5th Meeting of the Montreux Collaborative
15-19 November 2021

FISCAL SPACE, PUBLIC FINANCIAL MANAGEMENT, AND HEALTH FINANCING IN A TIME OF COVID-19

MEETING REPORT

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World Health Organization


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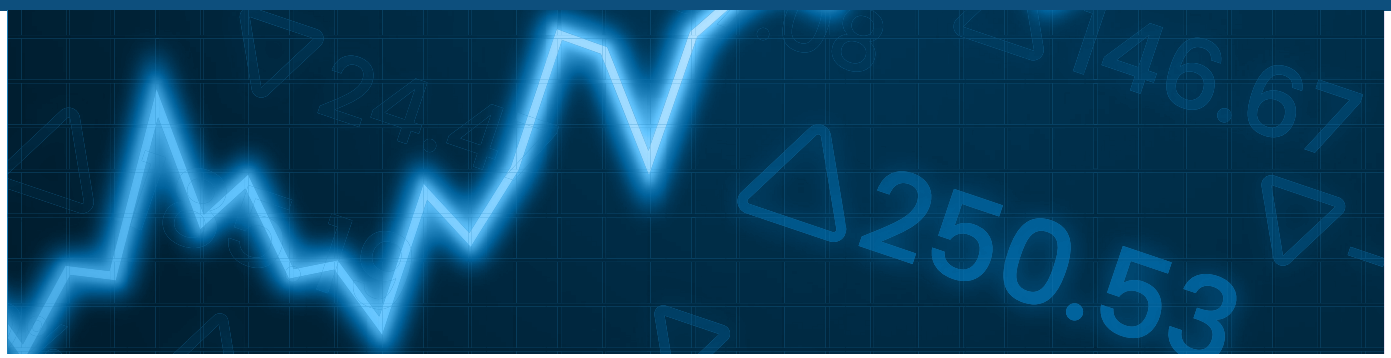


BACKGROUND

Since 2014 WHO has convened the Montreux Collaborative bi-annual meeting, bringing together experts and partners to discuss the critical relationship between fiscal space, public financial management (PFM) and health financing towards advancing universal health coverage (UHC).

The Montreux Collaborative aims to:

- → Raise the profile of public finance towards achieving UHC
- → Exchange ideas and lessons to support the implementation of effective and sustainable reforms in health
- → Broaden the network of experts and partners engaged in public finance issues for health

This year, 2021, not only marked the 5th meeting of the Collaborative, but it was also the first meeting held in the context of COVID-19. In response to the pandemic, many countries have either temporarily relaxed PFM rules to provide greater financial flexibility and to tailor accountability systems amid the crisis. However, the pandemic has also exposed and exacerbated systemic PFM bottlenecks in health spending that cannot be addressed by temporarily relaxing PFM rules, and which have implications on the progress towards attaining UHC.

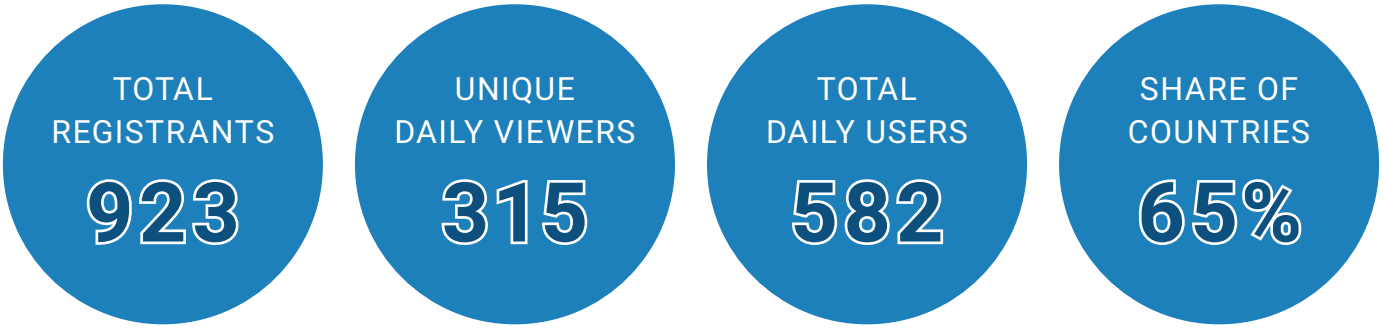
It was against this rapidly developing context that the 5th Montreux Collaborative meeting focused on the policy options available to countries to rebuild and strengthen health financing and PFM systems to ensure they support efficient and equitable health service delivery and are more responsive to future shocks.

The 5th Montreux Collaborative meeting was organized by the WHO Department of Health Systems Governance and Financing in collaboration with various development partners, foundations and civil society organizations active in the PFM and health agenda, including the World Bank Group, the International Monetary Fund (IMF), the Organisation for Economic Co-operation and Development (OECD), the United Nations Children's Fund (UNICEF), Gavi, The Vaccine Alliance, The Global Fund to Fight AIDS, Tuberculosis and Malaria, International Budget Partnership, Overseas Development Institute (ODI), Results for Development (R4D), and ThinkWell.

PARTICIPATION

The meeting was a virtual event, with a total of 923 registrants. Each day hosted on average up to 582 users over the 4 days. Most participants were country representatives, including representatives from ministries of health, ministries of finance, health insurance agencies, and local NGOs.

MONTREUX MEETING PARTICIPATION STATISTICS



Fifty experts from various organizations and countries were mobilized to chair sessions, deliver technical presentations, provide inputs into panel discussions or support the questions and answers' function.

LIST OF CONTRIBUTORS

SESSIONS	CONTRIBUTORS
Keynote speeches to mark the 5th Meeting of the Montreux Collaborative	Joe Kutzin, Chair (WHO) Cheryl Cashin (R4D)
Book launch – How to make budgets work for health: a WHO guide to designing, managing and monitoring programme budgets	Matt Jowett, Chair, (WHO) Hélène Barroy (WHO) Mark Blecher (Ministry of Finance, South Africa) Jason Lakin (International Budget Partnership) Richard Kabagambe (Ministry of Health, Uganda) Omi Castañar (formerly, the Department of Budget and Management, the Philippines) Linea Mills, Q&A support (WHO)
Macro-fiscal crisis and COVID-19: What are the implications for health financing and UHC?	Susan Sparkes, Chair, (WHO) Raphael Espinoza (IMF) Dileep De Silva (Ministry of Health, Sri Lanka) Mawuli Gaddah (Ministry of Finance, Ghana) Tamas Evetovits (WHO) Ajay Tandon (World Bank) Peter Cowley, Q&A support (WHO)

SESSIONS	CONTRIBUTORS
What can COVID-19 teach us about PFM?	Srinivas Gurazada, Chair (PEFA) Richard Allen (Public Finance consultant) Mario Villaverde (Ministry of Health, the Philippines) Ogali Gaarekwe (National Treasury, South Africa) Sarbani Chakraborty (Health finance consultant) Teresa Curristine (IMF) Hélène Barroy, Q&A support (WHO)
How to assess PFM bottlenecks and monitor reform progress in health: a rapid update on PFM tools	Toomas Palu, Chair (World Bank, UHC2030) Manoj Jain (World Bank) Julia Dhimitri (PEFA) Matt Jowett (WHO) Hélène Barroy (WHO) Jennifer Asman (UNICEF) Sierd Hadley (Overseas Development Institute) Adanna Deborah Ugochi Chukwuma (World Bank) Faraz Khalid, Q&A support (WHO)
Direct facility financing: what are the opportunities and challenges with PFM systems?	Joe Kutzin, Chair (WHO) Sophie Witter (WHO) Sheila O'Dougherty (Health financing and service management consultant) Gemini Mtei (USAID/Abt Associates) Nirmala Ravishankar (ThinkWell) Ayodeji Oluwole Odutolu (World Bank) Michael Borowitz (The Global Fund) Federica Margini, Q&A support (UNICEF)
Health budget execution performance: how to get on the same page?	Cheryl Cashin, Chair (R4D) Hélène Barroy (WHO) Moritz Piatti (World Bank) Loraine Hawkins (Health finance consultant) Sabeen Afzal (Ministry of Health, Pakistan) Fazeer Rahim (IMF) Sally Torbet (International Budget Partnership) Amna Silim, Q&A support (WHO)
Donor funding: how to facilitate alignment with domestic PFM systems?	Magnus Lindelow, Chair (World Bank) Moritz Piatti (World Bank) Zachee Iyakaremye, (Ministry of Health, Rwanda) Amir Aman Hagos (Global Financing Facility) Eric Boa (The Global Fund) Agnès Soucat (Agence Française de Développement) Sarah Alkenbrack, Q&A support (World Bank)
Digital technologies: what are the opportunities for better PFM in health?	Sanjeev Gupta, Chair, (Centre for Global Development) Manal Fouad, (IMF) Anupam Raj, (Ministry of Finance, India) Erick Kitali, (President's Office, Tanzania) Neil Cole (CABRI) Inke Mathauer (WHO) Fahdi Dkhimi (Q&A support, WHO)

SESSIONS	CONTRIBUTORS
Concluding Session	Joe Kutzin (WHO) Farhad Farewar (Management Sciences for Health) Gemini Mtei (USAID/Abt Associates) Midori de Habich (Abt Associates) Pura Angela Co (ThinkWell) Lachlan McDonald (WHO consultant) Cheryl Cashin (R4D) Hélène Barroy (WHO)

ACKNOWLEDGEMENTS

This report was developed by Amna Silim and Hélène Barroy, under the guidance of Joseph Kutzin from the Health Systems Governance and Financing Department of WHO. It has been reviewed by Sheila O'Dougherty and Susan Sparkes.

WHO acknowledges funding support received from GAVI, the Vaccine Alliance under the sustainability SFA. The Health Systems Governance and Financing Department of the WHO also benefited from funding support from the Canadian Funds for ACT-A. This support has been instrumental to prepare and deliver the meeting, as well as to support the program of work on fiscal space, public financial management and health financing in the context of the COVID-19 pandemic.

MORE INFORMATION

Agenda, PowerPoint presentations and sessions recordings are available at:
https://www.who.int/news-room/events/detail/2021/11/15/default-calendar/5th-meeting-of-the-montreux-collaborative

Background resources including working papers and daily summary of sessions Q&A are available at:
https://www.pfm4health.net/montreuxcollaborativeresources

PRE-MEETING EVENTS

15 NOVEMBER 2021

KEYNOTE ADDRESS

Reflecting on the past and looking to the future: shifts in the global PFM and health financing environment

CHERYL CASHIN
Managing Director, Results for Development

Moderator: Joe Kutzin, WHO

Highlights from the keynote

- There is now a deeper understanding of PFM and health financing issues, and their relationship to each other
- COVID-19 provides an opportunity to strengthen health financing and PFM systems to accelerate progress towards UHC
- PFM remains critical to achieving the objective of strengthening health financing. It is no longer about bypassing PFM systems but aligning and strengthening these systems to move towards UHC
  It is important to ensure that new and effective emergency flexibilities introduced in response to COVID-19 become more routine to strengthen service delivery
- Get specific about balancing flexibility and control to maximize results from health spending while ensuring accountability
- Understand that the transition from donor funding is an opportunity for structural reform.

Cheryl Cashin, Managing Director of Results for Development, delivered the keynote address for the 5th meeting of the Montreux Collaborative. As one of the initial conveners of the Collaborative, Cheryl discussed how far the thinking on PFM and health financing has come since the first meeting in 2014, whether the early objectives and the starting point for the Montreux Collaborative remain relevant today, and how the thinking may evolve in the future. The session was chaired by **Joe Kutzin**.

Early objectives of Montreux Collaborative:

1. Aligning health financing and PFM to institutionalize results-oriented reform.
2. Informing global debates and country policy dialogue on financial sustainability in the health sector and transition from aid.

Cheryl noted that the early objectives, while they have been refined further, remain relevant and have accelerated in urgency given the pandemic. Concerning where we are today, Cheryl explained that there is now greater analysis

and evidence, more productive engagements with partners, and deeper collaboration between health and finance stakeholders resulting in a deeper understanding of the issues.

The initial diagnosis: PFM systems can be an obstacle in effectively implementing health financing policy. This is because PFM systems can limit flexibility (particularly for health purchasing) and they can restrict how funds flow through the health system, which can make it difficult to achieve health financing objectives.

And now: The thinking has since advanced, now there is a recognition that although misalignments exist between PFM and health financing, PFM remains critical for strengthening health financing and service delivery. It is no longer about bypassing PFM systems but about strengthening these systems to achieve UHC.

1. After an assessment of how far the thinking has advanced, Cheryl went on to discuss the learnings since 2014. First, there is a better grounding of the health financing reality within the overall country budget framework (eg multi-year expenditure plan).

2. Second, there is a more nuanced understanding of health sector-specific PFM solutions. We are no longer talking about bypassing PFM systems but focusing efforts on how to leverage PFM systems better to achieve health sector objectives.

3. Third, to get the desired results from health spending there is a need to implement the right balance between flexibility and control within PFM systems and processes. This is a core area of tension between health and finance; however, accountability does not necessarily have to be compromised as part of achieving this balance but rather integrated into the equation.

4. Finally, any discussion about where we are today, would not be complete without a discussion about the pandemic, its implications, the learnings, and a way forward. Cheryl noted that the pandemic has ravaged our complacency about what we know about health systems and macro-fiscal principles, and it has also exposed systemic weaknesses. However, Cheryl also urged participants to ask themselves, in the context of the work we do, how can we turn this crisis into an opportunity?

Her reflections included making new emergency flexibilities, introduced in response to COVID-19, more routine to address the underlying uncertainty that is endemic to the health sector, not just the pandemic. Another important learning was that the health systems that have responded most effectively to the pandemic had more responsive, and adaptable PFM rules. And finally, experience so far has shown that the most effective responses involved granting frontline providers access to flexible funds.

To close, Cheryl highlighted the following actions that need to be addressed as a matter of priority to achieve UHC objectives. These included:

- Fully implementing programme-based budgeting
- Reducing ex-ante line-item controls
- Getting flexible funds that integrate output-based payments to frontline health care providers
- Increasing health provider autonomy
- Reduce fragmentation in funding sources, systems, and reporting—including and especially fragmentation caused by donors
- Invest in more systematic learnings from country-level progress.

The session closed with an engaging Q&A session with participants. The discussion focused on the balance between flexibility versus control, how to ensure accountability, understanding the use of budgetary frameworks to increase fiscal space, how to implement performance-based financing (PBF) as part of a broader PFM system, among other important themes.

One key topic discussed during the Q&A session was the need to review budgetary frameworks to increase budgetary space over and above the continued focus on generating or mobilizing revenue. Here, Cheryl once again emphasized the importance of working within existing mechanisms instead of only focusing on solutions outside the PFM or budgetary framework. The discussion also examined the role of formula-based budget allocations. During this discussion, Cheryl explained to the audience that this type of allocation allows the distribution of resources that better reflects needs and more equitable financing for services.

Other themes that were discussed included the role of PBF, adding new mechanisms to meet financing needs, the importance of provider autonomy and the need to integrate and align processes versus bypass PFM mechanisms. On PBF, Cheryl emphasized the need to recognize these mechanisms as an add on to existing payment systems and not a separate system. They can act as a catalyst to strengthen or balance incentives, however, if it is not integrated into health financing/purchasing and PFM frameworks and systems, Cheryl warned that it can create additional challenges. On adding new mechanisms or bodies such as health insurance agencies to health financing, Cheryl stressed to participants that it is critical to first do no harm – often to bypass PFM rigidities that stand in our way we avoid or add on to the existing system, however, there is a risk we inadvertently increase fragmentation that is debilitating health financing systems. And furthermore, it is hard to reverse these new mechanisms, and it is hard to defragment these systems. It is therefore worthwhile placing effort towards unpacking how to strengthen existing health financing and PFM systems before looking for options outside these systems.

Provider autonomy was also stressed during this session as critical towards achieving outcomes. As part of this discussion, the question of what conditions need to be met before flexibility is introduced was examined. Here, it was stressed that the role of the Ministry of Finance must not be overlooked, currently, there is limited capacity within finance to support the reforms discussed (i.e., programme budgets, extending flexibility) and this needs to be addressed.

Overall, this session highlighted to participants, many of whom have been involved since the inception of the agenda, that a lot of progress has been made on the conceptual front regarding the interplay between health financing, fiscal space and PFM systems. And this shared deeper understanding has served to make public money more effectively meet UHC goals.

BOOK LAUNCH

How to make budgets work for health: a WHO guide to designing, managing, and monitoring programme budgets in the health sector

Key messages

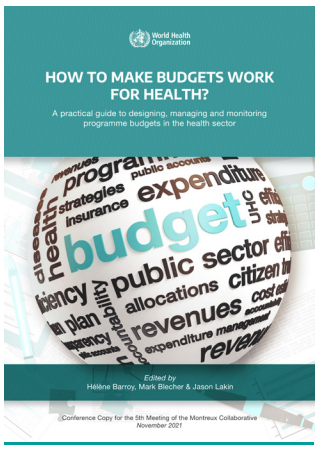
- Input-based budgets are not the most appropriate structure for the health sector
- The design and formulation of budgetary programmes matter
- Programme budgets provide flexibility to meet emerging health sector needs
- Not all programme budgets are conducive to reducing financial fragmentation in the health sector
- Need to integrate disease interventions into broader budgetary programmes
- Need to relax line-item controls and provide flexibility within programme envelopes
- Empowered and accountable funds managers are critical to its success– from top to frontlines
- Programmed budgets require an output-based accountability framework, linking expenditure to outputs.

The first session of the Montreux Collaborative opened with the official launch of the book *How to make budgets work for health: a WHO guide to designing, managing, and monitoring programme budgets in the health sector.* The session was chaired by **Matt Jowett**, WHO.

The editors of the book, **Hélène Barroy** (WHO), **Jason Lakin** (IBP) and **Mark Blecher** (National Treasury, South Africa) delivered the opening presentation highlighting the key messages of the book. Hélène started by presenting the rationale behind this programme of work which started in 2017. This work was driven by a growing understanding in the health and finance community that input-based budgets are not appropriate for the health sector. However, there was limited knowledge in the sector regarding how to introduce other forms of budgets, or how to transition to budgets that are formulated around programmes or outputs.

As a result, Hélène explained that the objectives of the book were to:

- Improve health stakeholder understanding of and engagement in budget formulation reforms and stakeholder discussions with finance/budgetary authorities
- Create a set of guiding principles to support health authorities in the design, management, and monitoring of programme budgets
- Highlight good practices from extensive country reviews to support future reform processes.

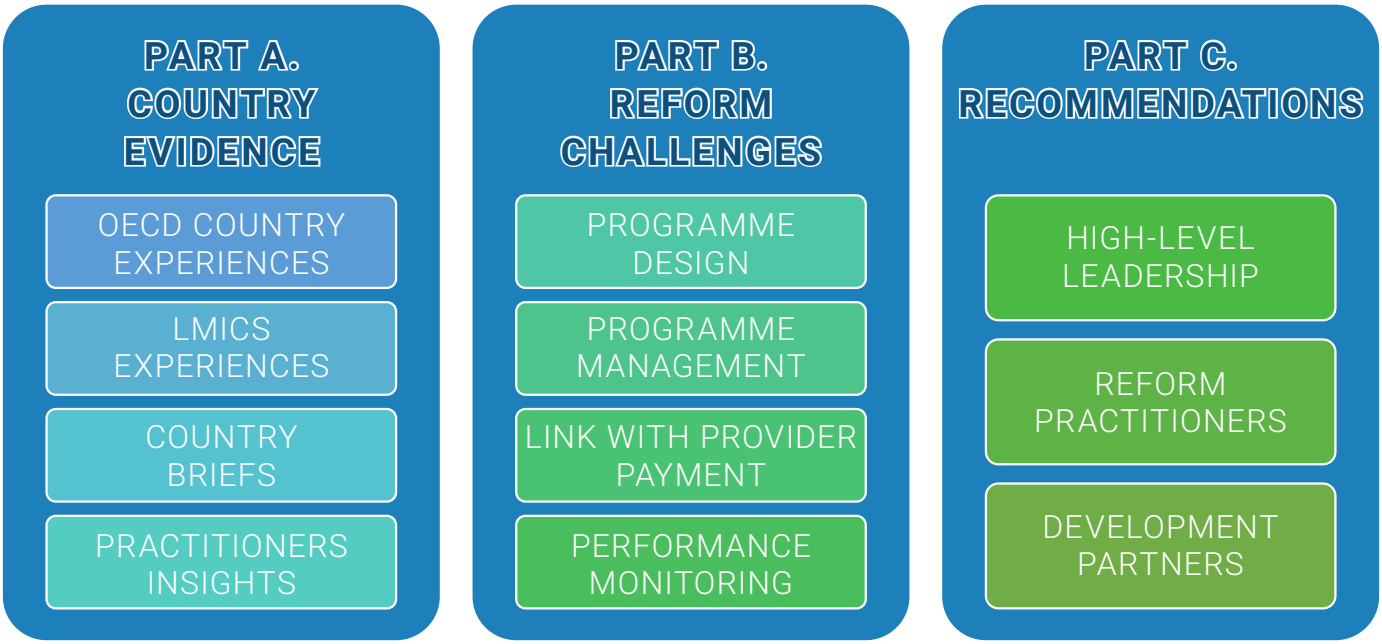


Hélène explained that the overall observation that has guided the development of this book is that health has some common features with other sectors, but that health is also very different. On the one hand, there is a recognition that health is one sector among other sectors and therefore during the transition towards budgetary programmes,

health needs to align with the common rules of program-based budgeting. On the other hand, the evidence also shows that health, as a sector, has some specificities which require special consideration in the transition to programme budgets. For example, one question that highlights the type of health specificities that need to be considered in the transition to programme based budgeting is how to include disease interventions in programme budgets. Should malaria-related interventions be a separate budgetary programme? Should they be integrated into broader programme structures? The answer to these questions will have some important implications for financing and delivering services. The book was developed with these unique needs in mind, and it aims to highlight and integrate PFM considerations (or the PFM language) to the health community and conversely also highlight health specificities to the PFM community to facilitate a two-way dialogue to make programme budgets work better for the sector.

Hélène then presented the overall structure of the book. In the introduction of the book, the authors provide the background and context for the work. The book is then separated into three parts: Part A looks at country evidence and provides lessons from OECD countries and low and middle-income countries (LMICs), as well as practical insights from reform practitioners. Part B looks at the design and formulation of budgetary programmes in health, the management of programmes, the key challenge of aligning programmes with provider payments, and then the monitoring of the performance – Part B is the core of the book. Part C provides key recommendations for leaders, practitioners, and development partners.

Book structure on programme-based budgeting in health



Jason focused on providing a summary of the book's technical recommendations. The book recommendations or key messages are grouped into three main areas: i) the design of programmes (in red below), ii) the management of programmes (in green) and the performance monitoring of programmes (in grey).

Book recommendations on programme-based budgeting in health

The editor's presentation was closed by Mark Blecher describing how practitioners can use this book to guide reform. The book is relevant for countries that are in the early design phase of the reform, but it also provides recommendations that can support reform refinements at a more mature stage. The editors remarked that the book includes a diverse range of global examples (14 in-depth country studies were conducted to generate evidence) and hopefully, these varied experiences can enrich and inform ongoing and future programme budget reforms.

The session also featured a video on key technical messages from book contributors and first-hand perspectives from practitioners from Uganda and the Philippines. The video included technical messages from **Chris James** (OECD), **Moritz Piatti** (World Bank), **Elina Dale** (Norwegian Institute for Health) and **Maarten de Jong** (public finance expert). The video also included a supporting message from **Santiago Cornejo**, from GAVI, a funding partner of this programme of work.

Richard Kabagambe, from the Ministry of Health, highlighted the key for effective programme budget implementation in Uganda was the need for political commitment and adopting a phased approach. **Richard** also highlighted to participants a few achievements from the reform, which included better alignment to the health sector development plan and accelerated progress towards certain health sector objectives. **Omi Castañar**, formerly of the Department of Budget and Management, noted that one of the challenges in the Philippines was crafting appropriate programs and sub-programs for the health sector, particularly as there was an inclination within the government to create lots of programmes. Omi also noted that the success of this reform is contingent on a clear understanding of how existing budget rules would be affected by the shift to programmes.

We heard about practical implementation challenges of programme budgeting in health

"Health as a sector has some specificities that need to be recognized when adopting program budgets"

HELENE BARROY

"Programme budgets need to be implemented well, otherwise can create more problems; good to understand common pitfalls and actionable recommendations to make them successful"

JASON LAKIN

"Most program managers at the DOH wanted their own program. A fragmented budget makes budget execution rigid"

OMI CASTAÑAR, The Philippines

"South Africa has gradually integrated disease interventions into broad programmes. We need to remove line-items controls as a next step to our programme budgeting reform"

MARK BLECHER, South Africa

MAIN EVENT'S SESSIONS

16-18 NOVEMBER 2021

TUESDAY 16 NOVEMBER 2021

Macro-fiscal crisis and COVID-19: What are the implications for health financing and UHC?

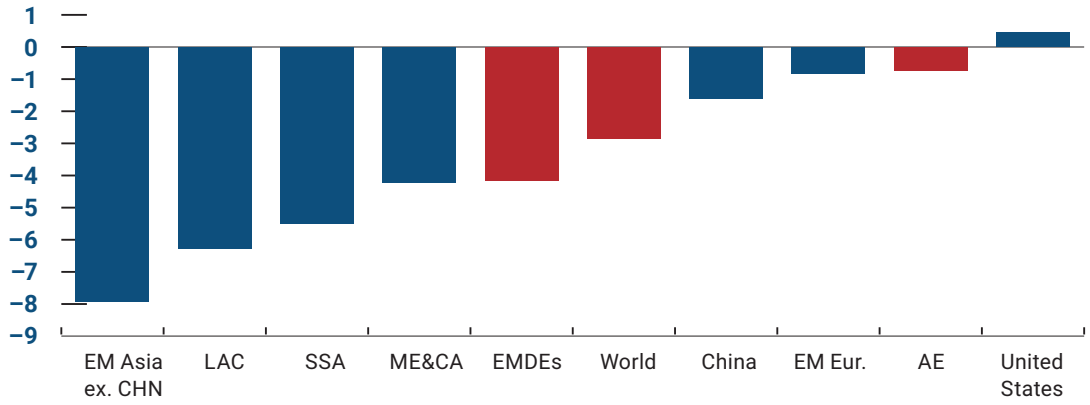
Key messages

- Divergent macro-fiscal impact and recovery across income and regions
- LMICs are more likely to experience deeper economic scarring due in part to divergence in access to vaccines and revenue/borrowing constraints
- Increased debt risk in LMICs, and reducing it will be a challenge in the medium term
- Budgetary flexibility is required to mitigate fiscal gaps
- Recalibrating deficit rules is being considered (mostly in HIC)
- Extra effort is required towards improving efficiency in spending
- COVID-19 exposed existing macro-fiscal weaknesses
- Solutions do exist e.g., broadening the revenue base, introducing automatic stabilisers, and de-linking access to services to employment-based contributions.
- Budget prioritization for health is essential to mitigate fiscal risks.

This session of the Montreux Collaborative, chaired by **Susan Sparkes**, WHO, focused on the macro-fiscal impact of COVID-19 on health financing and progress towards UHC. **Raphael Espinoza**, Fiscal Affairs Department at the IMF, started the session by presenting the latest macro-fiscal outlook. This broad overview provided the necessary context in which health financing policy is situated. The presentation highlighted how COVID-19 has triggered a severe global economic crisis, followed by divergent recoveries between countries, with LMICs facing deeper and longer contractions. Raphael discussed how access to vaccines and unfavourable borrowing conditions are contributing to a protracted and divergent recovery.

Medium-term GDP losses relative to pre–COVID-19, by region

(Revisions to projected 2024 GDP levels between the January 2020 and April 2021 WEO forecasts, per cent)



After highlighting the challenges that have emerged as a result of the pandemic, the session detailed the size and nature of the fiscal support received to address these challenges. Raphael noted that support to tackle the pandemic has varied across regions, for example in LICs, official support has largely protected health spending while in emerging economies it has also emphasized public works and social support. In addition, while health spending might have been protected in LMICs in the short-term, cuts in critical non-COVID 19 areas such as education and investment have also been experienced.

So, what more can be done? Raphael provided some reflections on policy options such as implementing budgetary rules to help achieve debt and deficit objectives. However, he noted, budgetary rules also need to provide enough flexibility to ensure a resilient recovery. In addition, the IMF has also stressed the importance of examining the room for improving the efficiency of spending, in other words, many governments could do more with existing resources.

After the presentation, discussants were invited to reflect on the impact of the macro-fiscal outlook on health financing. **Dileep De Silva** from the Ministry of Health, Sri Lanka, provided a summary of the impacts of COVID-19 on Sri Lanka's fiscal outlook. He described how the pandemic has exposed pre-existing macro-economic weaknesses (i.e., high debt and deficit) in Sri Lanka. De Silva also noted that the medium-term outlook is now clouded by 'pre-existing macroeconomic weaknesses and the economic scarring from the COVID-19 pandemic'. The government's primary strategy to respond to the COVID pandemic has focused on expanding vaccine coverage. To this end, Sri Lanka has mobilised its already well-established primary health care staff towards the vaccination drive, however, this has affected the delivery of routine maternal and child health services, school health and mental health. Finally, De Silva, explained that COVID-19 related challenges are likely to persist in the future and that even in a context where health has been historically prioritized, the health sector will likely see reduced allocations due to budgetary constraints in the future.

Mawuli Gaddah, Ministry of Finance, Ghana, provided a succinct overview of the impact of COVID-19 on the macroeconomic outlook, health financing and UHC in Ghana. Similar to the Sri Lanka experience, COVID-19 has had a profound impact on the economy. Before the pandemic, Ghana was making progress on their fiscal position, the deficit was contained within 5 per cent and the primary balance was positive. However, once the pandemic hit, GDP contracted, revenues were hit, and expenditure was overshot. In response to COVID-19, the Ghanaian Government took swift and decisive action, including suspending fiscal responsibility rules to respond effectively to the crisis. Ghana also introduced a COVID health levy after consultations with the public highlighted that "Ghanaians were willing to pay more taxes to support the government's effort to respond to the pandemic".

After hearing from country representatives, **Tamás Evetovits** from WHO EURO and **Ajay Tandon** from the World Bank closed out the session with a few more insights. Tamás highlighted the importance of vaccines in not only improving health outcomes but rebuilding and stimulating the economy by getting more people back to work. The case for investing in vaccines should therefore also include an analysis of how vaccines generate additional tax revenues and their contribution to economic recovery and growth. Tamás also reminded participants that this is not the first global crisis and that "we should learn lessons from previous crises". For example, previous crises have highlighted the importance of broadening the revenue base, introducing automatic stabilisers, and de-linking access to services to insurance contributions. Finally, there was a call for much stronger international solidarity. Without it, Tamás said 'there will be no recovery or sustainable health financing in LMICs if donor community does not invest more'. Ajay Tandon echoed many of the sentiments expressed earlier in the session. He emphasized that COVID-19 was not just a health shock and not just a macroeconomic shock – but it reverberated at the household level, with poverty rates rising in several regions. He argued that investing in the health sector and in particular vaccines will be very important for any recovery and that we are already seeing a divergence in economic recovery due to varying

levels of vaccine coverage. In addition, Ajay argued the case for universal health coverage is even more relevant with unemployment rising, and LMIC's with huge informal sectors particularly hard hit by the crisis.

To address financing constraints, Ajay argued, it is prudent to re-examine fiscal policy such as taxes on carbon, tobacco, and sugar products. Finally, to close, participants were reminded that in addition to efficiency and its relationship to extending service coverage, we must not forget critical equity considerations such as benefit incidence – particularly in LMICs which have experienced deep economic scarring.

How can countries mitigate fiscal risks in the context of COVID-19

What can COVID-19 teach us about PFM?

Key messages

- COVID-19 has accelerated the demand for strengthening PFM
- Lessons are being learnt from this crisis and previous crises and these need to be institutionalized
- Flexibility is critical for any response, countries with flexible PFM systems were better equipped to respond to the pandemic
- Utilizing existing flexibilities is often under-emphasized (e.g., authorized virements)
- Balancing flexibility and speed of response against transparency and accountability is key
- Beware of fragmentation: refrain from using extra-budgetary mechanisms to channel funding
- Building back better requires refining PFM emergency regulations and sustaining some emergency flexibilities to enable progress towards UHC.

Building on the previous discussion focusing on COVID-19 and the macro-fiscal outlook, this session focused on the implications of COVID-19 for expenditure and what lessons can be learnt to strengthen and tailor PFM systems.

Revenues are not enough; addressing PFM bottlenecks is also needed for an effective COVID-19 response and to support progress towards UHC.

Srinivas Gurazada, PEFA secretariat, the chair of the session, explained how COVID-19 has been a stress test for all PFM systems across the world. It has forced countries to adapt their PFM systems to provide greater financial flexibility and to tailor accountability systems amid the crisis. To learn and adapt to this ongoing pandemic, this session facilitated a critical discussion on early learnings.

To start the session, **Richard Allen**, one of the leading global PFM experts, formerly with the IMF, presented the main options to increase health spending during a crisis, followed by six key PFM lessons emerging from the COVID-19 crisis.

Six key PFM lessons from the pandemic

LESSON 1
Effective health financing systems and effective emergency responses require critical PFM fundamentals to be in place.

LESSON 2
Finance ministries should build an analytical framework to test whether emergency funding mechanisms add value and whether they should be sustained beyond the crisis.

LESSON 3
Balancing flexibility and speed of response against transparency and accountability is key.

LESSON 4
Extra-budgetary funds have been useful in some countries but can create large fiscal risks and a potential accountability deficit (should not be sustained post pandemic).

LESSON 5
Program budgeting can help facilitate emergency financing of COVID-19 responses (related to flexibility).

LESSON 6
Capacity constraints may limit the ability of LMICs to manage health-related resources efficiently and effectively.

After this broad discussion, country experts from the Philippines and South Africa were invited to discuss their experiences of the key PFM barriers and enablers for driving an effective emergency response. **Mario Villaverde** from the Department of Health described how the COVID-19 situation heavily stressed the PFM system and highlighted existing gaps in the health system. In the Philippines, the pandemic required adjustments such as the enactment of special laws, the availment of loans and grants, the creation of a benefits package to support health facilities, and the mobilisation of funds from other sources such as local government units and private corporations to support COVID-19 activities. Key lessons learned were also shared, for example, how different sources of financing can result in unsynchronized spending which creates inefficiencies within the system, hence, Villaverde emphasized the need for harmonization and integration in planning and financing mechanisms.

Next, **Ogali Gaarekwe**, from the National Treasury, South Africa, described how more than a decade of weak economic growth, rising debt, escalating debt service costs, and unpaid bills (accruals and payables) in the health

sector had severely constrained public finances in South Africa. As a result, once the pandemic hit, this crisis further exacerbated the already weak fiscal position. In addition, the pandemic also created new PFM issues that needed to be addressed, such as procurement challenges due to significant disruptions in the supply chain, or additional requirements for COVID-19 related multilateral loans. To tackle the pandemic in South Africa, there was a range of adaptations and solutions implemented such as accessing the disaster relief grant, utilizing existing PFM mechanisms, and engaging other emergency procedures. Ogali argued that effective PFM responses to the pandemic should include mechanisms that allow for rapidly augmenting allocations in-year and exploring the use of existing mechanisms before introducing new mechanisms.

Experience from the Philippines and South Africa told us that PFM rules can be adapted to cope with crisis

THE PHILIPPINES

- Realignment of savings from regular budget
- Special legislation to provide **additional budgetary allocations**
- Creation of benefit package for Covid-19
- **Adaptation of provider payments**
- Interim Reimbursement Mechanism of PhilHealth – allowing the **frontloading of funds** to health facilities.

SOUTH AFRICA

- **Ring-fenced transfer** from National Disaster Management Centre to provinces
- **Use of built-in flexibilities:** facilitated by programme budget
- **Flexible resource use:**
  - PFMA S29 authorises spending before the 2020 Appropriation Bill was enacted (23 July 2021).
  - PFMA S43 authorises virements within budgets; Appropriation Act s6 allows Minister of Finance to authorise expenditure for areas not budgeted for

Discussants were then invited to share their perspectives on possible ways to rebuild and transform PFM systems to make them more responsive and tailored to health needs. **Sarbani Chakraborty** reflected on how countries that had already started fundamental PFM reforms were better prepared to respond to COVID-19 needs, therefore countries should not wait for another emergency to launch reforms. Building on ongoing work with WHO, Sarbani also emphasised the need for flexibility as part of any effective response to the pandemic. In addition, countries that adopted programme budgeting were often able to move fast and reprioritise within programmatic envelopes. However, she stressed that programme budgeting isn't a magic bullet, we need to acknowledge that programme budget reforms take time but in the long run they can contribute to pandemic preparedness. The second discussant **Teresa Curristine** from the IMF provided further perspective on the response, and raised an important insight, that countries that have learnt from previous crises (economic and health) are better prepared in terms of budgetary response and emphasized the need to sustain these improved practices.

How to assess PFM bottlenecks and monitor reform progress in health: a rapid update on PFM and health tools

In recent years, several development partners have developed technical tools and guidelines to assess PFM bottlenecks and monitor PFM reform implementation in health. Team leads in charge of the development of these

tools joined this short and interactive session to reflect on the different assessment approaches, to discuss how they complement each other, and to identify remaining gaps to further support policy monitoring.

The session, chaired by **Toomas Palu**, World Bank, highlighted that there are several effective methods to identify and address PFM bottlenecks in the health sector, however, to avoid duplication and creating silos, effort is now needed to clarify how to use these tools in a complementary and effective way. Moving forward, the teams agreed to conduct a joint mapping of the various tools and approaches to support harmonization and complementary use at the country level.

World Bank FinHealth: PFM in Health Diagnostic Toolkit'

Presented by **Manoj Jain**, World Bank

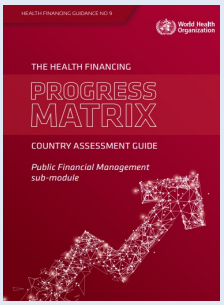
The World Bank FinHealth: PFM in Health Diagnostic Toolkit' aims to help country teams identify key challenges and opportunities associated with PFM arrangements in the health sector within their client countries and programs.

It also proposes possible ways to strengthen PFM arrangements for better planning and implementation of service delivery.

The Toolkit employs a problem-driven approach to identify and analyse the PFM and health finance bottlenecks or enablers that constrain or support service delivery results at the provider level.

These factors are then traced along the service delivery chain to identify the systemic root causes that hamper service delivery or outcomes at the service provider level.

The WHO Health Financing Progress Matrix Country Assessment Guide- PFM Module



Presented by **Matt Jowett** and **Hélène Barroy**, WHO

The WHO Health Financing Progress Matrix Country Assessment Guide is a standardized assessment of country Health Financing policies against 19 "desirable attributes"

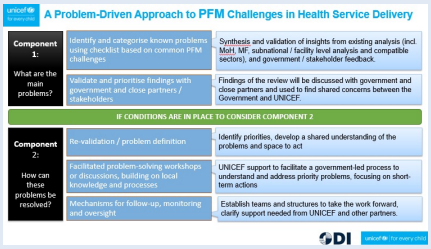
It involves 33 questions across seven assessment areas, one of which is PFM.

For the PFM module, there are five dedicated PFM questions; eight additional questions are mapped as relevant.

These thirteen questions constitute a close look at PFM issues, fully embedded within the health financing framework.

The matrix provides a broad assessment of the PFM system including identifying weaknesses in budget formulation, budget execution and budget reporting i.e., the key steps of the PFM framework and budget cycle.

UNICEF/ODI Problem-Driven Approach to PFM Challenges in Health Service Delivery



Presented by **Jennifer Asman**, UNICEF and **Sierd Hadley**, ODI

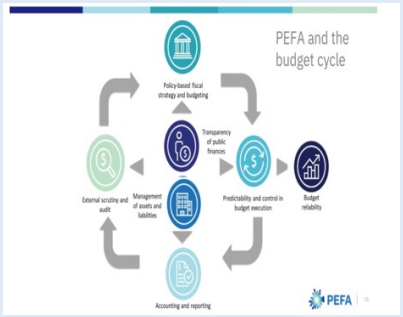
The UNICEF/ODI method adopts a problem-driven approach to the identification of public financial management (PFM) barriers to health service delivery. It builds on original research conducted by ODI examining the relationship between PFM and health services delivery and a subsequent paper reviewing existing diagnostic tools.

The approach has two distinct components:

Component 1: identify and prioritise PFM blockages in the health sector This component includes a methodology for synthesising data and identifying PFM-related problems in health services delivery. It provides a framework, categories, and terminology with which to rapidly identify potential PFM-related blockages in the health sector

Component 2: initiating a joint-UNICEF-Government process to validate and respond to PFM problems affecting the delivery of health services. This is a potential follow-on component designed to support governments where there is a clear desire to strengthen PFM processes in the health sector through structured enquiry and problem-solving.

The PEFA Module



Presented by **Julia Dhimitri**, PEFA

The PEFA module builds on the existing PEFA assessment and focuses on the PFM functions that are most important for service delivery

Taking advantage of the PEFA assessment, through a set of diagnostic questions, assess the extent to which the PFM performance enables efficient service delivery.

Diagnostic questions are mapped to the relevant PEFA framework indicators and cover the entire budget cycle.

No score. Analysis to be presented as a separate annex to the main PEFA assessment report.

Service delivery programs should be selected carefully.

A thorough analysis of the specific service delivery arrangements should be provided.

Currently, this tool is being piloted at the sub-national level, with plans to extend to the national level in further phases.

WEDNESDAY 17 NOVEMBER 2021

Direct facility financing: what are the opportunities and challenges of PFM systems?

Key messages

- Direct facility financing (DFF) = direct provision of funds to health facilities to meet their operational requirements
- A new term for some, but not necessarily a new approach; although it does recognize and enhance the relationship between health purchasing/output-based payment and facility autonomy, financial management, accountability and service delivery
- Main differentiating features: first, funds, including some government general revenues, are directly channeled through output-based payments to health facilities, and second, to improve financial management and accountability, facilities are given managerial autonomy for their use through facility-level PFM systems.
- Changes the nature, efficiency, and quality of public budgets to support the establishment of a provider management platform thus improving equitable service delivery including using budget funds to replace user fees.
- Alters the domestic engineering (or plumbing) of all health financing and PFM functions and systems; not a donor project (though can be supported from external funding)
- Certain preconditions must be met: DFF requires health facilities to set up independent bank accounts, as well as to have the autonomy (and capacity) to manage and be accountable for the funds
- As a system strengthening intervention, DFF has promise if designed with a good fit to the context and its health financing and PFM challenges and rigidities.
- DFF should be seen as a health system strengthening intervention and not just a health financing intervention, this requires DFF to link to other health systems functions including service delivery, human resources and drug supply management.

This session provided an overview of direct facility financing (DFF), summarizing existing literature and evidence, updating participants on the latest thinking and its applicability including examining the DFF experience in Tanzania. In many low- and middle-income countries (LMICs), public funds do not reach the frontlines due to systemic bottlenecks and rigidities in PFM frameworks. To address these bottlenecks, DFF has been implemented to empower service providers to manage public funds directly, giving them the ability to receive, access, manage, account and report on their own funds.

Joe Kutzin, the chair of the session, opened the discussion by emphasizing that DFF is not about a scheme or a project, instead, DFF focuses on how to get funds to front line providers. To open the session, **Sophie Witter** of Queen Margaret University, provided participants with an overview of the DFF concept and its rationale. The problem statement DFF is addressing, she explained, is that only a small proportion of funding reaches front line providers, instead, providers tend to rely on user fees to plug financing gaps. As a result, health service delivery particularly front-line primary health care providers are largely underfunded, which leads to poor efficiency, equity and quality, and this can make it difficult to justify greater funding. Therefore, DFF allows for the direct provision of funds to health facilities to meet their operational requirements. The main differentiating feature is that funds

are directly channelled from national levels to health facilities and that facilities are given managerial autonomy in their use. However, certain preconditions must be met: DFF requires health facilities to set up independent bank accounts, as well as to have the autonomy (and capacity) to manage and be accountable for the funds

Although DFF is often portrayed as a simple intervention it does require considerable groundwork. While the label implies a singular focus on finance, other health system functions are also important. Witter explained that in fact, DFF should be seen as a health system strengthening intervention and not just a health financing intervention.

To provide more practical insight, **Sheila O'Dougherty** highlighted the Tanzanian DFF experience and provided some key lessons for implementing DFF. Sheila framed the discussion using three key principles for DFF and how these principles were applied in the case of Tanzania.

Principles for Direct Facility Financing

PRINCIPLE	DESCRIPTION
Facility autonomy principle	Ensures health facility has status to receive, manage and account for funds from any legal source or funds flow Tanzania meets principle (condition): all health facilities required to have a bank account and they have a code in the country chart of accounts
Output based payment principle	"Buy the right thing" and better match payment to prioritized services Tanzania meets principle using PHC per capita payment system — Payment formula of base rate per health facility with simple payment adjustors for catchment population (need), distance from local government centre (equity), and utilization (performance) Mixed model: input-based payment for salaries, core output-based PHC per capita, and results-based financing (fee-for-service) on top leveraging all funds
Facility financial management	Facilities as management entities perform basic functions: plan, budget, procure, internal controls, account, report, use of data, audit trail Standard accounting system for all revenue sources or funds flows Reduce fragmentation and inefficiency in management of country and DP funds Tanzania meets principle through two cross-sectoral interoperable PFM systems extended to facility level

Sheila also highlighted some challenges and lessons related to DFF, for example, it does not inherently address pooling problems. Tanzania is currently working to unify the payment system across funds flows (e.g., general revenue/donor budget support, national health insurance/payroll tax, community-based health insurance/private premiums), to address pooling and fragmentation issues in the short term by ensuring consistent financial incentives at the facility level.

Overall, the introduction of DFF in Tanzania has improved: the predictability of the flow of funds to facility level; facility-level planning, budgeting, accounting, and reporting; expenditure and procurement at the facility level; HR motivation and management at the facility level; and governance at the facility level. Finally, the presentation highlighted the importance of recognizing health facilities as management entities requiring separate interventions to build a basic business management platform. This foundation is often overlooked in health financing and PFM design and implementation but can be triggered and established by successful DFF implementation.

The session was followed by discussants providing their views on the opportunities and constraints for scaling up DFF reforms in other contexts, participants heard from **Nirmala Ravishankar** (ThinkWell), **Ayodeji Oluwole Odutolu** (Global Financing Facility), and **Michael Borowitz** (The Global Fund). Overall, discussants emphasized the important contribution DFF can make to health financing, PFM, facility financial management, health service delivery, and moving towards UHC. According to Nirmala, DFF enhances facility autonomy and raises the need to further explore the relationship between devolution and health facility financial autonomy. Wole discussed the experience in Nigeria which included the application of DFF under a federal system, and the need for DFF to focus on the output-based payment principle. Michael echoed other discussants contributions and reflected on the experience of "Swadana" in Indonesia, which provides direct access to flexible funding for targeted facilities. Michael also stressed the importance of not getting caught up on the instrument but rather focus on the problem DFF is trying to solve.

The session closed with an engaging Q&A session with participants. The topics discussed included distinguishing the difference between PBF and DFF, whether DFF is an output-based approach and how it aligns with other payment systems and the preconditions for implementing DFF. This rich discussion provided participants with a broader understanding of DFF and helped to clarify some misconceptions around DFF. Joe closed the session by explaining that DFF is promising, however, it is not a magic bullet and that it should be framed as an approach that enables us to remove health financing and PFM roadblocks that arise during the transfer of funds to service delivery providers.

Health budget execution performance: how to get on the same page?

Key messages

- → Under execution of the health, budget is particularly prevalent in low-income countries
- → De-prioritization of health often happens during budget implementation
- → Previously centred on budget execution rate, but this provides a narrow view
- → Limited understanding of the health specificities and the driving factors of poor performance in the health sector
- → Need to more systematically unpack health and finance-related causes of poor budget execution in health.

Budget under-execution is pervasive in health. This problem is often attributed to the poor absorption capacities of health ministries; however, causes are often more complex. Building on work developed by WHO and the World Bank with support from the IMF, this session provided a preliminary analysis of budget execution in health, followed by a presentation on a common framework for assessing health budget execution issues, mapping their root causes, and identifying policy solutions in a coordinated manner between health and finance. Chaired by **Cheryl Cashin**, R4D, the session began with **Hélène Barroy**, WHO, noting that often budget execution issues fly under the

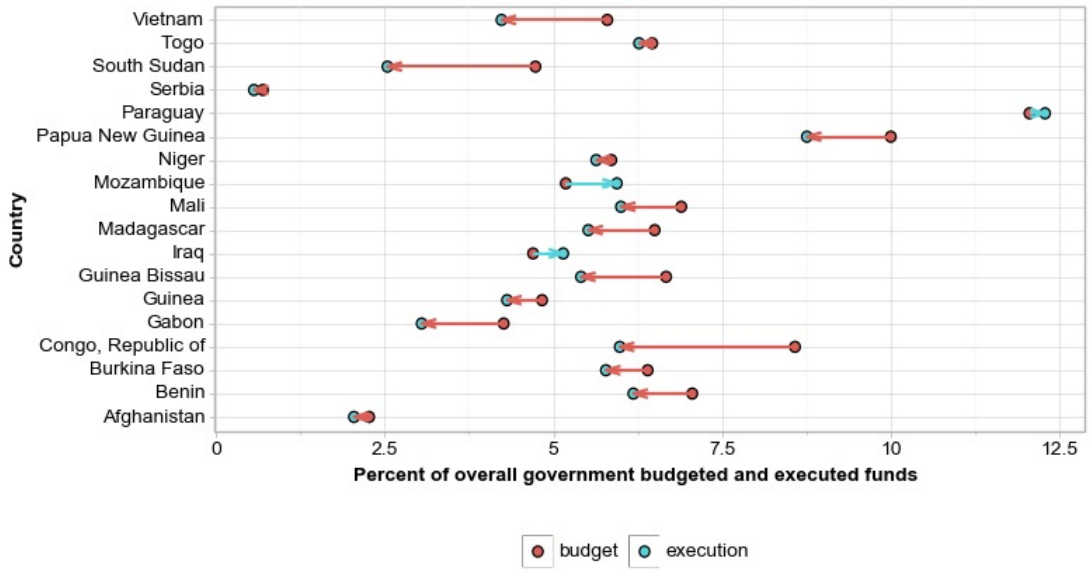
radar, and often the focus is on generating or mobilizing revenue. However, there is a significant loss of budgetary space due to poor budget execution and this requires further examination.

According to Hélène, most analysis on budget execution is limited to assessing execution rates, and there is not yet a clear understanding of the drivers behind poor execution. In this context, WHO and the World Bank have joined forces, Hélène explained, to raise the profile of this challenge, with IMF providing technical support, and Gavi providing financial support.

Moritz Piatti, from the World Bank, then presented findings from a World Bank/WHO background paper on budget execution in health – the first deliverable under this programme of work.

Under execution of the health, budget is particularly prevalent in low-income countries

Deprioritization of health during budget implementation



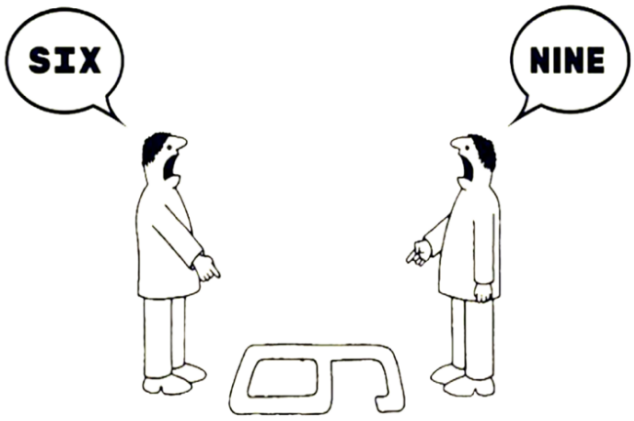
Moritz highlighted the following key findings coming out of the global data analysis of health budget execution rates from 70+ LMICs:

- The health sector in LMIC's is systematically under executed, and poor execution appears to be related to a country's level of income and maturity of the PFM system.
- The budget is not a good guide for how and where public resources are spent
- The health sector is deprioritized during budget implementation
- The health budget compared to the education budget in LMICs tends to be executed at a lesser rate.

So why is it important to get budget execution right? Moritz closed his presentation by explaining to participants that poor budget execution impacts UHC goals, leaving participants with a better understanding of the importance of strengthening budget execution towards meeting UHC objectives (as detailed in the figure table below).

UHC GOAL	HOW BUDGET EXECUTION ISSUES AFFECT THE UHC GOAL
Efficiency	Lacking budget credibility Delay in fund elease Operational budget cuts Arrears Rigidity in spending rules Fragmentation in budget execution protocols
Equity	Equity considerations in budget distorted Increase in user fees to compensate for funding shortfalls
Quality	Poor budget credibility compromise quality Slow and irregular cash releases compromise service quality
Accountability	Overspending without appropriations Lacking accountability undermines autonomy Excessive financial management requirements

This analysis was followed by a presentation from **Hélène Barroy**, WHO. This presentation defined a common analytical framework that can be used to understand budget execution performance and the key driving factors of poor performance in the health sector. Hélène explained that so far, many actors have different views of the budget execution problem and that there is a limited understanding of the health specificities and the driving factors of poor performance in the health sector. This limited understanding leads to little or no concerted action to address the problems.

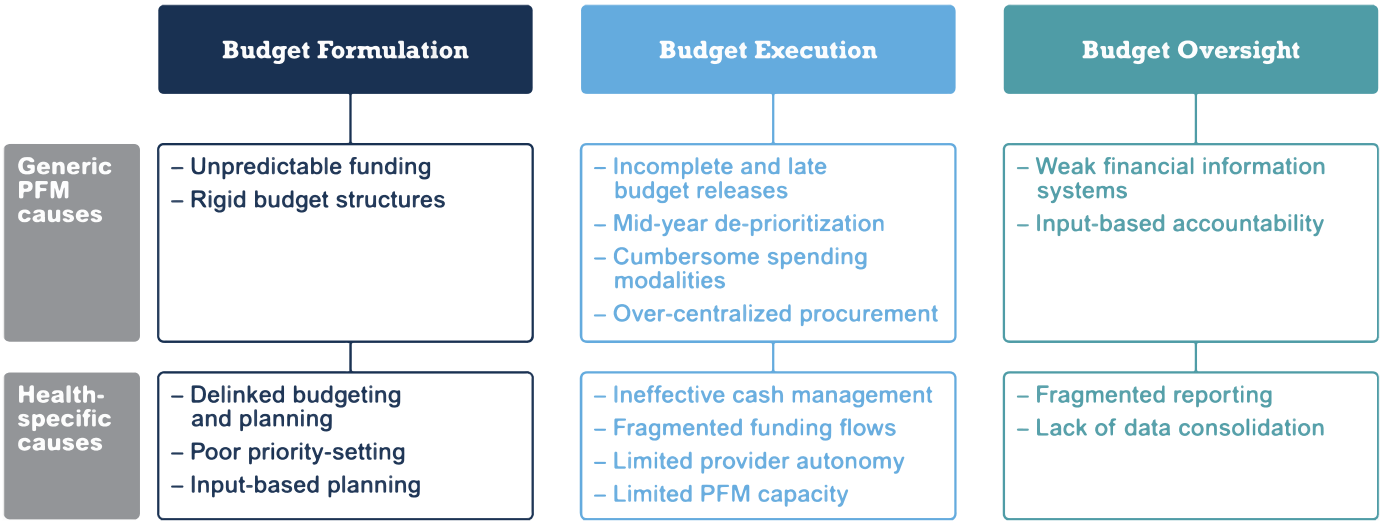


Therefore, to address this gap, Hélène presented a comprehensive analytical framework comprised of four components that enables health and finance to have a common understanding of health budget execution, its challenges, and to identify policy solutions. Key components of the framework include:

1. **Defining the health budget execution system** and its processes by mapping funding flows in light of health financing arrangements, and their spending procedures.
2. **Assessing performance through a multi-indicator approach** that combines both quantitative and qualitative measures to allow for a more comprehensive understanding of health budget execution performance.
3. **Mapping causes of poor performance** to systematically identify and categorize the common causes of poor health budget execution by phase of the budget cycle and by stakeholder (health, finance, sub-national levels).
4. **Identifying solutions.** Following a shared understanding of budget execution performance and its driving factors, health and finance can now work together to define shared actions to address bottlenecks.

As highlighted by Hélène, the approach offers a practical way forward to unpack the problem and find solutions and moves away from the common "limited absorption capacity" diagnosis.

Causes of poor health budget execution



The session also provided reflections from country applications of the framework in Ukraine and Kyrgyzstan from **Loraine Hawkins**. As part of this presentation, Loraine offered some perspectives on how to bring finance and health leaders together to put health budget execution on the agenda and coordinate effective policy change.

UHC goal	Budget execution issue	Present in KR?
Efficiency	Budget not credible	YES
	Delay in fund release	YES
	Operational budget cuts	YES
	Arrears to suppliers	YES
	Rigidity in spending rules undermines incentives for efficiency	YES
	Fragmented execution rules	YES
Equity	Equity in budget allocation distorted	YES
	OOP compensates for funding shortfalls	YES
Quality	Non-credible budget (capex, drugs, supplies) compromises quality	YES
	Slow & irregular cash releases compromise service quality	YES
Accountability	Overspending without appropriations	NO
	Lack of accountability undermines autonomy reforms	YES
	Excessive FM requirements, adding little value	YES

To close the session, participants heard from representatives from the Ministry of Health in Pakistan, the IMF, and the International Budget Partnership (IBP), thereby providing health, finance and civil society perspectives on the topic. **Sabeen Afzal** discussed common budget execution issues in Pakistan, noting that delays and cuts are typical in the health sector. Sabeen remarked that poor budget execution is partly a function of capacity constraints in health, with staff lacking the requisite skills for forecasting a credible budget and as a result often the ministry adopts incremental budgeting. Sabeen also described other challenges, including a cumbersome and rigid budget process in Pakistan, and the MTEF and IFMIS not 'trickling down' to the grassroots level where the actual spending happens.

Fazeer Rahim, IMF, provided an overview of how under execution can negatively impact fiscal policy objectives. He explained the two primary functions of the Ministry of Finance (policy function and transactional function) to participants and how poor execution impacts these core financial functions. Fazeer stressed that the Ministry of Finance has a clear stake in ensuring well-executed budgets across sectors – including the health sector. However, to achieve a well-executed budget requires strong capacity and a clear understanding of roles and responsibilities within the Ministry of Finance and the Ministry of Health. According to Fazeer, this requires better capacity within ministries to formulate budgets, cost policies and also requires the Ministry of Finance to have a stronger role in challenging the Ministry of Health without veering into micromanagement.

Sally Torbet, IBP, closed out by offering a perspective from civil society organizations (CSO). Her remarks highlighted how CSO's can help countries improve health budget execution. For example, CSO's can bring new evidence and perspectives on drivers of poor budget execution. Sally argued this is because problems in health services are best identified when 'we combine rigorous research with information on the lived experience of communities.' Sally also highlighted that budget credibility challenges tend to be both technical and political, and that civil society can help build bridges by creating coalitions for change in the political sphere.

THURSDAY 18 NOVEMBER 2021

Donor funding: how to facilitate alignment with domestic PFM systems?

Key messages

- Using government systems is important and the case for government systems is even stronger given the COVID-19 context
- Alignment is a spectrum; it is not a binary choice and there are many shades of grey in this space
- Government and development partners should set priorities together, and development partners should align to these agreed priorities
- Government can make better decisions when they have a full view of funding
- Development partners can align financing without giving up control or increasing fiduciary risk
- There is a need for a more nuanced dialogue around the use of government systems, this will lead to more meaningful reform
- Donors can also help strengthen some parts of domestic PFM systems.

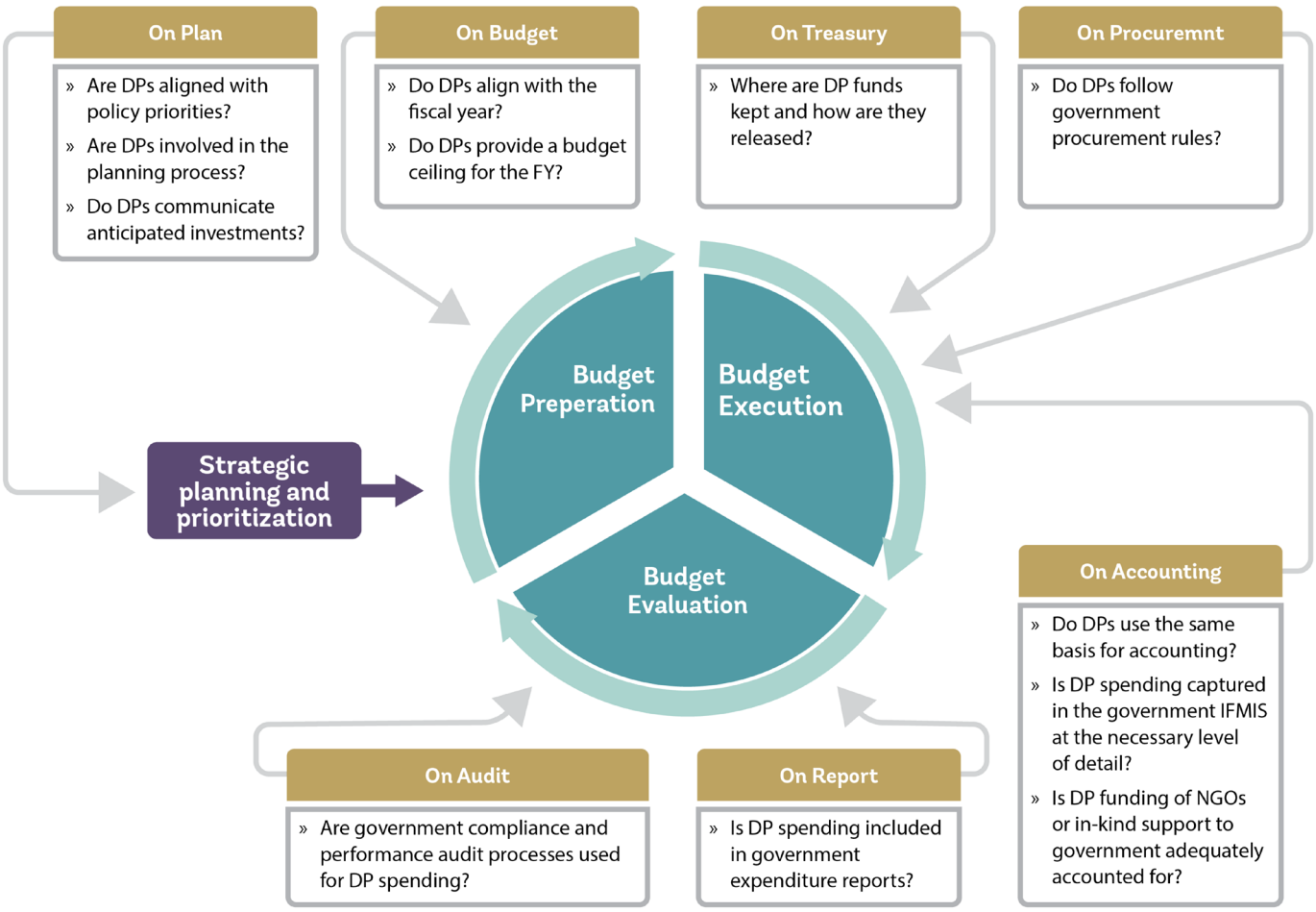
Chaired by **Magnus Lindelow**, World Bank, this session aimed to provide a more nuanced dialogue around the use of government systems, and ways to accelerate donor alignment. Despite many commitments over the last two decades to make greater use of country systems, there remains a lack of clarity on the definition of country systems, how partners can better align to PFM systems, and what can be done to accelerate further alignment.

To dig deeper into this topic, **Moritz Piatti**, World Bank, delivered a presentation highlighting the latest work undertaken by the World Bank on donor alignment. Moritz began the discussion by acknowledging that this was not a new effort, with several donor alignment initiatives implemented over the past few decades. However, despite all these commitments, there hasn't been a lot of progress. There is still duplication of activities, implementation of non-priority activities, slow response to emergencies, among other impacts and altogether this slows progress towards UHC. Therefore, it is worthwhile to reignite efforts to align external funding with the domestic PFM system.

To this end, Moritz presented key messages from a World Bank paper entitled 'Following the Government playbook'. This paper provides clarity on the definition of country systems, which is important as often the definition of government systems is vague, and its interpretation varies. For example, what do we mean by 'on system', 'on budget' or 'off budget'?

Thus far, whether countries use government systems has been a binary assessment, Piatti explained, it often asks 'Are we using government systems or no?'. However, unlike these assessments, the diagnostic in this paper encourages us to get away from this terminology and look at what it takes to be 'on'. This is done by assessing alignment through all the PFM stages to understand to what 'extent' are we aligned with the country systems. It also recognizes that at times it may be justified to not be 'on' for some aspects.

Being on budget: what does it mean



Following the opening presentation, **Zachee Iyakaremye**, Ministry of Health Rwanda, offered his perspectives on how donors have been able to align government systems in Rwanda. This is particularly relevant in the Rwandan context as development partner funding represents half of the total sector budget. Iyakaremye explained how development partner funds flowing through the use of country systems promotes sustainability. This is because, use of country systems requires government and development partners to plan together, prepare budgets together and monitor and account for the funding together. To facilitate coordination and alignment, Rwanda has several forums and sector reviews. Through these forums, Zachee noted that stakeholders understand who is active in each sector and thus avoid duplication and maximize impact. A prerequisite to alignment is transparency and accountability, otherwise, development partners may be reluctant to align to the use of country systems.

Participants also heard about the Ethiopian experience from **Amir Aman Hagos**, the former Minister of Health in Ethiopia, currently working for the GFF. Amir highlighted that alignment to government systems is a political issue more than a technical issue. This alignment discussion, he said, is like a rollercoaster sometimes it's a hot topic and sometimes it's just an 'on paper' exercise.

Eric Boa, Global Fund, provided an additional perspective regarding how to balance donor and government objectives, and why the use of country systems has sometimes been difficult. Eric noted that the use of country systems can present challenges from a financial management perspective, often development partners request

additional layers of accounting, reporting, and auditing information. This may lead to misalignment of requirements that can also exceed what the current PFM system can offer. But Eric explained that where the Global Fund has been able to leverage the PFM system and align their engagement – there has been higher performance. Finally, agreeing with other speakers, Eric emphasised it is not always necessary to be 100 per cent aligned with the country system, and that sometimes effort can also be placed towards strengthening the system.

To close the session, **Agnès Soucat**, AFD, provided a sober assessment of the use of country systems. She argued that based on the evidence, there has been little to no progress on alignment, therefore Agnès encouraged participants to look at this issue differently and it may be time to develop a new framing for the challenge. She argued that the model of aid should evolve – 'no attribution; no short-term results orientation; we need to acknowledge that fungibility is a fact, so rethink conditionalities to support domestic budgets for health.'

Digital technologies: what are the opportunities and risks for better PFM in health?

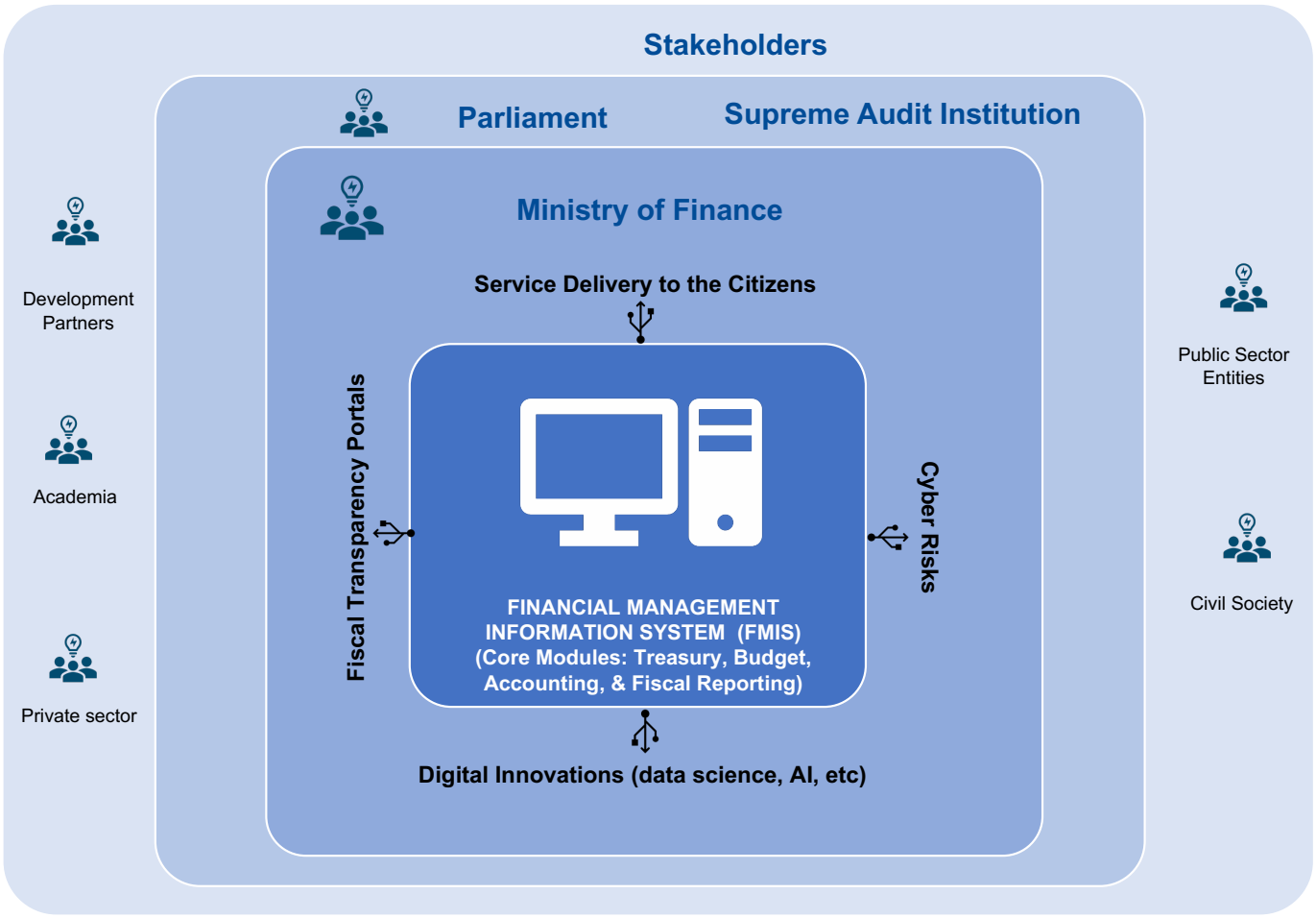
In the past decade, digital technologies have made significant inroads into the management of public finances. And now, their use has been further accelerated in the past 18 months as governments increased their spending, including health spending, to shield populations from COVID-19. As a result of their growing importance, the final technical session, chaired by **Sanjeev Gupta**, CGD, at Montreux highlighted how enhancements in digital technologies have contributed to strengthening budget development, execution, transparency, and accountability in LMICs for better service delivery.

An introductory overview by **Manal Fouad**, IMF, described how digital technologies are a key component of PFM functions, previously the key tool was FMIS but now there are many other innovations such as blockchain, big data and artificial intelligence. The key message raised in the introductory overview was to recognize that technology cannot automatically solve a problem, we must begin by identifying the problem or objective first, before determining whether or which technology provides the best solution. In addition, when implementing technology, it is critical to consider the country context, resources, capacity, and trends of use, according to Manal.

Digital technology can help:

- Enhance the efficiency of PFM processes and tools
- Reduce opportunities for corruption and misappropriation of public funds by improving and automatizing controls
- Support fiscal policy implementation by providing faster, timely and accurate information for decision-makers
- Strengthen fiscal transparency and accountability
- Implementation matters, digital technology is not a new magic bullet.

Digital PFM system



Country panelists from India and Tanzania discussed the expanding use of digital technologies as part of PFM practices in the health sector. **Anupam Raj**, Ministry of Finance India, explained that FMIS is widespread and carries out major functions including digital payment, digital receipts, near to real-time accounting, real-time MIS report. The Public Financial Management System, India's financial management system, is linked with various institutions that are part of the pipeline of delivering services. They are integral to several welfare schemes, and most implementing agencies use FMIS to spend or receive money coming from the provincial or central government. Anupam explained that, during COVID, it has made money more easily available to the economically vulnerable population, and it has supported the procurement of vaccines. In Tanzania, as **Erick Kitali**, from the President's Office Regional and Local Government, explained, digitalization has supported output-based payment and has ensured the proper financial management of 25,000 health facilities and schools. Digitalization has also been integrated into systems to manage the health workforce and enhance their productivity.

Global experts from CABRI and WHO provided reflections on possible ways to scale-up digital use for better PFM in health, especially in the context of COVID-19. **Neil Cole**, CABRI, noted that often a modular approach to adopting digital solutions works better, i.e., countries should adopt the part that is needed immediately and then this can be built upon once needs grow. During COVID-19, the use of digital systems has largely been positive and CABRI has also begun to gather evidence of how digital tools have supported business continuity during the pandemic. The

early findings suggest that digital tools including IFMIS have been at the forefront of combatting the impact of the pandemic and are central to ensuring business continuity. These systems have increased efficiency, effectiveness and potentially equity in the government's response to COVID-19. But they can also be a stumbling block if there is not adequate flexibility, or officials do not have incentives or capability to run the necessary actions through IFMIS. According to Neil, the digitalization of cash transfers is another area that the PFM systems had to expand to ensure that vulnerable and needy populations were able to receive COVID-19 grants. Digital payments have been critical in facilitating social distancing and minimizing the exchange of cash. Neil closed his reflections by stating that it is 'unclear whether the COVID-19 pandemic will serve as the critical juncture that significantly propels the pace of digitalisation in African finance ministries and health, but it has led to the optimisation of technology'.

Inke Mathauer, WHO, described how digitalization has improved efficiency for PFM and health financing, in particular with regards to purchasing health services. Digitalization has saved time and reduced costs. In addition, Inke noted that digitalization has the potential to improve accountability and transparency to strengthen trust between health and finance authorities. However, Inke stressed while digitalization has offered several benefits, it has not come without its challenges or unintended consequences. For example, applications have supported the increase in voluntary payments for health insurance, however, these types of payments are also associated with limited redistributive capacity, equity and movement towards UHC. Therefore, caution is advised when considering digital technologies that contribute to a pooling architecture with limited or reduced redistributive capacity. Inke closed on the following thought: there is an evidence gap on the effects of the range of digital technologies being used in health financing, and it is therefore important to evaluate the impact of these digital technologies. Finally, on the next steps, Inke suggested developing guidance and recommendations on the use and design of digital technologies for health financing to support progress towards universal health coverage.

CONCLUDING SESSION

19 NOVEMBER 2021

FRIDAY 19 NOVEMBER 2021

The final session of the 5th Montreux Collaborative meeting brought together a panel of discussants to reflect on the week's presentations and conversations.

Key messages

Joe Kutzin, WHO, started by providing a comprehensive summary of all the key messages from the sessions including some critical issues that are often resistant to change. The main themes from the sessions included the need for continued collaboration and constructive dialogue between finance and health to strengthen PFM and health financing systems to better meet UHC goals. There was agreement during the discussions that the PFM and budget framework is of prime importance, and that flexibility is necessary but not at the expense of accountability. In addition, it was also agreed that provider autonomy and improved financial management are critical in meeting emerging health needs and that programme-based budgeting and digitalisation can be important towards achieving UHC. However, results are not automatic, reform and innovation are important but equally important are how well you implement the reform and to ask, does this reform sufficiently address the problem you are trying to solve.

Joe highlighted the early work on-budget execution, and how it has revealed that there is much more to be done to strengthen execution, and doing so can increase efficiency, free up fiscal space and put less pressure on the difficult task of raising domestic revenues. Finally, Joe reflected on COVID-19, the impact it has had on PFM and health systems, and importantly the lessons that are beginning to emerge. The pandemic has exposed systemic weaknesses in health financing and PFM; however, this has presented an opportunity to reform and strengthen systems to meet UHC goals and better respond to both routine health service needs and emergencies in the future.

Joe then invited five country participants, **Farhad Farewar** (Management Sciences for Health), **Gemini Mtei** (USAID/Abt Associates), **Midori de Habich** (Abt Associates), **Pura Angela Co** (ThinkWell), **Lachlan McDonald** (WHO consultant) to share thoughts and key take-home messages. Country participants reflected on the role of local governments and the autonomy of facilities to use public funds, the need for solidarity from the global community, the fragmentation of health financing and the use of extra-budgetary funds to respond to the pandemic. Gemini Mtei discussed how focusing on raising additional revenue is not enough, and more broadly the difficulty associated with getting additional money to the health sector. In Tanzania, efficiency gains were experienced by strengthening alignment with PFM systems and using them to support rather than hamper health financing, management, and service delivery. Related to fragmentation, Gemini noted that reducing or harmonizing the multitude of funds flows is important and implementing health insurance agencies as a separate process may not be a solution. Midori de Habich highlighted some key points on: strengthening budget execution, the need to better align priorities and budgeting, and emphasised the need for the budget cycle to be analysed alongside the whole health system and not in isolation. Again, Midori echoed the importance of program budgeting, however, warned that if not implemented well, there are risks of this approach increasing fragmentation and adding another layer of control. Finally, Midori closed by telling participants the importance of remaining humble when approaching this work and to avoid jargon as this isolates this important discussion from key players.

Cheryl Cashin, R4D, also shared her reflections on key messages to close out the meeting. First, Cheryl discussed how the relationship between revenue and health spending is overemphasized, and that most increases in

government health spending in fact are a result of conducive macroeconomic conditions. However, this doesn't mean that the health sector should take a passive stance or stop advocating for additional revenues. As part of this strategy, Cheryl noted the importance of building public trust to raise revenues – for example in Ghana public trust enabled the government to raise a COVID levy. Also, by emphasising efficiency gains, Cheryl argued countries can strengthen public support for raising health revenues.

Second, Cheryl emphasised that it is important not to give up on advocating for increasing the priority of the health sector in the budget, this is necessary to avoid health getting deprioritised towards the end of the year. Third, improving budget execution is critical – it can have great effects on obtaining efficiency gains and expanding budgetary space, however improvement rests on both health and finance taking responsibility for strengthening execution. Finally, Cheryl closed on the need to strengthen existing health financing and PFM systems rather than bypassing them. This is also applicable to the donor community, where more effort is needed to align to PFM systems.

Ways forward

The conversation was followed by **Hélène Barroy**, WHO, sharing ideas on ways forward for the future Montreux Collaborative agenda.

Hélène highlighted the need **for follow-on work in several areas**. On PFM and COVID-19, the meeting made clear that PFM flexibility has been key for the response to COVID-19. Countries with flexible budgets and disbursement systems have been better able to respond to the crisis. Moving forward, more work is needed to turn this crisis into an opportunity and integrate the learnings into routine practices. On Tools – Hélène underlined that "this is certainly another area where we, as partners, need to come together to improve alignment and clarity on use". On budget execution – Hélène noted more demand to understand the underlying reasons for poor budget execution in health. Hélène explained that WHO, World Bank and IMF are currently carrying out in-depth country analyses to further unpack this and that the partners will be happy to share the findings of the deep dive in future events. In her view, there is also a need for systematizing data collection and analysis on health budget execution at the global level, given the interest received on the preliminary data work that was presented. Currently "there is no comprehensive global dataset addressing this part of the budget cycle, keeping the problem of poor budget execution in health invisible to many", according to Hélène. On donor alignment- it's certainly not the end of the conversation, Hélène noted. Moving forward, it is clear that a country-specific engagement is necessary to turn the tide and also to understand the impact of these moves on domestic government health budgets and systems. A related question refers to how co-financing for donor-supported programs is budgeted, disbursed and used in countries – extra work is needed to analyze these dynamics from the perspective of the domestic health budget

Hélène also outlined **new emerging themes** that came across the technical presentations and/or the Q&A, including:

- → Budgeting for health and climate, as intertwined goals
- → Links between decentralization and provider autonomy
- → The role of direct facility financing in strengthening the relationship between health purchasing and facility financial management
- → The potential of digital technologies for PFM and health financing
- → The political economy of budgetary reforms in health.

Hélène closed by saying that **more regular gatherings** of the Montreux Collaborative (e.g., every six months) could offer more space for deep-dives into a specific topic, tool or new country experience.

Joe Kutzin wrapped up the meeting by sharing some seminal thoughts, putting in perspective the meeting's messages with the broader health financing landscape. He highlighted how the agenda has advanced, recognising the need to move away from making changes at the margin, in the hopes that small schemes will have the necessary momentum to attain comprehensive and ambitious UHC goals. Now, there is a recognition that the budget is likely the most effective tool to raise, allocate and spend the funds required to achieve large scale change. To achieve this requires a deeper understanding of the financing framework, health systems and their connection to PFM. This approach moves the health sector towards more strategic purchasing derived from general budget funds and a non-contributory entitlement basis.

Joe also expressed to participants that achieving progress requires letting go of some previously held opinions. For example, we need to acknowledge that voluntary pre-payment doesn't work, despite good intentions to raise money and plug financing gaps in a sector that is often ill funded, it still does not hit the mark. As a result, Joe noted that instead 'we are left with the more fundamental and path-breaking work, the heavy lifting of reform – which is really the work to make systems function, to make budgets and payments more output-oriented, and strengthening the PFM systems and agenda.' Finally, the session closed with a word of caution, to not let global indicators and global targets get in the way of domestically relevant policies. Instead, the solutions rest on steady and consistent progress built on a solid health financing and PFM foundation, that ensures flexibility and adaptability as circumstances change. Of course, there is a need to give some voice to global targets, but Joe encouraged the audience to think of them as a direction and not a destination and to focus on building systems in a step-by-step manner. Many are currently building these systems and mechanisms in response to the pandemic, and now is the time to understand what elements need to be supported and integrated into the regular PFM and health financing systems.

ANNEX

MEETING AGENDA

MONDAY, 15 NOVEMBER 2021: PRE-MEETING EVENTS

13:00 - 13:30 CET Introduction session

This session will give an overview of the meeting's five-day agenda and provide IT and logistic details to participants.

- Background and overview of the meeting's agenda: Joe Kutzin (WHO)
- IT and logistics

13:30 - 14:30 CET: Keynote speech to mark the 5th Meeting of the Montreux Collaborative

Chair and moderator: Joe Kutzin (WHO)

To mark the fifth meeting of the Collaborative, this session will feature Cheryl Cashin, a key initiator and renowned member of the Montreux Collaborative meetings.

- Reflecting on the past and looking to the future shifts in the global PFM and health financing environment: *Cheryl Cashin* (Managing Director, Results for Development)
- Questions and answers

14:30 – 14:45 CET: Comfort break

14:45 - 16:00 CET: Book launch *How to make budgets work for health: a WHO guide to designing, managing and monitoring programme budgets in the health sector*

Chair and moderator: Matt Jowett (WHO)

Programme budgets can strengthen alignment with health sector policies and strategies, provide more flexibility in fund management, and facilitate stronger transparency and accountability towards health outputs. However, this transformation is not automatic. This session will introduce the new WHO guide on programme-based budgeting and provide lessons and recommendations on how to make budgetary reforms work better for health. It will also feature first-hand perspectives from reform practitioners from Uganda and the Philippines involved in the introduction of programme budgets in the health sector.

- Guidance book presentation by the editors: *Hélène Barroy* (WHO), *Mark Blecher* (National Treasury, South Africa), *Jason Lakin* (formerly, International Budget Partnership)
- Video recorded messages from book contributors: *Chris James* (OECD), *Moritz Piatti* (World Bank), *Elina Dale* (Norwegian Institute of Public Health), *Maarten de Jong* (PFM expert/Public Sector Auditor), *Santiago Cornejo* (GAVI)
- Perspectives from implementation: *Richard Kabagambe* (Ministry of Health Uganda), *Omi Castañar* (formerly, Department of Budget and Management, The Philippines)
- Questions and answers

Q&A support: *Linnea Mills* (WHO consultant)

TUESDAY, 16 NOVEMBER 2021: MAIN MEETING – DAY 1

13:00 - 14:00 Macro-fiscal crisis and COVID-19: What are the implications for health financing and UHC?

Chair and moderator: Susan Sparkes (WHO)

The session will reflect on the combined health and macro-fiscal impacts of COVID-19 for health financing and progress towards UHC. Beyond the immediate impact, the broader macro-fiscal outlook will be presented to provide the necessary context in which health financing policy will be situated. The panel discussion will consider health financing policy adjustments made during the pandemic and their implications for future policy priorities. Specific attention will also be paid to emerging health financing priorities in the short- and medium-term given macro-fiscal constraints and population health needs. These policy options will focus on those that can effectively safeguard UHC progress particularly for the poor and most vulnerable amidst shocks and macro-fiscal constraints.

- Macro-fiscal outlook: *Raphael Espinoza* (IMF)
- Discussants to reflect on macro-fiscal implications for health financing: *Dileep De Silva* (Ministry of Health, Sri Lanka), *Mawuli Gaddah* (Ministry of Finance, Ghana), *Tamás Evetovits* (WHO EURO), *Ajay Tandon* (World Bank)

Q&A support: *Peter Cowley* (WHO)

14:00 - 14:15 CET: Comfort break

14:15 - 15:30 CET: What can COVID-19 teach us about PFM?

Chair and moderator: Srinivas Gurazada (PEFA)

The COVID-19 crisis has been a stress test for all PFM systems across the world. It has forced countries to adapt PFM to provide greater financial flexibility and tailor accountability methods in the midst of the crisis. The session will feature global PFM leaders and country experts from South Africa and the Philippines to learn about the key PFM barriers and enablers for driving an effective budgetary response to health emergencies. The session will also share perspectives on possible ways to rebuild and transform PFM systems to make them more responsive and tailored to health spending needs.

- Global PFM lessons from the COVID-19 crisis: *Richard Allen* (public finance consultant)
- Country PFM bottlenecks and adjustments for COVID-19: *Mario Villaverde* (Department of Health, The Philippines), *Ogali Gaarekwe* (National Treasury, South Africa)
- Discussion: how to integrate and sustain lessons from COVID-19 for future PFM: *Sarbani Chakraborty* (health financing consultant), *Teresa Curristine* (IMF)
- Questions and answers

Q&A support: *Hélène Barroy* (WHO)

15:30 - 15:45 CET: Comfort break

15:45 - 16:30 CET: How to assess PFM bottlenecks and monitor reform progress in health: a rapid update on PFM and health tools

Chair and moderator: Toomas Palu (World Bank & UHC2030)

In recent years, several development partners have developed technical tools and guidelines to assess PFM bottlenecks in health. Team leads in charge of the development of these tools from PEFA, UNICEF, WHO, and the World Bank will join this session to reflect on the different assessment approaches, how they complement each other, and to identify remaining gaps to further support policy monitoring.

- Panel: *Manoj Jain* (World Bank), *Julia Dhimitri* (PEFA), *Matt Jowett* and *Hélène Barroy* (WHO), *Jennifer Asman* (UNICEF) and *Sierd Hadley* (for UNICEF/ODI tool)
- Country uptake: *Adanna Chukwuma* (World Bank), *Faraz Khalid* (WHO EMRO)

WEDNESDAY, 17 NOVEMBER 2021: MAIN MEETING – DAY 2

13:00 - 14:30 CET: Direct facility financing: what are the opportunities and challenges of PFM systems?

Chair and moderator: Joe Kutzin (WHO)

In many low- and middle-income countries (LMICs), public funds do not reach the frontlines due to systemic bottlenecks and rigidities in PFM frameworks. Recently, several initiatives have aimed to empower service providers to manage public funds directly, giving them the ability to access, manage and report their own accounts. This session will provide an overview on those approaches summarizing existing literature and evidence. The session will also examine the experience of direct facility financing in Tanzania and offer perspectives on scaling up similar reforms in other LMICs, particularly against the backdrop of widespread PFM and decentralization reforms.

- Concepts and rationale of direct facility financing: *Sophie Witter* (Queen Margaret University Edinburgh, UK)
- Tanzania: key lessons from aligning direct facility financing and the PFM system: *Sheila O'Dougherty* and *Gemini Mtei* (Public sector systems strengthening project, Abt Associates/USAID, Tanzania)
- Discussion: Opportunities and constraints for scaling up reforms: *Nirmala Ravishankar* (ThinkWell), *Ayodeji Oluwole Odutolu* (Global Financing Facility), *Michael Borowitz* (The Global Fund)
- Questions and answers

Q&A support: *Federica Margini* (UNICEF)

14:30 - 14:45 CET: Comfort break

14:45 - 16:00 CET: Health budget execution performance: how to get on the same page?

Chair and moderator: Cheryl Cashin (Results for Development)

Budget under-execution is pervasive in health. This problem is often attributed to the poor absorption capacities of health ministries; however, causes are often more complex. Building on work developed by WHO and the World Bank with support from the IMF, this session will provide a common framework for assessing health budget execution issues, mapping their root causes and identifying policy solutions in a coordinated manner between health and finance. The session will also provide reflections from country applications in Ukraine and Kyrgyzstan and offer some perspectives on how to bring finance and health leaders together to put health budget execution on the agenda and coordinate effective policy change.

- Assessing health budget execution performance: a country-level framework: *Hélène Barroy* (WHO), *Moritz Piatti* (World Bank)
- Putting the framework into practice: evidence from Kyrgyzstan and Ukraine: *Loraine Hawkins* (health finance consultant)
- Acting together: country and global reflections from *Sabeen Afzal* (Ministry of National Health Service, Regulation and Coordination, Pakistan), *Fazeer Rahim* (IMF), and *Sally Torbert* (IBP)
- Questions and answers
- Q&A support: *Amna Silim* (WHO consultant)

THURSDAY, 18 NOVEMBER 2021: MAIN MEETING – DAY 3

13:00 - 14:00 CET: Donor funding: how to facilitate alignment with domestic PFM systems?

Chair and moderator: Magnus Lindelow (World Bank)

Despite many commitments from the development partner community to make greater use of country systems over the last two decades, there remains a lack of clarity on the definition of country systems, how partners can better align to PFM systems, and what can be done to accelerate further alignment. This session will present insights on how development partners can enhance their alignment with domestic PFM processes and how to establish baselines and track progress for mutual accountability, the session will also highlight good practices from Rwanda. The session will reflect on aspects of PFM systems that may require further strengthening before development assistance can be channeled through country systems.

- Alignment of donor financial management systems and domestic PFM systems: rethinking opportunities and bottlenecks: *Moritz Piatti* (World Bank)
- Good practices from Rwanda: *Zachee Iyakaremye* (Ministry of Health Rwanda)
- Reflections from partners: *Amir Aman Hagos* (Chair of working group on donor alignment, GFF), *Eric Boa* (The Global Fund), *Agnès Soucat* (Agence Française de Développement)
- Questions and answers

Q&A support: *Sarah Alkenbrack* (World Bank)

14:00 - 14:15 CET: Comfort break

14:15 - 15:15 CET: Digital technologies: what are the opportunities and risks for better PFM in health?

Chair and moderator: Sanjeev Gupta (CGD)

In the past decade, digital technologies have made significant inroads into the management of public finances. Their use received further impetus in the past 18 months as governments increased their spending, including health spending, to shield populations from COVID-19. The session will highlight how enhancements in digital technologies have contributed to strengthening budget development, execution, transparency and accountability in LMICs for better service delivery. Following an introductory overview by an IMF representative, country panelists from India and Tanzania will discuss the expanding use of digital technologies as part of PFM practices in the health sector. Global experts will provide reflections on possible ways to scale-up digital use for better PFM in health, especially in the context of COVID-19.

- How digitalization can improve PFM operations and service delivery: *Manal Fouad* (IMF)
- Country perspectives with a focus on PFM practices in health: *Anupam Raj* (Ministry of Finance India), *Erick Kitali* (President's Office – Regional Administration and Local Government, Tanzania)
- Global reflections: *Neil Cole* (CABRI), *Inke Mathauer* (WHO)
- Questions and answers

Q&A support: *Fahdi Dkhimi* (WHO)

FRIDAY, 19 NOVEMBER 2021: MAIN MEETING – DAY 4

13:00 – 14:30 CET: Concluding session: the Montreux Collaborative agenda: next steps and ways forward in a world living with COVID-19.

This session will reflect on key messages that have emerged throughout the meeting and offer a platform for partners and country representatives to discuss the next steps and ways forward for the PFM and health financing reform agenda.

- Key messages from the event: *Joe Kutzin* (WHO)
- Country discussants: *Farhad Farewar*, Gemini Mtei, Midori de Habich, *Pura Angela*, Lachlan McDonald
- Way forward: *Hélène Barroy* (WHO)
- Concluding remarks: *Cheryl Cashin* (Results for Development).

5th Meeting of the Montreux Collaborative
15-19 November 2021

World Health Organization