Montreux Collaborative

World Health Organization

6th meeting of the WHO Montreux Collaborative on fiscal space, public financial management and health financing

13–17 November, 2023

Meeting report

ACKNOWLEDGEMENTS

This report was developed by Hélène Barroy, Senior Public Finance Expert at World Health Organization (WHO) headquarters, with the support of colleagues from the WHO Department of Health Financing and Economics.

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BACKGROUND

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

The aims of the Montreux Collaborative are to highlight the critical roles of public financing and of PFM systems in supporting progress toward UHC, and to share evidence on practical reforms to make budgets work better for health.

The 6th meeting of the WHO Montreux Collaborative on fiscal space, PFM and health financing was held from 13-17 November 2023, in Montreux and virtually.

The objectives of the 2023 meeting were to:

1) Take stock of lessons from COVID-19 for public financing reform, and identify PFM features conducive to resilient systems;
2) Deepen the understanding of PFM requirements for effective PHC financing;
3) Unpack health budget execution issues and discuss joint solutions between finance and health.

The meeting convened 150 participants on-site and a similar number of attendees attended online each day. Participants included high-level representatives from finance and health ministries appointed by governments from 18 low- and middle-income countries across the six WHO regions, as well as international and regional-level subject matter experts.

The meeting was organized by the WHO Department of Health Financing and Economics in close collaboration with the World Bank, International Monetary Fund (IMF), Organisation for Economic Co-operation and Development (OECD) and UNICEF, as well as Gavi, The Vaccine Alliance (Gavi), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund).

Seventy-five experts from various organizations and countries were mobilized to chair sessions, deliver technical presentations, and/or provide inputs into panel discussions.

Meeting materials are available on the Montreux Collaborative platform: www.pfm4health.net

AGENDA

6th meeting of the WHO Montreux Collaborative on fiscal space, public financial management and health financing

CET	Monday 13/11	Tuesday 14/11	Wednesday 15/11	Thursday 16/11	Friday 17/11
8:00		**Registration**	**Breakfast seminar** – How to assess PFM in health: Introduction to the mapping of PFM tools by WHO, World Bank & UNICEF	**Breakfast seminar** – IMF engagement on health spending issues in surveillance and programme work	
9:00		**Welcome and setting the stage**	**Financing for primary care services** – a framing introduction	**Health budget execution** – from bottlenecks to solutions Technical introduction Country posters Concluding remarks	**Post-event workshop:** Transitioning from external aid – implications for domestic budgets (by invitation only)
9:30		**Keynote** – Lessons and challenges from COVID-19 for future health financing policies			
10:00			**Coffee break**		
10:30		**Coffee break**	**Primary care in budgets** – leveraging program-based budgeting for effective primary care financing		
11:00	**Pre-event workshop:** Financing facilities directly (by invitation only)	**Health emergency funding** – how COVID-19 has changed global and domestic funding for pandemic preparedness and response			
12:00/12:15		**Lunch**	**Lunch**	**Lunch**	
13:00		**Lunch-time seminar** – Health taxes and earmarking: looking at the PFM bottlenecks	**Lunch-time seminar** – How to design a programme-based budget in health? Key tips from country experiences	**Lunch-time seminar** – Information, voice and oversight: promoting open and inclusive PFM systems for health	
		Lunch-time seminar – Corruption: standing in the way of effective PFM in health?	**Lunch-time seminar** – Performance monitoring and accountability: how to streamline financial and non-financial information	**Lunch-time seminar** – Regional focus of key PFM challenges and solutions in health in South-East Asia: findings from a WHO regional review	
14:00		**Epidemic-ready PFM:** what does it take?	**Facility autonomy for providing primary care services** – PFM and purchasing arrangements to go hand-in-hand	**Key conclusions and way forward** – Inputs from participants Partners' roundtable Wrap-up	
15:30		**Coffee break**	**Coffee break**		
16:00 – 17:15		**Cross-sectoral budgeting for emergency preparedness and response, and beyond** – how to enable joint budgeting and spending for health outputs	**What roles for subnational authorities in financing primary care services**	**Coffee break**	

Cocktail from 18:00pm

MAIN EVENT'S SESSIONS

DAY THEMES

Day 1 – **Leveraging lessons from COVID-19 to make public finance for health more agile and sustainable**

Day 2 – **Primary care and public finance – getting funds to the front lines within PFM systems**

Day 3 – **Addressing chronic challenges for budget execution in health**

HIGH-LEVEL TAKEAWAYS

- Making public financial management (PFM) more resilient implies expanding budget allocation flexibilities, streamlining budget spending protocols, and providing greater discretion to providers, while enabling better accountability for outputs through robust financial information systems.
- COVID-19 has underlined the need for cross-sectoral actions, as well as the challenges associated with engaging in budgetary and accountability mechanisms which bridge health and non-health sectors.
- Programme-based budgeting can enable prioritization of budget resources toward primary care, but its full potential has yet to be realized due to design issues and the maintenance of input-based control.
- Effective primary health care financing requires increased autonomy for service providers, including the ability to retain generated funds, influence budgeting, and have financial flexibility to manage operating costs.
- Health budget execution in low-income countries is poor and has deteriorated since 2010. Countries need to unpack PFM bottlenecks by budget-cycle stage and by actor, to identify joint solutions.

DAY 1

14 November 2023

14 NOVEMBER

Introductory session
Chair: Matthew Jowett

Welcome remarks (Assistant Director General, Bruce Aylward, WHO)

WHO ADG for Universal Health Coverage, Lifelong Course, Bruce Aylward highlighted the unique opportunity that the Montreux Collaborative represents for high-level dialogue between health and finance authorities to make budgets work better for universal health coverage (UHC). With countries at the chronological midpoint of implementation toward the Sustainable Development Goals, public funds remain essential to ensure financial protection against health risks and access to quality services. The ADG underlined the high priority of this agenda for WHO – "it is a fundamental priority in the upcoming WHO Global Programme of Work," and beyond. He pressed countries and partners to enhance partnerships on this agenda. "Given we are at the midpoint of SDGs, it is time to deepen this partnership to accelerate PFM country reform implementation in health and make this agenda even more central and visible to the UHC processes and goals."

Overview of the agenda (Hélène Barroy, WHO)

Hélène Barroy, lead organizer of the event, reminded the audience about the genesis of the Montreux Collaborative. Initiated in 2014, the Montreux Collaborative has evolved in scope ("from concepts to practicalities") and audience (from discussion between experts to a country-oriented learning approach), while the goal of enabling a common understanding between health and finance of budget related issues has remained. "The focus in Montreux is on budgets, domestic budgets, public spending." The Montreux Collaborative has facilitated the production of joint knowledge between WHO and several partners, including the World Bank, Results for Development (R4D), UNICEF, OECD, IMF, Public Expenditure and Financial Accountability (PEFA), and International Budget Partnership (IBP), over the years. Those resources are now available on the Montreux Collaborative online platform, available at www.pfm4health.net. Barroy presented the architecture of the meeting, developed around three main topical buckets: COVID-19 and PFM, PHC and public finance and budget execution, in addition to breakfast and lunch-time sessions.

Keynote address – Lessons and challenges from COVID-19 for future health financing policies (Joe Kutzin)

Joe Kutzin's keynote address focused on lessons from COVID-19 for defining future health financing policies. Kutzin highlighted the threats posed by COVID-19 for UHC, with falling growth rates, rising poverty and inequality, and increased debt-service risks limiting government capacity to pursue health financing reform. Making public spending more effective remains critical to making health systems pro-poor and more resilient. Priorities for health financing reform include promoting non-contributory entitlement funded from government budgets; output-based payment to better align funding with priority populations and services; financial flexibility for providers, to improve budget efficiency and use; and flexible budget structures to enable rapid adjustments. Gradual expansion of coverage should include explicit emphasis on poor and vulnerable populations, possibly including some form of targeting; this can be done through a unified benefit framework and data system, for example.

As one of the initial conveners of the Collaborative, Kutzin also discussed how the Montreux Collaborative's thinking has evolved since its initiation in 2014, moving from concepts to practicalities through purposeful development and dissemination of knowledge on how to make budgets work better for health. Kutzin noted how Montreux has contributed to bringing consensus on the importance of PFM in achieving UHC; provided 'how to' experience to inform the development of agile PFM systems; and fostered the mainstreaming of PFM in health systems/ financing applied research.

14 NOVEMBER

Session 1 | Health emergency funding – how COVID-19 has changed global and domestic funding for pandemic preparedness and response

Session overview

Chair	Peter Cowley, WHO	
Speakers	Priya Basu, World Bank Franck Berthe, World Bank	Overview of World Bank-hosted Pandemic Fund mechanism and key achievements
	Andrea Gamba, IMF	Introduction to IMF Resilience and Sustainability Trust (RST)
Panelists	Sanjeev Gupta, Center for Global Development	
	Boiama Kamara, Africa Centres for Disease Control and Prevention	
	Agnès Soucat, Agence Française de Développement	

Key messages

- The World Bank-hosted Pandemic Fund is a dedicated stream of additional, long-term grant funding for critical pandemic pandemic preparedness and response (PPR) functions in International Development Association (IDA) and International Bank for Reconstruction and Development (IBRD) countries.
- The Pandemic Fund has approved 19 grants for 37 countries for a total of US$ 338 million as of the end of 2023.
- The IMF RST has received a US$ 650 billion allocation, through which 143 eligible countries can channel Special Drawing Rights (SDRs) to contribute to longer-term prospective balance-of-payments stability (with a 10½-year grace period and 20-year maturity for RST loans).
- 11 approved RST (only climate-related, as of the end of 2023); IMF welcomes collaboration with World Bank and WHO to define associated reform packages for pandemic preparedness RST agreements.
- Panelists highlighted risks posed by the post-COVID-19 macro-fiscal environment for sustaining or increasing public spending on health, and underlined the critical role of the Pandemic Fund and RST instruments to ensure funding for priority common goods and accelerate preparedness for future shocks.

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Session 2 | Epidemic-ready PFM: what does it take?

Session overview

Chair	Joe Kutzin	
Speakers	Hélène Barroy (WHO) and Chris James (OECD)	PFM and health emergency response: lessons learned from COVID-19
Panelists	Mark Blecher, National Treasury, South Africa Ibu Becky, Ministry of Health, Indonesia Danielle Serebro, Collaborative Africa Budget Reform Initiative (CABRI)/Overseas Development Institute (ODI) Srini Gurazada, PEFA	

Key messages

- PFM matters for health emergency response – domestic public funding was primary source of funding for the health response to COVID-19
- Starting with budget allocation, programme-based budgets generally facilitated the rapid re-prioritization of approved budgets toward the health emergency response (as in South Africa), more effectively than through more traditional formulation by line items.
- Additional emergency funding was often difficult to activate, poorly regulated, generally associated with improvised spending procedures, and of limited transparency.
- In some contexts (such as Argentina), robust inter-governmental fiscal transfers facilitated allocation of COVID-19 resources to the frontline providers.
- Streamlined spending procedures accelerated health expenditure for COVID-19 (including, in the Philippines, advance payments to service providers); increased financial flexibility for providers was key in aligning resources with service needs (as in Indonesia).
- Where possible, adjustments in financial management information systems (FMIS) made it possible to track COVID-19 health expenditure (as in Burkina Faso). Financial accountability has been critical in a context of rapid implementation of emergency measures and increased flexibility in spending.
- Some 40+ countries opted for off-budget mechanisms, which often led to poor financial management and accountability. This experience encouraged countries to focus on strengthening regular PFM systems to ensure better preparedness for future shocks.
- COVID-19 demonstrated the benefits of more resilient PFM, consisting of expanding flexibility in budget allocation, streamlining budget spending protocols, and offering providers greater discretion, while increasing accountability for outputs through the development of robust financial information systems.

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Session 3 | Cross-sectoral budgeting for emergency preparedness and response, and beyond – how to enable joint budgeting and spending for health outputs

Session overview

Chair	Susan Sparkes, WHO	
Speakers	Stephanie Allan, Oxford Policy Management Jennifer Asman, UNICEF	Cross-sectoral budgeting mechanisms and examples
Panelists	Tika Ram Bhusal (Ministry of Finance, Nepal) Tamba Isaac (Ministry of Economy, Cameroon) Kwakye Kontor (Ministry of Health, Ghana)	

Key messages

- Pandemic preparedness, nutrition, PHC, and climate change are among the key areas requiring cross-sectoral interventions. However, PFM systems generally reflect sectorally-defined structures and are not well equipped to tackle complex cross-sectoral actions.
- COVID-19 underlined the need for cross-sectoral actions, and the challenges associated with implementing budgetary and accountability mechanisms across health and non-health sectors (as observed in Ghana and Nepal).
- Successful cross-sectoral coordination and action requires consideration of political economy dynamics. Governance of cross-sectoral interventions often requires high-level engagement (e.g., executive-level leadership), and strong coordination between central and subnational levels.
- Programme-based budgeting (PBB) can enable cross-sectoral budgeting, but support systems for accountability to ensure effective reporting and transparency are often lacking (as in Cameroon).
- A dual-budget tagging system (as introduced in Cameroon and Ethiopia for disasters and climate change), with its lower transaction costs, may be a suitable alternative to complex joint budgeting.
- Cross-sectoral priorities in the budgeting process can be addressed by identifying and allocating budgetary resources for specific areas that require cross-sectoral action (as introduced in the Philippines with Programme Convergence Budgeting).
- There is a need to explore the emerging practice of specific financial arrangements for cross-sectoral action, and to leverage progress achieved during the COVID-19 response.

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DAY 2

15 November 2023

15 NOVEMBER

Session 1 | Financing for primary care services – a framing introduction

Session overview

Chair	Matt Jowett, WHO
Speakers	Kara Hanson, London School of Hygiene & Tropical Medicine (LSHTM)

Key messages

- The Lancet Global Health Commission on financing primary health care, and the WHO primer on implementation of the PHC approach (chapter on health financing) highlight key issues of and define attributes for people-centred financing for PHC. The presentation focused on the PHC approach's service component (excluding multi-sectoral and community engagement).
- Systemic challenges affect PHC financing in most low- and middle-income countries (LMICs): funding is insufficient (US$ 3 per capita in low-income countries in 2018); systemic barriers prevent resources from reaching the frontlines; and funding is fragmented (with spending that is predominantly out-of-pocket), inflexible, and inefficient.
- New financing solutions, such as voucher systems, "mutuelles" (mutual health insurance), and performance-based financing schemes, may exacerbate pre-existing financial fragmentation.
- Higher government spending on PHC is often associated with increased coverage of PHC services.
- PBB can help make PHC more visible and better prioritized within allocated budgets.
- Assuring efficiency in PHC spending often requires refining payment methods for providers – blended payment with capitation at the core can be an appropriate way to put people at the centre, while allowing adjustments for the specific services delivered (as in Estonia).
- Political and social considerations are as important as technical elements in the design and implementation of efficient and equitable financing for PHC.

15 NOVEMBER

Session 2 | Primary care in budgets – leveraging programme-based budgeting for effective primary care financing

Session overview

Chair	Kara Hanson, LSHTM	
Speakers	Hélène Barroy (WHO), Linnea Mills and Triin Habicht (WHO Regional Office for Europe)	Mapping primary care services in PBB
Panelists	Benjamin Tsofa (Kenya Medical Research Institute [KEMRI] Wellcome Trust Research Programme , Kenya) Tetiana Semeniuk (National Health Service of Ukraine) Loraine Hawkins Cheryl Cashin (R4D)	

Key messages

- Public funding is a leading source of revenues to finance primary care in LMICs. However, rigid PFM rules mean that budget allocations do not always prioritize primary care. Specifically, budget formulation rules do not permit prioritization of certain service areas. With line-item budgets it is not possible to prioritize or make primary care visible in budgets.

- Most countries are transitioning to PBB, which has the potential to support better alignment of budget resources with primary care goals. However, little is known about whether and how primary care has been included in PBB structures, and whether this inclusion has provided greater flexibility and/or accountability in primary care spending.

- An ongoing WHO study shows that countries have included primary care in PBB structures via four main approaches: as a top-level programme, as a sub-programme, as a budget transfer to a separate purchaser, or through distribution of provisions across multiple programme lines. These approaches differ in the extent to which they prioritize primary care. Distributing budget provisions for primary care across multiple budget lines does not advance visibility or prioritization.

- Even when primary care is visible in PBB, political will remains important for ensuring prioritization in budget allocations – primary care programmes that are under-funded will be less effective.

- Consistent structures at sub-national levels are required to ensure consistent prioritization and tracking of primary care spending (as noted by panelist from KEMRI).

- Budget formulation should be aligned with payment modalities for providers (as observed in Burkina Faso), and major inputs (e.g., drugs, equipment, and to the extent possible, staff) are to be integrated into primary care budgetary envelopes (as in South Africa and Ukraine) to ensure efficient primary care spending.

- PBB offers a framework to consolidate financial and non-financial performance, but this potential has not been fully realized for accountability in primary care. Panelists noted that visibility and accountability do not mean more money for primary care. Primary care will grow more slowly than other parts of the health budget, if there is a lack of data and analysis showing that primary care is delivering services as promised.

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Session 3 | Facility autonomy for providing primary care services – PFM and purchasing arrangements to go hand-in-hand

Session overview

Chair	Ogo Chukwujewu (WHO Regional Office for Africa)	
Speakers	Sophie Witter (Queen Margaret University) and Inke Mathauer (WHO)	Defining provider autonomy and reviewing recent country reforms
Panelists	Purev Oyuntsetseg (Ministry of Health, Mongolia) Mai Farid (Ministry of Finance, Egypt) Martin Sabignoso Sheila O›Dougherty	

Key messages

- Provider autonomy refers to the ability of health providers to exert influence and control over the delivery of services. Provider autonomy represents a transfer of decision-making rights to facility managers. As observed in Mongolia, primary care providers can now decide on how to spend to achieve their goals and Can shift funds across line-items.
- Financial autonomy is not a dichotomy but rather a spectrum – the focus is on the level of autonomy within the various decision-rights and why and how changes happen in either direction.
- Provider autonomy is an important element in reforms at the intersection of health purchasing and PFM, rather than a final objective per se.
- Facility autonomy consists of the ability to do each of the following: 1) retain at least some funds generated; 2) influence budgets that apply to their level; 3) conduct virements across budget lines within reasonable limits; 4) address, at minimum, routine operational costs without prohibitive approvals and accounting.
- The risks of increasing autonomy are less in terms of fiduciary risks (primary care centres usually handle small amounts of money), than in terms of increased workload, inefficiencies, and missed opportunities.
- Although accountability is important, country data suggest that existing measures to control financial risks may be reducing autonomy. The question of commensurate accountability arrangements in line with the level of provider autonomy needs more attention.
- Support is needed to be able to move toward greater facility autonomy requires support (as observed in Argentina, this means providing primary care facilities with the means to be 'autonomous').

15 NOVEMBER

Session 4 | What roles for subnational authorities in financing primary care services

Session overview

Chair	Bill Savedoff
Panelists	Nirmala Ravishankar (ThinkWell)
	Edwine Barasa (KEMRI-Wellcome Trust, Kenya)
	Alia Luz (WHO Regional Office for the Western Pacific)
	Joe Kutzin

Key messages

- Subnational governments play a critical role as purchasers in financing primary care services. Subnational governments mostly receive funds from national level, but they control the budget for primary care costs.
- The prevalent view that conditional grants are a good way for national governments to influence subnational allocations for health needs to be revisited, given this meeting's discussions about the risks of earmarking. Budget flexibilities and PBB at subnational level, and the planning, management, and spending of budgets at that level, should be explored further.
- Subnational governments are by and large using input-based budgeting to allocate their PHC budget for core costs like salaries, infrastructure, and commodities. More discussion is needed about how these purchasing decisions can become more strategic – linked to information about population needs and provider behaviour.
- Subnational governments should be empowered to assure coherence across functions, and provided funding allocations that are sufficient. Subnational governments with the ability to allocate resources tend to prioritize PHC.
- Empowering subnational levels can generate more fragmentation, a risk that needs to be mitigated. It is important to assure the right mix of what is standardized/centralized and what is discretionary. Clarifying roles and responsibilities for actors at central, subnational, and facility levels is critical.
- Subnational-level authorities define the delivery strategy for 'territorial health planning,' area critical role.
- Ongoing discussions about facility autonomy must factor in the purchasing function of subnational governments, which often control which monies PHC facilities receive and how those monies may be used. In Kenya, subnational governments have an incentive to mandate that facility revenue should flow to county level – in part because the financial management system and the national budget oversight process are not configured to account for facility revenue as appropriation in aid. It is important to structure arrangements so that incentives align.

DAY 3

16 November 2023

16 NOVEMBER

Session 1 | Health budget execution – from bottlenecks to solutions

1.1 Technical introduction

Chair	Cheryl Cashin, R4D	
Speakers	Hélène Barroy (WHO), Moritz Piatti (World Bank), Justine Hsu (WHO) and Amna Silim	Health budget execution – from bottlenecks to solutions

Key messages

- Despite its critical role in supporting progress toward UHC, health budget execution has received little attention in global and national health financing agendas, given the traditional focus on resource mobilization and allocation.

- Against this background, WHO and World Bank teams decided in 2019 to join forces to increase the visibility of challenges in health budget execution ; enable a common understanding between finance and health authorities; and support the identification of actionable solutions. This joint effort included reviewing data from 115 LMICs, developing case studies, and mapping challenges and solutions.

- The data review's first observation was that health budget execution was generally poor in low-income countries and had deteriorated since 2010, with an annual loss of US$ 4 per capita, accompanied by high year-on-year volatility.

- Across income levels, health budgets were less well-executed than general government and other sectors (e.g., education), with significant underspending of the goods and services budget in health, negatively impacting service delivery.

- To enable a common understanding of the problem between health and finance, countries need to unpack challenges systematically by budget-cycle stage and by actor. The WHO and World Bank offer a framework to guide this process.

- In line with this framing approach, governments can identify solutions across budget-stages and actors. For example, to set appropriate and effective expenditure controls, the ministry of finance and the ministry of health should streamline their control policies and ensure they are context-appropriate; and local authorities should review existing policies with a view to increasing the flexibility and discretion offered to providers.

1.2 Posters session

Country and development partners involved in health budget execution work presented 16 country and thematic posters and discussed these with fellow participants in a peer-to-peer learning exchange format. The country posters used the WHO and World Bank framework mentioned above, mapping key issues and solutions for addressing health budget challenges by budget-cycle stage and by actor. The poster session generated lively discussions between presenters and fellow participants, and fertilized cross-country learning to help address systemic health budget execution challenges. PDF versions of the posters are available on the Montreux Collaborative platform.

Country/theme	Presenter
Cameroon	WHO and country delegation
Ethiopia	World Bank
Kenya	KEMRI-Wellcome Trust and country delegation
Kyrgyzstan	WHO and country delegation
Lao People's Democratic Republic	World Bank
Nepal	OPM and country delegation
Nigeria	R4D
Pakistan	World Bank
Peru	Abt Associates and country delegation
Solomon Islands	World Bank
Timor-Leste	WHO and country delegation
Uganda	WHO
Ukraine	WHO and country delegation
Budget execution in Global Fund programmes	The Global Fund
PFM capacity building in Gavi	Gavi
Role of civil society organizations (CSOs) in budget execution	IBP

Example of posters: Ukraine

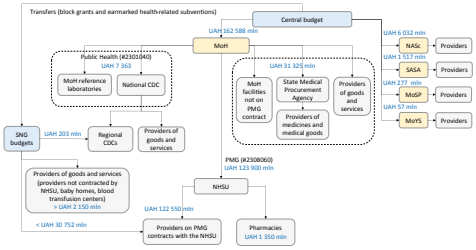
Ukraine: Budget Execution

World Health Organization

Health financing context

- The majority of government spending on health (60.9% in 2021) is dedicated to financing the Program of Medical Guarantees (PMG), the guaranteed benefit package.
- The PMG was introduced in 2018-2020 as the key innovation of health financing reform. The newly introduced PMG covers primary health care (PHC), outpatient and inpatient specialized care, emergency medical care, some outpatient prescription medicines, rehabilitation and palliative care.
- The PMG is funded by the central government through the MoH and administered by the National Health Service of Ukraine (NHSU), the single purchaser of health services which is an executive agency of the Government, overseen by the MoH.
- Sub-national governments own most health facilities and are responsible to cover all utility costs and may also provide supplemental financing for current and capital expenditure.
- Households also make out-of-pocket payments equivalent to roughly 1/2 of health financing, the largest category of which is pharmaceuticals.

Figure 1: Flow of Funds in Ukraine's Health System



Budget execution rates

- Overall health budget execution rates tend to be less than 5 per cent lower than adjusted annual plans in all years except post-crisis 2015 and 2020
- The central government adjusted plans tended to be relatively more accurate than sub-national budgets in 2016-2019 (with health budget execution rates at the central level 2-3 per cent lower than adjusted plans, while sub-national government spending was 3-6 per cent lower).
- Within the PMG itself, execution rates across types of services are more variable, reflecting the more challenging task of forecasting expenditure based on new payment methods and the new degree of flexibility of the NHSU to adjust plans within the integrated PMG budget.

Budget execution rates	2015	2016	2017	2018	2019	2020	2021
Consolidated budget	-6%	-4%	-5%	-4%	-3%	-6%	-3%
Central budget	-10%	-3%	-3%	-3%	-2%	-6%	-3%
SNG budget	-5%	-5%	-6%	-4%	-3%	-5%	-5%

Factors that impact budget execution

Factor	Generic PFM factors	Health sector factors
Credibility of the budget	Budget allocations to the MoH and PMG are below the level required to meet current policy commitments, if these were costed realistically.	Challenges in forecasting components of the PMG (e.g. Affordable Medicines Programme). Methodology for service costing and pricing is not sufficiently transparent. Costing does not cover expenses on PMG services that patient pay out of pocket (though most PMG services are theoretically free to patients).
Budget structure and rules for budget allocation	PMG budget appropriated by the legislature is a single programme line allocation. Disaggregation of the health budget by programme is provided in the budget for information. Re-allocation across programmes is possible via executive decisions however, this creates variability in re-allocations and execution rates.	New legal status of the providers provides more autonomy, moving away from the rigid input-based spending norms (such as staff numbers per bed and salary schedules) and controls to output-based contracts and ex-post reporting and monitoring of inputs. There is a lack of methodology for allocating PMG budgets across regions & services in line with patient needs. Allocations for many services are driven by supply, not need.
Regularity and predictability of funding flows	Precedents of reducing PMG budgets via executive CabMin decisions to cover unexpected cash needs of the wider Government create a risk of unpredictability.	Facilities have their own bank account which has led to some cash management issues, e.g. healthcare providers deposit revenues in commercial banks and hold balances to earn interest.
Appropriateness and effective-ness of spending protocols	Highly centralized and control oriented PFM system with a number of stages, approvals and rules. This prioritises discipline often at the cost of efficiency and result orientation. The intricate process of Treasury cross-checks to ensure that commitments remain within appropriations, expenditure ceilings, and available budget funds, makes the controls highly effective.	Annual processes for approving the PMG are complex, onerous and linked to the budget process, leading to very short time frames for contracting providers and provider uncertainty about future revenues until the beginning of the budget year or later. Facilities have almost complete flexibility in managing their budgets from NHSU revenues and revenues from paid services in theory, though sub-national government owners influence or limit changes to resource allocation in practice.
Relevance and quality of monitoring and accountability systems	Programme budget indicators are formulated and reported but are not yet as results-oriented as would be desirable. Programme indicators are not yet used actively to drive accountability or analysed and used to inform future budget allocation. Audits do not completely understand the health reforms and lack technical capacity. Audits have also become increasingly punitive. This has demotivated providers to exercise their new managerial flexibility and increase spending efficiency.	There is little facility transparency and accountability since provider autonomy and implementation of PMG. Payments to autonomous providers are accounted as "transfers to organizations" without the breakdown by economic classification lines. There is no publicly available information on actual amounts compare to the planned spending at the facility level. Facilities report expenditure quarterly to NHSU by inputs, but these reports are not audited and may differ from audited accounts available to sub-national governments.

Tested solutions

Public financial management and public administration reform occurred before health financing reform, creating a platform of systems and capacities that facilitated implementation of health financing reform. These included an automated Treasury system, programme budgeting, and performance agreements with directors of executive agencies such as NHSU.

Health financing reform - which included the shift to autonomous public providers, the PMG benefit package and output-oriented payment of providers - provided more flexibility and autonomy. Regulations that controlled health facility inputs were abolished. Previously, providers had almost no managerial flexibility to reallocate these expenditures in the process of budget execution. Amending the budgets was a bulky exercise requiring a complete repetition of the drafting and approval process. Overall, the speed of financial operations at the facility level following the health financing reform has increased rapidly.

Health care is one of only two areas where key spending units are allowed, in specified cases, to assume expenditure commitments stretching beyond one year (the second area being long-term contracts on energy-saving investment). Such commitments are allowed for up to three years on centralized medicines and medical goods purchases.

Re-allocations within the PMG are linked to adjustments in the forecast utilization of services, especially within the Affordable Medicines Program (AMP). For instance, the allocation for the AMP was reduced because of lower forecast utilization rather than deprioritization of this program.

(For full published report, see: https://www.who.int/ukraine/publications/i/item/WHO-EURO-2023-7195-46961-68018)

1.3 High-level remarks

Working together between health and finance to address health budget execution challenges

Chair	**Cheryl Cashin, R4D**
Panelists	Tajikistan – H.E First Deputy Minister of Health, Ghafur Muhsinzoda and H.E Deputy Minister of Finance, Sarvar Qurboniyon Nigeria - Ben Akabueze, Director General, Budget Office, Federal Ministry of Finance Nepal - Rajesh Panthi, Undersecretary, Policy Planning and Monitoring Division, Ministry of Health and Population Global - Midori de Habich, Technical Director, United States Agency for international Development (USAID) Local Health System Sustainability Project (LHSS) on budget execution and former Minister of Health, Peru

The panelists offered practical examples of effective collaboration between health and finance authorities, showing recognition of 'shared responsibility' to address the problem of low health budget execution. Examples included good practices in realistic health budget planning (Nepal), communicating budget ceilings to the health sector (Tajikistan), engaging early in budget negotiations from the health side (Nigeria and Peru), jointly identifying rigidities that specifically affect health spending (Peru), and improving reporting systems in health and more broadly (Nepal). There was agreement among panelists that good health budget execution concerns not only the level of spending but also about the 'how' (e.g., regularity of fund releases) and the 'what' (e.g., prioritization of spending).

16 NOVEMBER

Concluding session
Chair: Matthew Jowett, WHO

The concluding session featured feedback from participants on key takeaways from the meeting and how to inform countries' next steps in implementation of PFM reforms. Participants also shared insights on possible new topic-areas, including accountability, to be explored in future events. Several country representatives mentioned the intent to develop country roadmaps to facilitate and sustain dialogue between health and finance, in line with the Montreux Collaborative agenda.

Key development partners of the Montreux Collaborative shared views on how to strengthen collaboration and coordination on this agenda both globally and in countries. WHO, the World Bank, and UNICEF expressed their intent to strengthen collaboration to ensure better coordination in support to countries and consistency in overall messaging. The World Bank highlighted that "the time for PFM is now – it is critical to ensure every cent is put towards well-spent priorities that are well-accounted for." The Global Fund and Gavi, having initiated processes to channel resources through domestic PFM systems, emphasized that "PFM is the way"; they are willing to collaborate with the Montreux Collaborative partners to strengthen PFM systems. The OECD offered complementary support through the Senior Budget Officials network that gathers good practice from finance and health collaboration in OECD countries.

WHO ADG Bruce Aylward provided concluding remarks for the event. He reiterated the importance and urgency of this agenda for advancing UHC. The current constrained macro-fiscal environment requires countries to make their domestic public finance systems more efficient, more agile, and more responsive than ever. He welcomed the strategic alliance that is being developed between WHO and other partners to accelerate support to countries' implementation of PFM reforms. The ADG invited country representatives to bring the "Montreux spirit" with them to foster and sustain dialogue between health and finance dialogue back home.

Next steps of the Montreux Collaborative

- The next meeting of the Montreux Collaborative on fiscal space, public financial management and health financing will take place in November 2025.
- The Montreux Collaborative will organize virtual and/or face-to-face events, with a regional and/or topic focus, in between the two main face-to-face events.
- The Montreux Collaborative online platform www.pfm4health.net will include all resource materials from the 2023 meeting and will feature a blog page. Submissions to the blog can be made to the Montreux organizers who will enable a review and publication process.
- Production of knowledge in 2024-25 will be aligned with the needs and interests expressed at the 2023 meeting; main findings will be presented and discussed at the 2025 event.
- Topics that have gathered strong interest among participants, and for which additional work is needed, include accountability, cross-sectoral budgeting, political economy of PFM reforms, facility autonomy, procedural fairness in PFM, and donor alignment with PFM systems.
- WHO, the World Bank, and UNICEF will strengthen their collaboration on this agenda with a triple focus: i) better coordinated global and country support; ii) harmonized guidance to inform implementation of PFM reforms; and iii) joint events and capacity building.

World Health Organization

BREAKFAST AND LUNCH-TIME SEMINARS

A series of breakfast and lunch-time seminars was organized throughout the Montreux event to set the agenda for emerging topics on PFM in the health sector, present preliminary evidence, and gather input from participants in a discussion format to identify needs and next steps for further exploration.

Dates	Topics	Contributors
14 November	Health taxes and earmarking: looking at the PFM bottlenecks	Cheryl Cashin (R4D), Danielle Bloom (World Bank), Rowena Lora (Department of Finance, the Philippines), Kwakye Kontor (Ministry of Health, Ghana), Mr. Sudarto (Ministry of Finance, Indonesia), Susan Sparkes (WHO)
	Corruption: standing in the way of effective PFM in health?	Danielle Serebro (ODI/CABRI), Dave Clarke (WHO), Sanjeev Gupta (CGD), Sheila O'Dougherty, Jennifer Asman (UNICEF)
15 November	How to assess PFM in health: Introduction to the mapping of PFM tools by WHO, World Bank, and UNICEF	Hélène Barroy (WHO), Justine Hsu (WHO), Moritz Piatti (World Bank), Jennifer Asman (UNICEF), Mathew Jowett (WHO), Julia Dhimitri (ex PEFA)
	How to design a programme-based budget in health? Key tips from country experiences	Chris James (OECD), Helene Barroy (WHO), Christabell Abewe (WHO Uganda), Miriam Musyoki (National Treasury, Kenya), Iliich Ascarza Lopez (Ministry of Health, Peru), Sophie Witter (Queen Margaret University)
	Performance monitoring and accountability: how to streamline financial and non-financial information	Fahdi Dkhimi (WHO), Peter Berman & Girmaye Dinsa (Harvard T.H. Chan School of Public Health), Sanjeev Gupta (CGD), Mark Blecher (National Treasury, South Africa), Moritz Piatti (World Bank)
16 November	IMF engagement on health spending issues in surveillance and program work	Nick Carroll (IMF)
	Information, voice, and oversight: promoting open and inclusive PFM systems for health	Elina Dale (Norwegian Institute of Public , Ole Forheim (University of Bergen), Mark Blecher (National Treasury, South Africa), Sally Torbert (IBP), Nidda Yusuf (Save the Children), Agnès Couffinhal (World Bank)
	Regional focus of key PFM challenges and solutions in health in South-East Asia: findings from a WHO regional review	Tsolmon Tsilaajav (WHO Regional Office for South-East Asia), Jayendra Sharma, Mr Sudarto, Ministry of Finance for State Expenditures (Staf Ahli Menkeu Bidang Pengeluaran Negara, Indonesia), Rajesh Panthi (Ministry of Health and Population, Nepal), Cheryl Cashin (R4D), Valeria de Oliveira Cruz (WHO Regional Office for South-East Asia)

World Health Organization

PRE- AND POST-WORKSHOPS

PRE-EVENT WORKSHOP: FINANCING FACILITIES DIRECTLY

13 November

A group of 20 experts from WHO, the World Bank Group, Gavi, Abt Associates, R4D, ThinkWell, and ODI/CABRI met to discuss the practicalities of Financing Facilities Directly – an emerging approach to accelerate access to public funding for frontline health service providers while securing service performance and accountability. The workshop, chaired by Sheila O'Dougherty, contributed to advance the thinking on five key aspects to inform in-country implementation of Financing Facilities Directly, with a focus on primary care providers:

- Implementation sequencing;
- Provider autonomy;
- Provider payment;
- Facility financial management;
- Governance, including institutional roles and relationships.

Moving forward, the technical inputs will contribute to support the finalization of a how-to manual on financing facilities directly. The group planned to reconvene before the release of the manual to review its final version.

POST-EVENT WORKSHOP: TRANSITIONING FROM EXTERNAL AID – IMPLICATIONS FOR DOMESTIC BUDGETS

17 November

This half-day session brought together 50 country representatives and development partner representatives (World Bank, Gavi, the Global Fund, the United Kingdom [UK] Foreign, Commonwealth & Development Office [FCDO], the Norwegian Agency for Development Cooperation [Norad], the United States President›s Emergency Plan For AIDS Relief [PEPFAR], USAID, UNICEF, the Global Financing Facility for Women, Children and Adolescents [GFF], the Bill & Melinda Gates Foundation, CGD, European Commission) to delve into the implications for domestic budgets and sustainability of coverage of transitioning from external aid for health. Experiences from Kenya, Timor-Leste, and Uganda were shared and built on key messages from the WHO Health Financing, Alliance for Health Policy and Systems Research, and UHC2030 programme of work on "Transition from external assistance." Specific focus was given to approaches by both domestic governments and donors to support sustainable coverage of interventions and programmes that were previously supported by donors.

In the second part of the session, the discussions broadened to consider how to align external aid for health with domestic budgeting processes, priorities, and best practices. Governmental representatives from Ghana and Nepal, and speakers from the World Bank, the CGD, and the European Commission, highlighted challenges with how external aid for health is currently structured and channelled. Perspectives were offered on how to increase coherence from a PFM perspective, including through budget support-oriented approaches. There was broad consensus among participants to keep this discussion-space open for follow-up, as well as the need for coordinated actions to enable aligned, sustainable, transparent, and country-led approaches to external assistance for health.

This session was organized by Susan Sparkes, WHO.

World Health Organization

LIST OF PARTICIPANTS

A series of breakfast and lunch-time seminars was organized throughout the Montreux event to set the agenda for emerging topics on PFM in the health sector, present preliminary evidence, and gather input from participants in a discussion format to identify needs and next steps for further exploration.

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