HEALTH DIALOGUE

Keynote Report 2

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CABRI Health Dialogue

Value for Money in the Health Sector:
Policy and Budget Planning

Keynote Report 2

Planning Health Policy

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Acronyms and abbreviations

AfDB	African Development Bank
APHRC	African Population and Health Research Centre
AusAid	Australian Government Overseas Aid Program
BFP	budget framework papers
CAM	combined approach matrix
DALYs	disability-adjusted life years
DFID	Department for International Development
DSS	Demographic Surveillance System
ERS	Economic Recovery Strategy
GFHR	Global Forum for Health Research
HHA	Harmonization for Health in Africa
HRH	Human Resources for Health
IMF	International Monetary Fund
LFA	logical framework
MBB	marginal budgeting for bottlenecks
MDGs	Millennium Development Goals
MOH	Ministry of Health
MTEF	medium-term expenditure framework
NGO	non-governmental organisation
NHSSP	National Health Sector Strategic Plans
ODI	Overseas Development Institute
OECD	Organisation for Economic Co-operation and Development
PBB	performance-based budgeting
PHMTS	Provincial Health Management Teams
RBM	results-based management
STPH	Swiss Tropical and Public Health Institute
SWAp	sector-wide approach
TEHIP	Tanzania Essential Health Interventions Project
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNMHCP	Uganda National Minimum Health Care Package
VFM	value for money
WHO	World Health Organisation
WHO-AFRO	World Health Organisation Regional Office for Africa

Executive summary

The planning of health services is a critical function in all health care systems. It is even more important in economically constrained countries that planning be used as a process for effective allocation of scarce resources. It is a process that looks to the future, to find ways of meeting desired outcomes. Planning seeks to identify the vision, goals or objectives to be achieved, to formulate the strategies needed to achieve the vision and goals, to determine and allocate the resources (financial, physical, human) required to achieve the vision and goals, and to outline implementation arrangements, which include the arrangements for monitoring and evaluating progress towards achieving the vision and goals.

This paper[1] discusses the different types of planning processes, and makes a distinction between policy planning and corporate planning. Policy planning, in this context, is focused on population health issues and specific health problems. Corporate planning includes strategic planning and operational planning. Historically, planning was in the hands of a few at the central level. Current approaches stress the importance of the involvement of different levels of the health system (regional, district and local government). There is also greater demand for the involvement of the non-governmental sector in the planning process. This is particularly important as the public sector is increasingly involved as provider of health care services and trainer of human resources.

Governments are faced with addressing a number of health sector reform issues. These include civil service reform, public-private partnerships and decentralisation. Many tools have been developed nationally and internationally to gather information to support evidence-based decision-making and to involve more stakeholders meaningfully.

Policy-makers and other decision-makers are faced with competing claims on resources in allocation decisions. To help in the decision-making, there are economic and other priority-setting tools that are founded on values, community goals and disease-based variables. The different models of planning and priority-setting are driven by the need of countries to attempt to achieve value for money in the design and implementation of their programmes. This paper presents a few country examples of planning, which indicate that one of the objectives of health planning is the integration of health sector initiatives with broader national development initiatives. The examples show that there is a move towards planning for outcomes, to achieve value for money. The country plans show an increasing emphasis on the involvement of the non-government sector and on working with donors for greater integration of planning, programme development and budgeting.

The need to build local and national capacity for planning and to develop appropriate tools has been recognised by national authorities and international agencies. Capacity development and the collection and use of appropriate information are central to effective planning and decision-making.

1 This paper was prepared by Orvill Adams for for CABRI health dialogue on policy and planning in the health sector. The dialogue was held in Nairobi on 4–5 April 2011.

1. Introduction

All countries face how to reconcile great demand for health services with the finite resources available to them. They must make decisions about how to use their scare resources and on what to spend their money. According to Green (1995), before the 1970s these decisions were often made by small groups of senior individuals in health or finance ministries. Subsequent to this period, central departments responsible for planning have tended to expand their policy and planning processes to include local government and local health authorities (Lee & Mills 1982). Most recently, as discussed later in the paper, planning processes have sought to include the non-government sector and civil society. Formalised health planning, seen as an open, rational and systematic means of producing decisions about the allocation of resources, is further defined as 'a range of activities that share the goal of improving health outcomes, or improving the efficiency of health services provision or both' (MLTHC 2006). Green (1995) argues, however, that where planning is treated as a technical activity to be performed by planning specialists, the process becomes isolated from the service providers and can lead to plans that are less than relevant. Planning is a political process concerned with the allocation of valued, usually scarce, resources in which parties interested in the resources must compete for them (Baum 1988). Lee and Mills (1982) suggest that planning is also social, in that it should take into consideration the values of society; it is concerned with what must be done to make a desired future possible.

The above considerations introduce the notion that health planning is more than a process – it has objectives while paying attention to the costs in terms of time and effort to achieve them. They also suggest that planning requires measures of efficiency and of intended outcomes to be made explicit.

Planning can also be defined as a necessary activity to ensure value for money (VFM) in health services. VFM requires knowing what the goals of the health care system are and being able to measure what resources are required to meet the objectives and the outcomes. Thus, two fundamental questions are posed:

- Are we using resources well to produce services?
- Are we using services well to produce better health?

The introduction of VFM concepts in many countries is linked to the use of donor resources. A significant part of the health budget in low-income countries is received from donors or NGOs. In 2007, for example, more than half of the health spending in Rwanda was from these sources (Logie, Rowson & Ndagije 2008). Since the 1990s, there has been a trend towards greater accountability for government spending and for the effectiveness of aid. Among development partners, the Department for International Development (DFID) has been the leading proponent of the use of VFM in its support of countries' planning, budgeting and programming processes. The DFID understands VFM as 'the optimal use of resources to achieve the intended outcomes', which involves 'assessing whether the level of results achieved represent good value for money against the costs incurred: moving from results to returns' (OECD 2010a).

Two key economic analysis tools are used in the assessment of VFM:

- *cost-benefit analysis* (or internal-rate-of-return analysis), which estimates the respective economic costs and benefits and then expresses the net benefits in terms of the rate of return on the investment; and
- *cost-effectiveness analysis*, which compares the costs of various approaches towards achieving a given objective.

It is stressed that VFM is not only about reducing costs but is also about delivering better results and performance more effectively. In a technical guidance note, the Global Fund to fight HIV/AIDS, Malaria and TB defines VFM as using 'the most cost-effective interventions as appropriate to achieve the desired results' (UNAIDS 2010). VFM does not mean lowest cost; the objective is to achieve the biggest impact for money spent by balancing cost and effectiveness. The note states that 'perhaps the most important VFM concept…is that cost interventions are justifiable if you can demonstrate effectively that they lead to greater benefits over time'.

As shown in Figure 1.1, VFM is about the relationship between inputs, outputs and outcomes. Inputs (health professionals, technologies, financing, facilities and knowledge) are the resources that are used to produce health services. The services, such as doctors' visits, surgeries, medication and preventative care, are delivered to the population in need in order to produce health outcomes, such as reduction in disease rates, pain control and return to work. The goals of the health system can be expressed in terms of high quality health care and a sustainable health care system (Health Council of Canada 2009). In the search for VFM and increased equity, efficiency, effectiveness and responsiveness, countries are putting more emphasis on developing primary health care systems. The evidence indicates that health care systems in low-income countries with a strong primary health care orientation tend to be more pro-poor, equitable and accessible. At the operational level, the majority of studies comparing services that could be delivered as either primary health care or specialist services show that using primary health care physicians reduces costs and increases patient satisfaction, with no adverse effects on the quality of health care or patient outcomes. Primary health care is a VFM strategy (Atun 2004).

Developed countries are also searching for VFM in planning their health service delivery strategies. Integrated care models and the use of homecare services are strategies that produce VFM. Evidence from Canada, Italy and the USA shows that in the delivery of services to the elderly the following features contribute to a successful system:

- targeted hospital admission criteria;
- a case-managed team approach;
- access to a wide range of health and social support services to meet client needs; and
- active involvement of physicians. (CHSRF 2010)

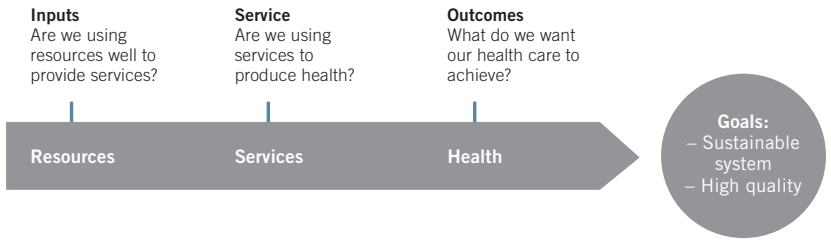
Countries in the Organisation for Economic Co-operation and Development (OECD) are all concerned with getting VFM in their health care sectors. The OECD (2010b) estimates that health care spending has risen by more than 70% in real terms since the 1990s. In the OECD, public health spending as a proportion of general government spending grew from 12% in 1996 to 16% in 2008. The general aim of the OECD countries is to achieve improved health outcomes while managing the increase in government spending. Strategies that can contribute towards VFM include:

- moving towards best practice, in order to make efficiency gains;
- reinforcing priority setting;
- ensuring that different administrative levels understand their responsibilities and accountabilities;
- more balanced provider schemes (for instance, between performance-related pay and set wages);
- targeting spending on quality-of-care issues;
- better quality and pricing information to users so that they can make informed decisions; and

- more stringent gate-keeping, in order to reduce the number of consultations and referrals to more expensive levels of service delivery. (OECD 2010b)

In low-income countries, there is great pressure on ministries of health to develop plans that will translate into activities that meet the needs of the population at reasonable cost.

Figure 1.1: Value for money



Source: Health Council Canada (2009): 'Value for Money: Making Canadian Health Care Stronger'

This introduction has identified that planning is a systematic process that tends to involve more than central authorities in trying to ensure a better link between future decisions and future desired goals. Planning is always conducted in an environment of scarce resources, especially in developing countries. There is an increasing demand domestically and among development partners to receive better VFM.

This paper distinguishes below between 'corporate planning' and 'health policy planning', and considers their potential contributions to the health system.

2. Types of planning and associated tools

2.1 Planning for health reforms

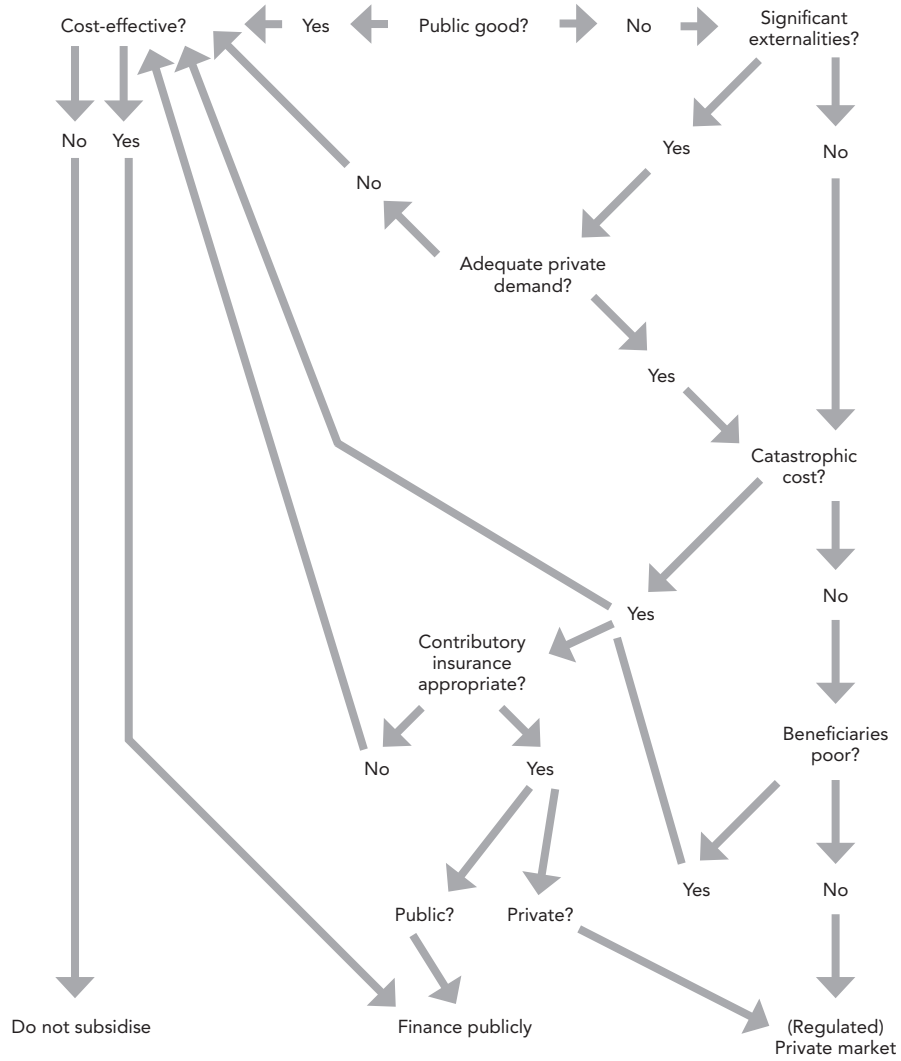
Most developing countries in Africa are engaged in health sector reform initiatives, which include the reform of public institutions, civil service reforms, the building of managerial capacities and the strengthening of the regulatory functions of the ministry of health and its agencies. They have adopted poverty reduction strategies as priorities within their overall macroeconomic directions. To what extent the private sector can assist in meeting their goals and what role sub-national levels of government can play as partners in addressing the constraints that are faced by the country are among the questions these countries are asking themselves. There has been an increasing shift from the role of the government as the provider to that of the purchaser of health services for the population, ensuring the quality of services delivered through purchasing arrangements such as contracting.

While many countries have the necessary regulations in place they do not have the mechanism or organisation required to enforce them. In particular, as the private sector plays an important role in the delivery and financing of health services in a growing number of countries, there is mounting pressure on the government, through the ministry of health, to ensure quality.

Public versus private

Musgrove (1999) presents an interesting decision tree on when to fund an intervention publicly and when to leave an intervention to the private health sector. As can be seen in Figure 2.1, public funds should be spent on interventions that are cost-effective and that disproportionately benefit the poor, and on catastrophically costly care, particularly when contributory insurance will not work effectively. Interventions that do not fulfil these criteria should either not be offered or be provided through regulated private markets.

Figure 2.1: Decision tree for public resource allocation to health care



Source: Musgrove (1999)

Decentralisation and planning

Decentralisation has been identified by the World Bank (1993) as potentially the most important force for improving efficiency and responding to local health conditions and demands. The following additional benefits of decentralisation are consistent with VFM approaches:

- technical efficiency improves through greater cost-consciousness at the local level;
- allocative efficiency increases, it is argued, because local decision-makers have access to better information on local circumstances than do central authorities, and they use this to tailor services and spending patterns to local needs and preferences; and
- the quality of services improves because the public provides input on local decision-making processes and holds local decision-makers accountable for their actions.

Various issues may act to minimise the potential impact of decentralisation. There are instances of information asymmetry where some levels of government have more information than the others and do not share it. Powerful local groups can also skew the planning process to benefit their own interests. If administrative and managerial capacity in the local government body is inadequate, decentralisation may not meet its intended objectives because of agents mismanaging finances and wasting resources.

Smith (1997) argues that central- and local-level health planners may have different goals and objectives for the health system. This may be because of different understandings of local needs or because of budgetary constraints. Various factors affect the participation of local officials and community members; these include 'political inequality, illiteracy, poverty, poor communications, physical insecurity, professional and bureaucratic hostility, and political centralization and tokenism'.

In addition to local government participants and communities, non-governmental organisations (NGOs) are becoming more involved in the decentralised planning process. This is supported by the international community, which has endorsed their role in poverty reduction strategy papers. The World Bank requires the participation of NGOs and local communities and providers in the planning processes and the development of the poverty reduction strategy papers.

Kolehmainen-Aitken (2004) agrees with Smith (1997) that countries can have multiple modes of decentralisation within the same sector. This makes planning more complex, and the lines of accountability can become confused. Other challenging issues of decentralisation include weak planning and management skills at the local level, lack of flexibility at the local level to add new posts or to re-profile existing posts, and rapid change leading to uncertainty and low staff morale. The planning process should consider the potential human and financial costs of decentralisation.

2.2 Corporate and policy planning

This part of the paper considers different types of planning, who the planners are, the process of planning and specific approaches to planning. A distinction is made between corporate planning and health policy planning. Corporate planning includes strategic planning and operational planning, and can be thought of as a process that produces the necessary strategies to achieve or attempt to achieve a specific organisational future (Jaeger 1982). Strategic planning builds on anticipated future trends, data and competitive assumptions. While it uses data, it tends to be ideas-driven and qualitative in nature. The process is intended

to produce a clear vision and goals for the organisation. Further, strategic planning deals with the development of policy and its translation, through the allocation of activities/policies/resources, into programmes of services (both capital and recurrent). Strategic plans should be bound not to the budget structures and annual time lines but to decisions about the direction and priorities of the health system.

Operational planning deals with short-term activities and is a sub-set of a strategic work-plan. It explains how or what part of the strategic plan will be put into operation in a defined time period. Operational plans are often linked to the annual budget cycle.

Policy planning is a process for achieving a given health goal. The health policy goals are usually focused on issues of improving health (such as the Millennium Development Goals), improving accessibility to health services and promoting efficiency in the provision of services. It asks four key questions:

- Where is the health system now (assessment, situation analysis)?
- Where do we want the health system to go (priorities, goals, targets, decisions)?
- What does the system have to do to get there (organisation and management)?
- How will we know what we have achieved (evaluation)?

Processes of planning

Other approaches suggest four slightly different steps through planning to implementation, namely situation analysis, assessment of needs, target setting and implementation. Table 2.1 sets out common activities associated with each main step.

Table 2.1: Processes of planning

Step	Associated actions
Situation analysis	Identify people to be served Review the context for the services Consult with relevant stakeholders Identify responsibility for the health budget and plan Review current public sector service resources Identify other sector service resources Review current service utilisation
Assessment of needs	Establish prevalence, incidence and severity of priority conditions Adjust prevalence data Identify number of expected cases per year Estimate service resources for the identified needs Cost resources for estimated services
Target-setting, development of options, organisation and management decisions	Set priorities by identifying the unmet need of the highest priority from gaps between the first and second steps Option development and appraisal Set targets for service plans on a medium-term time scale of three to five years Develop scheme of necessary organisational changes, actions and activities and management requirements
Implementation	Budget management Monitoring and evaluation

Planning is not always a rational process, and planners often encounter difficulties associated with political differences, power struggles and conflicting needs of various stakeholders.

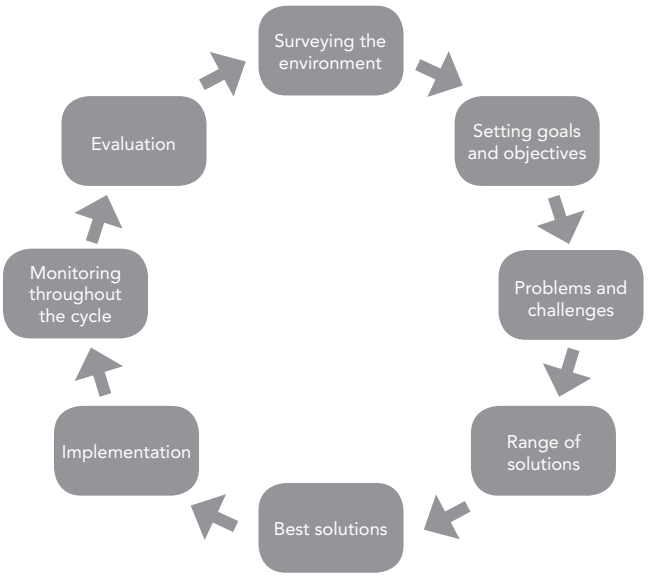
Planning involves a number of different processes, which include:

- identifying the vision, goals or objectives to be achieved;
- formulating the strategies needed to achieve the vision and goals;
- determining and allocating the resources (financial and other) required to achieve the vision and goals; and
- outlining implementation arrangements, which include the arrangements for monitoring and evaluating progress towards achieving the vision and goals.

A representation of the planning cycle is shown in Figure 2.2. The first step, surveying the environment, involves the gathering of information on the population health status, the resources available and the institutional arrangements. The second step, setting directions, goals and objectives, identifies the desired future state. This step establishes the standards against which current health profiles, or current organisational or system performance, will be compared. The third step, problems and challenges, identifies the gaps between what is and what ought to be. The fourth step involves identifying the range of solutions to each identified problem or challenge. The fifth step should include assessing each possible solution in terms of its feasibility, cost and effectiveness, so that alternative solutions can be compared with each other. The sixth step involves a choice of the best solution or set of solutions that should be implemented to address the challenges previously identified. The choice should take into account fiscal, political and other constraints. The implementation step usually begins with an implementation plan, which identifies what has to be done and who should do it.

Figure 2.2 identifies monitoring as a step. In fact, monitoring is an ongoing process that provides feedback to all stakeholders. The final step is that of evaluation, which involves rigorous measurement of the results of implementation to determine whether the implemented solutions are effective in achieving their goals. It also involves evaluating the environment to see if it has changed. This step should have an evaluation plan, developed long before the evaluation takes place. Planning is a learning process. While the discussion above might make it seem linear, planning is a dynamic process with feedback loops.

Figure 2.2: The planning cycle



A key element of the planning cycle is examining the range of solutions, which involves identification of the priorities for which the solutions are required. After surveying the environment and setting goals and objectives, and identifying gaps by examining problems and challenges, it is necessary to decide what challenges or gaps the government should address with its scare resources. This is the setting of priorities, an important health planning task in the distribution of health care resources (Segal & Chen 2001).

Why planning fails and what to do about it

Even when planners sequence their planning activities in line with ideal policy and corporate planning cycles, plans are not always implemented successfully. This section discusses key reasons for failed planning and presents a menu of areas that require intervention to ensure effective, resource-constrained and implemented plans. These are elaborated in the next section, which presents two specific tools that address many of the areas highlighted here.

The reasons for failed planning have not changed significantly since Amonoo-Lartson et al. (1984) discussed the causes of failed plans in *District health care: Challenges for planning, organization and evaluation in developing countries*. They argued that there is a lack of commitment by senior managers, who may not fully understand what 'corporate planning' means, and a lack of acceptance by operational personnel, who have to put the plan into action. Poor planning processes, which do not involve key stakeholders, and confusion between strategic and operational planning are also cited as reasons for failure. Overly complex plans that are poorly formatted and difficult to read also contribute to plans that are not used. A fundamental reason for failed plans is the lack of skill and competence of the planners. Plans that are not used in decision-making may demotivate all involved in the planning process.

More recent commentators have suggested that current health strategies and national plans are not robustly focused on scaling up evidence-based and outcome-oriented programmes. As a result, they are characterised by:

- lack of a multi-sectoral approach to achieving health outcomes;
- limited attention to country-specific bottlenecks; and
- poor costing of strategies based on normative and disease-focused approaches rather than an analysis of the cost of removing country-specific systemic bottlenecks to increasing coverage with lifesaving interventions. (see http://www.who.int/healthsystems/HSS_HIS_HHA_action_framework.pdf)

Over time, commentators have proposed a range of critical success factors, necessary actions, required approaches, and transparency and accountability mechanisms, to ensure that planning is effective, has the right scope and informs action. A consolidated view is presented below.

Integrating health planning processes: Health system constraints to improved health-related outcomes should be addressed holistically, to improve outcomes in a sustainable and effective manner (see box below on Harmonization for Health in Africa, HHA). The plans must reflect the context of the country and be linked to other processes such as sector-wide approaches (SWAps), poverty reduction strategy papers (PRSPs) and strategies to address the Millennium Development Goals (MDGs) (Barry & Mensah 2005). Plans should address multi-sector issues (e.g. across the health and water sectors), envisage multi-sector interventions and take into account the public, private and NGO sectors when planning for health. A final axis for integrating health planning concerns the integration of health planning and budgeting, to ensure that health plans are affordable and feasible and that health budgets and the use of resources are informed by health plans.

Quality of the planning process: *The health planner's toolkit* (MLTHC 2006) suggests six critical success factors in a health planning process: defining the right question; choosing the process relevant to the task (strategic or operational); engaging the stakeholders; establishing effective project management; planning within an ethical framework (assumptions underlying decision-making are clearly stated); and assessing and applying relevant information to the planning processes. Other commentators emphasise the need for planning to be clear, avoiding duplication and ensuring that plans are realistically costed, time-based and affordable (Planning and Budgeting 2007), and for planning to be process-based, with an emphasis on its effectiveness in steering health service delivery rather than being a compliance exercised focused on delivering a product. It is also suggested that better resource allocation can be achieved with an integration of capital and operating budgets.

Capacity-building: Building capacity for planning processes, and for linking implementation to planning through budgeting, monitoring and evaluation processes, is critical for the quality of plans and the likelihood that they will be implemented. The HHA initiative identified several aspects of capacity-building, including the need to develop national capacity for planning, costing and budgeting through training. The initiative is linked to efforts to build sound integrated planning, budgeting and managerial institutions in health. This type of initiative should be backed by the generation, promotion and dissemination of knowledge, guidance and tools in technical areas.

Focusing on results: Several commentators have noted poor linkage between planning processes and the identification, monitoring and achievement of target results as a key contributor to failed plans. Interventions to address this shortcoming include the development of systems for results-based financing and building capacity to monitor the performance of health systems (see HHA n.d.).

Monitoring, review, transparency and accountability mechanisms: Barry and Mensah (2005) identify the proper dissemination of plans as critical to their acceptance, ownership and implementation. This should be coupled with stakeholder engagement throughout the process (MLTHC 2006) and the publication of monitoring information. HHA (n.d), in turn, emphasises the need to undertake or improve national health policy reviews. Effective planning also requires an improvement in the lines of accountability and responsibility and a strong, independent audit process (Planning and Budgeting 2007).

Managing aid: A key obstacle to integrated, effective planning in the health sector in developing countries is the fragmentation of funding for health and health interventions linked to aid. The HHA initiative is focused largely on a set of joint solutions to address failures in the health sector through harmonised aid support. In particular, it points to the need to harmonise health interventions, to bring together funding from all global mechanisms and to develop strategies linked to aid effectiveness for health. The integration of vertical and horizontal programmes through interventions in the management of aid for health is critical.

Harmonisation for Health in Africa

To address concerns in respect of poor and/or fragmented management of the health sector in developing countries, the African Development Bank (AfDB), UNAIDS, United Nations Population Fund (UNFPA), WHO and the World Bank developed an Action Framework for tackling the barriers to scaling-up in health through a mechanism known as Harmonization for Health. The Framework has six key elements that are the focus of the mechanism:

- support countries in identifying, planning and addressing health system constraints to improve health-related outcomes in a sustainable and effective manner;
- develop national capacity through training in planning, costing and budgeting, harmonisation, stimulating peer exchange, establishing a roster of technical expertise in the region and developing partnerships with Africa-based academic institutions;
- promote the generation and dissemination of knowledge, guidance and tools in specific technical areas, focusing on strengthening health service delivery, monitoring health systems performance, results-based financing and synthesis of experience on aid effectiveness and health;
- support countries in leveraging predictable and sustained resources for the health sector, developing investment cases, providing a platform for bringing together funding from all global mechanisms;
- ensure accountability and assist in monitoring performance of national health systems, aid effectiveness and the performance of the International Health Partnership; and
- enhance co-ordination in support of nationally owned plans and implementation processes, helping countries to address the country-level bottlenecks arising from constraints within international agencies.

Source: http://www.who.int/healthsystems/HSS_HIS_HHA_action_framework.pdf

Information for planning

Another critical issue that acts against good planning is the availability of data and information for planning. All planning processes require data and information for the analysis of the current situation, the identification of gaps and the setting of priorities. Decisions have to be made throughout the planning process. There are many stakeholders at different levels of the health care system and a great mix of resources (physical, human, financial) and activities. The populations to be served differ in terms of gender, health status, disease profile and geographic location. Budgeting and planning also require financial and costing data from national and international sources.

The use of evidence in planning has been a fundamental part of the Tanzania Essential Health Interventions Project (TEHIP). The management information tools used to plan health-evidence-based interventions included:

- a district burden-of-disease profile tool to repackage population health information from the Demographic Surveillance System (DSS) in a way that district officials can easily understand;

- a district health accounts tool to analyse budgets in a standard way to generate easy-to-use graphics that show how plans for spending coalesce as a complete plan;
- a district health service mapping tool to allow health administrators to assess a quick visual representation of the availability of specific health services or the attendance at health facilities for various interventions across the district; and
- community voice tools to promote community participation and inform health planning, and to promote ownership. (ODI 2009)

It is reported that the tools produced information that resulted in a more appropriate allocation in terms of local needs

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A study of evidence-based planning and budgeting in the Philippines noted the following issues:

- identification of development goals relied on an inadequate data base;
- the plans did not include a situation showing historical trends, which might have indicated other less obvious but pressing concerns;
- the plans needed to be validated by better data;
- there were no annual targets;
- the plans were gender-blind;
- the plans did not include monitoring and evaluation methods that would facilitate implementation and the attainment of targets;
- global development partnerships were hardly visible; and
- economic and related data was lacking at sub-national and local levels (Orbeta 2006).

These issues are found in many countries. The WHO reports that planning efforts often are hampered by limited information. It is suggested, therefore, that planning should make use of simple indicators with an emphasis on ease of data collection (WHO 2003).

The type of information that is available will have an impact on the ability of finance officials to make and enforce expenditure decisions. VFM propositions need data that can be used in the development of performance and outcome indicators. Schick (1998) argues that to achieve positive public expenditure outcomes, it is necessary for information, incentives and other institutional arrangements to be in place.

The gathering and dissemination of information is costly. Careful decisions have to be made about the type and quantity of data that are required and how they will be collected. The approach to data gathering can depend on levels of analysis, individual, organisational, community or societal. Data can be collected on: risk factors; gaps in service; lack of resources; risk conditions; and threats. This has been characterised as a negative approach to data gathering. A positive approach would include gathering data on: resilience and personal strength; services, resources, opportunities for partnerships and collaboration; community assets and societal opportunities (HCU 2001). There is a need to develop an information- and data-gathering plan to support planning and budgeting and indicator development.

Among the initiatives that have been put in place are the following:

- The HHA is intended to support countries in improving national health policy reviews, planning and budgeting, as well as in aid provision, resource mobilisation and managerial and health systems development, over the long term.
- The Third International Roundtable on Managing for Development Results addressed the reform of planning and budgetary processes with a view to improving service

provision and enhancing the efficient use of resources. The Background Paper suggests that the link between planning and budgets and results is weak, and concludes that planning processes need to be clear, avoiding duplication and ensuring that plans are realistically costed, time-based and affordable (Planning and budgeting 2007). It was also noted that better resource allocation can be achieved with an integration of capital and operating budgets. Reforms require an improvement in the lines of accountability and responsibility and a strong, independent audit process. The roundtable found that in heavily aid-dependent countries, accountability mechanisms were often weak. It was stressed that major improvements take time and require the support of high-level policy-makers and managers. Appropriate incentive systems can contribute to the improvement in capacity and capability of planners and planning systems. The roundtable concluded that sub-national planning systems need to reflect the different tiers of government in trying to improve planning and budgeting.

- The Health Metrics Network (HMN), a global partnership launched in 2005, supports the strengthening of national health information systems for decision-making. The HMN has suggested that difficulties in collecting good public health data are a result not only of financial constraints but also of a deficit of accurate measurement methods in some countries. Also, the presentation of epidemiological data is generally aimed at specialists and other experts. More effort is necessary to make the information understandable to policy-makers, frontline health workers, non-health specialists and the public (WHO 2008).

The World Health Organisation (WHO) and other UN agencies and bilateral organisations have been working with countries in Africa to assist with their planning efforts. The WHO Regional Office for Africa (WHO-AFRO) has produced a guide for the development of a national health plan. The features of the guide are consistent with those discussed above.

Who are the planners?

Traditionally, planners have been employees of the ministry of health at the central level. As countries have become engaged in health sector reform activities, however, there has been a growing emphasis on the decentralisation of health systems.

The district level has become a focus of decentralised planning in Africa and in Asia. The WHO and other development partners have been working with countries to strengthen the formulation of their national health policies, plans and strategies. There is general agreement that health planners need to have the skills and competencies that allow them to participate in planning activities such as sector-wide programme management, health economics, public health expenditure reviews, health sector reviews, and the planning and monitoring of health programmes. Many countries have established health planning units. To be effective, these units should be staffed with multi-disciplinary teams. National and international institutions like the African Population and Health Research Centre (APHRC) and the Swiss Tropical and Public Health Institute (STPH) have been working to build the capacity of health planners in Africa. The STPH has worked with the Ministry of Health and Social Welfare, the Ministry of Finance and the Prime Minister's Office and Regional and Local Government and the University of Dar es Salaam Computing Centre to introduce computer-assisted planning tools that incorporate the concept of District Health Accounts for district health planners in Tanzania. The APHRC holds workshops on different aspects of health planning and information management (see www.aphrc.org/insidepage/). Investment in capacity development in health planning is a priority of many national governments and development partners.

2.3 Approaches to address health planning issues

This section discusses a number of approaches that are used in providing explicit ways to address the complex issues and stakeholders associated with health sector planning. Each of the approaches is concerned with results and, therefore, incorporates concepts of VFM.

Results-based management life cycle approach

The financing and delivery of health services in many low-income countries is largely dependent on development partners and the impact they have on the planning and budgeting processes. The UNDP (2009) has published a handbook that promotes an approach linking planning, monitoring and evaluation to results. It argues that projects and programmes have a greater chance of success when the objectives and the scope of the programmes and/or projects are properly defined and clarified, because the challenges in implementation are thereby reduced. It also supports previously discussed findings that the high-level engagement of users, clients and stakeholders in programmes and projects is critical to success. Communication between stakeholders is identified as a success factor because it helps to clarify expectations, roles and responsibilities. Progress and performance should also be communicated in order to encourage continued involvement of stakeholders. The handbook further argues that monitoring and evaluation are critical success factors because they tend to keep things on track. Monitoring allows for the early identification of potential problems so that they can be addressed, and contributes towards cost savings in the longer term.

It is argued that good planning helps ministries of health to focus on results that matter, and monitoring and evaluation provide information that can be used to improve decision-making. Results-based management (RBM) is a broad management strategy aimed at achieving improved performance and demonstrable results. The UNDP proposes that good RBM is an ongoing process of constant feedback, learning and improving. Figure 2.3 presents the steps in the RBM approach. The central principles of RBM are ownership, engagement of stakeholders and an emphasis on results. There is also a focus on gender in planning, monitoring and evaluation. Many low-income countries are becoming more concerned about issues of gender equity in their planning and service delivery.

The planning-for-results framework requires planners to consider explicitly the impact that their plans will have, and the outcomes of the actions and the outputs from the implemented activities. In order to measure the results of the plan, indicators are developed and monitored. Baselines are established for the critical concerns in the plan and explicit targets are set. The RBM framework also calls for the identification of the means of verification of the results of the different components of the plan.

The UNDP handbook puts forward the following key considerations in planning for results:

- planning should be focused on results and real development changes that help to improve people's lives, and should not be done merely to meet the requirements of supervisors or headquarters;
- planning should always be seen as a process, of which the actual plan is only one product;
- the planning process should include a plan and mechanism for managing, monitoring and evaluating, and well-developed ideas for partnering and collaborating to achieve the desired results;
- the planning process should be highly participatory and very open, encouraging frankness, creativity and innovation;

- planning must be guided by core principles of development effectiveness;
- the most important outcomes of the planning process are clarity of goals, objectives and a vision of the future, commitment and motivation of stakeholders, and clarity on the process to complement and manage the plans; and
- the planning document can serve as a useful record of what has been agreed and as a tool for communicating with new stakeholders. (UNDP 2009)

UNICEF (2003) states that results-based programme planning ensures that the sum of interventions is sufficient to achieve the expected result, and suggests that a complete results framework should contain the following:

- strategic results, which relate to the enjoyment of rights by children and women, or a change in their status – their achievement usually depends on many other factors, including the considerations of other partners;
- results related to institutional change, quality or coverage of a service, or behavioural change – their achievement may depend on the contributions of others; and
- results of completed projects or activities, or products – their achievement is largely under the control of the government, UNICEF and partners.

Figure 2.3: Results-based management life-cycle approach

The logical framework

The logical framework (LFA) is a systematic method of developing a project concept and selecting a project strategy. It is especially useful when planning to address a particular, narrow-focus policy problem. The Australian government and a number of aid agencies, multilateral and bilateral, including the DFID and UNICEF, have been using and promoting the LFA as a significant tool in their planning arsenal. AusAID (2005) has produced a user-friendly guideline that describes the LFA as an activity design methodology and an analytical, presentational and management tool that can help planners and managers to:

- analyse the existing situation during activity presentation;
- establish a logical hierarchy of means by which objectives will be reached;
- identify the potential risks to achieving the objectives, and to sustainable outcomes;

- establish how outputs and outcomes might best be monitored and evaluated;
- if desired, present a summary of the activity in a standard format; and
- monitor and review activities during implementation.

The LFA uses problem analysis, stakeholder analysis, objectives analysis and selection of a preferred implementation strategy as the four main analytical elements in the planning process. The log frame matrix is presented in Table 2.2.

The AusAID guidelines indicate that it is important for the analytical tools of the LFA to be applied in a participatory manner. Ownership of the processes and of the plan is critical for effective implementation and the sustainability of benefits for the domestic partners. It is also suggested that LFA is not an easy tool to apply, even for experienced users (AusAID 2005).

Table 2.2: Log frame matrix structure

Activity description	Indicators	Means of verification	Assumptions
Goal or impact – the long-term development impact (policy goal)	How the achievement will be measured, including appropriate targets (quantity, quality and time)	Sources of information on the goal indicators, including who will collect and how often	
Purpose or outcome –the medium-term result(s) that the activity aims to achieve in terms of benefits to the target groups	How the achievement of the purpose will be measured, including appropriate targets (quantity, quality and time)	Sources of information on the purpose indicators, including who will collect and how often	Assumptions concerning the purpose to goal linkage
Component objectives or intermediate results – this level in the objectives or results hierarchy can be used to provide a clear link between outputs and outcomes (particularly for larger multi-component activities)	How the achievement of the component objectives will be measured, including appropriate targets (quantity, quality and time)	Sources of information on the component objectives indicators, including who will collect and how often	Assumptions concerning the component objective to output linkage
Outputs – the tangible products or services that the activity will deliver	How the achievement of the outputs will be measured, including appropriate targets (quantity, quality and time)	Sources of information on the output indicators, including who will collect and how often	Assumptions concerning the output to component objective linkage

Performance-based budgeting

Performance-based budgeting (PBB) is particularly useful in a corporate planning context, and aims to improve the efficiency and effectiveness of public expenditure by linking the funding of public sector organisations to the results they deliver, making systematic use of performance information. The implementation of plans depends in large part on the budgeting processes. Financing of health programmes is often not viewed as contributing to the national economy and, therefore, is not a priority area in many countries. In an IMF technical note, Robinson and Last (2009) advise that PBB should not be considered in countries with dysfunctional public fiscal management and governance systems. Essential requirements for a basic performance-based system are said to be: information about the objectives and results of government expenditure in the form of key indicators; and a budget preparation process designed to facilitate the use of this information in budget funding decisions. The technical note argues that if the planning process is institutionally separated from the budgetary process, the desired results may not be achieved. Some countries have difficulty in ensuring that the priorities identified in the planning process are reflected in the allocation of the annual budgets. In

countries where PBB is believed to improve planning through the use of better performance information, there may be a greater respect for the plan by those formulating the budget. However, if budget decision-makers do not take the priorities identified in the plan seriously, this can lead to conflicts between planning and budgeting objectives, and may result in weakening government policy prioritisation.

Marginal budgeting for bottlenecks (MBB)

The World Bank, UNICEF and WHO have worked together to develop a tool that helps countries to identify implementation constraints on the health system that should be removed to optimise expected health outcomes and to estimate the marginal costs of overcoming these constraints. This tool – marginal budgeting for bottlenecks (MBB) – is designed to help governments in the formulation of their medium-term national or sub-national health plans. Knippenberg, Soucat and Vanlerberghe (2004) note that the tool can facilitate a long-term prioritisation process for government health expenditures that starts by improving the allocating efficiency of the newly available resources and provides a basis for policy dialogue and planning. Soucat et al. (2002) report that the MBB approach is now the basis of annual budgetary decisions in Mali, where it was used in developing the medium-term expenditure framework (MTEF). The budgets developed using MBB in Mali have resulted in a shift over time in the allocations between inputs. Human resources for health, home-based promotion services and poorer populations have been identified as areas that will benefit from increased marginal funding. Soucat et al. (2002) suggest that budgets developed on this basis show a potential incremental impact on health outcomes and a contribution to the MDGs that can be obtained by increasing resources strategically by a few US dollars more per capita and per year. MBB is said to be pro-poor.

The MBB tool asks the following questions:

- What are the major health system bottlenecks hampering the delivery of health services and what is the potential for improvement?
- How much money is needed for the expected results? Is it covered by new money available on the margin of the budget baseline?
- How much can be achieved in health outcomes by removing the bottlenecks?

It seeks to examine:

- What are the new interventions (home-based care, essential obstetrical care)?
- By whom (public/private sector)?
- How (demand- or supply-focused)?
- To whom (geographic/social targeting)?
- With what (input mix)?
- At what cost (for drugs, salaries, construction)?
- Who pays (public/out-of-pocket payments)?

These are the questions that all health planners and policy-makers must address.

SWAps: integration and co-ordination in planning

There has been a great deal of debate among policy-makers, funders and researchers in terms of vertical and horizontal funding and programming. Heinz (2010) suggests that in the last ten years there have been substantial increases in the levels of international funding earmarked for the health sector. However, 'a large proportion of the funds have been channeled through

donor driven programmes that targeted specific diseases and that can undermine health priorities within the recipient countries'. To address this concern and to give more ownership to countries, there has been an expanding use of an approach that is country-driven and combines funding from different national and external sources. This section discusses such an approach.

The SWAp is defined by Vaillancourt (2009) as 'an approach to a locally owned program for a coherent sector in a comprehensive and coordinated manner, moving toward the use of country systems'. SWAps are intended to provide joint support to nationally defined and led programmes that are focused on results. A review of health SWAps in six countries (Bangladesh, Ghana, Kyrgyz Republic, Malawi, Nepal and Tanzania) concluded that SWAps have been largely successful in putting in place critical tools and processes for improved sector co-ordination and oversight. The tools include: short- and medium-term plans of work; medium-term projections and expenditure plans, which outline the availability of resources; structures and processes for building and facilitating partnerships, especially between the government and development partners; and financial management capacity assessment tools. The study also found that in most cases the capacity for monitoring and evaluation was not very high. With respect to the predictability, flow and use of health sector resources, the study concluded that resource predictability has been undermined by inadequate estimations of programme-of-work costs, financing and financing-gap scenarios. Further, the non-government sector has not been sufficiently involved in costs and resource envelopes, and the alignment between development partner planning and budgeting is not always consistent with country cycles.

The DFID conducted an impact evaluation of the SWAp in Malawi (Pearson 2010), revealing two major system issues – the delivery of the prioritised essential-health package and human resources for health. Through the SWAp, these issues are now being addressed by means of a system approach rather than a fragmented, vertical disease-based approach. The evaluation asserts that a SWAp is only as good as the programme of work that it supports. The programme of work, result planning, and monitoring and reporting are said to be input-oriented. The evaluation finds that the SWAp has allowed for greater leveraging of support from the government and donors, and has increased the focus on human resources for health. Alignment and harmonisation of donor support has improved, but there is concern about the sustainability of financing, especially because of the dependency on donor funding. Public-private partnerships have improved but, according to the evaluation, there is room for further improvement. In addition, public funding has increased and is better targeted to the poor. In this case, the SWAp has been an important instrument for the realisation of the programme of work and the planning and budgeting that defines it.

3. Country examples of planning

3.1 Kenya

The Second National Health Sector Strategic Plan of Kenya, NHSSP II, 2005–2010 (MOH, Republic of Kenya 2005) provides an example of how health sector planning is being conducted in many African states. This health plan identified a specific objective of improving the health system through the strengthening of district health planning. District health targets were integrated into the national plan and the budget was linked to the annual inputs through the district health plans. The NHSSP II was designed to provide a framework with which more detailed annual operational plans for the national level could be developed. The plan is used to align health strategies with broader development priorities defined by the Ministry of Planning and National Development, the Public Sector Reform Secretariat, and the government of Kenya budget allocations, as defined by the Economic Recovery Strategy (ERS), the MTEF

and the annual public expenditure review for the health sector. There are six interlinked policy objectives with the aim of addressing the goals of reducing inequalities in health care and reversing the downward trend in health. The objectives are to:

- increase equitable access to health services;
- improve the quality and responsiveness of services in the sector;
- improve the efficiency and effectiveness of service delivery;
- enhance the regulatory capacity of the Ministry of Health;
- foster partnerships in improving health service delivery; and
- improve the financing of the health sector.

The planning approach gathers and collates information and health plans from all levels, and consolidates these into annual operational plans that are subsequently agreed upon by all stakeholders. The planning approach is said to be at the core of Kenya's SWAp in health. The approach is called 'three ones': one plan and budget; one monitoring system; and one co-ordinating framework. The NHSSP II was developed using a participatory process that involved the Provincial Health Management Teams (PHMTS), District Health Management Teams (DHMTs) and other stakeholders. The plan recognises the importance of the involvement of other stakeholders, including the private sector (not-for- profit and for profit), which owns approximately 49% of health facilities in Kenya, traditional healers, individuals and households, and development partners.

The first principle in the design of the plan is a shift from a disease-burden focus to a human capital development approach by focusing on health promotion and providing comprehensive support to the different phases of the human life cycle, while at the same time stimulating a human rights approach in all interventions.

3.2 Uganda

The planning and budgeting process in Uganda is led by the Ministry of Finance, and is guided by national priorities. The institutional frameworks for planning and budgeting include SWAps, the MTEF, the Poverty Action Fund (PAF) and the fiscal decentralisation process. The national budget is used as an economic policy tool to allocate public financial resources in accordance with policy priorities and to use financial resources effectively to achieve government policy goals. Transparency and openness and broad participation in the budget process are facilitated through the use of budget framework papers (BFPs) at all administrative levels. Rolling plans use a three-year planning horizon and set out planned outputs and the associated expenditures in the medium term. The planning framework has four levels:

- long-term planning and expenditure forecasting at the central government level – this is guided by the Development Plan Vision 2035 and is managed using the long-term expenditure framework;
- medium-term planning and expenditure forecasting at the central government level – this is guided by the Poverty Eradication Action Plan and is managed using the MTEF;
- medium-term planning at central government level and sector level – sector plans and budget framework papers are the tools used at this level; and
- short- to medium-term planning at district level – district development plans and local government budget framework papers are the tools used. (The Global Mechanism 2008)

For the health sector, the overall goal expressed by the Ministry of Health in 1999 is the 'attainment of good health by all people in Uganda in order to promote a healthy and productive life'. Odaga and Lochoro (2006) argue that it is not feasible for the health sector to address its constraints without significant increases in the budget. The country will not be able to meet the millennium development goal of reducing childhood maternal mortality by 2015. Odaga and Lochoro further suggest that the health sector is constrained by government ceilings that have been imposed because the government is concerned about fiscal stability and the possibility of increased donor funding resulting in a crowding out of the private sector.

The health sector, as it is in other countries, is often perceived as inefficient and, therefore, does not receive the priority support that it should. During the development of the latest Health Sector Strategic Plan (HSSP III), all health-related policies and plans were reviewed in an effort to better harmonise the HSSP with existing sector and inter-sectoral plans (MOH Uganda n.d.). HSSP III was developed with broad participation, organised through a MOH task force, which includes different departments within the ministry, universities, the private sector, civil society organisations and health sub-districts. The Uganda National Minimum Health Care Package (UNMHCP) is divided into four clusters:

- health promotion, disease prevention and community health initiatives;
- maternal and child health;
- prevention and control of communicable diseases; and
- prevention and control of non-communicable diseases.

A critical element required to enable the execution of the above programme areas is human resources for health (HRH). As with other African countries, Uganda has a serious shortage of health workers both in numbers and in skills mix. HRH policy and Strategic Plan 2005–2010 have been developed within the context of the overall Health Sector Plan. The private (not-for-profit and for-profit) sector produces the majority of health workers and employs approximately 40% of the total workforce. The need for close planning between the public and private sectors has been identified clearly in the Ugandan context.

3.3 Zambia

An increasingly central goal of many governments is the enhancement of equity within health systems. The vision of health reform in Zambia has been expressed as 'equity of access to cost-effective quality health care as close to family as possible, for all Zambians'.1 In order to achieve this, a decentralised, bottom-up approach to policy-making was initiated to take local needs and priorities into consideration.

A study was implemented in 2004 by the Parliamentary Committee on Health, Community Development and Social Welfare to determine if the approach to planning and budgeting based on the principles of leadership, accountability and partnership and a bottom-up approach was resulting in improved health outcomes (Ngulube, Mdhluli & Gondwe 2005). Using a policy-analysis approach, with a focus on the barriers to effective implementation of the policies, the Centre for Health, Science & Social Research (CHESSORE) found that there were three major barriers to achieving good health outcomes. The problems identified were:

- low and unrealistic planning figures received from central-planning-level officials;
- incorrect population figures used to determine funds to be made available to each district; and

1 www.access2insulin.org/html/Zambia_s_health_system.html

- human resources problems, which contributed to overworked, under-skilled and low-performing health personnel.

Each problem by itself is significant, but together they make the desired goals very difficult to achieve. Discussions with key stakeholders and an analysis of their responses provided the following findings:

- there has been insufficient training of community stakeholders in effective participation in planning and budgeting;
- lack of procedures to achieve consensus has resulted in distortion of policy implementation;
- some partners believe that uneven power relationships have led to biases in priorities and budget allocations; and
- the relationship between the centre and the lower levels is very unequal, resulting in the expressed problems of the lower levels often being ignored.

The study also argued that the parliamentary committee was too busy and did not have the resources required to oversee the health budget and pay attention to outcomes (Ngulube et al. 2005). It identified the importance of paying attention to power relationships and to recognising that stakeholder training is required to support participation in the planning and budgetary processes.

Unlike the planning and budgeting process in Uganda, the process in Zambia does not have much involvement of the private sector. While the National Health Strategic Plan (NHSP) 2006–2010 reports that there has been increased involvement of the private sector and the establishment of some public-private partnerships, the Churches Health Association of Zambia remains the major private sector participant (MOH Zambia 2005).

4. Prioritisation

4.1 How it fits with planning

A proper prioritisation process provides the link between plans and budgets. Use of the generic planning cycle discussed in section 2 above will provide policy-makers with a good understanding of the current and historical environment, and an explicit setting of goals and objectives, followed by an analysis of the problems and challenges. Analysing the difference between the goals and the problems will present policy-makers with the gaps. There will be a range of solutions, programmes and activities that can address the gaps (challenges). Given the limited resources, policy-makers are faced with choices. Prioritisation has been used as a method of addressing the conflicting demands by stakeholders, and different interests and needs, within a resource constraint.

Policy-makers are in the difficult position of having to decide among many competing priorities with only very limited resources. For example, they must decide which health programmes to fund, which drugs to place on the drug beneficiary formula and which patients should be referred to a critical care unit (Gibson, Martin & Singer 2002). All this is in the context of health, but they must also decide between health care and other sectors. Is it better to fund education, or improve sanitation, or supply electricity to households – all of which affect the prevention of ill-health – or is it better to fund health care services that will cure populations that are already ill?

Policy-makers have solved these problems implicitly for centuries, with varying degrees of success. In more recent years, there has been a shift towards explicitly setting priorities in

planning resource allocation. Explicit priority setting, which avoids using heuristic or intuitive approaches, has been employed in a number of African countries including Eritrea, Kenya, Ethiopia, Uganda and Tanzania (Baltussen & Niessen 2006).

Priority setting, defined simply as the process of determining how health care resources should be allocated among competing programmes or people (Baltussen et al. 2006), is critical for optimising a budget under constraints. In this section, we shall explore the key trade-offs that decision-makers must take into account when allocating minimal resources, analyse the types of priority-setting tools that are available, and look at examples of priority setting being used in Africa.

4.2 Key trade-offs

Policy-makers usually are faced with a number of competing priorities, making a trade-off between the various priorities necessary. Any trade-off in public spending needs to take into account the following criteria: economic efficiency, including cost-effectiveness, catastrophic costs and public goods; ethical considerations, including poverty reduction, and vertical and horizontal equity; and political considerations, particularly population demands (Musgrove 1999). Trade-offs may need to be made between donor and country priorities, between the public and private sector, and between equity and efficiency.

The current trend in aid effectiveness is to set up a contractual approach to donor and recipient governments with a clear set of rewards and penalties for both within a SWAp (Cruz & McPake 2010). Frequently, however, such systems are based on unstructured donor agreements and are lacking in quantitative benchmarks against which to measure progress, particularly when it comes to governance and accountability. Funds often continue to be disbursed despite lack of progress towards targets (Cruz & McPake 2010). In addition to this, due to the increasing number of donors in many countries, the amount of resources and competing priorities have risen dramatically (Sundewall et al. 2010). Not only do donors need to co-ordinate better among themselves, they must be better co-ordinated under the direction of the government and should be accountable to the local government.

Although it is possible that equity and efficiency may be congruent, there is usually a trade-off between the overall health of society and the health of the poorest populations. The inclusion of equity criteria, such as age, place of residence, gender and education level in the priority-setting exercises should result in interventions that favour the most disadvantaged within a society. Trade-offs between equity and effectiveness must be made explicit by clearly specifying criteria that reflect both of these concerns so that they can be discussed in an open and rational manner. These criteria must be weighted so that informed decisions can be made (James et al. 2005). Policy-makers could go one step further and implement pro-poor strategies, thereby giving the poor preferential treatment (James et al. 2005). Although this may sometimes result in less cost-effective solutions, the majority of diseases afflicting the poor can be combated easily by using cheap and effective primary health care measures (James et al. 2005).

Another trade-off is between investment in vertical programmes or in horizontal or integrated programmes. Vertical programmes refer to instances where the solution of a given health problem is addressed by means of the application of specific measures via single-purpose machinery. Integrated programmes seek to tackle the overall health problems on a wide front and on a long-term basis with a system of permanent institutions known as general health services (Atun et al. 2008). It is argued that weak general services in developing countries often fail to deliver high priority interventions. Multilateral organisations, bilateral agencies and global partnerships, therefore, have chosen in many cases to invest in disease-specific

health programmes rather than in the health system as a whole. This is a trade-off that affects the country's priority setting, planning and budgeting.

There is little debate on the merits of addressing the social determinants of health for the overall improvement of the health of the population. Health promotion policies, however, are consistently under-prioritised in many countries; they require long-term vision and the implementation of strategies and concrete measures (Council of Europe 2010). There continue to be powerful interests that support investments in curative care (especially hospital care) as opposed to primary health care.

These and many other trade-offs are faced by policy-makers. Explicit criteria for the setting of priorities can help policy-makers in reaching resource-allocation decisions.

4.3 Approaches and tools for prioritisation and planning

Priority setting can be a complex process and there are various tools that can be used. Before analysing these tools, it is useful to review some fundamental principles of priority setting.

- *Principle A*. The use of priority-setting tools is important as they help decision-makers to decide what issues to focus on, to choose between competing interventions, and to think about resources up front.
- *Principle B*. Priority-setting processes have three important elements:
  - identifying needs;
  - identifying effective interventions to be considered; and
  - allocating resources.
- *Principle C*. Legitimate and fair priority setting needs to have clear stakeholder involvement, the process and outcomes should be publicly stated so that there can be procedures for accountability, there should be a mechanism for reviewing and revising decisions based on input from stakeholders and, finally, there needs to be some form of monitoring and evaluation in place to assess the effectiveness of both the process and the interventions.

With these principles in mind, it is important to remember that priority setting can occur at a number of different levels, namely with government sectors, within health care organisations, within health technology assessment (Noorani et al. 2007) and within specific health areas, such as maternal and child health (Edejer et al. 2005).

The methods of priority setting have remained relatively stable over the last 20 years and can be divided into five major areas:

1. implicit historic-based model;
2. best-practice guidelines;
3. needs-based models and studies;
4. burden-of-disease model; and
5. sector-wide approaches.

Implicit historic-based model

This is a very common approach and relies on what has been done before, along with implicit assumptions. The major issue with this approach is that it assumes that the current allocation of resources is optimal and does not allow for significant change or redistribution of resources between programmes. An example of this type of approach to priority setting is deciding to fund this year's budget on the basis of last year's budget.

Best-practice guidelines

Best-practice guidelines have become increasingly popular over the last few years. Although they are not in themselves priority-setting tools, best-practice guidelines often are used to make decisions and allocate resources. An example of this type of approach is the WHO-CHOICE guidelines (http://www.who.int/choice/), which provide cost-effectiveness estimates for a growing number of health interventions for 17 world sub-regions. These tools do provide important information, but run the risk of being based on only one aspect. For example, the WHO-CHOICE guidelines are based almost exclusively on costing. Other guidelines may be based on quality-adjusted life years. Therefore, although they are important tools, they should be used in conjunction with other priority-setting mechanisms.

Needs-based models and studies

Needs-based models are those that take into account the input of stakeholders and, particularly, the community that the intervention will serve. A needs assessment is vital in establishing the needs of disadvantaged groups, such as the poor, the uneducated, women and rural persons. The use of needs-assessment tools has become more sophisticated in recent years and now almost all priority-setting tools include some form of needs assessment or stakeholder-involvement mechanism.

Burden-of-disease models

This approach dates back to at least the 1993 World Development Report, which attempted to quantify disease, injury, and health risk using disability-adjusted life years (DALYs) as the measure. The report stressed a basic package of personal and public health services on which public funds should be concentrated. This model sets priorities on the basis of the size of the problem and the availability of effective interventions, but does not address issues of funding or resource allocation.

Sector-wide approaches

Sector-wide approaches (SWAps) refer to a shift from project-based funding to the management of programmes that support an overall government sector. In this instance, priorities are set in terms of an overall sector budget and multiple criteria. The priority-setting tools that are required in this instance may be slightly more complicated than those that prioritise only a certain element. Although there are numerous tools that can be used for priority setting, we will focus on three that may be particularly useful to policy-makers employing a SWAp: the combined approach matrix; multi-criteria decision analysis; and the trans-disciplinary model of priority setting.

The 3D combined approach matrix

This approach is based on three equally important pillars: *process*, *tools* and *context* (GFHR 2009).

- *Pillar 1 (Process)*: It is important that the following five steps are followed to ensure that the priority-setting process is inclusive, transparent and effective –
  1. determine focus and level of analysis – global, national or regional;
  2. select stakeholders – including community, health professionals, managers and funders;
  3. collect data and prepare a background brief – this should be evidence based;

4. conduct a workshop to set priorities – with stakeholders represented, using the combined matrix approach; and
5. disseminate the findings.

- *Pillar 2 (Tools)*: The 3D combined approach matrix (CAM) is designed to enable collection, organization, and analysis of information. The CAM has three separate components – the public health dimension, the institutional dimension and the equity dimension. The CAM guidelines provide an excellent walk through on how to use this tool in practice (GFHR 2009).
- *Pillar 3 (Context)*: This refers to the availability of resources as well as the political factors that affect priority setting. The exercise of setting priorities is intensely value-laden and it is important to understand how power structures affect society and interact with health.

Multi-criteria decision analysis

Multi-criteria decision analysis uses a matrix that allows users explicitly to indicate the cost-effectiveness of interventions, the severity of the disease, equity considerations and the age of affected persons (Baltussen & Niessen 2006).The objective is to rank the level of importance of health interventions using these multiple criteria. Table 4.1 shows a simplified example of how this matrix might work. As can be seen, different options can be compared across their cost-effectiveness, the severity of the disease, whether the disease affects the poor and the age range affected. Once these criteria have been made explicit, a discussion involving stakeholders' views can be held to assign a level of importance to each criterion. It is important to note that various stakeholder views may conflict considerably and that very seldom is there one option that is clearly the best option.

Table 4.1: Multi-criteria decision analysis performance matrix

Options	Cost-effectiveness	Severity of disease	Disease of the poor	Age
Antiretroviral treatment in HIV/AIDS	US$200 per DALY	• • • •	√	15 years and older
Treatment of childhood pneumonia	US$20 per DALY	• • • •	√	0–14 years
Inpatient care for acute schizophrenia	US$2 000 per DALY	• •		15 years and older
Plastering for simple fractures	US$50 per DALY	•		all

Note: A tick indicates the presence of a feature. Severity of disease is shown on a four-star scale, with more stars indicating more severe disease.

Trans-disciplinary model of priority setting

This model is a combination of the ethically based accountability for reasonableness model and the empirically based diamond model (Gibson et al. 2002). It has been used to assess priorities for new technologies in medicine, but can be generalised to other areas. The model recommends the follow process for setting priorities:

- *Step 1*. Bring together a committee of fair-minded people to make priority-setting decisions. The group should include a broad spectrum of individuals from within the organisation, as well as patients and members of the public. They should focus on the *reasonableness* of the rationales for each decision.

- *Step 2*. Put into place processes to ensure the *transparency* of the decision-making activities (e.g. public notices and town hall meetings) and to ensure that the rationales are widely available.
- *Step 3*. Design methods to hear appeals regarding the rationales for decisions and to *respond* to further evidence or arguments.
- *Step 4*. Develop mechanisms of institutional *accountability* to ensure that the first three steps are followed.

Various tools for evidence-based priority setting have been developed, often collaboratively, by multilateral and other agencies. These include marginal budgeting for bottlenecks (MBB), WHO-CHOICE (Choosing Interventions that are Cost-Effective) and the Lives Saved Tool (LiST) (Rudan et al. 2010).

Examples of priority-setting exercises

The multi-criteria approach for priority setting: an application to Ghana (Baltussen et al. 2006)

Policy-makers in Ghana were asked to prioritise interventions taking into account cost-effectiveness, poverty reduction, age of the target group, severity of the disease, health effects and total budget impact. They did this by completing a series of discrete choice experiments wherein respondents chose their preferred option from two sets of scenarios. This continued until the options were ranked in order of preference. The study found that interventions that are cost-effective reduce poverty, target severe diseases, or target the young have a higher probability of being chosen than others. Further to this, they identified the prevention of mother to child transmission in HIV/AIDS control, and treatment of pneumonia and diarrhoea in childhood, as high priority areas in Ghana. This methodology could be used in similar settings to determine which areas are priorities.

Accountability for reasonableness framework used in Tanzania district health planning (Mshana et al. 2007)

Many countries, including Tanzania, have found that traditional priority-setting frameworks, which focus on burden-of-disease measures and cost-effectiveness analysis, are too simplistic. The accountability for reasonableness framework was thought to be empirically based and ethically justified and, thus, able to set priorities that are legitimate and fair. In 2005, Tanzanian scholars from the Primary Care Institute conducted six capacity-building workshops with senior health staff, district planners and managers, representatives of the Tanzanian Ministry of Health, users of health services, and non-governmental organisations to discuss improving priority setting. The participants from all six workshops demonstrated a high degree of acceptance and enthusiasm towards the approach. They found that the approach enabled a wider participation of stakeholders, greater transparency, and the scrutiny and development of relevant priority-setting criteria. There were some concerns with the approach, namely that it might be too technical and complicated for some users, that some stakeholders may not have the knowledge, skills or experience to fully participate, and that the criteria used in priority setting may be too complex to put into practice. Overall, the participants found this framework extremely helpful, as it directly addressed multiple stakeholder concerns.

Accountability for reasonableness framework used in Zambia to guide decisions on the delivery of malaria services (Tuba et al. 2010)

Zambia used the accountability for reasonableness framework to involve stakeholders and assess the legitimacy of decisions relating to the treatment of malaria cases within

public health facilities in a particular district. Following interviews and focus groups with managers, outpatient attendees and decision-makers involved in the prioritisation of malaria services at the district, facility and community level, the following issues emerged:

- decision-makers, patients and managers had conflicting criteria for judging fairness;
- decision-makers argued that there was fairness in delivery of malaria treatment and distribution of insecticide-treated nets (ITNs), based on alleged excessive supply of free malaria medicines, subsidised ITNs and the presence of a qualified health-provider at every facility;
- patients argued that there was unfairness due to differences in waiting time, distances to health facilities, erratic supply of ITNs, no responsive appeal mechanisms, inadequate access to malaria medicines, ITNs and health providers, and uncaring providers;
- decision-makers perceived only government bodies and donors/NGOs to be legitimate stakeholders to involve during delivery; and
- patients found themselves, government bodies, indigenous healers, chiefs and politicians to be legitimate stakeholders during both planning and delivery.

Thus, numerous conflicting views that came out during the discussions about how to prioritise malaria interventions. The shift from top-down to bottom-up approaches to prioritisation might be extremely difficult as demonstrated here, but the accountability for reasonableness approach brings out the issues for discussion and resolution in a fair and legitimate manner.

5. Conclusion

To be effective, planning and budgeting processes in health care must be guided by a set of clear directions and principles. There is an increasing emphasis on value for money and equity in the delivery of health care services. To achieve this, countries and development partners are attempting to use common approaches to achieve greater coherence between country planning and the plans of the development partners. SWAps and tools such as joint reviews and agreed planning frameworks are being used to better align priorities and funding cycles.

This report has discussed different types of planning approaches: policy planning, strategic planning and operational planning. The process of planning is more than technical, it is political and, as such, there is a need to recognise the interests of stakeholders and to involve them effectively in the process of planning.

Evidence-based decision-making demands investments in data, information systems and tools for collection, dissemination and use data in the process of decision-making. It is crucial that the capacity of planners to collect and use appropriate data be developed. Global partnerships and bilateral partners have developed initiatives to support countries in strengthening their capacity to use data for planning and evidence-based decision-making.

The approach to health planning is shifting increasingly from input-based to results-, or performance-based planning and budgeting. In performance-budgeting, the following key questions are asked. Who is responsible for setting the performance target? When are they held accountable? How is performance to be measured? What are the consequences if

performance is not achieved? For planning to be effective, there must be leadership and accountability. The ministry of health is usually the entity accountable at the central level; at the district level, it is often the district health council (or the district health team).

In most countries, national health plans, while identifying who is responsible, do not indicate what happens when performance targets are not met. Value for money is the underlying concept of performance. The measures are often economy, efficiency, effectiveness and the integrity of the process. Value for money is assessed by programme managers and by internal and external auditors. The auditors are often from the ministry of finance. NGOs and civil society also play a role in strengthening domestic accountability. Transparency in the planning process and a clear understanding of who is responsible leads to more effective planning and allocation of resources.

Planning is more effective if there is a realistic understanding of the budgetary framework. Effectiveness can be improved if there is agreement between the ministry of finance and the ministry of health on the process and the economic framework within which the planning is taking place. Planning and delivery systems are dynamic and are influenced by macroeconomic and political situations. It is, therefore, important to monitoring the planning and implementation process and the resultant performance of the health system. Research tells us that the capacity to monitor health systems and the evaluation of the decisions resulting from the planning process is a weakness in many countries. The literature suggests that greater linking of the planning and budgetary processes can be achieved through the use of such approaches as the medium-term expenditure framework.

A key strategy in the reform of health systems is decentralisation. Planning at decentralised levels is being supported by multilateral and bilateral development partners. There is also increased involvement of stakeholders at all levels of the health care system. This is recognised, and is a policy in many countries. As an example, the Ugandan HSSP III clearly states that the development of the plan, managed by the ministry of health, is broadly participatory. In this case, there is also significant involvement of the private sector. District health management teams are working with district councils to identify local priorities and to steer the allocation of resources. There continues, however, to be concern that the processes to involve stakeholders are not as effective as they could be. The stakeholders at the lower levels of the health care system are often reluctant to challenge the decisions from higher levels in the system. They often believe that their voice will not be heard because they do not have the power.

Health systems are faced with very difficult questions concerning the involvement of the non-government sector in the decision-making, planning and delivery of health services. For example, most of the training of primary health care staff takes place within the private, not-for-profit sector. The studies discussed above suggest that the private sector is not sufficiently involved in planning and decision-making on issues such as human resources for health development. While there are increasing attempts to involve the private sector and civil society in planning, there is still much work to done.

Many tools are available to assist in planning; however, the necessary skills and competencies often are lacking in the planning units that have been set up to lead this work. The World Health Organisation and other agencies are assisting countries to develop this capability within the respective ministries. In countries like Zambia, there is a growing partnership between the Centre for Health, Science and Social Research and the Ministry of Health. These partnerships are essential for the development of national capacity for planning. Domestic teams of planners have to be trained to use tools such as marginal budgeting for bottlenecks in deciding where best to allocate their limited resources.

Explicit, rational and transparent approaches to priority setting are the recent trend in most countries. Baltussen & Niessen (2006) cite studies in East Africa (Eritrea, Kenya, Ethiopia, Uganda and Tanzania), North Africa (Algeria, Morocco and Tunisia) and India (Andra Pradesh). Equity and interventions that will benefit the poor are increasingly the central objectives of policies and planning.

With increased decentralisation in countries, there is growing debate on who should be involved in the priority-setting exercises and how the involvement can be ensured. Matovu (2006) argues that there is a need to develop practical tools that will develop competencies that will contribute to a more balanced relationship between top-down and bottom-up participatory planning and budgeting. Further, this approach will act to improve co-ordination, transparency and accountability in action planning, priority setting and expenditure allocation. It is proposed that capacity development should target councillors and mayors, chief officers, citizens, community leaders, ministers, top officials and local government associations. There is general agreement that more support is needed at sub-national levels for planning, budgeting and priority setting.

There is mounting pressure on governments and ministries of health to demonstrate value for money as they strive to make the best use of their limited resources. They are faced with competing demands and objectives supported by often powerful interest groups. The domestic stakeholders outside of health are often critical that health is a consumer of resources and does not adequately contribute to the strengthening of the economic development in the country. International partners are increasingly having to demonstrate that their investment in developing countries provides value for money. Because of these and other pressures, policy planning and budgeting efforts are receiving more attention domestically and internationally.

Appendix A: Zanzibar malaria case study

As an input into the CABRI: Health/Finance Dialogue, Planning, Financing and Managing Health Expenditure, a case study on malaria control and elimination has been prepared in order to identify and demonstrate some of the complex planning and budgeting issues that are faced by ministries of health. The case study addresses the policy question of whether to continue with the control of malaria or to move to a policy of eliminating malaria. The case study tells us that malaria was funded almost entirely by donors in 2009/2010, with the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) accounting for approximately 95% of the funding. In countries where donor funding is significant, planning decisions are taken out of the hands of the domestic government. The malaria programme in Zanzibar falls under the Ministry of Health, but the ministry intervenes very little in the implementation of the programme. There is minimal alignment with other programmes or health system activities. For example, the case study indicates that the Ministry of Health is concerned that the staff of facilities are constantly attending training or are kept too busy with malaria programme activities. This is despite the fact that the MOH has established an external aid co-ordination unit, which is expected to help in avoiding overlaps and duplication of activities. The malaria programme is also planned outside of the budget cycle of the Ministry of Health.

The case study raises a number of questions, among which are:

- Who is accountable for the decision on control or elimination?
- What is the impact of the alternative choices on the other activities in the health care system?
- What role do the many stakeholders have in the decision-making?
- What are the key policy and priority-setting instruments that decision-makers need to use in exercising their choices?
- Are there equity questions that should be incorporated in the policy and planning framework?

The case study incorporates several complex relationships, domestic and international, local and national, that must be addressed by the decision-maker. The need for data and tools to assist in the planning and budgeting processes is demonstrated by the case study.

References/Bibliography

Amonoo-Lartson R, Ebrahim G, Lovel H & Ranken J (1984) *District health care: Challenges for planning, organization and evaluation in developing countries*. London: ELBS/ Macmillan.

Atun R (2004) *What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services?* Health Evidence Network report. Copenhagen: WHO Regional Office for Europe.

Atun R, Bennet S & Duran A (2008) *When do vertical programmes have a place in health systems?* Geneva: World Health Organisation.

AusAID (2005) *The logical framework approach*. Available at: http://www.ausaid.gov.au/ausguide/pdf/ausguideline3.3.pdf [accessed 18 July 2011].

Baltussen R & Niessen L (2006) Priority setting of health interventions: The need for multi-criteria decision analysis. *Cost Effectiveness and Resource Allocation* 4: 14.

Baltussen R, Stolk E, Chisholm D & Aikins M (2006) Towards a multi-criteria approach for priority setting: An application to Ghana. *Health Economics* 15(7): 689–696.

Barry S & Mensah O (2005) Health development planning in the African Region: A status report. *African Health Monitor* January–June. Available at: http://www.who.int/health_financing/documents/afhm-healthecon.pdf [accessed on 15 March 2011].

Baum HS (1988) Planning theory as political practice. *Society* 26(1): 35–42.

Bossert, T. (1998). Analyzing the decentralization of health systems in developing countries: decision space, innovations and performance. *Social Science and Medicine* 47(10): 1 513–27.

CHSRF (Canadian Health Services Research Foundation) (2010) *Better with age: Health systems planning for the aging population – Ottawa*. Available at: http://www.chsrf.ca/PublicationsAndResources/article/11-06-08/345948b7-9dbc-4389-b2be-26f44f651a19.aspx [accessed 12 July 2011].

Cruz O & McPake B (2010) The 'aid contract' and its compensation scheme: A case study of the performance of the Ugandan health sector. *Social Science and Medicine* 71(7): 1 357–1 365.

ECA (Economic Commission for Africa) (2004) *Best practices in the participatory approach to delivery of social services*. Available at: http://www.uneca.org [accessed 15 March 2011].

Edejer TT, Aikins M, Black R, Wolfson L, Hutubessy R & Evans DB (2005) Achieving the millennium development goals for health: Cost effectiveness analysis of strategies for child health in developing countries. *British Medical Journal* 331(7 526): 1 177–1 180.

GFHR (Global Forum for Health Research) (2009) *The 3D combined approach matrix: An improved tool for setting priorities in research for health*. Available at: http://www.globalforumhealth.org [accessed 15 March 2011].

Ghaffar A, Collins T, Matlen S & Olifson S (2009) *The 3D combined approach matrix: An improved tool for setting priorities in research for health*. Geneva: Global Forum for Health Research.

Gibson JL, Martin DK & Singer PA (2002) Priority setting for new technologies in medicine: A trans-disciplinary study. *BMC Health Services Research* 2:1–5.

Green A (1995) The state of health planning in the '90s. *Health Policy and Planning* 10(1): 22–28.

HCU (Health Communication Unit) (2001). *Introduction to health promotion program planning, Version 3.0*. The Centre for Health Promotion, University of Toronto, Canada.

HHA (Harmonization for Health in Africa) (n.d.) Harmonization for health in Africa: An action framework. Available at http://www.who.int/healthsystems/HSS_HIS_HHA_action_framework.pdf [accessed 15 July 2011].

James C, Carrin G, Savedoff W & Hanvoravongchai P (2005) Clarifying efficiency-equity tradeoffs through explicit criteria, with a focus on developing countries. *Health Care Analysis* 13(1): 33–51.

Knippenberg R, Soucat A & Vanlerberghe W (2004) *Concept note. Marginal budgeting for bottlenecks: A tool for performance-based planning of health and nutrition services for achieving millennium development goals*. Washington DC: World Bank.

Kolehmainen-Aitken R-L (2004) Decentralization's impact on the health workforce: Perspectives of managers, workers and national leaders. *Human Resources for Health* 2: 5.

Lee K & Mills A (1982) *Policy making and planning in the health sector*. London: Croom Helm.

Lethbridge J (2004) *Public sector reform and demand for human resources for health (HRH)*. Human Resources for Health 2. Available at: http://www.human-resources-health.com/content/2/1/15 [accessed 22 July 2011].

Logie D, Rowson M & Ndagije F (2008) Rwanda's health system: Some concerns - authors' reply. *The Lancet* 372(9 651): 1 729–1 730.

Matovu G (2006) Capacity building for participatory planning and budgeting in Africa: Initiatives and strategic perspectives. Pan African Conference of Ministers of Local Government held in

Mgomella G (n.d.) African Population & Health Research Centre, March 11–12 Workshop. Available at: www.aphrc.org/insidepage [accessed 15 March 2011].

MLTHC (Ministry of Long-term Health Care, Ontario) (2006) *The health planner's toolkit: Health system intelligence project*. Available at: http://www.health.gov.on.ca/transformation/providers/information/im_resources.html#health [accessed 15 March 2011].

MOH (Ministry of Health) Republic of Kenya (2005) *Reversing the trends: The second national health sector strategic plan of Kenya, NHSSPII 2005–2010*. Nairobi: MOH.

MOH Uganda (n.d.) *Health Sector Strategic Plan III 2010/11–2014/15*. Available at: http://www.health.go.ug/docs/HSSP_III_2010.pdf [accessed 19 July 2011].

MOH Republic of Zambia (2005) *National health strategic plan 2006–2010*. Available at: http://www.moh.gov.zm/?q=content/national-health-strategic-plan-2006-2010 [accessed 19 July 2011].

Mshana S, Shemilu H, Ndawi B, Momburi R, Olsen OE, Byskov J, Martin DK (2007) *What do district health planners in Tanzania think about improving priority setting using 'accountability for reasonableness'?* BMC Health Services Research 7: 180.

Musgrove P (1999) Public spending on health care: How are different criteria related? *Health Policy* 47(3): 207–223.

Ngulube J, Mdhluli L & Gondwe K (2005) *Planning and budgeting for primary care in Zambia: A policy analysis*. The Centre for Health Science & Social Research (CHESSORE), Zambia EQUINET Discussion Paper 29, October.

Noorani HZ, Husereau DR, Boudreau R & Skidmore B (2007) Priority setting for health technology assessments: A systematic review of current practical approaches. *International Journal of Technology Assessment in Health Care* 23(3): 310–315.

Odaga J & Lochoro P (2006) *Budget ceilings and health in Uganda*. Caritas Uganda. Available at: http://www.who.int/rpc/evipnet/uganda_report%20Budget%20ceiling%20and%20health.pdf [accessed 15 March 2011].

OECD (Organisation for Economic Co-operation and Development) (2010a) *Health system priorities when money is tight*. OECD Health Ministerial Meeting, 7–8 October, Paris. Available at: http://www.oecd.org/dataoecd/14/31/46098466.pdf [accessed 12 July 2011].

OECD (2010b) *Health care systems: Getting more value for money*. OECD Economics Department, Policy Notes No 2. Available at: www.oecd.org/dataoecd/21/36/46508904.pdf [accessed 12 July 2011].

Pearson M (2010) *Impact evaluation of the sector-wide approach (SWAp), Malawi: Final report*. DFID, Human Development Resource Centre. Available at: http://www.dfid.gov.uk/Documents/publications1/hdrc/imp-eval-sect-wde-appr-mw.pdf [accessed 15 March 2011].

Pillay Y, McCoy D & Asia B (2001) The district health system in South Africa: Progress made and next steps. Available at: www.doh.gov.za/docs/policy/dhsystem.html [accessed 15 March 2011].

Planning and budgeting (2007) Planning and budgeting: Linking policy, planning and budgeting. A background paper. Third International Roundtable on Managing for Development Results, Hanoi, Vietnam, 5–8 February.

Pollitt C. (2001) Integrating financial management and performance management. *OECD Journal on Budgeting* 1(2): 7–37.

Robinson M & Last D (2009) Technical notes and manuals: A basic model of performance-based budgeting. International Monetary Fund. Available at: http://blog-pfm.imf.org/pfmblog/2009/09/a-new-imf-fiscal-affairs-departments-publication-the-technical-notes-and-manuals.html [accessed 18 July 2011].

Rudan I, Kapiriri L, Tomlinson M, Balliet M, Cohen B & Chopra M (July 2010) Evidence-based priority setting for health care and research: Tools to support policy in maternal, neonatal, and child health in Africa. *PLoS Medicine* 7(7).

Schick A (1998) *A contemporary approach to public expenditure management*. Washington DC: World Bank Institute, Governance, Regulation and Finance Division.

Smith B (1997) The decentralization of health care in developing countries: Organizational options. *Public Administration and Development* 17: 399–417.

Soucat A, Vanlerberghe W, Diop F, Nguyen S & Knippenberg R (2002) *Marginal budgeting for bottlenecks: A new costing and resource allocation practice to buy health results*. Washington DC: World Bank.

Sundewall J, Johnsson K, Cheelo C, & Tomson G (2010) Stakeholder perceptions of aid coordination implementation in the Zambian health sector. *Health Policy* 95(2/3): 122–128.

Travis P, Egger D, Davies P & Mechbal A (2002). *Towards better stewardship: Concepts and critical issues*. Geneva: World Health Organisation.

Tuba M, Sandoy IF, Bloch P & Byskov J (2010) Fairness and legitimacy of decisions during delivery of malaria services and ITN interventions in Zambia. *Malaria Journal* 9(1): 309.

UNAIDS (Joint United Nations Programme on HIV/AIDS) (2010) *Technical guidance note: Addressing value for money in round 10 proposals for the Global Fund to fight HIV/AIDS Malaria and TB*. Available at: http://data.unaids.org/pub/BaseDocument/2010/20100618_unaids_vfm_guidancenote_en.pdf [accessed 15 March 2011].

UNDP (United Nations Development Programme) (2009) *Handbook on planning, monitoring and evaluating for development results*. Available at: http://www.undp.org/evaluation/handbook/toc.html [accessed 15 March 2011].

UNICEF (United Nations Children's Fund) (2003) *Understanding results-based programme planning and management: Tools to reinforce good programming practice*. Evaluation Office and Division of Policy and Planning. Available at: http://www.unicef.org/evaluation/files/RBM_Guide_20September2003.pdf [accessed 18 July 2011].

UNICEF (2009) Evidence-based strategic planning approach (ESP). Eastern and Southern Africa Regional Office Expanded Health Network Meeting, Summary Report.

Vaillancourt D (2009. *Do health sector-wide approaches achieve results? Emerging evidence from six countries*. IEG Working Paper 2009/4. Washington DC: World Bank.

Vitsha X (n.d.) Promoting accountability in the budget cycle: The experiences of the public service accountability monitor in South Africa. Available at: www.psam.org.za [accessed 15March 2011].

WHO (World Health Organisation) (1998) First joint session of South-East Asia advisory committee on health research and directors of medical research councils or analogous bodies and concerned research foci in the relevant ministries. Available at: http://www.searo.who.int/LinkFiles/Technical_Documents_23-research_information_for_supporting_health_planning,_se%E2%80%A6.pdf [accessed 15 March 2011].

WHO (2008) *Framework and country standards for country health information systems*. Geneva: Health Metrics Network/WHO.

World Bank (1993) *World development report 1993: Investing in health*. New York: Oxford University Press.

World Bank (1999/2000) *Decentralization: Rethinking government*. Washington DC: World Bank.

Ziria N (n.d.) Local revenue generation: Ugandan experience. Allied Management Consultants Ltd. Available at: http://www.ansa-africa.net/uploads/documents/ld/ANSA_conference_200805/Uganda_Revenue_Generation_Ziria_May2008.pdf [accessed 15 March 2011].

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