CABRI Report on Public Health Budget Practices and Procedures in Africa

How African countries budget for health

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Acronyms and abbreviations

CABRI	Collaborative African Budget Reform Initiative
CBAs	central budget authorities
DAH	development assistance for health
DALY	disability-adjusted life years
DRG	diagnosis-related group
GDP	gross domestic product
IFMIS	Integrated Financial Management System
MTEF	medium-term expenditure framework
NGO	non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
PAU	Public Accounts Unit
PEFA	Public Expenditure and Financial Accountability
PFM	public financial management
PNCFS	Plateforme Nationale de Coordination du Financement de la Santé (Platform for National Coordination of Health Financing)
SIGFIP	Système Intégré de Gestion des Finances Publiques (Integrated Financial Management System)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WASH	water, sanitation and hygiene
WAEMU	West African Economic and Monetary Union

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About the Collaborative Africa Budget Reform Initiative (CABRI)

CABRI is an intergovernmental organisation that provides a platform for peer learning and exchange for African ministries of finance, budget and planning. Since its inception, CABRI has investigated what works, what does not, and under which circumstances, from the perspective of the practitioner. CABRI understands that context matters, and it acts as a catalyst for change within countries.

Through its work, CABRI continues to strive to achieve its vision that:

> *Across Africa, public financial resources are managed with integrity, transparency and accountability for efficient and effective service delivery, sustainable economic growth and development.*

Executive summary

The CABRI Public Health Budget Practices and Procedures Survey in Africa, involving 15 countries, was administered in the second half of 2019. The aim was to provide African officials with information on budget processes within different countries, as a point of reference for the implementation of budget reforms.

The survey results reveal a wide variety of budget practices.

- Ministries of finance set budget envelopes while ministries of health decide how resources are spent. In most countries a formal coordinating mechanism for the health budget and for the prevention of some diseases exists. All countries (with the exception of Guinea-Bissau) use medium-term expenditure frameworks (MTEFs) though they are used differently across countries and all countries make a distinction between operating and capital expenditure.
- Ministries of finance monitor budget execution: a key challenge is the time within which expenditure data becomes available. The Public Expenditure and Financial Accountability (PEFA) standard of one month is often exceeded by two months or more. In Nigeria, long delays are due to the need to audit financial statements, while countries such as South Africa and Liberia indicate shorter turnarounds on expenditure information. Tracking resource utilisation in a timely manner is key to enabling effective use of resources in the sector. The data suggests that underspending seems to be a larger issue than overspending.
- Operational issues within the Ministry of Health are identified as the main cause of underspending, though slow release of funds from ministries of finance also appears to be a contributing factor.
- Most donor spending is not channelled through the regular public finance management process although all countries track donor health spending. Most countries have a body that coordinates development partners. Development partners often implement projects through their own staff, internal and financial systems, and separate monitoring and evaluation systems. This has the potential for misalignment between government and donor priorities as well as structures.
- Ministries of health have no role in the provision of bulk water supplies, but they are actively involved in the promotion of hygiene. WASH (water, sanitation and hygiene) activities are funded through central government revenues with donor support.
- In most countries the central government is the chief provider of primary and preventative health services. Only Benin, Côte d'Ivoire and Nigeria use a social insurance mechanism.
- Eight countries use a tender process to acquire drugs. In the case of large countries, tenders can work well. A case study examines South African and Nigerian approaches and finds that leveraging the monopsony power of government is important through centralising procurement and using one standard essential medicines list. Smaller countries may need alternate approaches, such as pooled procurement.

The findings imply a need for ministries of finance and health to work more closely together to achieve a more efficient use of resources in Africa. Similarly, better coordination between ministries of health and donors on budgeting and execution processes is likely to enhance resource use. Finally, ministries of health are likely to benefit from regular engagement with departments or institutions responsible for the development of infrastructure and water supplies, which the effectiveness of hygiene and sanitation programmes are dependent on.

The survey findings imply a need for ministries of finance and health to work more closely together to increase resource allocation and deliberate on a more efficient use of resources in Africa

1 Introduction

Over the years, the Collaborative Africa Budget Reform Initiative (CABRI) has built a core of evidence-based knowledge regarding what works and what does not, and the accompanying circumstances for each. CABRI's work in the health sector focuses on funding mechanisms, strengthening links between ministries of finance and health, the complementary roles of different actors in the policy and budget cycles within the sector, and value for money considerations in health spending.

The Survey on Public Health Budget Practices and Procedures in Africa aims to build on CABRI's knowledge of health systems in order to inform reform options and policy considerations and alternatives.

The delivery of public services within significant resource constraints is a challenge for many African countries. This problem is even more acute in the health sector because of its important function. The importance of health systems is greater in Africa, given the burden of diseases and the fact that poorer societies are often sicker. The role of the budget system is to ensure that the health system has enough funds to carry out its mandate in a sustainable manner and uses these funds as efficiently and as effectively as possible.

One assumption underlying this study is that devoting more resources to health will result in better health outcomes. Makuta and O'Hare (2015) show that this is correct to an extent: if the appropriate infrastructure and management practices are in place, then additional spending on healthcare should improve the health of citizens. However, in some contexts, due to the lack of systems and infrastructure, additional funding does not improve outcomes. Piatti-Fünfkirchen and Smets (2019) tested whether improved public financial management is associated with improved health outcomes. A one-unit improvement in Public Expenditure and Financial Accountability (PEFA) assessment is found to lead to a decrease in under-five mortality of 14 deaths per 1 000 live births. Importantly, these improvements are more significant in countries that channel most of their resources through public health systems. For countries where more than 75% of expenditure takes place in a public system, the improvement increases to 17 deaths per 1 000 live births. This gain could be linked to the direct impact of improved public financial management as well as the benefits of broader reforms to improve governance. If African economies can improve public financial management, there could be better health outcomes.

The survey was intended as an instrument to help governments learn from each other and understand the potential gaps and ways in which to address the gaps in budgeting and execution processes. While no two contexts are the same, there is space for officials from different African governments to scrutinise the experience of other countries in similar situations facing comparable problems and applying solutions to their own country.

The results of the survey provide a detailed outline of the budget process in each country. This detail will provide officials intending to improve their own budget process with the necessary information to understand how countries in similar situations have resolved issues.

The Survey on Public Health Budget Practices and Procedures in Africa aims to build on CABRI's knowledge of health systems in order to inform reform options and policy considerations and alternatives

2 Description of the survey and countries

The CABRI Survey on Public Health Budget Practices and Procedures aimed to obtain information on budget processes in various countries in Africa. The survey was administered in the second half of 2019. Forty-two countries were invited to participate in the survey. CABRI received 15 responses: Benin, Cameroon, Chad, the Democratic Republic of the Congo, Côte d'Ivoire, The Gambia, Guinea-Bissau, Lesotho, Liberia, Mauritius, Nigeria, Seychelles, Sierra Leone, South Africa and Uganda. The survey response rate was 35%. Nine officials who completed the survey were from ministries of finance, with the rest from ministries of health, except for Benin where officials from both health and finance completed the response.

The survey is an adaptation of the Organisation for Economic Co-operation and Development's (OECD) Survey of Budget and Health Officials on Budgeting Practices for Health. The OECD has implemented this survey in OECD countries and in Latin America. This is the first time the survey has been implemented in Africa. Adapting the OECD survey allows for comparison between regions. Certain aspects of the original survey, such as detailed questions about national health insurance were not relevant and were omitted from the final survey instrument.

The survey relied on self-reported data and where possible, the data was validated using budget documentation or other sources of information, such as PEFA reports.

In order to avoid misinterpretation of questions, the questionnaire included a comprehensive list of definitions of all terms. In addition, the survey instrument was piloted in South Africa to determine if the items were clear and explicit. Outcomes of the pilot indicated that some survey items needed to be adjusted to improve clarity and the specificity of questions.

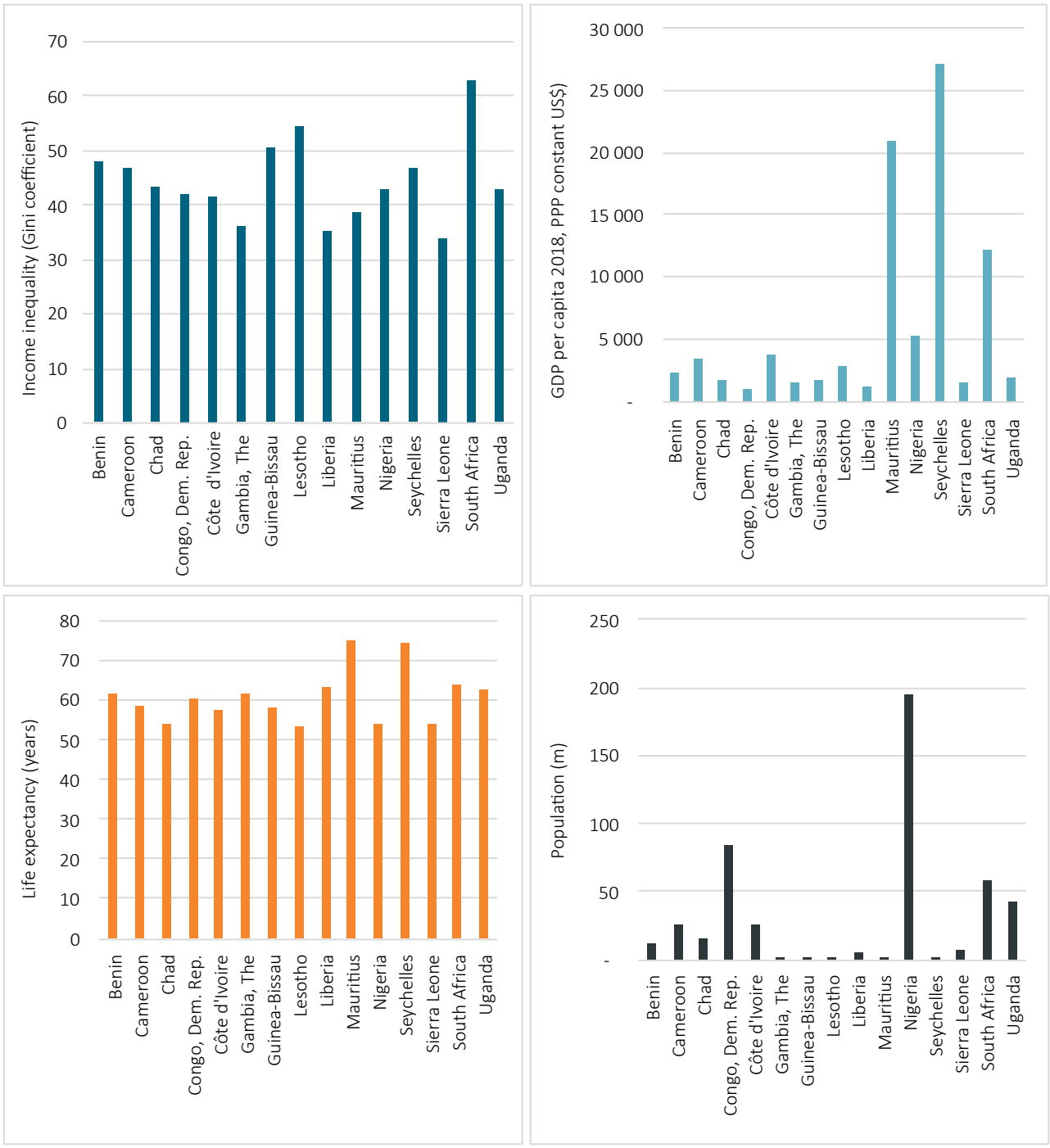
Respondents did not complete all the items on the questionnaire, so not all items will have 15 responses. The number of null responses for each item is indicated in the data below. The survey items on intergovernmental transfers and social health insurance schemes had fewer responses; those results were not reported. In some cases, responses may indicate the existence of a relevant government policy, as opposed to what is occurring in practice.

Countries Participating in the CABRI Survey on Public Health Budget Practices and Procedures in Africa

2.1 Social and health context of respondent countries

Respondent countries are heterogeneous in terms of health and socioeconomic conditions (as indicated in Table 1). Data from the World Bank's World Development Indicators show that in 2017, life expectancy ranged from 52.9 years in Lesotho to about 74.5 years in Mauritius and Seychelles. Average life expectancy in the sample countries was 60.6 years, which is close to the average for Africa (61.2 years), but significantly lower than the global life expectancy (72.0 years) estimated by World Health Organization (WHO) in 2016. Life expectancy has increased by an average of 7.8 years among the countries in the sample since 2000, implying improvements in child survival, among other things.

Figure 1: Respondent countries by GDP per capita, income inequality, life expectancy and population



Source: World Bank World Development Indicators

Table 1: General descriptive characteristics of sample countries

	Life expectancy, 2017 (years)	GDP per capita 2018, PPP (constant 2011 international $)	Total population, 2018	Income inequality, Gini Coefficient[1]
Benin	61.2	2 152	11 485 048	47.8
Cameroon	58.5	3 352	25 216 237	46.6
Chad	53.7	1 746	15 477 751	43.3
Congo, Dem. Rep.	60.0	827	84 068 091	42.1
Cote d'Ivoire	57.0	3 733	25 069 229	41.5
Gambia, The	61.4	1 517	2 280 102	35.9
Guinea-Bissau	57.7	1 596	1 874 309	50.7
Lesotho	52.9	2 865	2 108 132	54.2
Liberia	63.3	1 161	4 818 977	35.3
Mauritius	74.5	21 075	1 265 303	38.5
Nigeria	54.0	5 316	195 874 740	43.0
Seychelles	74.3	27 114	96 762	46.8
Sierra Leone	53.9	1 425	7 650 154	34.0
South Africa	63.5	12 145	57 779 622	63.0
Uganda	62.5	1 807	42 723 139	42.8
Sample Maximum	74.5	27 114	195 874 740	63.0
Sample Minimum	52.9	827	96 762	34.0
Simple Average	60.6	5 855	31 852 506	44.4
Median	60.0	2 152	11 485 048	43.0

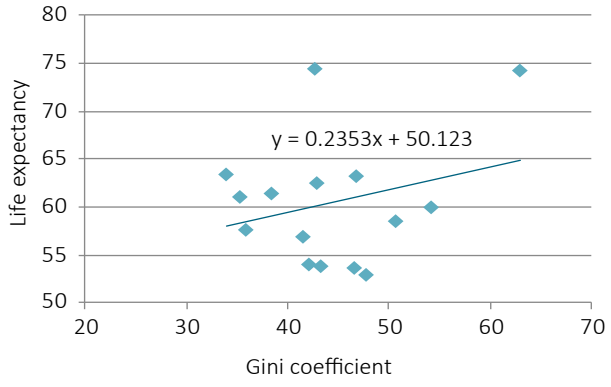
1 Most recent year for which estimate is available. Estimates are dated 2016 for Liberia and Uganda, 2015 for Benin, Cote d'Ivoire and The Gambia, 2014 for Cameroon and South Africa, 2013 for Seychelles, 2012 for the Democratic republic of the Congo and Mauritius, 2011 for Chad and Sierra Leone, 2010 for Lesotho and 2009 for Nigeria.

There is a large variation in levels of gross domestic product (GDP) per capita, with economies ranging from lowest income per capita in the world to upper middle-income economies. Four of the 10 countries with the lowest GDP per capita in the world are in the sample, namely the Democratic Republic of the Congo, Liberia, Sierra Leone and Guinea-Bissau. Levels of GDP per capita may reflect the ability of the state to raise revenue and use this revenue for health expenditures. Countries with a higher GDP per capita might be able to use extra funds to provide other public goods such as water, sanitation and hygiene (WASH) that also impact on health outcomes. On the other hand, poorer countries will face the burden of dealing with diseases of poverty caused by malnutrition.

The global average GDP per capita in 2018 was US$15 914, while the average for sub-Saharan Africa was US$3 536. The average for the sample is US$5 855, about 65% higher than the average for sub-Saharan Africa.

Population size is another distinguishing factor between respondent countries. The two island nations, Seychelles and Mauritius, have small populations of 97 000 and just more than a million people, respectively. At the other end of the scale, Nigeria is the most populous country in Africa.

Differences in how incomes are distributed are probably more important for social welfare than differences in the actual income between and within countries. Among the countries in the sample, South Africa has the most unequal economy in the world, reflected in a high Gini coefficient of 63 (a lower Gini coefficient shows a low level of inequality). Sierra Leone has a much more equal economy, with a Gini coefficient of 34.0. Income inequality might affect the structure of health systems at community levels, and household and individual levels. Truesdale and Jencks (2016) found that higher GDP per capita and lower income inequality were linked with better health outcomes for a country.



While the above contextual differences between the countries in the sample have implications on the scale of health system operations, they are less likely to have an impact on their budget processes. As such, it is possible to compare the budgeting processes in these countries and draw lessons from how health budgets are determined and executed.

2.2 Performance of respondent health systems

Infant and maternal mortality are simply the number of deaths that occur relative to a number of live births. The average infant mortality rate among the respondent countries was 51 per 1 000 live births, which is close to the sub-Saharan African average of 52.7, but substantially higher than the global average of 28.9. Mauritius and Seychelles have lower infant mortality rates than the global average, while six countries have death rates of more than 60 per 1 000 live births.

A similar pattern exists for maternal mortality ratio. Average maternal mortality rate among the respondent countries was 551, which is slightly lower than the sub-Saharan Africa average of 534 deaths per 100 000 live births, but substantially higher than the global average of 211. Mauritius and Seychelles are the best performers while maternal mortality is high in Chad and Sierra Leone. South Africa, Mauritius and Seychelles performed better than the global average.

Table 2 examines infant and maternal mortality rates in the sample countries as a means of determining the effectiveness of healthcare systems. Disability-adjusted life years (DALYs) lost is another measure used as an indicator of how effective health systems are. According to Neumayer and Plümper (2016), mortality is associated with several factors, of which health system effectiveness is just one. Other correlating factors, including income, level of education, nutrition, as well as hygiene and sanitation are some of the important determinants of morbidities and mortalities.

Table 2 lists the total DALYs lost per 100 000 people, allowing comparisons across countries on both morbidity and mortality. Years of life lost due to disability shows that quality of life suffers when an individual has a disability or an injury. DALYs lost were the highest in Lesotho. The level of DALYs lost for Seychelles and Mauritius were about a third of Lesotho's; the two island nations performed slightly better than the global average. The average DALYs lost of the respondent countries was about 51 800, which was close to the sub-Saharan average of 51 979, but significantly higher than the global average of 32 797. The number of DALYs lost shows a similar pattern to the other measures of the quality of healthcare.

Table 2: Mortality rates in respondent countries

	Mortality rate, infant (per 1 000 live births), 2017	Maternal mortality ratio (modelled estimate, per 100 000 live births), 2017	Mortality rate, adult, male (per 1 000 male adults), 2017	Mortality rate, adult, female (per 1 000 female adults), 2017	DALYs lost (per 100 000 people), 2017
Benin	61	397	261	214	50 235
Cameroon	51	529	341	317	52 120
Chad	71	1 140	380	335	63 127
Congo, Dem. Rep.	68	473	276	227	54 257
Côte d'Ivoire	59	617	406	364	57 691
Gambia, The	39	597	284	228	46 917
Guinea-Bissau	54	667	288	237	61 937
Lesotho	66	544	549	459	75 806
Liberia	54	661	250	210	51 220
Mauritius	14	61	190	94	27 766
Nigeria	76	917	368	328	53 712
Seychelles	12	53	203	98	28 044
Sierra Leone	79	1 120	396	383	62171
South Africa	29	119	379	258	45 453
Uganda	34	375	340	264	46 651
Sample Maximum	79	1 140	549	459	75 806
Sample Minimum	12	53	190	94	27 766
Average	51	551	327	268	51 807
Median	54	544	340	258	52 120

Source: World Bank World Development Indicators and Oxford University

2.3 Spending on healthcare

Impact of health spending

The impact of expenditure on health is contested. Famously, Filmer and Pritchett (1999) found that health expenditure had a near-zero impact on under-five mortality; factors such as GDP per capita, income inequality and measures of women's education were more important in determining infant mortality. The results for Africa, however, show that expenditure on health has a substantial impact on health outcomes. Novignon, Olakojo and Nonvignon (2012) examined the impact of health expenditure on health outcomes in Africa. The results show that an increase of 1% in health expenditure leads to an increase in life expectancy of between 0.6 and 0.7 years, and a reduction in death rates of 0.5 to 0.6 per 1 000 people. Importantly, public health expenditure seems to have a larger impact, reducing deaths by 0.8 per 1 000 people compared to 0.4 per 1 000 people for private spending, although the effectiveness of public spending depended on many socioeconomic and contextual factors. In terms of infant mortality, increased public expenditure reduces infant mortality by four infants per 1 000 live births, while private spending reduces infant mortality by two infants per 1 000 live births.

Makuta and O'Hare (2015) found that the quality of governance is an important factor that mediates the impact of health expenditure. South Africa is still worse off in respect of health outcomes and experiences a challenge in attaining positive outcomes for these goals. This study's main focus was to identify the association between public health expenditure and health outcomes in South Africa's nine provinces from 2002 to 2016. The study implemented fixed effects and a random effects panel data estimation technique to control for time effects and individual provincial heterogeneity. This was followed by employing the Hausman specification test to identify the fixed effects model as the appropriate estimator for the study. The study also employed the seemingly unrelated regression (SUR). If governance improves, health outcomes can improve, even if health expenditure itself does not increase. This occurs through better use of health expenditure and indirectly through the impact of better governance on economic growth. The results of Makuta and O'Hare (2015) show that increased health expenditure in a poor governance setting can have virtually no impact on health outcomes, while in good-governance environments the average impact of health expenditure is doubled. This is an important finding for the current survey, which seeks to improve governance of budgeting and execution processes. The effect of governance may also be one explanation for the counterintuitive findings by Filmer and Pritchett (1999).

Share of health spending in GDP and government expenditure

Health expenditure per capita can be an indicator of the resources economies are able to mobilise for health expenditure. Table 3 examines the resources that respondent countries in our sample are able to deploy for healthcare. Per capita health expenditure in the sample was US$147 (US$81 excluding the relatively high-income islands of Seychelles and Mauritius). Health expenditure is linked to GDP per capita, with the wealthiest economies, such as Seychelles and Mauritius in this sample, being able to spend more on health. Countries that have an effective taxation system, such as South Africa, are in a better position to raise more revenue than lower countries that have a larger informal sector. The fact that a relatively wealthy country like Nigeria is only able to spend US$79 per person on health is likely a result of relatively poor tax and revenue administration. Richer economies can spend more on other public goods that improve health, such as WASH.

Health spending accounts for 6.2% of GDP among the countries in the sample. The share of health in GDP is the largest in Sierra Leone, accounting for 16.5% of GDP, though as mentioned above, the GDP is low. On the other hand, the share of health in GDP is the lowest in Nigeria, accounting for just about 3.6%. The 2016 average for sub-Saharan Africa was 5.1% of GDP and the global average was 10%.

In the Abuja Declaration of 2001, African countries agreed to allocate 15% of their budgets to health. The WHO found that by 2010, only Tanzania and Liberia had been able to achieve this level, but that Liberia did so by including donor funds. Nineteen of the countries that had signed the Declaration had allocated less funding to health in 2010 than when they signed in 2001 (WHO, 2010). The Africa Health Strategy 2016–2030 found that most African states were still not allocating enough funding to health. The Strategy reiterated the call for African governments to achieve their Abuja commitments (African Union, 2016).

If governance improves, health outcomes can improve

Table 3: Spending on healthcare in respondent countries

	Current health expenditure (% of GDP)	Current health expenditure per capita (current US$), 2016	Domestic private health expenditure (% of current health expenditure)	External health expenditure (% of current health expenditure)	Out-of-pocket expenditure (% of current health expenditure)
Benin	3.9	30	49.0	30.5	43.5
Cameroon	4.7	64	77.3	9.3	69.5
Chad	4.5	32	66.5	14.6	61.2
Congo, Dem. Rep.	3.9	21	44.4	43.4	37.4
Côte d'Ivoire	4.4	68	59.2	15.0	40.1
Gambia, The	4.4	21	37.6	43.8	23.6
Guinea-Bissau	6.1	39	35.4	20.3	35.4
Lesotho	8.1	86	18.9	17.3	18.9
Liberia	9.6	68	55.3	30.1	47.3
Mauritius	5.7	553	55.7	0.2	48.2
Nigeria	3.6	79	76.7	9.8	75.2
Seychelles	3.9	597	2.2	1.9	2.1
Sierra Leone	16.5	86	47.8	41.0	41.6
South Africa	8.1	428	44.3	1.9	7.8
Uganda	6.2	38	43.1	40.4	40.3
Sample Maximum	16.5	597	77.3	43.8	75.2
Sample Minimum	3.6	21	2.2	0.2	2.1
Average	6.2	147	47.6	21.3	39.5
Median	4.7	68	47.8	17.3	40.3

Source: World Bank World Development Indicators

External health expenditure

External health expenditure is a measure of how much healthcare is funded through aid and development assistance. Low income countries and fragile states, such as post-conflict states, require external assistance for healthcare. The Gambia, Sierra Leone, the Democratic Republic of the Congo and Uganda all fund more than 30% of their healthcare expenditure through aid compared with Mauritius that receives aid for only 0.2% of its healthcare expenditure. The average share of aid assistance in sub-Saharan Africa in 2016 was 11.6% of current health expenditure. On this measure, the sample is more aid-dependent than a typical country on the continent, with average external health expenditure being 21.3% of current domestic expenditure (see Table 3). While the level of aid is inversely correlated to the level of socioeconomic development, it has no correlation with the burden of disease measured by DALYs.

Out-of-pocket health expenditure

Out-of-pocket health expenditure is any spending that the household has to incur in order to secure medical care, aside from contributions to social insurance or medical aid. High out-of-pocket health expenditure is a barrier to access for the poor. High out-of-pocket health expenditure may indicate that the public distrusts the quality of public healthcare and will continue to use private healthcare even when it is prohibitively expensive.

Mugisha et al. (2002) found that out-of-pocket health expenditure was incurred by patients in rural Guinea-Bissau for self-treatment for malaria, even though it was the leading cause of morbidity and mortality. When households were unable to afford medical treatment, they resorted to selling off assets. Over 90% of the out-of-pocket health expenditure was on drugs. Nabonga Orem et al. (2013) found a similar pattern in Uganda: patients would attempt to treat themselves for malaria, buying their own drugs, rather than seeing a private or public healthcare professional. Out-of-pocket health expenditure was a barrier to private healthcare, but patients would still rather self-treat than seek treatment in public facilities. The study notes that patients used pharmacies because they were easy to access and would possibly offer credit.

Levels of out-of-pocket health expenditure in the respondent countries are high; accounting for 39.5% of the current health expenditure on average. However, there is a large variation in share of out-of-pocket health expenditure, with the minimum of 2.1% in Seychelles and maximum of 75.2% in Nigeria. A large share of out-of-pocket expenditure in health spending is a barrier to the poor receiving quality care. Three countries in the sample finance more than 50% of healthcare expenditure from out-of-pocket expenditure, while nine countries finance more than 40%. The average share of out-of-pocket expenditure in health spending for all sub-Saharan African countries is 36.7% of current domestic spend on health, about double the global average of 18.5%. (World Bank, 2020).

The respondent countries are a heterogeneous grouping that reflects some of the dispersion in socioeconomic indicators seen in sub-Saharan Africa as a whole. The two island nations, Mauritius and Seychelles, appear to be slight outliers, with higher GDP per capita and better health outcomes than the other countries. The burden of disease appears to be particularly acute in Lesotho. In terms of spending on healthcare, Seychelles and Mauritius can convert high GDP per capita into high government spend on healthcare as well as better health outcomes. The literature indicates that under the right circumstances, better use of government resources can lead to improved healthcare. The next section will examine how countries budget for and spend their health allocations.

While the level of aid is inversely correlated to the level of socioeconomic development, it has no correlation with the burden of disease

3 Budget allocations for the health sector

Budgeting for health is complicated by the technical nature of the function and the range of actors involved in the health sector. In addition, countries make different political choices about healthcare provision, which results in different healthcare systems operating in different contexts. In Africa, this unfolds in a context of a high disease burden (for example, HIV), high poverty levels and, in some instances, fragility and post-conflict reconstruction.

3.1 Health budget formulation

This section examines how countries budget for health and how the interaction between various stakeholders, particularly between ministries of finance and ministries of health, unfolds. There appears to be two main models of delivering healthcare. In the first model, the central government oversees the entire health budget. In the second model, healthcare is a shared responsibility between the central government and some form of sub-national government. In this case, only part of the health budget will be reflected in the central government budget. Central government, in this example, refers to national governments as opposed to state or provincial government.

For example, in the case of South Africa, much of the health function is carried out at provincial level. It is financed both by transfers from the central government and by allocations from the provincial government's own funds. In the case of Uganda, some health functions are the responsibility of local governments, but a grant from central government funds staff wages, capital spending and operational expenses. Mauritius runs a similar system to Uganda. In Lesotho, the national budget includes all sources of revenue and links it to the sub-national level, i.e. districts and local governments.

According to the National Health Accounts for 2017 for Mauritius, the total government expenditure on health was Rs 11.317 billion, of which the Ministry of Health and Quality of Life spent Rs 10.114 million, the Ministry of Social Security spent Rs 97.49 million, the Ministry of Defence and Rodrigues spent Rs 23.12 million and the Ministry of Foreign Affairs spent Rs 3.8 million, municipalities and district councils spent Rs 684.7 million and Commission for Rodrigues Health and Social Security spent Rs 393 million.

Table 4: Are health expenditures included in the central government budget?

Fully	Partly	Not
Côte d'Ivoire	Guinea-Bissau	Benin
Congo, Dem. Rep.	South Africa	
Cameroon	Nigeria	
Chad		
Sierra Leone		
Uganda		
Seychelles		
Liberia		
Lesotho		
Mauritius		
The Gambia		

Source: Budgeting for Health in Africa Survey 2019 data

The next three tables examine the respective institutions that are assigned responsibility for aspects of the healthcare budget. Out of the 15 countries, 10 have a central budget authority. This is usually the Ministry of Finance, which sets expenditure levels for healthcare. Once the healthcare spending envelope is determined, it is the responsibility of the Ministry of Health to determine the most efficient way to spend the allocation. Chad's structure is representative of many other countries: the expenditure of all sectoral ministries and institutions is centralised by the Ministry of Finance and by the General Directorate of Budget Services. In terms of budget preparation, the General Budget Directorate allocates envelopes to the medium-term expenditure framework (MTEF) that each sectoral ministry adapts. Subsequently, the ministry allocates these budgetary envelopes in accordance with its needs (personnel, goods and services, transfers, and subsidies, and interior and exterior investments).

Table 5 shows the respective roles assumed by institutions with respect to budgeting for healthcare. Institutions taking a leading role have convening authority and discretion to make decisions. Those in supporting roles can provide assistance but are not able to make decisions. Projecting healthcare spending is a key determinant of budget allocations in the future. Central budget authorities (CBAs) perform the leading role only in Chad, while they perform the role jointly with ministries of health in nine countries. Legislatures play a supporting role in seven countries, while playing no role in four countries. Six countries have listed the social insurance agency as having no role because no such agency is used in the country.

Ministries of health and finance jointly propose a desirable healthcare spend, as well as requirements for fiscal consolidation. The leading role is taken by ministries of health in four countries, by the ministries of finance in two countries and is shared jointly in six countries. In Uganda, the legislature also plays a leading role alongside the two ministries. In South Africa, the two ministries are key, as well as budget authorities in provincial sub-national governments. This is because health is a function of central government, provincial government and local government in South Africa. All three levels of government are guaranteed equality in the Constitution, which means that all three levels of government play a role in determining how much healthcare is provided. Legislatures play a supporting role in eight countries.

As the functions get more technical and more closely related to the everyday functioning of the health system, CBAs play a smaller role. Proposing capital investment in the health sector is primarily the role of ministries of health. In eight countries, the Ministry of Health takes the leading role and in three other countries, the Ministry of Health and the CBA perform the leading role together. Sierra Leone involves traditional leadership and civil society in this aspect of budgeting for health, and in many other areas.

Legislatures play a supporting role in determining capital investment in healthcare, that is if they play a role at all. In Mauritius and Chad, the legislature plays no role. Calculating the cost of coverage is fundamental to determining how much coverage a country can afford and the cost of any future expansion of coverage. This is a role that ministries of health perform. In 10 countries, the Ministry of Health carries out the leading role in determining the cost of increasing coverage alone, while in three other countries, the Ministry of Health plays the leading role, alongside the CBA. This is a highly technical exercise which probably limits the ability of the CBA officials to play a meaningful role unless they have health expertise and experience. This would also apply to the legislatures, which play a supporting role in eight countries.

Table 7 examines the respective bodies that negotiate fees in the public health system, and that negotiate the wages of medical and other staff. Payment rates are often the function of ministries of health, sometimes in conjunction with ministries of finance. In six countries, the Ministry of Health performs this function and in five countries it is done in conjunction with the CBA. Sierra Leone appears to have an inclusive process involving the Ministry of Health, the CBA, traditional leadership and civil society. Legislatures play a supporting role in five countries.

Wage negotiation for the health sector appears to be a shared responsibility between ministries of health and finance. In four countries, ministries of health perform this function alone. In three countries, it is the responsibility of the CBA and in five countries, it is a joint function. In two countries, the two ministries and the legislature play the leading roles. In South Africa, the Department of Public Service and Administration conducts wage negotiations for all junior civil servants on behalf of government. In seven countries, the legislature plays a supporting role, as one would expect for a function with important political implications.

Out of the 15 countries surveyed, 10 have a central budget authority – usually the Ministry of Finance, which sets expenditure levels for healthcare

Table 5: Institutional responsibilities in budgeting for health – overall levels of healthcare

	Project health spending in forthcoming years			Propose a desirable amount of healthcare spending (or cuts)		
	Leading role[2]	Supporting role	No role	Leading role	Supporting role	No role
Benin	Health CBA	Legislature Social insurance agency		Health CBA	Legislature	
Cameroon	Health	CBA	Legislature	Health	CBA	Legislature
Chad	CBA	Health	Legislature	Health	CBA	Legislature Social insurance agency
Congo, Dem. Rep.	Health		Social insurance agency	Health CBA	Legislature	Social insurance agency
Côte d'Ivoire	Health	CBA	Legislature	Social insurance agency	Health CBA	Social insurance agency
Gambia, The	Health	Legislature CBA	Social insurance agency	CBA	Health Legislature	Social insurance agency
Guinea-Bissau	Health CBA	Social insurance agency		CBA	Health	
Lesotho	Health CBA	Legislature CBA		Health CBA	Legislature CBA	Social insurance agency
Liberia	Health CBA	Legislature CBA	Social insurance agency	Health	Legislature CBA	Social insurance agency
Mauritius	Health CBA		Legislature Social insurance agency	Health CBA		
Nigeria	Health			Health		
Seychelles	Health CBA	Legislature Health	Social insurance agency	Health CBA	Legislature Health	Social insurance agency
Sierra Leone	Health CBA	Legislature Local council chief Administrators Civil society		Health CBA	Legislature Local council chief Administrators Civil society	
South Africa	Health CBA Sub-national governments	Legislature Provincial CBA	Social insurance agency	CBA Provincial CBA	Health Legislature Provincial health	Social insurance agency
Uganda	Health CBA Legislature	Sub-national government Civil society		Health CBA Legislature	Sub-national government Civil society	

Source: Budgeting for Health in Africa Survey 2019 data

2 In the table, CBA refers to the central budget authority (usually a Ministry of Finance or Treasury), and Health refers to ministries of health, even in cases where the health ministry performs other functions.

Table 6: Institutional responsibilities in budgeting for health – capital and coverage

	Proposed capital investment for the health sector			Calculate cost of increasing health coverage		
	Leading role[3]	Supporting role	No role	Leading role	Supporting role	No role
Benin	Health	Legislature CBA		Health	CBA Legislature Social insurance agency	
Cameroon		CBA		Health	CBA	
Chad	Health	CBA	Legislature Social insurance agency	Health		CBA Legislature Social insurance agency
Congo, Dem. Rep.	Health	Legislature	Social insurance agency	Health	Legislature	CBA
Côte d'Ivoire	Health	CBA Planning		Health	Legislature	CBA Legislature Social insurance agency
Gambia, The	Health CBA	Legislature CBA	Social insurance agency	Health	CBA	Social insurance agency
Guinea-Bissau	Health	CBA		CBA	Health	
Lesotho	Health	Legislature CBA	Social insurance agency	Health	CBA	Legislature Social insurance agency
Liberia	Health	Legislature CBA	Social insurance agency	CBA Health	Legislature	Social insurance agency
Mauritius	Health CBA		Legislature Social insurance agency	Health CBA		Legislature Social insurance agency
Nigeria	Health			Health		
Seychelles	Health CBA	Legislature Health	Social insurance agency	Health CBA	Legislature Health	Social insurance agency
Sierra Leone	Health Legislature Local council chief Administrators Civil society	CBA		Health	Legislature CBA Local council chief Administrators Civil society	
South Africa	Health Sub-national Health	CBA Provincial CBA	Social insurance agency	Health Sub-national Health	CBA Provincial CBA	Social insurance agency
Uganda	Health Legislature	CBA		Health	CBA Legislature	

Source: Budgeting for Health in Africa Survey 2019 data

3 In the table, CBA refers to the central budget authority (usually a Ministry of Finance or Treasury), and Health refers to ministries of health, even in cases where the health ministry performs other functions.

Table 7: Institutional responsibilities in budgeting for health – payments and wages

	Negotiate payment rates and fees paid to facilities in the public health system			Negotiate wages in the public health system		
	Leading role[4]	Supporting role	No role	Leading role	Supporting role	No role
Benin	Health CBA	Social insurance agency	Legislature	Health CBA	Legislature	Social insurance agency
Cameroon	Legislature			CBA		
Chad	Health	CBA	Legislature Social insurance agency	Health CBA		Legislature Social insurance agency
Congo, Dem. Rep.	Health	Legislature	Social insurance agency	CBA Health Legislature	Legislature	
Côte d'Ivoire	Health	CBA	Legislature Social insurance agency	CBA	Health	Legislature Social insurance agency
Gambia, The	Health	Legislature CBA		Health	CBA	Social insurance agency
Guinea-Bissau	CBA Health	Legislature		CBA	Health Legislature	
Lesotho	CBA	Legislature Health	Social insurance agency	Health	CBA Legislature	
Liberia				CBA Health	CBA Legislature	Social insurance agency
Mauritius	Health CBA		Legislature Social insurance agency	Health CBA		Legislature Social insurance agency
Nigeria	Health			Health		
Seychelles	Health CBA	Health	Legislature Social insurance agency	Health CBA	Health	Legislature Social insurance agency
Sierra Leone	Health Legislature CBA Local council chief Administrators	Local council chief Administrators Civil society		Health	Legislature CBA Local council chief Administrators Civil society	
South Africa	Health Sub-national Health	CBA	Legislature Social insurance agency	Public service and administration	CBA Health	Legislature Social insurance agency
Uganda	Health	Legislature		Health CBA Legislature		

Source: Budgeting for Health in Africa Survey 2019 data

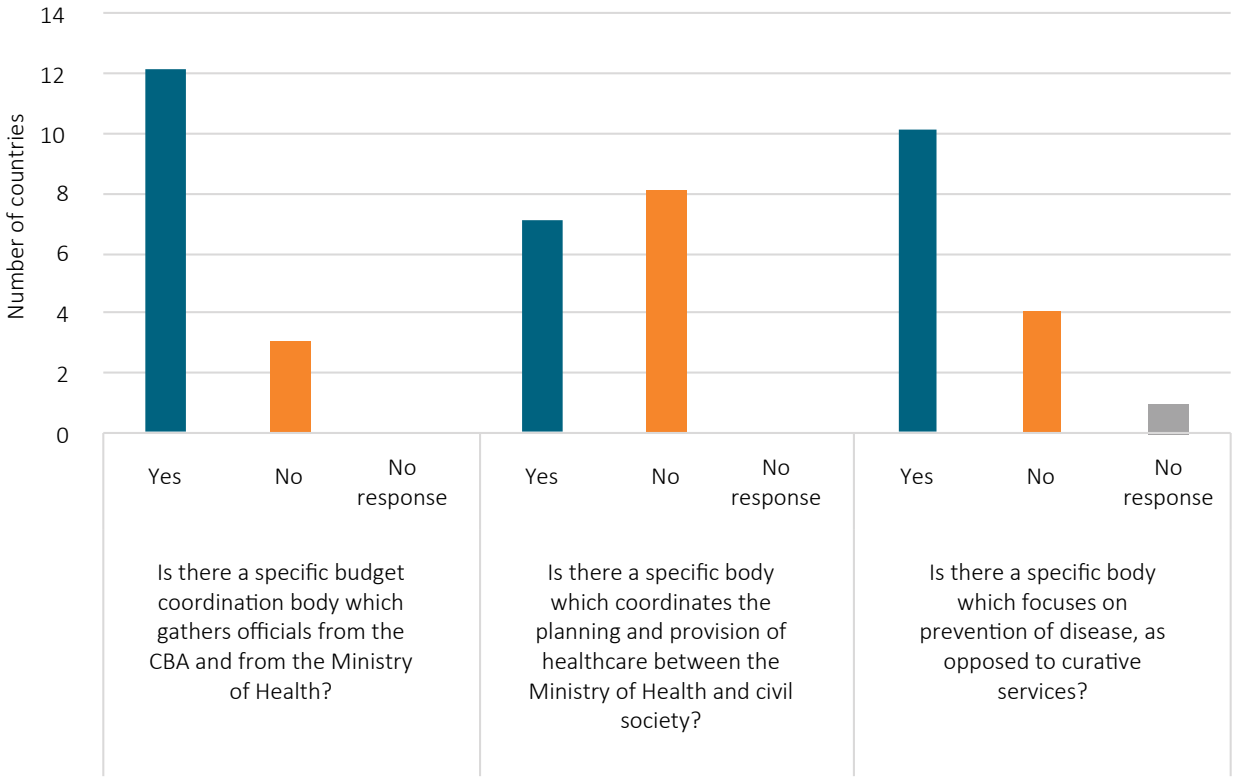
4 In the table, CBA refers to the central budget authority (usually a Ministry of Finance or Treasury), and Health refers to ministries of health, even in cases where the health ministry performs other functions.

3.2 Mechanisms for budgeting for health

Figure 2 focuses on the institutional structure of healthcare budgeting. Most countries have a specific body to coordinate budgeting for health. Only Benin, Liberia and The Gambia do not have such a coordinating body. The structure of the coordinating body varies across countries, depending on their healthcare system. In the Democratic Republic of the Congo, the Ministry of Budget arranges a budget orientation seminar and budget conferences to explain the assumptions that inform the budget. The Ministry presents the budget projections with a view to reach consensus on indicative ceilings and advocacy, and to obtain increases in order to better meet sectoral needs.

In the case of Sierra Leone, the Ministry of Health and Sanitation has a functional Budget Committee whose members include all directors and programme managers, the Vote Controller (administrative head), Chief Medical Officer (professional head) and the Budget Officer from the Ministry of Finance (secretary of the committee).The committee meets quarterly to discuss budgetary allocations published by the Ministry of Finance. They agree on key achievable activities and allocate funds. The committee updates budget execution and key deliverables bimonthly to keep top management and the Minister of Health and Sanitation informed. The committee also meets to plan the following year's budget, often advocating to meet the Abuja Declaration which targets an allocation of 15% of the government budget to the health sector. Key health civil society members are also co-opted when necessary.

Figure 2: Institutional structure of healthcare budgeting



Source: Budgeting for Health in Africa Survey 2019 data

Most committees seem to be structures of government but without any legal underpinning. In contrast, Côte d'Ivoire has established a Platform for National Coordination of Health Financing (PNCFS) through a proclamation by the Prime Minister. The PNCFS consists of cabinet ministers, representatives of the development partners, the World Bank, the WHO, representatives of the private sector and members of civil society.

In the case of South Africa, there are two coordinating bodies. In a typical budget process, there is a budget bilateral, which is a meeting between the National Treasury and the Department of Health. There is also a 10x10: a meeting with the Department of Health and the National Treasury, as well as the nine provincial health departments and treasuries.

Seven countries out of 15 have a mechanism to coordinate activities with civil society; eight countries stated that such a body does not exist. The Democratic Republic of the Congo is a good example of such a body in practice: several thematic task forces, including six thematic technical commissions comprising 20 to 30 members from various departments. These groups meet at least once a month. These technical commissions meet in a Technical Coordination Committee, at least once a quarter, under the chairmanship of the Secretary General for Health. A National Steering Committee, comprising public health actors, from the central level and from the provinces, technical and financial partners, as well as civil society meets once or twice a year, under the chairmanship of the Minister of Health.

In Sierra Leone, there is a Health Sector Steering Committee whose membership includes the Minister of Health and Sanitation, Minister of Lands and Country Planning, Minister of Environment, Minister of Labour and Social Security and Minister of Finance, among others. This committee meets quarterly to discuss reports forwarded by the technical working group to the Minister of Health, highlighting key challenging and flagship projects that need urgent attention.

The technical working group members include the planning directorate of the Ministry of Health, civil society members, development partners and programme managers. Each month, they discuss best practices, funds flow and interventions to reduce duplication of activities focusing on the President's agenda and co-financing of health interventions by partners of government. The ministry also has a non-governmental organisation (NGO)/donor liaison office that regularly liaises with international and local NGOs and other partners about activities for each financial year.

Prevention of disease is an important function of any health system. A specific body that focuses on prophylactic treatment exists in 10 countries. Only Liberia, South Africa, Côte d'Ivoire and Cameroon reported the lack of such a mechanism. In Seychelles, the Public Health Authority is a legally established body that regulates health and protects the health of the population. The authority is headed by a Board with representatives from different sectors, including civil society. It meets every two months to oversee strategic implementations. Trained health professionals conduct operations at centralised levels as well as decentralised levels. Functions include disease surveillance and response, environmental health, vector control and food safety. The Public Health Authority also coordinates with other national bodies, such as the Disaster and Response Management Agency.

Prevention of disease is an important function of any health system, and a specific body that focuses on prophylactic treatment exists in 10 countries – only Liberia, South Africa, Côte d'Ivoire and Cameroon reported the lack of such a mechanism.

3.3 Budget processes

Of all the respondent countries, only Guinea-Bissau does not have an MTEF, although evidence of an MTEF is not apparent in all countries' budget documentation. Table 8 compares this result with the relevant indicator in the PEFA assessment. This is complicated by the fact that results need to be compared across two PEFA frameworks (the 2011 Framework and the 2016 Framework). To obtain an A, a country would need to project expenditure levels for the current year and the following two fiscal years, allocated by economic, programme or administrative classification, such as capital and operating expenditure.

Lower performance would indicate that expenditure could not be allocated by economic or administrative classifications. A D rating indicates that medium-term budgeting is not used. The PEFA data provides some further detail to the CABRI results and shows that Cameroon is not using an MTEF, while South Africa and Uganda are fully employing an MTEF. While the other respondent countries are using MTEFs, these are partially developed. Further use of planning over the medium-term will allow countries to better link long term policy goals with budget expenditure, while still performing the macroeconomic management role of the budget (Holmes & Evans, 2003).

Table 9 contains information about the respondent countries' budget processes. The column on the left indicates the main question and then the four columns on the right-hand side of the table breakdown the responses of those countries which answered yes to the first question. Of those 14 countries, 10 include all health spending under budget ceilings, while four include only some health spending.

Ten of the 15 countries use healthcare functions in their budgeting. Seven countries use these categories as the basis of budget appropriations. Budgeting according to function can allow more flexibility than budgeting according to costs, such as personnel and facilities (Rajan, Barrow & Stenberg, 2016). Liberia uses budget programmes called 'Curative' and 'Preventative'. Lesotho uses categories such as 'primary healthcare' (mostly clinics), 'secondary healthcare' (hospitals) and 'disease control'. The Gambia uses categories such as 'epidemiology and disease control', 'infection control' and 'health education and promotion', though these are not the basis of budget appropriations.

Two-thirds of the respondent countries provide allocations for the prevention of specific diseases, and eight of these countries use these categories as the basis for budget appropriation. Allocations to specific diseases allow health officials to move funds within budgets during the fiscal year if the funds are still being used to fight the specific disease. A virement process to reallocate funding across different types of costs is not required. This flexibility enables a quicker response to health crises. Nigeria allocates funding to combat cancer, HIV, and malaria. HIV/Aids is mentioned specifically by five other countries besides Nigeria, as is malaria.

Twelve countries use budget allocations to provide for individual health facilities and in nine cases, these categories form the basis of budget appropriations. Some provide allocations to specific hospitals. For example, Sierra Leone provides allocations to Connaught Hospital and Children's Government Hospital. Benin provides an allocation for the Centre National Hospitalier et Universitaire Hubert Koutougou MAGA de Cotonou. South Africa provides allocations for the large tertiary hospitals, while Liberia has funding for John F. Kennedy Medical Center, Jackson F. Doe Hospital and Phebe Hospital.

Budget systems are quite flexible and allow countries to specify other allocations. Figure 3 shows that 10 countries use other types of allocations. Côte d'Ivoire has an allocation for the procurement of drugs. The Democratic Republic of the Congo uses categories such as remuneration, operational costs and capital spending. Cameroon makes allocations to improve governance and support institutions. Guinea-Bissau provides funding to personnel expenses, purchases of goods and services, transfers and investment. Sierra Leone makes provision for transfers to local councils, psychiatry and nutrition in the budget allocation for health. Uganda makes specific provision for pharmaceuticals.

All respondent countries distinguish between operating expenditure and capital expenditure, though the terms used differ slightly. In some countries the budget for recurrent expenditure is separate from the budget for capital expenditure.

Legislatures generally pass budgets with amounts specified for certain functions or cost centres. Ministries are usually allowed to reallocate some in-year funding within limits, which varies by country. In some cases, legislatures prevent any reallocation of funding from specific line items to protect funding. This usually indicates that the legislature views this expenditure as a national priority. Nine respondent countries use a mechanism to protect certain types of expenditure from budget cuts. Only Cameroon, Mauritius, Seychelles and Liberia reported the absence of such a tool. Chad reported that, except in an emergency, budget appropriations linked to staff costs are irreducible. In addition, under the programme with the International Monetary Fund, Chad reported health spending benefits since it is one of the priority sectors.

Sierra Leone noted that 'procurement of drugs and medical supplies, HIV/Aids, malaria, tuberculosis/leprosy, reproductive health, and wages and salaries' are protected from cuts, indicating that these items are of great importance to the government. South Africa has two mechanisms to protect certain expenditures: some allocations are marked as 'specifically and exclusively appropriated' and may only be reduced if a new Appropriation Bill is passed by Parliament. Other allocations are protected by a National Treasury earmark which prohibits these funds from being diverted without the approval of the Treasury. The Gambia noted that spending on drugs, dressings, medical supplies and vaccines cannot be reduced. Similarly, in Lesotho allocations for drugs, dressings, vaccines and salaries are seldom reduced.

Table 8: PEFA scores on use of the MTEF

	Year of PEFA assessment	PEFA Framework	Result
Benin	2014	2016	C
Cameroon	2017	2016	D
Chad	2018	2016	C
Congo, Dem. Rep.	2008	2011	C
Côte d'Ivoire	2019	2016	C
Gambia, The	2015	2011	C
Guinea-Bissau	2014	2011	D
Lesotho	2017	2016	B
Liberia	2016	2011	C
Mauritius	2015	2011	B
Nigeria	Not publicly released		
Seychelles	2017	2016	B
Sierra Leone	2018	2016	B
South Africa	2014	2011	A
Uganda	2017	2016	A

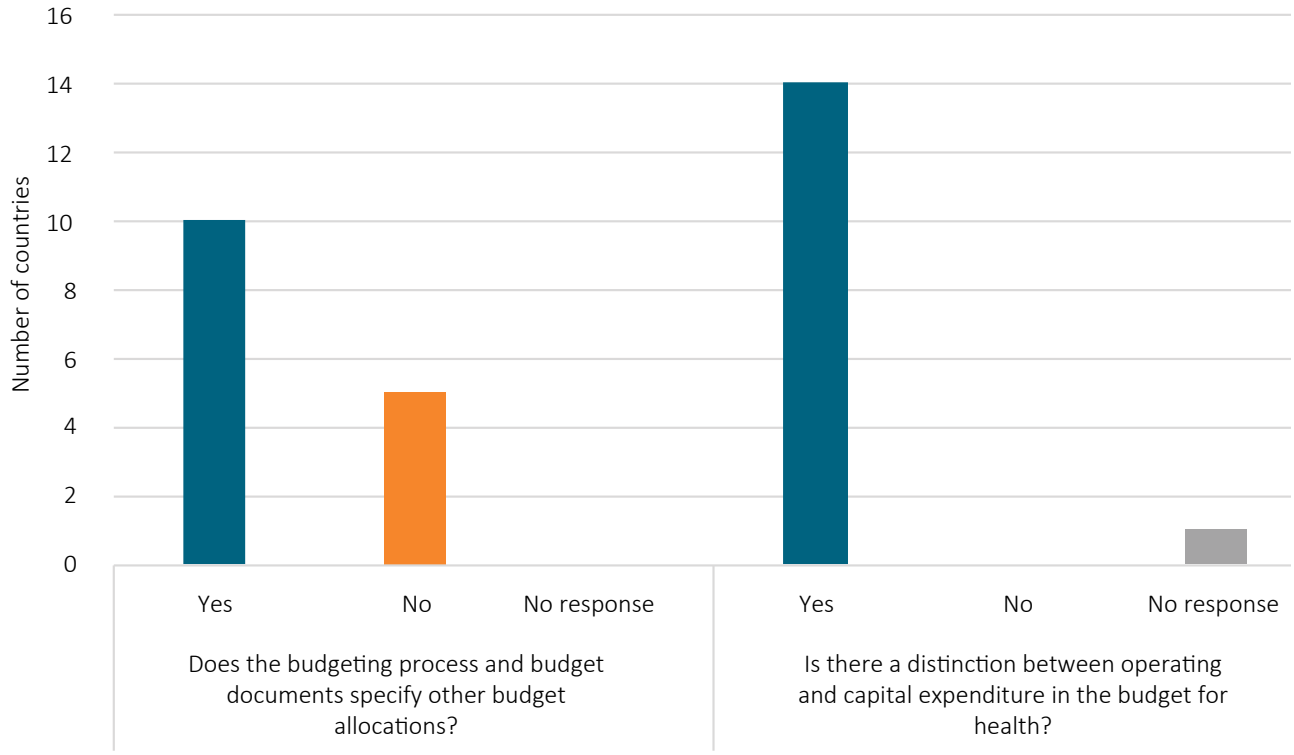
Source: PEFA. Elements assessed are PI-12.1 in the 2011 Framework and PI-16.1 in the 2016 Framework

Table 9: Budget processes: medium-term allocations

	Yes	No		Yes		No
Does your country have a medium-term fiscal and/or expenditure framework?	14	1	If yes: all health expenditures are included under the ceilings	10	If yes: No, health expenditures are not all included under the ceilings	4
Do the budgeting process and budget documents specify budget allocation by healthcare functions?	10	5	If yes: these categories are used for informative (non-binding) purposes	3	If yes: these categories form the basis of budget appropriation	7
Do the budgeting process and budget documents specify budget allocation to specific diseases?	10	5	If yes: these categories are used for informative (non-binding) purposes	2	If yes: these categories form the basis of budget appropriation	8
Do the budgeting process and budget documents specify budget allocation to individual health facilities?	12	3	If yes: these categories are used for informative (non-binding) purposes	3	If yes: these categories form the basis of budget appropriation	9

Source: Budgeting for Health in Africa Survey 2019 data

Figure 3: Budget process – other allocations and distinction between capital and operating expenditure



Source: Budgeting for Health in Africa Survey 2019 data

3.4 Performance-based budgeting

Performance-based budgeting uses performance indicators and a performance assessment framework (Robinson & Last, 2009) to establish a closer link between funds allocated to public bodies and the results that the funding obtains.

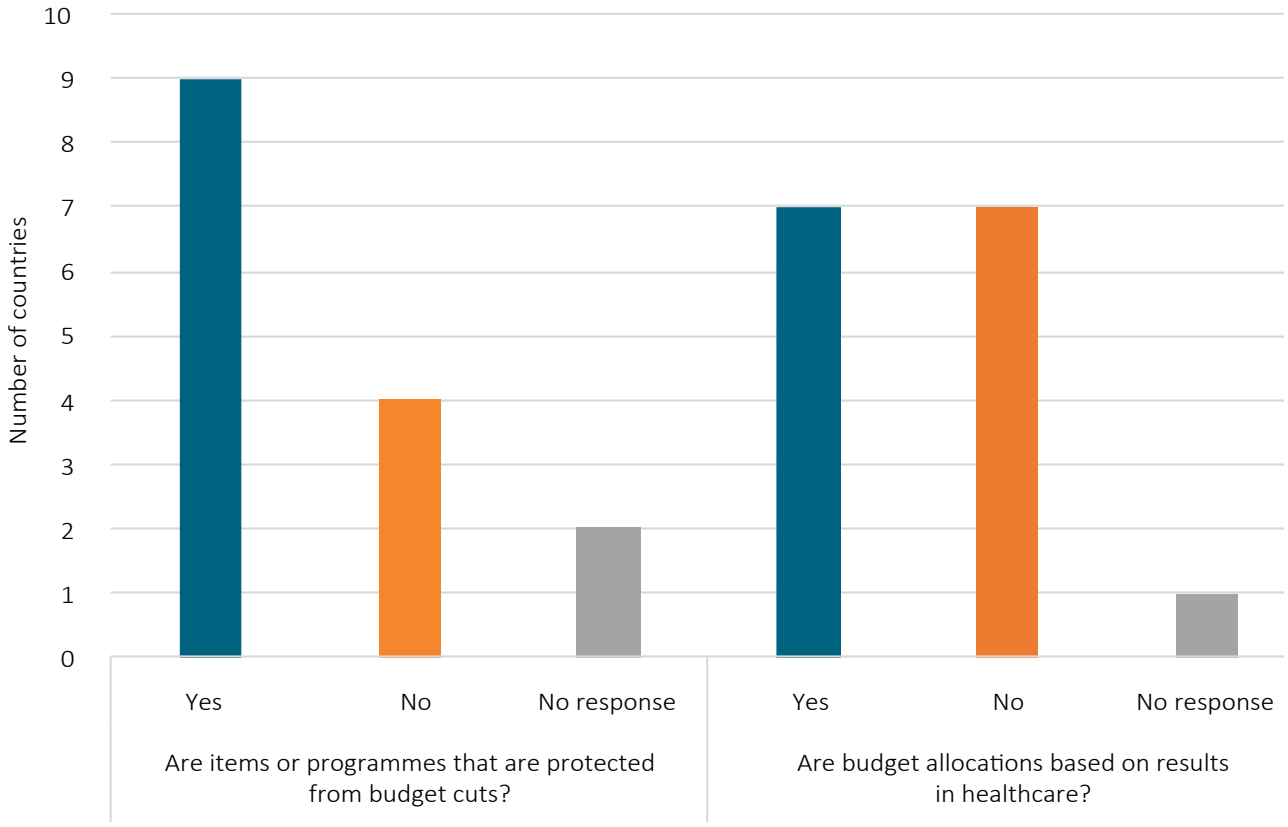
The sample is split with regard to the use of performance-based budgeting: seven countries use it and seven do not. Uganda did not respond. In Lesotho, performance-based financing is a World Bank funded programme which rewards performance to a set standard. If the standard is not achieved, an assessment to identify the cause of setback is made. If, for example, failure is due to a lack of equipment, equipment is made available. Additionally, staff performance is rewarded with salary top-ups.

Chad has just begun a performance-based budgeting process and is implementing programme budgeting. In 2019, as part of the preparation for the 2020 budget, performance indicators were retained in the context of the Annual Performance Projects (APP), which constitute the budget programming tools. However, the indicators are still experimental. They will only become binding in 2022, the date from which Chad should switch to the programme budget.

In 2013, CABRI noted that nearly 80% of African economies were considering implementing performance- and programme-based budgeting but that none had a fully implemented system. Mauritius and South Africa were listed as the countries closest to implementation. By 2018, several other countries were in the process of adopting performance-based budgeting. Burkina Faso had adopted performance-based budgeting, while Mali and Niger were scheduled to begin implementation in 2018 as part of the West Africa Economic and Monetary Union's (WAEMU) commitment to implement performance-based budgeting by January 2017, with a five-year transition window. Outside the WAEMU, Seychelles has staggered the implementation of performance-based budgeting, which started with education, agriculture and fisheries in 2015, and extended to the whole of government by 2017 (CABRI, 2019).

Sierra Leone provides performance incentives to staff. Payments for professional training, for example, undergraduate and postgraduate training, and specialist nursing courses are funded based on training progress reports and a proven track record in post-training achievements before additional funding is accorded for further specialist training.

Figure 4: Budget process – protection from cuts, and performance-based budgeting



Source: Budgeting for Health in Africa Survey 2019 data

3.5 Conclusions

Respondent countries run different budget processes but there are some commonalities that can be identified. Ministries of health are mostly responsible for the delivery of healthcare and most of the budget process once the central budget authority has been established. The more operational the function, for example planning for capital investment in the health sector, the less involvement from institutions outside the Ministry of Health. Most countries include all or virtually all spending in the central government budget.

Parliament plays an important role in the budget process. In terms of implementing health policies, parliaments often indicate national priorities by using mechanisms to prevent certain allocations from being reduced. These mechanisms were common in respondent countries and in some cases could be used by the central budget authority as well.

Deciding how to allocate funding can have significant implications when healthcare is delivered. Most countries used allocations to specific diseases or facilities. These allocations allow healthcare managers more flexibility than allocations to specific costs, such as personnel or capital.

The use of medium-term planning is almost ubiquitous. Comparisons with data from PEFA assessments shows that while most countries use an MTEF, the extent to which it is used varies. Performance-based budgeting is used in half of the respondent countries and this seems to be increasing, in line with the trend seen in other countries.

While most countries use MTEFs, the extent to which they are used varies

4 Health budget execution, purchasing and provider payments

This section reports on countries' financing strategies and their healthcare goods and service delivery methods. Healthcare can be paid for in a number of ways, with each mechanism imposing different risks on either the payer or service provider. In this section, we examine payment mechanisms and the structure of healthcare systems that respondent countries have employed to deliver healthcare effectively, while reducing risks and containing costs.

4.1 Institutional structure of health purchasers

The survey results suggest that the government is the main provider of practically all types of healthcare services, and while the central government is usually the main channel, some countries delegate healthcare functions to regional and local governments. In Sierra Leone, local councils provide primary care, covering 25% of the population.

Figure 5 and Figure 6 show the different health service purchasers for various services in the surveyed countries. The central government is the main provider of acute inpatient care. There is private health insurance in nearly half of the countries. In Chad, these services are solely delivered by private health insurance. Local or regional governments are also providers in Benin, Cameroon, the Democratic Republic of the Congo, Lesotho and South Africa. Moreover, Côte d'Ivoire is the only country with social health insurance.

Figure 6 presents the results for preventive service providers. Although the central government is the main provider in all countries, it often works in collaboration with local and regional governments. This is the case for Benin, Côte d'Ivoire, the Democratic Republic of the Congo, Nigeria, Sierra Leone, South Africa and Uganda.

In Uganda, all public health facilities are under the management of the national Ministry of Health. Primary healthcare facilities receive funding from both the central government and local authorities, but larger hospitals only get allocated funds from the national ministry. County and subcounty level facilities focus on preventive services, curative health services, maternity and inpatient services. Local governments only contribute funding. Management and regulation of the facilities is the responsibility of the Ministry of Health. Facilities deliver a standard package of services depending on how large they are. The smallest facilities at the parish level deliver the Minimum Activity Package, which is defined by the Ministry of Health (WHO, 2019).

Figure 7 shows similar results for primary care services, which are usually provided by regional or national governments, or in collaboration with each other. It is more often observed that private health insurance supports the provision of this type of service (in seven countries). Social health insurance is used in four countries, namely in Benin, Côte d'Ivoire and Nigeria.

All countries indicated that the central government is the main provider of specialist care and diagnostics. Nevertheless, private health insurance is also an important provider in nine out of 14 countries, as seen in Figure 8. Moreover, two other countries, Benin and Côte d'Ivoire, have further support from social health insurance.

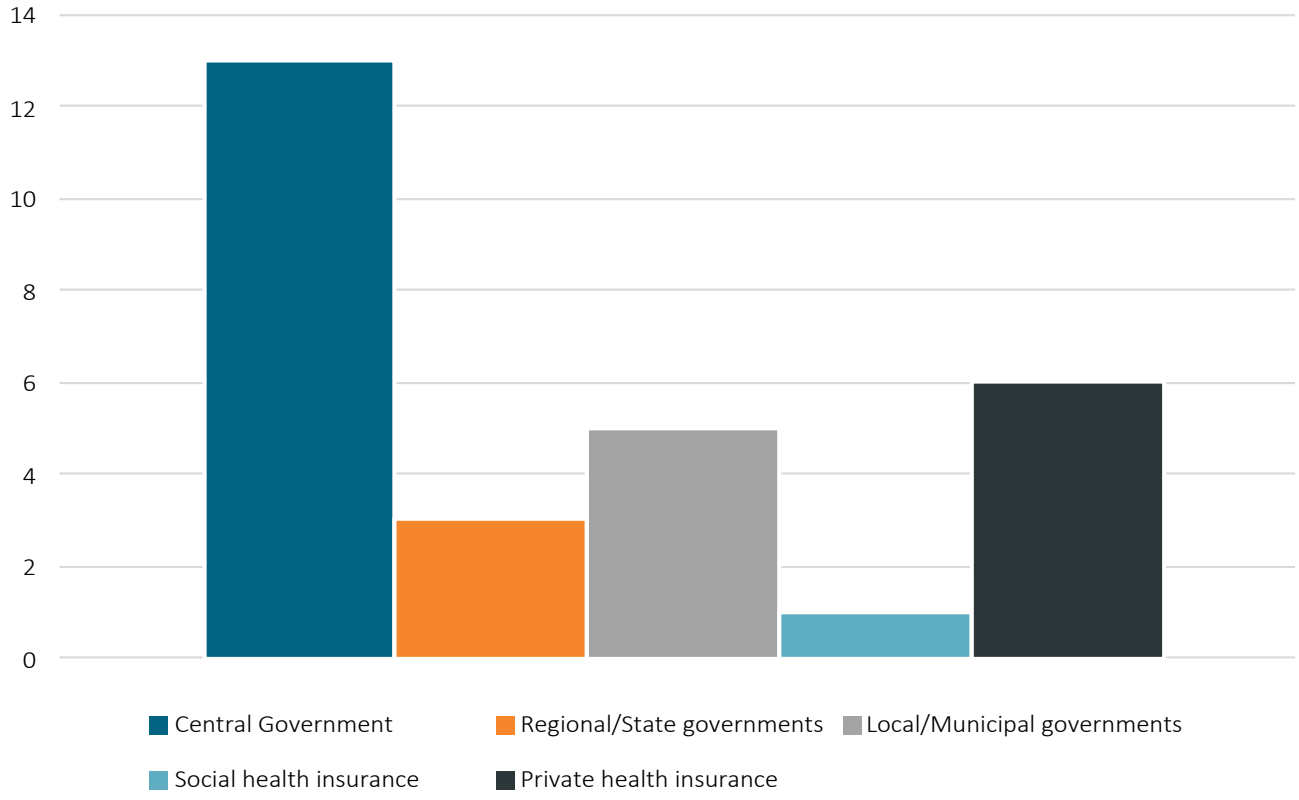
Data on the provision of pharmaceuticals (Figure 9) and public health services (Figure 10) were only available for five countries (Benin, Côte d'Ivoire, Guinea-Bissau, Nigeria and South Africa). The central government is cited as a provider in all countries and there is also collaboration with private health insurance.

Box 1: Social health insurance in Nigeria and Benin

Nigeria established the National Health Insurance Scheme of Nigeria in 1999. So far, it has been restricted to just civil servants, but voluntary contributions are also accepted. The Federal Government contributes 5% of the salary of all civil servants to the fund. The budget of the scheme is determined through projections of spending and revenue, and negotiations with the CBA. The budget must be submitted to Parliament for approval.

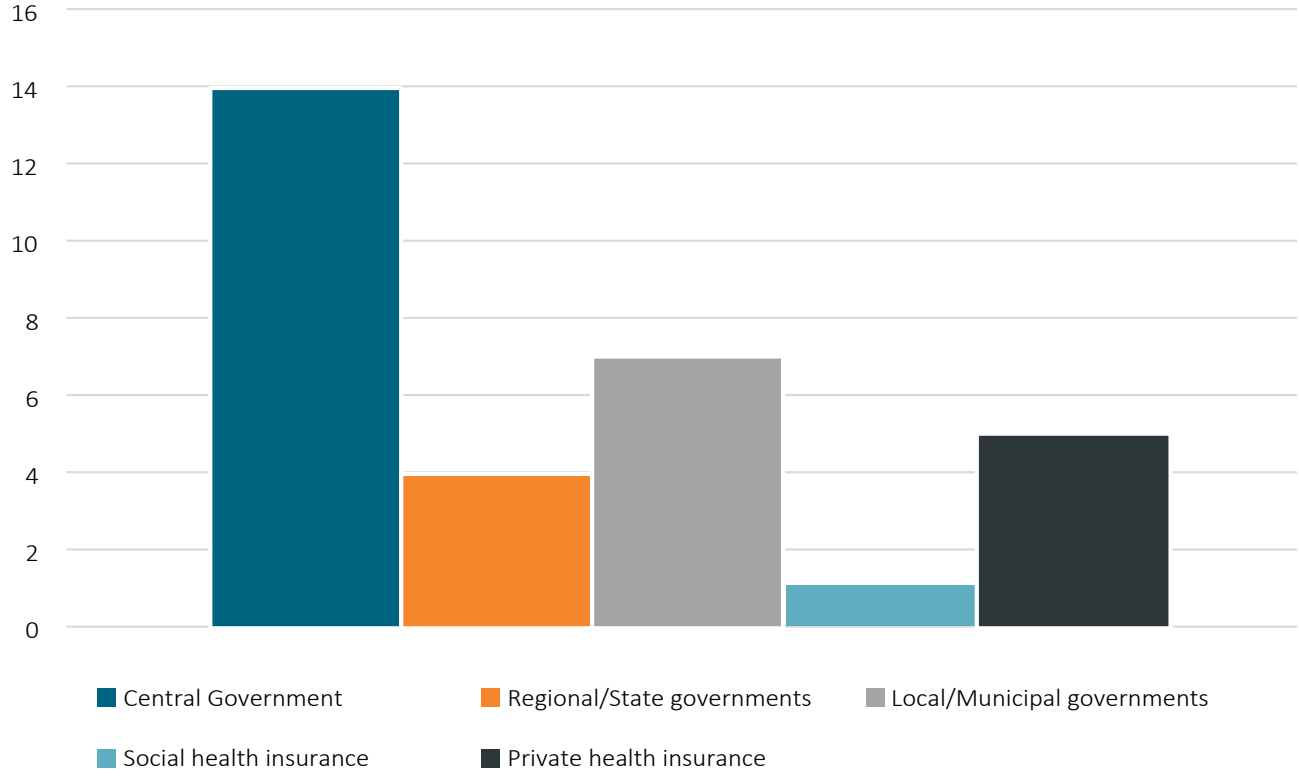
Benin established the Universal Health Insurance Scheme in 2016. Contributions are compulsory and the scheme covers disease, non-occupational accidents and maternal health. The scheme does not cover traffic accidents, work accidents and occupational diseases already covered by other social security schemes. Citizens of Benin outside the country and foreigners living in Benin may join voluntarily.

Figure 5: Main providers of acute inpatient services



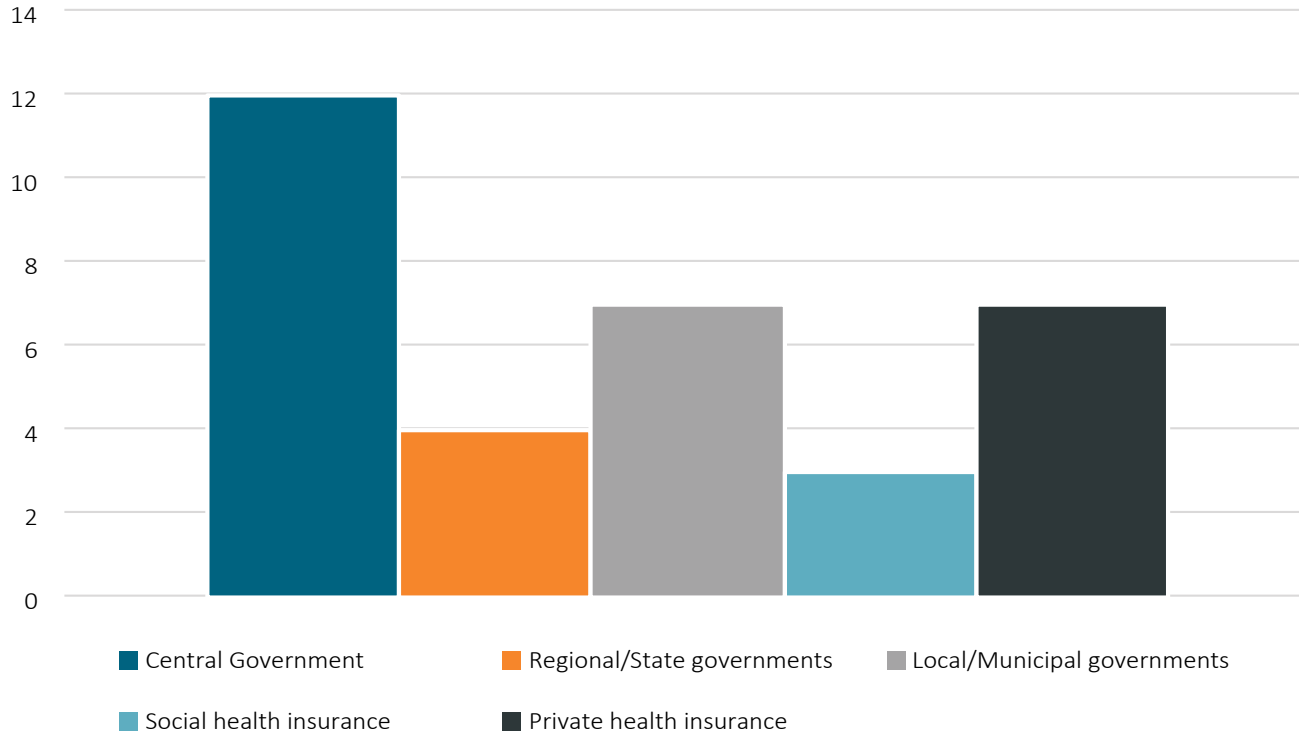
Source: Budgeting for Health in Africa Survey 2019 data

Figure 6: Main providers of preventive services



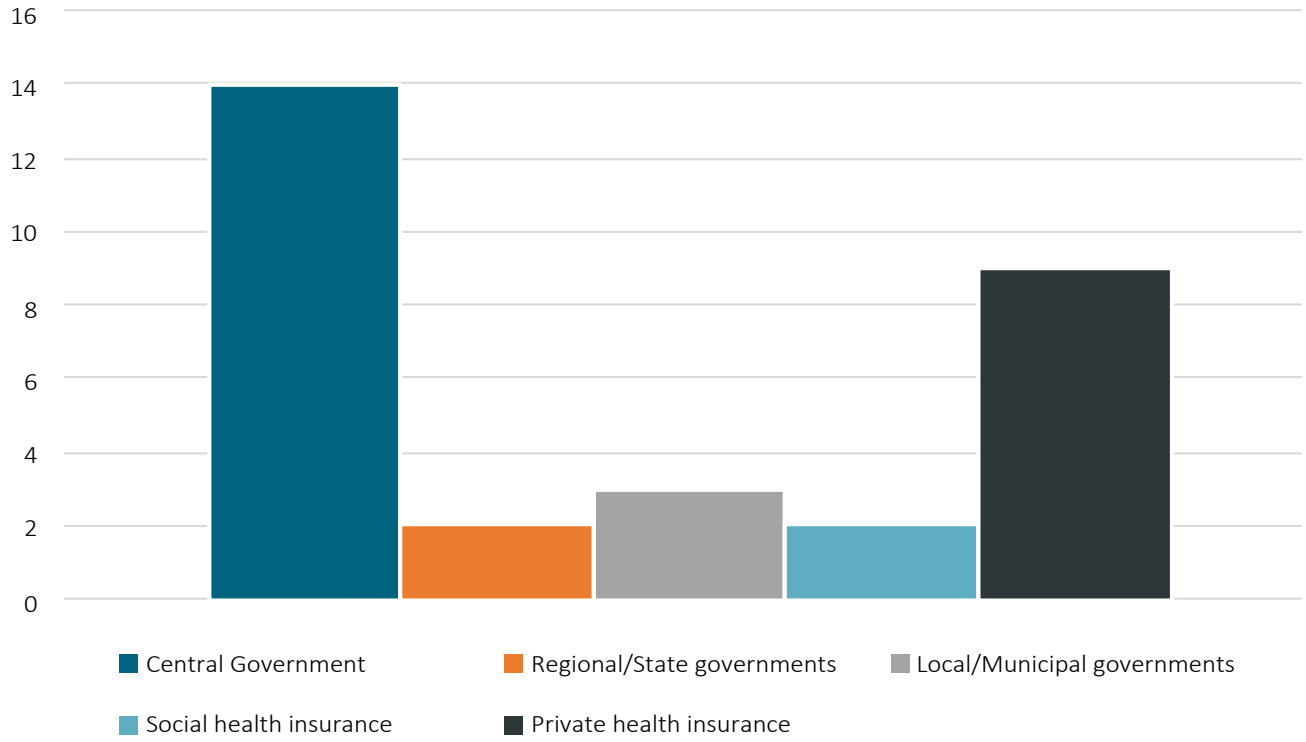
Source: Budgeting for Health in Africa Survey 2019 data

Figure 7: Main providers of primary care services



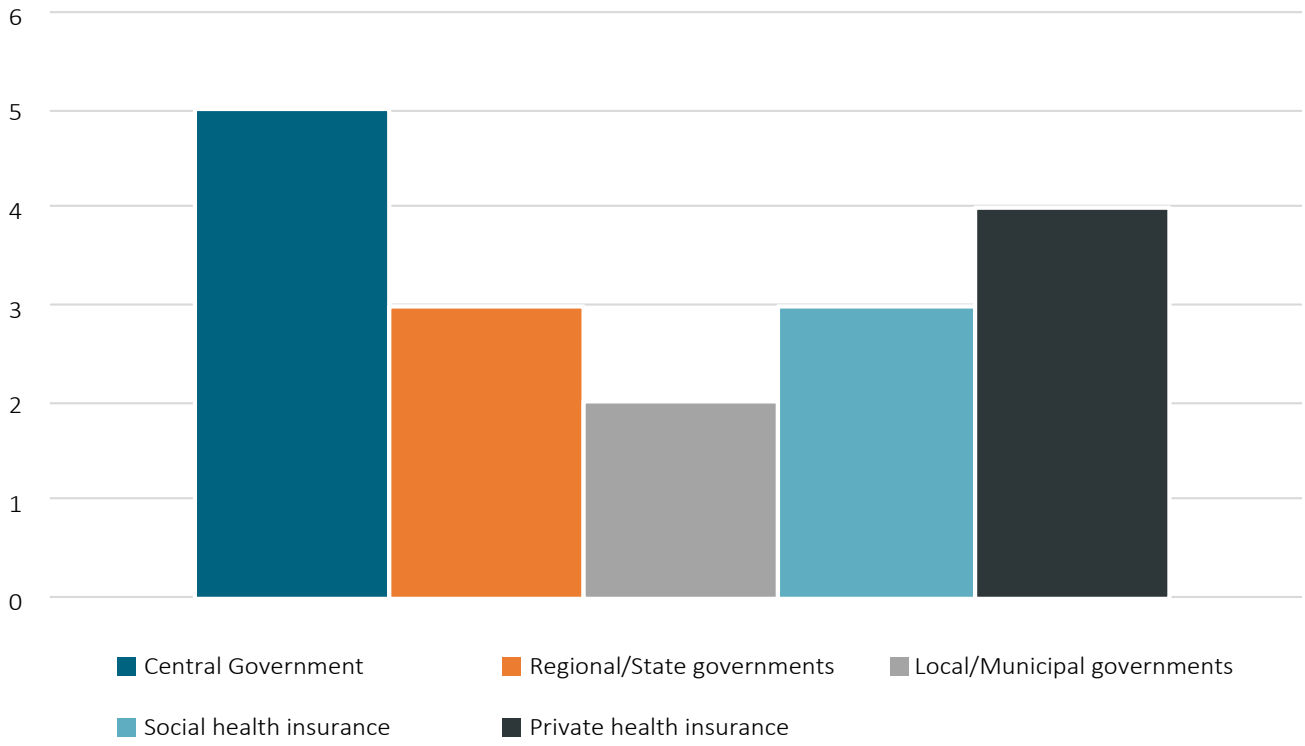
Source: Budgeting for Health in Africa Survey 2019 data

Figure 8: Main providers of specialist care and diagnostics



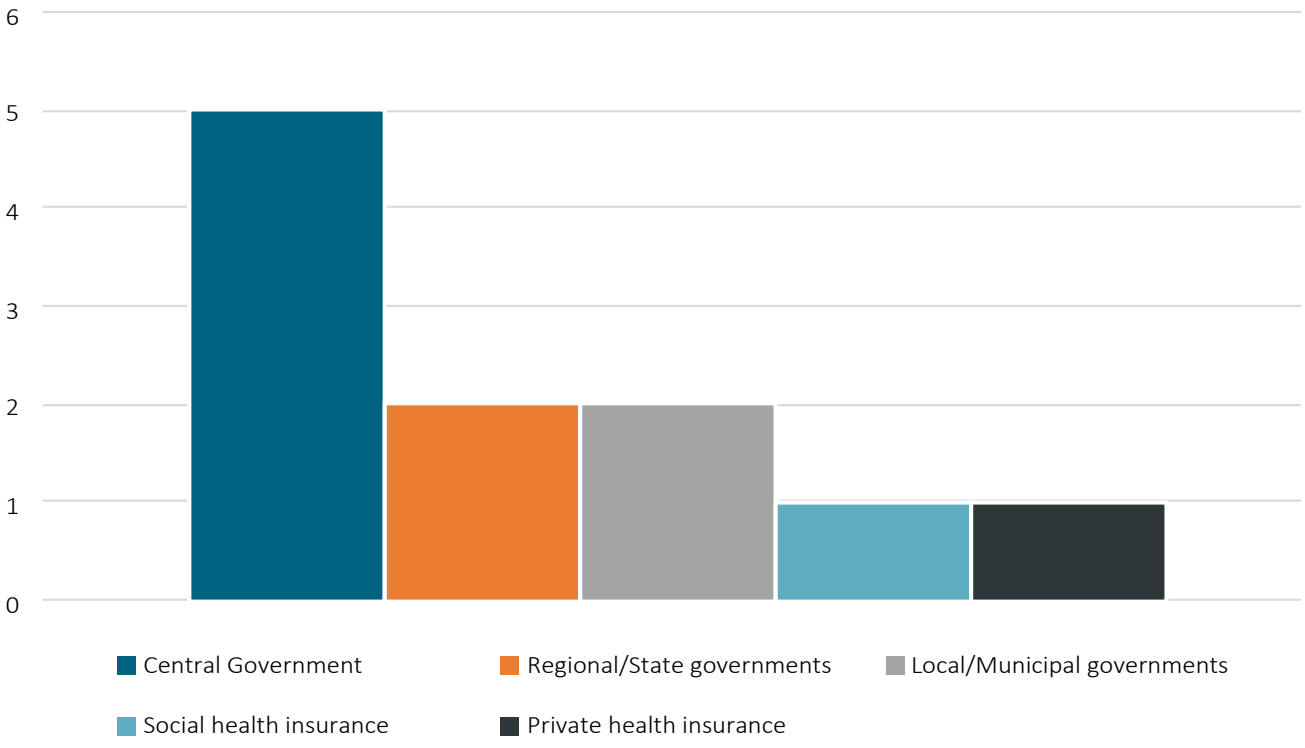
Source: Budgeting for Health in Africa Survey 2019 data

Figure 9: Main providers of pharmaceuticals



Source: Budgeting for Health in Africa Survey 2019 data

Figure 10: Main providers of public health



Source: Budgeting for Health in Africa Survey 2019 data

Table 10 shows whether health service provision is supported by health insurance in the surveyed countries. Health insurance is available throughout the respondent countries, with private insurance available in 10 countries, except for Cameroon, the Democratic Republic of the Congo, The Gambia, Guinea-Bissau and Liberia. Note, however, that this type of insurance is specifically used for the provision of specialist care and diagnostics. In contrast, only three countries use social health insurance, specifically Benin, Côte d'Ivoire and Nigeria, yet they do so for more types of services, such as preventive and primary care.

4.2 Provider payment systems

There are several types of payment methods that purchasers can use to pay for the provision of health services. While a line item budget allows for the bundling of health service types in groups, fee-for-services and case-based payment (also called diagnosis-related groups or DRGs) are methods where services are unbundled and paid for individually. DRGs are paid according to the cases treated. Unlike fee-for-services, where health services are paid by reference to the procedures used to treat patients, capitation works by paying a fixed rate per patient, regardless of how the patient is treated.

Table 11 shows that purchasers use different kinds of payment systems. The budget line item is an allocation of a fixed amount of funding to cover care or certain costs, for example healthcare workers' salaries. Fee-for-services is a payment based on services that have been offered. Usually these fees are agreed upfront and then payment occurs after the service has been provided. A case-based payment is a fixed amount paid to hospitals per admission or discharge, depending on certain clinical characteristics. For example, there could be a fixed fee paid per tuberculosis patient discharged. Capitation is the payment of a fixed fee to all providers for certain prescribed services.

The payment system most commonly used by central governments is a line item budget, showing up in as many as 12 countries, and this is often also used by the regional governments (in four countries). The fee-for-service and case-based payment (DRGs) are more commonly used by private health insurance, with six countries using each. For social health insurance, the most common method is capitation, present in six countries.

The least used methods are capitation and other bundle payments, for all purchasers and countries.

Capping total provider payments allows for diversification of providers and limits on their pricing power. Nevertheless, it is not a practice that is often observed in African countries. Indeed, only Côte d'Ivoire implements strict caps on payments to individual providers, while Benin and the Democratic Republic of the Congo apply flexible caps. Eight other countries did not provide an answer on this question, and Cameroon, Liberia, Seychelles and South Africa mentioned a lack of caps. These results are shown in Table 12.

Table 10: Provision of healthcare through health insurance

	Private insurance	Social insurance
Benin	✓	✓
Cameroon		
Chad	✓	
Congo, Dem. Rep.		
Côte d'Ivoire	✓	✓
Gambia, The		
Guinea-Bissau		
Lesotho	✓	
Liberia		
Nigeria	✓	✓
Seychelles	✓	
Sierra Leone	✓	
South Africa	✓	
Uganda	✓	

Source: Budgeting for Health in Africa Survey 2019 data

Table 11: Number of countries using each type of payment system

	Line item budget	Fee-for-service	Case-based payment	Other bundle payment	Capitation
Central government	12	5	5	2	3
Regional government	4	2	4	1	2
Local government	2	4	3	2	1
Social health insurance	1	2	2	1	6
Private health insurance	4	6	6	1	2

Source: Budgeting for Health in Africa Survey 2019 data

Table 12: Use of caps on payments to providers

	Strict caps	Flexible caps	No caps	Unanswered
Benin		✓		
Cameroon			✓	
Chad				✓
Congo, Dem. Rep.		✓		
Côte d'Ivoire	✓			
Gambia, The				✓
Guinea-Bissau				✓
Lesotho				✓
Liberia			✓	
Mauritius				✓
Nigeria				✓
Seychelles			✓	
Sierra Leone				✓
South Africa			✓	
Uganda				✓

Source: Budgeting for Health in Africa Survey 2019 data

Administration of caps is an important component of implementation. In Benin, a national primary healthcare agency has been created by decree in the Council of Ministers. It has financial and administrative autonomy. The payment limits for its acts will be defined.

In the Democratic Republic of the Congo, caps are implemented through a negotiated flat rate. Côte d'Ivoire administers caps through a budgetary control app called SIGFIP (Système Intégré de Gestion des Finances Publiques, or the Integrated Financial Management System). SIGFIP is used in Côte d'Ivoire, Benin, Senegal, Guinea and Togo (World Bank, 2004).

4.3 Procurement practices for pharmaceuticals

Figure 11 shows results of the procurement practices for pharmaceuticals dispensed in hospitals. Such procurement is usually done by the central health procurement unit for all countries. The exceptions are Nigeria, where procurement is done by individual health hospitals, and Chad and The Gambia, where it is done by drug stores and pharmacies.

Procurement of pharmaceuticals dispensed in the community or outside of hospitals is more varied. However, most of the surveyed countries use a central health procurement unit for this. Chad, Liberia and Uganda do it through individual healthcare providers (community pharmacies or outpatient centres), and Benin, Côte d'Ivoire and Guinea-Bissau do it through drug stores and pharmacies. These results are summarised in Figure 12.

Determining prices is crucial to the procurement process. The most common practice among the surveyed countries is through a tender process, which a total of eight countries follow. In five other countries, prices are regulated. Lastly, Seychelles is the only country to use individual negotiations to determine prices. No country uses market prices for pharmaceuticals. These results apply to pharmaceuticals dispensed in hospitals and those dispensed in the community (although with missing data for the latter in the case of the Democratic Republic of the Congo, Lesotho and Nigeria) and are summarised in Table 13.

The survey also enquired about the institutions in charge of price determination for pharmaceuticals. Although not all countries provided such information, it is often the case that specific institutions exist to coordinate and establish the processes. In Uganda, the tender process is carried out by the National Medical Stores and in Benin the prices are regulated through the Department of Pharmacy, Medicine and Diagnostic Exploration in collaboration with the Central Purchasing Centre for Essential Medicines and Medical Consumables. In Seychelles, it is the Ministry of Health that negotiates prices, and in Côte d'Ivoire, the Ministry of Health collaborates with the ministries of finance and commerce to regulate prices. More details on procurement in Seychelles, South Africa and Nigeria are contained in the case study on procurement.

The Democratic Republic of the Congo reported a centralised process with narrow coverage. Generally, patients are given a prescription to buy pharmaceuticals. However, some products are ordered by the state through the Federation to purchase essential drugs.

In Cameroon, a dedicated body oversees procurement. There are structures like CENAME[5], which is purely in charge of procurement of pharmaceutical products.

4.4 Conclusions

Central government is the most important provider of healthcare services in the respondent countries, though this varies according to the type of service provided. Central government provides primary healthcare, which is to be expected given the spill overs from preventing future healthcare expenditure if primary healthcare quality is weak. Local governments, usually in the form of clinics, are an important partner in primary care provision. Specialised services, such as diagnostics and specialist physicians, are provided by central government and private healthcare providers. In some of the respondent countries, high levels of income inequality are linked to the use of private healthcare providers, which includes specialists not available in the public sector. Benin and Nigeria have social health insurance schemes.

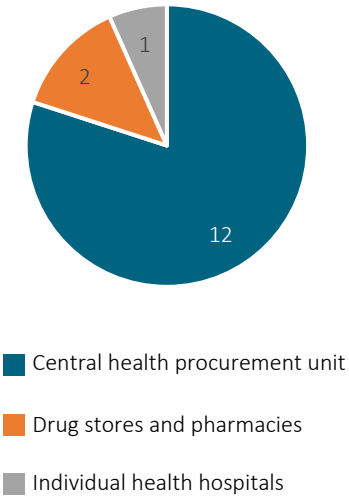
Respondent countries mostly use line item budgets for paying for healthcare services, especially when the implementing agent is the central government. Other payment methods could be explored for alternative delivery systems as these could balance risks more evenly between the state and the provider. Benin, the Democratic Republic of the Congo and Côte d'Ivoire have used caps on payments to providers, which imposes more risk on providers.

Procurement of drugs for the public sector is usually carried out through a centralised process by an agency of the central government. It is evident in the case study on procurement that centralised procurement can either increase or decrease costs, based on how the procurement is structured.

Central government is the most important provider of healthcare services in the respondent countries, though this varies according to the type of service provided

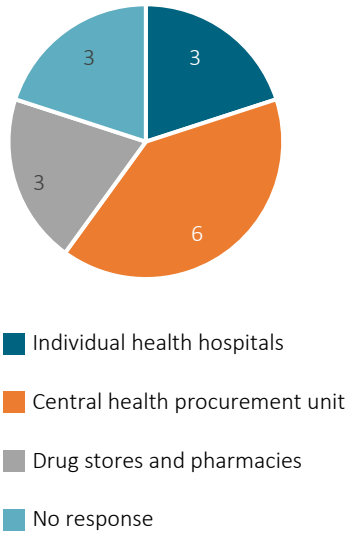
5 CENAME is the Centrale Nationale d'Approvisionnement en Médicaments et Consommables Médicaux Essentiels, or the National Central Supply of Medicines and Essential Medicinal Consumables.

Figure 11: Procurement of pharmaceuticals dispensed in hospitals



Source: Budgeting for Health in Africa Survey 2019 data

Figure 12: Procurement of pharmaceuticals dispensed in the community



Source: Budgeting for Health in Africa Survey 2019 data

Note: Data unavailable for the Democratic Republic of the Congo, Lesotho and Nigeria.

Table 13: Practices to determine pharmaceutical prices

Tender process	Regulated prices	Individual negotiations
Congo, Dem. Rep.	Côte d'Ivoire	Seychelles
Gambia, The	Cameroon	
Sierra Leone	Benin	
Uganda	Chad	
Mauritius	Guinea-Bissau	
South Africa		
Liberia		
Nigeria		

Source: Budgeting for Health in Africa Survey 2019 data
Note: Data unavailable for Lesotho.

Procurement of drugs for the public sector is usually done through a centralised process by a central government agency

5 Monitoring budgets

In order to improve budget planning and execution over time, governments need to monitor the quality and pace of spending. This monitoring takes place over two different timescales. In-year monitoring is mostly focused on the pace of expenditure to ensure that underspending does not occur, and that ministries stay within expenditure ceilings.

Quality of spending is more difficult to ascertain and requires more time and research to analyse adequately. This could range from site visits to the commissioning of academic papers to determine the impact of spending. Formal spending reviews can go so far as to examine every transaction over a certain period to establish if the funding was being spent as the legislature intended. In an ideal world, quality of spend and impact could be established through random control trials of government programmes, but these are expensive to carry out, potentially take years and their findings are limited to specific contexts.

5.1 Mechanisms for monitoring expenditure

Of the 15 respondent countries, only Chad does not have a mechanism for monitoring budgets. The monitoring systems mostly function in similar ways. The Gambia referred to an Integrated Financial Management System (IFMIS) and the quarterly public health budget expenditure analysis carried out by the Health Financing Unit at the Directorate of Planning and Information.

In Sierra Leone, the reporting mechanism also covers activities by NGOs. The Budget Bureau within the Ministry of Finance has an Excel data monitoring tool to ascertain the actual expenditure and the payables on a monthly basis. The Ministry of Health and Sanitation has an NGO unit that tracks the flow of funds from international and national NGOs' activity interventions. Additionally, the Government Accounting System stops any amount in excess of the approved budget and ceilings.

In Uganda, all institutions are required to prepare quarterly reports clearly detailing the funds received, expenditure and accomplishments against planned outputs. Additionally, the sector budget officers physically monitor projects to ascertain the status provided in the quarterly performance reports.

The process in Mauritius is similar. Quarterly monitoring by the Ministry of Finance is done on expenditure incurred on all items. Overspending requires clearance as per the rules of the Finance and Audit Act and the Financial Management Manual.

Table 14 shows that the institutions that are mandated to monitor budget execution are similar across countries. In all respondent countries except The Gambia, ministries of finance play an important role. In The Gambia, this function is undertaken within the Ministry of Health. Some countries involve a range of other bodies, for example, in Lesotho, Parliament, Cabinet, the ministries of finance and health are all involved in monitoring budget execution. A Public Accounts Committee is empowered to examine the financial statements of all government bodies. In addition, the Ministry of Health reports to the Parliamentary Cluster Committee, which discusses variances in expenditure.

Figure 13 shows how long it takes the Ministry of Health to report on health expenditures. As per the PEFA standard (PI-28), reporting takes place within a month (PEFA, 2019). Half of the responding countries report within a month. In six cases, countries' reporting can take more than three months to occur. A lag this long will make it difficult for the Ministry of Finance to perform its oversight role effectively.

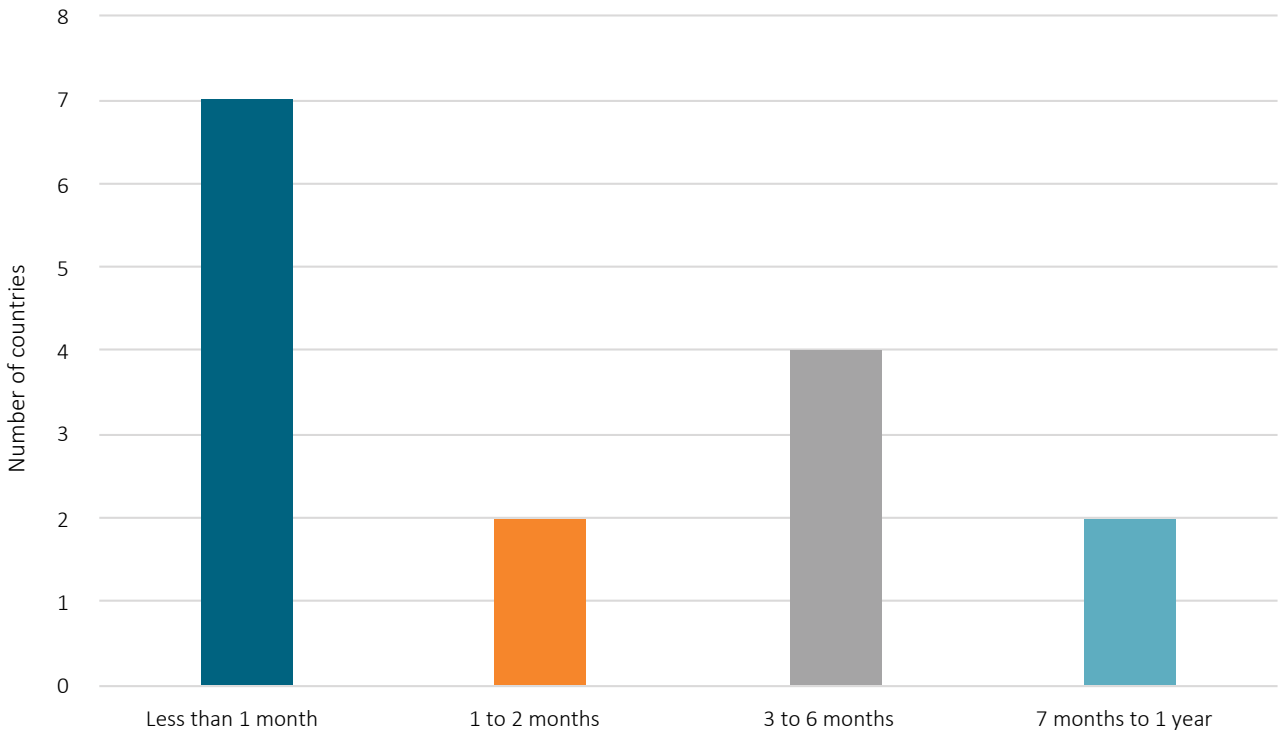
There are several reasons for the reporting delay. In Nigeria, delays are caused by audits, which explains the lag of more than six months in reporting on expenditure. In Lesotho, delays of three to six months in reporting are caused by the Ministry of Health. Liberia also has reporting delays of three to six months caused by healthcare service providers. Côte d'Ivoire has several explanations for reporting delays of more than six months. These are due to delayed reporting by the Ministry of Health and sub-national governments, a lack of appropriate technology to process data, delayed reporting by international funding agencies and insufficient administrative capacity.

Table 14: Responsibility for monitoring budget execution

	Parliament	Cabinet	Ministry of Finance	Ministry of Health
Benin			✓	✓
Cameroon	✓		✓	✓
Chad			✓	
Congo, Dem. Rep.			✓	
Côte d'Ivoire	✓	✓	✓	✓
Gambia, The				✓
Guinea-Bissau	✓	✓	✓	
Lesotho	✓	✓	✓	✓
Liberia	✓		✓	✓
Mauritius			✓	✓
Seychelles		✓	✓	✓
Sierra Leone			✓	
South Africa			✓	
Uganda	✓		✓	

Source: Budgeting for Health in Africa Survey 2019 data

Figure 13: Data availability for monitoring purposes



Source: Budgeting for Health in Africa Survey 2019 data

5.2 Budget execution

Not many respondents completed the section of the survey detailing budget allocations, the adjusted allocation and actual expenditure. The information that was submitted is captured in Table 15. The data reveals that budget execution rates are quite low. The last column of the table captures the ratio of actual expenditure to the original budgeted allocation.

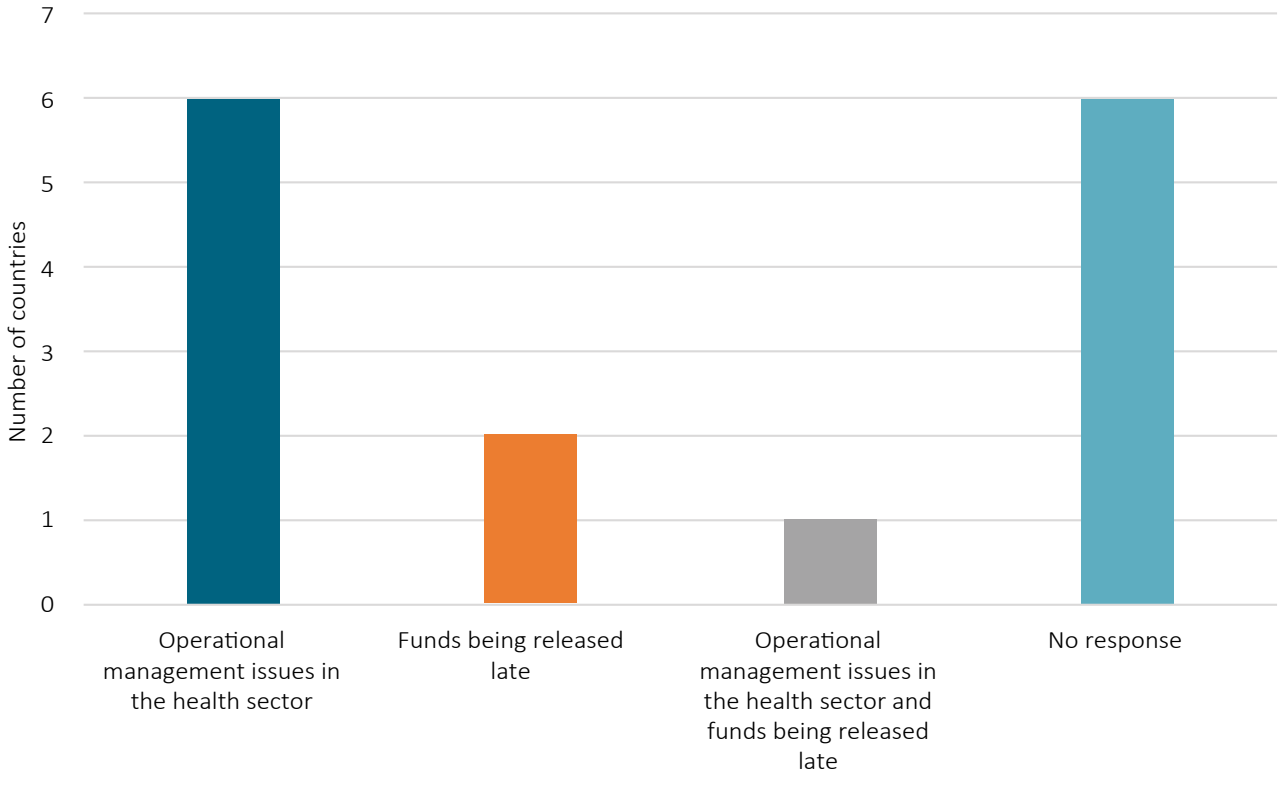
This ratio should be close to one. If the ratio is below one, governments are unable to spend their full allocation. This implies that there are service delivery objectives that are not being met because of operational shortcomings, and that funding is being foregone. On the other hand, if the ratio is above one, this suggests a lack of expenditure control.

The results show that Benin, the Democratic Republic of the Congo and Côte d'Ivoire all underspend their allocations, in some cases by large amounts. In the case of Benin, budget execution rates are very low. The table only contains data from the latest year. Benin's average budget execution rate over the last five years was 0.21. This implies that there are important operational problems in the health sector undermining service delivery and perhaps contributing to the low life expectancy in these countries. Sierra Leone has the opposite problem, with actual expenditure above the budgeted allocation. This implies poor financial controls in the Ministry of Health. Liberia and South Africa have good budget execution rates.

Table 16 reports the results of the assessment of budget execution from the respondent countries' reports. For budget execution to be rated A, the variance from budget had to be less than 5%, less than 10% for a B and less than 15% for a C. These budgets refer to expenditure covering 75% of government spending, not just that for the Ministry of Health. Nevertheless, the results in the table are congruent with the CABRI results in that levels of budget execution are low. The PEFA results indicate that this is probably due to systemic budget execution problems, rather than issues particular to health spending.

Figure 14 reports on the causes of underspending. This data should be interpreted with caution as the cause of underspending may vary depending on whether the respondent is placed in the Ministry of Finance or Health. Respondents in ministries of finance are more likely to blame underspending on operational issues in the health sector, while those in the Ministry of Health may blame funds being delivered late from the Ministry of Finance. Six countries responded that underspending is due to operational problems in the Ministry of Health. One country acknowledged that both causes could be true – it is probably no coincidence that this is Benin, the only respondent country where the survey was completed by officials from both the ministries of finance and health.

Figure 14: Reasons behind underspending



Source: Budgeting for Health in Africa Survey 2019 data

Table 15: Budget execution (US$)

	Budget allocation[6]	Adjusted allocation	Actual expenditure	Actual/Budget
Benin	120 187 488		23 771 291	0.20
Congo, Dem. Rep.	435 461 271		335 651 885	0.77
Côte d'Ivoire	629 220 555	504 645 262	433 439 815	0.68
Liberia	404 460		360 995	0.97
Sierra Leone	112 899		127 049	1.12
South Africa	3 540 429 237	3 567 878 887	3 530 328 887	1.00

Source: Budgeting for Health in Africa Survey 2019 data

Table 16: PEFA assessments on budget execution

	Year of PEFA assessment	PEFA Framework	Result
Benin	2014	2016	D
Cameroon	2017	2016	D
Chad	2018	2016	D+
Congo, Dem. Rep.	2008	2011	D
Côte d'Ivoire	2019	2016	C+
Gambia, The	2015	2011	C
Guinea-Bissau	2014	2011	C
Lesotho	2017	2016	D+
Liberia	2016	2011	C
Mauritius	2015	2011	C+
Nigeria	Not publicly released		
Seychelles	2017	2016	C+
Sierra Leone	2018	2016	D
South Africa	2014	2011	A
Uganda	2017	2016	D+

Source: PEFA. Elements assessed are PI-02 in the 2011 Framework and PI-02 in the 2016 Framework

6 Data is provided by respondent countries and converted into US dollars. This data is for the most recent year, usually 2018.

5.3 Performance agreements and assessments

Budget monitoring needs to assess performance and quality, not just expenditure levels. This is significantly more difficult and various approaches have been used.

Eight respondent countries use performance agreements. Table 17 explores how these performance agreements are operationalised. In six of the eight countries, the performance targets are determined by the executive of government, usually the office of the President or the Prime Minister. Cameroon involves several bodies in determining performance indicators, including the budgeting authority and the legislature.

Consequence management is an important process in any system. A number of responses are possible when performance indicators are not achieved and these are examined in Table 18. In four countries there are no consequences if performance indicators are missed. This illustrates the difficulties in budgeting for health. In other sections of government, underspending and missing performance targets would be resolved through reduced allocations but this is not a viable option in health. Lesotho does try to follow this path through implementing budget freezes. South Africa takes the approach of punishing leaders through publicising poor performance and imposing negative consequences in the leader's performance evaluation. Benin, Cameroon, Guinea-Bissau, Liberia and Sierra Leone provide more training to staff if they have not achieved targets. Benin and Lesotho opt to replace the previous leadership.

Performance-based budgeting is difficult to get right. The respondent from Seychelles indicated that programme-based budgeting has been fully introduced across government in 2018. The benefits to the Ministry of Health are yet to be appreciated.

Spending reviews are used by less than half of the sample. In Seychelles, spending reviews are carried out on an annual basis. Guinea-Bissau conducted spending reviews in 2018. Lesotho has conducted spending reviews in each of the last three fiscal years. The Democratic Republic of the Congo has conducted expenditure reviews, but the process has not been effective. An annual performance report has been drawn up since 2016, but this report is much more of an exercise before switching to budget-programme mode. It has no effect on the budgetary appropriations to be allocated to the sector.

Seven countries use other mechanisms to cut or expand expenditure. In the Democratic Republic of the Congo, the level of expenditure is tied to the level of revenue. If there is a revenue shortfall, then all expenditure, including health, is cut. Guinea-Bissau uses the budget process itself to cut expenditure, with funding allocated to where it is needed most. In some cases, this could be away from funding health. Seychelles uses adjustment budgets to provide further funding or to cut funding that will not be spent in the current fiscal year. In Benin: health expenditure projections also consider the measures envisaged in the sector. These include measures to maintain, scale up, or eliminate costs which may either lead to an increase in expenditure or to a reduction.

In Lesotho, cuts to certain areas in health are prohibited, like grants to the Christian Health Association of Lesotho, Baylor College of Medicine Children's Foundation Lesotho and Queen Mamohato Referral Hospital. Drugs, vaccines and the training line items are also not cut. Any other general administrative allocation can be cut.

Budget monitoring needs to assess performance and quality, not just expenditure levels – this is significantly more difficult and various approaches have been used in different countries

Table 17: Performance agreements – who decides on indicators?

	CBA	Executive of government	Legislature	Executive agency
Benin	✓	✓		
Cameroon	✓	✓	✓	
Lesotho	✓			
Nigeria		✓		
Seychelles				✓
Sierra Leone	✓	✓		✓
South Africa		✓		
Uganda	✓	✓		

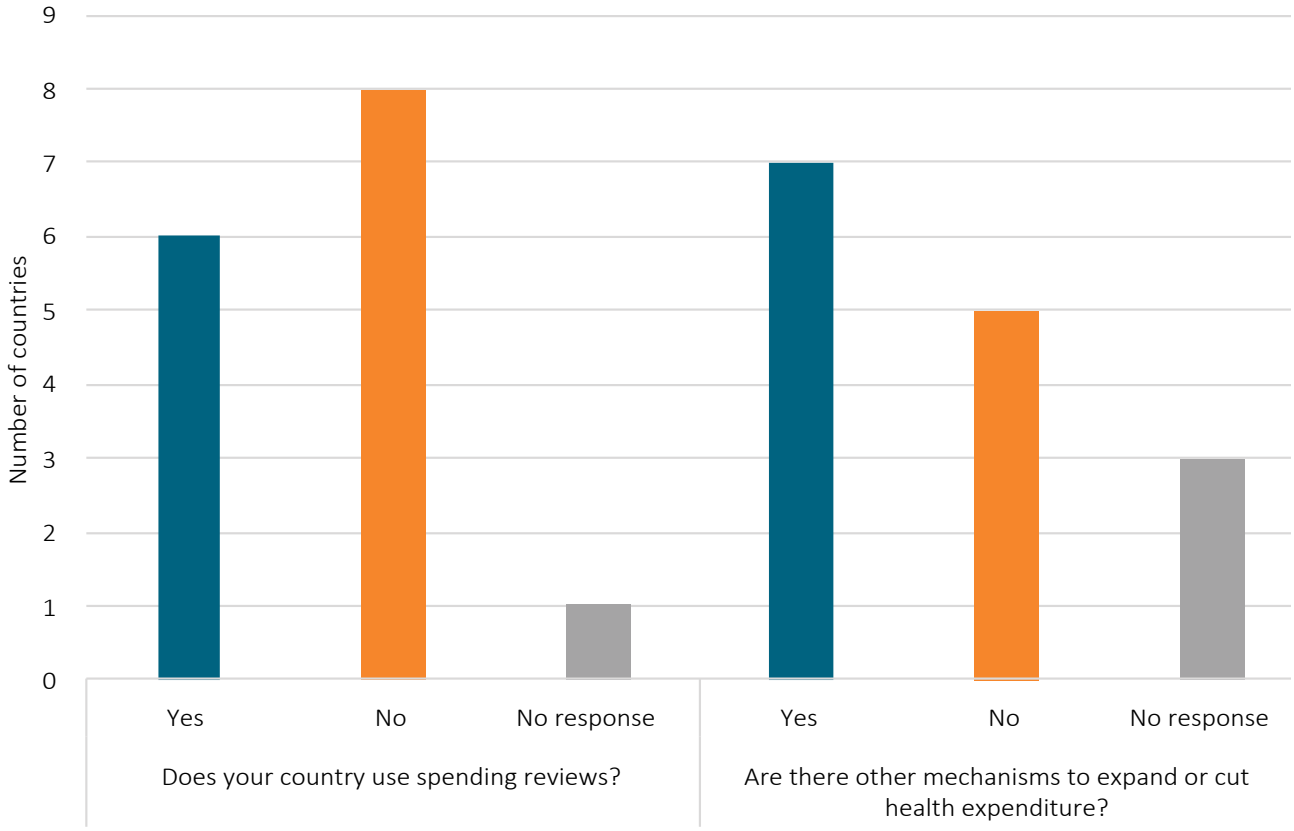
Source: Budgeting for Health in Africa Survey 2019 data

Table 18: Consequences of not achieving performance indicators

	Benin	Cameroon	Chad	Congo, Dem. Rep.	Guinea-Bissau	Liberia	Mauritius	Nigeria	Seychelles	Sierra Leone	South Africa	Lesotho
No consequence			✓	✓	✓				✓			
Poor performance made public	✓						✓			✓	✓	✓
More intense monitoring in the future	✓				✓	✓	✓			✓		✓
Budget decreases		✓										✓
More training provided to staff assigned	✓	✓			✓	✓				✓		✓
Budget increases					✓							
Budget freezes												✓
New leadership brought in	✓											✓
More staff assigned to programme or organisation												✓
Programme eliminated												✓
Negative consequences for leader's evaluations	✓					✓		✓			✓	

Source: Budgeting for Health in Africa Survey 2019 data

Figure 15: Use of spending reviews and other mechanisms to cut or expand spending



Source: Budgeting for Health in Africa Survey 2019 data

5.4 Conclusions

Allocations for healthcare, like any government expenditure, need to be monitored to ensure that funding is being spent well. All respondent countries have mechanisms to monitor expenditure and these are mostly quite similar with the CBA playing a central role. Legislatures are also informed of spending and particularly variances from budgets. These roles are dependent on data availability. If expenditure outcomes are only available more than six months after the event, it is difficult to play an active role when there are variances from budget.

Despite monitoring mechanisms, levels of budget execution in the survey were low and these were corroborated by PEFA assessments. Poor budget execution is about government processes rather than health.

Several respondent countries have used performance agreements to monitor performance. Indicators in the agreements are usually decided by the executive of government (often the Office of the President or Office of the Prime Minister) or the CBA.

Enforcement of performance agreements is problematic. In four countries, there are no consequences for poor performance. In other countries, sanctions range from bad publicity for political leaders, to spending cuts and further training for staff.

Allocations for healthcare need to be monitored to ensure that funding is being spent well

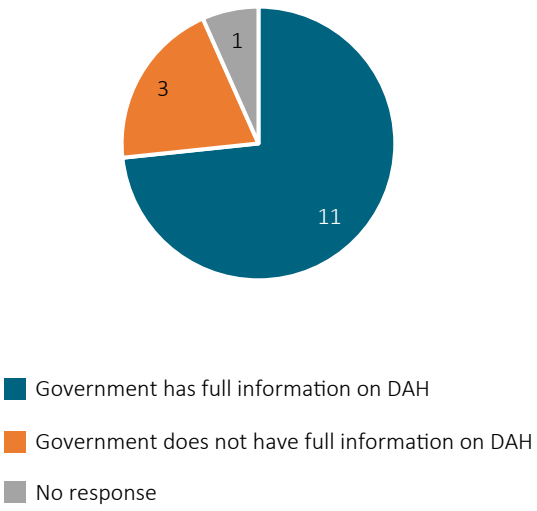
6 Management of development assistance for health

Development assistance for health (DAH) refers to the resources provided, whether in-kind or financial from international donors, to low-income and middle-income countries with the objective of improving health outcomes. This section sets out the management processes and policies for the use of DAH in the surveyed countries.

As seen in the discussion on health funding, donor flows are a significant part of total health funding for some respondent countries. In countries such as Benin, the Democratic Republic of the Congo, The Gambia and Liberia, more than 30% of health expenditure was from development partners but was less than 2% of health spending in Mauritius, Seychelles and South Africa.

Government awareness of the amounts of funds countries receive is vital for their efficient use and coordination. The survey results on government awareness depicted in Figure 16 shows that 11 of the 15 surveyed countries reportedly have full information on the amounts of funds committed and disbursed by international institutions and the projects which are financed. Nevertheless, three countries, namely Benin, Nigeria and Sierra Leone, did not have full information. The Gambia did not respond.

Figure 16: Government awareness of development assistance for health (DAH) funds and projects



Source: Budgeting for Health in Africa Survey 2019 data

Despite the high levels of awareness of projects, seven out of 10 countries reported that less than 25% of DAH funds are channelled through the regular budget process or through the public financial management (PFM) system, which means aid is rarely accounted for in the government's health expenditure plans. Cameroon, the Democratic Republic of the Congo and Guinea-Bissau reported that a higher percentage, as much as 50%, is incorporated through such a channel, and Mauritius performs best with more than 75% of aid accounted for in the PFM system.

In the case of the Democratic Republic of the Congo, the Support and Financial Management Unit manages funds from Gavi (the Vaccine Alliance), the Global Fund and the World Bank. The other technical and financial partners have their own financial management units, which hardly reports to the government.

Mauritius only uses development assistance for certain issues, which may explain why Mauritius is able to route much of the funding through the PFM system. Development assistance is only provided for the fight against HIV/Aids from the Global Fund. There is a national coordinating mechanism which includes members of civil society, NGOs and civil servants from various ministries. The Global Fund provided US$1.8 million for the period from 2015 to 2017, and US$2.4 million for the period from 2018 to 2020.

In Lesotho, there are various stakeholders in government: the Public Accounts Unit (PAU) in the Ministry of Health reports to the management of the Ministry of Health on the use of donor funding, ministries of finance and planning, as well as directly to the development partners.

Guinea-Bissau uses the Health Sector Coordination Committee within the Ministry of Health. It aims to create a space for consultation, strategic planning, execution of activities and monitoring of key indicators that contribute to the achievement of the goals proposed at national and international level.

There are usually mechanisms in place to coordinate and track the use of DAH with international partners. Ministries of health or finance have departments in charge of tracking the use of funds and ensuring regular communication with international development partners. Table 19 describes such mechanisms for the countries which provided information.

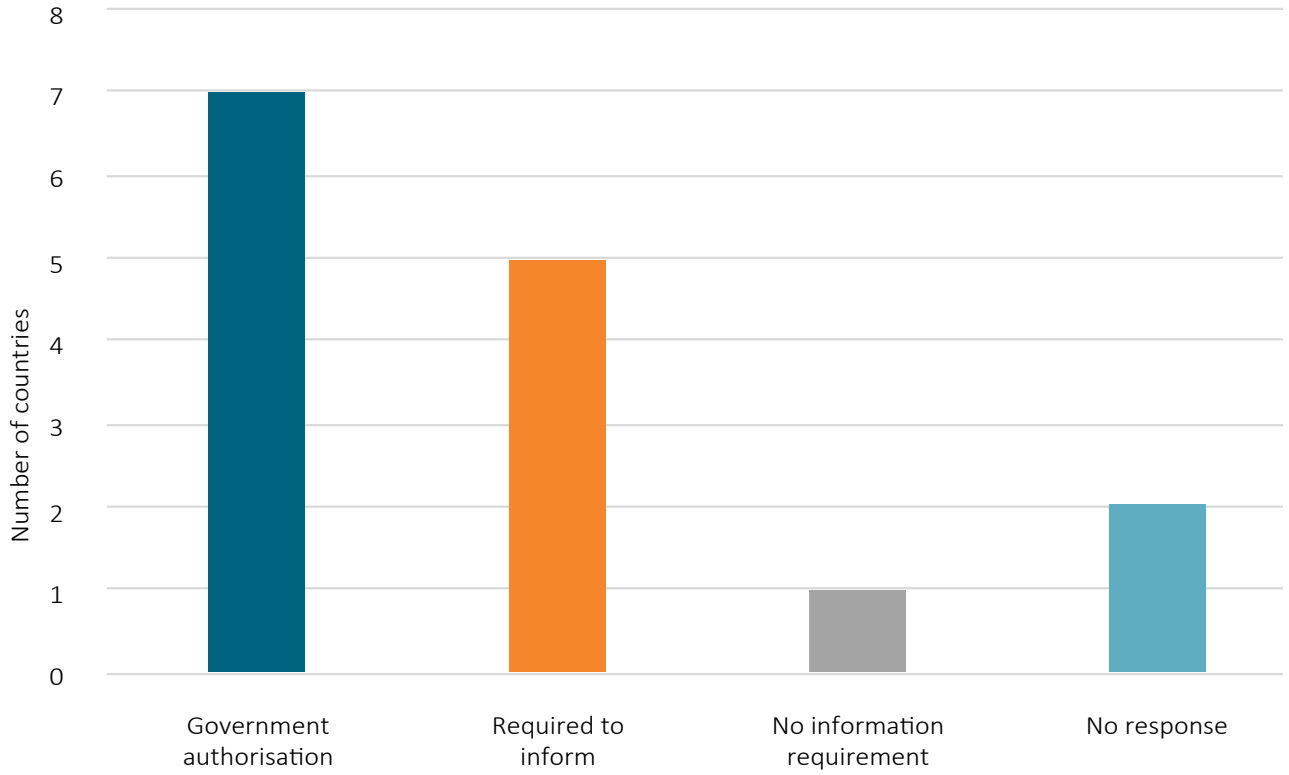
Table 19: Summary of DAH coordination mechanisms by country

	Mechanisms
Benin	The primary mechanism consists of a meeting held between the ministries of finance, health, foreign affairs and international cooperation, and planning and development alongside international partners, for the implementation of partnership agreements. A secondary mechanism exists that consists of regular joint reviews about the sector's management or on specific topics.
Chad	The mechanism, called the State-Technical and Financial Partners Meeting, promotes regular discussions between the government and the development partners.
Congo, Dem. Rep.	The Technical and Financial Partners are also part of the Health Sector Financing Commission.
Côte d'Ivoire	The National Coordination Platform for Health Financing is formed by a steering committee, with the Prime Minister, members of various ministries, civil society, private sector members as well as the international development partners. Its objective is to make sure health expenditures are in line with the National Development Plan and the National Health Development Plan.
Guinea-Bissau	There is a Health Sector Coordination Committee in the Ministry of Health, which oversees strategic planning in the sector, and monitors key indicators to accomplish national and international targets.
Lesotho	Several mechanisms are in place. In the Ministry of Health, the PAU negotiates arrangements with international development agencies. In the Ministry of Finance, the Debt Management Unit negotiates debt terms. In the Ministry of Development Planning, there is a Department of Aid Coordination which is responsible for development and management of aid policy.
Mauritius	There is a coordination mechanism with members of civil society, NGOs and civil servants from various ministries.
Nigeria	The Ministry of Finance has two departments that focus on aid coordination. It is especially relevant in counterpart funding assistance.
Sierra Leone	The Integrated Health Projects Administration Unit, within the Ministry of Health and Sanitation, is headed by specific Funds Leads and staffed with professionals in the areas of chartered accounting, procurement, information systems, and monitoring and evaluation, and other health partners.
South Africa	There are programme steering committees and annual consultations between the government and development partners.

Source: Budgeting for Health in Africa Survey 2019 data

As noted above, development partners are usually part of such mechanisms. Governments and development partners should work together to ensure aid coordination and efficient use of funds. As shown in Figure 17, all countries mentioned that either the government must authorise the development partners' activities and funding, or that they are required to inform the government of their activities. An exception is Seychelles, where no information requirement exists. Box 2 describes Guinea-Bissau's process for the use of external funds.

Figure 17: Management process for use of development assistance



Source: Budgeting for Health in Africa Survey 2019 data

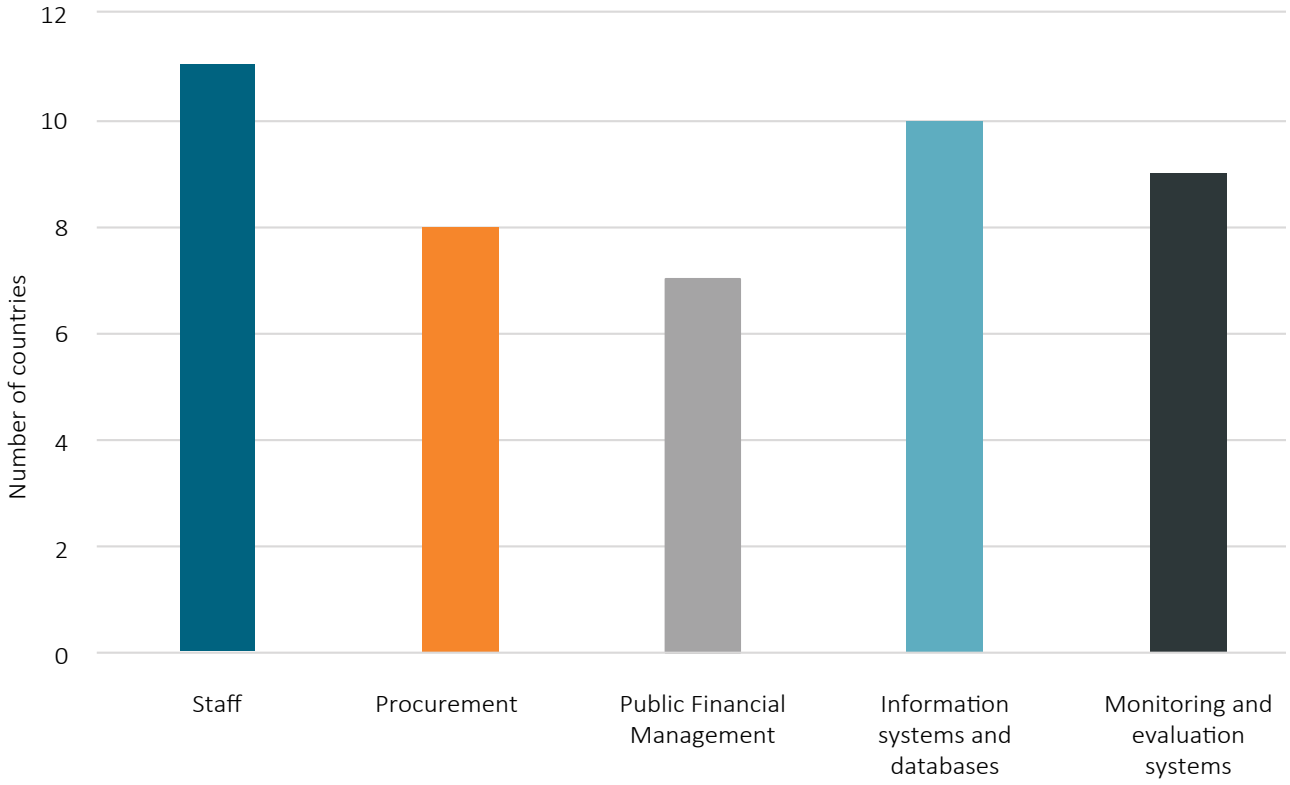
Box 2: Guinea-Bissau's process for the use of development assistance funds

For a project or programme to be given funding, the potential impacts are evaluated according to the priority sectors in the Strategic and Operational Plan 'Terra Ranka', as well as the ministries' sectoral plans. In the case of the health sector, this would be the National Plan for Health Development (PNDS III). Once the potential impacts are identified, and if the said project is aligned with current laws and environmental rules, the development partners may negotiate with the government for its approval and kick-off.

Source: Budgeting for Health in Africa Survey 2019 data

Governments and development partners should work together to ensure aid coordination and efficient use of funds

Figure 18: Establishment of additional structures for programmes and projects

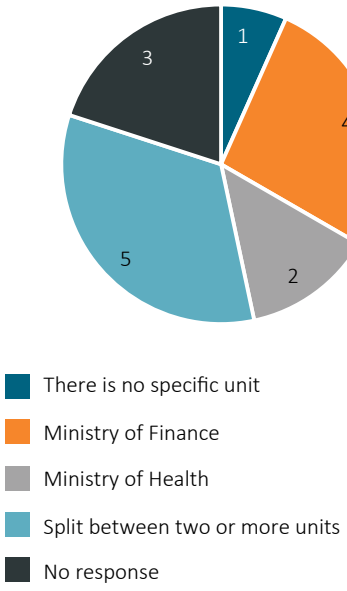


Source: Budgeting for Health in Africa Survey 2019 data

Development partners often establish further structures in addition to existing governmental ones, such as staffing and information systems. This is true for most of the countries, with 11 mentioning additional staff, and seven declaring structures for PFM.

The development assistance management function is often split between two or more units, one within the Ministry of Finance and another in the Ministry of Health. When there is a single unit, it is more frequently located in the Ministry of Finance. An exception is Seychelles, where the function does not exist. Figure 19 depicts such results.

Figure 19: Location of development assistance management function



Source: Budgeting for Health in Africa Survey 2019 data

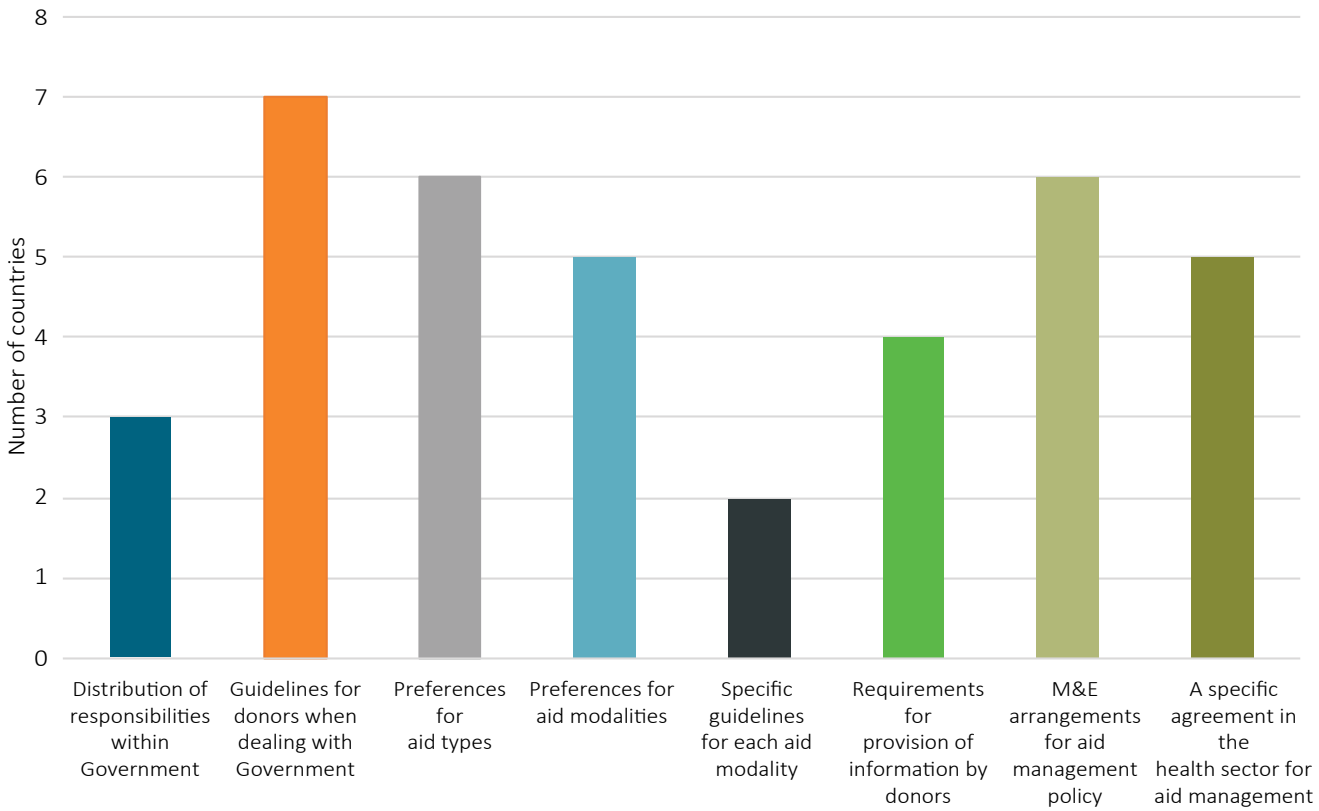
Other than in the Democratic Republic of the Congo, Chad, Liberia, Mauritius and Seychelles, there are explicit policies for managing development assistance in nine of 14 countries. The Gambia did not respond. When such policies exist, it is common for them to contain guidelines for donors dealing with the government, the preferences on the type of aid, as well as the monitoring and evaluation arrangements for the implementation of the aid management policy. The frequency of certain types of content in several aid management policies is depicted in Figure 20.

The survey suggests there is good data availability in all countries, even though the institutions in charge of aid coordination and management varies across countries (see Box 3 on Côte d'Ivoire overleaf). They all track and have databases on incoming funds for health. This is also true for the countries that do not have full information on disbursed and committed funds.

In Sierra Leone, the Development Assistance Coordinating Office, based in the Ministry of Planning and Economic Development, liaises with the Integrated Health Projects Administration Unit and holds funding and disbursement data. In Lesotho PAU, in collaboration with the procurement unit of the Ministry of Health, share this function. In Uganda, a database is kept on a platform called the Aid Management Platform. In Seychelles, a database is managed by the Director International Cooperation in the Ministry of Health.

The respondent countries have well-developed systems for dealing with development partners. Respondents reported that countries have good knowledge of the projects taking place in their countries. Development partners usually run projects through their own staff, internal and financial systems, and separate monitoring and evaluation systems. This could lead to a lack of alignment between government priorities and donor priorities, and government would have little ability to enforce their priorities.

Figure 20: Frequent content in aid management policies



Source: Budgeting for Health in Africa Survey 2019 data

Box 3: Côte d'Ivoire and the management of development assistance

According to the survey responses, Côte d'Ivoire has full information on the funds committed and disbursed by international institutions and all projects that are financed. Less than a quarter of development assistance is channelled through the budget process in Côte d'Ivoire and subjected to local PFM. According to data from the World Bank, 15% of gross domestic expenditure on health is financed from external sources, mostly aid. Côte d'Ivoire received development assistance of roughly US$1 million from UNAIDS per year, over the period 2015 to 2017 (World Bank, 2020).

In order to undertake activities in Côte d'Ivoire, international development partners need to inform government of their plans and any spending. Côte d'Ivoire grants wide latitude to donors, allowing partners to operate outside government's structures. Donors can hire staff outside of government processes, conduct their own procurement, establish their own information technology and databases, and run monitoring and evaluation processes.

There is currently a unit within the Ministry of Health, the Unité de Coordination des Projet-Financement Extérieurs, that monitors the activities of development partners and keeps a database of all aid inflows.

Côte d'Ivoire has a policy establishing the conditions under which development partners can work in the country. The elements of the policy include rules for donors when dealing with government, a preference for the type of aid (loans vs grants), a specific agreement on how aid can assist in the health sector, and guidelines on how government can conduct monitoring and evaluation to enforce the aid management policy. The policy does not include an explicit requirement for the provision of information by donors or the distribution of aid responsibilities across government.

Interestingly, government has established a high-level committee to improve coordination with donors. In April 2019, the National Coordination Platform for Health Financing (PNCFS, for its French acronym) was created by prime ministerial decree in Côte d'Ivoire. It is financed with funds from the National Budget, as well as additional funding from development partners. The PNCFS is chaired by the Prime Minister and its objectives are:

- To establish agreements on the objectives for health expenditure and to ensure they are aligned with the country's National Development Plan and National Health Development Plan
- To support the Ministry of Health with coordinating the sector and with the efficient use of domestic and external funds in line with national priorities
- To collect additional resources from other platforms from both the public and private sectors.

The PNCFS is composed of three entities:

- The Steering Committee is the decision-making body made up of representatives from the government, civil society, the private sector and development partners
- The Technical Secretariat is the implementing body in charge of administrative and logistic tasks for the Steering Committee reunions. Technical workgroups are designated by the Steering Committee with specific topics of study and missions.

The members of the PNCFS include officials from 10 government ministries and representatives from the private sector, civil society and seven donor organisations, namely:

- WHO
- United States Agency for International Development
- Agence Française de Développement
- the World Bank
- the United Nations Children's Fund (UNICEF)
- the United Nations Population Fund
- the Country Coordinating Mechanism of the Global Fund.

7 Financing of WASH activities

Although most spending on WASH activities is not direct spending on health, it contributes to health through activities that boost the health of the population. Waterborne diseases are still important factors causing mortality and morbidity in Africa. Better provision of water, sanitation and hygiene will play a role in reducing this impact. In 2016, UNICEF noted that 663 million people did not have access to clean water; 2.4 billion people did not have access to improved sanitation and 946 million people defecated in the open. Seven out of 10 people are without access to improved sanitation and nine out of 10 people living in rural areas had to go in the open. (UNICEF, 2016).

This provides an idea of the scale of the problem. For African governments to provide their citizens with better health, resources will need to be spent not only on healthcare, but also on programmes that improve health including WASH activities and nutrition.

7.1 Role of ministries of health in WASH activities

This section focuses on WASH activities and the role of the Ministry of Health in their provision, planning and implementation. The questions are based on the TrackFin (Tracking Finance to WASH) definition of WASH activities, which defines WASH activities at a granular level.

Table 20 notes the role of the Ministry of Health in each of the components of WASH. The Ministry of Health can either have no role or some role in policy, budget or implementation. The policy role is present if the Ministry of Health has developed a policy regarding how a particular aspect of WASH is delivered. A budget role is present if the Ministry of Health has an allocation for the WASH activity. The Ministry of Health does not need to carry out the function itself – it can use transfers to fund other bodies which carry out the actual implementation. The Ministry of Health can also have a coordinating role among implementers. The table lists implementation as the role of the Ministry of Health if the ministry itself employs staff and spends funds to carry out a certain aspect of WASH activity. The ministry can have more than one of the already mentioned roles.

Table 20 refers to the provision of water and sanitation. Other aspects of WASH are dealt with in Table 21. Response rates for this part of the survey were quite low, with between 10 and 12 responses on each question. As expected, ministries of health play little role in the implementation of water supply, with only Benin having an implementation role. In nine of 12 countries, ministries of health play no role in water supply that occurs through large network systems, or in basic drinking-water supply. Ministries of health have a bigger role to play in sanitation in three countries. In South Africa, the Ministry of Health plays no role in water or sanitation provision because these functions are competencies of provincial and local governments. As seen in the reporting on earlier questions, South Africa's intergovernmental system makes it difficult for national government departments to have oversight of other levels of government. A federal system like Nigeria might have provided similar responses.

Waterborne diseases are still important factors causing mortality and morbidity in Africa – and better provision of water, sanitation and hygiene will play a role in reducing this impact

Table 20: Role of Ministry of Health in WASH activities, water and sanitation

	Water supply through large network systems	Basic drinking-water supply	Sanitation though large network systems	Basic sanitation
Benin	No role	Implementation	Policy Implementation	Policy Budget Implementation
Cameroon	Budget	No role	Policy	Policy
Chad	No role	No role	No role	No role
Congo, Dem. Rep.	Policy	Policy	No response	No response
Côte d'Ivoire	No role	No role	No role	No role
Gambia, The	Policy	Policy Budget	No response	No response
Guinea-Bissau	No role	No role	Budget	Budget
Lesotho	No response	No response	No response	No response
Liberia	No role	No role	No role	No role
Mauritius	No role	No role	No role	No role
Nigeria	No response	No response	No response	No response
Seychelles	No role	No role	No role	No role
Sierra Leone	No role	No role	Policy Budget	Policy Budget
South Africa	No role	No role	No role	No role
Uganda	No response	No response	No response	No response

Source: Budgeting for Health in Africa Survey 2019 data

The Ministry of Health can use transfers to fund other bodies which carry out the actual implementation

Table 21: Role of Ministry of Health in WASH activities, water and hygiene

	Support services to the WASH sector	Water resources protection	River basin development	Hygiene promotion	Household-level hygiene activities
Benin	Policy Budget Implementation	Policy Implementation	No role	Policy Budget Implementation	Policy Budget
Cameroon	Policy	Policy	No role	Policy	Policy
Chad	No role	No response	No response	Policy Budget Implementation	Policy Budget Implementation
Congo, Dem. Rep.	Implementation	Implementation	No role	Policy	Policy Implementation
Côte d'Ivoire	No response	Policy	No role	Policy Budget Implementation	Policy Budget Implementation
Gambia, The	No response	No response	No response	No response	No response
Guinea-Bissau	Budget	No role	No role	Policy	Policy
Lesotho	No response	No response	No response	No response	No response
Liberia	No role	No role	No role	No role	No role
Mauritius	No role	No role	No role	Policy Budget	Policy Budget
Nigeria	No response	No response	No response	No response	No response
Seychelles	Implementation	No role	No role	Implementation	Implementation
Sierra Leone	Policy	No role	No role	Policy Budget	Policy
South Africa	No role	No role	No role	Policy Implementation	Policy Implementation
Uganda	No response	No response	No response	No response	No response

Source: Budgeting for Health in Africa Survey 2019 data

Ministries of health play little role in the implementation of water supply

Ministries of health have a much greater role in matters related to hygiene. With regard to the hygiene promotion function, the Ministry of Health has a policymaking role in nine of the 11 countries that responded. Only in Liberia does it not have a role. The results are similar for the promotion of household-level hygiene activity. Ministries of health have no role in river basin development, but they have a supporting role with regard to the WASH sector in six of the 10 countries. With respect to the water resources protection function, ministries of health play a role in four countries.

In Chad, only the hygiene component is managed by the Ministry of Health, while the water and sanitation component is managed by the Ministry of Water, Hygiene and Sanitation.

With responsibilities across different parts of government, it should be evident that there is a need to coordinate WASH activities. There is a specific coordinating body set up in five of the nine countries that responded on this item. Benin, Guinea-Bissau, Seychelles and Mauritius have no coordinating mechanism.

Liberia provides a good example of how such a mechanism could work. The government of Liberia has a WASH Commission to monitor and coordinate all wash and wash-related activities in Liberia. In South Africa, the mechanism has only just been established. The National Department of Health and Department of Environmental Affairs, Forestry and Fisheries have been tasked to establish a National Coordinating Committee, but it could not be confirmed whether this has taken place. Only Seychelles and the Democratic Republic of the Congo reported other mechanisms to coordinate delivery of WASH activities. In Seychelles: The Public Health Authority supports quality control of public water supplies. The public health officers educate and support households and institutions on hygiene.

Table 22 reports on countries' ability to finance WASH activities. National government revenue refers to direct financing by the central government, through taxation or borrowing. Sub-national government revenue refers to revenue raised by state or provincial governments. Transfers from the central government occur when funding from the central government flows to another level of government with a mandate to implement WASH activities. Transfers from sub-national governments are similar but the funding originates from a state or provincial government. Municipal revenue is funding that a municipal government raises on its own, usually through rates or a local business tax. User charges are levies based on consumption of the product – for example, fees paid per litre of water consumed.

Of the 11 countries that completed this section of the questionnaire, six reported that donor funding is used for WASH activities. It is the second-most popular form of funding reported in the table, behind the use of central government revenue. Sierra Leone and South Africa's wide use of funding strategies is notable. Sierra Leone channels much of its health spending (between 21% and 30%) through sub-national governments and it clearly uses a similar strategy for WASH activities.

Figure 23 refers to the monitoring of expenditure on WASH activities. All 10 countries that responded to this question monitor WASH spending. This is to be expected, given the result reported in Chapter 5 that only Chad does not have a system to monitor expenditure. These systems are probably used for all expenditure, not just for spending on healthcare or WASH activities.

Of the countries that responded to the question about coordination with donors, only Seychelles and Mauritius do not have a mechanism to coordinate WASH support. In Sierra Leone, the mechanism for coordinating with donors also appears to extend to WASH: the Donor Assistance Coordinating Office works with development partners in the planning and execution of activities linking with sector players, such as health. There is an existing donor liaison office.

Ministries of health have a much greater role in matters related to hygiene – with regard to the hygiene promotion function, the Ministry of Health has a policymaking role in nine of the 11 countries that responded

Figure 21: Role of Ministry of Health in matters related to hygiene

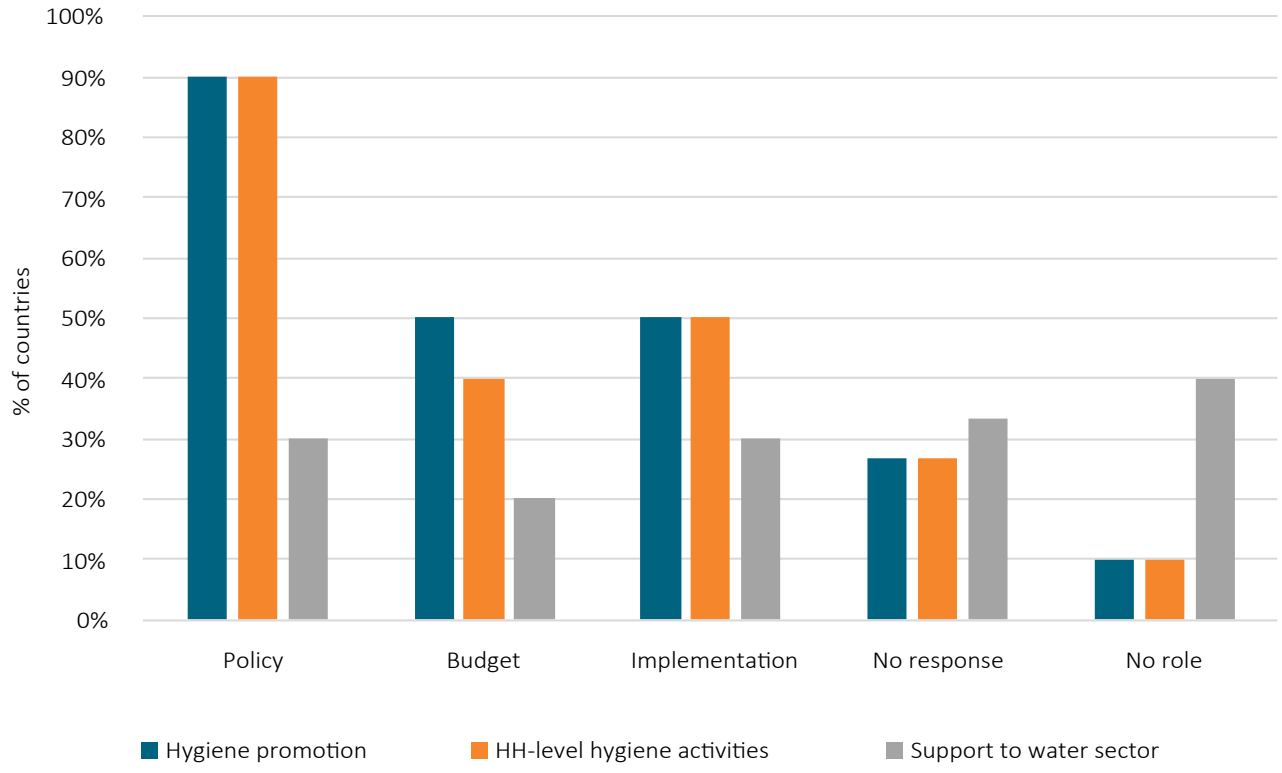
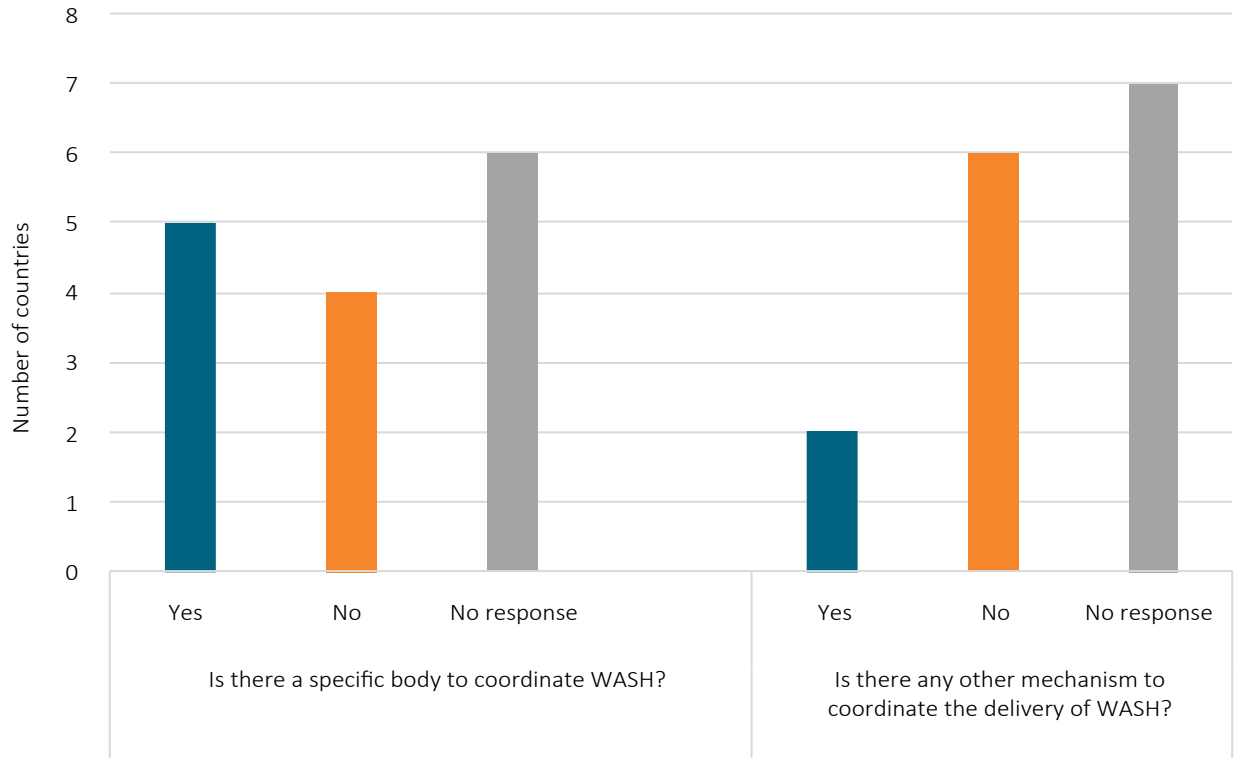


Figure 22: Coordination of WASH activities



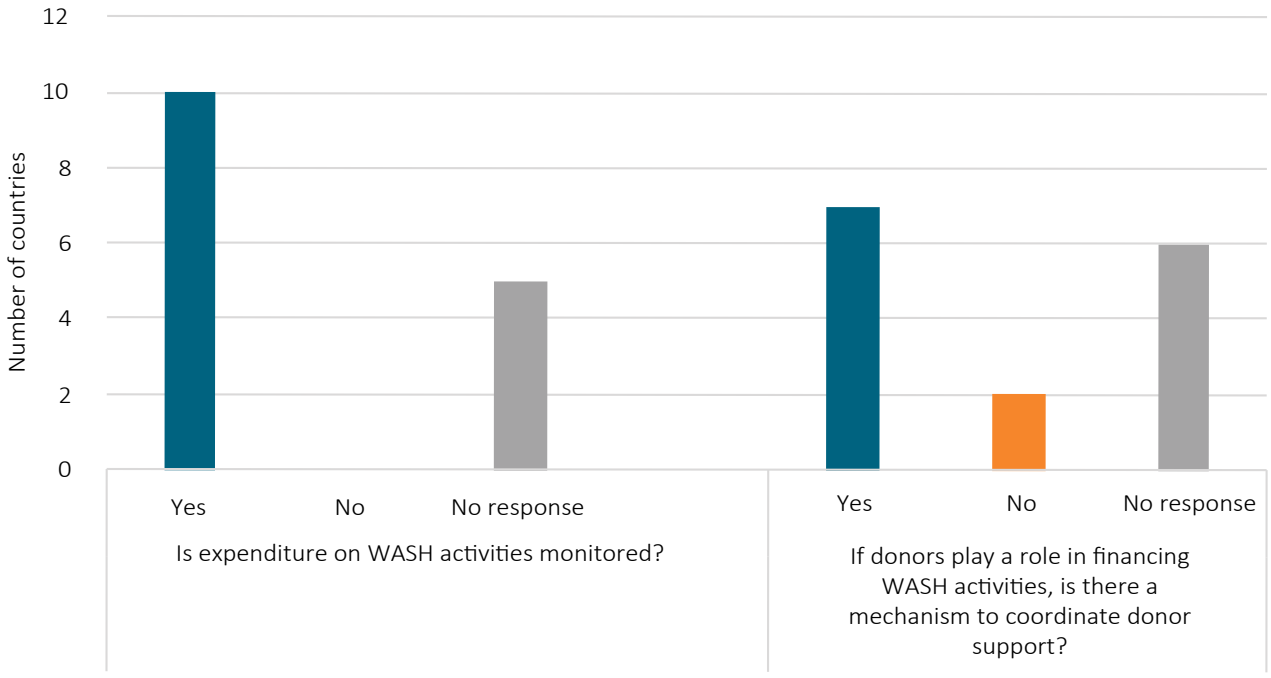
Source: Budgeting for Health in Africa Survey 2019 data

Table 22: Financing of WASH activities

	National government revenue	Sub-national government revenue	Transfers from central government	Transfers from sub-national government	Municipal government revenue	Donor funded	User charges
Benin	✓		✓			✓	
Cameroon			✓				
Chad	✓					✓	
Congo, Dem. Rep.						✓	
Côte d'Ivoire						✓	
Gambia, The							
Guinea-Bissau	✓		✓			✓	
Lesotho							
Liberia							
Mauritius	✓						
Nigeria							
Seychelles	✓		✓				✓
Sierra Leone	✓	✓	✓			✓	
South Africa	✓	✓	✓		✓		✓
Uganda							

Source: Budgeting for Health in Africa Survey 2019 data

Figure 23: Monitoring of WASH activities and coordination with donors



Source: Budgeting for Health in Africa Survey 2019 data

8 Conclusion

If management processes are effective and there is sufficient healthcare infrastructure, then increasing spending on healthcare can result in improved healthcare outcomes. As shown by Piatti-Fünfkirchen and Smets (2019), improvements in public financial management can be associated with significantly better health outcomes.

This survey sought to provide information on the health budgeting and execution processes in sub-Saharan Africa. It also aimed to learn more about budget monitoring, how donor resources are tracked and the role of the ministries of health in WASH activities. Using data from 15 countries, the findings of this study are diverse approaches to budgeting for healthcare. The key points of the study are summarised below:

- Overall, ministries of finance set budget envelopes while ministries of health decide how those budgets are spent. A formal coordinating mechanism exists in most of the countries for the health budget and for the prevention of some diseases. All countries use MTEFs and make a distinction between operating and capital expenditure.
- Ministries of finance are responsible for monitoring budget execution. The main challenge in budget monitoring is that it can take three months or longer to get expenditure data compared with the PEFA standard of one month. In Nigeria, long delays are due to the need to audit financial statements. South Africa and Liberia have good budget execution systems. Underspending is mostly blamed on operational issues in the Ministry of Health.
- Most donor spending is not channelled through the regular PFM process although all countries track donor health spending. Most countries have a body that coordinates development partners.
- Ministries of health have no role in the provision of bulk water supplies, but they are actively involved in the promotion of hygiene. WASH activities are funded through central government revenues with donor support.

The findings of this study shed light on the roles of ministries of finance and health in budget processes in Africa. Other stakeholders – such as legislators and donors – appear to fill gaps both in availability of resources and its execution. Going forward, it is crucial that ministries of finance and health work closely together for an increased resource allocation to health and more efficient use of resources in Africa. Similarly, a better coordination of budgeting and execution processes between the Ministry of Health and donors is likely to enhance resource availability and use. Finally, ministries of health are likely to benefit from involvement in, and networking with, units responsible for development of infrastructure and water supplies, on which the effectiveness of hygiene and sanitation activities are dependent.

The countries in the sample are heterogeneous, both in their defining characteristics and also in their approach to budgeting for healthcare. In general, the approach is that ministries of finance set budget envelopes and ministries of health determine how it is spent. However, many different approaches do exist.

Most countries have the central government as the chief provider of primary health services and preventive health services. Only Benin, Côte d'Ivoire and Nigeria use a social insurance mechanism. Most countries acquire drugs through a tender process.

The respondent countries try to track all spending by donors. Only Mauritius can channel more than half of donor funds through the regular PFM process, though this may be because donor funding to Mauritius is limited only to HIV/Aids. Most countries have a similar process for managing the relationship with development partners, mostly involving a formal body that meets with donors at regular intervals. Interactions with donors are an important part of the budgets of the sample countries, owing to the amount of resources they inject into country systems.

The survey sought information on the role of ministries of health in WASH activities. Ministries of health have no role in the provision of bulk water supplies. Their role in the promotion of hygiene are much more active. WASH activities are mostly funded through central government revenues and donor support and is monitored as closely as any other government expenditure would be.

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