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Health budget structure: key implications for immunization financing
Synthesis of key messages for GAVI



CDC

This note summarizes key findings and messages emerging from the health budget structure work developed by WHO Department of Health Systems Governance and Financing.

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Importance of public budgeting for immunization

- Robust public budgeting in the health sector is a necessary condition to enable the effective implementation of health financing reforms.
- As immunization financing transitions from an externally funded model, domestic public funds increasingly play – or should play – a dominant role in financing immunization activities.
- The shift from external to domestic is not only about the level of funding but also getting the domestic engineering of the system right.
- Making immunization sustainable means to embed it more directly in domestic budgeting systems and processes.
- Immunization financing should be viewed as part of the broader health financing environment, and be connected with the different functions of health financing: resource mobilization, pooling, and purchasing.
- An understanding of the core principles of public budgeting by immunization stakeholders is therefore essential.
- While countries differ in the size and scope of the budgeting problems, there is increased acceptance that budget preparation should be a core concern for the sector. More revenue will not help achieve the UHC goals if well-functioning budgeting systems are not in place.
- Specifically, budget formulation i.e. the way budget allocations are presented, organized and classified in budget laws and related documents, has a direct impact on actual spending and ultimately on the performance of the sector.

Change in budget classification systems

- The formulation, classification and organization of a budget are centrally important issues when preparing budget proposals. Budget classifications serve to present and categorize public expenditure in the finance law and thereby “structure” the budget presentation. They provide a normative framework for both policy development and accountability.
- There is a general consensus in the literature, as well as in country experience, that input-based budgets –formulated on the basis of economic classification– have major limitations in general, and for the health sector in particular.
- There are clear limitations with being accountable for health sector results while still allocating and monitoring resources based on detailed inputs at disaggregated levels, such as fuel ambulance, stationery for health facilities, or personnel training sessions.
- In light of these constraints, many countries have modified their regulatory and institutional frameworks to enable a change in the way budgets are formulated, adopted, appropriated and accounted. While countries have

embarked on budgeting reforms for different reasons, in general they have been willing to move the focus away from inputs (“What the money buys?”) towards measurable results (“What can the sector achieve with this money?”)

- A primary objective of this reform – and certainly a critical expectation for the health sector – is in general to foster alignment between resource allocation and public priorities, and to make the budget, and the underlying rules for execution, more responsive to evolving sector goals and needs.
- While overall programme-based budgeting reforms have a long history in high-income countries, most LMICs have faced challenges at both the design (e.g. How to align budgetary programmes with sector priorities?) and implementation phase (e.g. How to align expenditure management with a programmatic logic?).
- Specifically, in the health sector – a common pilot sector for budget reforms–, countries have faced challenges to design relevant budgetary programmes. In the absence of clear guidance, the overall quality of programmes – in terms of coverage, scope, and structure– and of their associated performance monitoring frameworks has varied greatly both between and within countries.
- Partly due to this lack of clear guidance on how to approach the design of budgetary programs, several LMICs use hybrid health budget structures (i.e. inputs, such as health personnel or infrastructure, are presented at the same level as programmes), rendering execution very cumbersome.
- Emerging evidence also suggests that the impact of budget classification reforms has remained relatively limited in LMICs. While reforms have had an impact on budget planning and formulation (i.e. the budget is presented and adopted using a programme logic), in a majority of countries the process has stopped there. Money continues to be appropriated by inputs.

Implications for immunization financing

- From a financing perspective, immunization traditionally includes funding for vaccines, outreach campaigns and routine activities integrated in PHC services.
- In input-based budgets, the purchasing of vaccines has typically been included in “goods and services” in national budgets, while other activities spread out among personnel, goods and services and transfers.
- In program-based budgets, immunization-related expenditure will most likely be re-grouped under one budgetary programme, in general at the level of actions or activities.
- Programs that often incorporate immunization expenditure are: primary health care; prevention and public health; access to health services; child health.

- While the benefits of new formulations are undeniable for the sector as a whole, for immunization, it presents the advantage of consolidating all immunization interventions under a single activity and offers the potential to embedding expenditure in a clear logical framework that links inputs (e.g. vaccines, number of outreach campaigns) to expected results (e.g. vaccine coverage).
- The change from input-to-programme-based budgeting has not, in general, reduced accountability in the sector and/or for immunization, nor level of spending. The reform has rather helped provide more performance information on sector results, when countries define and use appropriately the performance monitoring system that is attached to the introduction of programme budgets.
- The change in budget formulation also offers potential to better align financial monitoring systems in health, and in particular the system of National Health Accounts. For example, with a programme budget, the tracking of schemes and providers is facilitated.

Findings from case studies on budget structure reforms in the health sector

- The transition from input-to programme-based budgets in long and complex (20 years in Burkina Faso, more than 10 years in Armenia), but there are some good practices and pathways in both countries that may be helpful for other countries.
- It requires strengthening technical, institutional and regulatory environments to ensure that the transition leads to actual impact on health spending.
- Immunization has successfully transitioned as part of the reform process, and funding for immunization has not decreased (even increased in Burkina Faso, the year after the budget reform institutionalization).
- The reform gave more visibility to immunization, by consolidating immunization expenditures into one budgetary activity; expenditures are no longer spread across personnel, transfers, goods and services
- If the performance monitoring framework is well-defined, it can support better accountability towards the performance of the sector, including for immunization.

Findings from Armenia

- Until 2006, immunization services (costs related to cold chain and service delivery) were under the Maintenance of hygienic anti-epidemic service. Since 2007, immunization services became reflected in the budget as a separate activity – The National Immunization Program – within Public Health

Program. Procurement of vaccines was funded through external assistance and not reflected in the main budget.

- Currently, vaccine procurement, cold chain maintenance, outreach activities are all included in the main budget under one program and activity line (the National Immunization Program).
- Certain costs related to logistic services of the vaccine procurement and delivery such as transportation are reflected under a separate activity Population Sanitary-Epidemiological Safety and Public Health Services.
- Overall, domestic financing for immunization services has been steadily increasing over the past ten years with the corresponding gradual decline in the role of external support. Currently, 91% of vaccines are funded by the Government of Armenia. Allocations for the National Immunization Program have increased significantly over this period as the Government has taken on a growing share of vaccine financing. Funding for the National Immunization Programme has increased from AMD 160 million in 2007 to AMD 1890.4 million in 2017 (11.8 times).

Findings from Burkina Faso

- Before the budget structure reform, and until 2017, immunization was covered under two main budget lines: purchasing of vaccines (under recurring costs) and outreach campaigns (under transfers).
- Since the institutionalization of a programme budget in 2017, immunization expenditures are part of two budgetary programmes.
- The purchasing of vaccines is included in the “access” budgetary programme (ie budgetary programme n°1), while outreach campaigns are part of the “services” programme (ie budgetary programme N°2).
- As Burkina Faso has just institutionalized a new budgeting approach, the mapping of budget allocations/expenditure for immunization will be a particularly important aspect to monitor in the coming years to ensure good accountability in the use of domestic funds.
- Overall domestic funding for immunization has increased between 2017 and 2018, from FCFA 2.2 b to 3.2 b, as the reform process was institutionalized.
- Immunization has gained in visibility in the budget and is a top priority for the Government; the recently appointed Program Director for managing budgetary program N° 1, where most of the immunization expenditures are allocated, is the former EPI Manager.