Implementing Programme Budgeting in Health – links to payment methods

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Programme budgeting **aims to promote strategic resource allocation in accordance with public policy priorities, efficient use of resources & accountability for results.**

Public financial management reform including programme budgeting has similar objectives to strategic purchasing.

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The way public budgets are formed, allocated, disbursed and accounted influences how service providers can be paid in the health sector:

When a health purchaser seeks to reform payment methods, the budget classification system may prevent full implementation, particularly for payment to public providers

MOST COMMON PAYMENT METHODS USED BY HEALTH INSURERS /PURCHASERS

Method	Description	Usual Setting	
Fee for service	Activity based billing of individual services, patient visits, and bed days	Predominantly used for PHC and outpatient services	
Payment per case	Payment per patient admitted, classified by similar clinical condition and activities, e.g. DRGs	Predominantly for hospital inpatient care	
Capitation	Lump-sum payment per enrolled patient covering a range of services	Predominantly used for GPs	
Global budget	Lump-sum payment for services independent of actual volume of care	Payment for public hospitals in a number of countries	
Pay-for-performance	Payment for defined targets (results or outcomes) fixed in advance	Combined with any of the other methods e.g. quality bonuses	
Input-based payment by budget line items	Fixed allocation for input costs, e.g. personnel, utilities, medicines, supplies	Used for public healthcare providers in many countries	

useful for strategic purchasing

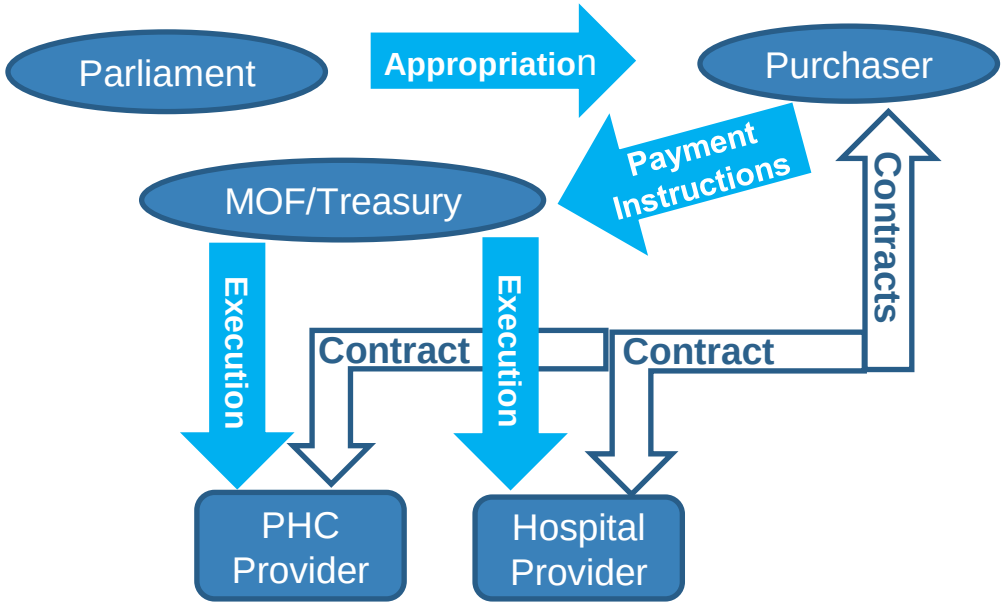
BUDGET CLASSIFICATION METHODS

Method	Description	Examples of use
Economic	Classifies expenditure by economic categories e.g. salaries, goods & services, capital expenditure	Always used for accounting. May be used in budget formulation, appropriation, or execution. If used for *ex ante* external control of execution, called “input-based payment”.
Administrative	Classifies expenditure by the entity responsible for managing the funds, or groups of these e.g. ministry departments, agencies, types of health facilities, regions	Often used in combination with economic classification. Can be combined with programme classification (under each administrative category).
Functional	Categorizes expenditures by sector e.g. health, then by functions e.g. PHC, hospital services. These may be further divided into classes, e.g. outpatient & inpatient services	Categories have been pre-defined internationally for purposes of comparison (e.g. System of Health Accounts, International Monetary Fund 2001)
Programme or output class	Classifies expenditure by policy objectives or outputs for the sector, e.g. maternal health, TBC control, PHC. Activity-based classification, e.g., provision of food supplements may be used under programmes	Used in some countries for appropriation and execution. Many countries use programme-based presentation of the budget only for information or accountability

FUNDS FLOW FROM BUDGETS TO PROVIDERS VIA AN ON-BUDGET PURCHASER

KEY MESSAGE

- Align classifications for:
- Appropriation
- Contracts/PPM
- Execution

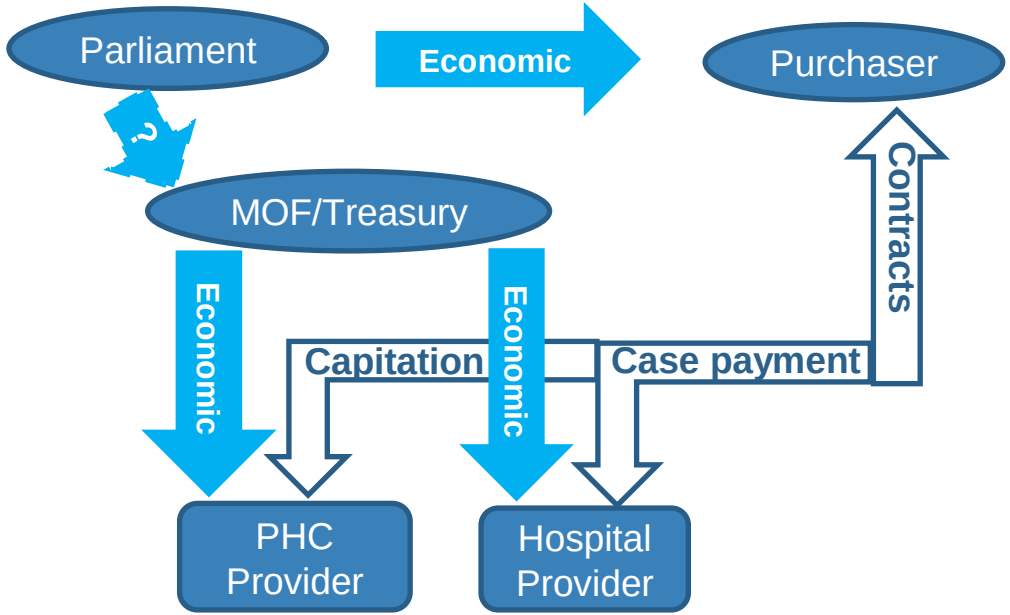


COUNTRY EXAMPLES

Country	Budget appropriations structure	Status of the purchaser	Provider Payment Methods
Ghana	Administrative (MDAs), economic and programme lines	Independent public entity, “on budget”, has own budget law.	capitation, FFS, Ghana DRGs; wages flow separately; global budget (tertiary hospitals)
Republic of Korea	Programme	Independent public entity, “on budget”, has own budget law	FFS, P4P, case payment
Philippines	Administrative unit, then programme/activity/project then input lines	Independent public entity “off budget”; MOH & local government (LG) also fund providers	FFS, capitation paid to LGs, but most LGs retain these funds & pay providers by input budgets
South Africa	Programme	No separate purchaser	Line item budgets to providers with direct payment of salaries

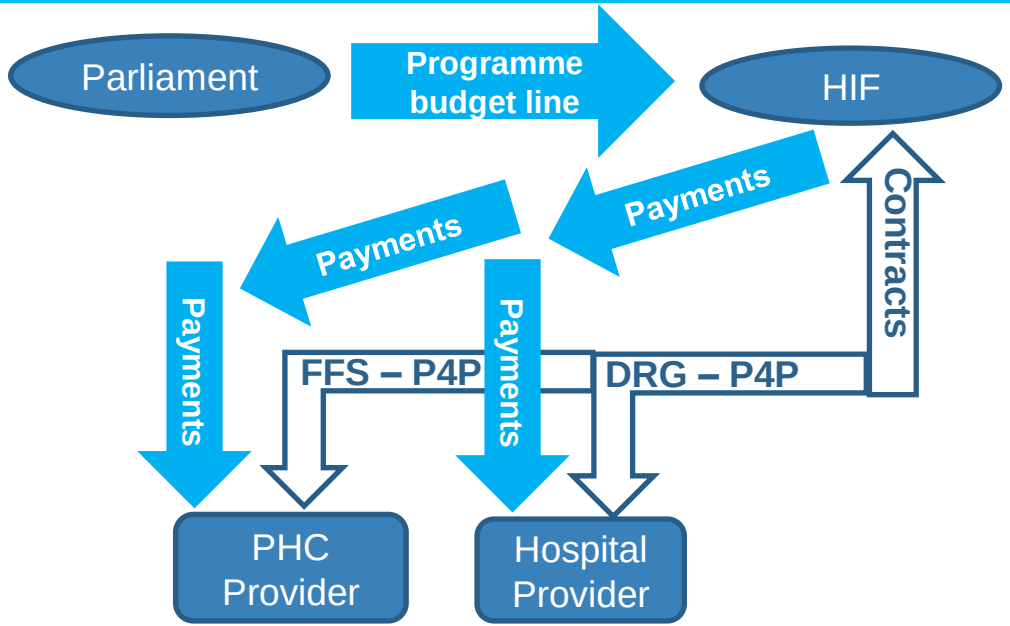
TYPICAL SCENARIO WHEN HEALTH FINANCING REFORM BEGINS BEFORE BUDGET REFORM

- Health Insurance Fund (HIF) established, output-based PPM
- Appropriation & execution still based on input line items for health facilities
- PPM used to set budget ceilings for providers during budget formulation



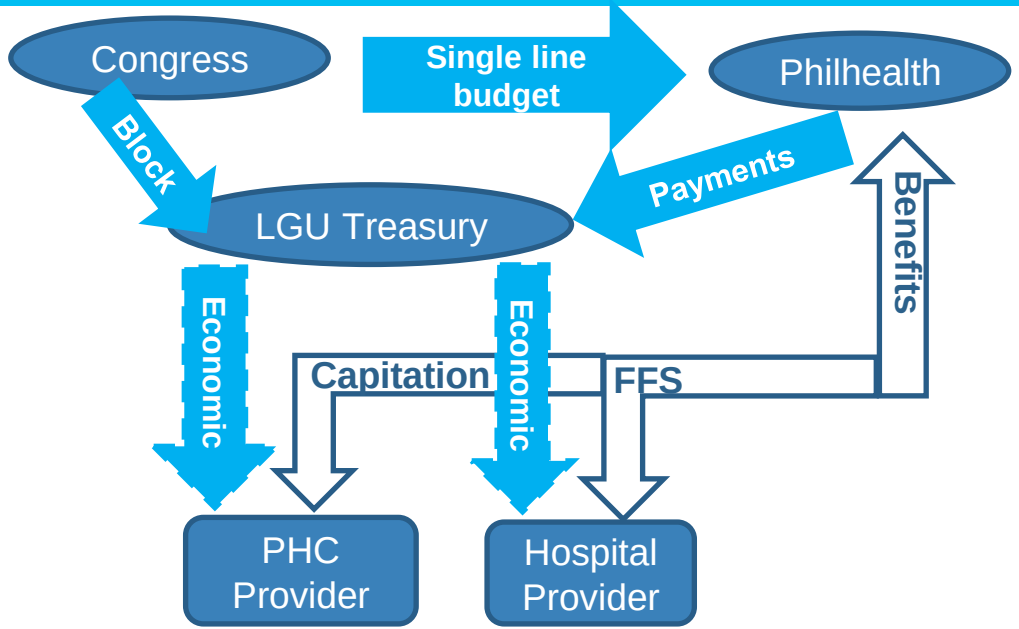
KOREA: MATURE SYSTEM -

- Budget subsidy is a single programme line
- HIF pools all revenue
- HIF pays using output based PPM – has own budget law
- Providers are either autonomous public entities or private – accountable for FM to their owners



PHILIPPINES: FRAGMENTED FUNDS FLOW WITH MISALIGNED STRUCTURES, CLASSIFICATIONS & INCENTIVES

- Single line in economic classification for transfer to HIF for poor
- HIF pays capitation & FFS benefits
- Parallel LGU budget funding based on input line items
- HIF payments go to LGU Treasury – often execution based on input line items



FRAGMENTED FUNDING UNDERMINES BOTH PAYMENT REFORM & PROGRAMME BUDGETING

KEY MESSAGE

- Pool fragmented funds flows **OR**
- Align classifications used for all funds flows to each type of provider

EFFICIENCY INCENTIVES OF OUTPUT-BASED PAYMENT COMPLETELY MUTED BY LACK OF PROVIDER AUTONOMY – EXAMPLE OF MONGOLIA

"If you save on food it is not possible to use for medicines. It is restricting efficient use of resources, and there is no incentive or benefit for efficient operations.

National Specialty Hospital

"We have some savings on electricity etc. but it is not allowed to shift them to use for staff costs. We save but incur debt in salary costs.

"We could make a request through MOH to MOF to move money between line items, or get a budget modification from Parliament"

District Hospital

"When there are savings and a surplus, it is taken back by the MOF at the end of year. Our revenue from paid services exceeds the plan every year, however it is taken back by the treasury."

Central Hospital

Efficiency gains are penalized

Source: Mongolia MOH. Assessment of systems for paying health care providers in Mongolia: Implications for equity, efficiency and universal health coverage (2014).

PHASES IN BUDGET/PFM REFORM TO INCREASE IMPACT OF STRATEGIC PURCHASING

LESSONS ABOUT ALIGNING BUDGET STRUCTURE, INCENTIVES, AUTONOMY, AND HEALTH SYSTEM PERFORMANCE OBJECTIVES

- Progress on strategic purchasing, particularly output-based provider payment, often requires accompanying reforms in budgeting and wider PFM processes.
- Programme budgeting can play a key role, but alignment in classifications is needed for all stages of the budget cycle and for all revenue sources for providers.
- For output-based payment to create effective incentives, providers need to have autonomy to respond to incentives.
- But autonomy needs to be balanced with governance & accountability for financial control & meeting health system objectives