencies and programmes	i. Establish or use existing online platforms to share the various analyses of fiscal space / financial analysis/ health expenditure projection models being commissioned and conducted in the context of graduating countries ii. Explore harmonization of investment case methodologies across health programmes and agencies, as well as the relevance of such work to national prioritization processes.
4) Development of "health and budget officials" networks and improve understanding of health budgeting practices	a) Improve collaboration between health and budget officials to further understanding of issues with a view to improving health service delivery	i. Develop and establish regional networks along the lines of OECD senior budget officials (SBO) health network in Europe. Use existing networks where possible (e.g. CABRI and JLN), and encourage country-to-country interaction based on regional champions
	b) Improve understanding of budget practices and issues for health system reforms in different regional contexts	i. Modify and conduct the OECD budget practices survey, incorporating elements of the institutional characteristics survey (e.g. to capture decentralization issues); conduct workshops to explain rationale, create demand, and facilitate implementation of the survey
	c) Improve understanding of the political economy of budget practices in selected countries	i. Produce a number of country case studies based on survey results, incorporating political economy analysis to identify good practices

SESSION 1: Overview of issues and challenges: health financing for UHC, fiscal space, and implications for the dialog between health and finance

Main objectives of the session

To provide an overview of the "terrain" to be addressed during the meeting and to start to build a common language between Health and Finance. Why fiscal context and PFM are central to the issue of health financing for UHC. How do things look from the Health sector and from the Finance perspective?

To identify some of the key challenges in dialog and technical issues from the perspective of Health and Finance ministries related to the broad questions of "how much money for health, and how this money can be better used". Therefore, issues of both revenues and expenditures were discussed. More specific issues addressed included the negotiation of funding levels, revenue flows, budgetary flexibility, expenditure reporting, and accountability. By the end of the sessions, the aim was to synthesize some key issues raised as important challenges and problems in the dialog, and ideally as well, some of the kinds of things that would help to facilitate a better process.

Main panelists and topics

1. Health financing for UHC: key lessons and directions with implications for fiscal policy and public finance management, Joe Kutzin, WHO
2. The Macroeconomic and Fiscal Context for Health Financing Policy, Cheryl Cashin, Results for Development Institute and World Bank consultant
3. How finance ministries view the health sector, Mark Blecher, National Treasury Department, South Africa
4. Panel session: what finance needs from health, what health needs from finance: how much money for health, and how to ensure that these funds are better used?
    a. Prastuti Soewondo, Working Group-Health, National Team on the Acceleration of Poverty Reduction – Office of the Vice President, Indonesia
    b. Kotsaythoune Phimmasone, Ministry of Health, Lao PDR
    c. Kwakye Kontor, Ministry of Health, Ghana
    d. Gijs van der Vlugt, Ministry of Finance, the Netherlands
    e. Jeremias Paul, Department of Finance, the Philippines

Key messages

a) Four "blocks" of issues that link health financing to fiscal and PFM issues are:
    - Macroeconomic and Fiscal Constraints,
    - Reflecting Priority for Health in the Government Budget,
    - Opportunities and Constraints in the PFM System to Improve Pooling and Purchasing, and
    - Inefficiencies and Fiscal Sustainability of Current Health Spending Patterns.

b) Fiscal capacity is heavily constrained in LMICs; countries have narrow tax base and low rate of collection.

c) MOFs think about whole government, not only about health sector or a disease program; the health sector must compete with many other sectors.

d) There is a perception in some countries that the MOH is well-funded from external donors, so MOF reallocates domestic revenues to other uses (substitution).

e) Compulsory (public) funding sources are central for UHC progress; furthermore, in Low and Middle Income Countries (LMICs) with relatively small formal sectors, this will mean predominant reliance on general government revenues.

f) In turn, the need for predominant reliance on general budget transfers raises a key issue for public finance systems: how to match public revenues for health to the defined priorities, given that many systems are constrained to use line-item budgets? The problem of line-item budgeting and expenditure control is that such payment arrangements cannot match directly priority services and populations. This risks making priorities merely "declarative", breaking trust with the population because there are no means to connect payment to promises (defined benefits).
g) National Treasuries/MOFs tend to have rules, regulations, and instructions that are enforced by audit. While they sometimes find it difficult to understand why their financial management rules are limiting for the health sector, there is recognition that different rules may be applied to different organizational forms (e.g. line ministries as compared to attached public agencies such as compulsory health insurance funds).
h) In order to ensure that health spending is not decreased as a result of economic crisis, it is valuable to separate revenue from expenditure issues in national policy discussions, particularly in the short-run. This is because revenues are affected by economic cycles, while the need for spending may be counter-cyclical. In Netherlands, for example, the MOF sets the ceiling on spending in real terms for five years as a way to insulate policy decisions from short-term revenue fluctuations.
i) It is important to have clear "rules of the game", including default steps if parties do not discuss or agree on changes, for the dialog between Health and Finance ministries. Fiscal policy rules must be simple and flexible. They should not try to delineate everything.
j) It would be useful to the MOF if the MOH could show a clearly planned, predictable sectoral development pathway, including a long term sectoral projection model, carefully considered and well-costed strategies, sound budget management, strong system of accountability, and demonstrable progress on health outcomes and quality of care.
k) Sin taxes in Philippines are allocated to health sector. However, from the perspective of MOF, there is an issue of absorptive capacity. The MOF would like to see a Medium Term Expenditure Plan from the health sector with clear deliverables.
l) Salaries consume a large share of health resources; at the same time, they are often considered a "protected item" in the budget and hence difficult to coordinate as part of an overall sectoral reform. They are also a highly politicized issue, bringing pressure to increase salaries. In countries such as Ghana where health workers in public facilities are considered to be civil servants, it is also difficult make changes just within the sector as there is a pressure to harmonize wages and increase salaries across the board.
m) Scope for efficiency gains exists within the health sector and is a priority for policy attention; no country can simply spend its way to UHC, as the experience of the USA shows.
n) Public providers should have more autonomy or flexibility to allocate resources and should not need to transfer internally generated funds (official user fees or insurance reimbursements) back to the Treasury because doing so creates incentives for under-reporting (lack of transparency) and inefficiency.
o) Related to this, it is important to look at "who captures the savings" from efficiency gains. A lesson learned from Kyrgyzstan is that both technical and political issues can arise in retaining savings from efficiency gains in the health sector. Technical issues can relate to savings falling out of the health budget especially when budgets are formed based on inputs using standards or normatives. This issue was addressed in Kyrgyzstan through a combination of reforms that reduced fragmentation in the pooling of funds, fully realized program budgeting, and transitioned to output-based provider payment systems. These changes in technical mechanisms were necessary but not sufficient to overcome the initial response by the MOF to take the savings back to the budget, away from the MOH (and thereby effectively reducing the MOH budget as a consequence of efficiency gains in the sector). Over time, however, political will was mobilized (from a combination of internal and external pressures) to maintain the level

of the total health budget rather than penalizing the sector for improvements in efficiency. It may be useful to look at other country experiences, focusing on the technical aspects – alignment of the health system's provider payment incentives with the process of budget formation and expenditure reporting in the wider PFM system – as well as the underlying political processes.

Key points of discussion to inform follow-up work

a) What is needed to enable the MOH to communicate more effectively with MOF and also other ministries and parts of government (e.g. presidential administration, Parliament)? In particular, what processes might be supported to engage more directly with Parliamentarians?
b) What would be appropriate metrics to use for justification of budget requests?
c) There is a need for pooling and cross-subsidization, but at what point, from a political perspective, might there be "too much cross-subsidization"? In other words, if only 10% of the population are providing the funds for the whole system, it may be politically unacceptable even if this would potentially be very equitable. Political economy analysis of this issue might prove useful
d) While some countries are engaged in decentralisation others are undertaking recentralisation. What are the issues that should be considered in this process, and how can MOHs be supported to cope with such changes, particular in contexts where decision-making on resource allocation rests with local authorities? It was suggested that a normative paper on "functional specification" in the health sector might be useful in regard to this.
e) How have some countries managed to obtain both flexibility in budget allocations (i.e. a move away from strict line-item controls) while still ensuring (output-oriented) accountability for the use of scarce public funds?
f) Can salaries be incorporated into output-based provider payment systems? What is the experience with this in different countries?
g) It would be important to distinguish health insurance as a source of funds (where the impact is likely to be minimal) from health insurance as an institutional arrangement that can enable strategic purchasing with general budget revenues. A paper on this might be useful for unpacking these issues and potentially removing some of the ideological aspects of debates around the role of health insurance.
h) A desire was expressed for a single knowledge portal on issues of health financing, fiscal sustainability, and PFM.

SESSION 2: Sustainability and fiscal space for health

Objective of the session

To understand the core concepts and measurement metrics of fiscal space and financial sustainability with special reference to providing fiscal space for health. What would help to promote a more effective dialog on the level as well as the stability and predictability of the flow of budget funds to the health sector?

Main panelists and topics

1. Assessing fiscal sustainability and fiscal space for health, Ajay Tandon, World Bank
2. Fiscal space for the Tanzanian health sector, Tomas Lievens, Oxford Policy Management
3. Implications and use of the fiscal space analysis in Tanzania, Mariam Ally, Ministry of Health, Tanzania

Key messages

a) Based on international spending benchmarks, there is a large funding gap between the available resources and what is required to fully fund the Minimum Benefits Package in many LMICs, such as Tanzania.
b) Fiscal space for health depends on conducive macroeconomic conditions, availability of sector specific sources of revenue, re-prioritizing health within the government budget, external support for health, and increasing efficiency of health outlays.
c) Earmarked taxes are likely to be relatively small in comparison with higher allocation to health from government revenues, and Ministries of Finance in general do not welcome them, as in the case with Tanzania where all proposals for new earmarked taxes were rejected.
d) When discussing the absorption rate, one has to be careful and look not only at planned vs. actual spending but also when the disbursements are made. PFM bottlenecks (e.g. rigid line item budgets) may contribute to low absorption.
e) Countries at all levels of income need to consider diversification of public revenue sources for the health sector.

Key points of discussion to inform follow-up work

a) Are projections based on general benchmarks, such USD 86 per capita, to ensure universal coverage for a basic package of services always appropriate? Funding gap may not be as large if based on actual costing of the benefits package for a country. Furthermore, such "gap analysis" should not be the main driver of a reform agenda as it might lead to undue focus on unrealistic solutions. In particular in the case of Tanzania, the analysis led to an over-emphasis on contributory health insurance contributions for the informal sector, which international experience indicates would provide an insignificant contribution to overall sectoral revenues. Such analysis may also inadvertently convey the message that countries spending less than the target cannot do much to reform their health financing systems, and/or that countries surpassing the target have somehow solved their UHC problem (both of which are demonstrably untrue). An issues paper on this topic may make a valuable contribution in refining policy debates.
b) Targets can be important from an advocacy perspective because it is possible to build campaigns around them at both national and international levels, particularly from the civil society perspective. However, some of these targets do not add up. How do the different existing targets fit with each other? Are they realistic?
c) Fiscal sustainability applies at the level of overall public sector, and every sector argues for a certain proportion of total government expenditures. So from the point of view of the Ministry of Finance, it is a matter of balancing competing priorities. Also, from the resource allocation

perspective in many countries, health is not viewed separately from education, and thus the MOF looks at total spending on the social sector. It may be worth exploring the implications for the health sector of embedding arguments for increased funding within a broader social sector framework?

d) Improving tax administration (efficiency of collection) can make an important contribution to overall fiscal sustainability. Similarly, for some LMICs, improving the management and transparency of natural resource revenues is a potentially important topic for intervention.

e) Despite public finance concerns about earmarking, many countries use this for at least some public allocations to health. There is a view that the stronger the connection between inputs and outputs the stronger the rationale for earmarking. At the same time, it is not clear that earmarks have led to a net increase in public spending on health due to the potential for offsets. There is a need for a review of country experience with earmarking and offsets, thus considering the issues within a broader fiscal framework. More generally, what has enabled some countries to systematically increase priority for health in public spending, and others not?

SESSION 3: Fiscal and reform implications of increased national financing of health programmes

Objective of the session

To understand (a) perceptions of "sustainability" from a programmatic perspective, (b) the fiscal implications (and reform opportunities) of a transition to increased national financial responsibility, and (c) how health and finance ministries view these issues given the number of health programmes that exist in any one country. In addition, seek to synthesize some important and relevant issues that can be addressed in a work programme that is not currently receiving adequate attention in any of the programme-specific sustainability work.

Main panelists and topics

1. Strengthening fiscal sustainability and health programmes: an application to HIV/AIDS, Jack Langenbrunner, AIPHSS/DFAT
2. Fiscal and health reform implications of "transition": threats and opportunities, Christoph Kurowski, World Bank
3. Panel session: Sustaining health programme coverage and reducing dependence on international funding flows: fiscal and health reform issues
    a. Nalinee Sangruchee, PEPFAR
    b. Santiago Cornejo, GAVI
    c. Michael Borowitz, GFATM
    d. Christoph Kurowski, World Bank (on behalf of the Global Financing Facility (GFF) for Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH))
    e. Dan Chisholm, WHO NCDs programme
4. Reaction – how do these issues look from a funder's perspective? Julia Watson, DFID

Key messages

a) Several health program funding mechanisms have "graduation" (or "transition") mechanisms that envision increased co-financing by countries until they take the full cost of the program. However, these graduation plans differ in their specificity or flexibility. When discussing graduation challenges it is important to remember that there are financial as well as non-financial or institutional barriers to sustainability.

b) Graduation can serve as an opportunity for innovation, involving both specific reforms (e.g. RBF) as well as investments in cross-cutting integrated support systems (e.g. supply chain, information systems, provider payment systems) that can enhance the capacity of governments to sustain program interventions in the long-term.

c) In the area of NCDs, the main challenge is not graduation, but how to increase international development assistance. For example, mental health has received very little external support and is often outside of any basic packages due to challenges in integrating mental health needs into service delivery. A Global Coordination Mechanism for NCDs has been established, but the reality facing LMICs is that meeting funding needs will be largely a domestic responsibility.

d) Fiscal constraints are not the main concern for the first wave of countries graduating from GAVI because the cost of vaccines is only around 1% of government health spending, and thus it is not a major concern for them. The issue for these countries is access to appropriate pricing post-GAVI support. This suggests that broader institutional capacity is also fundamental to ensure financial sustainability (procurement, regulations, decision-making etc). There is a need for comprehensive assessment to identify potential bottlenecks for sustainability in order to mitigate them during transition, which requires engagement with stakeholders beyond EPI, including at sub-national level.

e) Conceptually, the personal health services provided under the global health initiatives and disease programs can potentially be integrated in a basic benefits package in a manner to improve overall system efficiency, so long as the purchaser(s) prioritize these services and are held accountable for ensuring their effective delivery.

Key points of discussion to inform follow-up work

a) Thinking about harmonizing and joining efforts by the global initiatives comes at the right moment, as several replenishment processes will be happening in the near future. There are also many parallel "investment case" exercises taking place contributing to a perception of competition and without a clear link to national budget and priority setting processes. WHO's neutral position enable it to be well-placed to facilitate these efforts of alignment and harmonization, as there are certain incentives and disincentives for development partners and governments to harmonize, and these need to be thought through and addressed to move forward.
b) What are specific systems and processes that are shared within countries across different health programs? Developing an approach to analyze these across programs, followed by some country case studies, could be helpful.
c) What are the lessons learnt from the graduation and sustainability planning experiences of the existing GHIs that could be applied to the GFF?
d) Sustainability is understood in different ways (increased share of domestic financing, institutional sustainability etc.), so use of more precise terms can be helpful.
e) Competition for human resources among different initiatives and the country's health system creates distortions. How to address these as countries move towards graduation?
f) Criteria could be developed to identify those personal health service interventions of disease control programs that could be integrated into national benefit packages and purchased by the same agency (or agencies) that purchase other personal services.

SESSION 4: Projections, Indicators, Benchmarks and Targets

Objective of the session

To explore examples of what is being used both internationally and at country level to measure, report on, and assessment of health expenditures, and how this fits into policy dialog.

Main panellists and topics

1. Health spending: projection methods, indicators, benchmarks and targets, Chris James, OECD
2. Expenditure indicators and benchmarks at country level
    a. Jeremias Paul, Department of Finance, the Philippines
    b. Bernadette Wanjala, Kenya Institute for Public Policy and Research Analysis
3. How to optimize the fiscal space projection module of the OneHealth tool: what can it do; what is better done elsewhere? Tessa Tan Torres, WHO
4. Data, methods and key variables for financial projections, Ajay Tandon, World Bank

Key messages

a) There is considerable benefit from having benchmarks, dashboards, etc., and we should continue to produce and use such information. But the evidence base behind benchmarks varies. For example, there is good evidence behind the benchmark on the share of out-of-pocket in total health spending (based on the relationship between this and the risk of catastrophic expenditures), but some of the others are based primarily on median values of distributions or political decisions.

b) For analyses and projections of fiscal space for health to be most helpful, it is important to incorporate broader indicators of both fiscal sustainability (constraints) and fiscal space. An example of the former is the debt-to-GDP ratio where the IMF has defined benchmarks for different country income groups. Fiscal space indicators include those related to (i) the macroeconomic environment, and (ii) health-specific variables, such as the share of health in total public spending etc.

c) The OneHealth Tool (OHT) facilitates integrated planning, taking into account health system strengthening needs and promoting consistent and standardized approaches across different disease programme areas. The tool is intended primarily to inform strategic planning and not annual operational plans and budgets. It includes a module for projecting the likely available fiscal space. In order to do a fiscal space analysis for health properly, one needs to cost out all components in terms of the required expenditures, including health systems, since there are likely increasing requests for resources from multiple programmes within MOH (and not just the incremental requirements of one or two diseases).

d) OHT is useful for costing and linking inputs to outputs and outcomes. In terms of comprehensiveness, a surgery component will be added to OHT in 2015. In the meantime countries can expand the costed package by entering user-defined programs and interventions; or choose to look primarily at marginal costs if contextualized inputs do not reflect the full need. OHT fiscal space component should be sent to Ministries of Finance for review.

e) The ratio of GGHE/THE is less in the Philippines than in other comparable LMIC countries. The government's commitment to UHC led to a sin tax reform, resulting in significant rise in tobacco and alcohol excise collections. The incremental revenues are earmarked for health, the majority of which have gone towards expanding coverage of the poor in the national social health insurance fund, PhilHealth, as well as to other specific programs to support progress on the MDGs. Some revenues from the tax were also earmarked for supporting tobacco farmers to switch to other crops. In some areas of the budget however, the related expenditures have been below target and the government is facing spending challenges. The MOF is generally not

supportive of ear marking but in this case an exception was made given the political commitment to UHC, and the sin taxes are perceived as a sustainable financial source for UHC.

f) Kenya is facing mounting pressures to increase health expenditures in a context of revenue shortfalls. Current challenges in the Kenyan health financing context include:
   - Over-reliance on external funds for some line items and lack of coordination framework for counties.
   - Health functions are decentralized to counties with autonomous planning at local level. Allocation of health expenditure to counties is not related to resource allocation formula, and budgetary priorities are set by county governments. Most counties report underspending for health in relation to budgetary targets. Some county governments generate additional revenues for health, but this is wide variation across the country and these revenues can be difficult to forecast and incorporate in national plans.
   - Going forward it would be helpful to set some kind of guidelines/benchmarks for minimum allocation to health within the county budgets.

Key points of discussion to inform follow-up work

a) The importance of engaging with the IMF on these issues was noted.
b) The group can consider producing guidance on how fiscal space projection tools and benchmarks can be used to guide various processes such as the GFF, and graduation from GFATM/GAVI.
c) Value would be added from making the World Bank's Fiscal Health Fact Sheets interactive such that scenarios could be generated and sensitivity analysis performed, and engaging technically to explore methodological harmonization with the projection tool in the OHT. For example, specifically with regards to the OHT fiscal space module, the modelling of debt in relation to government spending should be strengthened. Other further developments of the OHT should consider building in stronger links with UHC, such as linking to the 13 WB/WHO agreed UHC indicators.
d) With regards to sin taxes, the tobacco community has long developed models that look at excise taxes for tobacco products. These should be studied and reflected upon. Examples of recommended best practices include the adoption of a relatively simple tax system that applies equivalent taxes to all tobacco products, with at least 70% excise tax share in final consumer price.
e) Some participants argued that international agencies such as WHO and the World Bank should put a spotlight on those countries that devote very low shares of public spending to health (described as the "six percent-ers" in relation to the low priority they give to health in their public resource allocations).

SESSION 5: Health financing and PFM: aligning for implementation

Objective of the session

Disaggregate and crystallize the key interactions between health financing and wider PFM arrangements, highlighting critical aspects where alignment is essential. In relation to this, identify key knowledge gaps that might be addressed in follow-up work.

Main panelists and topics

1. Public sector financial management and the health sector, Soukeyna Kane, World Bank
2. Aligning PFM rules (budget formation, execution, provider payment systems, funds flow, and treasury system reporting) with pooling and purchasing reforms, Cheryl Cashin, R4D and World Bank consultant
3. Budget formation and accountability related to implementation of Performance-Based Financing (PBF) in Burundi, Olivier Basenya, Ministry of Health, Burundi

Key messages

a) The way public budgets are formed, disbursed, and accounted for can either align with or pose obstacles to achieving health sector objectives.

b) The way sectoral budget ceilings are set often does not reflect political commitments on level/source of funds, or sector objectives, strategic and operational plans. It is difficult to match health spending to priorities when budgets are classified and formed based on inputs. Furthermore, budgets disbursed and accounted for according to input-based line items tend to be quite rigid, with lack of provider autonomy to shift resources across the line items. In addition, the structure of program budgets is often by type of facility rather than the types of services to be purchased. This common "disconnect" results in a system that is focused on funding buildings rather than purchasing benefits for the population.

c) There is a need to improve revenue forecasting in order to have realistic budget envelopes and avoid ad hoc or across-the-board adjustments.

d) Budget credibility also depends on outturn compared to the original approved budget, including e.g. share of primary vs secondary and tertiary health care; vertical disease programmes vs general health system financing.

e) Poor information systems and monitoring capacity undermine accountability. Weak internal and external audit functions in the health sector, weak capacity in procurement, inventory management, and asset management, lack of effective measures for payroll control need to be addressed as part of health financing reforms.

f) Key principles of financial management (FM) harmonization and alignment promoted under IHP+ are:
   - Must align with country systems whenever they meet the minimum acceptable level
   - Harmonize among development partners even when all or part of the national PFM system is not sufficiently developed
   - Joint FM Assessment, joint action plan for strengthening the system and joint supervision
   - Not wait until all problems have been solved, but use elements of country systems as part of the process of improving systems and developing capacity

g) Tools already exist that may be relevant to many countries. For example, a toolkit for PFM self-assessment in the health sector produced by the Health Finance and Governance Project was shared with participants. There are also broader PFM tools available; for example, a recent publication of the IMF includes tools for evaluation of fiscal transparency and tax administration.

h) As the experience of PBF in Burundi shows, it is important to involve MOF and Treasury in the development of the PBF program, and more specifically into the process of forming the budget and aligning payment methods with existing PFM rules. In Burundi, MOF and Treasury were

involved in developing the program operational manual to ensure compliance with public spending and accounting procedures.

i) "Flexibility on the margin" is an important facilitating condition for performance and can exist inside or outside the PFM system. Often, countries have not exploited existing flexibility in their PFM systems. Measures such as integration of pools from different revenue sources, MTEF, different classification systems for budget formation and accounting, may provide opportunities for this flexibility within the system. In some cases, moving health funds outside of the core budget system can be used as an alternative (e.g. in compulsory health insurance funds that exist as a public agency attached to the government structure but operating under different rules).

Key points of discussion to inform follow-up work

a) Language is a big issue – often same words are understood differently by people from different disciplines. What specific products can be developed to promote a common understanding between public finance and health finance professionals?

b) More generally, it will be important to explore what the "PFM community" has already been doing and to engage with them rather than trying to invent things separately for the health sector.

c) What are common important weaknesses in national PFM systems that impede health reforms and can be identified as areas for improvement? For example, what are the obstacles to separating processes for budget formation to processes for provider payment? There are also many operational issues at provider level that need to be considered to enable alignment with changes in provider payment. This may be particularly true for public facilities, and includes basic issues such as whether a health facility has a bank account. In turn, this may relate to the specific legal status of the providers. How have countries addressed these kinds of challenges?

d) How to address issue of salaries that consume large parts of the operational budgets, particularly when they are determined and paid directly by the Ministry of Finance or Treasury? In countries that have moved away from input-based budgeting, some have not shifted salaries to this mode, while others have. What has driven such decisions?

e) Can the PFM and health financing system capacity pre-requisites for moving to output-based payment be identified? Can indicators/measures be developed to support a reduction in the barriers to harmonization of health purchasing and PFM?

f) Reviewing historical experiences of how countries (e.g. the UK) moved from input- to output-based accountability in their budgeting practices might be useful.

g) What challenges are raised by the existence of different budget formulation processes, pooling arrangements and purchasing arrangements for different revenue streams (e.g. health budget, payroll tax, donor), and how have countries addressed these?

h) It may be useful to develop both conceptual work and country case studies on the PFM perspective on quasi-public SHI funds, particularly with regard to those that manage substantial budgetary revenues. This might also incorporate experience with the role of a national health insurance agency in the context of devolution/decentralization.

i) Different issues of fragmentation arise in different settings, and strategies to overcome these need to be developed. For example in Burundi, there is a virtual health funding basket for the PBF mechanism. So while there are multiple funders, there is one information and payment system, and this generates invoices to be paid by each funder. While addressing some problems of fragmentation, this leaves others, as for example when the different funders execute their payments on different schedules. This contributes to some degree of lack of predictability in revenues for facilities.

SESSION 6: Instruments and mechanisms used in OECD to enhance knowledge and dialog: adaptable for Low and Middle Income countries?

Objective of the session

Learn from experience with mechanisms initiated by OECD to enhance the health/finance policy dialog and explore how these might be adapted for application in low and middle income countries.

Main panelists and topics

1. The Senior Budget Officials (SBO) Networks
    a. SBO Network on Fiscal Sustainability of Health Systems, Camila Vammalle, OECD
    b. SBO Collaborative Africa Budget Reform Initiative (CABRI) Network, Neil Cole, CABRI
2. The Senior Budget Officials Network on Fiscal Sustainability of Health Systems: OECD practice and potential relevance for LMICs
    a. Gijs van der Vlugt, Ministry of Finance, the Netherlands
    b. Kyo Hyun Kim, Health Insurance Review and Assessment Service, Republic of Korea
    c. Neil Cole, CABRI Network
3. Methods and findings of the OECD surveys of health budgeting practices
    a. Camila Vammalle, OECD
    b. Gijs van der Vlugt, Ministry of Finance, the Netherlands

Key messages

a) Health is a particularly complex spending area, both for technical (hard to determine causality between inputs, outputs and outcomes) and political reasons (outcomes are particularly important to citizens, great number of actors involved). This was part of the motivation for establishing the SBO Health Network.
b) The main objectives of the SBO Health Network are: (a) to establish institutional dialogue to promote clarity of roles, objectives and vocabulary between all actors involved, and (b) to identify and disseminate good practices in managing the budget of the health sector. This is done through periodic (at least annual) meetings of health and finance officials, survey of budgeting practices for health, analytical papers and country case studies.
c) The OECD Survey on health budgeting practices consists of seven parts, including general information, projecting health expenditure, decentralisation of health financing and expenditure, decision-making and assessment, expenditure frameworks and ceilings, revenues, and deficits. It is a new tool and may be further refined, particularly to make it applicable to LMICs.
d) CABRI offers technical advice, knowledge sharing, advocacy, research facilitation and includes officials from finance and health ministries. It can offer a good platform for dialogue to improve alignment of health financing reforms and PFM processes.
e) It was suggested that the benefit of an SBO-like network for LMICs is the potential for sharing and understanding of rules and guidelines because often MOF and MOH do not speak the same language.

Key points of discussion to inform follow-up work

a) Joint meetings of MOH and MOF through similar types of networks could be useful as they provide a chance for them to go through the analysis jointly, which sets the basis for agreeing on common issues and measures to address them. Also, the process itself is important.
b) Success stories and in-depth studies on decision-making regarding fiscal sustainability will be useful for further learning.

c) The process of completing the survey of health budgeting practices is also useful because MOF will have to think about and find their own figures and details of how their processes work. It can also facilitate comparison of their own countries with others, which may be helpful in the MOH-MOF dialogue.
d) The survey needs to be adapted for LMICs, and the big question is process of how to do so, and how to get a good response rate. Also, more conceptual work on the content is required.
e) One potential gain from networking would be to examine/compare health program budget structures across countries, and how health program spending is monitored.

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APPENDIX 2: AGENDA

Day 1: Tuesday 9 December

08:30 - 09:00	**Welcome, Objectives of the meeting, and Introduction of participants** David Evans, Tessa Tan Torres, Joe Kutzin, WHO
1: Overview of issues and challenges: health financing for UHC, fiscal space, and implications for the dialog between health and finance	
	Chair/moderator: David Evans, WHO
09:00 – 09:15	**Health financing for UHC: key lessons and directions with implications for fiscal policy and public finance management** Joe Kutzin, WHO
09:15 – 09:40	**The Macroeconomic and Fiscal Context for Health Financing Policy** Cheryl Cashin, Results for Development Institute and World Bank consultant
09:40 – 10:00	**How finance ministries view the health sector** Mark Blecher, National Treasury Department, South Africa
10:00 – 10:30	**Discussion**
10:30 - 11:00	**COFFEE/TEA BREAK**
	Chair/moderator: Sheila O'Dougherty, WHO consultant
	What finance needs from health, what health needs from finance: how much money for health, and how to ensure that these funds are better used?
11:00 – 12:00	**Country Panel** Prastuti Soewondo, Working Group-Health, National Team on the Acceleration of Poverty Reduction – Office of the Vice President, Indonesia Kwakye Kontor, Ministry of Health, Ghana Jeremias Paul, Department of Finance, the Philippines Kotsaythoune Phimmasone, Ministry of Health, Lao PDR Gijs van der Vlugt, Ministry of Finance, the Netherlands
12:00 – 12:25	**Plenary discussion**
12:25 – 12:30	**Synthesis: challenges and priorities for enhancing the dialog between Health and Finance**
12:30 - 13:30	**LUNCH**

2: Sustainability and fiscal space for health	
	Chair/moderator: George Schieber
13:30 – 13:50	**Assessing fiscal sustainability and fiscal space for health** Ajay Tandon, World Bank
13:50 – 14:10	**Fiscal space for health: a country example** Tomas Lievens, Oxford Policy Management
14:10 – 14:25	**Discussant** Mariam Ally, Ministry of Health, Tanzania
14:25 – 15:00	**Plenary discussion: what would help to enhance Health Ministry capacity to engage on these issues with Finance**
15:00 - 15:30	**COFFEE/TEA BREAK**
3: Fiscal and reform implications of increased national financing of health programmes	
	Chair/moderator: Mark Blecher, National Treasury, South Africa
15:30 – 15:45	**Fiscal and health reform implications of "transition": threats and opportunities** Christoph Kurowski, World Bank
15:45 – 16:00	**Fiscal sustainability and health programmes: an application to HIV/AIDS** Jack Langenbrunner, Australia-Indonesia Partnership in Health Systems Strengthening (AIPHSS/DFAT)
16:00 – 16:20	**Plenary discussion: initial reactions to approach for sustainability and health programmes and the implications of transition**
16:20 – 17:00	**Sustaining health programme coverage and reducing dependence on international funding flows: fiscal and health reform issues** **Short interventions:** Nalinee Sangruchee, PEPFAR Santiago Cornejo, GAVI Michael Borowitz, GFATM Christoph Kurowski, World Bank (of behalf of Global Financing Facility for Reproductive, Maternal, Neonatal, Child and Adolescent Health) Dan Chisholm, WHO NCDs programme **Reactions from bilateral donor and country perspectives?** Julia Watson, DFID MOH/MOF representatives
17:00 – 17:30	**Plenary discussion: refining a potential work agenda on fiscal space, health programmes, and system efficiency**

Day 2, Wednesday 10 December

1: Projections, Indicators, Benchmarks and Targets	
	Chair/moderator: Mthuli Ncube, Oxford University
09:00 – 09:30	**Health spending: projection methods, indicators, benchmarks and targets** Chris James, OECD
09:30 – 09:50	**Expenditure indicators and benchmarks at country level** Jeremias Paul, Department of Finance, the Philippines Bernadette Wanjala, Kenya Institute for Public Policy and Research Analysis
09:50 - 10:30	**Discussion: data and methods; role/use of projections in health financing policy and the dialog between health and finance**
10:30 - 11:00	**COFFEE/TEA BREAK**
	Chair/moderator: Hong Wang, Bill and Melinda Gates Foundation
11:00 – 11:45	**How to optimize the fiscal space projection module of the OneHealth tool: what can it do; what is better done elsewhere?** Tessa Tan Torres, WHO Chris James, OECD
11:45 – 12:05	**Discussant: data, methods and key variables for financial projections** Ajay Tandon, World Bank
12:05 – 12:30	**Plenary Discussion**
12:30 - 13:30	**LUNCH**
2: Health financing and PFM: aligning for implementation	
	Chair/moderator: Chris Lovelace, Abt Associates
13:30 – 13:50	**Public sector financial management and the health sector** Soukeyna Kane, World Bank
13:50 – 14:10	**Aligning PFM rules (budget formation, execution, provider payment systems, funds flow, and treasury system reporting) with pooling and purchasing reforms** Cheryl Cashin, R4D and World Bank consultant
14:10 – 14:25	**Budget formation and accountability related to implementation of Performance-Based Financing in Burundi** Olivier Basenya, Ministry of Health, Burundi
14:25 – 15:00	**Discussion of PFM and health financing issues for possible inclusion in a follow-up workplan**
15:00 - 15:30	**COFFEE/TEA BREAK**

3: Instruments and mechanisms used in OECD to enhance knowledge and dialog: adaptable for Low and Middle Income countries?	
	Chair/moderator: Michael Borowitz, GFATM
15:30 – 15:50	**The Senior Budget Officials (SBO) Networks** **a) SBO Network on Fiscal Sustainability of Health Systems** Camila Vammalle, OECD **b) SBO Collaborative Africa Budget Reform Initiative (CABRI) Network** Neil Cole, CABRI
15:50 – 16:10	**Panel: The Senior Budget Officials Network on Fiscal Sustainability of Health Systems: OECD practice and potential relevance for LMICs** Gijs van der Vlugt, Ministry of Finance, the Netherlands Kyo Hyun Kim, Health Insurance Review and Assessment Service, Republic of Korea Neil Cole, Collaborative Africa Budget Reform Initiative (CABRI) Network
16:10 – 16:40	**Plenary Discussion: is this process worth replicating in LMICs? What adaptations would be needed?**
16:40 – 17:05	**Methods and findings of the OECD surveys of health budgeting practices** Camila Vammalle, OECD Gijs van der Vlugt, Ministry of Finance, the Netherlands
17:05 – 17:30	**Plenary discussion: relevance of this approach for Low and Middle Income Countries? What adaptations?**

Day 3, Thursday 11 December

1. Changing the nature of accountability for public funding: workplan issues	
	Chair/moderator: Jeanette Vega, National Health Insurance Fund, Chile **What are key knowledge gaps that can be addressed to help countries move from input to output oriented accountability in the health sector?**
08:30 – 09:10	**Key messages from yesterday's session on health financing and PFM** Sheila O'Dougherty, WHO Consultant Jack Langenbrunner, AIPHSS/DFAT
09:10 – 09:20	**Tools to support health and PFM alignment** Chris Lovelace, Abt Associates, Health Financing and Governance Project
09:20 – 09:50	**Plenary discussion: what kinds of tools, products and capacity building activities would help facilitate a shift from input- to output-oriented budgeting and accountability? What other PFM issues are potentially important for health financing reforms?**

2. What's needed? Priorities for a workplan on fiscal space, public finance management, health programmes, and health financing for UHC	
	Chair/moderator: Joe Kutzin, WHO
09:50 – 10:15	**Panel discussion of finance and health ministries: priorities, challenges, and key unknowns to facilitate improvement** MOH and MOF representatives
10:15 - 10:45	**COFFEE/TEA BREAK**
10:45 – 12:15	**Breakout groups: What topics, products and processes for a work program on health financing, fiscal policy, health programmes (including international aid flows) and PFM? What will contribute to a more productive engagement between health and finance ministries? Next steps to improve methods for projections of fiscal space for health**
12:15 - 13:15	**LUNCH**
	Chair/moderator: Tessa Tan Torres, WHO
13:15 – 14:30	**Reporting back main points to plenary and discussion of proposals**
14:30 – 15:05	**Reflections and perspectives on next steps** Christoph Kurowski, World Bank Camila Vammalle, OECD Hong Wang, Bill and Melinda Gates Foundation Michael Borowitz, GFATM Tessa Tan Torres and Joe Kutzin, WHO
15:05 – 15:15	**Closing of the meeting** Tessa Tan Torres and Joe Kutzin, WHO
15:15	**COFFEE/TEA AND DEPARTURE**

Health System Governance, Policy and Aid Effectiveness (HGS)

Health Financing Policy (HFP)

Cost Effectiveness, Expenditure and Priority Setting (CEP)

WE ARE ALSO PROUD TO HOST THE SECRETARIATS FOR:

ihp+ P4H Social Health Protection Network

In an increasingly interconnected world, we know that we achieve more when we work with others.

Recent collaborations include: Abt Associates Inc.; Australian Agency For International Development (AusAID); Bill & Melinda Gates Foundation; European Commission – Europeaid Cooperation Office (AIDCO); France, Ministry Of Foreign And European Affairs; Global Alliance for Vaccines and Immunisation (GAVI); Germany, Deutsche Gesellschaft Für Internationale Zusammenarbeit (GIZ) Gmbh; Global Fund To Fight Aids, Tuberculosis And Malaria (GFATM); Luxembourg Development Cooperation; Netherlands, Ministry of Health, Welfare and Sport; Norwegian Agency For Development Cooperation (NORAD); Republic of Korea, Ministry of Health and Welfare; Republic of Korea, National Health Insurance Service (NHIS); Rockefeller Foundation; Susan G. Komen Breast Cancer Foundation Inc.; Spanish Agency for International Cooperation and Development (AECID); Swedish International Development Cooperation Agency (SIDA); United Kingdom-Department For International Development (DFID); United Nations Development Programme (UNDP); United States Agency For International Development (USAID).

And we are proud to be part of the Providing for Health Initiative (P4H) and to co-host the secretariat for International Health Partnerships (IHP+).

Work with us so we can support countries to reach our shared objective:
country health governance and financing systems that ensure universal and sustainable coverage.

For additional information, please contact:

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